

BECOMING AN RN: A HERMENEUTIC PHENOMENOLOGY STUDY  
OF THE SOCIALIZATION OF GRADUATE RNS

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## **DEDICATION**

To: Jo and Bill

For providing a home full of love;  
I am indebted to you.

For encouraging growth and curiosity;  
I thank you.

For being my rock and guiding light;  
I respect you.

For being my parents;  
I will always love you

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Part of the mission of the School of Nursing at IUPUI is to create a community of learning that addresses society's need for caring and scientifically prepared nurse professionals. Through the scholarship of creative pedagogy, discovery, application, and integration (IUPUI) will improve the health and quality of life ...by meeting society's need for nurses at different educational levels who are prepared to be effective in a range of practice settings.

I have seen this mission lived by the faculty and staff – from the first meetings through the last moments of dissertation preparation. I am thankful for the wisdom and guidance I have received from each of the faculty members.

I want to give a special thank you to my dissertation committee:

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Nationwide, there has been a trend for acute care facilities to hire a greater percentage of new graduate registered nurses (GRNs). It has been estimated that in acute care 42% of newly hired Registered Nurses (RNs) are likely to be new graduates; and turnover rates for these new hires can range between 35 and 60 percent. A high turnover rate of RNs can have several negative consequences including increased cost in training and recruitment, and decreased quality of patient care.

Current literature has identified challenges that occur during the transition period between being a student and becoming a registered nurse. There is a gap in the literature regarding an understanding of the experience of the newly graduate RNs and an understanding of when GRNs feel like they are fully functioning as an RN and part of the health care team.

A Hermeneutic Phenomenology study was conducted in a 500 bed acute care facility in Northeast Ohio. Ten GRNs agreed to participate in the study and completed one-on-one interviews with the researcher.

Themes that emerged focused on the process of transitioning into the role of RN. Participants discussed challenges of the new RN role, especially their first

code experience. Major themes that emerged included: self-esteem and confidence, development of critical thinking, mentoring, bullying, amount to learn, and high expectations.

Deanna L. Reising PhD, RN, ACNS-BC, FNAP, ANEF,  
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## **LIST OF ABBREVIATIONS**

AACN – American Association of Colleges of Nursing

Cath Lab – Cardiac Catheterization Laboratory

CCNE – Commission on Collegiate Nursing Education

CVS – Cardiovascular Surgery

CVSICU – Cardiovascular Surgery Intensive Care Unit

DAV – Department of Veteran’s Administration

ED – Emergency Department

GRN –Graduate Registered Nurse

ICU – Intensive Care Unit

IOM – Institute of Medicine

IRB – Institutional Review Board

Med-Surg – Medical-Surgical Unit

NCSBN – National Council of State Boards of Nursing

NCLEX - National Council Licensure Examination

VA – Veteran’s Administration

## LIST OF DEFINITIONS

Graduate Registered Nurse (GRN): a registered nurse who has graduated from an accredited nursing school and passed the National Council of State Boards of Nursing (NCLEX-RN) licensure examination within 6 months of hire.

Hermeneutic Circle: a metaphor that is used to describe the analysis of data in a hermeneutic phenomenology research study.

Mentor: someone who can help the new graduate “learn the ropes”, they provide moral, social and emotional support and help the GRN to have a stronger sense of belonging to an organization.

Orientation: a training period organized by an institution that includes formal and informal training.

Preceptor: an employee that is assigned to work with a GNR. The focus of the preceptor is to ensure the GRN has competent skills, abides by hospital policy and procedures and delivers safe patient care.

Socialization: the process by which an individual learns the values, norms, and required behaviors that allow him or her to become a member of an organization. Socialization is a process that occurs as an individual joins into and becomes a part of a specific group. It is influenced by the structural components established by the group as well as the beliefs, perceptions, and values that the individual brings with them.

## **CHAPTER 1: INTRODUCTION**

### **Introduction of the Problem**

It is a widely accepted fact that a nursing shortage exists both globally and in the United States (Kovner, Djukic, Fatehi, Fletcher, Jun, Brewer & Chacko, 2016). The Bureau of Labor Statistics (2017) has projected that there will be a 16 percent increase in nursing jobs in the United States from 2014 to 2024, which means an additional 439,300 jobs. This rate of increase, which is much faster than the average for all occupations, has been attributed to an increased emphasis on preventive care, growing rates of chronic conditions, and increased demand for healthcare services for an aging population (Bureau of Labor Statistics, 2017).

Compounding the increased need for nurses is the issue of high rate of registered nurse (RN) turnover. Studies have been conducted to investigate RN turnover, but there is wide variance in reporting methods, no clear definition of turnover, and no standard methodology to determine costs (Duffield, Roche, Homer, Bucham & Dimitrelis, 2014; Kovner et al., 2016). Additionally, turnover can be measured at different levels: professional, organizational, and unit. It can also be classified as a voluntary or involuntary move (Duffield et al., 2014; Kovner et al., 2016, Van Maanen & Schein, 1979). Professional turnover is when someone changes to another profession, or stops working altogether. Organizational turnover is when someone changes positions between different organizations, and unit turnover is when someone changes positions or job classifications within the organization. Voluntary turnover is when the decision to

change is driven by the individual's desires; involuntary is driven by the organization either through cut backs or termination. (Kovner et al., 2016; Li & Jones, 2013; Van Maanen & Schein 1979).

Nationwide, there has been a trend for acute care facilities to hire a greater percentage of new graduate registered nurses (GRNs) to fill staffing needs compared to RNs with experience. (Kovner et al., 2016; Santucci, 2004; Yu & Kang, 2016). It has been estimated that 42 percent of RN hires are likely to be new graduates (Goode & Williams, 2004); and first year turnover rates can range from 35 to 60 percent (Delaney, 2003; Edwards, Hawker, Carrier & Rees, 2015; Goode & Williams, 2004; Halfer & Graf, 2006; Kovner et al., 2016; Li & Jones, 2013). Kovner et al. (2016) reported that turnover for GRNs is higher than turnover rates for experienced nurses.

### **Consequences of Turnover**

The high rate of turnover in GRNs has significant negative consequences for acute care facilities. One area of impact is the budget. It has been estimated that a nurse with less than one year of experience will cost an acute care facility approximately \$36,567 to \$88,000 in orientation expenses (Halfer & Graf, 2006; Kovner et al., 2016; Yu & Kang, 2016). The total cost of RN turnover, which includes orientation, human resource expenditures, and overtime by staff to cover staffing shortages, can cost as much as \$1.5 million per hospital per year (Li & Jones, 2013).

There is also a negative impact in the quality of patient care that stems from increased GRN turnover. Approximately 95 percent of direct patient care in

the acute care setting is provided by RNs (Krozek, 2008). When GRNs leave their position, they create a vacancy that needs to be filled by another RN and it may take several months for that vacancy to be filled. Acute care facility managers typically rely on existing staff to work extra hours to cover the vacant shifts or they increase the workload of nurses through increased patient to nurse ratios. Another choice in addressing vacancies is to rely on temporary agency nurses, who may be lacking in experience. (Anderson, Linden, Allen & Gibbs, 2009; Kovner et al., 2016; Li & Jones, 2013; Reinsvold, 2008; Yu & Kang, 2016). An increase in patient mortality, morbidity, and overall length of patient stay may occur when the nurse workload increases or there is an increase in the percentage of inexperienced nurses. (Aiken et al., 2014; Spetz, Harless, Herrera & Mark 2013).

Another stakeholder that is negatively affected by high RN turnover is the general population, or the taxpayer (Kovner et al., 2016). As the acute care facility incurs greater costs related to RN turnover, those costs are passed on to the payers of medical care; including the tax payers since tax dollars support the Medicare and Medicaid programs. The estimated cost to United States tax payers for nurses who leave their first job within three years of starting is 1.4 to 2.1 billion dollars (Kovner et al., 2016).



## **Causes of Turnover**

Stress is often cited as a major contributor for the high GRN turnover rate. The first three months in a nurse's career have been identified as the most stressful (Delaney, 2003). Part of the stress can be attributed to lack of experience in the new graduate nurse (Goode & Williams, 2004) and part can be attributed to poor socialization. Van Maanen and Schein (1979) defined socialization as the process by which an individual learns the values, norms, and required behaviors that allow him or her to become a member of an organization. It begins with entrance into an organization and continues while the relationship is maintained. For the majority of nurses in the acute care setting, job socialization begins in orientation.

## **Orientation**

The orientation process has been a subject of numerous studies (Alspach, 1995; Benner, Hooper-Kyriakidis & Stannard, 1999; Crimlisk, Grande, Krisciunass, Costello, Fernandes & Griffin, 2017; Edwards, Hawker, Carrier & Rees, 2015; Kramer, Halfer, Maguire & Schmalenberg, 2012; Pittman, Herrera, Bass & Thompson, 2013; Rashotte & Thomas, 2002; Reising, 2002; Stasser, 2005). Benner (2001) has been a leader in developing theory to show progression of the GRN from novice to expert. Benner's theory has a strong focus on the development of critical thinking. Reising (2002) studied the process of socialization into critical care units. Alspach (1995) has published widely in regards to development of skill acquisition and competency training in GRN orientation. The literature is somewhat lacking in regards to the socialization of

nurses; particularly how the nurse learns expected behaviors, values, and norms of the organization and the specific unit in which they work. The literature is also lacking in the socialization of nurses from the viewpoint of the GRN; understanding the meaning of the transition experience from nursing student to an RN that is functioning as a team member.

### **Specific Aims of this Study**

Aim 1: To understand the meaning of the lived experience of being a GRN.

Aim 2: To understand the meaning of self-identification as an RN.

Aim 3: To understand the meaning of feeling like a team member at work.

## **CHAPTER 2: LITERATURE REVIEW**

### **Background and Significance**

In 1974, Marlene Kramer wrote *Reality Shock*, which examined reasons why nurses leave nursing. While this piece was written more than 40 years ago, the topic of nurse retention remains important today. Discrepancy between what the GRN learned and valued in school and the reality of the real world they experience has been identified as a major reason that nurses leave the profession (Boyle, Bott, Hansen, Woods & Taunton, 1999; Delaney, 2003; Klingbeil et al., 2016; Kramer, 1974; Krozek, 2008). Anxiety at the loss of the familiar role of student and the need to learn new roles, responsibilities, and behaviors of graduate nurses makes the transition period even more challenging (Block & Sredl, 2006).

### **Transition Challenges**

The transition period between nursing student and RN roles has been the focus of several studies that describe ways to improve the orientation process and enhance the socialization of GRNs in hopes of decreasing turnover rates. (Block & Sredl, 2006; Cochran, 2017; Crimlisk et al., 2017; Edwards, et al., 2015; Goode & Williams, 2004; Keller, Meekins & Summers, 2006; Kramer, Halfer, Maguire & Schmalenberg, 2012; Newhouse, Hoffman, Sulflita & Hairston, 2007; Pittman et al., 2013; Reising, 2002; Santucci, 2004;). Some of the major areas identified in the studies as challenges during the transition period are: decreased self-esteem, skill acquisition, lack of mentoring, and development of critical thinking.

**Decreased self-esteem.** New graduate nurses often begin employment with a positive self-image and high self-esteem, but they frequently begin to have self-doubts after a few weeks of work and they may even start to question their choice of profession (Lavoie-Tremblay, Viens, Forcier, Labrosse, Laliberte & Lebeuf, 2002). Decreased self-esteem and increased anxiety can be compounded if nurses have unrealistic expectations of themselves (Chang, 2017) and are required to take care of high acuity patients early in the orientation (Lavoie-Tremblay et al., 2002). Van Maanen and Schein (1979) identified self-esteem as a component of organizational socialization. The level of self-esteem can be related to job performance; higher levels of self-esteem correlate with improved job performance. Also, higher levels of self-esteem are correlated to increased job satisfaction.

**Skill acquisition.** Both new graduate nurses and nurse executives (CCNE, 2008; Hopkins & Bromley, 2015) have identified that additional skill and knowledge are needed for the GRN to become competent and confident as an RN (Keller et al., 2006). In *The Education Process and Staff Development*, Alspach (1995) summarizes much of her previous research and writing regarding the best methods of teaching skills to GRNs. She advances many examples of pathways and logs that help to indicate when, where, and how nursing skills can be taught. In spite of the well-established resources regarding the development of skills, skill acquisition is still identified in the literature as a key area of orientation needing further development.

**Mentoring.** Transition into the professional nursing role can be enhanced with a comprehensive orientation and one-to-one mentoring (Newhouse et al., 2007). Nationwide, there is no standard orientation period for GRNs entering employment at an acute care facility. It can range from a few weeks to several months. The use of a preceptor to oversee new hires is a standard component of orientation for acute care facilities. (Santucci, 2004; White, Brannan & Wilson, 2010; Zinsmeister & Schafer, 2009). The primary role of the preceptor is to work with the GRN at the bedside and oversee delivery of patient care. The focus of the preceptor is to ensure the GRN has competent skills, abides by hospital policy and procedures, and delivers safe patient care (Rush, Adamack, Gordon, Lily & Janke, 2013; Santucci, 2004; White, Brannan & Wilson, 2010; Zinsmeister & Schafer, 2009). Frequently the terms preceptor and mentor are used interchangeably, but there is a difference in the roles.

A mentor is someone who can help the new graduate “learn the ropes.” New graduate nurses who have a mentor that provides moral, social and emotional support have a stronger sense of belonging to an organization, and also report higher job satisfaction (Halfer & Graf, 2006; Lavoie-Tremblay et al., 2002) and higher levels of self-esteem (Van Maanen & Schein, 1979) than GRNs who do not have a mentor. While a preceptor can help the GRN develop skills, a mentor can help the new graduate nurse develop personal standards (Santucci, 2004), integrate into the institution (Krugman, Bretschneider, Horn, Krsek & Moutafis-Smith, 2006), and develop supportive relationships that can help create a less stressful transition period (Ruth-Sahd & Hendy, 2005).

**Development of critical thinking.** Critical thinking is a difficult concept to address because it has been identified and measured in many ways. A general belief is that critical thinking develops through both education and experience (Benner et al., 1999; Dracup & Bryan-Brown, 2004; Ruth-Sahd & Hardy, 2005). Acute care facilities with orientation programs that incorporate planned critical thinking education and bedside nursing experience are more likely to have lower GRN turnover rates (Benner et al., 1999; Dracup & Bryan-Brown, 2004; Ruth-Sahd & Hardy, 2005).

### **Transition Period**

The transition period is not clearly defined; it is often referred to as socialization. It is generally believed to be the time it takes “to learn the ropes” or to learn the values and expected behaviors of the organization (Ajjawi & Higgs, 2008). In nursing this can be identified as the time when GRNs self-identify as RNs. It is a process that occurs over time and involves both the individual and members of the organization. It typically begins with a structured orientation program that occurs when GRNs are first hired as RNs.

### **Orientation Processes/Programs**

Many hospital administrators view GRNs as an immediate solution to staffing shortages, causing them to focus on recruitment rather than retention and professional development (Casey, Fink, Krugman & Propst, 2004). When recruitment has a priority over nursing development, orientation programs are likely to be less than adequate. Several studies have shown that GRNs do not feel comfortable for 12 to 18 months after hire into their first RN position (AL-

Dossary, Kitsantas & Maddox, 2014; Block & Sredl, 2006; Casey et al., 2004; Cochran, 2017; Letourneau & Fater, 2015, Newhouse et al., 2007). When orientation ends after a few weeks and the GRN is left without support, there is increased likelihood that the GRN will leave the position, or even the profession (Kovner et al., 2016; Yu & Kang, 2016).

Hansen (2014) described the evolution of nursing education over the past few decades. In the beginning of the 20<sup>th</sup> century most nursing education occurred at the bedside. As nursing education transitioned from the hospital and into the collegiate classroom, there was a loss of bedside experience. The change in experience created the gap between what students learned in nursing school and the real world; an issue addressed by Marlene Kramer in 1974. Nursing orientation and nurse residency programs were developed as a way to address this gap. Formal training programs were designed to have an increase in length of orientation time, and increase in types and quality of education offerings in order to promote integration (socialization) into the acute care setting (Goode & Williams, 2004; Keller et al., 2006; Krugman et al., 2006; Newhouse et al., 2007).

A review of orientation programs revealed that significant variation exists in the training or orientation experiences of GRNs (Krugman et al., 2006). Currently there is no national standardization of GRN orientation; orientation lengths varied from four weeks to two years, technical content ranged from none to 90 percent, and critical thinking content ranged from 20 to 100 percent (Goode & Williams, 2004). Many orientations do not distinguish between GRNs and

experienced RNs and offer the same orientation to RNs with various educational and experiential backgrounds.

There is also wide variance in the implementation of nurse residency programs as part of orientation. Some facilities have no nurse residency programs and others have well developed nurse residency programs that last for 24 months (Goode & Williams, 2004). While there is no standard program or protocol for a nurse residency program, there are some common features: a defined resource person, peer support opportunities, and a mentor (Cochran, 2017; Rush et al., 2013). Nurse residency programs typically include staff nurses who have completed training to enhance and develop mentoring and coaching skills (Keller et al., 2006). Another common feature of nurse residency programs is an increased length of orientation. Experts agree that an increased amount of time for orientation allows for improved educational content and improved skill acquisition and development of critical thinking. Additionally, better prepared educators, mentors, and preceptors can increase self-esteem, and assist with integration into the new RN role (Cochran, 2017; Goode & Williams, 2004; Keller et al., 2006; Krugman et al., 2006; Newhouse et al., 2007).

There have been some attempts to create standardization with nursing orientation and nurse residency programs. The American Association of Colleges of Nursing (AACN) formed the Commission on Collegiate Nursing Education (CCNE) in order to support nursing education. The CCNE is an accrediting agency that contributes to improved public health through the promotion of voluntary, self-regulatory accreditation for nursing education. Their



focus is on baccalaureate and graduate education, as well as nurse residency programs. In 2008, the CCNE published *Standards for Accreditation for Post-Baccalaureate Nurse Residency Programs* to provide guidelines to develop and implement nurse residency programs that provide training and support to GRNs. The CCNE proclaim “Education training and support for new nurses are necessary to fully develop professional practice and skills critical to patient safety and quality of care.” (p. 3).

The *Standards for Accreditation for Post-Baccalaureate Nurse Residency Programs* (2008), provides standards and key elements to include in a nurse residency program. The CCNE (2008) declared that the support and education provided through nurse residency programs “are designed to improve retention and job satisfaction for new nurses and to strengthen their lifelong commitment to professional nursing.” (p. 5). The ultimate goal is that nurses will stay in nursing, thus turnover decreases, and quality of patient care will increase.

The orientation period is a critical time when GRNs are socialized into the role of RN as well as the role of an employee at a specific institution. While there have been attempts to provide standardization guidelines for orientation and nurse residency programs, there remains a large degree of variance nationwide. This lack of standard quality protocols and programs has contributed to several challenges that may hinder the socialization of GRNs.

These challenges include:

- Expectation that GRNs can function as proficient RNs and fill staffing needs
- Change of focus for nursing education away from the bedside and toward collegiate setting
- Lack of stratification of education based on experience and education.

One way to improve the orientation and socialization of GRNs, is to identify their level of competence and tailor education and training to that level of competence. In 1984, Patricia Benner developed a theory, *Novice to Expert* that addresses the stages of learning and skill acquisition across the career of nurses. Her theory stresses that there are differences in skill acquisition and critical thinking ability between a GRN and experienced RN.

### **Theory of Novice to Expert**

Benner first published *Novice to Expert: Excellence and Power in Clinical Nursing Practice* in 1984. In this book, she applies the Dreyfus model of skill acquisition to nursing practice. The Dreyfus model was originally developed to examine pilots' performance during emergency situations (Benner, 2001) and has intuition (or critical thinking) as a key phenomenon. This model examines the development of critical thinking and problem solving skills through the 'external' criterion of skill acquisition and the 'internal' criterion of intuition development (Paley, 1996).

The primary premise of Benner's theory is that the problem solving skills of an expert nurse differs from the problem solving skills of a beginner or novice

nurse. This premise supports other literature stating that GRNs are not proficient and need education and training before they can be considered proficient. The difference between a novice and an expert can be attributed to knowledge that is acquired through experience over time (Benner, 2001). This becomes apparent as GRNs graduate with fewer clinical hours; their experience upon which to base decisions is limited. Benner's model also provides a framework upon which education can be structured to meet the needs of nurses who are in different stages of their career (Rashotte & Thomas., 2002). There are five stages in this model: novice, advanced beginner, competent, proficient, and expert. The following table (Table One) identifies the five stages and the expected skills and decision-making abilities for each stage.

**Table One: Benner's Theory Novice to Expert**

<b>Novice to Expert</b>	
<b>Stage 1:</b> <b>Novice</b>	Novice nurses have no experience of the situations in which they are expected to perform. They are taught about these situations by teachers, preceptors, or mentors. Their decision-making skills are very limited and they rely on rules to guide them in task completion.
<b>Stage 2:</b> <b>Advanced Beginner</b>	Advanced beginners demonstrate marginally acceptable performance. They are beginning to identify global characteristics that can only be identified through limited prior experience.
<b>Stage 3:</b> <b>Competent</b>	Competent nurses have been in the role two to three years. These nurses are now able to see their actions in terms of long term goals and consequences. They are able to use analytical thinking and consider future situations.
<b>Stage 4:</b> <b>Proficient</b>	Proficient nurses are those who are able to see a situation as a whole, rather than in terms of parts or specific aspects. Decisions are based on experience and previous events. Nurses in this stage see the whole and are able to identify when expectant results do not occur.
<b>Stage 5:</b> <b>Expert</b>	Expert nurses no longer rely on analytical principle (rule governed maxims). They are able to understand situations and zero in on problems. They have an enormous background of experience and an intuitive understanding. Their performance is flexible and proficient

Developed through hermeneutic phenomenology, Benner's theory provides a description of the characteristics of skill proficiency and critical thinking ability (or intuition) for each stage as it applies to nursing. The stories told by nurses in different stages of their career helped Benner identify the critical thinking ability and skill proficiency that occurs in different stages (Benner, 2001).

### **Review of the Theory**

Benner's theory identifies that learning occurs throughout the career and the education needs are different for nurses who are in different stages (Rashotte & Thomas, 2002). Additionally, there is a focus on the RN rather than the institution (Cash, 1995) and an emphasis on learning (Gobet & Chassy, 2008). The theory advances concepts of the development of critical thinking as well as skill acquisition. For example, the GRN is in the novice stage and has a focus on tasks, and skill development. With experience, critical thinking develops and the GRN will become an advanced beginner.

While Benner based her adaptation of the Dreyfus model to nursing on the results of several interviews and observations of nurses in the clinical setting, there has been criticism of the theory due to an absence of objective validation of the theory (Altmann, 2007; Cash, 1995; English, 1993; Paley, 1996). Additionally, there is a lack of operational definitions for the concepts of "intuition" (Cash, 1995) and "expert" (Cash, 1995; English, 1993; Woodall, 2000). The stages do not provide adequate definition with regard to whether the described characteristics pertain to individuals or behaviors (Gobet & Chassy, 2008).

