7-12-2016

Being in Transition: Accessing the Transition Experience of Bachelor of Science in Nursing Graduates Using a Heideggerian Hermeneutic Approach

Tracy Lynn Poelvoorde

Follow this and additional works at: http://digscholarship.unco.edu/dissertations

Recommended Citation
http://digscholarship.unco.edu/dissertations/348

This Text is brought to you for free and open access by the Student Research at Scholarship & Creative Works @ Digital UNC. It has been accepted for inclusion in Dissertations by an authorized administrator of Scholarship & Creative Works @ Digital UNC. For more information, please contact Jane.Monson@unco.edu.
UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

BEING IN TRANSITION: ACCESSING THE TRANSITION EXPERIENCE OF BACHELOR OF SCIENCE IN NURSING GRADUATES USING A HEIDEGGERIAN HERMENEUTIC APPROACH

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

Tracy L. Poelvoorde

College of Natural and Health Sciences
School of Nursing
Nursing Education

July 2016
This Dissertation by: Tracy L. Poelvoorde

Entitled: Being in Transition: Accessing the Transition Experience of Bachelor of Science in Nursing Graduates Using a Heideggerian Hermeneutic Approach

has been approved as meeting the requirements for the Degree of Doctor of Philosophy in College of Natural and Health Sciences in School of Nursing, Program of Nursing Education

Accepted by the Doctoral Committee

____________________________
Melissa L. M. Henry, Ph.D., FNP, RN, Research Advisor

____________________________
Lory Clukey, Ph.D., Psy.D., CNS, RN, Committee Member

____________________________
Vicki Wilson, Ph.D., MS, RN, Committee Member

____________________________
Kathryn F. Cochran, Ph.D., Faculty Representative

Date of Dissertation Defense ______________________________

Accepted by the Graduate School

____________________________
Linda L. Black, Ed.D.
Associate Provost and Dean
Graduate School and International Admissions
ABSTRACT


This study used Heideggerian hermeneutic phenomenology to access the transition experience of baccalaureate prepared nurses with 12-18 months of practice experience. The transition theory of Chick and Meleis (2010) was used to frame existing knowledge relative to the transition experience. The philosophy of Martin Heidegger (1927/1962) provided a philosophical framework for this study and was used to guide study methodology. The following overarching research question guided this study:

Q1 What is the experience of moving/transitioning from being a student in a Bachelor of Science in Nursing program to being a practicing professional registered nurse?

The Diekelmann, Allen, and Tanner (1989) seven-step process was used to interpret and analyze data. Units of meaning from each story of new nurse transition were identified. Significant statements were offered to substantiate the identification of each unit of meaning. Five relational themes were identified by considering the data within and across all stories of transition and included: My work provides me with meaning; You Must Look Outside Yourself to Make an Impact; I Need a Supportive Environment to Thrive; Trust Is a Two-Way Street; and If You Teach Me, I Will Grow. Through this process, three constitutive patterns describing the transition experience of
new nurses in transition emerged: Being a Nurse is Impactful; When Nurses Support Nurses, the Patient is at the Center of Care; and Nurse-Doctor Interaction: Do No Harm.

Within the constitutive pattern of Being a Nurse is Impactful, the nurses in this study found deep meaning in the act of providing nursing care. After they became familiar with the routines and practices of their job, they found an outward awareness and focus not described in previous research investigating new nurses in transition. The profound meaning these nurses ascribed to their nursing practice helped them ameliorate the intensity inherent to the act of providing nursing care.

The constitutive pattern--When Nurses Support Nurses, the Patient is at the Center of Care--revealed that nurses in transition depend not only on the support of their preceptor but also on the support of other nurses on their unit of practice. The findings of this study highlighted the importance of a supportive environment beyond the initial orientation period as well as throughout the first year of practice to ensure the nurses continue to grow and develop in their role.

The constitutive pattern--Nurse-Doctor Interaction: Do No Harm--provided a deeper understanding of the new nurse-physician relationship than what had been previously described. The new nurses in this study gained an understanding of how ineffective patterns of interaction with physicians on their units not only impacted patient safety and quality of care, these ineffective patterns also created more stress for them in their daily work as a nurse. The phenomenon of “double-standards” and a perception of “the doctor knows more than the nurse” attitude spoke to the new nurses’ beliefs about interactions between physicians and nurses.
The findings of this study could be of use to nurse educators, leaders in nursing practice, bedside nurses, physicians, and advanced practice nurses. These findings could assist healthcare professionals to understand and assist new nurses transitioning to practice.
TABLE OF CONTENTS

CHAPTER I. INTRODUCTION ........................................................................................................... 1

The Current Situation: Being-the-There ..................................................................................... 3
Significance of the Problem ......................................................................................................... 5
Problem Statement ...................................................................................................................... 8
Research Question ...................................................................................................................... 9
Chapter Summary ...................................................................................................................... 10

CHAPTER II. REVIEW OF LITERATURE ................................................................................... 11

Chick and Meleis Transition Theory .......................................................................................... 11
Nature of Transitions .................................................................................................................. 14
Transition Conditions ................................................................................................................ 16
Patterns of Response .................................................................................................................. 25
Progress Indicators .................................................................................................................... 26
Summary .................................................................................................................................... 28

CHAPTER III. METHODOLOGY .............................................................................................. 30

Philosophical Underpinnings ..................................................................................................... 31
Phenomenology: Two Philosophical Schools of Thought ......................................................... 32
The Philosophy of Martin Heidegger ......................................................................................... 36
Assumptions ............................................................................................................................... 40
Study Methodology .................................................................................................................... 41
Trustworthiness .......................................................................................................................... 47
Ethical Considerations ............................................................................................................... 49
Summary .................................................................................................................................... 50

CHAPTER IV. FINDINGS .......................................................................................................... 52

Description of Participants ....................................................................................................... 52
Participant Stories of Transition ................................................................................................. 53
Relational Themes ....................................................................................................................... 95
Constitutive Patterns .................................................................................................................. 96
Trustworthiness .......................................................................................................................... 102
Chapter Summary ..................................................................................................................... 104
CHAPTER V. DISCUSSION ........................................................................................................... 105
Constitutive Patterns .................................................................................................................. 106
Transition Theory ..................................................................................................................... 118
Significance of Findings .......................................................................................................... 121
Study Limitations ..................................................................................................................... 123
Implications .............................................................................................................................. 125
Summary .................................................................................................................................... 130
REFERENCES .............................................................................................................................. 134
APPENDIX A. CHICK AND MELEIS TRANSITION THEORY ........................................... 143
APPENDIX B. LETTER OF PARTICIPATION ........................................................................... 145
APPENDIX C. LETTER OF INFORMED CONSENT ................................................................. 147
APPENDIX D. INSTITUTIONAL REVIEW BOARD APPROVALS ............................................ 150
APPENDIX E. PARTICIPANT DEMOGRAPHIC INFORMATION ............................................... 154
APPENDIX F. INTERVIEW GUIDE/QUESTIONS ....................................................................... 156
# List of Tables

1. Units of Meaning/Category Development for Participant #1: Bryan ............... 61
2. Units of Meaning/Category Development for Participant #2: Liz .................. 67
3. Units of Meaning/Category Development for Participant #3: Alyce .............. 73
4. Units of Meaning/Category Development for Participant #4: Olive ............... 81
5. Units of Meaning/Category Development for Participant #5: Kate ............... 88
6. Units of Meaning/Category Development for Participant #6: Kara .............. 95
CHAPTER I

INTRODUCTION

Does time itself manifest itself as the horizon of Being?
(Heidegger, 1962, p. 488)

Although the nursing profession has experienced shortages in the past, the American Association of Colleges of Nursing (AACN; 2009) has projected the current nursing shortage will be twice the magnitude of any nursing shortage experienced since the mid-1960s and will last well beyond 2020. Factors contributing to this shortage include an aging population who will require increasing health care, more people gaining access to health care with the passage of the Patient Protection and Affordable Care Act (ACA) of 2010 (greater than 32 million people who were previously uninsured have gained access to health care), a large number of nurses reaching retirement age, and a nursing faculty shortage that hampers the ability to fully expand capacity within American nursing schools (AACN, 2014). To accommodate an increasing number of Americans accessing health care, the U.S. Department of Labor (U.S. Bureau of Labor Statistics, 2012) projects the nursing workforce will need to grow from 2.71 million in 2012 to 3.24 million in 2022. Additionally, it is estimated that 525,000 replacement nurses will be needed by the year 2022 (U.S. Bureau of Labor Statistics, 2012).

The current nursing shortage is unlike shortages experienced in the past. This shortage is affected by both supply and demand components of the nursing workforce
equation. Between 2010 and 2030, 80 million Americans will have reached retirement age (Buerhaus, Auerbach, & Staiger, 2014). The aging of baby boomer nurses has created a situation where there will be large numbers of nurses retiring from the profession over the next 20 years. In 2013, the National Council of State Boards of Nursing National Workforce Survey (Budden, Zhong, Moulton, & Cimiotti, 2013) revealed that 53% of the nursing workforce was 50 years of age or older.

Further aggravating concerns of a nursing workforce that currently falls short of meeting future health care demand is an alarming report that anywhere from 13-70% of new graduate nurses entering the profession leave their first job within the first year of employment (Bowles & Candela, 2005; Casey, Fink, Krugman, & Propst, 2004; Pellico, Brewer, & Kovner, 2009). By their third year of employment, MacKusick and Minick (2010) reported 30-50% of recently graduated nurses will have left their first job or have exited from the nursing profession altogether. In 2006, Cowin and Hengstberger-Sims reported nearly one-third of new nurses had left the profession or reduced their hours to part-time by their third year of practice. Turnover amongst new nurses is significantly higher than the average turnover rate of experienced nurses. In 2007, the Pricewaterhouse-Coopers’ Health Research Institute reported the average nurse turnover rate in American hospitals was 8.4% while the voluntary turnover rate for the new graduate nurse within the first year of employment was 27.1%. Statistics relative to new nurses leaving their first jobs or leaving the profession are concerning in an environment of a nursing workforce shortage. These statistics are even more staggering when one considers that 42% of all nurses hired within American hospitals are new graduate nurses (Goode & Williams, 2004).
The nursing shortage we are currently facing is not expected to subside in the near future. The Health Resources and Services Administration (2013) estimates that within the next 10-15 years, one-third of all registered nurses will reach retirement age. This will not only have an impact on the expertise level of registered nurses across the United States but will also likely increase the percentage of new graduate nurses hired into healthcare organizations. By all estimates, the number of nurses who will be exiting the profession over the next 20 years could exceed the number of nurses entering.

Addressing the high turnover of new nurses and creating stability amongst the supply of new nurses entering the workforce is one way to help address the nursing shortage.

**The Current Situation: Being-the-There**

Being-the-there, or the current situation as it relates to new nurses entering the profession, is multifactorial. Nurses new to the profession are entering an environment that is undergoing rapid change and is experiencing a high degree of uncertainty. The environment in which nurse’s practice today is quite different than the nursing practice environment as it existed even five years ago. The passage of the Affordable Care Act (2010) has triggered dramatic reform to the American healthcare system. This changing and uncertain environment will continue as provisions of this Act are phased in and implemented. Accountable care organizations (ACO) are evolving as a mechanism for healthcare institutions to maximize reimbursement for care provided within a new system that emphasizes quality outcomes over payment based on volume of patients treated. A focus on preventive care services and population disease management is leading to the proliferation of the medical home concept and use of community healthcare centers that shift care from a costly acute care setting to a less expensive setting that emphasizes
disease prevention and chronic illness management. Great responsibility resides with the nursing profession because many quality outcome indicators tied to patient care reimbursement are the direct result of the care provided by nurses. According to Buerhaus et al. (2012), these changes will be best addressed through a care environment that emphasizes the use of health care teams, effective use of information technology, care coordination, and effective nursing leadership. Quality, safety, and efficiency will be the hallmarks of effective care and will drive reimbursement. One must also keep in mind these changes are taking place within the context of a persistent nursing shortage--an environment where the new nurse is increasingly relied upon to fill this gap.

In 2010, the Institute of Medicine (IOM) released an unprecedented report titled *The Future of Nursing: Leading Change, Advancing Health*. The vision articulated in this landmark report was one of access to high-quality, patient-centered care by all Americans. The nursing profession, in collaboration with medicine, was cited as a crucial partner in realizing this vision through the development of partnerships to address a dynamic and evolving health care environment in need of reform (IOM, 2010). To optimize these partnerships, the IOM stated that nurses must attain higher levels of education. The evidence-based recommendations put forth in this report provided a springboard from which the collective nursing profession (education and practice) could convey its value and significance in providing high quality, patient-centered care accessible to all Americans.

One way to convey the value of nursing to the American public, as well as all health care colleagues, is to aggressively address the IOM (2010) recommendation of increasing the proportion of nurses prepared at the baccalaureate level. The specific
recommendation put forth by the IOM was to increase the percentage of nurses prepared at the baccalaureate level to 80% by the year 2020. Currently, in the United States, 50% of nurses hold a bachelor’s or master’s degree in nursing with 36.1% holding associate degrees and 13.9% holding a diploma in nursing (Fiese, Lake, Aiken, Silber, & Sochalski, 2008). A growing body of research shows a link between the level of educational preparation of the nurse and improved patient outcomes (Aiken, Clarke, & Sloane, 2008; Kutney-Lee, Sloane, & Aiken, 2013; Tourangeau et al., 2006). Providing high quality health care that is safe, efficient, and effective is dependent upon a nursing workforce that is educated at the baccalaureate level or higher and is sufficient in numbers (AACN, 2015; Buerhaus, 2008).

To realize the IOM (2010) recommendation of a nursing workforce that consists of 80% baccalaureate prepared nurses and to ensure an adequate number of nurses within the workforce, attention must not only be paid to educational preparation but also to the turnover rate of new nurses entering the profession. Only by addressing these significant issues facing the profession can steps be made toward ameliorating the current, persistent nursing shortage while preparing a nursing workforce capable of providing safe and effective health care that improves the safety and care outcomes of the patients served.

Significance of the Problem

Discourse regarding the preparation of the newly graduated registered nurse for entry into practice is a topic that resonates with academic nursing educators as well as individuals employed in the practice setting. According to a survey conducted by the Nursing Executive Center (2008a), while 89% of administrators surveyed within academic nursing education programs believed newly graduated nurses are adequately
prepared to provide safe and effective nursing care upon entry into the practice setting, 89% of nurse executives and nurse administrators responsible for hiring newly graduated nurses believed the new nurse is not prepared to meet the demands of the profession. Given these findings, the perception of an education-practice gap relative to new graduates entering the profession of nursing seems evident. Add to this phenomenon concerns relative to the nursing shortage (AACN, 2014), a nursing faculty shortage (AACN, 2015), fears of a nursing expertise gap (Orsolini-Hain & Malone, 2010), and a volatile health care environment and the profession of nursing may be finding itself at the center of a perfect storm.

History shows nursing shortages are cyclical in nature. However, the current nursing shortage has characteristics that are unprecedented and unrelenting. An aging American population, implementation and implications of the Affordable Care Act of 2010, an aging nursing workforce, the graying of nurse educators within American nursing schools and colleges, and a nursing experience gap all hold the potential of thwarting attempts to address the current nursing shortage while maintaining a workforce capable of providing safe, effective, and efficient patient care. These unprecedented factors highlight the importance of effectively transitioning and maintaining bachelor-educated new nurses within the profession.

Statistics reveal the turnover rate for newly graduated nurses is significantly higher than the turnover rate for all experienced registered nurses. The IOM (2010) recommended nursing implement nurse residency programs for graduates of pre-licensure (and advanced practice) degree programs to facilitate new graduate transition and retention. The National Council of State Boards of Nursing (Spector & Echternacht,
2010) supported this recommendation and developed a regulatory model for transitioning newly graduated nurses to the practice setting. But given the current uncertainty of the American healthcare environment and the key role nurses play within this environment, more must be done to understand the transition experience of new nurses.

Concerns over the challenges new graduates face when transitioning into a rapidly changing, complex healthcare environment have resulted in great interest in the new graduate’s first year of practice. Many studies of the new nurse’s first year of practice have focused on technical skills, competencies, stressors, work environment, and how well the new nurse is prepared for practice by their educational program (Candela & Bowles, 2008; Casey et al., 2004; Halfer & Graf, 2006; Smith & Crawford, 2003). These studies were conducted from an epistemological perspective—looking at what the nurse knows. Most of these studies concentrated on the first six months of the new nurses’ practice with some extending the period of study to 12 months of practice. The majority of these studies occurred prior to the implementation of the Affordable Care Act (2010), which involved a practice context quite different from the nursing practice environment of today. Additionally, few studies have explored the new nurses’ experience at or beyond the first year of entry into the profession (McKenna & Newton, 2008). Even fewer qualitative research studies exist to offer insights into what the meaning of the transition experience holds for the newly graduated nurse nor how they could be better prepared for this transition.

Adequacy of preparation for entry level nursing practice has many implications for nursing students, new graduate nurses, nursing education, potential employers of nursing graduates, and consumers of health care services. With 42% of all new hires
within U.S. hospitals being new graduates, all of these stakeholders have a vested interest in the adequacy of preparation of new nursing graduates (Goode & Williams, 2004). Adequacy of preparation includes an understanding of the transition experience of newly graduated nurses and the meaning this transition holds for them.

The research problem identified for this study involved interpretation of the nurse’s experience of being a newly graduated nurse transitioning to the practice of nursing. Newly graduated nurses face many challenges as they enter a workforce that faces a well-documented shortage. If not addressed or understood, these challenges have the potential of adding to an already high turnover rate amongst new nurses. This type of turnover is very costly to healthcare organizations on many levels. According to Young, Stuenkel, and Bawel-Brinkley (2008), a key to reducing the number of nurses who leave the profession early in their practice is ensuring appropriate professional socialization and transitioning are provided for new graduates. Professional socialization, according to Young, et al. (2008), must begin in the nursing education program and continue into the work setting. By gaining an increased understanding of the new nurse’s transition experience and the meaning the new nurse ascribes to this experience, the academic and practice communities of nursing will be better poised to help address current workforce challenges.

**Problem Statement**

The 21st century has certainly presented the profession of nursing with unprecedented challenges. However, with any challenging circumstance, there is an opportunity for understanding that can result in a far-reaching, positive impact. An opportunity for meaningful change can be realized through the collaborative efforts of the
education and practice sectors within the nursing profession. Educating nurses with the appropriate skill levels and degree levels to meet the needs of a changing healthcare landscape is one way to address current challenges. Considering the high degree of turnover amongst nurses new to the profession, exploration of the transition experience of newly graduated nurses into the nursing profession can provide valuable knowledge that has the potential of reducing this alarmingly high turnover rate. A reduction in turnover amongst newly graduated nurses can impact costs incurred by health care organizations, enhance patient safety, improve patient outcomes, and, ultimately, impact the nursing shortage.

Gaining an understanding of the meaning the transition experience holds for the new nurse is an essential component of balancing the supply of new nurses entering the profession with the number of nurses exiting. Existing research relative to the transition experience of new nurses has focused heavily on the adequacy of educational preparation for nursing practice, nurse executive perceptions of adequacy of new nurse preparation, new nurse skill competency, and confidence levels of the new nurse to assume this new role. Many studies of the new nurse transition experience have investigated the first six months of practice; fewer studies have explored the new nurse’s experience over the first year of practice. This study explored the meaning of transitioning from being a student in a Bachelor of Science in Nursing (BSN) program to being a practicing professional registered nurse. This research study begins this exploration with new nurses who have 12-18 months of experience as a professional registered nurse.
Research Question

The purpose of this study was to investigate the meaning of being a nurse as experienced by nurses new to the profession. The meaning of being a nurse as revealed by graduates of a BSN program at 12-18 months after beginning their first job as a professional registered nurse was explored. The following research question guided this study:

Q1 What is the experience of moving/transitioning from being a student in a Bachelor of Science in Nursing program to being a practicing professional registered nurse?

An understanding of the meaning the new nurse ascribed to the transition experience was accessed using an ontological perspective and a Heideggerian hermeneutic approach. The knowledge generated from this study provided a more intimate understanding of the transition experience of baccalaureate prepared nurses, thus facilitating the safe and effective transition of the new nurse to practice.

Chapter Summary

The successful transition of new nurses to the practice setting is a phenomenon of interest to nursing practice leaders, nursing education leaders, practicing nurses, and, ultimately, the recipients of health care. The Affordable Care Act (2010) has created a tremendous amount of change to the environment in which all nurses practice. A key to achieving necessary healthcare reform involves having a nursing workforce that meets the needs of an increasing number of healthcare recipients. It also involves having the appropriate number of nurses prepared at an appropriate educational level. Gaining an understanding of the transition experience of the baccalaureate-prepared new nurse is a key element to safely and effectively moving these nurses into the practice environment.
as well as retaining well-educated nurses in the profession. Accessing nurses with 12-18 months of experience as a practicing nurse holds the potential of understanding the transition experience from a perspective never before explored.
CHAPTER II

REVIEW OF LITERATURE

It is not change that is so difficult but the transition

Adequacy of preparation for entry level nursing practice has many implications
for nursing students, recently graduated nurses, academic nursing education, employers
of new nurses, and consumers of healthcare services. With 42% of all new hires within
U.S. hospitals being new graduates, all stakeholders have a vested interest in the
adequacy of preparation of nursing program graduates as well as the successful transition
of new nurses to the practice setting (Goode & Williams, 2004).

Chick and Meleis Transition Theory

The transition from being a nursing student to that of a practicing registered nurse
is a complex and multifaceted process. This study used Chick and Meleis’s (2010)
middle-range theory of transition to understand what is currently known about the
transition experience of new nurses. The Chick and Meleis transition theory consists of
three major components that frame the transition experience: nature of the transition,
transition conditions (facilitators and inhibitors), and patterns of response (see Appendix
A). Use of this theory provided a framework for understanding what is currently known
about the transition experience of new nurses as well as illuminating areas where further
understanding is needed. The Chick and Meleis transition theory is briefly described
followed by a review of literature framed within this theory.
Nature of Transitions

According to the Chick and Meleis’s (2010) transition theory, there are four major types of transition: developmental, situational, health/illness, and organizational. Each transition possesses a pattern: singular, multiple, sequential, simultaneous, related, or unrelated. Transition types are not always discrete or mutually exclusive experiences. In the case of the newly graduated nurse, he/she might be experiencing a developmental as well as situational transition simultaneously or sequentially while transitioning from student to practicing nurse. Therefore, the transition pattern must be taken into consideration when investigating the transition experience of recently graduated nurses. It is also useful to consider that transitions are non-linear, complex events that possess many dimensions (Chick & Meleis, 2010).

The nature of a transition also includes the properties of that specific transition. Properties of a transition are not always discrete and involve a complex process. These inter-related properties include awareness, engagement, change and difference, time span, and critical points and events (Chick & Meleis, 2010). To be in transition, the nurse must have some awareness of the process. Awareness is also related to perception and knowledge. Specifically, what does the new nurse know about the process of transitioning to his/her new role as a registered nurse and what is his/her perception of this process? Engagement, another property of the transition experience, involves the degree to which the new nurse demonstrates involvement in the transition process. The level of awareness of the transition has a direct impact on the level of engagement the new nurse displays.
Change and difference are similar but distinct properties of the transition experience. According to Chick and Meleis (2010), to fully understand the transition process, it is essential to reveal the effects and meaning of the change involved. Difference in the transition process is illustrated by seeing things in a different way, being perceived as different, and having unmet or divergent expectations. As a property of transition, time span involves flow and movement over a period of time. The transition of the new nurse begins with the first anticipation of moving from a structured learning environment to practicing as a licensed professional registered nurse. Time span for the transition of the new nurse includes periods of instability, progression, and regression to an eventual period of increased stability.

According to Chick and Meleis (2010), most transitions involve critical points and events as a property of the experience. During these points, the new nurse often gains an increased awareness of the changes occurring with his/her transition to practice. Often times, these critical points and/or events are marked by more active engagement with the transition experience. The culmination of critical points is characterized by a feeling of increased stability.

**Transition Conditions**

Individual perceptions and meaning are significant aspects of any given situation. So too are conditions under which a transition experience occurs. According to Chick and Meleis (2010), personal, community, and societal conditions have an influence on the transition experience. When seeking to understand transition experiences, it is important to consider personal and environmental conditions that promote or inhibit an effective
transition. Equally important is consideration of the impact of personal, community, and societal conditions as facilitative or constraining forces relative to the transition process.

**Patterns of Response**

Patterns of response relative to transition theory as presented by Chick and Meleis (2010) include progress indicators and outcome indicators. Because transitions extend over time, consideration of progress indicators as the new nurse moves into the practice setting can be used to guide the assessment of the new nurse. According to Chick and Meleis, feeling connected, interacting, location and being situated, and developing confidence and coping are specific transition progress indicators that can be used to assess the nurses’ transition experiences. Outcome indicators for the transition experience include the degree to which the new nurse experiences mastery of the skills needed for functioning in the practice setting and the development of a fluid and integrative identity as a nurse.

The Chick and Meleis (2010) transition theory delineates specific components of transition and offers a frame of reference through which to explore this phenomenon amongst recent graduates of a BSN program. This framework guided the exploration of what is currently known about the transition experience of recently graduated nurses.

**Nature of Transitions**

The transition from student to practicing nurse can be a challenging, emotional, and stressful time for the new nurse (Pellico et al., 2009). An intense work environment filled with high technology and high patient acuity can lead to a high turnover rate when new nurses are not prepared or supported in this transition. It is estimated that 35-60% of new nurses will leave their first job within the first year of practice (Beecroft, Kunzman,
& Krozek, 2001; Halfer & Graf, 2006). In a classic study, Kramer (1974) described the initial work experience of new nurses as reality shock. Kramer described role conflict as a major issue for the new nurse as he/she learns to balance patient needs with work environment demands and needs.

Transition of the newly graduated nurse to the practice setting has been described as both developmental and situational--developmental because the new nurse is assuming a role where he/she is expected to be independent and responsible without the instruction and guidance of a faculty member and situational because this professional role is different from the role he/she assumed as a nursing student (Duchscher, 2008).

Duchscher (2001, 2008) used phenomenological inquiry to investigate the first six months of five new baccalaureate-prepared nurses as they transitioned to practice. One-to-one interviews were conducted at two and six month intervals. Analysis of these interviews uncovered three themes describing developmental aspects of the new nurse’s transition experience: Doing Nursing, The Meaning of Nursing, and Being a Nurse. During the first three months of practice, the new nurses found the pace and intensity of the work environment to be extremely overwhelming. Because of this intensity, new nurses reported they were unable to focus on why they were performing certain functions. Their focus was on establishing and keeping a pace that would allow them to accomplish needed tasks. The new nurse was Doing Nursing. Efficiency was the goal during this period of transition. A great amount of energy was expended to establish a routine. By three to five months, the new nurse became more comfortable with routines and tasks. This comfort precipitated an increase in stability and self-awareness. At this time, the new nurses’ practice became more reflective, they began to trust in their own abilities,
and they began to understand at a deeper level. They were coming to understand The Meaning of Nursing. As the new nurses became less focused on performing tasks, they began connecting caring with knowing. By five to six months of practice, the new nurses began to acknowledge that although there was a lot they did not know, a great amount of development had taken place relative to their nursing practice and their interactions with patients. For the new nurses, questioning took on new relevance. No longer concerned about being perceived as weak or standing out, the new nurses began viewing questioning as a necessity for growth in their professional role. With this, the new nurses were in the beginning stages of Being a Nurse. Duchscher reported the new nurses began to make connections at a higher level and were beginning to see the relevancy of higher information and prioritization of nursing actions.

Other researchers have described/uncovered the developmental nature of the new nurse transition process. Casey et al. (2004) in investigating the stresses and challenges encountered by new nurses during the transition process found although new nurses perceived a high level of comfort and confidence as they began their career as a nurse; their level of comfort and confidence consistently declined until they had been in the role for 12 months. The most challenging period during this developmental and situational transition was reported during 6 to 12 months of practice. Halfer and Graf (2006) found new nurses did not develop comfort, confidence, and competence in the nursing role until approximately 12-18 months of practice.

**Transition Conditions**

Personal and community conditions can serve as inhibitors or facilitators of new nurses’ transition experiences. Personal conditions involve the meanings and perceptions
of knowledge and preparation the new nurse ascribes to the transition experience. Community conditions refer to the perceptions of those who have a stake in the transition of the new nurse to the practice setting. The new nurses’ community relative to the transition experience includes education partners, practice partners, and the recipients of nursing care.

Personal meaning, knowledge, and the level of preparation the new nurse perceives he/she received to prepare for moving from the role of student to practicing nurse have been explored using both quantitative and qualitative methods. Community conditions that impact the new nurse’s transition experience have been explored from the perspective of coworker perceptions and attitudes, nurse leader perceptions of readiness for practice, and the new nurse’s perceptions of the nursing profession.

**Personal Conditions**

New nurse preparation and knowledge has garnered significant attention in transition research. According to a survey conducted by the Nursing Executive Center (2008a), while 89% of academic nurse educators surveyed believed new nurses were adequately prepared to provide safe and effective nursing care upon entry into the practice setting, 89% of nurse executives and nurse administrators responsible for the hiring of new nurses believed the new graduate was not prepared to meet the demands of the profession. These dichotomous beliefs reveal little ground has been made to narrow the perception of an education-practice divide.

Li and Kenward (2006), researchers with the National Council of State Boards of Nursing, surveyed nurses relative to the adequacy of their educational preparation. Average length of time of employment at the time of the survey was 9.9 months of
practice experience. These new nurses reported difficulty with analyzing multiple data sources to make clinical decisions, delegating to others, understanding the pathophysiology of patient conditions, and working effectively with the healthcare team. These newly graduated nurses were more likely to feel prepared for practice when their educational program included the use of information technology and evidence-based practice, integrated critical thinking and pathophysiology throughout the curriculum, and involved a higher percentage of faculty teaching in both didactic and clinical courses.

A survey conducted by Smith and Crawford (2002) revealed new nurses felt most prepared to provide direct care for two patients. These new nurses reported they were least prepared to care for six or more patients, supervise care provided by others, and know when and how to call the physician. In this study, new nurses who reported inadequate educational preparation with basing decisions on assessment and diagnostic data, performing psychomotor skills, supervising care provided by others, working effectively as a team member, and how/when to call the physician were more likely to be involved in patient care errors. Forty percent of the new nurses in this study felt unprepared to use electronic medical information in a manner that enhanced the delivery of patient care.

Using the Survey of Nurses’ Perceptions of Educational Preparation, Candela and Bowles (2008) surveyed nurses who had graduated within five years prior to their study. Participants in this study expressed overall satisfaction with technical skill preparation. These new nurses reported being inadequately prepared in pharmacology, clinical practice, leadership and management, and the use of electronic medical records (EMR). Seventy-six percent of participants reported they were unprepared to access and manage
the electronic patient data system. There was no difference in perceptions of preparedness to use the EMR whether the nurse was a recent graduate or had five years of experience. Fifty-one percent of the participants reported they were better prepared for the NCLEX-RN than they were for clinical practice.

Retrospective data were used by Marshburn, Engelke, and Swanson (2009) to explore the relationship between new nurse performance-based development system scores (del Bueno, 1990) and new nurse perceived competence as measured by the Casey-Fink Graduate Nurse Experience Survey (Casey & Fink, 1999). Nurses who met the minimum criteria for problem management on the problem-based development system (PBDS) were found to be more confident in providing nursing care as determined by the Casey-Fink Graduate Nurse Experience score. Marshburn et al. reported new nurses who met minimum problem management on the PBDS appeared more confident in communications with physicians, families, and patients.

Casey et al. (2004) surveyed new nurses from six acute care facilities using a descriptive, comparative study design. Data were collected at baseline 3-, 6-, and 12-month intervals during the nurses’ first year of practice. The Casey-Fink Graduate Nurse Experience Survey (Casey & Fink, 1999) was used to query new graduates relative to skills they found challenging, their level of comfort and confidence in providing nursing care, the support they received, and satisfaction with their job. The Casey-Fink survey included four open-ended questions relative to the new nurses’ perceptions of the work environment and perceived challenges with transitioning to the role of registered nurse. Consistency with preceptors was a concern for 39-59% of the respondents in this study, who reported more than three preceptors during their orientation period. The new nurses
were asked to list the top three skills they were most uncomfortable performing. Skills mentioned included code blue, chest tubes, intravenous skills, epidurals, central lines, blood administration, and patient-controlled analgesia. Graduate nurses reported a lack of comfort and confidence communicating with interns, residents, and physicians. At baseline, the new nurses rated themselves as comfortable and confident in their role as a registered nurse. This level of confidence declined at three months and even further declined from 6 to 12 months of practice. Casey et al. (2004) reported new nurse comfort and confidence scores peaked after 12 months of practice. When asked open-ended questions relative to the difficulties, if any, they experienced with the transition from student to practicing nurse, the following themes emerged across all settings and time periods: lack of confidence in skill performance and deficits in critical thinking/clinical knowledge, relationships with peers and preceptors, wanting to be independent but reliant on others, frustration with the work environment, organization and priority setting skills, and communication with physicians.

Community Conditions

The significance of professional community as a facilitator or inhibitor of the new nurse’s transition process was described by Berkow, Virkstis, Stewart, and Conway (2009); Chandler (2012); Duchscher (2001); Dyess and Sherman (2009); and Pellico et al. (2009). Two major community facilitators for the new nurse’s transition to practice were the practice and education sectors. Berkow et al. (2009) reported the findings of a study conducted by the Nursing Executive Center. In this survey, the New Graduate Nurse Performance Survey was used to investigate how well nurse leaders in education and practice perceived new nurses were prepared relative to six broad skill categories:
clinical knowledge, technical skills, critical thinking, communication, professionalism, and management of responsibilities. The six skills categories encompassed 36 competencies believed to be indicative of the provision of safe and effective nursing care. For the purposes of this survey, the new nurse was defined as having less than 12 months experience. Survey participants included 400 nurse leaders from academia and 5,700 nurse leaders from the practice setting. Findings from this survey revealed 89% of nurse leaders from the academic setting believed new nurses were prepared to provide safe and effective nursing care at the time of graduation; while 89% of nurse leaders from the practice setting believed new nurses were not prepared to provide safe and effective care. Based on the responses of all practice setting nurse leaders, new nurses met the performance expectations on only two competencies: utilization of information technologies and rapport with patients and families. Competencies in which the new nurse exhibited the lowest perceived competency, according to practice leaders, were taking initiative, tracking multiple responsibilities, and delegation (Berkow et al., 2009; Nursing Executive Center, 2008b).

Using appreciative inquiry as a theoretical guide, Chandler (2012) sought to explore the process of effective transitioning for new nurses and to describe supports that facilitated the new nurse in developing the knowledge and skills requisite for the first year of practice. Using a qualitative, descriptive approach, Chandler’s interview questions related to transition, relationship, knowledge, skill, and attitudes. Using inductive content analysis, Chandler revealed three themes: They were there for me, There are no stupid questions, and Nurturing the seeds. New nurses who remained in their first position for one year and who perceived themselves as effective in their
position attributed their successful transition to staff, preceptors, and other graduates. These new nurses reported they were welcomed to the unit and included as a new staff member. Managers, preceptors, and other staff members checked in on them routinely. These nurses were encouraged to ask questions and reported receiving ample feedback on their progress. Patient assignments were added when the new nurse and preceptor determined the new nurse was ready. Many new nurses believed the social support provided was one of the most important aspects of their transition. This facilitated the development of a non-judgmental, trusting, and safe environment for the new nurse.

Nurses who left their position during the transition period reported feeling unwelcomed. On some occasions, staff on the unit were not aware a new nurse was working their shift. These nurses described the environment as competitive versus collaborative. They reported feeling humiliated by coworkers and made to feel as if they were outsiders. These new nurses reported they were given full patient loads early on in their transition and were left to manage on their own (Chandler, 2012).

Units where new nurses thrived created a culture where information and ideas were shared, questions were encouraged, and the use of best practices was integral. The new nurses described staff members on these units as collaborative, interdisciplinary, and role models for the use of critical thinking. Nurses who left their first position prior to the completion of the first year of practice were more likely to report a culture where they felt intimidated or were made to feel stupid for asking questions, felt bullied, and did not receive encouragement (Chandler, 2012).

Pellico et al. (2009) reported inhibiting conditions similar to those reported by Chandler (2012). Pellico et al. conducted a secondary analysis of data from a sample of
612 newly licensed nurses who were 6 to 18 months post successful completion of the NCLEX-RN. The parent survey used in this study included 207 closed-ended items seeking information relative to attitudes about work, intentions about future work, job opportunities, and work attributes. The open-ended question analyzed for the purpose of the Pellico et al. study asked participants to comment on their current work experience. These researchers used Krippendorff’s technique to analyze this secondary data for themes. Three themes relative to community transition conditions emerged: The need for speed, You want too much, and How dare you. Many new nurses in this study indicated they were pushed through orientation and expected to reach the skill level of an experienced nurse in a short period of time. Many participants stated they carried full patient loads from the first day on the job. This added a great deal of stress to the new nurse in transition. Many new nurses reported the administration applied a great deal of pressure to ensure overtime was held to a minimum. This was reported to have a negative impact on the new nurses’ perception of the value placed on getting to know their patients or strive to do their best work. The new nurses in this study also reported too much work, too much responsibility, and too much pressure. Many nurses reported there was limited or no time for breaks or meals. Documentation was reported as a time consuming task that prevented the new nurse from spending quality time with their patients.

Mistreatment by colleagues was a common theme reported by new nurses. Relationships with physicians were reported as extremely stressful. Many new nurses perceived seasoned nurses as abusive, harsh, and cruel. In many instances, management was perceived as turning its back on the abusive behavior of physicians, nurses, and other
staff members. Pellico et al. (2009) reported 41% of all comments received from the open-ended questions on this survey reported conditions inhibitory to the new nurses’ transition experience.

Dyess and Sherman (2009) conducted a qualitative study to explore the transition and learning needs of the new nurse. Participants included new nurses, nurse leaders, and new nurse preceptors. All new nurse participants were engaged in a one-year transition program. Pre and post transition program focus groups with all participants were conducted by the researchers. Using hermeneutic analysis, Dyess and Sherman uncovered four themes relative to community transition conditions that inhibited the transition experience of new nurses: Experiencing horizontal violence, Perception of professional isolation, Complex units require complex critical decision-making, and Contradictory information. New nurses in this study reported frequent instances of horizontal violence on the nursing unit. As a topic in each focus group, this violent behavior involved members of the same shift as well as across shifts. Although many new nurses stated nursing leadership purported zero tolerance for workplace violence, study participants perceived a work environment free from coworker violence was not supported.

Participants acknowledged the chaotic nature of the healthcare environment. Many new nurses reported feeling overwhelmed and professionally isolated, having to deal with the chaos on their own. They perceived everyone on the unit was busy and they were left to their own devices. The new nurses in this study reported they were often placed in situations where they needed to make critical decisions quickly without the opportunity to think through their decisions. This lack of time to reflect on their practice
was voiced as a concern. Many new nurses revealed they often received contradictory information from colleagues on their unit. This was viewed as confusing, especially in challenging and emergent situations. Having one consistent preceptor was viewed by the new nurses as valuable for continuity of the transition process (Dyess & Sherman, 2009).

Duchscher (2001) uncovered findings related to the nurse’s community similar to those described by Dyess and Sherman (2009). Interactions with physicians were a significant stressor for the new nurses, especially during the first five months of practice. New nurses also reported a lack of guidance from senior staff members. This created frustration for the new nurses and left them feeling unsupported. The new nurses viewed experience as tantamount to their professionalization; yet with a lack of support from coworkers, gaining this experience seemed elusive. These new nurses indicated their education had failed them because it was fragmented and did not allow them the opportunity to engage in a role that was realistic for a practicing nurse. These nurses indicated they were sheltered as students and this inhibited their ability to develop adequate clinical decision-making skills.

**Patterns of Response**

Because transition of the new nurse unfolds over time, process indicators could be used to determine if the transition was progressing in an effective manner. Early identification of a less than optimal transition could signal the need for intervention. According to the Chick and Meleis (2010) transition theory, indicators of a successful transition include feeling connected, interacting, location and being situated, and developing confidence and coping.
Progress Indicators

Duchscher (2001) found at approximately three to five months of practice, the new nurses began to leave the student mentality behind and began to feel like a professional nurse. This change was precipitated by increased stability with routines, reconciliation with what was learned as a student and what was observed in practice, and feeling more on the same plane with professional peers. Duchscher found that during this period of transition, new nurses were more able to reflect upon what nursing means in their lives and how they compared to their peers. In what Duchscher coded as Comfort with Fallibility, the idealism with which the new nurses viewed the profession began to fade. This allowed the new nurses to begin to see how they fit in as a nurse and a member of the healthcare team. Feeling more independent and building relationships with colleagues facilitated this feeling of connection. During this period, Duchscher observed a shift in the new nurses’ focus from being inward and personal to a perspective that considered the patient and the care provided. At five to six months, the way the new nurses interacted with peers and patients began to shift and a professional maturation was observed. Questioning took on new relevance for the new nurses. They were no longer concerned about drawing attention to themselves. The new nurses began to view questioning as a necessity. According to Duchscher, the new nurses came to understand that in order to grow in their professional role, they must question and ascribe meaning to their nursing actions. In what Duchscher labeled Professional Relativity, participants began to view themselves as nurses; this in turn had an impact on how they interacted with others. They began to talk about student nurses as something separate from where they currently were in their practice.
Duchscher (2001) indicated that over the six-month course of her study, participants evolved in their ways of being a nurse. The new nurses’ ways of knowing changed as they gained experience and their focus toward patient care evolved from a task/self focus to the ability to consider the patient at the center of the care provided. Duchscher compared the first six months of transition for the new nurse to Lewin’s (1943) force field analysis. Change was constant for these individuals and, at times, the transition was traumatic. Restraining forces were the new nurses’ familiarity with the student role and the unknown of entering into the profession. The driving forces for the new nurse were the need to be accepted as a peer and thinking beyond themselves and tasks. Duchscher noted that by two to three months, the new nurses reached an unfreezing phase when they found the student role was an uncomfortable role to play. By six months, the new nurses were observed to be in a state of refreezing--gaining confidence and independence and viewing questioning as a path to growth and a mechanism to improve patient outcomes.

In a study using a qualitative focus group design, McKenna and Newton (2008) investigated how new nurses developed knowledge and skills over the first 12 months of their nursing practice. Nine new nurses from three different hospitals participated in this study. Focus groups were conducted at baseline, 6-, and 12-month intervals. Colaizzi’s (1978) framework was used for data analysis. Three themes emerged as positive progress indicators of the transition process: Sense of belonging, Independence, and Moving on. New nurses in this study participated in a nurse residency program. As part of this residency program, the new nurses travelled to a variety of nursing units. These new nurses reported a greater sense of connection and belonging once they were able to stay
on one unit consistently. This did not occur until after their first year of practice. These new nurses also perceived they were treated differently by nursing staff and other staff members following their first year of practice.

Participants in this study perceived they had developed greater confidence, were able to take on increasing responsibility, and had gained more knowledge since their first year of practice. These new nurses indicated the first year taught them to stand on their own. In this new-found autonomy, the new nurses felt more confident in the decisions they made relative to their practice. They also reported they needed to seek clarification less frequently. The new nurses reported much of the knowledge they gained in the first year of practice was more relevant to clinical and institutional situations versus theoretical knowledge gained in their academic program. Many new nurses in this study perceived the value of obtaining a mentor after their transition period. This was viewed as a way to challenge their knowledge and skills and to keep learning and growing as a professional nurse (McKenna & Newton, 2008).

Summary

The transition theory of Chick and Meleis (2010) was used to frame what is currently known about the transition experience of new nurses. The literature review revealed the developmental nature of the transition experience has been previously explored. These investigations primarily centered around what new nurses know (or do not know), the stressors encountered, and their development of comfort, confidence, and competence within the first 6 to 12 months of practice. Investigation of transition conditions as facilitators and inhibitors of the transition experience have also been investigated. These studies focused primarily on the knowledge and preparation of the
new nurse as well as facilitators and inhibitors present within the community in which new nurse transitions. Research relative to patterns of response and, more specifically, progress indicators of the new nurse’s transition experience was reviewed. These studies revealed new nurses developed increased comfort in their role as nurses as time progressed. With time, the successful transition resulted in a nurse who was able to progress from an inward, almost egocentric type of thinking to thinking that considered the patient and the care environment.

Use of this middle-range theory was not only used to provide a framework through which to view what is currently understood about the new nurse’s transition experience but to also illuminate areas where gaps in understanding exist. From this review of literature, a gap in understanding relative to the properties of the new nurse’s transition experience exists. Specifically, these properties, a component of the nature of the transition experience according to Chick and Meleis (2010), include aspects such as awareness, engagement, and critical points and events.

Based on the literature review conducted for the purposes of this study, considering the current state of the nursing workforce shortage, and considering the current health care environment in which new graduate nurses are transitioning to practice, a research study investigating the transition experience of newly graduated nurses at 12-18 months of practice was warranted. Research questions for this study aimed to gain an understanding of the meaning new nurses ascribe to the everyday experience of transitioning to the practice setting.
CHAPTER III

METHODOLOGY

Historically, empirical research was viewed as the only valid method for the conduct of academic research. This type of positivist approach deals with what is observable, controllable, and measureable. The result of such empirical research methods is prediction and explanation and the claim that one reality can be known or discovered (Laverty, 2003; Mackey, 2005; Merriam, 2009). Even research conducted with a post-positivist orientation asserts that empirical evidence can be used to make a claim that is more likely true than not true or vice versa (Merriam, 2009). However, research in the field of human science and, most specifically, nursing is not always amenable to such quantitative, positivist, or post-positivist approaches. The use of phenomenology and, more specifically, hermeneutic (interpretive) phenomenology within the discipline of nursing offers an approach to inquiry that allows the researcher the ability to gain a unique understanding of meanings and interactions with individuals and their environment (Lopez & Willis, 2004).

The transition experience of new nurses is a complex and multifaceted phenomenon that involves rich, lived, and contextual experiences. According to Duchsher (2008), inquiry relative to the transition experience of new nurses is an emerging area of nursing research. When using the theoretical framework of Chick and Meleis (2010) to uncover what is known about the transition experience of newly
graduated baccalaureate nurses, a gap in knowledge that related to the nature of this experience, specifically the properties of this type of transition, existed.

**Philosophical Underpinnings**

Phenomenological inquiry as a research approach has been increasingly used to build knowledge within the nursing discipline. With this increase in use have come recent criticisms (Laverty, 2003; Lopez & Willis, 2004; Mackey, 2005). First, there is great concern that researchers often fail to establish or articulate the philosophical position from which their phenomenological research is conducted. Because philosophical stance drives the method(ology) used within a given research study, failure to establish this linkage can result in ambiguity and diminished credibility of purpose, design, and findings. A second criticism of the use of phenomenological research within the discipline of nursing deals specifically with a failure of the researcher to distinguish between descriptive and interpretive research approaches. Researcher assumptions are formed based on the school of phenomenology selected for a specific line of inquiry. These assumptions are significant to the researcher because they provide the basis of methodological decisions (Lopez & Willis, 2004; Mackey, 2005). Although there are similarities between descriptive or eidetic and interpretive or hermeneutic approaches to inquiry, distinct and important differences exist (Laverty, 2003). These differences center on how the research question is articulated, methodology used to collect data, and how the findings are used to advance knowledge within the discipline (Lopez & Willis, 2004).
Phenomenology: Two Philosophical Schools of Thought

It is not uncommon to see the terms phenomenology and hermeneutic phenomenology used interchangeably. Although similarities exist between phenomenology (descriptive) and hermeneutic (interpretive) phenomenology, these two research approaches are derived from differing philosophical perspectives. As such, there are significant methodological differences and implications when using each of these research approaches (Laverty, 2003; Lopez & Willis, 2004). A brief overview of the descriptive phenomenology of Edmund Husserl (cited in Laverty, 2003) and the hermeneutic phenomenology of Martin Heidegger (1927/1962) is provided to elucidate the differences in philosophical perspective. In this discussion, methodological implications are articulated.