Benner's *Novice to Expert Theory* is lacking as an overall theory of socialization in that it does not address internalization of the values, norms, and beliefs of an organization. Additionally, the progression from novice to expert is a process that occurs over several years. The GRNs undergoing socialization in their first RN role would be limited to the stage of novice, and would progress to the advanced beginner stage after completing several months of experience in their new RN role. A literature review of socialization provided another theory to address these issues.

### **Literature Review of Socialization**

Socialization is a process that occurs as an individual joins into and becomes a part of a specific group. It is influenced by the structural components established by the group as well as the beliefs, perceptions, and values that the individual brings with them. (Merton, 1957). A literature review was conducted with the focus of organizational socialization. Searches were conducted in nursing, health sciences, management, and human resource management data bases. Results of the searches could be broadly classified into those articles that addressed the theory of socialization, the process of socialization, and the outcomes of socialization.

### **Theory of Socialization**

Organizational socialization begins with entrance into an organization and to a lesser extent when changing positions within an organization (Saks & Ashford, 1997). It is the process by which an employee "learns the ropes" – or how to become a successful member of the organization. This socialization

includes learning the required behaviors and values that allow the new employee to become an effective member of an organization (Ajjawi & Higgs, 2008; Gruman, Saks & Zweig, 2006; Kelly & Ahern, 2008; Mooney, 2007; Nesler, Hanner, Melburg & McGowan, 2001; Van Maanen & Schein, 1979). It includes internalization of attitudes and values that are critical to the development of professional identity (Hart & Miller, 2005).

Socialization is a process that occurs over time and involves both the organization and the individual (Brennan & McSherry, 2007; Griffin, Colella & Goparaju, 2000) as the employee learns about and adapts to new jobs, roles, and culture of the workplace (Ballard & Blessing, 2006; Cooper- Thomas & Anderson, 2005). This period of new employee adjustment is typically supported with formal and informal training – frequently known as an orientation period.

**Research and theory development regarding socialization.** Merton (1957) was an early researcher in the field of socialization. He defined socialization as the way people selectively acquire values, attitudes, skills and knowledge that are inherent to the group to which they want to belong. Van Maanen and Schein built upon the work of Merton and developed *Toward a Theory of Organizational Socialization*, which was first published in 1979. Van Maanen and Schein (1979) clearly state that their goal in developing, writing and publishing *Toward a Theory of Organizational Socialization* was to offer a descriptive scheme that could be used to further develop theory and support additional research. Van Maanen and Schein (1979) described the various forms that socialization can take and explained why a certain type of socialization

results in certain individual or collective behaviors. Their model consists of six bipolar tactics where one end represents an organization focus and the other end represents an individual focus (Griffin, Colella, & Goparaju, 2000). These tactics are displayed in table two.

**Table Two: *Toward a Theory of Socialization: Six Bipolar Tactics***

	Organizational Focus	Individual Focus
1	Collective	Individual
2	Formal	Informal
3	Sequential	Random
4	Fixed	Variable
5	Serial	Disjunctive
6	Investiture	Divesture

As the bipolar tactics are listed above, the left side represents actions that are driven by the organization and are bureaucratic in nature. The right side represents actions that are driven by the individual and are considered professional in nature (Eckhardt, 2002).

***Collective vs. individual.*** This tactic categorizes the manner in which new hires are grouped during the transition period. The collective side occurs when a group of new employees are kept together as they progress through a common set of experiences. The individual side is dominating when experiences



for the new hires are tailored to the individual (Eckhardt, 2002). Collectivity strengthens the influence that new hires have on each other as they bond and grow together. Individuality strengthens the influence of the organization as the interactions and experiences are more tightly controlled by the organization (Hart, Miller & Johnson, 2003).

**Formal vs. informal.** Formal aspects of this tactic occur when there is segregation of new employees from established employees and the new employees are given material that has been developed specifically for them. This method separates new hires from established employees rather than combining them. Formal tactics may produce bureaucratic responses unless they are organized in a way that relates classroom experiences to real life (Eckhardt, 2002). The informal style tactic occurs when new hires are integrated with established employees. There is little structured training and learning occurs by trial and error (Gruman et al., 2006).

**Sequential vs. random.** Sequential training offers discrete and recognizable steps leading to full membership. There is frequently a plan and timeline regarding what will be accomplished and who is responsible for each step. Random training has fewer specifically stated steps and there is a greater sense of ambiguity. Randomness can be beneficial in that it can produce critical and innovative thinking (Eckhardt, 2002), but it may also lead to frustration for the new employee.

**Fixed vs. variable.** This tactic relates to the degree to which education/training is fixed with a definite timeline. Fixed tactics provide a specific

time frame for completion of a boundary passage (orientation period) and provide precise knowledge of completion time (Hart Miller & Johnson, 2003). The fixed tactic approach tends to lower stress, raise innovation and contribute to professional responses. Variable tactics do not have a specific timeframe. The lack of a timeframe and variability offers few clues about the future, raises anxiety, and produces bureaucratic responses (Griffin, Colella, & Goparaju, 2000).

***Serial vs. disjunctive.*** Serial tactics offer access to prior role occupants or other's role expectations. It is coordinated through an experienced member of the organization and occurs with more experienced faculty and advanced peers (Griffin, Colella, & Goparaju, 2000). Disjunctive tactics frequently have changing faculty, no peer models, and prior occupants are not available. Serial tactics can produce old ways of doing things and bureaucratic responses whereas disjunctive tactics can help to remain flexible in orientation producing professional responses (Hart, Miller & Johnson, 2003).

***Investiture vs. divestiture.*** Investiture tactics affirm personal characteristics and there is validation of incoming identity and personal characteristics. Previous knowledge and experience are valued as opposed to being devalued or denied. Divestiture tactics occur as there is an attempt to strip away personal characteristics and have greater emphasis on conformity (Hart, Miller & Johnson, 2003).

**Review of the theory.** Most research on organizational socialization theory is based on the Van Maanen and Schein model (Griffin, Colella, &

Goparaju, 2000). The bureaucratic tactics (collective, formal, sequential, fixed, serial, and investiture) tend to yield more compliant employees while the individual tactics (individual, informal, random, variable, disjunctive, and divestiture) yield more creative employees (Griffin, Colella, & Goparaju, 2000). Additionally, the bureaucratic factors decrease role ambiguity and encourage employees to accept preset roles (Hart, Miller & Johnson, 2003). The individualized tactics encourage employees to develop their own approach to roles (Hart, Miller & Johnson, 2003).

While *Toward a Theory of Organizational Socialization* (Van Maanen & Schein, 1979) has been described as the most conceptually advanced model of socialization (Ashforth, Saks & Lee, 1997), there is still some criticism regarding the theory. One criticism of this model is that the individual is considered passive (Gruman, Saks & Zweig, 2006; Tuttle, 2002). Hart and Miller (2005) rebut this criticism and state that the emphasis of the model is the manner in which the individual is socialized; the individual is not really passive. Griffin, Colella, & Goparaju (2000) state that during socialization, both the organization and the individual are involved in the transformation process. Much research has been conducted regarding actions of the organization but little has been done regarding individual contributions (Gruman, Saks & Zweig, 2006).

In spite of the research addressing theory of socialization, the concept still remains a fragmented body of literature with research conducted in a piecemeal fashion (Saks & Ashforth, 1997). Professional bias and culture are concepts that are not addressed in *Toward a Theory of Organizational Socialization* (Van

Maanen & Schein, 1979). Professional bias and culture incorporates the values and beliefs that are held by the profession or organization that are perpetuated through ongoing reinforcement in activities such as orientation (Seron, Silbey, Cech & Rubineau, 2015). This includes concepts such as: physicians are more important than nurses, new nurses need to prove themselves, and females should make less money than males.

The process of socialization is poorly understood and most research has focused on broad concepts. (Kelly & Ahern, 2008). Additionally, there is a tendency to separate socialization context and content when studying the concept of socialization (Hart & Miller, 2005).

### **Application of Socialization Theory to Nursing**

*Toward a Theory of Organizational Socialization* (Van Maanen & Schein, 1979) provides a description of organizational socialization, which seems to be applicable in many settings. In an attempt to improve the transition period and improve socialization for GRNs, most hospitals have developed orientation programs for their newly hired RNs (especially the GRNs). These orientation programs usually have a combination of bureaucratic factors (collective, formal, sequential, fixed, serial, and investiture) and individual factors (individual, informal, random, variable, disjunctive, and divestiture) as described in *Toward a Theory of Organizational Socialization*. Many nursing orientation programs begin with a didactic classroom setting where there is a strong influence on bureaucratic factors (Newhouse et al., 2007). This is important because it

outlines expectations of the RNs and reviews many of the essential policies and procedures.

If the nurse is not successful in learning the rules during the orientation, he/she will learn them independently. A disadvantage of learning the rules without guidance is that the new nurse will draw upon his/her personal experiences that were developed as a student. Frequently, the rules learned as a nursing student are not congruent with the role of RN. This can lead to misunderstandings and negative responses from the established nursing staff. The negative reactions of established staff can challenge new nurses and create further conflict which can be detrimental to the socialization process (Taylor, Wescott & Bartlett, 2001).

A focus on the individual tactics occurs as a nurse completes the unit-based portion of orientation. This is a time when a new nurse is assigned to spend time with another experienced nurse in order to learn the bedside aspect of providing patient care. During this time there is a focus on individualized instruction and the structure is much less formal than the bureaucratic-focused classroom component. The person chosen to lead the time of individual instruction is often called a preceptor. If the preceptor is not seen as an effective professional role model, new nurses will interpret the rules of their new position through their personal filters and develop their own means to fit in with the new group of coworkers (Taylor, Wescott & Bartlett, 2001). In order for successful socialization to occur, the preceptor should have training in effective methods of structuring the individualized component of training.

## Process of Socialization in Nursing

Socialization to the profession of nursing occurs during a period identified as role transition. Experts believe that role transition begins in nursing school with development of core competencies and learning the complexities of the nursing role (Spoelstra & Robbins, 2010). There is general consensus that socialization continues for 12-18 months after commencing the first position as an RN (Allen, 2006; Etheridge, 2007; Newhouse et al., 2007; Price, 2009; Thomka, 2001; Zinsmeister & Schafer, 2009). This transition period is a time of heightened stress (Kelly & Ahern, 2008) and new graduates report feeling unsupported, overwhelmed, and “hung out to dry” (Christmas, 2008).

The manner in which a GRN is socialized will affect the function of the nurse and ultimately patient care. Inadequate socialization can lead to low productivity, increased conflict, job dissatisfaction, and demoralization. The end result is poor patient care (Boyle, Popkess-Vawter & Taunton, 1996; Taylor, Wescott & Bartlett, 2001) and nurses leave their profession (Kramer, 1974; Kramer et al., 2012; Kovner et al., 2016; Yu & Kang, 2016).

**Role discrepancy.** Marlene Kramer, 1974, examined the difficulties faced during the GRN transition period. She identified a discrepancy between what was learned and valued in school and the reality of the real world. This transition period is made even more challenging when new nurses do not find mentoring and support from established nurses (Gill, Deagan & McNett, 2010). Reality shock may be worse today than when Kramer first wrote *Reality Shock* (1974) because the transition period is compounded by higher patient acuity,

decreased patient length of stay, increased complex technology, and a nursing shortage (Dyess & Sherman, 2009).

Several studies support that the issues described by Kramer (1974) are still concerns for the graduate nurse today. There is continued frustration between what was learned at school and what is practiced in the real world (Cochran, C., 2017; Duchscher & Myrick, 2008; Edwards et al., 2015; Kramer et al., 2012; Mooney, 2007; Price, 2009; Yu and Kang, 2016; Zinsmeister & Schafer, 2009). This contradiction often leads to feelings of being frustrated vulnerable, stressed and disappointed. GRNs frequently reported a feeling of being overwhelmed by the responsibility of care, and many stated that they did not have accurate perceptions of the demands that would be placed upon them as RNs (Etheridge, 2007). Additionally, GRNs perceive stressful working conditions, poor administration, and lack of support from peers (Gill, Deagan & McNett, 2010).

**Support.** Organizational socialization is an important issue in nursing socialization because those GRNs who do not feel supported in the socialization process are less satisfied, perform poorly, and are not committed to remaining within the organization/profession (Kelly & Ahern, 2008). In a review of the literature, Edwards et al. (2016) found that there were many strategies that could be used to support the GRN during transition. Support can come from peers, preceptors, mentors, administrators, and physicians. They found the evidence to be lacking regarding a method to determine a best approach for support, but

concluded that a variety of methods over an extended period of time appeared to be useful.

There are times when support from peers is lacking. An example is horizontal bullying (or nurse-to-nurse bullying). There has been a long held belief that nurses “eat their young.” Granstra (2015) found that several studies have shown that 65 to 80 percent of surveyed nurses had witnessed bullying and 53.3 percent had experienced horizontal bullying. The effects of bullying include: sleeplessness, increased anxiety, depression, increased stress, and decreased performance (Baez-Leon, Morreno-Jimenez, Aguirre-Camacho & Olmos, 2016; Granstra, 2015; Wilson, 2016).

**Education/learning.** Learning is a central component of professional socialization – newcomers must learn about their roles, colleagues, and the organization. If an encouraging learning environment is supported, there is a reduction in uncertainty and GRNs show improvements in performance and increased job satisfaction (Cooper-Thomas & Anderson, 2005). A key determinant of successful socialization is the manner in which the newcomer learns the new role and how that learning is supported (Laschinger et al., 2017).

Regardless of whether or not a formal education program exists, employees will eventually become socialized (Ballard & Blessing, 2006). When managers fail to use the first few weeks of orientation to promote corporate values, employees educate themselves through informal means. Formal education has greater benefits than informal education because it promotes



increased organizational commitment, job involvement, and decreased turnover (Ballard & Blessing, 2006).

GRNs must also learn critical thinking and core competencies that pertain to the new RN position. As the high rate of nursing turnover persists and increased numbers of GRNs are hired, there is a higher new graduate nurse –to- experienced nurse ratio (Theisen & Sandau, 2013). According to Benner’s Novice to Expert theory (1984) this means that there is an increase of percentage of novice nurses in staffing. Their limited knowledge and inexperience in critical thinking mean that these GRNs are in need of more support (Benner, 2001; Theisen & Sandau, 2013). Many hospitals have incorporated increased orientation time and nurse residency programs as a way to address this concern (Cochran, 2017; Edwards et al., 2015; Hopkins & Bromley, 2015; Kovner et al., 2016). Increased didactic instruction is beneficial in reducing stress and helping GRNs feel more comfortable (Newhouse et al., 2007). Research has shown that GRNs have more commitment following an orientation that provided a more structured format (Mitus, 2006).

**Preceptors/mentors.** Hospital administrators have realized that socialization tactics used to help newcomers adapt to early employment experiences can lead to decreased levels of uncertainty and anxiety (Allen, 2006). In an effort to improve retention, many administrators have made attempts to improve orientation programs through the addition of mentor programs, preceptor programs, group support, and nurse residency programs (Adams et al., 2015; Dyess & Sherman, 2009; Edwards et al., 2015; Hopkins &

Bromley, 2015; Klingbeil et al., 2016). Nurses have reported a supportive work environment and positive preceptor experience as being a positive influence during transition (Zinsmeister & Schafer, 2009).

Preceptors are a key element to a successful orientation (Cochran, 2017; Nesler et al., 2001) as they try to link theoretical knowledge to practice (Smedley, 2008). GRNs rely on preceptors for assistance with the practical application of newly acquired nursing knowledge and technical skill. Many preceptors also provide mentoring in the form of professional role modeling, guidance, support, and leadership during transition (Thomka, 2001). The preceptor who teaches at the bedside may significantly shape the viewpoint and development of the GRN (Adams et al., 2015; Perry, 2009; Reddish & Kaplan, 2007).

In addition to a preceptor role, literature supports the importance of a mentor role as well (Edwards et al., 2015). Often times the terms preceptor and mentor are used interchangeably, but there is a difference between them. A preceptor is someone who is assigned to a GRN for a short period of time to assist with the unit-based individual orientation. A mentor relationship extends beyond the role of preceptor and includes consultation, guidance, support, encouragement, and feedback (Trowler & Knight, 1999; Wareing, 2011; White, Brannan & Wilson, 2010). Characteristics of mentoring include: generosity, competence, self-confidence, and commitment to mentor relationship. Those GRNs who have been mentored have higher promotion rates, greater career satisfaction, and higher overall compensation (Allen, McManus & Russell, 1999). Many hospitals have formal mentor programs.

There are several ways to provide preceptor and mentor support (Edwards et al., 2015). Some orientation programs assign a specific preceptor and allow for spontaneous development of mentor support. Sometimes one person can fill the role of both preceptor and mentor. There can also be a specified person to act as preceptor and another specified person to act as mentor.

### **Outcomes of Socialization**

Successful socialization is the transformation of an outsider to an insider. Indicators of success are: job satisfaction, role clarity, task mastery, values congruence and fit among others (Ajjawi & Higgs, 2008; Gruman, Saks & Zweig, 2006; Kelly & Ahern, 2008; Mooney, 2007; Nesler, Hanner, Melburg & McGowan, 2001; Van Maanen & Schein, 1979). Research has shown that successful socialization leads to an increase in job satisfaction, greater social integration, and improved role clarity and task mastery (Allen, 2006).

Successful GRN socialization is learning to think like a nurse, (Etheridge, 2007) and includes: making clinical judgments, emergence of confidence, acceptance of responsibility, an awareness of one's self and belief in one's ability for competence and accountability (Dinmohammadi, Peyrovi & Mehrdad, 2013). There is also internalization of norms and values.

The development of clinical reasoning has been identified as a determinant of successful socialization in nursing. A challenge with using clinical reasoning is that it is comprised of thinking and decision-making which is difficult to measure because it is both cognitive and interactive and mostly unobservable

(Ajjawi & Higgs, 2008). Additionally, Benner (1984) describes critical thinking as developing throughout the five stages outlined in her theory; From Novice to Expert. This means that the development of critical thinking evolves over several years.

Socialization is not a single event but rather it is ongoing and developed through interaction with numerous people. Socialization is a process which manifests as the acceptance of a discipline's attitudes and values and is demonstrated through behaviors and it can occur throughout the professional life (Faulk, Parker & Morris, 2010).

Education has been described as an essential component of socialization. Yet, it is difficult to evaluate teaching strategies because role transition is such an abstract concept (Spoelstra & Robbins, 2010). Content mastery and the process of learning have been identified as mediating factors in successful socialization (Klein, Fan & Preacher, 2006). They are included in both the organizational tactics and the individual tactics but, it is difficult to identify the direct impact of education on socialization.

There have been several studies that identify unsuccessful outcomes as evidenced by high nursing turnover (Adams et al., 2015; Edwards et al., 2015; Kramer et al., 2012; Kovner et al., 2016). Job satisfaction has been identified as an indicator of successful organizational socialization. Job satisfaction is also an indicator of a person's intent to stay in a position and frequently used as a factor in determining job turnover (Chen, Chu, Wang & Lin, 2006; Kovner, et al., 2016). If one considers that research has shown job turnover during the first year of

employment as a GRN ranges between 27.1 and 61 percent (Christmas, 2008; Duchscher & Cowin, 2004; Gill et al., 2010) the assumption that many GRNs are not getting successful organizational socialization can be made.

### **Gaps in Literature**

Successful socialization involves identity by the outside world as well as recognition of that identity within self (du Toit, 1995) but, there is little information to identify when this recognition occurs. In general, research is lacking on the GRN socialization process (Klein et al., 2005). As this section of the literature review regarding socialization has shown, there is some research regarding the process of socialization, and even less regarding the outcomes of socialization. Additionally, those studies looking at the outcomes of socialization have focused on job satisfaction, task mastery, and turnover rates. There have been no studies that examine the lived experience of the GRN and the meaning of the lived experience. No studies were found that inquire of the GRN when they felt like they were fully functioning as an RN and a contributing member of the organization. Also, there are few studies that examine the GRN's experiences of what factors of the socialization, or orientation process were helpful and which factors were not helpful in the process of becoming an RN (Adams et al., 2015; Klingbeil et al., 2016; Kovner et al., 2016; McKenna, Brooks & Vanderheide, 2017). The lived experience of the GRN is not thoroughly researched and thus orientation programs may not reflect the true needs of GRNs (Kelly & Ahern, 2008; Kovner et al., 2016).

This qualitative research was conducted to examine the lived experience of the GRN. There are three main aims of this research.

Aim 1: To understand the meaning of the lived experience of being a GRN. What are the stories that the GRN want to tell? What were the highlights and what were the frustrating times during the transition? How do GRNs describe and define the experience?

Aim 2: To understand the meaning of self-identification as an RN. Is there a specific experience that the GRNs had that lead them to realize that they are functioning as an RN? How do GRNs describe the internalization of the role identification as an RN and what does it mean to them?

Aim 3: To understand the meaning of feeling like a team member at work. What are the stories the GRNs want to tell regarding working in the acute care setting? What are the internal milestones that need to be present in order for the GRN to feel like they 'have made it' – that they are part of the team and a fully functioning RN?

## CHAPTER 3: METHODOLOGY

### Introduction

As the researcher was reviewing the literature of GRN socialization, she kept asking “what did the GRN experience during the socialization period?” The researcher had experience as a nursing faculty in a Bachelor of Science in Nursing (BSN) program as well as a staff development instructor in an acute care facility. (See Appendix A). She had seen nursing students do well in school and then struggle in the new role of the GRN. Her personal experience of trying to help the struggling GRNs was a basis for choosing “the socialization of GRNs” as a research topic. More specifically, the researcher wanted to gain insight into the meaning of the socialization experience from the viewpoint of the GRN. A phenomenology methodology was chosen for this reason.

The researcher was drawn to discover the personal stories of the GRNs and discern the meaning of the GRN experience to each participant. Hermeneutic phenomenology was the specific type of phenomenology methodology chosen. Hermeneutic phenomenology seeks to answer the question of the meaning of being –Heidegger argued we are inseparable from the world and we are always adapting to the world as we give meaning to different situations. (Heidegger, 1962/1926).

The “meaning of the experience of becoming an RN” is the phenomenon of interest for this research. This phenomenon occurs during the transition from the role of student nurse to the internalization of the RN role (or self-identity as

an RN). As discussed in the previous chapter, there is a gap in the research literature regarding this phenomenon.

### **Phenomenology**

Phenomenology answers questions about the core or essence of a phenomena or experience (Richards & Morse, 2007). It supports the re-examination of common/taken-for-granted experiences and examines the qualities which allow one to identify its essence (Balls, 2009). This methodology is the best fit for answering questions about the phenomena of becoming an RN and understanding the meaning of the experience.