Philosophical Tradition of Edmund Husserl

Edmund Husserl (cited in Laverty, 2003), referred to as the father of phenomenology, advanced philosophical thinking that resulted in the development of descriptive phenomenology. Husserl believed phenomenology could provide a methodology through which the essence of everyday lived experiences, and thus human consciousness, could be accessed. Moreover, Husserl believed phenomenology provided a way to look at reality and derive true meaning. He believed structures of consciousness could be accessed through study of the essential components of lived experiences (Laverty, 2003; Lopez & Willis, 2004). Husserl’s view that reality could be objectively described through the essences of lived experiences regarded inquiry from an epistemological perspective (Laverty, 2003).
An assumption of Husserlian phenomenology is the researcher is free from all pre-existing personal and expert knowledge relative to the phenomenon of study. To accomplish this, it is recommended the researcher not perform an extensive literature review nor have a specific research question in mind prior to initiation of the study. Through this approach, the researcher seeks to attain transcendental subjectivity—a state free of biases and preconceptions relative to the object of inquiry (Lopez & Willis, 2004). To this end, Husserl advanced the concept of bracketing, whereby the researcher identifies and holds at bay all preconceptions, ideas, or beliefs about the phenomenon of study from his/her consciousness (Laverty, 2003; Lopez & Willis, 2004).

Another Husserlian assumption deals with universal essences or eidetic structures. In descriptive phenomenology, essences are aspects of the lived experience common to all individuals who have that experience. Essences are believed to be representative of the true nature of the phenomenon being investigated and provide a mechanism through which the phenomenologist is able to derive a correct interpretation of the experience (Laverty, 2003; Lopez & Willis, 2004). The use of bracketing and the belief that reality provides an objective interpretation was Husserl’s attempt to make descriptive phenomenology a rigorous form of inquiry and science (Lopez & Willis, 2004).

The Philosophical Tradition of Martin Heidegger

Edmund Husserl (cited in Laverty, 2003), the teacher of Martin Heidegger (1927/1962), had a strong influence on Heideggerian thought even though this influence was in the form of Heidegger’s rejection of Husserl’s basis of phenomenology. Heidegger’s philosophical stance was greatly influenced by Aristotle’s work, *Metaphysics* (cited in Cohen, 2014). In his work, Aristotle examined “being qua being”--
a study of being that concerns itself solely with the being aspect of being. Other philosophers who had an impact on Heidegger were Kant, Nietzsche, and Kierkegaard. The influence of these philosophers tied Heidegger to the existential genera, an attribution Heidegger rejected. Wilhelm Dilthey (cited in Cohen, 2014), a hermeneutic philosopher, influenced Heidegger’s view of the significance of history in the interpretation of being.

Heidegger (1927/1962), like Husserl (cited in Laverty, 2003), was interested in studying the lived experience. However, Heidegger and hermeneutics are concerned with moving beyond describing the essences of phenomena to looking for meaning in the everyday lived experience or, according to Heidegger, being-in-the-world. Heidegger believed consciousness is not something separate from the world in which we live; it is constituted by historicality (personal history and background) and impacts the way we are in the world. For Heidegger, understanding was an a priori condition for being-in-the-world as opposed to understanding as viewed by Husserl as a way we know the world (Laverty, 2003).

According to Heidegger (1927/1962), meaning is embedded in an individual’s lifeworld or everyday activity and might not always be immediately evident to that individual. Through interpretation of narratives offered by individuals, the researcher uncovers meaning--apparent and hidden. Hermeneutic phenomenology is concerned with that which humans experience in their day-to-day life as opposed to descriptive phenomenology, which is concerned with what individuals know relative to their experience (Lopez & Willis, 2004). For Heidegger, understanding as a way of everyday being is from an ontological perspective and is the central focus of inquiry in
Heideggerian hermeneutic phenomenology (Koch, 1995; Laverty, 2003; Lopez & Willis, 2004). While Husserl was interested in what we know (an epistemological question), Heidegger was interested in how we know (an ontological question).

Presuppositions or fore-structures are another philosophical and methodological variation between Husserlian phenomenology and Heideggerian hermeneutic phenomenology. According to Heidegger (1927/1962), expert knowledge regarding the phenomenon of interest is both valuable and necessary for the research endeavor. Heidegger posited it is this knowledge that brings the researcher to understand that inquiry is needed in a specific area as well as how that inquiry should be conducted to generate useful meaning. Therefore, bracketing, as described by Husserl (cited in Lopez & Willis, 2004) and as a technique used in descriptive phenomenological inquiry, is not used within a hermeneutic approach (Heidegger, 1927/1962).

In hermeneutic phenomenology as opposed to descriptive phenomenology, the use of a conceptual or theoretical framework is acceptable. Although theory is not formally utilized within a hermeneutic phenomenological approach, it can be used to determine where research is needed and therefore may be used to guide a research question (Lopez & Willis, 2004). For the purposes of this study, Chick and Meleis’s (2010) transition theory was used to guide the review of available literature relative to the transition experience of new nurses. From this review of literature, an overarching research question was formulated to uncover the meaning the new nurse ascribes to the properties of the transition experience, thus leading to an increased understanding of the transition to practice experience.
Co-constitutionality is an inherent aspect of Heideggarian hermeneutic phenomenology. The meanings derived from the interpretive process in this type of inquiry are an amalgamation of meaning from both the researcher and the participant. This is referred to as a fusion of horizons where fore-structures of the researcher and the fore-structures of the study participant meet and new meaning is revealed or uncovered (Heidegger, 1927/1962; Laverty, 2003; Lopez & Willis, 2004). In hermeneutic (interpretive) phenomenology and consistent with Heideggerian philosophy, there is no one true meaning. However, the interpreted findings of a hermeneutic study must be plausible and logical and must be supported by the narratives offered by study participants (Geanellos, 2000).

The Philosophy of Martin Heidegger

It is important for the hermeneutic phenomenologist to consider philosophical concepts consistent with Heideggerian philosophical thought when making methodological decisions. Heidegger’s (1927/1962) philosophy provided both a philosophical framework and an investigative method for the study of the everyday experience of new nurses transitioning to practice.

Being-in-the-World

Heidegger (1927/1962) used being-in-the-world as a way to articulate the position that humans are not detached from the objects within their realms of existence. According to Heidegger, the most significant way of being-in-the-world involves being aware of one’s own existence (or Being). Heidegger referred to this state of being aware of one’s own existence as Dasein (German for existence). A human who exists as Dasein has access to awareness of their being and is said to exist “authentically” (Heidegger,
1927/1962, p. 68). *Being and Time*, a major philosophical work of Heidegger, is where he philosophizes about the meaning of Being. As Heidegger works through the meaning of Being, he uses a process that today is known as the philosophical basis of hermeneutic phenomenology. This is a methodology for uncovering the meaning of Dasein in its “average everydayness” (Heidegger, 1927/1962, p. 38). Average everydayness contains fore-structures usually not noticed or described. By describing Dasein in its everydayness, essential aspects of the character of Being can be uncovered (Heidegger, 1927/1962).

Heideggerian hermeneutic phenomenology is based on the deep meaning described in everyday being-in-the-world, thus opening the way for interpretation and understanding. The hermeneutic researcher must accept the participants’ accounts as their reality of the phenomenon. Using the hermeneutic circle, the researcher engages with participants and their understanding of the phenomenon, moving beyond description to a fusion of participant and researcher fore-structures to uncover meaning and understanding (Mackey, 2005).

**Fore-Structures**

Hermeneutic analysis is based on what Heidegger (1927/1962) referred to as fore-structure. Fore-structures are brought to the research project by both researcher and participant. Pre-understanding or background knowledge constitute the context-dependent knowledge and experiences brought to the research endeavor (Mackey, 2005). According to Heidegger, interpretation uncovers what is already understood. The fore-structures of the participant and researcher uncover this understanding of the phenomenon (Heidegger, 1927/1962).
As was mentioned above, fore-structure refers to the pre-understanding, background, and context-dependent knowledge an individual brings to a situation. In hermeneutic research, both the participant and researcher bring fore-structure, knowledge, and awareness to the study.

The Hermeneutic Circle

Heidegger (1927/1962) articulated the process of hermeneutic interpretation as a circle of understanding. In this process, the fore-structures of understanding are explicated, they are considered as a whole and as parts, they are considered and reconsidered, and this process proceeds back and forth until understanding is reached (Mackey, 2005). The seven-stage interpretive data analysis process proposed by Diekelmann, Allen, and Tanner (1989) and used for data analysis in this study uses this same circle of uncovering and understanding.

Consistent with the hermeneutic circle, van Manen (1990) presented a methodological technique for hermeneutical phenomenological writing. This technique uses a circular process of writing and re-writing to attain deeper understanding of the phenomenon. This process fosters reflection, distance, and nearness with the data to a culminating point of an increased understanding of the phenomenon. In this process, writing is well developed prior to defining relational themes and constitutive patterns (Mackey, 2005; van Manen, 1990). The hermeneutic phenomenological writing technique described by van Manen (1990) was used in the data analysis phase of this study.
Time

Time is a main concept in the philosophy and methodology of Hediggerian hermeneutics. According to Heidegger (1927/1962), time is “…the horizon for all understanding of Being…” (p. 39). In interpretive phenomenology, time is not equivalent to clock time; rather, it is temporally experienced. Temporality allows humans to conceive of their existence by experiencing the past, present, and future in union. In describing the experience of time, Heidegger (1927/1962) referred to temporality as having an “ecstatical character” (p. 39). This refers to things that stand out to individuals distinct from that of the flow of time or clock time. According to Mackey (2005), the Heideggerian researcher must be attuned to things that stand out to participants and are reflected in their narratives. This description situates the participants’ experience in time, thus reflecting things that are meaningful to participants.

Space

Spatial situatedness is what Heidegger refers to as the-there. This spatial situatedness deals with what is important or of concern to a human being. Heidegger (1927/1962) used the word care (or in German sorge) to describe the most fundamental ways of being-in-the-world. Both time and space can be viewed in terms of horizons. An individual will bring that which is of concern or that which matters close and that which is not of concern or that which does not matter to the person is placed in the background (Heidegger, 1927/1962; Mackey, 2005). Listening carefully to participants’ descriptions of phenomena is important in hermeneutic phenomenology to determine what is of concern and is in the foreground of their attention.
Assumptions

The following assumptions guided this Heideggerian hermeneutic study of the transition experience of newly graduated baccalaureate-prepared registered nurses.

1. The individual exists as being-in-the-world. The individual and the world co-constitute one another. There is a philosophical assumption of indissoluble unity between the individual and the world in which he/she lives.

2. The individual is always involved in the practical world of experience.

3. All interpretation has both a fore-structure (presuppositions) and an as-structure (meaning). This is opposed to Husserlian phenomenology that posits consciousness and perception provide access to the essence of a lived experience.

4. The world is interpretable (Moules, 2002).

5. Meaning is always in the context of something (one’s culture, practices, history, and traditions). An experience cannot be separated from the context of the entirety of involvements.

6. Meaning does not arise from consciousness but from being-in-the-world.

7. Hiddenness is intrinsic to the Heideggerian hermeneutic phenomenological process. Although understanding and meaning is revealed, meanings will never be completely revealed nor will the participants be completely understood. (Johnson, 2000).
Study Methodology

According to van Manen (1990), hermeneutic phenomenological research does not involve a fixed method or predetermined procedure. Rather, hermeneutic phenomenology entails scholarship. “The process of doing hermeneutic phenomenology is represented as a journey of ‘thinking’ in which researchers are caught up in a cycle of reading-writing-dialogue which spirals onwards” (Smythe, Ironside, Sims, Swenson, & Spence, 2008, p. 1389). Additionally, Heideggerian hermeneutic phenomenology provides a philosophical foundation and a methodological approach to inquiry that facilitates the examination of the contextual and personal features of the lifeworlds of new nurses transitioning to the practice setting.

The phenomenological philosophy of Heidegger (1927/1962) and Diekelmann et al.’s (1989) seven-step methodology for hermeneutic data analysis were used to explore the lifeworld of nurses who had graduated from a BSN program and had transitioned to practice within the past 12-18 months.

Participant Sampling

Purposive sampling was used to access participants who could provide an in-depth understanding of the transition experience of new nurses. The sample was derived from baccalaureate graduates of a private nursing and health sciences college in the Midwest region of the United States. This pool consisted of 46 baccalaureate degree graduates. Inclusion criteria included an earned BSN degree, graduation from a professionally accredited nursing college or university in the United States (Accreditation Commission for Education in Nursing [2015] or Commission on Collegiate Nursing Education [2013]), and 12-18 months of experience as a registered nurse (if gaps in
Recruitment of Participants

The researcher accessed potential participants using directory information relative to 2014 graduates of a BSN program at a private nursing and health sciences college in the Midwest region of the United States. Each graduate was mailed and emailed a letter of invitation to participate in the study (Appendix B--Letter of Participation). For those who agreed to participate in the study, a Letter of Informed Consent was signed prior to initiation of the interview (see Appendix C). In the event a sufficient sample size was not reached using these recruitment strategies, the researcher sent a second email to potential participants. This email was followed by a personal phone call from the researcher, seeking new nurse participation in this study. Participant interviewing began once human subject approval for this study was obtained from the University of Northern Colorado Institutional Review Board (IRB) and the Unity Point Health-Trinity Institutional Review Board (see Appendix D). Participant consent (acknowledged by signature) was obtained prior to each interview.

Purposeful sampling is frequently used in qualitative research. This type of sampling allows the researcher to select participants who have an understanding of the phenomenon of study. Creswell (2007) stated that a common sample size for phenomenological research is 3-10 participants. For qualitative research, Lincoln and Guba (1985) indicated sampling should continue until redundancy or saturation has occurred. In a study conducted by Duchscher (2001), which explored new nurses’ perceptions of their first six months of practice, a purposeful sample of five nurses was
used. With purposeful sampling, the researcher used a sample that was determined to hold information specific to the phenomenon of interest. Therefore, redundancy of information was the primary criterion used to determine sample size (Lincoln & Guba, 1985; Merriam, 2009). For the purposes of this study, a sample size of 6-10 BSN graduates with 12-18 months of employment as a registered nurse was the goal of participant recruitment. This range allowed the researcher to continue interviews until redundancy was reached and no new information was obtained.

**Data Collection**

One-to-one interviews began when individual participant consents had been received. A mutually agreed upon location was used that considered privacy, comfort, and a quiet environment. Interviews were anticipated to take approximately two hours. Participants were informed they could withdraw from the study at any time.

Each interview began with the researcher providing each participant a high level overview of the study purpose. The researcher answered any questions posed by participants. The interview continued with conversation relative to the background questions listed in Appendix E (Participant Demographic Information), which included length of time employed as a registered nurse, current work setting, length of time on current unit, number of positions held since entering the profession, type of BSN program attended (accelerated, second degree, generic), highest degree held, length and type of orientation received, full-time equivalency status, and current shift worked.

An overarching research question was used to frame the interview session. A semi-structured interview process was used, allowing the participants to share their lived experiences as a nurse transitioning into the practice profession. An interview guide was
used (see Appendix F). Questions were posed by the researcher when clarification was needed or to encourage participants to share their transition experiences.

**Research Question**

The following research question guided this Heideggerian hermeneutic study:

Q1 What is the experience of moving/transitoning from being a student in a Bachelor of Science in Nursing program to being a practicing professional registered nurse?

For the purpose of this study, transition was defined as an “inner reorientation and self-redefinition” that happens when change occurs in an individual’s life (Bridges, 2004, p. xii). In the instance of the newly graduated nurse, transition referred to the inner reorientation and self-redefinition that occurred as the new nurse moved from student to practicing nurse.

**Data Analysis**

The purpose of analyzing the texts generated from interviews conducted with recently graduated baccalaureate-prepared nurses was to gain further understanding of the lifeworld of new nurses in transition. According to Polit and Beck (2014), there are two approaches for Heideggerian hermeneutic data analysis: the seven-stage analysis approach of Diekelmann et al. (1989) and the three-stage process of Benner (1994). According to Polit and Beck (2014), Benner’s approach to Heideggerian hermeneutic analysis involves the search for paradigm cases, thematic analysis, and analysis of exemplars to interpret the phenomenon of interest. Data for this study were analyzed using the seven-step method of textual analysis described by Diekelmann et al. The methods of hermeneutic text analysis as discussed by van Manen (1990) was incorporated in this process and is consistent with Heideggerian philosophy.
Data analysis involved a three-member research team: the researcher as the principal investigator, a content expert--Dr. Melissa Henry, and a Heideggerian scholar--Dr. Heidi Storl. Dr. Henry holds a Doctor of Philosophy in Nursing, has eight years of experience teaching baccalaureate nursing students, and has 17 years of experience in the nursing practice setting. Dr. Heidi Storl is a Heideggerian scholar; she holds a Doctor of Philosophy in Philosophy and has 27 years of undergraduate teaching experience. Dr. Storl evaluated the degree to which the philosophy of Martin Heidegger (1927/1942) was reflected in the analysis and interpretation of interview data.

**Stage one.** In the first stage of analysis, each verbatim text was read in its entirety. The researcher reflected on the text to gain an overall understanding of the meaning of the lived experience as offered by the new nurse. The researcher and all members of the research team read the texts as they were collected and transcribed to gain an overall understanding of the phenomenon. According to Diekelmann et al. (1989), the researcher reads, rereads, and reflects, thus allowing the text to speak.

**Stage two.** The second stage of hermeneutic analysis involved identification of categories using a selective reading approach (van Manen, 1990). In this approach, texts were read line-by-line multiple times. Phrases that appeared to uncover meaning relative to the phenomenon of study were identified. According to van Manen (1990), these meanings or categories are structures of experience that capture the experience under study. To move understanding to a deeper level, the researcher began to ask questions relative to the data. In this stage of data analysis, understanding is naïve and the categories remain very close to the participant’s words (Parsons, 2010). The researcher presented a written interpretation of the categories.
**Stage three.** In this stage of analysis, the texts were further analyzed. Movement between the researcher’s analysis and the verbatim text ensued as the meaning of each participant’s experience was interpreted. The researcher generated a written summary of each participant’s experience. This included meaning/interpretation uncovered in stage two. At this early interpretive stage, researchers are not concerned with an exact interpretation. However, each preliminary interpretation must resonate with the data provided by each study participant (Diekelmann et al., 1989).

**Stage four.** Relational themes that corresponded to participants’ experiences were identified in this stage of interpretation. As relational themes were identified based on meaning uncovered in stage three, preliminary themes identified in stage two were further elaborated upon, clarified, or abandoned. According to Diekelmann et al. (1989), relational themes are themes that cut across all participant texts. Documentation was presented to support relational themes.

**Stage five.** Constitutive patterns began to emerge in this stage of analysis. Constitutive patterns are considered the highest level of hermeneutic analysis and express the relationship of relational themes. Constitutive patterns were derived by reading interview texts in their entirety to obtain a comprehensive perspective of participant stories and linking the relational themes to the meaning that arose from all participant interviews (Diekelmann, et al., 1989).

**Stage six.** In the sixth stage of analysis, the researcher used existing forms of knowledge to determine if the interpretation derived made sense and was plausible. The research team members (content expert and Heideggerian scholar) reviewed the interpretation offered by the principal researcher.
Stage seven. Credibility of the interpretive analysis occurred during this stage—the final stage of interpretive analysis (Diekelmann et al., 1989). During the final stage of analysis, Lincoln and Guba’s (1985) criteria for trustworthiness of qualitative research were used to evaluate the merit of this study.

Trustworthiness

In qualitative research, trustworthiness is used to describe the rigor with which a specific research study is conducted. Trustworthiness connotes that the results obtained from a study’s qualitative texts are representative or authentic to the phenomenon being studied. This type of validity and reliability can be attained through careful attention to study conceptualization, data collection, data analysis, data interpretation, and presentation of findings (Merriam, 2009).

Lincoln and Guba (1985) established the following criteria for the trustworthiness of a qualitative research study: credibility, transferability, dependability, and confirmability. These criteria provide a standard for evaluating the trustworthiness of a hermeneutic phenomenological research study. These standards as set forth by Lincoln and Guba include techniques to insure both internal and external worth.

Credibility is attained when meanings and descriptions derived from interpretations of the texts are true to the experience of participants and the interpretation of data is plausible. In this study, credibility was established through verbatim transcription of participant interviews. The hermeneutic circle was used to enhance credibility by reviewing whole and parts of transcripts and using a back and forth method throughout the seven steps of the analysis process. A content expert, Dr. Melissa Henry, participated in data interpretation to assist in hermeneutic analysis and credibility of
interpretation of participant texts. The ultimate test of credibility and goal of analysis/interpretation in this study was to derive interpretation that resonates with readers of the research study. Prolonged engagement is a technique that aids in credibility of an interpretive phenomenological study. Investing time to learn and understand the phenomenon of interest facilitates obtaining deep and meaningful data (Lincoln & Guba, 1985). The researcher for this study worked with nursing students and faculty familiar with the experience of preparing nursing students to enter the practice setting. This researcher also had regular contact with nurses and administrators in the community who engage with new nurses in transition. This perspective served to promote rapport with participants during the interview process. Interviews were conducted in a non-rushed manner in a quiet and private environment. Member checking, another technique to enhance credibility of research findings, was used during interviews to seek clarification or to obtain deeper meaning when needed (Lincoln & Guba, 1985).

Transferability addresses the ability of research findings to be applied in other contexts and is a measure of external validity (Merriam, 2009). Although findings from a qualitative study cannot be generalized in a statistical sense, Lincoln and Guba (1985) suggested transferability lies less with the original researcher than with the individual seeking to make the generalization. It is the original researcher’s role to provide description that is deep enough to allow for this transferability of meaning. Thick description is a technique that facilitates transferability of findings. It was the intent of this researcher to provide a description of the transition experience of new nurses that
would provide meaning to new nurses and those who educate new nurses in academic and practice settings.

Dependability of qualitative research findings addresses consistency and repeatability of findings (Lincoln & Guba, 1985). In this hermeneutic phenomenological study, the researcher was the instrument through which data were collected. To enhance dependability of analytic findings, an external/inquiry audit was used. This was accomplished by enlisting a researcher not directly involved with the study (Dr. Heidi Storl) to critique the process and product of the research analysis.

Confirmability is the standard used to determine the degree to which research findings are neutral, reflect the meaning offered by research participants, and are free of researcher bias. An audit trail and reflexivity are techniques to enhance confirmability of research findings (Lincoln & Guba, 1985). A clear description of the research actions taken was articulated in this study, thus providing a transparent audit trail. The seven-step process for data analysis offered by Diekelmann et al. (1989) was used to analyze data. A rationale for decisions was provided. The researcher maintained a reflexivity journal throughout the research process. This journal addressed the process of knowledge construction and articulated researcher preconceptions. Methodological decisions, reasons for these decisions, and assumptions were addressed in this reflexive journal (Day, 2012; Dowling, 2006; Drew, 2008).

**Ethical Considerations**

Human subjects approval from the institutional review boards of the University of Northern Colorado in Greeley, Colorado and UnityPoint Health-Trinity in Rock Island, Illinois were received prior to the conduct of this research project (see Appendix D).
Confidentiality of all participants was protected throughout and following the conclusion of this study. All digital recordings of interviews, transcribed interviews, and reflexive journals were maintained on the researcher’s password-protected personal computer. Any handwritten audit trail information was locked in a file cabinet in the researcher’s personal office. Anonymity of participants was maintained by using a coding system rather than participant names. This coding system was used to identify all participant transcripts and data analysis documents. Pseudonyms were used to report research findings. No participant identities were released for any report, presentation, or publication. All digital recordings will be destroyed/deleted at the conclusion of this study. Signed participant consent forms will be retained in a locked file drawer of the office of the Research Advisor. These forms will be destroyed three years after the conclusion of this study.

Informed consent for this research study was obtained from participants prior to initiation of interviews. Informed consent assured participants that participation in this study was voluntary and they were free to withdraw from the study at any time without any form of repercussion. Participants were informed via the informed consent form that participation in this research study involved minimal risk such as stress or emotional distress related to discussing the new nurse transition process.

**Summary**

This chapter presented a Heideggerian hermeneutic approach to the investigation of the transition experience of newly graduated nurses. A comparison of the descriptive phenomenological approach of Edmund Husserl (cited in Laverty, 2003) and the hermeneutic (interpretive) approach of Martin Heidegger (1927/1942) was offered. This
chapter also provided a plan for conducting a Hedgesgerian hermeneutic study investigating the transition experience of newly graduated BSN registered nurses with 12-18 months of work experience. This plan included participant sampling, recruitment of participants, data collection, data analysis, trustworthiness, and ethical considerations.
CHAPTER IV

FINDINGS

Data for this study were derived using face-to-face interviews with bachelor-prepared nurses with 12-18 months of practice experience. Interviews sought to uncover the transition experience of these new nurses as they moved from being a student to a registered nurse. The following overarching research question guided this study:

Q1 What is the experience of moving/transitioning from being a student in a Bachelor of Science in Nursing program to being a practicing professional registered nurse?