Phenomenological research provides a structure that promotes a deeper understanding of the nature and meaning of the human experience as it is lived (Broussard, 2006; Laverty, 2003). Phenomenology makes no attempt to generalize theory or predict outcomes (McConnell-Henry, Chapman, & Francis, 2011; Van der Zalm & Bergum, 2000). While there is a descriptive component to phenomenology, the main focus is the value of an individual's experience as it is lived (Balls, 2009; Dowling, 2007). Through focusing on an individual's perception of an experience, a rich and detailed description of the experience can be developed and vague concepts can begin to be clarified (Appleton, 1995).



## **Contributions of Husserl**

Phenomenology is both a philosophy and a research methodology (Drew, 2008). The modern version of phenomenology as a philosophy was developed by Edmund Husserl (1859 - 1938) (Magill, 1990). Husserl believed that people create meanings of events or phenomena as they interact with the world. Additionally, human actions are influenced by what people perceive to be real (Lopez & Willis, 2004). His aim was to gain a better understanding of these meanings. He believed that experience as perceived by human consciousness has value and should be the object of scientific study (Lopez & Willis, 2004). Therefore, the task of phenomenology research is to re-examine taken-for-granted experiences and evaluate the critical role these experiences play in making sense of the lived experience (Balls, 2009; Koch, 1995).

Husserl described that an essence is what makes a phenomena identifiable as a particular object or experience (Lavery, 2003). Universal essences are features of lived experience that are common to all who have had the experience and they represent the true nature of the phenomena. Phenomenology as a research science involves identification of the commonalities of essences as described by individuals experiencing the phenomena so that a generalized description is possible (Lopez & Willis, 2004).

Husserl based much of his philosophy of phenomenology on the work of Descartes; especially work relating to the model of mind-body split known as Cartesian duality (Koch, 1995). He believed it was essential to shed all prior personal knowledge in order to grasp the essential essence of the lived

experience (Lopez & Willis, 2004). This was accomplished through the process of bracketing or phenomenological reduction. Bracketing occurs when all assumptions about causation, consequences, and the wider significance of the phenomena under investigation are eliminated or set aside. In other words, there is an elimination of all preconceived notions. Successful bracketing involves setting aside not only the outer worlds but also the individual consciousness. The reality of the outer world is neither confirmed nor denied; rather it is bracketed in an act of phenomenological reduction (Koch, 1995).

### **Contributions of Heidegger**

The work of Husserl was developed even further by Martin Heidegger. Martin Heidegger (1889 – 1976) (Magill, 1990) was a contemporary of Husserl and they worked together at the same university (Lavery, 2003). Like Husserl, Heidegger believed that the focus of phenomenology was illuminating the lived experience. He stated that the focus of phenomenology research should be experiences; and a focus on details and the seemingly trivial aspects can help to create meaning and understanding (Flood, 2010; Heidegger, 1962/1926) However, he postulated some concepts that were different from the concepts of Husserl. Heidegger modified and built on Husserl's theory and developed the interpretive tradition which goes beyond describing the essence of a phenomenon and includes the meaning of the experience. This departure is known as hermeneutic phenomenology

Heidegger sought to answer the question of the meaning of being – he argued we are inseparable from the world and we are always adapting to the

world as we give meaning to different situations. Heidegger believed that relationship to the real world should be the focus of inquiry (Heidegger, 1962/1926). It is impossible for the researcher to separate self from the processes that lead to the desire to research a particular topic (Lopez & Willis, 2004). In other words, the researcher is an active participant in the process (Draucker, 1999). Humans are embedded in their world in which they live and subjective experiences are connected with social, cultural, and political events (Flood, 2010; Heidegger, 1962/1926).

Related to this, Heidegger rejects bracketing and phenomenological reduction because he believed that the human is never without presuppositions (Earle, 2010). Heidegger described the world as a meaningful matrix of relationships, practices, and language that humans live in by virtue of being born into a particular time and place. Arriving at a state with no preconceived notions or pre-understanding is not something a person can accomplish (Heidegger, 1962/1926). Nothing can be encountered without reference to a person's background and every encounter involves interpretation which is influenced by a person's background. Heidegger believed that our background and presuppositions become a part of our research. They converge in every aspect from choosing the topic, to which questions we ask, and how we interpret the responses. Therefore as a researcher, it is important to show how our own experience has shaped choice of research topics, questions, and interpretations. (Balls, 2009). Heidegger defined this concept as co-constitutionality and described the research as a blend of the participants' response and the

researcher's interpretation. (Lopez & Willis, 2004; Heidegger, 1962/1926; Koch, 1995). The researcher of this study realized her personal background and presuppositions were an influence on the research subject, types of questions asked of the participants, and interpretation of the data. Her background is included in Appendix A.

The concept of time and space are described by Heidegger as being pivotal; every time an experience is revisited the meaning may alter (McConnell-Henry, Chapman & Francis., 2011; Whitehead, 2004). Temporality refers to the concept that humans live simultaneously in the present, influenced by the past and always looking to the future (Heidegger, 1962/1926; Parsons, 2010). It is possible for alternative descriptions to exist because the life-world does not remain static (Van der Zalm & Bergum, 2000).

Balls (2009) and Koch (1995) wrote that the task of phenomenology research is to re-examine taken-for-granted experiences. Socialization into the role of RN can be classified as a taken-for-granted phenomenon that all RNs experience, though the experience has different meaning for each individual. It is a phenomenon that all RNs encounter yet, after years in the profession, one may lose touch with this experience and one may find difficulty in relating to those GRNs who are currently experiencing the phenomenon. By having GRNs relate their lived experience, the phenomenon of socialization may be understood more clearly.

## **Methods**

This research used a hermeneutic phenomenology design and examined the experience of becoming an RN. The research team consisted of five people: the student investigator and four faculty members who were part of the researcher's dissertation committee. Analysis of the interview transcripts and researcher notes was conducted by the research team throughout the research period (Sandelowski, 1986; Whitehead, 2004).

### **Setting**

This research was conducted at a not-for-profit hospital in northeast Ohio. The hospital has approximately 500 beds and is located within a metropolitan setting. Approximately 72 percent of the GRNs in the region have graduated from a four-year Bachelor of Science in Nursing (BSN) degree program and 28 percent graduated from a two-year Associate Degree (AD). For the past three years there have been no new RN hires with a diploma in nursing.

The research facility, at which the participants are employed, has a structured orientation program, but it does not have a residency program in place for GRN hires and there is no formal method to develop GRN/mentor relationships. As identified in the literature review, the major areas identified as challenges during the transition period are: decreased self-esteem, skill acquisition, lack of mentoring, and development of critical thinking. The orientation has a strong focus on skill acquisition. The concept of critical thinking is addressed during the orientation, but it is assessed through the judgment of the preceptor, educator, and unit manager. There is no formal method to assess

critical thinking. Self-esteem and mentoring are not addressed in any formal way during the orientation period.

All newly hired GRNs have an orientation period of approximately 12 weeks. The orientation is structured and involves input from the human resource department, staff development department, unit manager, and RN preceptors. The standard practice is to have GRNs begin the orientation on day shift. After six to eight weeks they are then switched to the shift for which they were hired. The overall orientation period can be described by using the six tactics described by Van Maanen and Schein in their theory detailed in *Toward a Theory of Organizational Socialization*.

**Collective vs. individual.** Collective socialization occurs when new hires are kept together as a group. Individual socialization occurs when new hires receive training that is tailored to their specific needs (Eckhardt, 2002). The GRNs experience both tactics during their orientation.

The orientation period begins with a mandatory generalized hospital orientation that is conducted by the human resource department and strongly collective in nature. All newly hired hospital employees are grouped together and attend all day lecture-type presentations regarding hospital-wide issues and procedures. Some topics include: safety, confidentiality, compliance, and chain of command. The GRNs continue collective based training by attending classes for all RNs hired into the hospital. These classes are conducted by the staff development department and include lecture-type presentation as well as hands-on skill competencies. Topics include: electronic medical record documentation,

infection control, management of central lines, and multiple basic nursing skill competencies. The total time for both types of training is approximately 80 hours.

The remaining ten weeks of orientation are dedicated to training that is tailored to the individual. Each GRN works on the unit to which they were hired. Each is paired with an RN preceptor. Ideally each GRN will only have one preceptor for day shift orientation and one preceptor for night shift orientation. But, due to scheduling conflicts, each GRN usually ends up working with three or four different preceptors. Before an RN can serve as a preceptor, they need to complete specialized formal training. This training includes the process of GRN development and methods for progressing the GRN toward the ability to fully function independently.

**Formal vs. informal.** Formal socialization occurs when new hires are kept together as a group and they receive specialized education material (Eckhardt, 2002). Informal socialization occurs when new hires are placed with established employees and they receive training that occurs by trial and error (Gruman, Saks & Zweig, 2006). The majority of training for GRNs leans toward the informal tactic.

The only time newly hired GRNs are segregated from established employees is during the general hospital orientation and the nursing orientation classes. The training during this time is formally structured with education materials and activities developed specifically for the new hires.

The remainder of the orientation time is more in the realm of informal tactic in that is conducted on a specific unit and focused on the specific

GRN/preceptor pair. Through active bed-side care of patients, GRNs enhance their skills and critical thinking. They also develop an understanding of hospital and unit policies and protocols. This experience is trial and error only in the sense that skills and patient care experiences are based on the type of patient presenting to the unit during the GRN orientation period. Though this time is based on individual training, there are several formal guidelines, checklists and competencies that must be completed in order for the GRN to be able to “come off orientation.”

**Sequential vs. random.** Sequential training has discrete recognizable steps whereas random lacks specific steps (Eckhardt, 2002). The orientation for GRN hires is strongly based on sequential tactics.

The orientation for GRNs has an overall plan with some specific goals and a general flow from easy to complex. The orientation plan is specific to each unit based on the specific needs and challenges of that unit. In general, a GRN will begin the orientation period caring for one or two patients with relatively low acuity and then progress to taking a full assignment with minimal assistance from the preceptor. Throughout the orientation period, the GRN and preceptor meet with the unit manager and educator to address any specific issues and make sure the GRN is making progress as expected.

During the orientation period there are several competencies that must be mastered. Many of the competencies are skill-based and include topics such as: managing a patient with chest tubes, caring for a patient with a temporary pacemaker, or managing equipment such as intravenous (IV) pumps. These



competencies are random due to the fact that the opportunity to demonstrate skill is based on the patient population. If the GRN does not get the opportunity to experience a certain skill, such as sheath pulls in a patient following a cardiac catheterization, arrangements can be made for the GRN to spend a day in the cardiac catheterization lab.

**Fixed vs. variable.** The fixed tactic has a specific timeframe for completion of the orientation period and variable tactic lacks a specific timeline (Eckhardt, 2002). The GRN orientation follows the fixed tactic.

The GRN orientation is based on a 12 week plan. There are scheduled meetings throughout the 12 week period with the GRN, preceptor, unit manager and educator to assess the GRNs progress. The GRN needs to be able to progress from a simple to complex assignment and there are some suggested goals to aid in assessing the progression. For example, A GRN in ICU should be able to care for one high acuity patient with minimal assist from the preceptor by week eight. If the GRN is having difficulty with the progression, orientation can be extended. There is a definitive end point to the orientation. This involves a meeting with the unit manager, preceptor and GRN to review competencies, and abilities and a decision by all three that the GRN is now able to function independently.

**Serial vs. disjunctive.** Serial tactics include training by employees who have held the position for which the new hire is training. Disjunctive tactics have no peer models and prior occupants are not available (Griffin, Colella & Goparaju, 2000).

The GRN orientation is strongly serial in nature. The GRN is paired with a preceptor who is an experienced RN who has the same job description and job function. The GRN is exposed to multiple experienced RNs who show, demonstrate, and describe the correct skills, and protocols. These peer models can also help the GRN to learn the unit politics and identify any hidden issues that could affect the GRN's success.

**Investiture vs. divestiture.** Investiture tactics value the previous knowledge and experience of the new hire. Divestiture tactics strive for conformity and attempt to strip away personal characteristics (Hart, Miller & Johnson, 2003). Investiture tactics are dominant in the GRN orientation.

Throughout the orientation there is a goal to have each GRN build on the knowledge and skills previously learned through school and experience. In fact there is an assumption that the GRN brings with them a basic foundation of knowledge and skills and the orientation builds upon that foundation. There is some degree of stripping away personal identity in that GRNs must conform to the professional standards as defined by the state and institution. At the research facility there are some specific standards:

- All RNs must wear navy scrubs and wear name badge
- No visible tattoos and no body piercings (other than ear rings)
- No false nails
- No smoking

## **Sample Criteria and Justification**

The sole basis for sampling in a phenomenology study is to select participants who have first-hand experience of the phenomenon of interest. Purposive sampling occurs when participants are selected based on their experience of a particular phenomenon and their willingness to share and discuss or express their experience (de Witt & Ploeg, 2006; Speziale, Streubert & Carpenter, 2011). Another sampling technique that is common in qualitative research is snowballing. Snowballing occurs when one research participant contacts another person to become an additional study participant (Speziale, Streubert & Carpenter, 2011). A phenomenology research project uses a sample that includes a small group of participants in order to allow for in-depth data collection. The size is adequate when interpretations are visible and clear and new participants no longer reveal new findings (Crist & Tanner, 2003). The sample size for this research study was ten participants.

This research utilized purposive sampling with some snowballing sampling. Inclusion criteria were established to ensure that all participants were GRNs working in an acute care setting with 12 to 18 months of experience. This criterion helped to reveal what an experience (becoming an RN) meant to a particular group (GRNs) (Crist & Tanner, 2003). It is desirable to have participants who have reached a point where they feel like they are functioning as RNs and contributing members of the organization/hospital; they feel like “they have made it.” Literature supports that this point occurs within 12 to 24 months of hire as an RN (Casey et al., 2004; Newhouse et al., 2007; Price, 2009;

Zinsmeister & Schafer, 2009). All GRNs who hired into the acute care facility from July 2013 through July 2014 were asked to participate in the research. This ensured that all participants had between 12 and 24 months of experience.

**GRN definition.** A GRN is defined as a registered nurse who has graduated from an accredited nursing school and passed the National Council of State Boards of Nursing (NCLEX-RN) licensure examination within six months of hire. The literature supports that someone who has had prolonged length of time since graduation may have an altered course of socialization (Benner, Hooper-Kyriakidis & Stannard., 1999; Delaney, 2003; Goode & Williams). Consistency is lacking within the literature in regards to defining GRN according to level of education. Krugman et al. (2006) focused on BSN graduates while other authors did not differentiate nursing education as a research focus. Because the majority of literature does not use nursing education as a method of defining GRN; level of nursing education was not an inclusion or exclusion criterion for this research project. Additionally, the staff development department at the research facility did not differentiate GRNs by level of education; they all experienced similar orientations.

## **Procedures**

This research study was approved by the Institutional Review Boards (IRB) at the acute care facility as well as Indiana University/Purdue University – Indianapolis as an expedited study. Recruitment of GRNs began once approval had been obtained from the IRB at both facilities. Recruitment was completed through the staff development department since they had contact information for

all new GRNs hired into the facility and they were responsible for the orientation of the GRNs. The researcher created information packets that were distributed by the secretary in the staff development department to the new GRN hires through interoffice mail. Each packet contained a letter from the researcher that described the study, and gave the contact information and instructions for contacting the researcher if the hired GRNs were interested in scheduling an interview. Additionally, unit managers received an information packet that described the research project. Participation in this research project was voluntary.

Written informed consent was obtained at the time of the interview. Informed consent implies that the participants are fully aware of both the risks and benefits of participating in the study (Munhall, 2007). Since neither the researcher nor participant truly knows how the process will unfold, one can argue that informed consent can never be fully obtained. In order to address this, consensual decision-making can be utilized. Consensual decision-making requires the researcher to re-evaluate participants consent to participate in the interview at various points during the interview. This is very important when discussing phenomena that may be emotionally charged. If the participant experiences distress, it may be necessary to renegotiate the consent (Broussard, 2006; Walker, 2007). There was no evidence of emotional distress of the participants describing the phenomena of becoming an RN throughout the interview process and there were no occurrences when the renegotiation of consent was necessary.

Interviews were recorded, transcribed then erased at the completion of the study. To address the potential for loss of confidentiality, pseudonyms were used for participants and any detailing information that could be used to identify the participant was changed. All transcripts and recordings were kept in a locked file within a locked office. Additionally, the acute care facility will not be mentioned by name in this dissertation or any future publications or presentations.

### **Interview Process**

Data was obtained through one-to-one interviews between the researcher and the participant. An advantage of the interview process is that it allows for an opportunity for the interviewer to clarify unclear answers. The researcher can encourage participants to expand upon answers, to go deeper and obtain more detailed data, and clarify potentially unclear answers. A disadvantage of the interview process is that it is time consuming and the quality of data is dependent on the researcher's interview skills (Appleton, 1995).

An unstructured interview is the gold standard for obtaining data in a hermeneutic phenomenology study (Balls, 2009; Walker, 2007). With the unstructured interview, the researcher starts with a general plan of the direction the interview will take. The actual direction of the interview will be developed by the participant through describing what is meaningful to them. In general, the researcher needs to guide the participant through three stages 1) establishing the context of the interviewee's experience, 2) constructing the experience; and 3) reflecting on the meaning the experience holds (Flood, 2010). Throughout the

interview the researcher needs to ensure that necessary and sufficient components of the experience are being described. Also, participants need to describe the phenomena in terms of how it has meaning to them – or how the feelings or experience connects with being a human (Vivilaki & Johnson, 2008). Throughout the interview the interviewer should listen with intent and avoid interrupting and jumping to conclusions. Rather than making assumptions, the interviewer should clarify and ask open ended questions to obtain more detail (McConnell-Henry, Chapman & Francis, 2011; Sandelowski, 1986; Whitehead, 2004). The interviewer asks questions that illuminate the participant's experiences until both parties feel satisfied that a shared understanding has been achieved.

During the interviews a few key interview questions were developed, but the process remained unstructured to allow the participants to guide the flow of the interview process. The main questions, organized by research aims were:

- Aim 1: To understand the meaning of the lived experience of being a GRN.
  - Describe your first year as a GRN.
  - Tell me a specific story of your first year as a GRN.
  - What does that mean to you?
- Aim 2: To understand the meaning of self-identification as an RN.
  - When did you feel like you had become an RN?
  - Describe the process of becoming an RN.
  - What does being an RN mean to you?

- Aim 3: To understand the meaning of feeling like a team member at work
  - Do you feel like you functioning as a team member at work?
  - What were some factors that helped you achieve this status?
  - How does this make you feel?

The researcher did not return to the participants and ask them to verify their summaries or ask the participants to provide an additional written exercise. Throughout the interview process, a research journal was kept regarding the interview process and data analysis. This was shared with the dissertation committee and used to identify personal biases that might affect interpretation of the participant's data (Walker, 2007; Whitehead, 2004).

### **Data Quality**

Historically, most research was conducted using quantitative methodology and the quality of the research was determined through reliability and validity. As qualitative research developed, it became apparent that new evaluation methods were needed. Emden and Sandelowski (1998) declared that “qualitative research is distinguished by complexities and nuances far beyond those capable of being captured by the traditional usages of reliability and validity.” (p. 209).

Evaluation of hermeneutic phenomenology research begins with a review of the topic under investigation. The researcher needs to identify the topic and explain why the research is needed (Gelling, 2015). Review of a theoretical framework can serve to focus data collection and clarify important concepts (Ryan, Coughlin & Cronin, 2007). A fundamental evaluation criterion is that the



methodology remains consistent with Heideggerian philosophy (Draucker, 1999). The literature review and methodology sections of this paper illustrate how these criteria were met for this research study.

**Establishment of rigor.** As previously stated, it is not possible for the researcher to totally separate personal bias from data obtained from the participants. Heidegger believed that knowledge is never independent of interpretation (Heidegger 1962/1926). This concept makes the establishment of rigor important. Sandelowski (1986) has identified four factors that are foundational to the determination of rigor in qualitative research. They are: truth value, applicability, consistency, and neutrality.

**Truth value.** Truth value is maintained when the researcher remains faithful to the participants' description of the phenomenon or experience. It is essential that the researcher provide an accurate interpretation of participants' statements without adding preconceived ideas and personal biases. (Appleton, 1995; Gelling, 2015; Lincoln & Guba, 1985; Sandelowski, 1986).

Many phenomenological researchers return to the participants and have them verify summaries of data in an attempt to support credibility (Whitehead, 2004). Re-entering the field to acquire more data does not necessarily equate to obtaining richer data; it can even dilute the true essence of the experiences. Participants may not agree with the researcher's interpretation or worse yet may change their minds. Time delays can influence the recounting of the participant's stories (McConnell-Henry, Chapman & Francis, 2011). This belief is supported by Heidegger's description of temporality and the belief that meaning of an

experience can differ when reviewed at different times (Heidegger, 1962/1926). In order to stay true to the philosophy of Heidegger, the researcher did not return to the participants for review and clarification.

Another practice that is employed by some phenomenology researchers is having participants conduct a written exercise regarding the phenomena under investigation. Van Manen (1990) states that writing is more reflective than interviewing, which makes it more difficult for the writer to stay with the experience as it was lived (Van Manen, 1990). A writer is more likely to focus on aspects such as grammar and spelling rather than the lived experience. For this reason, there was no written component for the participants to complete.

The researcher maintained truth value throughout the interview process by frequently asking for clarification of participant statements. Often the researcher would say to the participant “What you mean is...” The researcher would also ask “What does that mean to you?”

Truth value can be enhanced if the researcher keeps a journal and notes throughout the research process and identifies insights and reactions that occur. These notes can be shared with the research team to help ensure that the researcher remains true to the participants’ descriptions. (Drew, 2008). Throughout the interview process, a research journal was kept regarding the interview process and data analysis. This was shared with the dissertation committee and used to identify personal biases that might affect interpretation of the participant’s data (Walker, 2007; Whitehead, 2004).

**Applicability.** Applicability is the ability of the research findings to be applied to situations other than the study from which they are derived (Lincoln & Guba, 1985). In quantitative research this concept is referred to as external validity. In qualitative studies, applicability is enhanced by asking another researcher, who has experience in the area of study, to review the data (Appleton, 1995). It occurs when the results are reported in a clear and detailed manner so that they are meaningful to another (Ryan, Coughlan, & Cronin, 2007). The role of the researcher is to provide enough detailed data to enable the readers to judge if the findings are applicable to different situations (Ferrari, 2006). This occurs with a well delineated outline and discussion of the research process as well as written summary of the data. The researcher worked with her dissertation committee to ensure that data were presented in a clear and detailed manner, thus providing meaning to others.

**Consistency.** Consistency is related to the concept of reliability (Sandelowski, 1986). This can be challenging in qualitative research because it has been acknowledged that qualitative study focuses on human experience which can be unique. It can be more informative if the researcher obtains a variation in experiences rather than identical repetition (Sandelowski, 1986). Rather than being able to repeat a study with similar findings, an independent researcher should be able to come to similar conclusions when provided with the original research notes and documentation (Lincoln & Guba, 1985, Sandelowski, 1986). Consistency can also be enhanced through development of the researcher's interviewing skills and data gathering abilities (Appleton, 1995).

**Neutrality.** Neutrality is freedom from bias (Sandelowski, 1986; Appleton, 1995). This can be challenging because the nature of qualitative research requires in-depth interaction between the researcher and participant. Neutrality is the ability to report data without bias. This can be accomplished through researcher self-reflection, interaction of a research team, and ongoing monitoring of research notes (Appleton, 1995; Lincoln & Guba, 1985, Sandelowski, 1986). The researcher reviewed notes and transcripts in an attempt to identify any personal bias. There was also ongoing discussion with the dissertation committee during the data collection and analysis phases. Table Three summarizes the four factors of rigor.

**Table Three: Four Factors of Rigor**

<b>Four Factors of Rigor in Qualitative Research</b>	
Truth Value	Definition: researcher remains faithful to the participants' description of the phenomenon or experience.
	Application: frequently asking for clarification of participant statements during interview process; Ongoing review with dissertation committee.
Applicability	Definition: ability of the research findings to be applied to situations other than the study from which they are derived.
	Application: Research process described in detail throughout this paper; Ongoing discussion with dissertation committee.
Consistency	Definition: an independent researcher should come to the same conclusions, using interview transcripts, and researcher's notes.
	Application: Research process described in detail throughout this paper; Ongoing discussion with dissertation committee.
Neutrality	Definition: freedom from bias
	Application: Ongoing self-analysis and discussion with dissertation committee

**Hermeneutic circle.** Each of the four factors of qualitative rigor contains an aspect that is related to interpretation of the data. One aspect of interpretation is the analysis of data. The hermeneutic circle is a metaphor that is used to describe the analysis of data in a hermeneutic phenomenology research study. It is a process of moving back and forth from the specific to the general. It provides a systematic method of data review and interpretation (Ajjawi & Higgs, 2007; Parsons, 2010; Sandelowski, 1986; Walker, 2007; Whitehead, 2004). There are several methods to accomplish this process, each with varying stages. Most hermeneutic phenomenology researchers report data analysis in stages, but there is lack of consistency regarding specific actions taken in each stage. The following description of analysis stages is an adaptation of the stages as described by Ajjawi & Higgs (2007). The researcher used these stages for data analysis.

**Stage one.** Each interview was transcribed verbatim by the researcher. The transcripts were read and re-read to get a sense of the meanings of the lived experience. Additionally, there was critique of the interview process to identify missing or unclear data and identify concepts that need further exploration (Crist & Tanner, 2003).

**Stage two.** The transcripts were compared to each other and to the researcher's notes to get a sense of global perspective and emerging ideas. The research team identified central concerns, themes or meanings (Crist & Tanner, 2003). They also identified participant's descriptions that capture details of the global phenomena (Ajjawi & Higgs, 2007). Overall there was a systematic

analysis of the whole to gain perspective and depth of understanding. This broad understanding was then used to gain an understanding of the parts. The global perspective was then reviewed in light of understanding gained from the parts (Leonard, 1994).

**Stage three.** Segments of individual interviews or summaries were then grouped together in order to create themes and sub themes (Ajjawi & Higgs, 2007). The overall unifying concept is the shared meanings between interviews (Crist & Tanner, 2003). The shared meanings were determined by reviewing similarities in the transcripts and researcher notes. The data were compiled with participant's quotes arranged by theme. See Appendix C

**Stage four.** The last stage involved going to the literature for links to themes and sub-themes that might further illuminate and illustrate the phenomena. There was on-going critique by the research team through critical debate along with final review of literature for key developments that could impact on or increase understanding of the phenomena.

**Ongoing analysis.** Dialogue occurred between the researcher and dissertation committee throughout the analysis to maintain rigour (Ajjawi & Higgs, 2007; Parsons, 2010). Data analysis was ongoing and occurred throughout the research process in hermeneutic phenomenology. During the interview, the researcher continuously analyzed the data to ensure the research questions were supported.

Analysis of the data occurred throughout the interviewing process. The researcher continually reviewed data relating to the phenomena of socialization

as well data that supported various themes and subthemes. The ultimate judge of a qualitative research rests with the reader. A clearly written research report is essential to convey steps taken throughout the project and demonstrate rigour. The report should include a description of the research process as well as the process of data analysis (Draucker, 1999).



## **CHAPTER 4: RESULTS**

### **Introduction**

The purpose of this qualitative study was to understand the meaning of the experience of becoming an RN and the method used was a hermeneutic phenomenology design. Interviews were conducted between September 30, 2015 and February 21, 2016. All interviews were one-on-one with the participant and the researcher. The interviews were recorded and then transcribed by the researcher. Sixty-five GRNs employed at the acute care facility received information about the research study through interoffice mail, and were instructed to call the researcher if they were interested in participating. Eight participants called as a result of the mailing. Two others became participants at the encouragement of someone who had already completed an interview.

### **The Specific Aims of this Study**

Aim 1: To understand the meaning of the lived experience of being a GRN. What are the stories that the GRN want to tell? What were the highlights and what were the frustrating times during the transition? How do GRNs describe and define the experience?

Aim 2: To understand the meaning of self-identification as an RN. Is there a specific experience that the GRNs had that lead them to realize that they are functioning as an RN? How do GRNs describe the internalization of the role identification as an RN and what does it mean to them?

Aim 3: To understand the meaning of feeling like a team member at work. What are the stories the GRNs want to tell regarding working in the acute care setting? What are the internal milestones that need to be present in order for the GRN to feel like they 'have made it' – that they are part of the team and a fully functioning RN?

### **Population Description**

The population for this study was GRNs who were working at an acute care facility between 12 and 24 months. A GRN is defined as a registered nurse who has graduated from an accredited nursing school and passed the National Council of State Boards of Nursing (NCLEX-RN) licensure examination within six months of hire. For this research study, level of nursing education was not an inclusion or exclusion criterion.

### **Sample Description**

The sample for this research consisted of ten participants. Ninety percent were employed in a critical care unit. This differs from the hiring trends of the hospital in that only 23 percent of new GRNs are hired into the critical care units. Sixty percent of the participants had changed positions between the time of hire and time of interview. One participant moved from a nursing home to the ICU in a hospital. This is an example of organizational turnover from the nursing home to the acute care facility. Five participants transferred to different units within the hospital, which is unit turnover. At the time of interview, one participant was considering quitting in order to stay at home with her new baby, which would be considered professional turnover. All participants who changed jobs were

examples of voluntary turnover. Eight participants had previous jobs, before becoming an RN. They were:

- Paralegal for 15 years
- Navy aviation ordinance specialist for 5 years & nursing aid during nursing school (3 years)
- Hostess in a restaurant then 2 years as a nurse technician in the Emergency Department
- Machine shop, cashier supervisor, hospital transporter for 3 years
- Air Force Medic, home health aide, hospital nursing technician
- Boutique/collectibles store, then 4 years as emergency department nursing technician
- Nursing aide for 3 years
- Restaurant server, banking, nursing assistant 3 years

The age range of the participants was 23 to 44 years. Table four provides a summary of the participant demographics.

**Table Four: Participant Demographics**

<b>Characteristic</b>	<b>Number of Participants</b>	<b>Characteristic</b>	<b>Number of Participants</b>
<b>Identified Gender</b>		<b>Unit worked at Time of Interview</b>	
Male	2	Intensive Care Unit	2
Female	8	Cardiovascular Intensive Care	2
<b>Nursing Degree Type</b>		Telemetry	2
BSN	9	Emergency Department	2
AD	1	Cardiac Catheterization Lab	1
<b>Identified Ethnicity</b>		Medical-Surgical	1
African American	1	<b>Months of Experience as an RN</b>	
Caucasian	9	12 – 18 months	

## Results Classified by Study Aims

Through the use of the hermeneutic circle and ongoing analysis, several themes emerged from the data. Table five identifies the themes and subthemes arranged by research study aims.

**Table Five: Identified Themes and Sub-themes**

<b>Aim One: To Understand the Lived Experience of Being a GRN</b>		
Theme: The Rollercoaster		
Theme: Changes in Role		
Theme: The First Code		
<b>Aim Two: To Understand the Meaning of Self-Identification as an RN</b>		
Theme: Not quite there yet/amount to learn		
Theme: Pulling it all together		
	Sub-theme Confidence	Sub-theme Critical thinking
	Sub-theme Self-doubting	Sub-theme High expectations
Theme: Not quitting		
Theme: Been there done that		
<b>Aim Three: To Understand the Meaning of Feeling like a Team Member</b>		
Theme: Bullying		
	Sub-theme Witness bullying	Sub-theme Experiencing bullying
Theme: Being a team		

## **Aim One: To Understand the Lived Experience of Being a GRN**

The lived experience of being a GRN was a complex emotional time for all participants. When asked to describe this experience each participant took time to pause and reflect on the past few months before sharing their stories. A few themes emerged when the participants began to describe their transition experience. The first theme (The Roller Coaster) addresses the participants' overall perceptions of the first months as a GRN. A second theme is "Changes in Role." Some participants discussed the difference between being a nursing student or nursing tech, and the role of being a nurse. "First Code" is the third theme that emerged. Every participant related a story of a patient who was coding or in a crisis situation.

**The roller coaster.** When asked to describe the experience of being a GRN, each participant took time to review the events and happenings of the past few months. Some made comments like "I don't know where to start" or "there was so much". In general, they spoke of the stress and how the actual experience varied from their own personal expectations. As individuals, the participants had good and bad experiences – sometimes both in the same day. One participant described the experience as being on a rollercoaster. Overall their comments exposed a full range of experiences highlighting stories that were pessimistic or optimistic in nature.

***Stories that were pessimistic in nature.*** As participants described their transition into the RN role, they shared several disheartening and pessimistic comments about the situation. There was a general consensus that the transition

was hard, much harder than expected. Some participants made statements that the transition period was scary, terrifying, and challenging.

Heidi became tense and seemed angry as she described her transition. She began working as a GRN in a nursing home and stated “it was torture.” She attributed this experience to the fact that she had minimal orientation. She stated, “I had three days orientation and I was thrown on my own and I was the charge nurse, I was the only RN in the building in charge of everybody and did not get the proper training.” Her experience was so bad she thought about leaving nursing.

When Rachel described her transition, she seems relieved that it was over. Rachel stated, “God, I don’t ever want to live through something like that again... it was - I don’t want to say it was bad - but it was it was pretty terrible some days.” She started working in the intensive care unit (ICU) and did not have any previous work experience, and she felt overwhelmed on most days.

***Stories that were optimistic in nature.*** Others told stories that were more optimistic in nature. Heidi changed positions from a nursing home to the ICU and her experience in the ICU was described as being better than the nursing home. She had some negative and positive comments – but overall felt it was a good experience. She stated,

Actually it has been wonderful. Granted it has been scary because it is the ICU and I doubted my ability -- and things can happen at any time, so because I doubted my ability, I was scared to death, but honestly, I don’t regret it one minute the people on the floor have been wonderful and you are taught what you need and people are there to help, you aren’t just thrown out there to wing it.

Rachel felt her experience was a rollercoaster for a while and she stated “I don’t think I will ever forget that year so I think I will be helpful to students and new grads-- it turned out good and I’m glad.”

There were a few participants who did not express specific stories; they seemed overwhelmed by the amount of things that had happened since being hired. For instance, Stephanie, Susan and Amy talked about how they “learned a lot”. They paused during the interview and reflected on the past few months. Susan just shook her head and said “Oh, I don’t know – there was just so much.”

**Changes in role.** Another theme that emerged was the difficulty in the change of role. As the participants discussed this theme, they seemed surprised about the significant differences between the role of the RN and that of a nursing student or technician. They knew the role of RN differed from the other roles, but they did not realize the extent of the difference or the difficulties of transitioning into the new RN role.

Jason and June discussed the difference between being a nursing student or nursing tech and being a nurse. They felt that being a nurse was more challenging and held more responsibility. Jason stated,

I wouldn’t say it was easy -- the first day on the job you have no idea what you are doing-- I mean you learn everything in -- in school -- but it is completely different from doing it in real life.

June’s first job as an RN was in the Emergency Department, which is where she had worked as a nursing technician for several years. June recalled,

As a tech you were really helping the nurses a lot, but as an RN you are the one who is now responsible for these people, you are



the one who is giving the medications, you are the one .... The doctors expect more from you because they want you to know more about what is going on.

Vivian identified the amount of responsibility as a key component in the difference between the nursing student and RN roles.

In nursing school you have a nursing instructor that has your back and when you are a nurse aid you have a nurse that has that patient. Well when you are the nurse on the floor and your patient starts to go downhill you can't go say let me go get your nurse or get the nursing instructor. You are responsible for that patient.

In general, the comments regarding the differences in the role of nursing student or technician and RN focused on the amount of responsibility as an RN and the feeling of being alone. In their previous roles the GRNs always had someone to turn to; either their instructor or an RN. Most of the participants felt frustrated and felt they had lost a safety net. Some felt let down and thought they should have been better prepared in nursing school. No one discussed turning to mentors for help and support.

**The First code.** The participants were asked to tell a story of something that happened to them; each responded "something good or bad?" They were told to describe whatever they felt was important. Almost everyone described a situation in which the patient was doing poorly or an actual code situation. The stories about patient codes or crisis situations were very passionate. And, the stories about the first codes reflected the fear they felt. The first codes were described as surreal and caused them to feel like they were going to panic.

Heidi described her first code – which was in a nursing home setting, as well as a code in her new position in the ICU.

Well -- my first code situation happened on a holiday when I was the only RN in the building. I was not even shown where the crash cart was ... .. I mean that really ruined me. That code situation ruined me from the start and I doubted my abilities.

(A second code in ICU for Heidi) actually another code situation where the lady had internal bleeding ... we called a code ... and the teamwork was so much more smooth. There was so much teamwork and everybody was working together to make it better and it just made a huge difference.

Jason described how his first code occurred during his orientation. He thought he was going to panic, but the other nurses on his unit were “awesome” and he knew who to listen to and what to do. Susan also had a code during her orientation. She found a patient who was not breathing and called the code. She stated that she was really scared and tried to stay calm and hide her fear, but the other nurses noticed.

Rachel had a code during orientation where a patient suddenly became unresponsive and was in asystole she discussed how she just froze and everything seemed surreal. She stated that she felt in the way and she also felt responsible for causing the patient to become unresponsive because she had just administered 4mg of morphine.

He died and I felt really bad... I know this is not true...but I kept thinking I killed him with the morphine... I was like guilty and questioned everything – should I have done something different... what if.... He actually had an internal hemorrhage but.. I ... I don't think I will ever forget.

Mary and Amy described situations where the patient was in a critical situation. About a year after hire, Mary had a pacemaker stop working in a

patient that was dependent on the pacemaker. She was the most experienced nurse and had to take charge of the situation. She stated:

I felt that was a good experience for me and it was a good experience for teamwork and mentoring because I had no idea of what I was supposed to be doing at that particular moment but we worked together

Amy described a big trauma in the Emergency Department when she was on orientation. The patient was unstable and the team was doing several procedures in an emergent manner. She recalled:

At first I thought I was going to throw up...I was nervous and excited both. But I held my own and did what I should. After we talked about it and I didn't do anything really stupid. I guess I felt good because I did participate and did what I was supposed to do. But I guess... I felt a little out of place.

When Stephanie described her first code, she did not give details of the experience. Instead she described how being in the role as an RN is different than being in the role as a nursing student in the simulation lab and how there is much to learn even after graduating from nursing school – two concepts discussed earlier. Stephanie replied,

The first time I had a patient go bad and just the experience of it all ... no matter how much you learn in school and how much you prepare for stuff there is no way to prepare for that kind of thing. It doesn't matter how many books you read -- it is just the experience. We had mock codes in simulation in school... it didn't really sink in and it wasn't anything like real.

While all participants felt their first code or crisis situation was stressful and nerve-wrecking, it was also described as a learning experience and an experience that made them feel closer to the other nurses. Many participants felt that the code situation was also used as a way to mark progression or

improvement. Some participants described codes that occurred later in orientation and the participants saw how much they had improved. They knew what to do and they did not become do nervous.

### **Aim Two: To Understand the Meaning of Self-Identification as an RN**

At the time of interview, participants had between 12 and 18 months of experience in the role of RN. They all stated that they considered themselves to be fully functioning RNs – they thought of themselves as an RN. The self-identification as an RN occurred between 9 and 16 months. In general, the participants did not connect a specific incident with a realization that they “are really an RN now.” Most made comments like “they had fewer bad days” or “they seemed to be getting things done more quickly” or “they just felt comfortable.” When talking about the meaning of feeling like an RN, they seemed to be more lighthearted. Their faces lite up and they seemed happy. One participant giggled and said it was awesome. There was a general sense of feeling more confident and asking fewer questions.

In telling the stories of transformation to self-identification as an RN, several themes appeared. The first theme is titled “Not quite there yet/amount to learn. Most participants discussed the amount to learn and knowing that they were not “there yet”. This aligns with Benner’s stage of “Advanced Beginner.” The participants self-identified as RNs and they were functioning at a level higher than the “Novice”, but they still could not be considered “Experts.” The next theme was pulling it all together which had sub-themes of: critical thinking, confidence, self-doubt and high expectations. The next theme for this study aim

was “not quitting.” Participants shared stories of how there were times when they felt hopeless and lost and they wanted to quit, but they continued. Been there, done that is the last theme that emerged. This theme was based on stories that told how previous employment helped with the transition.

**Not quite there yet/amount to learn.** Many participants stated that there was a lot to learn as a new GRN and some felt surprised by this. Many felt frustrated by not knowing what to do in their new roles. There were also comments about the amount of time it took to start to feel comfortable as an RN, and that it took longer than they had expected. Rachel explained that people had told her it would take about a year to feel comfortable but she did not “expect it to be so long and frustrating.” Mary voiced,

I feel that there was so much more that I needed to learn, I didn't have much official classes (orientation) but I did a lot of on the job and working with preceptors .... I felt like I was expected to know more than I knew just starting.

Susan also described how she thought there was a lot to learn and how it was harder than she expected.

There was so much to learn and do. Not just nursing but computer, policies, hospital stuff and all.... I thought it would be really easy. I mean people told me it would take a year or so and I didn't believe them. I have always done well in school and nursing school and I thought I would just breeze in and have this great time, but it was so much harder at least the actual patient care.

She further elaborated by stating,

I had a good experience-- Nursing school I learned a lot, and did well. And I had almost a 4.0 average. I didn't have any problems getting ready for boards and I felt really prepared but I guess I wasn't. There were so many things that I didn't know or maybe I knew just a little or a part and it was hard to keep up with

everything that needed to be done like dressings and IVs and calling the doctors and discharging and charting.... we have a lot of heart failure patients and I know we learned about that in school but there is so much more that you need to know; labs and treatments and I think I struggle with what you need to teach patients and-- and when they ask questions-- so many times I don't know the answer and I feel really stupid and I seem like I'm reviewing so much stuff-- just to get to where I need to be.

Vivian also supported the need to learn a great deal of information and she discussed how much she learned in the first few weeks after hire. She also felt she continued to learn after her orientation period was over. She felt there was "a lot that I feel I didn't really know and I had to go and ask and look up policies all the time."

Several participants commented that they felt like an RN, but they were aware they still had a lot to learn. Jason stated, "I think of myself as an RN, I just know that I don't know everything. I don't try to wing it; I usually ask a lot of questions." Vivian expressed similar thoughts.

Sometimes I am nervous you know, when I get report sometimes I get a little freaked and think how am I going to take care of this patient ... You are never going to be the only one in the hospital ... I have learned that if I am uncomfortable or I feel something is wrong just call a rapid.

Mary felt that she could contribute to the team and manage her patient load, but she still had a lot to learn and did not feel as good as the other nurses. Amy also felt that she had more to learn so she began studying for the certification for emergency nursing (CEN). She stated, "I just got a study guide and that really helps and I do feel more confident when I read the different things and know that I really know that - so it just keeps getting better."

In general, the participants seemed to connect a lack of knowledge with not really being an RN. Because they did not know who to call, or what to do in a specific situation, they did not feel like an RN. Once they had some experience and gathered some knowledge, they began to think of themselves as an RN.

**Pulling it all together.** Many of the participants described the process becoming an RN as occurring over time. They stated they had fewer bad days, asked fewer questions, and knew what to expect. Susan stated, "There are still some days when I feel like I'm off my game, but most of the time I feel like I'm on target." Participants also used words such as "starting to" or "becoming better" to describe feeling like an RN. Mary felt that she was very task oriented in the beginning and it was hard to "go beyond all the little things" that needed to be completed and "look at the big picture." She stated, "I feel like just now a year later I'm finally becoming better." Stephanie felt that she was starting to feel surer of herself when making decisions. Tim stated that there were times when he "got that nervous feeling", but gradually

It was a lot easier to go to work for sure, I don't know I felt like so relieved and I actually felt like everything kicks in and you are functioning better and it is better for you and your patient you are working in all cylinders and it seems like it is all going a lot better and it is easier to focus on your patients.

Some of the participants described a code or trauma that happened later in the transition period and noted that they performed better and had more confidence than the codes that occurred shortly after hire. Rachel commented.

I had a code the other day and I knew what to do, I was getting things from the cart and getting drugs ready before they were ordered-- I mean, it's like this fear, not really fear maybe excitement

but I don't know something kicks in and this other person takes over and I just get into this mode or something.

Initially, Amy felt as though she was standing in the background during codes and traumas, but a few months before the interview she felt as though,

I was right there doing things; I helped with chest tube and foley. It felt, I was responsible, I wasn't just helping out--I was doing things. I guess it was the first I really felt the difference in being an RN.

All participants agreed that the ability to "pull it all together" took time. The researcher felt that those participants who had previous work experience in a health-related field had a realistic expectation of the process. Those participants who had no previous work experience appeared more frustrated when discussing this process. While "pulling it all together" was greatly influenced by time and experience, four sub-themes appeared. They are: confidence, critical thinking, self-doubting, and high expectations.

**Confidence.** Confidence was a word that was used to describe the feeling of being an RN. Amy stated, "I was more confident and knew answers when asked and knew orders to expect--and when it gets busy like really busy, I may get behind but I don't really feel like I'm drowning. And I just feel more confident now." Stephanie talked about how she did not feel confidence as a new GRN but feels it is getting better now.

I feel I don't want to say confident ... The first couple of months when I was on my own it was very-- I didn't look at myself as the nurse I still felt like a nursing student who just graduated and still learning but ... I have gotten to see and got a lot of experience within a year, but I'm just starting to feel a little better about myself I feel that I have enough experience to say I'm really a Cardiovascular ICU nurse... But now that I'm orienting other people, I see others see me that way and--I guess I do too. I have more confidence.



Susan also felt like she was gaining more confidence as she progressed through the transition period.

I'm still a little slow- but I feel like I pretty much know what I'm doing. I am better at getting orders from the doctors. I know what they need to know and don't stumble around. I'm not staying so late to finish up charting. I guess more confident.

June became more aware of her confidence when she changed positions from emergency department to the cardiac catheterization lab.