A semi-structured interview process using an interview guide (see Appendix F) was used to provide relative consistency across all interviews. Six in-depth interviews were conducted. Interview length ranged from 58-121 minutes. The seven-stage method of textual analysis as described by Diekelmann et al. (1989) was used to guide the process of analysis. This chapter describes how this process was used to present the findings of these interviews.

Description of Participants

Five of the six one-on-one interviews were conducted in the office of the researcher as the principal investigator. One interview was conducted at a public library in a private study room in a town 150 miles from the researcher’s place of residency. All participants reviewed and signed a Letter of Informed Consent for participation in the study prior to each interview (see Appendix C.). Participants were asked if they had any
questions before beginning the interview. An introductory statement describing the purpose of the study was then read to each participant (see Appendix F.). Each interview began by asking the participants general demographic information regarding their employment as a registered nurse (see Appendix E). Each interview was digitally recorded.

Six new nurses with an average of 16 months practice experience were interviewed. Practice settings included Operating Room \((n = 1)\), Medical-Telemetry \((n = 1)\), Medical Intensive Care Unit \((n = 1)\), Pediatrics \((n = 1)\), Medical-Surgical/Pediatrics \((n = 1)\), and Cardiac Step-down \((n = 1)\). Five of the nurses interviewed had held the same position as when initially hired \((n = 5\) or 83\%). One nurse held her second position, having transferred from a Medical-Surgical unit to a Medical-Surgical/Pediatrics unit within the same organization five months prior to being interviewed \((n = 1\) or 17\%).

All new nurses interviewed held full-time positions on their work unit. Three nurses worked on the day shift \((n = 3\) or 50\%). Two nurses rotated between the day and night shift or day and evening shift \((n = 2\) or 33\%). One nurse worked the night shift \((n = 1\) or 17\%). Half of all nurses interviewed received their BSN degree through an accelerated program designed for individuals who held a non-nursing bachelor’s degree \((n = 3\) or 50\%). The remainder of nurses interviewed \((n = 3\) or 50\%) received their BSN through a traditional nursing program.

**Participant Stories of Transition**

Verbatim transcripts were generated for each interview. The researcher transcribed each interview as the interviews were conducted. Transcripts were checked for accuracy; each digital interview was listened to twice in its entirety. The act of
transcribing the interviews allowed the principal investigator to move closer to the data and gain an understanding of the participants’ tone, inflection, and cadence as they described their journey from being a student to becoming a nurse with 12-18 months of practice experience. Transcripts were emailed to the interview team as they were transcribed. Each transcript was read to get a raw feel for the participants’ experience (Stage one). Next, each transcript was read line-by-line multiple times. Units of meaning were identified within each transcript that uncovered the experience of transition for each new nurse. Category names/labels were then assigned to each unit of meaning (Stage two). The researcher then developed a narrative using the units of meaning identified in Stage two. As this early interpretation took form, attention was given to ensure the interpretation was consistent with the data provided by each new nurse participant (Stage three). Stages one through three were conducted for each of the six participant interviews.

What follows are the stories of transition that evolved from interpretation of the interview transcripts of the participants in this study. The process of the hermeneutic circle was prevalent as interpretation ensued and meaning was uncovered. The researcher moved back and forth within each text, focusing on lines and paragraphs as well as looking at the transcript as a whole. After multiple writing and re-writing of each story, the following stories of transition emerged. This circular process of writing and re-writing allowed the researcher to gain a deeper understanding of the transition experience of each participant (van Manen, 1990). The direct words of each participant have been included to ensure the interpreted meaning resonates with the experiences the participants
shared. After each story of transition, a table is presented and depicts the units of meaning (or categories) identified as the interpretation process proceeded.

**Participant #1: Bryan’s Journey**

Bryan is an Operating Room (OR) nurse with 14 months of practice experience as a registered nurse (RN). Bryan was unsuccessful in a nursing course while attending nursing school. The experience of failing a nursing course and thus slowing down his progression later came to be a lesson that translated to the experience of transitioning to the role of RN. He shared, “Not passing the first time, I took that pretty hard. That was very difficult for me.” Bryan stated that prior to working as an RN, he often did only what was needed to get by. This was often his approach to nursing school. Bryan said, “I think in looking back I probably didn’t study as hard as I should have.” His failure in nursing school was difficult for him because he thought he would get by, just as he always had in the past. As Bryan reflected upon his transition, he shared other situations that had occurred over time that led to his “growing up.” Another circumstance that caused him to “grow up” was getting married. He disclosed, “I wasn’t just doing things by myself anymore.” All of these life situations, along with his transition to a new career in nursing, “…came together and it was time for me to grow up,” Bryan revealed. These lived experiences have played a part in making him the nurse he is today.

Bryan started his career feeling very confident in his skills and abilities. He passed the NCLEX-RN in 75 questions--the minimum number of questions required for licensure. He came out of nursing school thinking “…I finished school and I know how to be a nurse.” After about two months of practice, Bryan started receiving feedback from co-workers, physicians, and his preceptor that he was not as prepared as he initially
thought. He shared, “…having a couple of these doctors tell me that I need to learn more from my preceptor and not to think you know more than her [his preceptor]” was an awakening for Bryan. This had an impact on his confidence. He related this drop in confidence, along with learning humility, had an impact on the nurse he is today. Bryan shared, “I had to have that awakening to realize that you cannot be arrogant as a nurse. That nurses cannot be arrogant.”

Bryan recalled a situation that stood out in his mind because it showed what it was like being a new nurse in the OR. A critical patient came to the OR who was septic with a bowel obstruction that had ruptured. Bryan described, “It was sort of a code situation as far as the OR goes: giving blood, giving platelets. It was very eye opening as everyone was doing a job and they knew exactly what to be doing.” This was the first emergency situation Bryan had experienced as an RN. He said, “I had a good idea of what I needed to be doing, but until you learn to work with the team as a nurse…it was just very stressful.” He shared that from this situation he learned the value of teamwork in the operating room. But he also realized, “…I guess I don’t know as much as I thought I did.” After this case, Bryan recognized he not only needed to know what he was doing and where things were in the OR but it was also critical to think ahead and anticipate what would be needed in these emergent situations “because you can’t really be part of the team if you don’t know.” After this case, Bryan thought it was important to take the time to familiarize himself with all of the equipment, supplies, and medications in the OR environment. This situation was not only “eye opening” for Bryan, it was also stressful. This opened Bryan’s eyes to the responsibilities of being an RN.
In the first 14 months of practice, Bryan came to realize that wearing the “badge of RN” holds a great deal of responsibility. He came to understand that “once you wear the badge of RN, well then it’s like people look to you.” For Bryan, it was not only important that patients and families trust the RN but there must also be trust amongst his coworkers and physicians. Bryan said, “It becomes one of those things that once they [the doctors] know that you know what you are doing and they can trust you in what you are doing they’ll put tasks off on to you.” Bryan knew he had gained the doctors trust when they no longer double-checked lab values he relayed to them.

Bryan valued his preceptor. He stated, “One of the most important things for a new nurse would be having a good preceptor. That makes the biggest difference in the world on how you get to go and do your job afterwards.” Not only did this preceptor share her skill and knowledge, she also impressed upon Bryan how nurses behave and the important role nurses play. Although Bryan did not directly state he was arrogant and cocky in his early tenure as an OR nurse, he came to understand this was not a behavior characteristic of a good nurse. He disclosed, “I had to have that awakening to realize that you cannot be arrogant as a nurse…that’s not what a nurse is. That’s not what a nurse does.” Bryan also valued his preceptor because “she was very good at understanding the circumstances that I did and did not feel comfortable with just by my body language.” The ability to assist with her mere presence or unobtrusive assistance was important to Bryan. Bryan continues to this day to reach out to his preceptor if he needs assistance. Bryan also shared that his preceptor was “more than willing to give you any knowledge you ask for, as long as you listen.” He said, “It was always good for me to know that in case I needed her, she was there.”
Bryan had worked as a surgical technologist in the OR for eight years prior to becoming an RN. Because of this, he felt confident entering this practice setting as a nurse. At approximately two months, Bryan began to get feedback about his performance in the OR. He recalled “having a couple of people talk to me and be like, you need to just keep learning.” This resulted in a drop in confidence for Bryan. He further realized “that drop in confidence and that aspect of humility that I had to learn was extremely important.” This made Bryan realize “you can’t be arrogant as a nurse” because this interferes with the nurse-patient relationship. He continued to say he realized as a nurse you have “to understand the importance of your job as far as the impact and what you do for patients.” Bryan said patients and families have to “trust when you come in that what you are telling them is correct…that you are going to take care of their family member. That is such an important part of nursing, understanding the role you play.” Bryan credits his preceptor with helping him understand “the importance of our job and the responsibility it has.”

Bryan felt his nursing education was “saturated” with learning experiences and activities with a great amount of learning occurring over a short period of time. Learning the basics of nursing while in school was something Bryan believed assisted in his transition as a new nurse. He referenced a learning experience that occurred while he was a student in the intensive care unit (ICU). Bryan was with an ICU nurse who was part of the code blue team. Bryan was able to observe and participate in this code situation that unfolded over a 45-minute period of time. This real-time code blue had a profound impact on Bryan’s learning that day. Bryan shared, “It was the best learning experience I had as far as the things that just were set in stone in my mind.” Bryan’s
story of what stood out to him because it showed what it was like to be a new nurse (the septic, ruptured bowel case) also provided a look into the real-time learning that occurs with becoming a nurse. He referred to this situation as “eye opening,” “almost stressful,” and a situation where “you can’t really be a part of the team if you don’t know.”

Shortly after Bryan began working as an OR nurse, he came to understand nursing is both an art and a science. He referred to learning that a textbook may teach “one thing versus what real-life nursing is.” He came to understand that learning the difference between the two “was definitely a part of growing up as far as being a nurse.”

Something that stood out to Bryan was “school doesn’t teach you about the politics in health care.” Favoritism, different standards, “having to keep your mouth shut,” and administration’s tolerance of unacceptable physician behavior were aspects of the political work environment that stood out to Bryan. He was surprised some physicians received preferential treatment or were held to different standards, stating, “We are not going to say that to you, but our actions will show you that he can do whatever he wants.” His perception of this situation was summed up by stating, “We can’t buy this for you guys [nurses] even though it’s something you use every day and it costs five thousand dollars. But then one doctor makes one complaint the next week and they buy a $10,000 machine that he wants that day!”

Bryan’s advice to new nurses included being patient and allowing yourself to continue to learn. He said, “I wanted to jump in. I was ready to be a nurse. I was done with school. But that’s just the beginning of your education.” Bryan has come to understand that when he began nursing, he knew the “basics” of how to be a nurse. During his transition to nursing practice, he came to understand he needed to continue to
learn. For Bryan, learning humility seemed to be a significant aspect of the learning and becoming process.

After 14 months of nursing practice, Bryan gets great satisfaction from being trusted by the people with whom he works. Bryan shared, “I still carry around a little bit of that I can do it better attitude. But now it’s not so much of an arrogance thing. It’s a, I’ve seen myself do it better.” When asked if an attitude of arrogance has been replaced with an attitude of personal challenge, Bryan shared his wife would like him to begin reading during his down time. Bryan shared he preferred to watch television as a way to decompress. He also shared that recently he began thinking about reading, perhaps reading about emergency nursing. Bryan stated if he were to begin reading in his down time, “I might as well read something I can use in my everyday life.” He seems to want to make an impact in nursing. Bryan shared, “You can’t count on other people to do things for you all of the time. So, yeah, I might pull out my old books and start reading them, just because, I would rather be the person who knows.”

Eleven categories of meaning emerged from Bryan’s story of transition to nursing practice. Table 1 presents significant statements from his narrative to support the uncovering of these units of meaning.
### Table 1

**Units of Meaning/Category Development for Participant #1: Bryan**

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life lesson/Growing up</td>
<td>I think in looking back…didn’t study as as hard as I should have.</td>
</tr>
<tr>
<td>Ready to practice</td>
<td>I finished school and I know how to be a nurse.</td>
</tr>
</tbody>
</table>
| Learning to work with the team                | • You can’t really be part of the team if you don’t know  
• Until you learn to work with the team as a nurse… it was almost stressful at first. |
| Nurses are expected to know                   | Once you wear the badge of RN, well then it’s like people look to you.                                    |
| Responsibility of being a nurse               | Realizing the importance of our job and the responsibility it has.                                        |
| A great preceptor                             | • Having a good preceptor. That makes the biggest difference in the world on how you get to go and do your job afterwards.  
• She was very good at understanding.     |
| Preceptor tough love                          | As long as you are listening, she is more than willing to give you any knowledge that you ask for as long as you listen. |
| Drop in confidence/I don’t know as much as I thought | Having a couple of people talk to me… you need to just keep learning.                                      |
| Nurses don’t act like that                    | I had to have that awakening…you cannot be arrogant as a nurse.                                         |
| Nursing is important work                     | To understand the importance of your job as far as the impact and what you do for patients.                |
| Earning trust from the doctors                | It becomes one of those things that once they know that you know what you are doing and they can trust you in what you are doing. |
| Doctors will let you know                     | Having a couple of these doctors…not to think you know more than her [preceptor].                          |
| Book teaches one thing                        | [The textbook may teach you one thing] versus what real life nursing is.                                  |
| Theory and practice                           | It was the best learning experience…set in stone in my mind.                                             |
| Wow, the politics!                            | We are not going to say that to you, but our actions will show you that he can do whatever he wants.       |
| Double standards                              | School doesn’t teach you about the politics in health care                                               |
Participant #2: Liz’s Journey

Liz is a Medical Intensive Care unit (MICU) nurse with 14 months of practice experience. Liz was a student in an accelerated BSN program. She had a bachelor’s degree in biology prior to enrolling in her nursing program. Liz believed her previous degree helped her tremendously during her nursing education. She also credited the accelerated nursing program with preparing her for entering into the intense world of nursing practice. Liz shared that entering her nursing program was like entering into her nursing job, stating, “It was overwhelming at first. I remember the first day in the first summer. Holy cow!”

Liz recalled being overwhelmed as she began her job in the MICU. She recounted, “I was overwhelmed every day when I started. It’s overwhelming just thinking, emotionally and physically, and everything about it is overwhelming.” She shared that early in her orientation, her preceptor had her take two patients, which is considered a full patient load in the MICU. Liz recalled, “She’s [her preceptor] like, just try it, I want to see you deal with it.” Liz stated, “I can remember going home and crying because I was like, this is overwhelming!” Liz struggled for the first two to three months of her orientation, describing the experience as feeling like she was “underwater” or “drowning.” Liz believed that in her early days of nursing practice, she focused too much on the “little things” and her time management skills were in need of improvement. The “little things” that plagued Liz’s ability to provide nursing care were those things that were to be performed “by the book.” She gave the example of completing the electronic documentation while in the patient’s room-- something that was dictated to her during her
orientation. She felt this was not possible when patients or patient families were asking her questions. Liz shared,

They teach you to do it, but in reality it’s probably better for your time management skills and for your patient if you just remove yourself [in order to chart/document patient care] and answer as many questions as you can; but realize that you have to move on to something else. You can’t spend two hours in there.

During her orientation, Liz was able to figure out a routine for providing care that worked for her. Liz reflected, “She [her preceptor] just does things differently than I do now. And I realized that.” In discussing her early transition, Liz said, “It’s just hard to focus all your thoughts.”

Liz came to realize her preceptor pushing her into taking a full patient load early in her orientation was a “changing point, one of the changing points” for her in her transition to becoming an MICU nurse. Liz knew she wanted to be an ICU nurse. This eye opening experience told her, “This is what you have to prepare for, so make a plan and figure it out.” She likened this experience to a reality check--something she states she needs sometimes, even now.

Another aspect of transitioning Liz had to learn was “to detach yourself from some things.” She had to learn to leave work issues at work and not dwell on such issues when she was outside of the work setting. Liz offered, “You have to learn that or else you are going to be in a world of hurt for a while.” In Liz’s mind, this was a crucial aspect of the understanding that occurred in her transition. Otherwise, “you will get yourself worked up every day, then not want to go back to work.” The ability to detach from work, in Liz’s mind, was critical to a successful transition.

Liz came to appreciate the technique used by her preceptor, stating, “She pushed me and made me realize what I am going to have to work for. It taught me what I was
going to have to do and if I was prepared enough to do it.” Ultimately, Liz acknowledged her preceptor “made me the nurse I am now, the ICU nurse that I am right now.” Thinking back to her early days as a new nurse, Liz believed she is “different now because of what she [her preceptor] did then.” Liz now understands that as a nurse, “I have to think ahead. I have to prioritize a little better.”

Liz is proud of being an ICU nurse. She was glad she had the opportunity to experience ICU nursing as a student in a one-on-one clinical immersion experience. Prior to her clinical immersion, Liz thought she might like to practice in a critical care setting but thought she would do this after first gaining experience on a medical-surgical unit. This experience helped her to solidly make the decision to accept a position in the MICU. She stated, “If I wouldn’t have had that I wouldn’t have known for sure what I wanted to do. It would have been a lot harder for me to say with certainty that was what I wanted to do.” Liz was able to work with the same nurse during her clinical immersion and during her orientation to the MICU. When describing her preceptor, Liz stated, “I had a really good preceptor.” She respected her preceptor for her knowledge, skills, and pushing her “further than maybe I wanted to go.” Liz said her preceptor helped her “…realize that this is not a joke. You know, it’s real.”

Besides her ICU immersion experience, Liz also credited her four years working as a scribe in the emergency room (ER) as something that facilitated her transition to nursing practice. Liz came from a family of nurses—a mother who is an advanced practice nurse and a grandmother and aunts who are registered nurses. As a child, she often heard stories told by her nurse relatives. Being an adolescent who wanted to be independent, Liz said, “I wanted to do something different because I was still young. I
was like I don’t want to do that!” Liz recalled that while working as a scribe in the ER and seeing “nurses in action,” it became clear in her mind she wanted to become a nurse.

After 14 months of practice experience in the MICU, Liz came to understand the high degree of responsibility nurses hold. Early in her transition, she viewed a nurse’s work as completing tasks ordered by the physician. Liz has now come to understand nurses as the “sculptors of care…if something’s wrong, they see it first.” Liz continued, “You’re not just a little busy person. You have to really think about it.” Although Liz described her early transition as feeling as if she was “drowning,” she believes her confidence is improving. Early in her transition, Liz said her confidence was low and she was always second guessing herself. After 14 months in the MICU, Liz now understands her confidence is on an upward trajectory but qualified this statement by saying it is “still wavering.” She stated, “There are days I don’t feel confident. I feel more overwhelmed.”

The collegiality of the nurses with whom Liz worked was very meaningful to her as she transitioned from being a student to a practicing nurse. Liz did not experience nor perceive this level of teamwork amongst nurses when she was a nursing student. She believed she would not have made it through her “overwhelming days” if it had not been for her co-workers. Liz said, “We help each other out a lot.” She recalled taking care of her first organ donor patient. Liz was overwhelmed by the emotions involved in the patient’s care as well as the intensive care required by the procurement team to ensure the organ remained viable for donation: “They come in and want eight-thousand things done. I was so overwhelmed.” Liz’s co-workers assumed the care for her other patient, thus allowing her to focus on this single patient. This cohesive team Liz referred to as “amazing” allowed her to feel comfortable asking questions. Liz stated, “If I had
something I had a question on, which I do every day, I go and ask somebody, come in and look at this right now. They will drop what they have and come in and look at it.”

For Liz, this collegiality was extended by some, but not all, of the physicians working in the MICU. She referred to the ICU intensivists as “a whole different group of people.” Liz shared this group of physicians had previously employed two nurse practitioners who had “left and gone elsewhere.” Liz appreciated the nurse practitioners who worked with the ICU intensivist group: “They would take the time to teach you and help you out and explain things.” Liz revealed, “Now it’s just the doctors, and that is kind of daunting.” She appreciated a new physician who had joined the group of intensivists, stating, “She was a nurse before she was a doctor. So, she’ll teach you. She knows the nurse’s value.” This doctor was at Liz’s side as she worked through the complexity of caring for her first organ donor patient. She recalled, “I was so overwhelmed. And Dr. Smith was there and she helped me right along.”

Although the work of the nurse, and especially transitioning as a new nurse, is difficult, Liz believes the rewards outweighed the challenges. She stated, “Your patients care for you and they really do appreciate you whether you think it or not.” Liz recounted a patient she cared for who ended up being a Code Chill—a type of medically induced hypothermia to preserve brain and heart tissue during a major cardiac event. This patient was intubated and posturing during this cardiac incident. She related, “Three days later he was extubated and eating. That’s what makes it rewarding. To see you had a part in that.”
Eleven categories of meaning emerged from Liz’s story of transition to nursing practice. Table 2 presents significant statements from her narrative to support the uncovering of these units of meaning.

Table 2

*Units of Meaning/Category Development for Participant #2: Liz*

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition is overwhelming</td>
<td>• I was overwhelmed every day when I started.</td>
</tr>
<tr>
<td></td>
<td>• I can remember going home and crying.</td>
</tr>
<tr>
<td>Preceptor challenged me</td>
<td>• She pushed me and made me realize what I am going to have to work for.</td>
</tr>
<tr>
<td></td>
<td>• This is what you have to prepare for…figure it out.</td>
</tr>
<tr>
<td>More than one right way</td>
<td>• She just does things differently than I do now.</td>
</tr>
<tr>
<td></td>
<td>• They teach you to do it, but in reality…</td>
</tr>
<tr>
<td>Leave work at work</td>
<td></td>
</tr>
<tr>
<td>Put together</td>
<td>Learn to detach yourself.</td>
</tr>
<tr>
<td>Putting it together</td>
<td>• I have to think ahead. I have to prioritize a little better.</td>
</tr>
<tr>
<td></td>
<td>• It’s just hard to focus all of your thoughts.</td>
</tr>
<tr>
<td>Comfort with choice of job</td>
<td>• [About her preceptorship] If I wouldn’t have had that…for sure what I wanted to do.</td>
</tr>
<tr>
<td></td>
<td>• [Seeing] nurses in action…</td>
</tr>
<tr>
<td>Nurses have enormous responsibility</td>
<td>• Realize that this…is not a joke…it’s real.</td>
</tr>
<tr>
<td></td>
<td>• [Nurses] sculpt the care. If something’s wrong, they see it first</td>
</tr>
<tr>
<td></td>
<td>• You have to really think about it.</td>
</tr>
<tr>
<td>Wavering confidence…still</td>
<td>• There are days I don’t feel confident. I feel more overwhelmed.</td>
</tr>
<tr>
<td></td>
<td>• We help each other out a lot.</td>
</tr>
<tr>
<td></td>
<td>• They will drop what they have and come in and look at it.</td>
</tr>
<tr>
<td>Working with the doctors—teach me</td>
<td>• She was a nurse before she was a doctor. She knows the nurse’s value.</td>
</tr>
<tr>
<td></td>
<td>• [Intensivists are] a whole different group of people.</td>
</tr>
<tr>
<td>A lot of meaning in what I do</td>
<td>Your patients…really do appreciate you.</td>
</tr>
</tbody>
</table>
**Participant #3: Alyce’s Journey**

Alyce is a Pediatric nurse with 16 months of practice experience. Alyce was not planning on working on a pediatric unit. She shared, “I just kind of happened into it. But I love it! I expected to work on an adult floor.”

Early in our conversation, Alyce recounted a significant patient care situation that stood out in her mind because it showed what it was like to be a new nurse. This situation occurred after she was six months into her job. She was off of orientation, was working the night shift, and was the only staff member on the unit. Alyce was caring for a child with a fever who started to seize. She recalled being “terrified’ in this situation. Later in the conversation, Alyce recounted, “You look at the situation and you look at what could I have done better? Or, what could I have changed?” Even though the doctor on call that night told Alyce she handled the situation well, she still reflected on her practice. She said she thought to herself, what “if I had noticed sooner; if I hadn’t been alone?” After this incident, Alyce felt a sense of responsibility to share her concerns. She grasped the gravity of this situation and recognized a stable patient could change very quickly and nurses “should not be alone” on a unit. She stated,

> He was perfectly fine. No history. He just had a fever. And then he wasn’t fine. We should not be alone. It’s not safe. I had a big talk with my manager about how it’s not okay! And then it was shortly after that they hired the techs. And now we are not alone anymore.

Although Alyce stated she was very happy on the pediatric unit, she did reveal that if they were to return to staffing with just one nurse on the unit, she would reconsider her employment. She shared, “After that happened, I contemplated changing jobs, because I was terrified that night.”
As Alyce discussed the relationship she has with the pediatricians on her unit, she revealed she was glad it was a particular doctor who was on call the night her patient seized and she was alone. She stated, “I was just glad it was that doctor and that she got there that quickly. Because some of the other docs, you have to drag them in!” Alyce shared she occasionally meets with her friends from nursing school. The conversation of physician behavior was discussed during one of these get-togethers. Two of her peers told stories of physicians who yell at the nurses. Alyce stated, “I couldn’t imagine working in that type of environment.” Although Alyce shared the doctors have coached her relative to her patient care problem solving, she stated, “They always do it in a polite manner.” She reflected, “I don’t know if it is because they deal with kids or what. I have never been yelled at by a doctor.” Alyce appears to have a collegial relationship with the physicians on her unit, stating, “Half of the job is calling them and being like, okay, this is what I am seeing. This is what I am seeing. What should we do?”

The aspect of nursing education that assisted Alyce the most in her transition to the pediatric unit was the degree to which she learned about culture. She believed this knowledge prepared her to better care for her patients and their families. Alyce shared, “I feel like on peds, you just deal so much more with families. It’s just nice to have that cultural background.” Alyce believes she connects well with people and this has helped her tremendously in her role as a pediatric nurse. She stated, “When you can connect with your patient and they trust you, and the parents, that’s a really big thing for them to trust you to treat their child.” Alyce believes building trust with her patient and their family is very significant to her work as a pediatric nurse.
Alyce valued her preceptor and she respected her for her knowledge. Although Alyce wished her preceptor could have allowed her to participate in more experiences that presented during her orientation, she understood her preceptor’s protective nature, stating, “It’s okay to be protective of your patients. You know, they need protecting.” Alyce did feel she was able to experience a wide array of patients and situations during her orientation with her preceptor. This preceptor role modeled clinical problem-solving for Alyce. Alyce still considers her a valuable resource and shared this about her preceptor: “She really thinks it through, which helps. She doesn’t just follow the doctor’s orders. She’s like, well, okay, this is happening, what else can we do? What other tests can we run? What else should we look at?” This co-creation of meaning and understanding between Alyce and her preceptor was very beneficial to Alyce during her orientation and beyond: “She made me critical think. She would ask me stuff. Okay, well why would this happen or what’s going on here?” Alyce’s relationship with her preceptor has evolved into a mentor-mentee relationship: “I feel like I can call her in the middle of the night and be like this is what’s going on. I don’t have any idea what to do. And she would walk me through it.” Alyce revealed to this day when she provides her preceptor/mentor report at change of shift, her preceptor/mentor offers suggestions for care or challenges her with questions to improve her thinking.

Alyce acknowledged her confidence level has improved since she began working on the pediatric unit. She recalled moving from nursing school to the practice setting was intimidating. Now, “I just have that comfort level where I can address the situation and handle it,” Alyce revealed. Whereas a year and a half ago, “I would have just stood in the back and listened and watched.”
The teamwork on the pediatric unit is something that holds a great deal of meaning for Alyce. She believes “the staff is amazing” and they “have each other’s backs.” Alyce wondered if units that care for adults have the kind of teamwork and support she perceives on the pediatric unit. Having this type of caring culture amongst her co-workers was important to Alyce. She again referred to the situation of the seizing child. Although she was alone, there was a co-worker on a pediatric unit at a different campus. Alyce recalled she called this co-worker to tell her what was happening and to ask for her input. Although this nurse did not offer Alyce any suggestions, Alyce shared, “She knew what was going on and could at least make calls for me.”

Alyce recognized that nursing is very hard work and her education was very hard too. Her advice to a new nursing student would be “It’s challenging and you just have to be ready to apply yourself.” For a new nurse, Alyce offers the following advice: “absorb everything.” Alyce recalled that early in her transition, she spent a good amount of time reading, stating, “If I didn’t know anything, I looked it up. Before I did anything, I would read.” Alyce now understands the tremendous responsibility nurses have in caring for patients. She stated that while she was in nursing school, “You can kind of grasp it [the responsibility], but you really don’t.” Now she understands: “It’s a really huge responsibility.” Alyce referenced a child with a chronic illness who frequented the pediatric unit: “It’s a big responsibility, because I am in charge of him! His mom always leaves because she has other kids. So this kid is my responsibility. That’s a lot!”

Alyce appreciates what the nurse brings for the patient and their family. As a nurse, she values what she calls continuity of care--taking care of a sick child and seeing him/her get better and be discharged. Alyce revealed, “It’s just amazing to see them
progress and get better and improve. I love continuity of care.” She also acknowledged
the impact having a sick child has on a parent or caregiver, stating, “It’s stressful for
them. Yeah it’s hard to see your kid.” For Alyce, having continuity of care on the
pediatric unit allowed her to better care for her patient: “Because you build relationships
with your patients and your parents. Then they know what to expect.” Alyce co-created
meaning and understanding with her patients and families in the same manner this
unfolded between her and her preceptor/mentor--through trust and respect.

Nine categories of meaning emerged from Alyce’s story of transition to nursing
practice. Table 3 presents significant statements from her narrative to support the
uncovering of these units of meaning.
Table 3

*Units of Meaning/Category Development for Participant #3: Alyce*

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>How my education prepared me</td>
<td>It’s just nice to have that cultural background.</td>
</tr>
<tr>
<td>Value of preceptor</td>
<td>• She made me critical think.</td>
</tr>
<tr>
<td></td>
<td>• She really thinks it through.</td>
</tr>
<tr>
<td></td>
<td>• She doesn’t just follow the doctor’s orders.</td>
</tr>
<tr>
<td></td>
<td>• I feel like I can call her [preceptor] in the middle of the night.</td>
</tr>
<tr>
<td>More assertive and confident</td>
<td>• I just have that comfort level where I can address the situation.</td>
</tr>
<tr>
<td></td>
<td>• A year and a half ago I would have just stood in the back.</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>You look at the situation…what could I have done better? Or what could I have changed?</td>
</tr>
<tr>
<td>Nursing is powerful</td>
<td>• It’s amazing seeing them progress. I love continuity of care.</td>
</tr>
<tr>
<td></td>
<td>• You build relationships with your patients.</td>
</tr>
<tr>
<td>A group of supportive nurses/peers</td>
<td>• The staff is amazing.</td>
</tr>
<tr>
<td></td>
<td>• Have each other’s backs.</td>
</tr>
<tr>
<td>Responsibility of the nurse</td>
<td>It’s a really huge responsibility. [As a student] you can kind of grasp it, but you really don’t.</td>
</tr>
<tr>
<td>Overwhelming situation</td>
<td>• I was terrified that night.</td>
</tr>
<tr>
<td></td>
<td>• He was perfectly fine…Then he wasn’t fine.</td>
</tr>
<tr>
<td>Nurse-physician interactions/relationships</td>
<td>• I have never been yelled at by a doctor.</td>
</tr>
<tr>
<td></td>
<td>• I’ve had doctors tell me my thinking was wrong or this is what they would do.</td>
</tr>
<tr>
<td></td>
<td>• Half of the job is calling them and being like, this is what I am seeing.</td>
</tr>
</tbody>
</table>

**Participant #4: Olive’s Journey**

Olive is a Cardiac Step-down nurse with 17 months of practice experience. The unit she works on is fast-paced with high acuity patients. Olive states they can turn over
as many as 21 patients in a day on her unit. Olive shared, “I’ve gone through as many as eight patients in one day shift.” According to Olive, 69% of all admits at the hospital where she works have touched her unit at some point during their stay.

Olive described being overwhelmed as a new nurse:

It’s just learning delegation and time management skills. I mean, probably the first month when I was by myself I was overwhelmed a lot of the time. But thankfully because of the preceptorship [a clinical immersion that occurred in the final semester of Olive’s BSN curriculum] it was a little bit smoother.

Olive had an emergency room clinical immersion/preceptorship experience in her nursing curriculum. She was thankful for the procedures and “tasky” duties she encountered during this immersion experience. Olive said when she first started working as a nurse on the Cardiac Step-down unit, she was overwhelmed not only by learning how to provide care to the patients on this unit but she was also overwhelmed by all of the demands of working with multiple healthcare team members such as physicians, hospitalists, and case managers. To deal with her feelings of being overwhelmed, Olive realized early in her orientation she needed to work on her time management skills.

When asked how she learned to manage her time, Olive responded, “It was practice. It was, you know, I try this out, this doesn’t work. I try this and this does.” Olive identified two other aspects of her new role that led to this profound feeling of being overwhelmed: working with patient care technicians and determining how to organize her care in a manner that made sense to her way of providing patient care. She recognized early into her transition that having a trusting relationship with the care technician she was working with was crucial. Olive stated, “If there’s no trust between you and the tech, it puts a lot more stress on me.” Olive realized in such a fast-paced environment where she was ultimately responsible for the care of her patients, a trusting relationship with her care
assistant was very important. Another significant aspect of her early transition was determining how she would organize her nursing care. Some things she kept the same as her orientation nurse had taught her. Olive disclosed, “And some of them, it was things that I adapted that I liked better my way. So, it was kind of getting to know what practice I liked and how to do things. Every nurse does things different.”

Olive recalled her feelings of being overwhelmed began to diminish about two months after being off orientation. She revealed, “I feel like I got a further grasp on things probably about six months.” Olive qualified this, “There are still times you question yourself. There’s still times that that I’m like, oh, am I doing this right?”

Olive used her experiences during her early transition to make sense of what seemed to be a chaotic work environment. She shared the experience of a patient who died 15 minutes after she came on shift. Olive had not been to this patient’s room before he expired. She disclosed, “I wasn’t told in report that he was that close to death. I didn’t even get to assess him before a tech came and grabbed me, and she’s like his breathing is getting really shallow.” Olive has also become familiar with the more routine care situations on her floor such as open-heart surgeries. She has developed a strong knowledge base relative to caring for the types of patients seen on her unit and this has assisted in reducing her feelings of being overwhelmed. Olive shared, “This is what I do every morning for my routine. Okay, who needs to be seen first? Who is the biggest priority to be seen now? And who can wait till last?” Olive continued, “I definitely feel like now I have a system.”

Olive acknowledged the doctors intimidated her when she began working on her unit. She realized she needed to build credibility with them. Olive shared, “In the
beginning they kind of look at you like, oh, you’re young. Oh, you’re a new nurse. And they kind of talk down to you a little bit.” Olive indicated, “My relationships with the doctors have gotten better over time.” She has learned to anticipate the doctor’s needs and preferences and this has enhanced her relationships with them. Olive has been a victim of bad physician behavior in the time she has been practicing as a nurse. She stated, “Some doctors are always going to be rude.” She believed this poor behavior was inconsistently addressed by management on her unit and by administrators within the hospital. She also perceived a double standard when it came to addressing unacceptable behavior. Olive stated,

Sometimes it gets swept under the rug. If they are notorious for throwing a fit like a two-year old, they’ll get away with it. I’ve seen some people, doctors, really act ridiculous toward various nurses at various skill levels. Just because they can! And you know what? If I did something like that, you would have my job!

When asked why she thought this type of behavior was tolerated, Olive stated, “It’s still that doctor-nurse, I know more than you do. I am the authoritarian. I mean, especially with some of the older doctors.” Olive described a personal experience:

I’ve been called something very nasty in front of a patient before. So much that the patient refused to let the doctor come back into the room until he apologized, to me, in front of her! And then she called the manager before I even had a chance to call the manager!

Olive stated, “So unfortunately some of them [physicians] do get away with murder. And sometimes they get in trouble.”

Olive believes something that could have better prepared her for the transition to nursing practice would have been to experience longer clinical days early in her nursing curriculum rather than waiting until her final year for full-day experiences. She reflected that with longer days, the student has the time “to get the process” and a better
understanding of “what is going on within the nurses’ day-to-day responsibilities.” She stated, “I don’t think I could have learned anything more in the classroom.” Olive continued, “I feel like them [student] being there longer days would provide more, I don’t know, comfort. It really doesn’t matter what kind of patients they are taking care of, as long as they are starting to learn to understand what it is like to be a nurse.” Olive disclosed her transition was “a little bit of a shell shock… It’s like I have to do all of this!”

In her transition, Olive came to understand the importance of relationship building with everyone with whom she came in contact. She believes there is value in “treating other people, whether it is dietary, your cleaning lady, whatever, treating them all nicely! Because the nicer you treat them, the nicer they are to you.” To Olive, this was a vital aspect of getting things done for the sake of the patient: “I have seen nurses that are crabby toward these other people or treat them badly. Why? Why would they rush to help you?”

Olive worked as a patient care technician prior to entering nursing school. She believes this experience helped her learn organizational skills and become familiar with healthcare terminology. She believes having this experience helped her understand the nurse-patient care technician relationship. Olive shared, “That’s another thing we see with nurses who have never ever had any experience in the health care field. They expect a lot. And they don’t necessarily treat the techs the best. They are my right hand!”

Olive views her job as being more rewarding now than it was when she first began her transition. She reported her confidence has increased. She felt embarrassed to ask questions as a new nurse, stating, “Like, as a new nurse, if I didn’t know, I was
embarrassed. Now I’m not embarrassed.” Olive shared her unit is known as the “mean unit.” Although she attributed this to the high level of patient acuity and the fast-paced nature of the unit, Olive also perceived her unit as “cliquey” and at times unwelcoming. Olive described her unit in this way: “I think it’s a great place to start out. But I think if you don’t have the tough skin to do it, I think it can destroy you! Because there’s times I have gone home and I’m like, I don’t think I can do this anymore. And it’s not being a nurse.” Olive felt “since I was new, I was the outsider. And I was stupid! Because I was a new nurse, and you know, you felt those kinds of stereotypes a little bit.” What concerns Olive about her unit is “there is very few expert, senior nurses that have been there a long time.” Olive attributed this to the high turnover rate on her unit prior to her being employed, which she believed was a function of the physical and emotional demands of the unit.

Olive was thankful for her preceptor as she was transitioning. She stated,

The nice thing about having your orientation nurse is that you kind of build a relationship with that nurse. And she’s kind of like your confidant. If you are scared to go to the charge nurse because you think you are going to be embarrassed, you can go to that nurse.

Olive was often reluctant to go to the charge nurse on her unit because she was made to feel “stupid sometimes.” Even after orientation, Olive would go to her preceptor or a trusted senior nurse if she had questions. Olive shared that because of the culture on her unit, it was important for her to have her preceptor “or another senior nurse that you’re friendly enough with that you feel comfortable going to them and them not belittling you.” Olive enjoys working on the weekends because they do not have a dedicated charge nurse on the weekends. Instead, she works with nurses with three to five years of experience. She indicated, “They are more likely to help you out.”
Olive feels an obligation to teach nursing students she works with on her unit. Her focus was to emphasize the aspects of nursing she feels were deficient in her educational experience. Olive has a strong sense of assisting new students in their work to become a nurse. Her advice comes from what she experienced as a new nurse in transition. Some of her advice to nursing students is very practical—how to organize and manage your time, and how to receive a thorough report and prioritize your patients. An insightful piece of advice Olive learned from her experience of transition was this:

“Nursing is not like other careers where you graduate with all the knowledge you need for that career and you’re going to go into that career and just knock them out. Health care will never be that cut and dry.”

As Olive reflected on her transition, an aspect that holds great meaning for her is “seeing how much of a difference you make.” Although she feels her efforts often go unacknowledged and some patients and families appear unappreciative, she takes great pride when she “makes a difference in somebody’s day.” Olive said at first it was difficult for her when a patient was indifferent or appeared not to like her. She confided, “Some people are never going to like you. And that’s a hard pill to swallow for a lot of people! For me it was! Like, you don’t like me? I never did anything to you. I am here to take care of you.” But on the other side of this picture were the patients and families who had been impacted by the nursing care they received. Olive continued,

And then some people will shock you! Because you will have no idea of how much of an impact you make. I’ve gotten emails to my manager, phone calls, letters, and stuff like that. Then some people will flat out tell you that they love you and that you’re awesome.
The positive affirmation is what holds great meaning for Olive as she is learning the art of nursing practice. She stated, “At the end of the day, for every terrible, crying, atrocious day I have, there’s ten more like it that are good.”

Eight categories of meaning emerged from Olive’s story of transition to nursing practice. Table 4 presents significant statements from her narrative to support the unfolding of these units of meaning.
Table 4

*Units of Meaning/Category Development for Participant #4: Olive*

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everyone does it different/</td>
<td>- It was kind of getting to know what practice I liked and how to do things. Every nurse does things different.</td>
</tr>
<tr>
<td>Theory versus practice/</td>
<td>- It was practice…I try this out, this doesn’t work…this does.</td>
</tr>
<tr>
<td>Managing nursing care/</td>
<td>- I definitely feel like now I have a system.</td>
</tr>
<tr>
<td>Learning a routine</td>
<td></td>
</tr>
<tr>
<td>Nurses have a great deal of responsibility</td>
<td>- It was a little bit of a shell shock for me.</td>
</tr>
<tr>
<td>Wavering confidence</td>
<td>- It’s like, I have to do all of this!</td>
</tr>
<tr>
<td>Transition is overwhelming</td>
<td>If there’s no trust between you and the tech…more stress on me.</td>
</tr>
<tr>
<td>Nurse-physician interactions/ relationships/</td>
<td>- Some doctors are always going to be rude.</td>
</tr>
<tr>
<td>Building trust/ Double standard</td>
<td>- In the beginning they kind of look at you like… you’re a new nurse.</td>
</tr>
<tr>
<td></td>
<td>- Sometimes it gets swept under the rug.</td>
</tr>
<tr>
<td></td>
<td>- Just because they can.</td>
</tr>
<tr>
<td></td>
<td>- If I did something like that, you would have my job.</td>
</tr>
<tr>
<td>Culture of unit/ Working together…or not</td>
<td>- If you don’t have tough skin…it can destroy you.</td>
</tr>
<tr>
<td></td>
<td>- I was like the outsider.</td>
</tr>
<tr>
<td></td>
<td>- If there’s no trust…it puts a lot more stress on me.</td>
</tr>
<tr>
<td></td>
<td>- [The weekend nurses] are more likely to help you out.</td>
</tr>
<tr>
<td></td>
<td>- I was nervous to ask my charge nurse a lot of things.</td>
</tr>
<tr>
<td>Value of preceptor</td>
<td>She’s kind of your confidant.</td>
</tr>
<tr>
<td>Nurses make a difference</td>
<td>- Seeing how much of a difference you make to that one patient.</td>
</tr>
<tr>
<td></td>
<td>- It’s rewarding.</td>
</tr>
<tr>
<td></td>
<td>- Makes a difference in somebody’s day.</td>
</tr>
<tr>
<td></td>
<td>- You will have no idea of how much of an impact you make.</td>
</tr>
<tr>
<td>Relationship building</td>
<td>- Treating other people…nicely!</td>
</tr>
<tr>
<td></td>
<td>- I have seen nurses…treat them badly.</td>
</tr>
<tr>
<td></td>
<td>- They don’t necessarily treat the techs the best.</td>
</tr>
</tbody>
</table>
Participant #5: Kate’s Journey

Kate is a Medical-Surgical-Pediatric nurse with 17 months of practice experience. She started her nursing career on a Medical-Surgical unit but transferred to a Medical-Surgical-Pediatric unit within the same hospital after 12 months of employment. Her reason for transferring to a new unit was to gain pediatric experience. Kate’s ultimate goal is to work on a pediatric unit at a larger hospital that specializes in the care of children.

Kate shared early in her transition to nursing, she would seek confirmation from the charge nurse when she needed to make patient care decisions. Kate shared, “I would know what to do, but since I was new I still felt like I had to go ask someone to make sure that I was making the right decision and stuff.” Kate recalled she did this for a couple of months. As her questioning continued, Kate reached a point where she thought to herself, “that’s exactly what I thought, but now you probably think I didn’t know that.” Kate’s confidence was at a place where she “wanted to double check” her care decisions. Eventually, Kate started making those decisions on her own. She recalled, “And then when it happened, I just immediately started doing things.” When this happened, she recalled thinking to herself, “Oh! I am starting to get confidence. I actually know what I am doing!”

What stood out to Kate as the most significant aspect of transitioning from being a student to being a nurse was the degree of responsibility that came with the title of registered nurse. Even though she was taught about the responsibilities of the nurse as a student, Kate said, “I don’t know if it’s just the responsibility of this is completely my patient or what. But it just seemed so much more emotionally draining.” She believes
this emotional stress and overwhelming sense of responsibility has lessened since her confidence has improved. Although she was not prepared for this great sense of responsibility, Kate believed her nursing education prepared her well for her transition to nursing practice. She did, however, wish the nurses on the units where she practiced as a student were more open to sharing nursing experiences with her when patients outside of her care were receiving treatments or procedures. Referring to nurses on the units where she practiced as a student nurse, Kate stated, “Something might not happen that day. But, there’s someone somewhere else that something’s happening. And they don’t think, I could show the student this.”

Kate shared a situation where she was learning how to use a piece of equipment on her unit--an auto-transfuser for orthopedic patients. Kate stated, “I watched someone do it twice and then I bent down to do it and I was like, I don’t know. I never really touched it.” Kate referred to herself as a “hands-on learner.” This situation confirmed her understanding of herself.  

Kate was a student in an accelerated BSN program. She believes her prior biology degree helps her understand the physiologic processes going on with her patients. She also felt strongly her anthropology and sociology minors assist her with patient and family interactions. Kate believes her anthropology minor aids her in caring for individuals from diverse backgrounds. She stated, “A lot of people I feel like don’t either know or don’t really know how to work with people from diversity. Or don’t realize that diversity is not just race or something like that.” Kate went on to discuss a Hispanic cancer patient she cared for; this patient would not tell her he was having pain. Kate shared that the nurse needs to “try to encourage those people that we want to keep you
comfortable and we have this medicine for you to help you. And you know, kind of help them to help themselves.”

Kate believes having an aunt with severe cerebral palsy also assisted her transition to nursing practice. Kate’s aunt is non-verbal and has significant muscular-motor impairment. She revealed, “Just interacting with her has helped me a lot.” There is a developmental/handicap center near the hospital where Kate works and her unit frequently cares for patients from this facility. She believes interacting with her disabled aunt has helped her in caring for patients with cognitive and physical disabilities. Kate shared, “Most people I feel like would just go in there, push the medicines in and that stuff. You still need to talk through it. Talk to them like they are an actual patient.”

Kate considers herself to be a “shy” person. She believes she is now more comfortable with patient interactions than when she first started her job. Kate recalled interacting with patients while her preceptor was present: “When I was working with my preceptor I would just kind of feel awkward in front them [patient and preceptor]. But when it was just me in the room with them [patient], it was fine.” Kate described her confidence as steadily increasing since she began working as a nurse. She shared, “I started off pretty low.” She shared that her confidence is still increasing and she feels “pretty confident” now. She is surprised at the fact that new nurses are starting to come to her when they have questions. “It’s weird, but I feel comfortable answering them for the most part,” Kate replied.

For the new nurse transitioning to the practice setting, Kate’s biggest piece of advice was, “Don’t be afraid to ask questions and don’t be afraid to ask for help.” Kate recalled she asked a lot of questions at the beginning of her transition. Then there was a
point when she began apologizing for asking so many questions, saying, “I’m sorry, I’m probably being annoying.” Then she began to worry her co-workers would think she did not know anything. Sometimes Kate would ask questions she had already asked because her confidence was low and her overwhelming sense of responsibility placed her in a state of concern for causing harm to a patient. Kate stated she had a very supportive charge nurse who “stressed to me it’s no problem. Everyone asks questions in the beginning. You’d rather ask than do something wrong.” Kate would also tell a new nurse,

Listen to your gut. Because a lot of times you can tell that it’s starting to go bad before it really shows. And taking the time to kind of know your patient’s even if it’s busy. It’s just so you can see those subtle changes that could be warning signs. Like, try to catch the problem before it occurs.