I mean I got that point where I was pretty confident in my job and felt like I knew what I was doing -- but I think the time when I really felt like a nurse was when I went to my new job you know this is I know I can do this. It was obvious that I did not need as much direction in a new position as I did when I was a new grad nurse.

As the participants gained knowledge and experience their level of confidence also increased. This was supported by statements that they did not feel like they were drowning and they knew what to do and expect.

**Critical thinking.** Critical thinking is an area that was identified by many participants as a challenge during their transition period. Mary identified that her "biggest thing was the critical thinking and putting everything together." She stated,

I don't know if it is just me and my problem or if other nurses have said this as well, but really that was my biggest issue and trying to pull everything together. I didn't seem to have this problem as a medic in school, but I just, at times it was like my brain just freeze up. I think it is just me and I need to just work at it,

Some participants identified that they had learned critical thinking in school but it seemed more challenging in real life. Amy stated, "I really felt lost

with the critical thinking and I know they pushed that in school but it seems like we needed more real life settings to develop it.” Susan stated,

You know we talked about that in school and I guess I got it but I was really focused on skills and getting everything done. When I started to get better at it, I got what they were trying to say. At first ... I really focused on getting stuff done like vital signs, charting, and treatments, but now I’m looking at labs and thinking how do these affect my patient--is there anything I need to do, need to plan for.

Amy went further in her self-analysis regarding critical thinking and described how critical thinking differs between the role of a nurse tech and an RN. She felt that when she was working as a nurse tech in the emergency department,

I didn’t always think about why--like I would get blood and not think about what and why ... I always checked to see if we needed sample before taking patient to the bathroom. As a nurse you need to know what to expect. So I’m working on getting that follow through. I was really surprised to see the docs don’t always give all the orders they need and someone has to remind them and not make them mad so that is something that is new to me. And sometimes I don’t know so I try to ask or look up before I do anything.

Critical Thinking can be a difficult ability to identify in yourself; and, it is difficult to see improvement. They discussed how they had learned critical thinking in school, but it seemed more difficult in the real world. Some also noted that they noticed a difference in level of critical thinking between the roles of nursing technician and RN.

**Self-doubting.** The participants described role internalization as a process. They did not identify a single episode as a causative event to make them feel as though they were an RN. In the beginning of the transition period

many had self-doubts. Heidi doubted why she became a nurse as well as her ability to be a good nurse. She felt she constantly doubted herself and her decisions. Shortly after getting her first RN position, Susan was subpoenaed for a law suit regarding a patient she cared for as a student she stated that, "that kinda put some fear in me and I feel like I lost a lot of confidence during that time." She continued by stating:

Around week five or six of my orientation and I was really feeling down overall. I started off feeling confident, like I knew what to do, and I was so happy to be done with school and working in my first real job -- but then ... it seemed like I couldn't get anything right. I didn't know why I wanted to be a nurse so bad--I guess I just doubted everything I did.

In the beginning of work as a GRN, Rachel also had self-doubts about being an RN and even considered leaving nursing and going back to school for another career. She responded,

The first couple months most days were-- not real good I second guessed everything-- and I criticized myself because there were things I should have known. Sometimes there were patients who were real bad and I just felt like it was too much and I starting thinking about going back to school for something else and I just wanted to call off and all... a few weeks before orientation was over I felt like I was getting things together-- but I was still really unsure.

Mary was another participant who had several doubts she stated, "I felt like I didn't know anything and I was nervous and afraid I would do something wrong. But I didn't and it was good."

Most of the participants discussed self-doubt in a general manner related to an overall lack of confidence and not knowing enough to function well as an RN. Susan revealed doubts that were directly related to the death of a patient

she had a code where the patient died and she stated that it “really was hard.”

She stated that after the code.

I just didn't want to come back to work-- I thought I had made a big mistake-- didn't want to work ever again. I had never had a patient die-- I really didn't know anyone at least anyone close who had died and I don't know what I expected but it was-- I don't know --hard

Heidi was similar to the other participants in that she did not have a specific incident that made her feel as though she was an RN. Instead, she felt role internalization when she reviewed what she has done over the past few months. She stated,

Being in the ICU and dealing with more critical situations, I finally realize that I can handle it because I have done it, so I'm getting over that fear a little bit....Like I said now that I've dealt with more critical situations, I've proven that I can do it.

At the time of the interviews the level of self-doubting had decreased for the participants, but some felt it was still happening. Most connected self-doubt with level of confidence. They felt both improved over time as they gained in knowledge and experience.

**High expectations.** Many of the participants described themselves as being high achievers and expecting perfection from themselves. Mary felt that “It is really hard for me because I am always the best and it is hard to not to be the best.” Rachel echoed this feeling stating:

I've always done this and had high expectations of what I should do and all -- I did really well in school and it was like I knew what to expect I could study and have a good grasp and I like my critical care class and all so I thought I was ready and would just slip into a new job well I guess I thought there may be a few bumps but maybe not much -- but I walked on the unit that first day and it was like I didn't know anything it was all different.

Amy also discussed her desire to be perfect.

Things started pretty good – I mean I thought it was perfect -- but then I took on more and my preceptors started to back away and I was. I guess overwhelmed. I mean I guess I want it all to be perfect and I want to be perfect and I wasn't and it was hard.

While not all participants used the words “perfection” and “high expectations”, it was an underlying tone through many of the discussions. Participants used phrases like; “I should have done better,” “It shouldn't have taken so long,” and “I expected to do better.” As participants discussed these high expectations, there was a greater sense of frustration and maybe even disappointment, than other times during the interviews.

**Not quitting.** Throughout the interviews, there were several stories that told of fear and self-doubt. Some participants described high anxiety and some even stated they considered leaving nursing. When the participants were asked why they kept coming back to work and did not give up, the responses included: nursing is my calling; I did not want to disappoint others, and the financial need to keep working. Heidi described her reason for not quitting.

Well to be honest I always wanted to be a nurse, ever since high school... I think the main thing is just because I want to be a nurse, I feel this is my calling and I mean I love what I do and I seriously love being a nurse.

June had financial reasons for not quitting and she had hope that things would improve in the future. She stated:

Well basically-- I needed a job and I couldn't afford to quit... and I knew that someday I would find a job that I liked and that I really

enjoy doing and that I wanted to be in the job, so I just had to keep working through it.

Rachel hoped that things would improve after a year, she always wanted to be a nurse and she did not want to disappoint her parents.

Oh so many times I wanted to quit-- And I so often wanted to call off but-- I just kept thinking I would be a disappointment -- I've wanted to be a nurse all my life and I liked school and thought this is what I was supposed to be doing-- I like patient care-- I like the critical care unit--but I don't know -- it was just hard. I think one of the things that kept me from quitting was my parents. I still live at home and I knew I couldn't call off they would get on my case and I wasn't ready for that--and I not really a quitter-- so I just kept going. I had that year goal in mind. You know I can survive anything for a year.

Mary got through the difficult times by focusing on the good things that she was doing as a nurse and by realizing that she really did make a difference in the lives of her patients.

It was just-- you know little things that made me appreciate what I was doing. Someone came in who was very sick and I got to have them the whole time and I discharged them and they were better ... in the end it is the patient their responses that makes me continue doing what I'm doing. I just like being with the patients and I think I make them feel better when they are in a bad situation and I like to see that I really do make a difference but you don't always see that and sometimes it--it is hard. But you just work through when it is hard and look at when it is good.

Susan discussed financial reasons and disappointment from her Dad as reasons that prevented her from quitting. She also discussed support that she received from friends and her church group:

I knew I couldn't give up. I have student loans so I have to work!! Plus my Dad would have killed me. I got support from my church group – lots of prayer. Also friends from school...I do try to focus on good things. There are so many times I feel like I really help someone and they do seem to appreciate that. And there are patients who are really bad who turn around and end up going

home -- so I guess don't focus on the bad things that happen I had a good preceptor who helped me. So you just keep going.

Many participants shared how they worked through the self-doubt. Mary worked through her self-doubt by trying to stay positive in her attitude. June stated, "Basically just working through the first days until you feel comfortable in your skin and feel comfortable and know what you are doing. You just have to go with it." When asked what advice they would give to a GRN June stated,

As clueless as you may feel in the beginning it will get better you will become comfortable in what you are doing ... the first day you are going to be like oh my goodness what did I get myself into but it does get easier. You learn how to become a nurse and you learn how to be comfortable in your position and what you are doing.

Throughout the interview, Amy discussed her self-doubts and high self-expectations. After reflecting on her transition period, she discussed the advice she would give a new GRN.

Don't be afraid or try to be perfect. When you graduate you think you know everything, but then you realize you don't know anything and it can be scary when you are taking care of people and it can be a lot but you need to show up and keep doing your best. When you don't know something look it up. When you have a bad day and are really disorganized and can't get caught up have an honest conversation with your preceptor and try to figure out what went wrong and how to be better. Don't beat yourself up if you are not perfect-- just keep working on getting better. And be honest.

Each of the participants spoke of difficult episodes during the transition into an RN. They spoke of fear, frustration, and self-doubt. No participant discussed mechanisms within the institution that helped them get through these periods. Instead, they turned to people outside the institution to get through these times. They turned to previous classmates, family, and church members.

They also spoke how they just “kept on going.’ They discussed how they “could handle anything for a year,” or “they just tried to stay positive.”

**Been there done that.** Several of the participants had work experience before becoming an RN. When asked if the previous employment was helpful in acclimating to the role of RN, most replied in the affirmative. Previous work experience in a medical setting helped the participants feel comfortable in their new GRN role in a hospital; some worked on the same unit and felt knowing the staff was helpful. There was also benefit in working in non-medical settings because the participants felt they learned communication and social skills that could be applied when interacting with other healthcare team members and patients, and their significant others.

Tim worked at a grocery store before entering nursing school and he felt that experience helped him to develop a sense of customer service and the ability to communicate and interact with people. He worked as a patient transporter during nursing school and stated.

I think everything adds up to make you who you are and what you bring to any job but I feel like the transporter thing helped me get my foot in the door for the medical thing and it helped me see how things work and get experience working with patients.

Amy worked at a store and sometimes dealt with difficult customers. She had a belief that the customer is always right and learned to work with the customer until they were satisfied. She feels this is an important skill for nursing and often sees it being played out with doctors or patients.



Stephanie was a nursing aid in the hospital during nursing school. She floated to multiple floors and felt it was the best thing she did.

I can honestly say ... the best experience of anything was ... working at the hospital...I just feel that working at the hospital and the charting and like knowing all of that and being around patient care for a couple of years, I think that is what helped me the most.

Mary had mixed feelings about her past employment as a medic in the Air Force. She felt it helped her at school. Nursing school was easy for her and she did not really have to study that hard to get good grades; but now, she felt she should have studied more and “not just relied on what (she) knew.” She felt it was also a bit of a hindrance because, “I was so task oriented and I had a huge problem when I started working as a nurse because things weren’t getting charted... And honestly I think that was maybe because I was a medic – we were more task oriented.”

### **Aim Three: To Understand the Meaning of Feeling like a Team Member**

During the interviews the topic of teamwork was frequently mentioned. All participants felt they were functioning as a team member at the time of the interviews. The process of feeling like a team member and being accepted as a team member took time. There was some discussion of feeling like they needed to prove themselves and dealing with bullies and attitudes. Overall there was a feeling of being supported by the team members through orientation and afterwards.

**Bullying.** One of the issues discussed by study participants was bullying from other nurses and staff. There was a general consensus that it did occur but

participants either weren't bothered by bullying or they did not put up with it. Their stories fell into two sub-themes: witnessing bullying in other GRNs and not putting up with bullying

***Witnessing bullying in other GRNs.*** Some participants felt that other GRNs were bullied, but they did not experience the bullying. Some said that they had worked in the department before working as a GRN and felt this was helpful. It was like they had already proved themselves worthy and were already accepted. June stated:

I've worked there before so everybody knew me and everybody was wanting to help me and wanting me to do good I think you are completely new to the department knowing nobody, sometimes people are not as willing to help.

Tim worked as a hospital transporter and interacted with nurses throughout the hospital. He also completed the nursing school preceptor class on the medical surgical unit to which he was hired. He stated, "I thought they treated me well. It kinda helped that I knew some of them already ...everybody treated me well and everybody was willing to answer questions and they would point you in the right direction."

Another discussion that occurred was the perception that bullying was happening to other GRNs, but those GRNs were not competent and they deserved the bullying. Mary stated, "I didn't have any problems with that. Some did and they were maybe not real good at the job, I honestly think they should not be in ICU." Jason voiced a similar opinion. He saw negative attitude and bullying

happening to another GRN and felt it was because she “did not know what she was doing” and “should never have been hired.”

***Not putting up with bullying.*** There was some belief that the older or more experienced nurses still “eat their young.” They can have the attitude that the new GRNs are not worthy and they are not accepted until they prove that they are capable of being an RN. Heidi reported, “I just feel like new nurses are looked down upon and some of the nurses were very rude, they don’t want to help and they bite your head off for everything.” Rachel felt that most of the nurses were supportive, but she did have difficulty with one person she said, “I definitely had the feeling that I had to prove myself to her but ... I got the feeling that ... she was a bully in high school. She was just not a happy person.”

Amy felt that the nurses in the emergency department were supportive overall but she did have an issue with one person.

I think maybe some did want me to prove that I was ready but they weren’t mean well there was one ... she was always kinda difficult ... But I was strong ... and my preceptor supported me so there wasn’t really any big issues.

All three participants felt the best way to deal with the “attitude issues” was to focus on the job and ignore the attitude.

Vivian had a different perspective on the bullying. She saw young, new nurses coming in with attitude and being difficult with the older established RNs.

I see a lot of younger nurses just coming out of school ... and trying to tell them how to do their job and I feel like that really causes a barrier when you come out as a know it all and start telling experienced people how to do their job. It is wrong and causes a barrier.

There was some discussion about differences in attitude from nurses on different shifts. Participants believed night shift nurses were more supportive and had less bullying attitudes than the day shift nurses. They made several comments on the difficulty of giving shift report, but when asked how they felt about it, all stated they did not let it bother them.

Some of the participants voiced that they did deal with some nurses with attitude or bullying attempts, but they did not “put up with it.” Previous work experience helped these participants deal with attitude issues. Heidi was 44 years-old and had worked for 15 years as a paralegal and nursing assistant. She stated:

I just had to make it clear that I was not going to deal with that and it is probably because I had been in the workforce for so many years that I was able to say that I’m not going to be bullied like that.

Jason was an ordinance specialist in the Navy and he felt that “the military helps you learn assertiveness.” He felt that was beneficial in dealing with others who might try to bully him.

Participants identified some other methods to deal with negative attitude or bullying. Tim stated, “Sometimes you would get some attitude, like you just got that vibe that they thought you were a new grad and looked down at you.” He felt you “get pretty thick skin working as nurses.” His method of dealing was, “kill them with a smile well not really blow them off but just smile and go on and do what you are supposed to do.”

Vivian summed up her belief of workplace bullying by stating:

You know I feel that with any job ...you have those people who have been doing it forever and are very welcoming and willing to show you stuff and you are going to have a few who are not helping and you need to prove yourself and you need to figure out how they function and what you need to do to approach them and I feel that is with any job.

**Being a team.** All participants felt that the overall experience with their coworkers was positive. There were several comments stating things like “everyone on my unit was so nice,” or, “my preceptor was very helpful and caring.” As participants discussed patient codes, there was frequent mention of teamwork and how they were helped through the challenging situations. Stephanie discussed the teamwork during a difficult experience she had with a patient that was not doing very well:

It was very overwhelming but at the same time everybody took a role and... there (was) lots of help and you are never alone -- so I didn't feel at all like I was just left out by myself to figure it out because there was a physician at the bedside and everyone ran over to help me.

She went on to say:

I think just the fact that we are a team... they spend a lot of time training you and I feel that once you feel that you are part of the team more than just about yourself, it is about the patient and the team and have a very reputable unit you know we have patients tell you all the time how good their care was.... for the most part it is very positive and people talk about the wonderful care.

While all of the participants felt like they were able to function as a team member at the time of the interviews, there were some who had a hard time fitting in and finding their place. They aware of the teamwork, but they felt like they did not fit in. Mary commented:

Honestly it was hard to really fit in and feel like a team. I guess it was just me...in the military it was very structured and we all had our place, knew exactly what to do and it was a team, like a community, you belonged. But not like that at hospital (you) work with different people every day and no real team so I felt a little lost, like I didn't belong anywhere. I mean people were nice but I felt like I was free floating.

Susan also expressed feelings of not fitting in:

I feel like I don't fit in-- even now. I can't explain it. In nursing school there was such a bond – we supported each other and it was good. Now I feel like I'm still going back to my school friends. The nurses on the stepdown don't support and encourage. I feel like I'm all alone. It's not really bad but it could be better. I guess we are just so focused on our own assignment.... And also there has been a big turnover in staff so many don't really know each other and we have a lot of floats working on the unit.

There were divergent views from the participants regarding teamwork. All participants saw teamwork, especially during crisis situations. Many made comments regarding the support and encouragement they had from preceptors and other nursing staff. Participants also felt as though they were able to function as a full team member. There were a few participants who felt as though they were not a part of the team – they had trouble “fitting in.”

## **CHAPTER 5: DISCUSSIONS, IMPLICATIONS, RECOMMENDATIONS**

### **Introduction**

The literature review identified several studies on the topic of orientation and socialization, but those studies were fraught with inconsistencies regarding definition of orientation and socialization. There were few studies that examined the socialization process of the GRN and even fewer that reviewed the outcomes of the socialization of the GRN. No research was found that examined the lived experience of the GRN. This research sought to:

To understand the meaning of the lived experience of being a GRN

To understand the meaning of self-identification as an RN

To understand the meaning of feeling like a team member at work

### **Discussion of Results**

Ten participants were interviewed using hermeneutic phenomenology methodology. Data collection ended when there was evidence of saturation. This was evident when there was emergence of themes and sub-themes within the stories told by the participants and eventually no new themes emerged during interviews. During the literature review several studies were found that identified four major challenges that occur during the transition period: decreased self-esteem, skill acquisition, mentoring, and development of critical thinking (Block & Sredl, 2006; Cochran, 2017; Crimlisk et al., 2017; Edwards, et al., 2015; Goode & Williams, 2004; Keller, Meekins & Summers, 2006; Kramer et al., 2012; Newhouse, Hoffman, Sulflita & Hairston, 2007; Pittman et al., 2013; Santucci,

2004). Data analysis of the participants' stories showed the following key themes: changes in role, amount to learn, first code, confidence, critical thinking, high expectations and bullying. There was some overlap between the themes found in the literature and themes identified in the participants' stories.

### **Decreased Self-Esteem**

Decreased self-esteem was identified as a theme in the literature review and identified as a sub-theme of pulling it all together in the participants' narratives. Self-esteem is a person's subjective emotional evaluation of their own worth. It includes emotional states (such as confidence) and beliefs (such as 'I am a good nurse'). Self-esteem is not constant and it can be influenced by both internal and external factors (Crepaz-Keay, 2017).

Lavoie-Tremblay et al., (2002) noted that a few weeks into orientation GRNs begin to have self-doubts and lose confidence. Several other research studies have identified that self-doubt and loss of confidence make the transition period more difficult (Edwards et al., 2015; Fink et al., 2008; Klingbell, 2016; Kramer et al., 2012). This research supports the previous findings regarding decreased level of self-esteem in GRNs during the socialization process (Rantanen, et al., 2016). Many participants stated they began orientation and the new job feeling excited and confident, but they lost confidence after a while. Some of the participant's comments were: "I started doubting myself", "I doubted my ability to be a good nurse", "it ruined me", "I was feeling down overall", "I felt like I couldn't do anything right", and "getting over the fear".



One way to help to maintain high levels of self-esteem is through the support of peers (Crepaz-Keay, 2017). This can be a challenge to GRNs because they are new to a profession and they may not have established peer relationships. Some of the participants discussed finding support from family, church members, and friends from nursing school. Participants made a few comments that they thought 'the preceptor was helpful' or 'everyone on the unit was nice' but none of the participants stated they found support from a mentor.

### **Mentoring**

Mentoring is a theme identified in the literature review. Study participants did not mention mentoring when telling their stories. But, many of the issues they discussed could have been prevented or at least lessened if they had access to a good mentor. Nursing socialization is a complex and interactive process (Dinmohammadi, Peyrovi & Mehrdad, 2013). The interactive component occurs as the GRN relates with peers, administrators, physicians, patients and society as a whole. Within this process knowledge, skills, behaviors, and a sense of professional identity are developed. Structured communication regarding these interactions can lead to a less stressful transition (Xiaowei, Brinthaup & McCree, 2017). One way to accomplish this is through mentor-type position. This could be accomplished through having an individual who is selected to serve as a mentor or a preceptor who also fills the function of a mentor. A mentor relationship can also develop informally.

The acute care facility in which the research was conducted did not have a formal mentoring program in place for GRNs. The participants in the research

did not mention turning to a mentor (either formally or informally) for help during the challenging moments. The lack of mentoring can be a disadvantage because GRNs may feel isolated and unsure of themselves. There have been studies that show those GRNs who have mentoring programs as part of the orientation have higher confidence when compared to those in groups without mentorship programs (Komaratat & Oumtanee, 2009). Van Maanen & Schein (1979) reported that mentors help new hires develop a sense of belonging and acceptance.

### **Skill Acquisition**

Skill acquisition is a theme noted in the literature, but it was not a theme that identified through the participant discussions. Alspach (1995) has published widely in regards to development of skill acquisition and competency training in GRN orientation. She has developed numerous orientation guidelines and pathways that primarily focus on skill acquisition and competencies. The importance of mastering skill competencies has been supported by others as well (Block & Stredl, 2006; Dyeese & Sherman, 2009) and skill acquisition is one of the key factors in *Benner's Novice to Expert Theory* (1984).

None of the participants shared stories related to having poor skill mastery. Some shared that they felt lost or scared during crisis situations, but these instances were based on anxiety and stress caused by the situation not lack of ability to perform a task. One reason for this might be a well-developed skills-based orientation.

The orientation program at the research facility had a structured component to facilitate classroom education and bedside skills. There are several key nursing skills that must be mastered and proficiently demonstrated before the GRN is allowed to perform them independently.

### **Development of Critical Thinking**

Critical thinking is a cognitive skill that involves logical thinking and scientific analysis (Wu, Yang & Xinyu, 2016). Several of the participants discussed the challenges of critical thinking. There was a general consensus that they had learned critical thinking in nursing school but it seemed harder in real life. There was concern that they had trouble moving from a task oriented position, such as Air Force medic or nursing technician, to the role of an RN.

Most of the literature on critical thinking deals with the development of critical thinking in nursing students (de Oliveire et al., 2016). The AACN (2014) has declared that critical thinking is an essential ability for all nursing students. Additionally, the AACN (2014) stated that critical thinking was Important to train professionals that are critically reflective and able to make complex decisions based on knowledge of scientific evidence.

A challenge occurs when the literature regarding critical thinking has inconsistent definitions making the comparison of studies difficult (Wu, Yang & Xinyu, 2016). Most studies concerning critical thinking look at teaching methods for nursing students; such as problem-based learning scenarios, simulation, and case studies.