A source of stress for which Kate felt she was not prepared was the legal aspect of nursing: “There’s so much that you just have to cover yourself for just in case. And it’s just so stressful to just make sure that you document everything so that it couldn’t come back to you if something would happen.” She shared a patient care situation that involved a patient from the nearby developmental/handicap center. This patient received multiple blood draws and multiple intravenous (IV) starts. When the patient returned to their residential center, the caretakers observed multiple bruises. The hospital was contacted when personnel from this residential center became concerned about the bruising. The patient record at Kate’s hospital showed no indication that the bruising existed on this patient. Kate revealed she was told, “We need you to go back and make sure the bruise is documented for this time and this time. Because if not they could come after us for abuse.” Kate continued, “So, just something simple like that could turn.”
Kate works both evening and day shifts. She appreciates the sense of teamwork present on the evening shift and attributes this in part to the fact that all faculty and managers being gone during this shift. She said, “We just kind of have each other.” According to Kate, the afternoon shift is the busiest and most stressful shift of the 24-hour day with numerous admits and discharges. She said, “But I think that pulls us together. You have to work together to get the stuff done.” Kate continued by saying, “If one person is having a bad night, we try to like pitch in and help. It’s just from the experience of knowing what it’s like to be the one in that situation that just makes you want to help someone else.” Kate described the day shift as being “more intimidating than approachable. They are the ones that have been there like for 35 years. The lifers, you know?” She does not perceive the same type of teamwork on the day shift that she experiences on the evening shift. Kate views day shift nurses as “doing your own separate thing.”

Working with the doctors as a nurse has been an experience that differed from what Kate observed in nursing school. While in school, Kate observed the doctors wanted the nurses to do rounds on patients with them. Kate shared, “They want you to hear what they have to say.” At her current job, Kate perceived the doctors “kind of look at you to get out of the room. So then I feel like I can’t do anything. And I feel like either the patient or the family is asking me questions afterwards and I’m like, I don’t know what he said. I wasn’t in there.” To answer patients’ questions, Kate then has to look through the doctor’s progress notes. Kate disclosed,

I’ve learned, something that I didn’t notice at first I guess, was that I wasn’t really paying attention to who was ordering what and, you know, those kinds of situations. Now I’m paying attention to that and I can just kind of guess what’s coming when I see a doctor’s name.
She reported the doctors intimidated her when she first began her job. Kate indicated receiving orders from physicians was particularly challenging, “especially when you are new and you are not knowing what to expect them to order.” Kate also learned a strategy to enhance her relationship with the doctors on her unit. She shared,

> When they are available or like in the nurse’s station or something, I’ve started to try to create a conversation with them. So if they know who you are, they don’t get near as mad when you call them. They are much more willing to answer you and be nice about it.

The aspect of nursing most meaningful to Kate is “the comforting factor. Like comforting patients and comforting families. Just putting that little extra in to make the family feel special and that you care is pretty meaningful.” Kate shared it is nice to be recognized by patients and families: “You know that you made a difference. It’s less in the skill and more in the interaction I feel that is meaningful.”

Seven categories of meaning emerged from Kate’s story of transition to nursing practice. Table 5 presents significant statements from her narrative to support the unfolding of these units of meaning.
Table 5

*Units of Meaning/Category Development for Participant #5: Kate*

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence/Trust in yourself</td>
<td>• I would know what to do. I still felt like I needed to go ask someone.</td>
</tr>
<tr>
<td></td>
<td>• Now you probably think I didn’t know that.</td>
</tr>
<tr>
<td></td>
<td>• I started out pretty low. I feel pretty confident now.</td>
</tr>
<tr>
<td></td>
<td>• People are starting to come to me now when they have questions. It’s weird. I am comfortable answering them for the most part.</td>
</tr>
<tr>
<td></td>
<td>• I actually know what I am doing.</td>
</tr>
<tr>
<td></td>
<td>• Listen to your gut.</td>
</tr>
<tr>
<td></td>
<td>• Those subtle changes that could be warning signs.</td>
</tr>
<tr>
<td>Responsibility of nursing</td>
<td>• It’s just the responsibility…this is completely my patient.</td>
</tr>
<tr>
<td></td>
<td>• So much more emotionally draining.</td>
</tr>
<tr>
<td>Past experience that helped transition</td>
<td>A lot of people…don’t really know how to work with people from diversity.</td>
</tr>
<tr>
<td>Teamwork/(Un)Helpful behaviors</td>
<td>• Afternoon shift…They’re much more approachable.</td>
</tr>
<tr>
<td></td>
<td>• Day shift ones…are more intimidating than approachable.</td>
</tr>
<tr>
<td></td>
<td>• The afternoon shift is really busy. I think it pulls us together.</td>
</tr>
<tr>
<td></td>
<td>• We just kind of have each other.</td>
</tr>
<tr>
<td>Nurse-physician relationships</td>
<td>• They just kind of look at you to get out of the room.</td>
</tr>
<tr>
<td></td>
<td>• Now I’m paying attention…I can kind of guess when I see the physicians name.</td>
</tr>
<tr>
<td></td>
<td>• If they know who you are, they don’t get near as mad when you call them.</td>
</tr>
<tr>
<td>Impact of the nurse</td>
<td>• You know that you made a difference.</td>
</tr>
<tr>
<td></td>
<td>• Less in the skill and more in the interaction.</td>
</tr>
<tr>
<td>Legal implications of nursing</td>
<td>• Document everything so it couldn’t come back to you.</td>
</tr>
<tr>
<td></td>
<td>• Something like that could turn.</td>
</tr>
</tbody>
</table>
Participant #6: Kara’s Journey

Kara is a Medical-Telemetry nurse with 17½ months of practice experience. Kara was an accelerated student who started her BSN program three weeks after completing her first bachelor’s degree. For Kara, the most significant aspect of moving from being a student to being a nurse was the realization she was entering into a career and would be responsible for supporting herself. She shared,

I think that transition of realizing, I guess I’m an adult now. I’m out of school now. I have to work. That realization was something I wasn’t prepared for. I mean you always think eventually I will be done with school, but you never see the end till it’s actually there.

Kara’s career as a nurse meant that she was now able to transition from a college dorm and her parents’ home to living in the world as an adult. She shared she now has a car, a car payment, is buying a house, and is getting married. Kara further elaborated, “All of this stuff would have never been able to happen had I not gone to school and got a job that pays well and gives me lots of opportunities to go millions of different ways or places.”

Time management was one of the greatest challenges for Kara as she transitioned to practice. Kara believes being a student in an accelerated BSN program helped prepare her for being a nurse. She stated, “Being able to manage and juggle all of the things of being a BSN-A was something that, you know, being able to juggle 40 things at once. That’s what you do as a nurse. You juggle 40 things.” Learning how to structure her day was a challenge as she began as a new nurse. It became apparent to Kara early in her transition that she needed to plan for when “something is thrown at you later in the day.” To get to that point, Kara said, “It just takes a while to know the flow of the patients and the flow of your unit too. Because we have a lot of really sick patients on our unit.”
Kara also appreciated being able to experience clinical rotations on a variety of units when she was a student. She elaborated, “Having the experience and knowing going into it, that you are not accepting a job that you know you are not going to like. When I had to pick jobs I was like, I will not work on Step-down. I know I don’t like the environment of Step-down. But Med-Tele I would love.” Kara believes this is a critical component of making the new nurse feel more comfortable in his/her transition. She proclaimed, “It’s always scary because you’re like, I don’t know anything!”

Kara believes her confidence level is “markedly better” since she began her job: “They trust me enough to have an orientee and I have only been a nurse for…” [17 months]. Kara shared a story that contrasted where she was currently as a new nurse compared to where this orientee with one month of experience was in her practice. A patient care technician had taken the blood pressure of one of Kara’s (and the orientee’s) patients. The blood pressure was low but the care technician did not report this to Kara and the orientee. When they discovered this two hours later while documenting it in the chart, the two nurses immediately went to check on the patient. Kara reported the blood pressure had come up but was still low. Kara remained calm in this situation but stated, “She’s [the orientee] freaking out because she’s new. And I’m like he’s fine. Everything’s fine. Well she’s like why are you so calm?” Kara continued to say to the orientee, “He’s sitting in the chair talking to us. You know, everything’s fine. He feels fine.” Kara continued to describe the orientee’s reaction to this situation: “She’s like I don’t know why you are not freaking out right now!” Kara reflected it took her about six months to one year to be confident enough to begin to put a clinical picture together in a situation such as the one described. Kara reflected,
It takes a while. It takes confidence in yourself and someone reassuring you when you’re freaking out, that it’s okay. He’s okay. And there were times when I would definitely, probably would have freaked out, or gone to someone and been like, what do I do? I don’t know what to do.

Kara conceded, “Some days I still feel like a new nurse. Sometimes I still don’t’ know what to do.”

What helped Kara improve her confidence and practice was having co-workers who are supportive and helpful. Kara stated, “The people I work with I was never afraid to say, uhh, hey, I really don’t know what is going on. Can you help me here?” The experienced nurses on the unit provided Kara with a great deal of support during her orientation and continue to do so today. Kara shared, “I don’t want to hurt anyone obviously. I still ask questions all the time.” Kara also found support from other peers who were new nurses in transition. Kara stated, “A lot of times we would run things by each other. And if we still didn’t know what to do, we would go to someone else who had been in nursing longer than us.” The sense of support and teamwork Kara perceived on her unit went beyond getting her questions answered. She shared an occasion where she had a heavy patient load and was “swamped.” She asked her co-workers to assist her with administering medications for her patients. Kara said, “They replied, ‘Sure!’ And all of a sudden they’re up and it’s not an issue.” This sense of teamwork appears to be pervasive on this unit and Kara extends this same courtesy to her coworkers. Because her unit has very complex patients, she often answers call lights stating, “If the techs are just running crazy trying to get their baths in, they can’t answer all of the lights. Sometimes they just can’t do it all.”

Kara was appreciative of her preceptor. She described her preceptor as “very knowledgeable. But the way she kind of carries herself sometimes throws people off,
because she’s not the most personable. She’s not the kind of come up and laugh kind of nurse.” Although the technique used by this preceptor might not be helpful to everyone, Kara believes her orientation experience prepared her well for independent practice. Kara reported she simply watched her preceptor for the first couple of days of her orientation. Kara reflected, “Then she said, here’s your patients. Here you go. And I felt for me that was good. Because you kind of learn on your feet.” Kara continued, “Not that she wasn’t behind me every step of the way and answering my questions and all that stuff.” Kara believes this technique made it less “overwhelming” for her when she was off of orientation. Kara stated this technique forced her to do things she did not feel she was ready to do. She recalled phoning the doctor for the first time--an experience she described as “the most horrifying thing in my whole life.” This experience ended up not as bad as Kara anticipated but she feared, “What if they think I am an idiot? What if they ask me questions I don’t know the answer to?” As she made this first call, her preceptor was at her side to offer her support and assistance. Kara shared, “I think I am a better nurse because of being with her. I think that’s the whole point of it anyway.”

Kara’s advice to the new nurse was, “Don’t be afraid to ask questions because it’s the only way you learn. It’s the only way you get more confident.” She further elaborated by saying,

If you make a decision and you ask is this what you would do and they agree with you, then you are like, okay I do know. It’s more reinforcement that I do know what I am talking about. Or if they are like, no, no, no. Don’t do that, then like, oh crap! Maybe I need to re-evaluate here. Not your skill set, but your way of thinking on that particular thing.

Kara also advised the new nurse to

use your experiences that you’ve had on clinical to decide what the best fit is for you; patient load and that kind of stuff. Use those experiences to make the
decision where you are going to be the happiest. And not just take a job because it’s a job.

Kara’s relationships and interactions with physicians have developed since her first “horrifying” call to a physician during her orientation. She believes developing these relationships were intimidating initially because of her limited direct interaction with doctors while she was a student. Kara stated, “You see the doctors sometimes when you are a student. But they don’t really interact with you. They interact with the nurses and you’re there.” Kara continued, as a nurse “you are on the phone with them and they’re like, well what’s going on? Why are you calling me? And sometimes they make you feel dumb.” Kara described the new nurse-doctor relationship as a situation where the doctor does not “have confidence in you in the beginning because they don’t know what kind of nurse you are” and the new nurse does not have confidence because he/she has minimal experience interacting with the physician in this manner. Kara believes a more collaborative relationship with some physicians would allow her to be more effective and efficient in caring for patients. Kara shared, “Some of them I wish would talk to us more. Because some of them come in, they pop in, and they are gone before you even blink an eye! So it makes it really hard.”

When Kara began her first undergraduate degree, her career goal was to become a doctor--a childhood dream. As she pursued a degree in biology, she came to realize doctors “don’t actually see their patients and they don’t actually take care of their patients. And the people who actually take care of them are nurses.” Although Kara reports there are days where nursing is extremely challenging and “some days I come home and I want to bang my head against the wall,” she is confident in her career choice. Kara does not perceive these challenging days are a function of her lack of experience
nor her lack of confidence. She believes it is based on the acuity of the patients for whom she cares.

What makes this career choice so rewarding and meaningful for Kara are the “days when your patients and their families are so grateful, and they know what you are sacrificing to care for them. Those are the days where I am like, I chose the right thing. You make a difference in these peoples’ lives.” Kara revealed she did not realize the impact she would have on patients and families when she entered the profession. She recalled a recent encounter when she saw a family member of a patient for whom she had cared. This family member knew Kara by name even though the care Kara had provided was six months prior. Kara shared the family member told her, “We think about you guys all the time.” Kara stated, “There are patients’ family members who you can’t please. That part’s not the greatest. But, the good outweighs the bad by a lot, I think.”

In her 17-month career, Kara has achieved recognition for the nursing care she provides. She shared, “I have been nominated for a couple of Daisy Awards.” The Daisy Award program is a national program that recognizes achievements of nurses who provide exceptional patient care. Kara revealed her first award was while she was on orientation and the second award was two months later. Kara said, “The recognition that someone is realizing what we are doing” holds great meaning for her.

Eight categories of meaning emerged from Kara’s story of transition to nursing practice. Table 6 presents significant statements from her narrative to support the unfolding of these units of meaning.
### Table 6

*Units of Meaning/Category Development for Participant #6: Kara*

<table>
<thead>
<tr>
<th>Category</th>
<th>Significant Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of confidence</strong></td>
<td>• Some days I still feel like a new nurse.</td>
</tr>
<tr>
<td></td>
<td>• I don’t want to hurt anyone obviously. I still ask questions all the time.</td>
</tr>
<tr>
<td></td>
<td>• It takes confidence in yourself and someone reassuring you.</td>
</tr>
<tr>
<td><strong>Support of coworkers</strong></td>
<td>• I was never afraid to say I really don’t know what’s going on.</td>
</tr>
<tr>
<td></td>
<td>• [Asking for help]: Sure! And all of a sudden…and it’s not an issue.</td>
</tr>
<tr>
<td><strong>Preceptor’s approach</strong></td>
<td>• Then she said here’s your patients.</td>
</tr>
<tr>
<td></td>
<td>• I think I am a better nurse for being with her.</td>
</tr>
<tr>
<td></td>
<td>• You kind of learn on your feet.</td>
</tr>
<tr>
<td><strong>Challenges of transition/Prepared for transition</strong></td>
<td>• To be a BSN-A, you have to manage your time well.</td>
</tr>
<tr>
<td></td>
<td>• It just takes a while to know the flow of patients’… unit too.</td>
</tr>
<tr>
<td><strong>Transitioning to life/Growing up</strong></td>
<td>• Going from being a student…to…I have a job.</td>
</tr>
<tr>
<td></td>
<td>• Realizing…I am an adult now.</td>
</tr>
<tr>
<td><strong>Grateful patient/Nursing is powerful</strong></td>
<td>• Days when your patients…are so grateful…they know what you are sacrificing to care for them.</td>
</tr>
<tr>
<td></td>
<td>• You make a difference in these peoples’ families, their lives.</td>
</tr>
<tr>
<td><strong>Nursing is a lot/A lot of responsibility</strong></td>
<td>Being able to juggle 40 things at once. That’s what you do as a nurse.</td>
</tr>
<tr>
<td><strong>Nurse-physician relationship/interaction</strong></td>
<td>• Sometimes they make you feel dumb.</td>
</tr>
<tr>
<td></td>
<td>• Some of them I wish would talk to us more.</td>
</tr>
<tr>
<td></td>
<td>• They don’t have confidence in you in the beginning.</td>
</tr>
<tr>
<td></td>
<td>• What if they think I am an idiot?</td>
</tr>
</tbody>
</table>

### Relational Themes

Fifty-four units of meaning/categories were uncovered from across all six interview narratives based on interpretations that occurred in stages one, two, and three of
the Diekelmann et al. (1989) hermeneutic analysis process. In stage four of data interpretation, the units of meaning/categories identified in each of the participant’s stories were expanded, collapsed, or abandoned within each narrative and across all narratives. The researcher again read each participant’s story. The units of meaning were viewed as a web of belief as the researcher analyzed existing relationships and connections that cut across all participants’ stories.

Five relational themes emerged from the six stories of transition and the resultant units of meaning/categories: My Work Provides Me with Meaning, You Must Look Outside Yourself to Make an Impact, I Need a Supportive Environment to Thrive, Trust Is a Two-Way Street, and If You Teach Me, I Will Grow.

**Constitutive Patterns**

A constitutive pattern is the highest level of hermeneutic analysis. Constitutive patterns express the interconnection of the relational themes identified in Stage four of this analysis and reflect the meaning revealed from all participants’ transition experiences. Three constitutive patterns of being-in-the-world as a new nurse in transition emerged from the stories shared by the participants in this study: (a) Being a Nurse Is Impactful; (b) When Nurses Support Nurses, the Patient Is at the Center; and (c) Nurse-Doctor Interaction: Do No Harm.

The constitutive pattern--Being a Nurse Is Impactful--included the relational themes of My Work Provides Me with Meaning and You Must Look Inside Yourself to Make an Impact. The constitutive pattern--When Nurses Support Nurses, the Patient Is at the Center--included the relational theme I Need a Supportive Environment to Thrive. The final constitutive pattern--Nurse-Doctor Interaction: Do No Harm--included the
relational themes of Trust Is a Two-Way Street and If You Teach Me, I Will Grow. Support for the emergence of these constitutive patterns and relational themes are discussed below.

**Being a Nurse Is Impactful**

The constitutive pattern--Being a Nurse is Impactful--was derived from the relational themes of My Work Provides Me with Meaning and You Must Look Inside Yourself to Make an Impact. This meaning was revealed in the stories of transition shared by all participants.

With all of the stress inherent in nursing and particularly in transitioning as a new nurse, all of the participants shared a great deal of meaning was derived from the impact they made on their patients and their families. For Bryan, his transition experience caused him to move from a more inward focus to an outward, bigger focus in which he came to realize it was difficult for an arrogant nurse to connect with his/her patients. He shared, “You can’t be arrogant as a nurse” because this interferes with the nurse-patient relationship. Liz came to understand the rewards of being a nurse far outweighed the challenges she had experienced: “To see that you had a part in” making your patient better provided great meaning to Liz being a nurse. She believed, “Your patients care for you and they really do appreciate you whether you think it or not.”

Alyce valued the impact she had on both her patients and their families. What brought meaning to Alyce as a nurse was taking care of a sick child and seeing them get better and go home. Alyce shared, “It’s just amazing to see them progress and get better and improve.” Olive took pride in making “a difference in somebody’s day.” She shared it was difficult for her at first when a patient appeared to not like her. The greatest
meaning for Olive came from “seeing how much of a difference you make.” Although she worked on a high acuity, high stress unit, she shared, “At the end of the day, for every terrible, crying, atrocious day I have, there’s ten more like it that are good.”

Kate shared the aspect of nursing that held the most meaning for her was “the comforting factor…just putting that little extra in to make the family feel special.” Kate believed nursing is “less in the skill and more in the interaction” that is meaningful. For Kara, the meaning of nursing came from the “days when your patients and their families are so grateful, and they know what you are sacrificing to care for them. Those are the days where I am like, I chose the right thing.” “The recognition that someone is realizing what we are doing” was very powerful to Kara.

**When Nurses Support Nurses, the Patient Is at the Center**

The constitutive pattern--When Nurses Support Nurses, the Patient Is at the Center--was derived from the relational theme--I Need a Supportive Environment to Thrive. Overall, the participants in this study shared positive experiences with the nurses they worked with and the units where they practiced. When mentioned by these new nurses, the preceptors played a significant role in the new nurses’ transition and understanding of what it means to be a nurse.

The nurses in the OR supported Bryan as he learned to become an effective surgical team member. He believed his preceptor had a significant impact on his transition. Bryan came to understand having the support of a preceptor “makes the biggest difference in the world on how you get to go and do your job.” Bryan also appreciated the constructive feedback he received from his coworkers early in his
transition. This feedback served as an “awakening” for Bryan, thus allowing him to continue to develop in his role.

Liz shared her preceptor pushed her further than perhaps she wanted to go. This push made her “the ICU nurse I am right now.” Liz credited her coworkers for helping her make it through her “overwhelming days.” She shared, “We help each other out a lot.” Something that had a huge impact on Liz was when her coworkers took over a patient for her when she was caring for her first organ donation patient. Liz referred to her coworkers as “amazing.”

Alyce described her coworkers as a group of nurses who “have each other’s backs.” She believed there was a high degree of teamwork on her unit. Alyce was particularly appreciative of the role her preceptor played in her transition. This relationship evolved into a mentor-mentee relationship. Alyce said, “I feel like I can call her in the middle of the night.”

Olive had a more challenging experience with nurses on her unit. She shared her unit was known as the “mean unit.” She perceived the nurses to be “cliquey” and at times unwelcoming. As a new nurse, she was made to feel like an “outsider.” Olive considered her preceptor to be a “confidant” while she was orienting to the unit. She shared that often times, the charge nurses on the unit made her feel “stupid sometimes.”

Kate had a supportive charge nurse on her unit during her orientation. Kate shared this charge nurse stressed it was not a problem to ask questions. Kate worked rotating day and afternoon shifts. She stated the nurses on the day shift were “more intimidating than approachable.” She saw these nurses “doing their own separate thing.” Kate perceived great support on the afternoon shift. She stated they “pull together to get
the stuff done.” Kate shared, “If one person is having a bad night, we try to pitch in and help. It’s just from the experience of knowing what it’s like to be the one in that situation that just makes you want to help someone else.”

Kara viewed the nurses on her unit to be very supportive. This was the case during her orientation and this continues today. This supportive culture seems pervasive on Kara’s unit. She shared that she helps answer call lights, “If the techs are just running crazy trying to get their baths in, they can’t answer all the call lights. Sometimes they just can’t do it all.” Kara shared that’s she was never afraid to ask questions of the nurses on her unit. She was very appreciative of her preceptor stating, “I think I am a better nurse because of being with her.”

**Nurse-Doctor Interaction: Do No Harm**

The constitutive pattern—Nurse-Doctor Interaction: Do No Harm—is derived from the relational themes of Trust Is a Two-Way Street and If You Teach Me, I Will Grow. The participants in this study shared stories of nurse-physician interactions that were both helpful and hurtful to the transitioning nurse. For Bryan, the physicians with whom he worked offered him valuable feedback relative to the manner in which he was comporting himself early in his transition. Bryan shared that “having a couple of the doctors tell me I needed to learn more from my preceptor” was a turning point for him. Although this resulted in a brief drop in his confidence, Bryan came to understand arrogance was not a useful quality for a nurse. Bryan was surprised to find preferential treatment occurred in his work setting. He noticed doctors were held to a different standard than others, stating, “We [management] are not going to say that to you, but our actions will show you that he can do whatever he wants.”
Liz appreciated the interaction between the nurse practitioners who worked in the MICU: “They would take the time to teach you and help you out and explain things.” Liz was also excited about a doctor who joined the MICU intensivist group because she “knows the nurse’s value.” This doctor worked side-by-side with Liz as she worked through her first organ donation case. Alyce also encountered positive nurse-physician interactions on the pediatric unit. Although Alyce had heard stories from her nursing school peers where physicians yelled at the nurses, this was not her experience. Her experience with the physicians on her unit was from the perspective of coaching and developing her to become a better problem solver.

Olive, Kate, and Kara had different experiences relative to nurse-physician interactions. Olive shared she had encountered abusive physician interactions, which had been witnessed by patients. She believed these behaviors were frequently “swept under the rug” and were inconsistently addressed by those in positions of authority. Olive believed there was a double standard relative to bad physician behavior and this would not be tolerated from the nurses on the unit.