Kaddoura (2010) stated that critical thinking is the cognitive engine that drives processes of knowledge, development, and critical judgment in nursing. Kaddoura (2010) found that clinical simulation is a technique that is used to replace real patient experiences with the guided practice that imitate substantial aspects of the real world. Simulation scenarios help to develop confidence, and thus develop clinical competence. This research was focused on nursing students, but there was an implied thought that it could also be applied to new GRNs. Research has shown that critical thinking is an issue for new GRNs (Fink et al., 2008; Klingbell, 2016; Kramer et al., 2016). Poorly developed critical thinking makes the transition period from nursing student to GRN more difficult

A key component in Benner's *Novice to Expert Theory* (1984), is intuition (or critical thinking). She believes that critical thinking develops over time as a nurse gains more experience. The novice nurse has no experience and depends on rules to guide decision-making. The expert nurse has intuition and understanding and they are able to see situations in a global manner. Most of the participants in this research were in the advanced beginner stage and they were just beginning to grasp the global aspects of situations.

The literature review showed that decreased self-esteem, mentoring, skill acquisition, and development of critical thinking were key challenges for GRNs in the transition period. Through the interview discussions, research participants identified other challenges. These identified challenges are: changes in role, amount to learn, first code, high expectations, and bullying.

## Changes in Role

Many participants discussed role changes they experienced as a GRN. Several had worked in health care related positions (Air Force medic, nursing tech, hospital transporter) before and during nursing school. There was a general belief that the experience they gained in these positions was helpful. They became comfortable interacting with patients, knew the hospital environment, and knew many of the staff members they worked with as GRNs. But, some difficulties were also reported. Some participants identified difficulty in moving from a task oriented role to a critical thinking role. They also noted the increased amount of accountability and responsibility they felt as a GRN, compared to their previous positions.

The change that occurs between the role of nursing student and the role of RN has been a topic of review for several years. Kramer (1974) identified this challenge in her book, *Reality Shock*. One cause for the difficult transition between the roles of nursing student and GRN is a gap between education and practice (Everett-Thomas et al., 2015). Many participants discussed that they did not feel prepared to practice as an RN. This was especially true of the experience of the first code or crisis situation. They Block & Sredl (2006) observed that anxiety at the loss of the familiar role of student and the need to learn new roles, responsibilities, and behaviors of graduate nurses can make the transition from student nurses to RN challenging. McKenna, Brooks & Vanderheide (2017) sought to understand perceptions of nursing students regarding the role of nurse. They found that many nursing students who

responded to their survey did not have a sound understanding of the nurse's role beyond caring and a few individual clinical skills. They noted that the lack of understanding of the nurse's role can make transition into the role of nurse challenging. Ethenridge (2007) found that most GRNs were not aware of the demands that would be placed on them as RNs

### **Amount to Learn**

The participants made several comments regarding the amount of learning that occurred during the first few months as an RN. They seemed to be surprised about this – as though they had an expectation that learning stopped after they finished school and passed boards. The need to continue learning new material and skills is the foundation for providing an orientation period to the newly hired GRNs. Keller, Meekins and Summers (2006) identified that both new GRNs and administrators identified the need for additional knowledge in order for the GRNs to be competent and confident.

Benner (2001) identified the progression of a new nurse from novice to expert. This progression is based on the development of critical thinking and problem solving skills and occurs in five basic stages: novice, advanced beginner, competent, proficient and expert. According to Benner (2001), the study participants are still in the advanced beginner stage and still have more to learn and experience before they obtain the expert level.

## **First Code**

Each participant related a story of a patient in a code or near code situation. These stories included comments such as “I froze,” “I didn’t know what to do,” “I felt in the way” and “I was afraid”. One participant stated a code situation almost ruined her. The majority of participants were working in critical care settings and had the opportunity to be in a few codes or near-code situations by the time they were interviewed. The later code situations they discussed were frequently referred to as a way of ‘measuring’ the progression they felt they had experienced. These participants made comments like “I was reaching for medications before the doctor ordered them,” “I was able to assist,” “I felt like I was working on all cylinders.”

The ability to function effectively as an RN does not begin until at least 12 weeks of orientation (Beyea, Slattery & von Reyn, 2010), and the ability to function effectively in a code situation or crisis can occur much later. All of the participants were required to have current American Heart Association training in cardiopulmonary resuscitation (CPR). Due to the somewhat infrequent nature of actual coding patients, the application of information and skills learned in the CPR training classes occurs infrequently. Reece, Cooke, Polivka & Clark (2015) identified that knowledge of resuscitation skills deteriorates as quickly as two weeks after training (Reece, et al., 2015). So nurses, especially new nurses, may find these situations extremely challenging.

## High Expectations

Participants discussed several emotions during the interviews. Lack of confidence and self-doubt were emotions that were expressed by all. They discussed how they doubted their ability, lacked confidence and criticized themselves. Participant discussions revealed that their levels of self-confidence fluctuated during their transition period. One way they judged themselves to be functioning as an RN was an increase in confidence and less self-doubt.

Self-doubt and lack of confidence can be exacerbated when one has unrealistic expectations of themselves (Chang, 2017). This was a factor with the research participants as evidenced by claims made by several participants to have high expectations of themselves and several said they were perfectionists. Some actually stated they expected “to be perfect” or “I’ve always been a perfectionist.” Almost all participants used terms such as “I should have known,” or “I should have done,” indicating they held themselves to a high standard.

Perfectionism is a personality trait where an individual sets high performance standards and frequently becomes very self-critical and engages in negative self-talk (Chang, 2017). Decreased self-esteem and increased anxiety can be compounded if nurses have unrealistic expectations of themselves (Chang, 2017). Negative self-talk can produce anxiety and eventually lower performance standards. It is better to strive for positive self-talk (Marin & Rotondo, 2017).

Literature is lacking in regards to the feeling of perfectionism in GRNs and the effects of negative self-talk in GRNs. However, there is strong evidence in



sport exercise physiology research that positive self-talk has a motivational function with resulting improved performance (Shinet et al., 2017). The ability to deliver a speech has been shown to be affected by self-talk. In a research study comparing self-talk with anxiety and level of speech performance, it was discovered that negative self-talk had a positive correlation to increased anxiety state scores and decreased speech delivery scores (Xiaowei, Brinthaupt & McCree, 2017).

### **Bullying**

In 1986, Meissner, used the phrase “eat their young” to describe how some experienced nurses treated nursing students and GRNs. Her studies showed that the experienced nurses were often rude and unsupportive of the younger less experienced nurses and there was a sense of proving your worth before being accepted. More recently the terms “horizontal violence” and “bullying” have been used to describe this phenomenon. Rodwell and Demir (2012) define bullying as a situation that occurs over time where individuals perceive themselves to experience negative actions and behaviors from others. Dressler describes bullying as “singling out someone to harass and mistreat.” Bullying can have extensive emotional impact on a person and can lead to dissatisfaction, causing an individual to leave the position (Kellt, 2008).

The state of horizontal violence or bullying has become an increasing problem in nursing (Granstra, 2015). The majority of participants experienced or witnessed some form of bullying. During the interviews, participants made statements such as, someone tried to give me attitude but I did not take it.

Another statement was “I didn’t have any issues with bullying, but I saw it happen to someone else.” Participants described the other person as someone who ‘probably shouldn’t be a nurse’ or ‘someone who was having a hard time getting it.’

Those who bully often choose victims who have a hard time defending themselves (Granstra, 2015). The participants who had previous job experience stated they would not take any “attitude” probably repelled those who tried to bully. It is possible that the participants in this study had good nursing skills and life experience and were better able to defend themselves against bullying.

### **Implications of Findings**

This study is important because it was an opportunity to hear the stories of the transition from student to GRN from their point of view of the GRN. Several themes have been identified and discussed throughout this dissertation. This data is useful because it can be used to guide decisions occurring in several realms, which include; the socialization process, socialization theory development, nursing education and nursing practice.

### **Socialization Process**

Halfer and Graf (2006) describe that socialization is a process. The participants’ stories supported this. They stated things like “I was getting better”, “I was gaining confidence”, and “I was having fewer bad days’.

During socialization there are patterns in the level of confidence and job satisfaction (Halfer & Graf, 2006). The first few weeks, GRNs have high

confidence and job satisfaction. GRNs feel comfortable working with preceptors and asking questions. This corresponds to the time when they are in orientation and was supported by participants' comments. During the 6<sup>th</sup> to 12<sup>th</sup> month job satisfaction and confidence decreases. This is the time when most GRNs are off orientation and functioning on their own. Participants' discussed this time period by describing their fear about being 'on their own', and not being ready to function without a preceptor. Satisfaction improves again around the 18<sup>th</sup> month. This was supported by the stories told by participants in this study. By the time the GRNs reached their 18 month, they considered themselves to be RNs and functioning as a part of the healthcare team. Yu and Kang (2016) suggest designing different programs for each of these stages of transition. Programs using multiple approaches over an extended period are best – but the evidence is lacking as to the best design and structure of the programs (Edwards et al., 2016).

Yu and Kang (2016) report that socialization is affected by organizational factors which includes things like orientation and preceptor programs, and mentoring programs. The participants in this study went through an orientation that had a strong focus on skill development. None of the participants related stories that focused on learning skills, which indicates that the orientation was effective in that regard. However, the participants related several stories pertaining to emotional distress and development of critical thinking skills. These are topics that could be addressed in a residency-type orientation, and/or the use of mentors during the transition period for the GRNs

## **Socialization Theory**

The majority of research regarding professional socialization has occurred in the business setting including *Toward a Theory of Organizational Socialization* (Van Maanen & Schein, 1979). The evidence has shown that the bureaucratic tactics (collective, formal, sequential, fixed, serial, and investiture) tend to yield more compliant employees while the individual tactics (individual, informal, random, variable, disjunctive, and divestiture) yield more creative employees (Griffin, Colella & Goparaju, 2000). To date, the literature is lacking regarding the best mix of tactics to use for successful nursing socialization.

The Human Resource and Staff Development departments at the research setting had a structured orientation program that can be described using the six tactics as developed by Van Maanen and Schein (1979). This is displayed in table six. The data obtained in this research was from participants who experienced an orientation with a specific structure. Administrators and educators can use this data to make structural changes in orientation programs to obtain different outcomes.

**Table Six: Description of Orientation Program at Research Facility based on *Toward a Theory of Socialization: Six Bipolar Tactics***

	Organizational Focus	Individual Focus
1	Collective	Individual
Research Facility Structure	2 weeks of structured classroom education	10 weeks one-on-one training with preceptor
2	Formal	Informal
Research Facility Structure	2 weeks of structured classroom education. New hires segregated	10 weeks one-on-one training with preceptor. New hires interacting with existing employees.
3	Sequential	Random
Research Facility Structure	Specific goals and steps – general progressing from easy to complex	Specific competencies may be random due to types of patients seen during orientation period
4	Fixed	Variable
Research Facility Structure	Follows a specific 12 week plan	Slight variation from plan to address specific needs of GRN
5	Serial	Disjunctive
Research Facility Structure	Paired with a preceptor who has same job description as GRN	None
6	Investiture	Divesture
Research Facility Structure	Strong attempt to build on previous knowledge and experience	Must conform to hospital standards

## **Nursing Education**

Spoelstra and Robbins (2010) asserted that socialization of GRNs actually begins in nursing school as the student begins to lay the foundations for the role of RN. Kramer, 1974, observed that dissonance between what was learned in school and the reality of the real world makes the transition period challenging. Data from this research supports these findings and supports the belief that practices in both nursing schools and acute care facilities affect the transition period and successful socialization of the GRN.

As nursing education has moved into the collegiate setting, there has been less focus placed on clinical experience (Hansen, 2014). One way to address this shift in focus, is to enhance the clinical experiences. In her dissertation research, Shipman (2014) studied the effectiveness of a nurse externship program. She defined a nurse externship as “a paid program that assists nursing students in getting hands-on experience in clinical settings under the guidance of an experienced RN outside of nursing school training” (p.2). The participants in her study completed the externship at the hospital where they planned to work after graduation. The increased clinical time and familiarity of the hospital that occurred through the externship helped the participants in their transition. Her research showed that externship participants reported greater skill competence and greater levels of satisfaction as they transitioned into the RN position. In general, increased clinical time and/or increased preceptor experiences could help return the focus of nursing education back to the clinical experience.

Each participant in this research study discussed the emotional distress and challenges of their first code or crisis situation. It has been reported that GRNs do not start to feel confident until 12 – 18 months in their positions. It may take even longer to be confident in crisis situations, especially if the need skills are not routinely preformed (Reece et al., 2016).

One way to overcome the challenges of maintaining proficiency in skills that are not frequently used, is through the use of simulation. Most studies regarding the effectiveness of simulation exercises focus on nursing students. Beyea, Slattery & von Reyn (2010) looked at the use of simulation in a nurse residency program and demonstrated that simulation-based training showed an improvement in confidence, competence, and readiness to function after just 12 weeks of a nurse residency program. Everett-Thomas et al., (2015) propose that simulation can help to bridge the gap between nursing education and nursing practice.

One challenge with simulation is the high cost associated with the purchase of equipment and ongoing management of the equipment and software. An alternative identified by (Reece et al., 2016) is the use of mock code training. During a mock code training exercise, interventions occur in real time and there is interaction with all the team members. Reece et al., 2016 recommended that hospital educators and administrators should plan frequent mock code scenarios that include debriefings and discussions with all participants in order to help less experienced nurses gain experience and confidence with code situations.

## Public Policy

Throughout the interview, participants discussed themes related to challenging situations that hindered their socialization into the RN role. They discussed the changes seen between the role of nursing student or nursing tech and the role of RN. They discussed how much there was to learn and the increased responsibility they felt. The development of critical thinking and ability to “pull everything together” were also topics that were addressed. Most had concerns that they were not ready to be “on their own” at the end of the 12-week orientation. These concerns support findings of the Institute of Medicine (2010) as described in *The Future of Nursing: Leading Change, Advancing Health*. These identified challenges make the transition into RN more difficult, but they also affect the quality of the nation’s health.

Several agencies (AACN, CCNE, and IOM) support the development and implementation of transition-to-practice programs. These programs are designed to improve skill, critical thinking, and competence of the GRN. They can occur between graduation and employment as with nurse externships. Or, they can occur after employment as with nurse residency programs. Currently, the Department of Veteran’s Affairs has mandated that all VA hospitals implement transition-to-practice programs (Shipman, 2014).

There is also support for enhanced opportunities before graduation. The AACN (2014) supports changes to curriculum that include the opportunity to function as part of a multidisciplinary team. Through collaboration with other disciplines, there is improved communication, fewer medical errors, and overall



improved patient safety (Shipman, 2014). Currently most nursing students are educated in isolation and they have minimal interactions with other disciplines. During the interviews, participants made several comments that support this position. They discussed how they “didn’t know who to notify,” or they were “afraid to call the doctor.”

## **Bullying**

Bullying is a theme that was discussed by several participants. Literature has shown that bullying among nursing co-workers occurs at an alarming rate (Gangstra, 2015). Oftentimes a mentor who can guide and support a GRN is suggested as a solution to prevent bullying; but, Gangstra (2015) identifies that mentors may be a GRN’s first experience with bullying. This is more likely to occur when mentors do not have adequate training and are assigned to work with GRNs without having input. Bullying is a learned behavior. Often it is the preceptors and mentors who bully GRNs, thus socializing them to become bullies over time (Wilson, 2016).

Several participants discussed that they had witnessed bullying, but they did not experience it themselves. While this may seem to have no concerns at first glance, research has shown that there are several negative consequences of witnessing bullying. (Baez-Leon et al., 2016). Witnesses of bullying may experience emotional distress. There can be conflict regarding becoming involved or remaining impassive. There can also be fear of retaliation if they step in to assist the victim (Baez-Leon et al., 2016).

Several actions must be taken to stop horizontal workplace violence. First, organizations must have policies that prohibit workplace violence and those policies must be enforced (Baez-Leon et al., 2016). The educators who work with GRNs, preceptors, and mentors need to provide adequate education regarding bullying and dealing with difficult personalities (Gangstra, 2015). Managers and educators need to be involved with staff and be aware of instances of horizontal violence.

This study provided the opportunity for GRNs to express their stories related to socialization into the role of RN. It allows managers, administrators, policy makers and educators to make decisions regarding onboarding, education, and socialization programs.

### **Limitations of this Study**

There are limitations of any study. The following discussion addresses some of the limitations of this research study.

### **Researcher Assumptions**

The researcher met with each participant at a mutually agreed upon place for one-to-one interviews and tried to make each participant feel at ease throughout the interviews. Several assumptions were made by the researcher including:

- Participants had trust that the researcher would hold all information confidential and would be non-judgmental as they told their stories.
- Participants would share their stories truthfully

- Participants would share positive and negative aspects of their socialization experience
- Participants would feel comfortable stopping the interviews if they felt it was necessary

### **Setting**

The participants in this research were RNs hired into a 500 bed hospital in Northeast Ohio. The hospital had a 12-week orientation for newly hired GRNs. The participants stated they oriented on day and night shifts and they each worked with several preceptors during the orientation period. The GRNs hiring into facilities that are larger or smaller, or those with residency programs might have a different experience.

There was no residency program at the research hospital. The literature shows that a well-developed residency program can better prepare educators, mentors, and preceptors in assisting GRNs through the transition period. The GRNs who transition through a nurse-residency program report increased self-esteem, better critical-thinking and smoother integration into the new RN role (Cochran, 2017; Goode & Williams, 2004; Keller et al., 2006; Krugman et al., 2006; Newhouse et al., 2007, Rush et al., 2013). The fact that the participants did not experience a nurse residency program may have influenced their experiences.

## **Sample**

The sole basis for sampling in a phenomenology study is to select participants who are willing to share and able to discuss or express their experience of a particular phenomenon (de Witt & Ploeg, 2006). Since the participants in this sample volunteered, the researcher was not able to control for selection bias. The tendency to volunteer might be indicative of traits or experiences that differ from those GRNs who did not volunteer.

Ninety percent of the participants entered the RN position as a BSN graduate, and 90% were working in a critical care unit. This differs from the hospital trends in that only 72% of newly hired GRNs have a BSN and only 23% of GRNs are hired into a critical care unit.

The participants in this research study were limited to those GRNs who were still employed as RNs at the research facility. Seventy percent of the participants had transferred positions within the facility or to the research facility within one year of becoming an RN. This aligns with the literature that reports that first year turnover rates can range from 35 to 60 percent (Delaney, 2003; Edwards, Hawker, Carrier & Rees, 2015; Goode & Williams, 2004; Halfer & Graf, 2006; Kovner et al., 2016; Li & Jones, 2013). There were no participants who transferred out of the research facility or any who left nursing altogether.

## **Researcher**

Heidegger believed the researcher is an active participant in the research process (Draucker, 1999) because it is not possible to arrive at a state with no preconceived notions or pre-understanding (Heidegger, 1962/1926). He believed

that our background and presuppositions become a part of our research. They converge in every aspect from choosing the topic, to which questions we ask, and how we interpret the responses. Heidegger defined this concept as co-constitutionality and described the research as a blend of the participants' response and the researcher's interpretation. (Lopez & Willis, 2004; Heidegger, 1962/1926; Koch, 1995). Therefore as a researcher, it is important to show how one's own experience has shaped choice of research topics, questions, and interpretations (Balls, 2009).

The researcher has experience as a staff development instructor and BSN faculty. The research topic came about from the researcher's experience of working with students in the BSN setting and then working with them as they hired into their first RN position. The researcher saw the challenges faced by the GRNs during the socialization process; this influenced the desire to learn more about the GRN socialization process. The researcher worked with her dissertation committee throughout the process, but the majority of analysis and interpretation was through the lens of the researcher. Appendix A provides more detail of the personal involvement of the researcher.

### **Recommendations**

This study allowed GRNs to share their stories which revealed several meaningful themes. The study was conducted at a 500 bed hospital that had a 12 week orientation which had a strong focus on skills. The orientation included the use of preceptors, but there was little consistency in matching a GRN with a

single selected preceptor. The research facility did not have a residency-type program.

The results of this study would be strengthened if a comparable study was conducted with GRNs who had a residency-type orientation. The results could be compared to see if there was any difference in the reporting of emotional struggles that occurred. In *The Future of Nursing: Leading Change, Advancing Health*, The Institute of Medicine supports the transition of new nurses into practice through the implementation of nurse residency programs. Further research can help to gather information from all the stakeholders in the implementation and evaluation of nurse residency programs. This can aid in the development of the best fit for the residency programs.

When it comes to nurse residency programs, the Robert Wood Johnson Foundation recommends them, the Carnegie foundation advocates for them, the Association of Colleges of Nursing can accredit them, the Advisory Board Company exemplifies them, the National Council of State Boards of Nursing is modeling them, healthcare organizations need them, nursing schools teach their students about them, and new nurses shop for them.

A challenge occurs when discussing nurse residency programs and their effectiveness, because at present, there is no standard definition even though several agencies recommend their implementation. Further research is needed regarding the best type of program and the best implementation methods.

Another area of concern is the resistance to implementation of nurse residency programs. There is a plethora of literature supporting the benefits of

nurse residency programs including: improved transition of GRNs, decreased costs, and improved patient safety. Yet many hospitals have not taken steps toward putting these programs into practice. The research facility and neighboring acute care facilities do not have nurse residency programs. Further research examining causes of resistance to implementation of nurse residency programs would be beneficial.

The literature shows that first year turnover rates can range from 35 to 60 percent (Delaney, 2003; Edwards, Hawker, Carrier & Rees, 2015; Goode & Williams, 2004; Halfer & Graf, 2006; Kovner et al., 2016; Li & Jones, 2013). First year turnover for the participants in this study was 70 percent. Further research is needed to help determine whether the turnover rate in this facility is a trend nationwide, and to determine the causes of this high percentage in order to find potential solutions.

One last area that merits further examination is that of horizontal violence, or bullying. The participants of this study discussed how they saw bullying, but they did not think they had experienced bullying. Were the participants of this study more out-going or assertive? Did this prevent others from bullying them? Some of the participants discussed how they saw others bullied and they seemed to suggest that it was merited because those who were bullied were not very good nurses. One participant stated she thought some younger GRNs may have initiated bullying because they had “attitude” toward the older, experienced nurses.

## **Conclusion**

This research allowed GRNs to tell their stories relating to the socialization process of becoming an RN. Several themes emerged and have been discussed in this dissertation. While there are a few limitations in this study, the themes that were revealed through analysis of participant stories are supported in the current literature. This information can be utilized by managers and educators as they plan and develop nursing orientation programs. By listening to the stories told by the GRNs future orientation programs may be designed to better meet the needs of the GRNs. This could result in a less stressful transition period, and the GRNs may be more likely to remain in their position. The end result could be less RN turnover, better financial outcomes, and safer patient care.