Although Kate and Kara did not share experiences of unacceptable physician behavior directly, both of these nurses understood specific physician behaviors impeded their work as a nurse. Kate understood the physicians on her unit as not wanting to collaborate with the nurse. She shared the doctors “kind of look at you to get out of the room” when they were making rounds. Kate disclosed this then placed her in an awkward position when patients had questions for her regarding their care. Now that Kate was more confident in her role as an RN, she had started to interact more with the physicians on her unit because “if they know who you are, they don’t get near as mad
when you call them.” Kara described the new nurses’ interactions with physicians as one where the doctor had no “confidence in you in the beginning because they don’t know what kind of nurse you are” and the new nurse has little confidence to interact with the doctor because they received minimal experience doing this as a student. Kara would like greater interaction with the physicians on her unit. She shared, “They pop in, and then they are gone before you even blink an eye!” This type of physician behavior made her less efficient and effective as a nurse.

**Trustworthiness**

The trustworthiness of this study of the transition experience of new nurses with 12-18 months of practice experience was addressed by paying close attention to study conceptualization and methodological design. One-on-one interviews were conducted in a private and confidential location. All participants engaged in this study freely and without coercion. All participants were past students at the college where the researcher was employed. However, no teacher-student relationship existed between the researcher and any of the study participants. Informed consent forms were obtained prior to the initiation of all interviews for this study. Lincoln and Guba’s (1985) criteria for the trustworthiness of qualitative research are presented below to describe the rigor with which this study was conducted and the data analyzed.

**Credibility**

The researcher in this study generated verbatim transcripts. These transcripts formed the data for the transition experience of the new nurses in this study. Use of the hermeneutic circle, a process whereby the wholes and parts of individual and collective participant transcripts were analyzed, enhanced the credibility of the findings of this
study. Dr. Melissa Henry served as the content expert for this study. Prolonged engagement with the data promoted deep understanding of the shared meaning that came from this study. The researcher posed clarifying questions during the interview process when clarification or deeper meaning was desired (Lincoln & Guba, 1985).

**Transferability**

Transferability is a measure of external validity and addresses the degree to which the findings of a study can be applied in other contexts (Lincoln & Guba, 1985). Deep description of the transition experience of the six participants was provided in the individual stories co-created by participants and principal researcher. The use of the Diekelmann et al.’s (1989) seven-stage process for data analysis provided an established method for data interpretation.

**Dependability**

Dependability, the repeatability and consistency of findings, was enhanced using an external audit. The principal researcher consulted with Heideggerian scholar, Dr. Heidi Storl, throughout the data collection and analysis process. Dr. Storl received and reviewed all interview transcripts and individual participant stories of transition developed by the primary researcher.

**Confirmability**

Confirmability describes the degree to which research findings are neutral, free of bias, and are true to the stories shared by study participants. Actions taken during the process of data analysis were clearly articulated by using the seven-stage process for analysis developed by Diekelmann et al. (1989). The principal researcher also maintained a reflexive journal in which interpretive decisions were reflected.
Chapter Summary

This chapter presented the findings for a study that investigated the transition experience of six baccalaureate-prepared nurses with 12-18 months of practice experience. Heideggerian hermeneutics provided the philosophical framework for this study. The Diekelmann et al. (1989) seven-stage process was used to analyze and interpret the findings of this study.

Individual stories of the transition experience for each participant were developed. Writing and re-writing processes that used the hermeneutic circle as a process for interpretation served to reach a deeper understanding of the transition experience of the new nurses who participated in this study. The researcher first met with participants for one-on-one interviews. Verbatim transcripts provided the medium through which the participant and researcher co-created meaning.

Six participant stories of transition resulted in 54 units of meaning and five relational themes. Analysis culminated in the emergence of three constitutive patterns describing the meaning new nurses ascribed to the transition experience: Being a Nurse Is Impactful; When Nurses Support Nurses, the Patient Is at the Center; and Nurse-Doctor Relationship: Do No Harm. Evidence supporting these three constitutive patterns was discussed. A discussion of trustworthiness of the data analysis process was provided to validate the rigor with which this study was conducted and the data were analyzed.
CHAPTER V

DISCUSSION

The new nurse participants in this study averaged 16 months of practice experience as a registered nurse. As the researcher and six new nurses discussed the transition experience using a one-on-one, semi-structured interview process, what emerged was a story of the new nurses’ journey of becoming a nurse. This co-creation of meaning and understanding illuminated the challenges and victories of these new nurses as they continued to learn and grow and become a respected member of one of this country’s most trusted professions. Although each journey was unique to the individual new nurse, similarities in experience and understanding were brought forward using a Heideggerian hermeneutic process to analyze these stories of transition. The forestructure—the background knowledge or pre-understanding of the new nurse and the researcher—constituted the sharing of context-dependent experiences and as a result, new understanding was revealed.

A main concept in Heideggerian hermeneutic methodology is time. Based on Heideggerian philosophy, time is experienced temporally. This temporal experience of time allows an individual to conceive of their existence by experiencing the present, past, and future all at once. In doing so, things that matter to an individual stand out distinct from the flow of clock time. Heidegger (1927/1962) referred to this as the ecstatical character of time. Spatial situatedness or what Heidegger referred to as “the-there” deals
with what is important or of concern to an individual. Conversations shared between the researcher and the new nurse participants in this study provided the data from which what was of importance or of concern relative to the transition experience of the six participants could be uncovered. The temporality of time was evidenced as the participants shared their history prior to entering into their nursing program, while in their nursing program, and in the 12-18 months since becoming a practicing nurse. This history became a part of the transition story and the “everydayness” of being a new nurse in transition.

Three constitutive patterns constituted what was of concern to the new nurses in this study: Being a Nurse Is Impactful; When Nurses Support Nurses, the Patient Is at the Center of Care; and Nurse-Doctor Interaction: Do No Harm. This chapter discusses these three constitutive patterns by linking what is currently known about the transition experience of new nurses to the findings of this study. The significance of these findings and the impact on the discipline of nursing are also discussed. Limitations of the study and a direction for future work are presented.

**Constitutive Patterns**

**Being a Nurse Is Impactful**

Something that stood out to the new nurses in this study was the profound impact of being a nurse. Although the participants described being overwhelmed, stressed, or surprised by the level of responsibility inherent in the work of being a nurse, the ability to impact the lives of a patient or the patient’s family had profound meaning to these nurses. They had moved beyond the intensity of learning the routines and practices of their unit inherent in their early transition to understanding the impact of nursing at a deeper level.
The constitutive pattern--Being a Nurse Is Impactful--was derived from the relational themes of My Work Provides Me with Meaning and You Must Look Inside Yourself to Make an Impact.

Duchscher (2001) conducted a phenomenological study, investigating how five new nurses perceived their first six months of nursing practice. These nurses were interviewed at two and six months. At the initial two-month period, the nurses were found to be very focused on themselves with great emphasis placed on task accomplishment. Duchscher reported the new nurse was very linear, looking for right or wrong answers to problems. After approximately three to five months of practice, the new nurses began to detach from the student role and were able to reflect on the significance of professional nursing. They had established their daily routines and were feeling more on a plane with their more experienced peers. Duchscher reported that during this time, the new nurse began to see how they fit into the healthcare team and felt more of a connection to their peers. At five to six months of practice, the new nurse began to ascribe meaning to their nursing actions and questioning became a vital way to learn. By six months of practice experience, the new nurse evolved from a focus on task and self to a focus on the patient as the center of nursing care.

Findings described by Duschsher (2001) were similar to the experiences of the nurses in this study. Early in their transition, these new nurses struggled to find a routine that worked for them. Many of the nurses realized what was learned from a textbook was not always what occurred in actual practice. During their early transition, all of the new nurses in this study reported being focused on tasks, establishing a routine that worked for them, becoming familiar with the equipment in their work environment, and facing
the challenges of working with all members of the healthcare team. As Liz described her early transition to MICU, she shared she was “overwhelmed every day” and she focused too much on the “little things.” She also recalled during this time feeling like she was “underwater” or “drowning,” she did not really recall specific patients for whom she provided care. These new nurses were not only learning the routine of the unit but also how to care for the types of patients common to their unit of practice. Alyce shared that early in her transition, “Before I did anything, I would read.” Kara reported she struggled with time management in her early transition to the Medical-Telemetry unit. She shared, “It just takes a while to know the flow of patients and the flow of the unit too.”

The practice experience of the nurses in this study ranged from 14 to 17½ months. In that time, these nurses progressed from a task-oriented focus to developing a deep understanding of the impact their nursing care had on their patients and families. But they also came to understand how the nursing care they provided impacted their being as a nurse. All of the new nurses in this study shared how impacting another individual’s life in this manner was what made their stressful, chaotic, and fast-paced jobs worthwhile. It gave their job profound meaning. Bryan came to understand a lesson he learned early in his transition, “You can’t be arrogant as a nurse,” would later have a significant impact on his ability to establish relationships with his patients. For him, knowing the patients and families he cared for trusted he would take good care of them was very meaningful. Liz came to understand nurses as the “sculptors of care” as opposed to the task-focused care provider she viewed nurses to be early in her transition. Kate succinctly stated her impact on patients was “less in the skill and more in the interaction.” When sharing the great meaning Olive derived from making a difference in
a patient’s day, she concluded by saying, “At the end of the day, for every terrible, crying, atrocious day I have, there’s ten more like it that are good.”

Although it was not possible to know the specific clock time when each new nurse in this study transitioned from an inward-focus to a focus that was much greater than and beyond themselves, all participants had evolved from the self and task-focused nurses they were early in their transition to a place where there was a significant understanding that their work was very impactful and greater than themselves. The nurses in this study appeared to have a deeper understanding of the meaning—a personal, yet patient focused type of meaning—they ascribed to the impact of their work. This meaning was more evolved than the meaning experienced by the new nurses in the Duchscher (2001) study. Perhaps there was a time dependent connection to this development of deeper meaning because the participants in Duchscher’s study were nurses with a maximum of six months of practice experience. In this study, the phenomenon—Being a Nurse Is Impactful—was experienced by nurses with an average of 16 months of nursing practice.

When Nurses Support Nurses, the Patient Is at the Center

Another phenomenon that stood out as significant to the transition experience of the new nurses in this study was the importance of having a supportive environment in which nurses supported nurses. The constitutive pattern—When Nurses Support Nurses, the Patient Is at the Center—was derived from the relational theme I Need A Supportive Environment to Thrive.

The new nurses in this study shared that although their confidence levels had improved since beginning their jobs, they still had days that were overwhelming and they
continued to need support. Five of the six nurses in this study reported being on a unit where the support they received from their nurse colleagues was highly appreciated, amazing, and essential to their continued evolution. Early in their transition, all of the new nurses relied heavily on the support and guidance of their preceptors. Bryan referred to his preceptor as skillful and knowledgeable. His preceptor helped him learn the importance of teamwork and “that nurses cannot be arrogant.” Liz’s preceptor helped push her “further than maybe” she wanted to go. Liz believes her preceptor made her the ICU nurse she is today. Alyce’s preceptor role modeled critical thinking and “thinking it through.” For Olive, her preceptor served as her “confidant” and trusted resource when she was made to feel like an “outsider” or “stupid” by other nurses on her unit. Kate appreciated her orienting charge nurse for encouraging her to ask questions because “everyone asks questions in the beginning.” Kara credited her preceptor with preparing her for independent practice and forcing her to do things she did not feel she was ready to do: “I think I am a better nurse because of being with her. I think that’s the whole point of it anyway.” All of these nurses shared they still considered their preceptors as valuable resources because although their confidence had improved since beginning their jobs, they continued to have questions and had overwhelming or stressful days.

All participants in this study reported having supportive preceptors who facilitated their growth and development as a new nurse. Many of these new nurses indicated their preceptor was still considered a source of support even though their official orientation had come to an end. This finding refuted the findings of Casey et al. (2004) who reported new nurses with less than 12 months of practice experience complained of lack of consistency with preceptors during orientation. New nurses in the Casey et al. study also
reported dissatisfaction with their preceptors because they lacked an understanding of what the new nurse in transition needed. These new nurses also reported a lack of respect and acceptance from their preceptors.

It was apparent the nurses in this study credited their preceptors with assisting them through their early transition period and these preceptors continued to be important supports to these nurses in transition. But the support of only their preceptor was not enough for the successful transition of these new nurses. What also stood out as meaningful to the new nurses in this study was the support (or lack of support) they received from nurse colleagues on their unit of practice. For Bryan, his coworkers supported him by providing him candidly crucial feedback. He shared, “Having a couple of people talk to me and be like, you need to just keep learning” was a turning point in his transition. This helped Bryan understand the responsibility inherent in the role of the nurse. Liz credited her RN colleagues in the MICU for helping her through her overwhelming days. She shared, “We help each other out a lot.” Liz viewed her team as a cohesive group of nurses who would “drop what they have” to come to her assistance. Alyce believed her pediatric nurse colleagues were amazing and they had “each other’s backs.” Kate worked a rotating day and evening shift schedule. She found her peers on the evening shift to be more helpful than the nurses with whom she worked during the day shift. She described the day shift nurses as “more intimidating than approachable.” Kate viewed these nurses as experienced nurses (she referred to them as “lifers”) who went off and did their “own separate thing”; while she felt support from her evening shift colleagues, stating they “pull together” and “work together to get the stuff done.” Kate shared the afternoon shift was staffed with less experienced nurses than on the day shift
and if someone on this shift was struggling, “we try to pitch in and help. It’s just from the experience of knowing what it’s like to be in that situation that makes you want to help someone else.” Kara believed her supportive RN peers had helped her improve her confidence and practice: “I was never afraid to say…I really don’t know what’s going on. Can you help me here?” Kara shared she also found support from other new nurses who were transitioning on her unit. These new nurses would discuss care issues and if they were unable to come to a resolution, they would “go to someone else who had been in nursing longer than us.”

Olive was the only nurse in this study who reported transitioning on a unit that lacked consistent support from her RN peers. Although she reported having a preceptor whom she considered to be “a confidant,” she disclosed that as a new nurse, she was made to feel “stupid” by her peers at times. Olive shared this “cliquey…mean unit” atmosphere resulted in times where she had “gone home and I’m like, I don’t think I can do this anymore. And it’s not being a nurse.” She shared the nurses she worked with on the weekends were “more likely to help you out.” Olive disclosed the turnover rate on this unit was high prior to her being employed there. This finding is concerning considering the high turnover rate on Olive’s unit as well as the high turnover rate amongst all nurses new to the profession. PricewaterhouseCoopers Health Research Institute (2007) reported the turnover rate of new nurses at 27.1% compared to an 8.4% voluntary turnover rate for all nurses in American hospitals. Candela and Bowles (2008) found 58% of new nurses left their first job within two years of employment, citing work environment as the primary reason for departure.
Casey et al. (2004) reported many new graduates felt a lack of respect and acceptance from their experienced nurse colleagues. In a study using appreciative inquiry, Chandler (2012) explored the process of effective transition in nurses with 12 months of practice experience. Chandler found nurses who remained in their first position for 12 months perceived themselves as effective in their position. These nurses attributed this success to their preceptors, peers, and other graduates who were undergoing a transition. These nurses perceived the social support provided during their transition was crucial to their successful transition. A non-judgmental and trusting work environment was felt to facilitate the new nurses’ development. Nurses who left their unit perceived an unwelcoming work environment (Chandler, 2012). Duchscher (2001) reported new nurses in transition often avoided asking their peers questions for fear they would be criticized. This differed from the findings of this study: the majority of nurses reported a supportive environment where questions were welcomed and even encouraged. Even Olive, who perceived the nurses on her unit as unhelpful, reported going to her preceptor/confidant when she had questions.

For the most part, the new nurses in this study reported they worked on a unit where the registered nursing staff was supportive of one another. Those nurses who reported a supportive environment had remained in the same position as when they first entered the profession. Kate perceived her RN colleagues as supportive on the evening shift but stated this was not the case with the more experienced day shift nurses. Kate was now working on her second unit within the same hospital since being employed as an RN (she transferred from the medical-surgical unit to the medical-surgical-pediatric unit). She stated she changed units to fulfill her desire to work with pediatric patients. Olive
shared she worked in an environment where new nurses were not made to feel welcome. She stated she had no intention of leaving this unit at this time. Research by Candela and Bowles (2008) and Chandler (2012) indicated new nurses were likely to leave units where they felt unsupported.

**Nurse-Doctor Interaction: Do No Harm**

Nurse-doctor interactions were another phenomenon that stood out as meaningful to the new nurse in this study. For some of these new nurses, the physician served as a healthcare team member who fostered their development. In other instances, the manner in which the physician interacted with the new nurse ranged from unhelpful or obstructive to egregious. The constitutive pattern—Nurse-Doctor Interaction: Do No Harm—was derived from the relational themes Trust Is a Two-Way Street and If You Teach Me, I Will Grow. Many of the nurses in this study believed a more collegial relationship with physicians would reduce some of the stress they experienced in their job and would allow them to provide safer, more effective patient care.

Many of the new nurses in this study shared being intimidated by physicians when they were in the early months of their transition. Olive said, “In the beginning they kind of look at you like, oh you’re young. Oh, you’re a new nurse. And they kind of talk down to you a little bit.” Kate also shared doctors intimidated her early in her transition. She said she was uneasy receiving verbal orders from doctors, “especially when you are new and you are not knowing what to expect them to order.” Kara referred to her first phone call to a physician as “the most terrifying thing in my whole life.” She recalled thinking, “What if they think I am an idiot?” The reactions reported by these new nurses have been found in nurses early in their transition. Several studies reported new nurses
experienced difficulties in communicating with physicians and knowing when and how to phone physicians (Casey et al., 2004; Duchscher, 2001; Li & Kenward, 2006; Smith & Crawford, 2003). These studies reported this phenomenon in nurses with less than 12 months of practice experience.

Many participants in this study appeared to have moved beyond the initial intimidation of interacting with the physician reported in other studies. Some of the nurses in this study shared ways in which they had worked to improve their relationships with physicians. Liz shared that over time, she has learned to anticipate the needs of the physicians on her unit and she has become familiar with their preferences. This in turn has enhanced her relationships with physicians on her unit. Kate has started to initiate conversations with physicians when they are in the nurse’s station on her unit. She has learned that “if they know who you are, they don’t get near as mad when you call them. They are much more willing to answer you and be nice about it.” Kara also shared she believed interactions with physicians were challenging because of the limited direct interaction she experienced with doctors while learning as a student. She described the nurse-doctor relationship as the doctor having little confidence in the new nurse “in the beginning because they don’t know what kind of nurse you are” and the new nurse lacking the confidence to interact with the physician because they have had limited experience interacting with the physician in this manner. Li and Kenward (2006) found only 44% of nursing programs surveyed in the 2006 National Council of State Board of Nursing Survey of Educational Practices reported allowing nursing students to call physicians while learning clinical practice.
Other concerns expressed by participants in this study centered on the need to develop a collegial nurse-physician relationship where the patient is the nucleus of the interaction. Several nurses in this study shared experiences of physicians who did not welcome the nurse in the patient’s room as they rounded on patients or physicians who would quickly come in and see their patients and exit the care area without interacting with the nurse. These new nurses felt that this lack of interaction created lapses in care or created an inefficient and less effective work environment. These nurses reported feeling unprepared when their patients had questions that resulted when the doctor made a visit. It was frustrating to these nurses when they had to take the time to decipher the doctor’s notes to answer the patient’s questions.

Positive collaborative relationships between nurses and physicians have been directly linked to optimal patient outcomes and improved patient satisfaction (Johnson & Kring, 2012; Lindke & Siekert, 2005). Improved efficiency of patient care, decreased length of patient stay, and an enhanced understanding of the role nurses play have also been linked to collaboration amongst nurses and physicians (Nelson, King, & Brodine, 2008). Additionally, Key Message #3 in the IOM (2010) report, The Future of Nursing: Leading Change, Advancing Health, addressed the need for nurses and physicians to work in a collaborative manner and be accountable for the delivery of high-quality patient care.

Some new nurses in this study reported having positive interactions with physicians or interactions that benefitted their development as new nurses. Alyce shared the pediatricians on her unit had assisted her in her clinical problem solving abilities. She shared that while they would correct her on the way she was thinking about a patient care
situation, “they always do it in a polite manner.” For Bryan feedback from physicians in the OR caused him to take a second look at the way he was behaving as a new nurse. Although this initially resulted in a dip in his confidence, Bryan ultimately referred to this physician feedback as an “awakening.”

Two aspects of the nurse-physician relationship that came out in this study and were viewed as destructive to nurse-physician interactions were “double-standards” for physicians and a “doctor-nurse, I know more than you do” mentality amongst some physicians. Some new nurses shared doctors on their unit were allowed to get away with behaviors viewed as abusive toward nurses. Behaviors such as arriving late for scheduled appointments, demanding the purchase of specific equipment, calling nurses untoward names (sometimes in the presence of patients), and “throwing a fit like a two-year old” were examples of such behavior. New nurses who witnessed this type of behavior perceived management’s reaction to these physician behaviors as anywhere from inconsistent to non-existent. Bryan shared although management said they would take action against unacceptable physician behavior, their actions “will show you that he [the physician] can do what he wants.” Olive’s perspective on this issue was “sometimes it gets swept under the rug. I’ve seen some people, doctors, really act ridiculous toward various nurses at various skill levels. Just because they can!” Tolerance for or inaction toward this type of physician behavior appeared to have a detrimental effect on some of the new nurses in this study. These nurses perceived similar behavior by nurses would be considered highly unacceptable and disciplinary action would most certainly be taken against them.
In a survey of nurses with up to 18 months of experience, Pelico et al. (2009) found physician rudeness and criticism were viewed by nurses as adding to their stress and dissatisfaction. Management was perceived as turning their back on this type of abusive physician behavior. This finding was consistent with the findings of this study where many nurses reported a double standard or management sweeping the issue under the rug when dealing with inappropriate physician behavior. Nelson et al. (2008) stated disruptive physicians were a contributor to the nursing shortage. Unequal power between nurses and physicians and ineffective communication were reported as significant barriers that still exist between nurses and physicians (Johnson & Kring, 2012).

**Transition Theory**

The Chick and Meleis (2010) transition theory outlines three major components to frame the transition experience: nature of the transition, transition conditions (facilitators and inhibitors), and patterns of response (see Appendix A). In Chapter II, this theory was presented in detail and was used as a framework for understanding what was currently known about the phenomenon of transition to practice for newly graduated registered nurses. Although this transition theory was not used to analyze the findings of this study, it is used here to highlight the knowledge derived from this study regarding the transition experience of baccalaureate-prepared nurses with 12-18 months of practice.

According to Chick and Meleis (2010), the nature of all transitions can be categorized according to the type(s), pattern(s), and properties of the transition. The transition experience of the new nurses in this study were categorized as both developmental and situational. In this study, a great deal of development occurred over the near year and half since the new nurses entered the profession. This transition could
also be viewed as situational in the sense that movement from a more protected educational environment to the fast-paced health care environment initiated this transition. Some participants in this study reported multiple transitions occurring simultaneous to the transition from school to practice. Kara shared she felt as if she was transitioning to being an adult with all of the adult responsibilities that accompany the change. For Bryan, he was transitioning to a world of responsibility and accountability, not only as a nurse but also as a partner in a marriage.

Several properties of transition defined by Chick and Meleis (2010) were evidenced in the transition experience of the participants in this study. The new nurses shared critical points and events that occurred across the year and half since their entry into practice. A critical point for Bryan was an awakening that as a nurse, it is not productive to have an arrogant attitude. Liz learned being an ICU nurse has a great deal of responsibility and being a nurse involves more than just performing tasks and carrying out doctors’ orders. Olive learned despite an unfriendly and unwelcoming unit of practice, she was able to persevere and continue to grow within her job. Kate realized she had the confidence to make decisions on her own and she was beginning to trust what her gut was telling her. Kara realized her preceptor encouraged her to develop the skills and abilities necessary for independent practice.

The transition time span for the participants in this study offered a unique look into the new nurse transition experience. Most studies of this phenomenon have focused on the 0 to 6-month and 0 to 12-month time period for transition. This study offered a unique perspective by looking at the transition experience over an 18-month time span.
The participants’ experiences were a culmination of the tremendous learning that occurred over this period of time and led them to a new level of awareness as a nurse.

A second major component of the Chick and Meleis (2010) transition theory addresses transition conditions. These conditions serve as facilitators or inhibitors of the transition experience. Overall, the nurses in this study believed their nursing education prepared them well for the transition experience. Many nurses shared their appreciation for the clinical immersion that occurred in the final semester of their nursing curriculum. The experience allowed them to work in the area of their choice with a one-on-one preceptor. Participants in this study viewed this as a valuable experience that helped prepare them for their transition to practice. As far as knowledge for transition, the participants felt the knowledge shared while in their nursing program had reached a saturation point. Many of the participants described having to learn the difference between what was taught in the textbook and what made sense in actual nursing practice. Bryan referred to this aspect of his transition as a part of growing up as a nurse. Liz and Olive shared they had to learn what made sense for their own nursing practice.