## **APPENDIX A**

### **Personal Involvement**

## **Personal Involvement**

I have several years of experience teaching undergraduate nursing students in a baccalaureate nursing program. Since I have had the opportunity to teach a variety of classes (sophomore level foundations, medical- surgical, leadership, research, and critical care), I have seen how nursing students mature and develop throughout the nursing program. After six years of teaching at the university, I transitioned into a staff development position in an acute care setting. I was in charge of the nursing orientation program for all new nursing hires (RNs, LPNs, and nursing assistants). It was in this position that I saw the difficulty of the transition period for the GRN. I saw GRNs who had been excellent students struggling with becoming a new RN. At times, I experienced great frustration in that the GRNs became discouraged and had difficulty completing tasks and organizing care. I worked closely with several GRNs to help them through their first year, and sadly a few actually left nursing because they felt it was not a good fit for them. I turned to the literature and other experienced staff development instructors to try and find ways of improving the orientation period.

When I began coursework for a PhD in nursing at Indiana University, I had the challenges of GRN socialization in mind as I wrote papers and completed the foundation coursework for the PhD. My minor was in education -- so I had the opportunity to delve into curriculum development, program evaluation, and the use of technology as an assist in education. I have made several changes to the hospital orientation program based on insights gained from these classes. Also, I

have had the opportunity to develop some new orientation programs, and preceptor training courses.

Several of the courses in the PhD program included assignments that allowed me the opportunity to practice my interviewing skills, including, a descriptive qualitative study with six participants. The participants were nurses who served as preceptors for GRNs and the interview questions focused on how they viewed the socialization process of the GRNs. Much of the literature review and background information for this research was begun as part of the PhD coursework requirements.

**APPENDIX B**  
**Participant Handouts**

Date:

Dear (insert name):

Congratulations on your first RN position. My name is Jennifer Hostutler and I am in the process of completing my PhD through Indiana University. I would like to ask for your help in a research project. The research project is aimed at gaining a better understanding of the experience of new RNs in their first RN position. It will involve meeting with me for an interview that will last approximately 45 minutes and will involve me asking you questions about your experiences as a new RN.

If you are interested, give me a call and we can set up a time to meet.

Thanks,

Jennifer Hostutler PhD (c)

XXX-XXX-XXXX

## **INDIANA UNIVERSITY INFORMED CONSENT STATEMENT**

### **INDIANA UNIVERSITY STUDY INFORMATION SHEET**

#### **Becoming an RN: A Hermeneutic Phenomenology Study of Graduate RNs**

You are invited to participate in a research study that is looking at the experiences of a new Registered Nurse (RN) during the first year of work in your first RN position. You were selected as a possible subject because you are a new RN. Please read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Jennifer J Hostutler PhD (c) in partial fulfillment of PhD requirements. There is no funding for this study.

#### **STUDY PURPOSE**

The purpose of this study is to gain a better understanding of the experiences of the new RN during the first year of employment as a newly graduated RN.

#### **NUMBER OF PEOPLE TAKING PART IN THE STUDY:**

If you agree to participate, you will be one of up to 24 subjects who will be participating in this research.

#### **PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following things:

- Sign a consent form
- Participate in an interview conducted by Jennifer Hostutler. The interview will be recorded and last approximately 45 minutes
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#### **RISKS OF TAKING PART IN THE STUDY:**

There is a possible risk of loss of confidentiality from participation in the study. If at any time you do not want to answer a question, or you wish to change the topic, you are free to do so. Additionally, you may stop the interview at any time without any consequences.

#### **BENEFITS OF TAKING PART IN THE STUDY:**

There are no direct benefits to you for participating in the study. It is hoped that information gained through this research can lead to changes that would enhance the transition period for the new RN.

## **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published. Names of all participants will be changed in any reporting. There will be no use of specific identifiers (such as place of employment, or nursing school attended). Additionally, individual data will not be shared with management.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees, and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections (OHRP).

## **COSTS**

There are no costs to you for taking part in this study may

## **FINANCIAL INTEREST DISCLOSURE**

The Institutional Review Board (an ethics committee which helps protect people involved in research) has reviewed the possibility of financial benefit. The Board believes that the possible financial benefit is not likely to affect your safety and/or the scientific integrity of the study. If you would like more information, please ask the researchers or study staff.

## **PAYMENT**

You will not receive payment for taking part in this study.

## **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study, contact the researcher Jennifer Hostutler at XXX-XXX-XXXX

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

## **VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with Mercy Medical Center.

## **SUBJECT'S CONSENT**

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

**Subject's Printed Name:** \_\_\_\_\_

**Subject's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
(must be dated by the subject)

**Printed Name of Person Obtaining Consent:** \_\_\_\_\_

**Signature of Person Obtaining Consent:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**APPENDIX C**  
**Interview Quotes**

<b>Roller Coaster</b>	
<b>Heidi</b>	It was torture -- the nursing home I had three days orientation and I was thrown on my own and I was the charge nurse, I was the only RN in the building in charge of everybody and did not get the proper training. Seriously, after that, I did not want to be a nurse any more.
<b>Jason</b>	I wouldn't say it was easy -- the first day on the job you have no idea what you are doing-- I mean you learn everything in -- in school -- but it is completely different from doing it in real life.
<b>June</b>	You are kind of on your own -- I don't really want to say on your own because you have the person who is orienting you but you are just... it feels like you are responsible for these people.
<b>June</b>	As a tech you were really helping the nurses a lot, but as an RN you are the one who is now responsible for these people, you are the one who is giving the medications, you are the one .... The doctors expect more from you because they want you to know more about what is going on.
<b>Tim</b>	I feel like I got a lot of really good experience. I guess at times it was a little overwhelming-- I know with any new job you have to get used to the little things like getting organized and stuff like that but I think -- the biggest thing was the patient load and -- adapting to calling doctors on the phone.
<b>Rachel</b>	God, I don't ever want to live through something like that again -- it was -- I don't want to say it was bad -- but it was it was pretty terrible some days. People said it would take time and I guess I knew that but didn't expect it to be so long and frustrating.
<b>Mary</b>	I feel that there was so much more that I needed to learn, I didn't have much official classes (orientation) but I did a lot of on the job and working with preceptors .... I felt like I was expected to know more than I knew just starting.
<b>Stephanie</b>	My first year as a nurse has been good I have learned a lot.
<b>Amy</b>	I don't know where to start, umm there was so much -- it was good, I really feel good
<b>Susan</b>	There was so much to learn and do. Not just nursing but computer, policies, hospital stuff and all -- I thought it would be

	<p>really easy. I mean people told me it would take a year or so and I didn't believe them. I have always done well in school and nursing school and I thought I would just breeze in and have this great time, but it was so much harder at least the actual patient care.</p>
<b>Vivian</b>	<p>The first year I was confused about what I wanted to do. It is definitely a hard experience coming from school and I know we didn't get a whole lot of orientation – maybe 6 weeks which seems like it is enough but when you are on a med-surg floor and you see everything -- when I came off orientation there was a lot that I was still unsure about -- a lot that I feel I didn't really know and I had to go and ask and look up policies all the time and it got a little bit easier but I think what I am struggling with right now is trying to find a niche and trying to find something that is going to work</p>

<b>First Code</b>	
<b>Heidi</b>	Well -- my first code situation happened on a holiday when I was the only RN in the building. I was not even shown where the crash cart was -- I mean that really ruined me, that code situation ruined me from the start and I doubted my abilities.
<b>Heidi</b>	(a second code in ICU) actually another code situation where the lady had internal bleeding and started coding we called a code and she was bleeding from every orifice you can think of and the teamwork was so much more smooth. There was so much teamwork and everybody was working together to make it better and it just made a huge difference.
<b>Jason</b>	Well, I guess I had my first code during orientation and that was my only one and you think that you are going to panic, but people who work on my floor and the people that came up to the code were just really amazing -- and I ---there was this moment of clarity and the adrenaline starts pumping and you just know what to do and who to listen to.
<b>June</b>	Probably one of the biggest things that you struggle with is when you have a full team and you are on your own and you have 4 patients that should be 1 on 1. A -- and all four of those patients are yours and you have to bounce back and forth and try to figure out how to balance your time and figure out what needs to be done and each should really be 1:1.
<b>Tim</b>	I remember I was getting a bunch of frequent flyers, I don't know if I was getting a little burned out but one day I was giving report to somebody and I was just frustrated and -- I made a comment about how the family member was kinda like freaking out -- and that is not my personality but I was going on about her freaking out and I didn't know why -- and she was like it is probably because this is new for them and she is overwhelmed. And I thought about the comments that I had made and it made me take a step back and remember why I became a nurse to help people and I just realized in that moment that I was like burned out and even though you may have rough days you need to keep a good head and remember that you are here to take care of people and remember to not let the little things or the bad situations get in the way.
<b>Rachel</b>	I don't know-- I guess the first thing I can think off is my first code. I was terrified. And didn't know what to do. I was still on

	<p>orientation-- I had seen patients code before and patients die but not one of mine--I had just given my patient 4 of morphine and he was talking and ok-- then he just was unresponsive--like nothing and it was asystole-- I just froze ... everything happened so fast—and-- like I did things--but I just felt like I was in the way-- it was almost surreal--he died and I felt really bad -- I know this is not true -- but I kept thinking I killed him with the morphine-- I was like guilty and questioned everything – should I have done something different -- what if --. He actually had an internal hemorrhage but, I -- I don't think I will ever forget.</p>
<b>Mary</b>	<p>Well just recently I had an issue where a pacemaker stopped working and the patient was dependent on the pacemaker-- (I was working with) a float nurse-- a nurse from a different floor who had no idea so it was her and I working to call the appropriate people and call drX and drY and consult an emergency pacemaker placement and getting him hooked up to the crash cart ... I felt that was a good experience for me and it was a good experience for teamwork and mentoring because I had no idea of what I was supposed to be doing at that particular moment but we worked together.</p>
<b>Amy</b>	<p>Well I guess the thing that I see is one of the big traumas we had when I was orienting. I was working with my preceptor in another room and he pulled me to the trauma, I was actually doing stuff, part of the team -- We did a chest tube, lines, and everything and I had to be there. It was really good I mean I knew what to do and I was sorta prepared. But yet I was like in a fog. Really crazy. At first I thought I was going to throw up --I was nervous and excited both. But I held my own and did what I should. After we talked about it and I didn't do anything really stupid. I guess I felt good because I did participate and did what I was supposed to do. But I guess-- I felt a little out of place. It just felt different. I don't know.</p>
<b>Stephanie</b>	<p>Probably just the first time I had a patient go bad and just the experience of it all-- like I think you learn quickly that no matter how much you learn in school and how much you prepare for stuff there is no way to prepare for that kind of thing. Luckily -- it was a very controlled environment and everyone was willing to help but it doesn't matter how many books you read -- it is just the experience. We had mock codes in simulation in school -- it didn't really sink in and it wasn't anything like real.</p>

<b>Susan</b>	Well the first thing I can think of is my first code. I got report and was checking on my patients and she wasn't breathing and looked gray. She was a COPDer and had surgery and was doing pretty good the day before when I had her so I wasn't prepared for this at all. I was OK --I called the code and then I just felt like I was lost, I didn't know what to do. Later they told me I looked really scared. I thought I was trying to stay calm and hide it, guess I didn't. Then I don't think I ever got caught up for the rest of the day and it was just bad. I think I worked over two hours. I was really tired. I went home and thought about everything and worried that I should have done something differently.
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<b>Doubt Being a Nurse</b>	
<b>Heidi</b>	Not only did I doubt why I became a nurse, but I doubted my ability to be a good nurse.
<b>Rachel</b>	Rachel: the first couple months most days were-- not real good I second guessed everything-- and I criticized myself because there were things I should have known. Sometimes there were patients who were real bad and I just felt like it was too much and I starting thinking about going back to school for something else and I just wanted to call off and all-- a few weeks before orientation was over I felt like I was getting things together-- but I was still really unsure. I was meeting with the unit director and he told me things were good and orientation was over and I was a little freaked because I felt I should be better and I was really scared to be off orientation.
<b>Mary</b>	I didn't know what I was doing – well I guess I did a little bit but I felt like I didn't know anything and I was nervous and afraid I would do something wrong. But I didn't and it was good.
<b>Amy</b>	I thought it would be easier as a nurse--but I think a lot still think of me as a tech and I think sometimes I'm a tech. At first it didn't seem real to be a nurse.
<b>Susan</b>	I had a good experience-- Nursing school I learned a lot, and did well. And I had almost a 4.0 average. I didn't have any problems getting ready for boards and I felt really prepared but I guess I wasn't. There were so many things that I didn't know or maybe I knew just a little or a part and it was hard to keep up with everything that needed to be done like dressings and IVs and calling the doctors and discharging and charting – I really hate all the charting and this system is bad, can't do what you want to do. I don't want to do anything wrong – no mistakes, but I can't get it all done-- I just seem really slow. And I'm really trying but --. Like we have a lot of heart failure patients and I know we learned about that in school but there is so much more that you need to know -- labs and treatments and I think I struggle with what you need to teach patients and-- and when they ask questions-- so many times I don't know the answer and I feel really stupid and I seem like I'm reviewing so much stuff-- just to get to where I need to be.

<b>Susan</b>	<p>Week 5 or 6 of my orientation and I was really feeling down overall. I started off feeling confident, like I knew what to do, and I was so happy to be done with school and working in my first real job -- but then-- it seemed like I couldn't get anything right. I didn't know why I wanted to be a nurse so bad--I guess I just doubted everything I did. So having a code (and the patient died) really was hard. I just didn't want to come back to work-- I thought I had made a big mistake-- didn't want to work ever again. I had never had a patient die-- I really didn't know anyone at least anyone close who had died and I don't know what I expected but it was-- I don't know --hard.</p>
<b>Susan</b>	<p>I feel that you can't go in being scared. I ran into an issue right after nursing school and that kinda put some fear in me and I feel like I lost a lot of confidence during that time.</p>
<b>Vivian</b>	<p>In nursing school you have a nursing instructor that has your back and when you are a nurse aid you have a nurse that has that patient. Well when you are the nurse on the floor and your patient starts to go downhill you can't go say let me go get your nurse or get the nursing instructor. You are responsible for that patient.</p>



<b>Experience in New Position</b>	
<b>Heidi</b>	Actually it has been wonderful. Granted it has been scary because it is the ICU and I doubted my ability -- and things can happen at any time, so because I doubted my ability, I was scared to death, but honestly, I don't regret it one minute the people on the floor have been wonderful and you are taught what you need and people are there to help you aren't just thrown out there to wing it.
<b>Tim</b>	I kinda guess I got a little burned out. For I little bit. I was thinking about going back to school for my masters but I wasn't too sure what I wanted to go back for like an FNP or business side so I was debating that and I didn't want to make a decision until I did something else. I had all the nursing stuff under my belt already it was just the different charting but it was so easy to catch on to-- but I felt like it was way easier to make the transitions...I feel like it was a lot smoother it was a totally different experience.
<b>June</b>	I think the thing that really helped me was working in the emergency department before I went down there made all the difference in the world. I mean if I hadn't been a tech and been exposed to that environment before I went down there as a nurse, I don't know if I would have made it. So I think that was a huge a huge thing.

<b>Not Quitting</b>	
<b>Heidi</b>	Well to be honest I always wanted to be a nurse, ever since high school, I never had the opportunity to go to college.
<b>Heidi</b>	I think the main thing is just because I want to be a nurse, I feel this is my calling and I mean I love what I do and I seriously love being a nurse.
<b>Heidi</b>	Well I mean I think that questioning my ability is always in the back of my head just because of fear sometimes but now that being in the ICU and dealing with more critical situations, I finally realize that I can handle it because I have done it so I'm getting over that fear a little bit....Like I said now that I've dealt with more critical situations, I've proven that I can do it.
<b>June</b>	Basically just working through the first days until you feel comfortable in your skin and feel comfortable and know what you are doing. You just have to go with it-- especially for me my orientee was in the room with me at first for every single day and then I was slowly starting to take one patient at a time then I would take two and work my way up to a full team of patients.
<b>June</b>	Well basically-- I needed a job and I couldn't afford to quit... and I knew that someday I would find a job that I liked and that I really enjoy doing and that I wanted to be in the job, so I just had to keep working through it.
<b>June</b>	As clueless as you may feel in the beginning it will get better you will become comfortable in what you are doing ... the first day you are going to be like oh my goodness what did I get myself into but it does get easier. You learn how to become a nurse and you learn how to be comfortable in your position and what you are doing.
<b>Rachel</b>	Oh so many times I wanted to quit-- And I so often wanted to call off but-- I just kept thinking I would be a disappointment -- I've wanted to be a nurse all my life and I liked school and thought this is what I was supposed to be doing-- I like patient care-- I like the critical care unit--but I don't know it was just hard. I think one of the things that kept me from quitting was my parents. I still live at home and I knew I couldn't call off they would get on my case and I wasn't ready for that--and I not really a quitter-- so I just

	kept going. I had that year goal in mind. You know I can survive anything for a year.
<b>Rachel</b>	Oh yes. I mean it was like a rollercoaster for a while, but I really learned a lot--I like where I work--and I feel like I fit in--. I don't think I will ever forget that year so I think I will be helpful to students and new grads-- it turned out good and I'm glad.
<b>Mary</b>	I tried to stay positive-- it was just-- you know little things that made me appreciate what I was doing. Someone came in who was very sick and I got to have them the whole time and I discharged them and they were better ... in the end it is the patient their responses that makes me continue doing what I'm doing. I just like being with the patients and I think I make them feel better when they are in a bad situation and I like to see that I really do make a difference but you don't always see that and sometimes it--it is hard. But you just work through when it is hard and look at when it is good.
<b>Susan</b>	I knew I couldn't give up. I have student loans so I have to work!! Plus my Dad would have killed me. I got support from my church group – lots of prayer. Also friends from school. We compared notes – we all ended up in different ... Look at what you are doing good and focus on that-- I do try to focus on good things. There are so many times I feel like I really help someone and they do seem to appreciate that. And there are patients who are really bad who turn around and end up going home -- so I guess don't focus on the bad things that happen I had a good preceptor who helped me. So you just keep going.
<b>Vivian</b>	Well you have to realize that it is-- you can't know everything and you can ask and I think now if I'm not sure, I will go to multiple people and ask until I'm sure instead of going to one person and compare their answers or try to find the policy or even try to call someone higher up like the coordinator and get answers from them I always chart who I talk to and I try to cover myself so if something unfortunate would happen you know that you would think it was so small but in reality it could be a big deal.

<b>Self-Identification as an RN</b>	
<b>Heidi</b>	I'm starting to. There are so many things that can happen and of course, I'm a perfectionist so I'm very hard on myself when it comes to that so because I don't feel like I know-- I was scared to death when about being on my own.
<b>Jason</b>	I think of myself as an RN, I just know that I don't know everything. I don't try to wing it, I usually ask a lot of questions of the people that have been there and there is a couple charge nurses that are really good and know almost everything.
<b>June</b>	Yeh I did, I mean I got that point where I was pretty confident in my job and felt like I knew what I was doing -- but I think the time when I really felt like a nurse was when I went to my new job you know this is I know I can do this. It was obvious that I did not need as much direction in a new position as I did when I was a new grad nurse.
<b>Tim</b>	It was like every now and then things would come up and it was like -- geeze what am I going to do now and like the new experiences and stuff I feel like it probably took like 9 months before I felt like I don't know-- I didn't go into-- I think there were like times when I was driving to work and got that nervous feeling and it was like geeze what is going to happen today but I think that probably stopped at like 9 months.
<b>Tim</b>	It was a lot easier to go to work for sure, I don't know I felt like so relieved and I actually felt like everything kicks in and you are functioning better and it is better for you and your patient you are working in all cylinders and it seems like it is all going a lot better and it is easier to focus on your patients.
<b>Rachel</b>	(the doctor) told me I had good assessment skills and I was like really happy. And then I ... I stood up to a doctor ... another nurse was in the room with me and I sorta thought I was -- I just wanted the floor to swallow me-- I was waiting for them to yell at me-- but they didn't.
<b>Rachel</b>	You know the really good thing... I had a code the other day and I knew what to do, I was getting things form the cart and getting drugs ready before they were ordered-- I mean, its like this fear, not really fear maybe excitement but I don't know something

	kicks in and this other person takes over and I just get into this mode or something.
<b>Mary</b>	I feel like just now a year later I'm finally becoming better at that but that was my biggest thing. I don't know how to get that you don't just read a book. I was so task oriented. I have to get this done, I have to get that done there, it was really hard for me to go beyond all the little things I needed to get done and look at the big picture.
<b>Mary</b>	I feel as like I still have a lot to learn I feel like I contribute and try to help other nurses and I feel like I do my work, my fair share but I feel like I still have a lot to learn I don't know what I should know sometimes.
<b>Mary</b>	Really probably about a year I think it really took about 12 months I didn't believe when people told me that when I first started you know it will take about a year for you to feel comfortable and I was like no, no no it will be shorter for me but it really did take about a year. And I was upset about that because I thought I would be better. I guess I still chip on shoulder... but I was a medic and I thought I would just jump in and be this awesome nurse right away-- I was a good medic-- I want to be good with everything so it was hard for me to not be really good and not meet what I thought I should be.
<b>Amy</b>	(with other codes)I was in the room but like in the background. I was mostly to run and get stuff or watch other patients. But this time.. it was.. right there doing things, I helped with chest tube and foley--it felt,I was responsible, I wasn't just helping out--I was doing things. I guess it was the first I really felt the difference in being an RN.
<b>Amy</b>	I guess--when orientation was done-- I guess I was ready. I was still a little scared but I did feel ready. And, I was more confident and knew answers when asked and knew orders to expect--and when it gets busy like really busy, I may get behind but I don't really feel like I'm drowning. And I just feel more confident now.
<b>Amy</b>	I really felt confident about 6 months ago or so I know I still have a lot to learn but I feel like I do good. And I'm starting to think about the ED certification. I've been reviewing books all along but I just got a study guide and that really helps and I do feel more confident when I read the different things and know that I really know that so it just keeps getting better