Conditions that presented as inhibitors or facilitators to the new nurses’ transition experience were identified as two of the constitutive patterns in this study: (a) When Nurses Support Nurses, the Patient Is at the Center of Focus and (b) Nurse-Doctor Interaction: Do No Harm. These transition conditions were described in detail above. Another facilitator of the transition experience for the nurses in this study was the constitutive pattern--Being a Nurse Is Impactful. Over the 18 months since the nurses transitioned to the practice setting, they moved from an inward focus of learning routines, procedures, and preferences to a practitioner who gave of self to the care they provided.
and the patients under their care. These nurses came to realize they were working in a stressful environment but the power of the work they did had great meaning for them and the patients they served.

The final component of the Chick and Meleis (2010) transition theory is the pattern of response. Feeling connected, being situated, and developing confidence are patterns of response to transition. All nurses in this study felt a strong connection to their preceptor. They learned a great deal from them during their early transition and orientation and they continued to view them as either a mentor or trusted resource. The new nurses in this study also shared their confidence had improved significantly over the 18 months since they had entered the nursing profession. Although they reported they still had days that were stressful and they continued to have questions, the support of their preceptors and coworkers helped them to continue thriving. The constitutive pattern of Nursing is Impactful attested to the notion that these nurses were becoming situated as nurses. They had moved beyond the task to the impact of nursing. To reiterate what Kate shared, “It is less in the skill and more in the interaction.”

Significance of Findings

Few studies have been conducted of new nurses’ experiences of transition beyond the first year of entry into practice (McKenna & Newton, 2008). Most studies of new nurses’ transition experiences were comparative and descriptive in design, focusing on technical skills, competencies, stressors, and how well the new nurses’ educational program prepared them for practice (Candela & Bowles, 2008; Casey et al., 2004; Halfer & Graf, 2006; Smith & Crawford, 2003). Most of these studies focused on the new nurses’ first six months of practice with even fewer studies reaching to the first year of
practice. The use of Heideggerian hermeneutic methodology and a new nurse participant sample of nurses with 12-18 months of practice experience for this study resulted in the sharing of deep and rich experiences of new nurses in transition. What resulted was meaning and understanding of a phenomenon not previously uncovered.

The new nurses in this study had evolved in their transition to a point where they were now grasping how powerful it was to be a nurse. The meaning these nurses ascribed to the work they did as nurses was shared at a deeper level than had been shared in past research. Although Duchscher (2001) found the new nurse detached from the student role at approximately three to five months of practice and was able to reflect on the significance of professional nursing, their understanding of the impact nurses had on patients was not reported at the level of the meaning the participants in this study described. Having practiced nursing for 12-18 months, the participants in this study came to understand the impact they had on their patients and how this impact affected them in their work as nurses. These new nurses shared how the meaning ascribed to this patient connection made their work worthwhile and served to mitigate some of the stress and chaos inherent in their daily work.

Another significant finding in this study was the degree to which the participants appreciated preceptors and coworkers who challenged them. Whether it was pushing them to limits they did not know they could achieve or pointing out personal characteristics in need of reflection, these new nurses shared critical points or events that had an impact on their transition to practice. Considering the current nursing shortage, this finding is significant to those who work with new nurses in either a preceptor role or as a supportive colleague on a nursing unit. The support of preceptors and RN colleagues
is essential to the successful transition of new nurses well beyond the initial year of practice.

Another aspect of the transition experience that held great meaning to the nurses in this study was the nurse-doctor relationship. The fact that physicians intimidated these nurses while they were early in their orientation was not unlike studies conducted in the past (Casey et al., 2004; Duchscher, 2001; Li & Kenward, 2006; Smith & Crawford, 2003). However, what was significant in this study was these nurses recognized how unhelpful physician behavior created barriers to safety and effective patient care. Some nurses in this study recognized their relationships with physicians were strained or ineffective and they had taken steps to try and improve them. Other nurses in this study recognized collegial nurse-physician relationships reduced the stress they experienced in their job and led to a more efficient work environment. Although their studies were not conducted in relation to the new nurse transition experience, Johnson and Kring (2012) and Lindke and Siekert (2005) supported the assertions made by the new nurses in this study—positive collaboration between nurses and physicians resulted in improved patient outcomes and improved patient satisfaction. Furthermore, improved efficiency of patient care and an enhanced understanding of the nurse’s role have been found to be linked to collaborative nurse-physician interactions (Nelson et al., 2008).

**Study Limitations**

A potential limitation of this study was the sample size ($N = 6$). Creswell (2007) stated a common sample size for phenomenological research is 3-10 participants. For qualitative research, Lincoln and Guba (1985) indicated sampling should continue until redundancy or saturation has occurred. The emergence of three constitutive patterns was
evidence a degree of saturation had occurred in this study, although more patterns could have potentially emerged if the study had included more participants.

All participants in this study were graduates from the college where the researcher was employed. Although the researcher was not involved in the direct education of any of the participants in this study, this relationship did exist.

As with all qualitative research, concerns of transferability of findings existed. Lincoln and Guba’s (1985) criteria for the trustworthiness of qualitative research were followed and ensured trustworthiness of the data collected. Use of Dieklemann et al.’s (1989) seven-stage process provided an established method for data interpretation and analysis, thus adding to the rigor of the interpretation and analysis process. However, with a small sample size, there were still potential concerns for transferability of the results to populations different than the participants in the study.

Overall, the participants in this study experienced a mostly positive transition with supportive preceptors and mostly supportive nursing peers. Based on other research that spoke to challenges with transitioning to practice (Casey et al., 2004; Duchscher, 2001; Pellico et al., 2009), this was not always the case for new nurses in transition. This raises questions about the participant sample in this study. Did only new nurses who had a positive transition experience participate? Were there nurses who had moved on to new jobs since becoming a nurse who did not volunteer to participate? Were there new nurses who remained in their first job but experienced a negative transition who chose not to participate? Or was this sample representative of all potential participants in this study? As with any research study, the answers to these questions could not be fully known.
Implications

The turnover rate of nurses new to the profession is of concern to leaders within the practice and academic sectors of the nursing community. Considering 13-70% of new graduate nurses leave their first job within the first year of employment and 42% of all new nurses hired within American hospitals are new graduates (Bowles & Candela, 2005; Casey et al., 2004; Goode & Williams, 2004), the findings of this study hold great significance to nursing education and nursing practice. The current nursing shortage, a shortage that is predicted to be persistent and severe, adds to the importance of successfully transitioning new nurses to the profession. Few studies of the new nurse’s transition experience have been conducted with nurses who have more than 12 months of practice experience (McKenna & Newton, 2008). However, based on available turnover data, this appears to be a vulnerable time for nurses new to the profession. This study used Heideggerian hermeneutic analysis to investigate the transition experience of baccalaureate prepared nurses with 12-18 months of experience. Use of this methodology provided a unique understanding of the phenomenon of new nurse transition. Implications of the findings of this study are presented in the following paragraphs.

This study provided a look into the “everydayness” of being a bachelor-prepared nurse transitioning to the practice setting. What “stood out” to the participants in this study as meaningful aspects of the transition experience provided the fore-structure for beginning to understand what was of significance to nurses with 12-18 months of practice experience. Questions that arose from the overall findings of this study and should be considered for future research included: Is there a link between new nurses who have
successfully transitioned through the first 12-18 months of practice and the likelihood they will remain in their first position for two, three, and four years? What meaning does the nurse with two, three, and four years of experience ascribe to the “everydayness” of his/her nursing practice? What factors impact the decision of a nurse with one, two, three, and four years of practice experience to leave or remain on a nursing unit?

**Implications for Nursing Education**

New nurses in this study were offered the opportunity to provide their perspectives on aspects of their nursing education that facilitated or inhibited their transition to practice. One aspect of their nursing education participants believed facilitated the transition to practice was a clinical immersion that occurred in the final semester of their curriculum. This clinical immersion paired the student with an experienced nurse in the practice setting of the student’s choice. Participants in this study shared this immersion experience not only garnered a plethora of experiences in which they could practice technical skills but it also allowed them gain a more realistic impression of the work of the nurse. Several participants disclosed this immersion experience allowed them to experience the “everydayness” of a specific practice area and this was an important aspect of the decision-making process for their first job.

One participant shared having longer clinical days earlier in the nursing curriculum, rather than waiting until the final year to engage in full-day clinical experiences, would have facilitated her transition to practice. She felt full days early in the curriculum would allow students time to “get the process” and gain a better understanding of “the nurse’s day-to-day responsibilities.” This participant believed
longer clinical days would provide the nursing student with more “comfort” when it came
time to transition to practice.

Another aspect of the findings of this study that hold significance to nursing
education is the revelation that participants in this study were challenged with nurse-
physician interactions. Previous studies have addressed the challenges new nurses face
early in their transition with regard to communicating with physicians (Casey et al., 2004;
Duchscher, 2001; Li & Kenward, 2006; Smith & Crawford, 2002). Considering only
44% of nursing colleges report allowing nursing students to call physicians while in
clinical rotations (Li & Kenward, 2006), this practice should be reconsidered. Providing
nursing students the opportunity to interact directly with physicians while the student is
in a pre-licensure nursing program would not only increase this type of experience for the
nursing student but would also afford the physician community the opportunity to better
understand the new nurse as well as the role the nurse plays in the daily care of patients.
Nurse educators in both academic and practice settings should consider enhancing
aspects of the nursing curriculum that emphasizes nurse-doctor relationships. Using
physicians as guest lecturers at specific points in the curriculum could enhance
interdisciplinary interactions from both nursing and medicine. Active learning strategies
that emphasize nurse-physician communication, interactions, and dynamics could serve
to further expand the new nurse’s understanding of the collaborative nature of the nurse-
physician relationship.

**Implications for Nursing Practice**

The healthcare environment is undergoing rapid and unpredictable changes. With
many quality outcome indicators tied to patient quality of care versus the old payment
methodology of fee for service, developing strategies to enhance nurse-doctor relationships within the practice setting is important. According to Buerhaus et al. (2012), an environment in which effective healthcare teams work collaboratively is essential to quality, safety, and efficiency. The results of this study offered insight into specific areas of focus for leaders in the practice sector. This study revealed a more collegial relationship between nurses and physicians could benefit nursing satisfaction, patient satisfaction, and patient outcomes. Strategies to bring nursing and medicine together with the patient at the center of these collaborative interactions would address IOM (2010) Key Message #3, which speaks to the need for nurses and physicians to collaborate in order to deliver high-quality patient care.

An understanding of effective strategies that could be used to enhance nurse-physician collaboration would benefit the patient, new nurse, experienced nurse, physician, and healthcare organization. The findings of this study highlighted the significance of nurse-physician relationships. Exploration of the following questions seems warranted. What are the inhibitors and facilitators of helpful nurse-doctor interaction? Are there organizational barriers that impede effective collaboration between these two groups of healthcare providers? Strategies to promote nurse-physician interaction include offering interdisciplinary seminars or in-services offered by experts from both nursing and medicine, using physicians and nurses on the same organizational work teams, and encouraging interdisciplinary nurse-physician research teams to explore this phenomenon.

Another area in need of focused attention from the practice sector with regard to nurse-physician interaction is the idea of “double-standards” and the tolerance of
unacceptable physician behavior. Nurses continue to rate their relationship with physicians lower than their doctor counterparts (Schmalenberg et al., 2005); effective collaborations between nurses and physicians have been shown to improve patient satisfaction, nurse satisfaction, and patient outcomes (Johnson & Kring, 2012; Lindke & Siekert, 2005; Schmalenberg et al., 2005). Therefore, it is imperative that leadership in the practice sector address these nursing concerns. Considering the nursing profession is in the midst of a nursing shortage, this issue takes on new and urgent meaning. An investigation of organizational barriers that inhibit effective nurse-doctor interactions would address this important issue.

New nurse participants in this study also revealed their nurse colleagues played a significant role in their transition experience. This brings attention to the impact of work environment and collegial support when the new nurse is transitioning to the practice setting. The new nurses in this study indicated support beyond the initial orientation period, and even first year, is essential to their continued growth and development. A question for further investigation of this area of new nurse transition includes: What impact does nurse-to-nurse support have on nursing unit turnover rates? The notion that new nurses remain on practice units they perceive to be unsupportive is an intriguing phenomenon and is counter to existing research (Candela & Bowles, 2008). This raises the following questions: What factors facilitate the new nurse remaining on units he/she perceives to be unsupportive? What specifically are these unsupportive factors?

Findings of this study offered areas of focus for those involved in nursing education and nursing practice. The successful transitioning of new nurses to the practice setting is the responsibility of those engaged in practice within both of these settings.
The use of Heideggerian hermeneutics to explore the meaning of the transition experience for new nurses with 12-18 months practice experience provided a unique look into the evolution of becoming of a new nurse. Understanding gained from this study raises many questions regarding the new nurse transition phenomenon. Recommendations for further exploration into this phenomenon have been offered.

Summary

This study used Heideggerian hermeneutic phenomenology to investigate the transition experience of baccalaureate-prepared nurses with 12-18 months of practice experience. The participants in this study provided a unique, yet rich and deep understanding of the new nurse’s experience of transition to practice. In light of the current and persistent nursing shortage facing the American healthcare system (AACN, 2009) along with a well-documented high turnover rate among nurses new to the profession (Bowles & Candela, 2005; Casey et al., 2004; Goode & Williams, 2004; Pellico et al., 2009; Pricewaterhouse-Coopeurs, 2007), the findings of this study have provided information that could make an impact on the successful transition of new nurses entering the profession.

In Chapter II of this study, the transition theory of Chick and Meleis (2010) framed the knowledge of the transition experience that existed prior to this study. In Chapter III, the philosophy of Martin Heidegger (1927/1962) provided a philosophical framework for this study and was used to direct study methodology. The following overarching research question guided this study:

Q1 What is the experience of moving/transitioning from being a student in a bachelor of science in nursing program to being a practicing professional registered nurse?
Participants in this study were new nurses with 12-18 months of practice experience. Purposive sampling yielded a sample of six participants with a range of 14-17½ months and an average of 16 months of practice experience. Six one-on-one interviews were conducted and resulted in rich data derived from the transcription of the six verbatim interview transcripts. Diekelmann et al.’s (1989) seven-step process of data interpretation and analysis was used to develop individual stories of each participant’s transition experience. The hermeneutic circle was used throughout the process of data interpretation and analysis. A content expert and Heideggerian scholar analyzed the findings to ensure they resonated with participant stories and Heideggerian philosophy was evidenced in the analysis.

In Chapter IV, Diekelmann et al.’s (1989) seven-step process was used to identify units of meaning (or categories) from each story of new nurse transition. Significant statements were offered to substantiate the identification of each unit of meaning. Five relational themes were identified by considering the data within and across all stories of transition: My Work Provides Me with Meaning; You Must Look Outside Yourself to Make an Impact; I Need a Supportive Environment to Thrive; Trust Is a Two-Way Street; and If You Teach Me, I Will Grow. Through this process, three constitutive patterns describing the transition experience of new nurses were derived: Being a Nurse Is Impactful; When Nurses Support Nurses, the Patient Is at the Center of Care; and Nurse-Doctor Interaction: Do No Harm.

Chapter V presented the findings of this study, comparing what was known about the transition experience of new nurses prior to this study with the findings of this study. Three constitutive patterns—Being a Nurse Is Impactful; When Nurses Support Nurses,
the Patient Is at the Center of Care; and Nurse-Doctor Interaction: Do No Harm--were used to guide this discussion. Relative to the constitutive pattern Being a Nurse Is Impactful, the nurses in this study found deep meaning in the act of providing nursing care. After they became familiar with the routines and practices of their job, they found an outward awareness and focus not described in previous research investigating new nurses in transition. The profound meaning these nurses ascribed to their nursing practice helped ameliorate the intensity inherent to the act of providing nursing care.

The constitutive pattern When Nurses Support Nurses, the Patient Is at the Center of Care revealed nurses in transition depend on the support of not only their preceptor but also the support of the other nurses on their unit of practice. These findings differed from previous research regarding nurses transitioning to practice where new nurses with less than 12 months of practice expressed concerns regarding unwelcoming work environments, preceptors who were unfamiliar with the unique needs of a new nurse, and an environment where new nurses were afraid to ask questions (Casey et al., 2004; Chandler, 2012; Duchscher, 2001). The findings of this study highlighted the importance of a supportive environment beyond the initial orientation period and first year of practice for new nurses to ensure continued growth and development in their new role.

The constitutive pattern Nurse-Doctor Interaction: Do No Harm provided a deeper understanding of the new nurse-physician relationship than what was described in the literature. Many studies noted the difficulties new nurses had in interacting with physicians as they entered nursing practice (Casey et al., 2004; Duchscher, 2001; Li & Kenward, 2006; Smith & Crawford, 2003). Although this study revealed a similar finding, a deeper understanding of the nurse-physician relationship was revealed. The
new nurses in this study gained an understanding of how ineffective patterns of interaction with physicians on their units not only impacted patient safety and quality of care, these ineffective patterns also created more stress for them in their daily work as a nurse. The phenomena “double-standards” and a perception of “the doctor knows more than the nurse” attitude spoke to the interaction between physicians and nurses.

Chapter V of this study also provided study limitations and implications for nursing education and nursing practice. The findings of this study could be used by nurse educators, leaders in nursing practice, bedside nurses, physicians, and advanced practice nurses to gain an understanding of new nurses’ transition experiences during their first 18 months of practice. This fore-structure relative to the transition experience of nurses with 12-18 months practice experience provides a foundation for meeting the needs of new nurses in transition.
REFERENCES


APPENDIX A

CHICK AND MELEIS TRANSITION THEORY
TRANSITION THEORY

APPENDIX B

LETTER OF PARTICIPATION
Dear ________:

My name is Tracy Poelvoorde and I am a student in the Doctor of Philosophy (PhD) in Nursing Education program at the University of Northern Colorado in Greeley, Colorado. I am currently conducting research as a partial requirement for completion of a PhD degree.

The purpose of my research project is to explore the meaning of the transition experience as experienced by the newly graduated baccalaureate prepared nurse. I am seeking participants for this study who have 12-18 months experience as a registered nurse.

If you agree to participate in this study you will be asked to participate a one on interview relative to your experience as a recently graduated nurse. This interview will take approximately two hours and will be conducted in my office at Trinity College or at a mutually agreed upon location.

If you agree to participate in this study, you will be able to withdraw at anytime during the process without negative consequences. Data obtained relative this study will be coded using a numeric coding system and a pseudonym for all participants. All necessary measures will be taken to ensure participant confidentiality and anonymity.

As a token of appreciation for your time and for sharing your experiences as a new nurse, you will receive a $25 Starbucks gift card. If you would like to participate in this study or if you have questions regarding participation, please contact me at:

Tracy Poelvoorde
Tracy.Poelvoorde@trinitycollegeqc.edu

Thank you for taking the time to read this letter of invitation.

Sincerely,

Tracy L. Poelvoorde, MS, RN
Doctor of Philosophy (PhD) in Nursing Education Student
University of Northern Colorado
APPENDIX C

LETTER OF INFORMED CONSENT
CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
UNIVERSITY OF NORTHERN COLORADO

Project Title: Being in Transition: Accessing the Transition Experience of Bachelor of Science in Nursing Graduates Using a Heideggerian Hermeneutic Approach

Researcher: Tracy L. Poelvoorde, MS, RN
E-mail: Tracy.Poelvoorde@trinitycollegeqc.edu

Research Advisor: Melissa Henry, PhD, RN
Phone: 970/351-1735
E-mail: melissa.henry@unco.edu

Purpose and Description: The primary purpose of this study is to gain an understanding of the transition experience of newly graduated bachelor of science in nursing prepared nurses who have 12-18 months of practice experience as a registered nurse. To gain this understanding, one-on-one interviews will be conducted with new nurses and myself, the principal investigator in this study. I will ask you questions such as: “Tell me a time that stands out in your mind because it shows what it is like to be a new nurse?” or “Looking back at all of the experiences that have taken you to where you are today as nurse; what in your nursing education prepared you for entering this profession?”

The one-on-one interviews will be conducted in a private setting, my office or a mutually agreed upon location. This interview should take approximately two hours and will be digitally recorded. Upon completion of the interview, your digitally recorded interview will be transcribed. This transcription will be a verbatim account of the interview and will serve as the data for this research study. I will share your verbatim transcript with you at your request. The data relative to this study will be coded and will not include participant names. All necessary measures will be implemented in an attempt to safeguard participant confidentiality. All data will be securely maintained within my personal office and/or on a password protected personal computer.

Potential risks related to participation in this project are minimal. You may experience emotions related to your specific transition experience.

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. 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. 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 Sherry May, IRB Administrator, Office of Sponsored Programs, 25 Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

Upon completion of the one-on-one interview, you will receive a $25 Starbucks gift card. This serves as a token of appreciation for sharing your experiences as a recently graduated, BSN prepared nurse.

<table>
<thead>
<tr>
<th>Participant’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Researcher’s Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

INSTITUTIONAL REVIEW BOARD APPROVALS
DATE: November 4, 2015

TO: Tracy Poelvoorde

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [814779-1] Being in Transition: Accessing the Transition Experience of Bachelor of Science in Nursing Graduates Using a Heideggerian Hermeneutic Approach

SUBMISSION TYPE: New Project

ACTION: APPROVED

APPROVAL DATE: November 4, 2015

EXPIRATION DATE: November 4, 2016

REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of November 4, 2016.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

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.
Thank you for your patience with the IRB process. Your application is thorough and clear. There are no requests for amendments or modifications.

Best wishes with this research and don’t hesitate to contact me with any IRB-related questions or concerns.

Sincerely,

Dr. Megan Stellino, UNC IRB Co-Chair

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.
November 11, 2015

Ms. Tracy Poelvoorde,
Trinity College of Nursing
2122 25 Avenue
Rock Island, IL 61201

Dear Ms. Poelvoorde,

I have received and read the documents you have submitted to Trinity' IRB for approval of your doctoral project, entitled Being in Transition: Accessing the Transition Experience of Bachelor of Science in Nursing Graduates Using a Heideggerian Hermeneutic Approach. I agree with the University of Northern Colorado IRB that it qualifies for expedited review. Therefore you do have approval from Trinity’s IRB to proceed as you need to with data collection.

This study should be conducted in compliance with the IRB policy for research involving human subjects. A copy of this policy is available on Trinity’s internet.

According to our policy, all studies must be renewed annually. Therefore if you are still involved in collecting data next November, you need to submit an application for renewal.

Best wishes with this study. If you need any further assistance, please feel free to call me.

Sincerely yours,

[Signature]

Co-chair, Trinity Institutional Review Board
APPENDIX E

PARTICIPANT DEMOGRAPHIC INFORMATION
Demographic Information:

- Length of time employed as a registered nurse
- Current work setting
- Length of time on current unit
- Number of positions held since entering profession
- Type of bachelor of sciences in nursing program (accelerated, second degree, generic)
- Highest degree held
- Length and type of orientation
- Full-time equivalency status
- Current shift worked
APPENDIX F

INTERVIEW GUIDE/QUESTIONS
In this study, I am looking at how the bachelor’s prepared nurse with 12-18 months of practice experienced their move from being a student to being a nurse. My hope is that you will tell me about how it was for you to become the nurse that you are today. When I refer to the word ‘transition,’ what I am talking about is what occurred as you moved from being a student nurse to being a licensed RN practicing within a patient care setting. As you know from the Letter of Consent, our conversation is being recorded and will provide data for this study. But before we begin talking about your experience of entering the nursing profession, I want to ask you some questions such as where you are practicing and the shift you work. [Participant Demographic Information: Appendix D]

Tell me a time that stands out in your mind because it shows what it is like to be a new nurse?

What stands out to you as the most significant part of your journey of switching from being a student to being a nurse?

Looking back at all of the experiences that have taken you to where you are today as nurse; what in your nursing education prepared you for entering this profession?

What in your nursing education could have better prepared you for entering this profession?

What did you learn or know, inside or outside of your educational experience, that helped you in your transition to being a practicing nurse?

If you were to talk to a new graduate, what would you tell them about transitioning into practice?

Tell me what has been most meaningful for you as you transitioned into practice?