<b>Stephanie</b>	I think I fee--I I don't want to say confident, but I'm starting to feel more sure of myself when I make decisions. The first couple of months when I was on my own it was very-- I didn't look at myself as the nurse I still felt like a nursing student who just graduated and still learning but I starting, I think it is because I usually work a lot like there has only been a couple weeks where I actually worked only my 36 hours so I have gotten to see and got a lot of experience within a year, but I just starting to feel a little better about myself I feel that I have enough experience to say I'm really a CV nurse.
<b>Stephanie</b>	I think a few months ago I started to feel that way some-- I don't say I always feel like that because some days I don't. But now that I'm orienting other people, I see others see me that way and--I guess I do too. I have more confidence and I, I think I'm thinking more independently-- more aware of things. I -- there wasn't one big event that sticks in my mind. It's just, I feel like I'm more a part of the team, more accepted. I didn't really feel that when I began, sort of like an outsider – no one was mean or anything --- it just took time to feel like a part of the team.
<b>Stephanie</b>	It feels good I finally feel like all that hard work I did from school and the years as an aid are starting to pay off because I am what I've been working toward being and it is definitely a rewarding experience. I guess I'm growing more confident.
<b>Susan</b>	Yes, I think so, most of the time, There are still some days when I feel like I'm off my game, but most of the time I feel like I'm on target – I'm still a little slow- but I feel like I pretty much know what I'm doing. I am better at getting orders from the doctors. I know what they need to know and don't stumble around. I'm not staying so late to finish up charting. I guess more confident.
<b>Vivian</b>	Yes ..yes I do think of myself as an RN I am proud to do so but I never go to work and think you know, I know everything and I can do it all sometimes I am nervous you know, when I get report sometimes I get a little freaked and think how am I going to take care of this patient but you know you have stuff you can say you know I went to school for this and if there is something that I am uncomfortable there is someone and physicians. You are never going to be the only one in the hospital you know and I have learned that if I am uncomfortable or I feel something is wrong just call a rapid what is the worst that can happen that a

	patient is fine – so yes I do think myself as an RN I don't think I am perfect.
<b>Vivian</b>	You know I think when I first started I was so excited I just kept thinking I'm an RN I'm an RN and I felt like an RN when I started my job I didn't feel like a student anymore I was proud of my autonomy but-- I think it is humbling to take those patients. It is just a humbling thing to do

<b>Prove Self/Bullies/Attitudes</b>	
<b>Heidi</b>	You have your older nursing who are basically eat their young.
<b>Heidi</b>	I just feel like new nurses are looked down upon and some of the nurses were very rude, they don't want to help and they bite your head off for everything and if you make a mistake by god they make sure you know that you made the mistake. They are not nice about it.
<b>June</b>	I 've worked there before so everybody knew me and everybody was wanting to help me and wanting me to do good I think you are completely new to the department knowing nobody sometimes people are not as willing to help you because they don't know you they don't know you ????? sometimes ... they don't care you could be just another face in the department and they don't take the time to know you or bother helping.
<b>Tim</b>	I thought they treated me well. It kinda helped that I knew some of them already, but I mean I thought everybody treated me well and everybody was willing to answer questions and they would point you in the right direction, but I think I have found that everywhere here – more so on night shift than day shift ... I don't know why but day shift seems to be more every man for himself and night shift seems to work together.
<b>Tim</b>	some of the people, sometimes you would get some attitude, like you just got that vibe that they thought you were a new grad and looked down at you but it wasn't really all that often. Sometimes like giving report.
<b>Rachel</b>	Yeh I definitely had the feeling that I had to prove myself to her but I think-- I don't know I guess I got the feeling that she was like maybe she was a bully in high school she was just not a happy person or something.
<b>Mary</b>	I feel like I was very lucky all the other nurses were very helpful and I know others didn't have that experience, but my biggest problem was just me and I tried to hide it and that I was nervous, and was late getting my charting done and sometimes they said something about that and no lunch.
<b>Mary</b>	I didn't have any problems with that. Some did and they were maybe not real good at the job, I honestly think they should not be in ICU. But no definitely no bullying or being mean.. maybe



	sometimes a little short like I was disorganized in giving report but it was OK.
<b>Amy</b>	No there was never any bullying even as a tech. Pretty much everyone is helpful and all. There are some that are less helpful ... more to themselves – but most everyone really works as a team and they help each other. I think maybe some did want me to prove that I was ready but they weren't mean well there was one -- Maybe more thought that-- thought of me as a tech. But one tech did give me a hard time it was-- she was always kinda difficult. I didn't work with her much as a tech and when I did she would tell me what to do and try to give me her work to do. And, sometimes I just did her work. I don't know maybe that was a bad thing but it was just easier. Now I don't know some say she is resentful I mean she isn't in school or anything and I don't think she doesn't like the techs who only work prn then go on and be nurses. But I was strong. I would tell her things to do and my preceptor supported me so there wasn't really any big issues.
<b>Vivian</b>	Until I went out on the floor and had my first rapid I had no idea what that felt like so like what was going to happen and realizing this is my patient they are under my care and are under my watch so you now when that happens and you are unsure if the patient is going to be ok or if they are going to make it you can take it really personally especially if you have had that patient a few days but umm but I think the more that you have experience I think that is what is hard about the first year you know that happens and you go home with it and you think about it and you dwell on it I think the helps.
<b>Vivian</b>	I don't know, yes definitely I don't know how to say this without sounding terrible but I have seen a few who are 21, 22 and I've seen a lot of young nurses who come out and are just wonderful nurses but I see a lot of younger nurses just coming out of school and being to the older nurses or the nurses who have worked a long time and I know trying to tell them how to do their job and I feel like that really causes a barrier when you come out as a know it all and start telling experienced people how to do their job it is wrong and causes a barrier and then they don't want to help but I have seen that happen and then I've seen nurses straight out of high school go into nursing and they are wonderful and very caring and they are wonderful and very caring but I have seen that happen.

<b>Vivian</b>	You know I feel that with any job I have done like when I was in banking and when I was in HR umm you have those people who have been doing it forever and are very welcoming and willing to show you stuff and you are going to have a few who are not helping and you need to prove yourself and you need to figure out how they function and what you need to do to approach them and I feel that is with any job. But here I feel that most of the people were so helpful and willing to help but like I said you are always going to have some that don't
<b>Heidi</b>	I just had to make it clear that I was not going to deal with that and it is probably because I had been in the workforce for so many years that I was able to say that I'm not going to be bullied like that.
<b>Jason</b>	Everybody on my floor has been good – but I mean I don't know I mean if you kinda grasp new things quickly and maybe that is part of what helps.
<b>Jason</b>	Well for the military I think the military helps you learn assertiveness. I don't like to call doctors but I'm not afraid.
<b>Tim</b>	Usually, I think we all get pretty thick skin working as nurses so it didn't really bother me too much just kinda like, kill them with a smile well not really blow them off but just smile and go on and do what you are supposed to do.
<b>Rachel</b>	Well I made it through (laugh). I don't want to sound mean or anything because I usually try have an open mind but I really didn't like the first person I had. And even now I don't like her and give report ... but I had off unit training then she was on vacation and I was with someone else who I really liked and she was helpful and I got a lot from her and then I went to nights and they are more helpful so it was ok.

<b>Been There Done That</b>	
<b>Tim</b>	I think everything adds up to make you who you are and what you bring to any job but I feel like the transported thing helped me get my foot in the door for the medical thing and it helped me see how things work and get experience working with patients while I was in nursing school and then for marcs and the transport thing it helped me develop the sense of customer service because essentially that is what it is all about and interactions and communications with people whether they are your coworkers or your patients I think that definitely helped a lot.
<b>Mary</b>	I think it did -- at school it was a hindrance it would be easy for me and I came into nursing with a chip on my shoulder and going through school I didn't have to study as hard as the others and I got good grades, but honestly I think I should have studied harder and learned more – not just go for the grade or rely on what I knew.
<b>Mary</b>	I think going through the preceptorship and orientation everyone said that I was so task oriented and I had a huge problem when I started working as a nurse because things weren't getting charted because I liked having things--you don't get that in the hospital so it was hard for me to do that in the hospital. OK these meds may be late or I may need to chart later on. And honestly I think that was maybe because I was a medic – we were more task oriented and didn't really look and nursing process, we did what we did and worked with nurse.
<b>Amy</b>	There were times at the store when someone would be like really nasty and I was like really? It isn't that important. But there was the customer is always right, So I like see some of this stuff in patients and with the docs- you know same stuff just a different setting. So I think it helped. And I was a little older--not much but I had a little responsibility before school and that helped
<b>Stephanie</b>	I can honestly say probably the best experience of anything was probably working at the hospital before I got-- I became a nurse. I know XXX was a good program, but I just feel that working at the hospital and the charting and like knowing all of that and being around patient care for a couple of years, I think that is what helped me the most but I still feel I'm still learning.

<b>High expectations</b>	
<b>Rachel</b>	I'm sure it's just me -- like I've always done this and had high expectations of what I should do and all -- I did really well in school and it was like I knew what to expect I could study and have a good grasp and I like my critical care class and all so I thought I was ready and would just slip into a new job well I guess I thought there may be a few bumps but maybe not much -- but I walked on the unit that first day and it was like I didn't know anything it was all different equipment and the patients were really high acuity and my first patient was a CVVHD and there were like a ton of family issues about code status and treatment and ethics and all and I just well it was like it was too much. And a resident walked in the room and asked what the residual was-- or like how much--and I couldn't even thing of what the residual was and I knew I didn't know and he was waiting and I should know but I just couldn't remember, I said I didn't know and he was mad and left the room to get a real nurse and I just felt terrible and it was my first day.
<b>Mary</b>	That it is a lot harder I mean I came in a little blind. I had a lot of medical experience and I thought it was going to be easy for me and it really wasn't.
<b>Mary</b>	Absolutely. It is really hard for me because I am always the best and it is hard to not to be the best. At the eye banc and military I was really good, I knew what I needed to do and did it. I didn't hate those jobs I just wanted more I really wanted to be a nurse and I was, honestly I was very passionate about it and thought it would be a good fit and be an easy move.
<b>Amy</b>	Don't be afraid or try to be perfect. When you graduate you think you know everything, but then you realize you don't know anything and it can be scary when you are taking care of people and it can be a lot but you need to show up and keep doing your best. When you don't know something look it up. When you have a bad day and are really disorganized and can't get caught up have an honest conversation with your preceptor and try to figure out what went wrong and how to be better. Don't beat yourself up if you are not perfect-- just keep working on getting better. And be honest.

<b>Vivian</b>	Yes I did. I think I was a float as an aid so I kinda knew the flow of the floors, like med-surg, tele, rehab, ortho, psych, I feel pretty comfortable with and I felt pretty comfortable, I did most of my training on the med-surg units which was wonder which is where I started at first and that is where I got most of my skills down and then I started branching into ortho and the more specialized floors and I would I was really glad I did that because I got a little of you know.
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<b>Critical Thinking</b>	
<b>Mary</b>	My biggest thing was the critical thinking and putting everything together.
<b>Mary</b>	Critical thinking skills, I don't know if it is just me and my problem or if other nurses have said this as well, but really that was my biggest issue and trying to pull everything together. I didn't seem to have this problem as a medic in school, but I just, at times it was like my brain just freeze up. I think it is just me and I need to just work at it, I don't know if anyone could help – you just have to do it and get through and learn from what you are doing.
<b>Amy</b>	When teching I didn't always think about why--like I would get blood and not think about what and why-- I always checked to see if we needed sample before taking patient to the bathroom. As a nurse you need to know what to expect. So I'm working on getting that follow through. I was really surprised to see the docs don't always give all the orders they need and someone has to remind them and not make them mad so that is something that is new to me. And sometimes I don't know so I try to ask or look up before I do anything.
<b>Amy</b>	I guess like the only thing I can think is that I really felt lost with the critical thinking and I know they pushed that in school but it seems like we needed more real life settings to develop it. Maybe I did just not enough. Some of my friends had a hard time calling the docs – like when and what. Not so much for me cuz the docs are right there. I guess I just needed more critical thinking.
<b>Susan</b>	You know we talked about that in school and I guess I got it but I was really focused on skills and getting everything done. When I started to get better at it I got what they were trying to say. At first, during orientation-- at first I really focused on getting stuff done like vital signs, charting, and treatments, but now I'm looking at labs and thinking how do these affect my patient--is there anything I need to do, need to plan for.

<b>Team Support</b>	
<b>Mary</b>	Honestly it was hard to really fit in and feel like a team. I guess it was just me--in the military it was very structured and we all had our place, knew exactly what to do and it was a team, like a community, you belonged. But not like that at hospital (you) work with different people every day and no real team so I felt a little lost, like I didn't belong anywhere . I mean people were nice but I felt like I was free floating.
<b>Stephanie</b>	It was very overwhelming but at the same time everybody took a role and you know how it is down there-- there is lots of help and you are never alone-- so I didn't feel at all like I was just left out by myself to figure it out because there was a physician at the bedside and everyone ran over to help me.
<b>Stephanie</b>	I think just the fact that we are a team-- they spend a lot of time training you and I feel that once you feel that you are part of the team more than just about yourself, it is about the patient and the team and have a very reputable unit you know we have patients tell you all the time how good their care was and there are some who feel differently but for the most part it is very positive and people talk about the wonderful care and they knew a husband or friend or someone who did so well in our unit-- so it does make you feel good.
<b>Susan</b>	Well yes, but No one was nasty-- but I feel like I don't fit in-- even now. I can't explain it. In nursing school there was such a bond – we supported each other and it was good. Now I feel like I'm still going back to my school friends. The nurses on the stepdown don't support and encourage. I feel like I'm all alone. It's not really bad but it could be better. I guess we are just so focused on our own assignment...don't get to connect much. And also there has been a big turnover in staff so many don't really know each other and we have a lot of floats working on the unit.
<b>Vivian</b>	I go to work because I love my patients and I will seriously try to make a difference and try to make them comfortable you know do my job appropriately and you feel at times you know I try to carry my weight sometimes you know if I feel overwhelmed I may have some people carry part of my weight and then there are other times when you know there are people are in the position where they need your help and you need to carry part of their weight so I don't think you can say you know if you are

	<p>carrying the weight as a team it is different you know you come to work and the next day it is a totally different group of people and so you have one assignment then you have a different assignment so you try to carry your weight but sometimes you can't do it and sometimes you are doing it for yourself and for other people so I think it just depends it varies</p>
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## REFERENCES

- Adams, J.M., Alexander, G.A., Chisari, R.G., Banister, G., McAuley, M.E., Whitney, K.B., & Erickson, J.I. (2015). Strengthening new graduate nurse residency programs in critical care: Recommendations from nurse residents and organizational stakeholders. *Journal of Continuing Education in Nursing, 46*(1), 41 – 48.
- Ajjawi, R., & Higgs, J. (2007). Using hermeneutic phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning. *The Qualitative Report, 12*(4), 612 – 638.
- Ajjawi, R., & Higgs, J. (2008). Learning to reason: A journey of professional socialisation. *Advances in Health Science Education, 13*(2), 133 – 150.
- Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R.... Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet, 383* (9931), 1824 – 1830.
- AL-Dossary, R., Kitsantas, P., & Maddox, P.J. (2014). The impact of nurse residency programs on new nurse graduates' clinical decision-making and leadership skills: A systematic review. *Nurse Education Today, 34*(6), 1024 – 1028.
- Allen, D.G. (2006). Do organizational socialization tactics influence newcomer embeddedness and turnover? *Journal of Management, 32*(2), 237 – 256.

- Allen, T. D., McManus, S.E., & Russell, J.E.A. (1999). Newcomer socialization and stress: Formal peer relationships as a source of support. *Journal of Vocational Behavior*, 54(3), 453 – 470.
- Alspach, J. (1995). *The Educational Process in Staff Development*. St. Louis: Mosby.
- Altmann, T.K. (2007). An evaluation of the seminal work of Patricia Benner: theory or philosophy. *Contemporary Nurse Journal for the Australian Nursing Profession*, 25(1-2). 114-123.
- American Association of Colleges of Nursing. (2002). *Hallmarks of the professional nursing practice environment*. Retrieved from <http://www.aacn.nche.edu/publications/white-papers/hallmarks-practice-environment>.
- American Association of Colleges of Nursing (2014). *Interdisciplinary Education and Practice*. Retrieved from <http://www.aacn.nche.edu/publications/positions/interdisciplinary-education-and-practice>.
- Anderson, T., Linden, L., Allen, M., Gibbs, E. (2009). New graduate work satisfaction after completing an interactive nurse residency. *Journal of Nursing Administration*, 39(4). 165-169.
- Appleton, J.V. (1995). Analyzing qualitative interview data: Addressing issues of validity and reliability. *Journal of Advance Nursing*, 22(5), 993 – 997.

- Ashforth, B. E., Saks, A. M., & Lee, R. T. (1997). On the dimensionality of Jones' (1986) measures of organizational socialization tactics. *International Journal of Selection and Assessment*, 5(4), 200 – 214.
- Ashforth, B. E., Saks, A. M., & Lee, R. T. (1998). Socialization and newcomer adjustment: The role of organizational context. *Human Relations*, 51 (7) 897-926.
- Baez-Leon, C., Morreno-Jimenez, B., Aguirre-Camacho, A., & Olmos, R. (2016). Factors influencing intention to help and helping behavior in witnesses of bullying in nursing settings. *Nursing Inquiry*, 23(6). 358 – 367.
- Ballard, A., & Blessing, L. (2006). Organizational socialization through employee orientations at North Carolina State Universities libraries. *College & Research Libraries*, 67(3), 204 – 248.
- Balls, P. (2009). Phenomenology in nursing research: Methodology, interviewing, and transcribing. *Nursing Times*, 102(32), 30 – 32.
- Benner, P. (2001). *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Commemorative edition. Upper Saddle River New Jersey: Prentice Hall.
- Benner, P., Hooper-Kyriakidis, P., & Stannard D. (1999). *Clinical Wisdom and Interventions in Critical Care*. Philadelphia: Saunders.
- Beyea, S. C., Slattery, M.J, von Reyn, L.J., (2010) Outcomes of a simulation-based nurse residency program. *Clinical Simulation in Nursing*, 6(5). 169-75.

- Block, V., & Sredl, D. (2006). Nursing education and professional practice: A collaborative approach to enhance retention. *Journal for Nurses in Staff Development, 22*(1), 23 – 28.
- Boyle, D. K., Popkess-Vawter, S., & Taunton, R. L. (1996). Socialization of new graduate nurses in critical care. *Heart & Lung, 25*(2), 141 – 154.
- Boyle, D.K., Bott, M.J., Hansen, H.E., Woods, C.Q., & Taunton, R.L. (1999). Managers' leadership and critical care nurses' intent to stay. *American Journal of Critical Care, 8*(6), 367 – 371.
- Brennan, G., & McSherry, R. (2007). Exploring the transition and professional socialization from health care assistant to student nurse. *Nurse Education in Practice, 7*(4), 206 – 214.
- Broussard, L. (2006). Understanding qualitative research: A school nurse perspective. *The Journal of School Nursing, 22*(4), 212 – 218.
- Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2016-17 Edition*, Registered Nurses, on the Internet at <https://www.bls.gov/ooh/healthcare/registered-nurses.htm> (visited April 07, 2017).
- Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303 – 311.
- Cash, K. (1995). Benner and expertise in nursing: A critique. *International Journal of Nursing Studies, 32*(6). 527 – 534.
- Chang, Y. (2017). Benefits of being a healthy perfectionist. *Journal of Psychosocial Nursing, 55* (4). 22 – 28.

- Chen, H.C., Chu, C.I., Wang, Y.H., & Lin, L. C. (2006). Turnover factors revisited: A longitudinal study of Taiwan-based staff nurses. *International Journal of Nursing Studies*, 45(2), 277 – 285.
- Christmas, K. (2008). How work environment impacts retention. *Nursing Economics*, 26(5), 316 - 318.
- Cochran, C. (2017). Effectiveness and best practice of nurse residency programs: A literature review. *MED-SURG Nursing*, 26(1). 53-64.
- Cochran, C. (2017). Effectiveness and best practice of nurse residency programs: a literature review. *MEDSURG Nursing*, 26(1). 53-63.
- Commission on Collegiate Nursing Education. (2008). *The Standards for Accreditation for Post-Baccalaureate Nurse Residency Programs*. AACN. Retrieved from <http://www.aacnnursing.org/CCNE-Accreditation>.
- Cooper-Thomas, H. D., & Anderson, N. (2005). Organizational socialization: A field study into socialization success. *International Journal of Selection and Assessment*, 13(2), 116-128.
- Crepaz-Keay. (2017). Peer support in community settings: getting back to our roots. *Mental Health & Social Inclusion*, 21(3). 184-190.
- Crimlisk, J.T., Grande, M.M., Krisciunass, G.P., Costello. K.V., Fernandes, E.G., & Griffin, M. (2017). Nurse residency program designed for a large cohort of new graduate nurses: Implementation and outcomes. *MED-SURG Nursing* 26(2). 93 – 104.

- Crist, J.D. & Tanner, C.A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing Research*, 52(3), 202 – 205.
- Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *Journal of Nursing Education*, 42(10), 437 – 443.
- de Oliveira, L.B., Rueda-Diaz, L.J., Carbogim, F.C., Rodrigues, A.R.B., Puschel, V.A.A. (2016). Effectiveness of teaching strategies on the development of critical thinking in undergraduate nursing students: a meta-analysis. *Journal of School of Nursing*, 50(2). 350-359.
- de Witt, L., & Ploeg, J. (2006). Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advance Nursing*, 55(2), 215 – 229.
- Dinmohammadi, M., Peyrovi, H., & Mehrdad, N. (2013). Concept analysis of professional socialization in nursing. *Nursing Forum*, 48(1). 26-34
- Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International Journal of Nursing Studies*, 44(1), 131 – 142.
- Dracup, K., & Bryan-Brown, C.W. (2004). From novice to expert to mentor: Shaping the future. *American Journal of Critical Care*, 13(6), 448 – 450.
- Draucker, C. B. (1999). The critique of Heideggerian hermeneutical nursing research. *Journal of Advance Nursing*, 30(2), 360 – 373.
- Drew, N. (2008). The primacy of Intersubjectivity. *Advances in Nursing Science*, 31(1), E74 – E80.

- Duchscher, J. E. B., & Cowin, L. S. (2004). The experience of marginalization in new nursing graduates. *Nursing Outlook*, 52(6), 289 – 296.
- Duchscher, J.B. & Myrick, F. (2008). Prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum*, 43(4). 191 – 206.
- Duffield, C.M., Roche, M.A., Homer, C., Bucham, J., & Dimitrelis, S. (2014).A comparative view of nurse turnover rates and costs across countries. *Journal of Advance Nursing*, 70(12), 2703 – 2712.
- du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization and the development of a nursing identity among nursing students at two universities in Brisbane Australia. *Journal of Advance Nursing*, 21(1), 164 – 171.
- Dyess, S. M., & Sherman, R.O. (2009). The first year of practice: New graduate nurses' transition and learning needs. *The Journal of Continuing Education In Nursing*, 40(9), 403 – 410.
- Earle, V. (2010). Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy*, 11(4), 286 – 296.
- Eckhardt, J. A. (2002). Effects of program design on the professional socialization of RN-BSN students. *Journal of Professional Nursing*, 18(3), 157-164.
- Edwards, D., Hawker, C., Carrier, J., Rees, C. (2015). A systematic review of the effectiveness of strategies and interventions to improve the transition from

- student to newly qualified nurse. *International Journal of Nursing Studies* 52(7).1254 – 1268.
- Emden, C. & Sandelowski, M. (1998). The good, the bad and the relative, part one: Conceptions of goodness in qualitative research. *International Journal of Nursing Practice* 4(4), 206 -212.
- English, I. (1993). Intuition as a function of the expert nurse: A critique of Benner's novice to expert model. *Journal of Advance Nursing*, 18(3). 387 – 393.
- Etheridge, S. A. (2007). Learning to think like a nurse: Stories from new graduates. *The Journal of Continuing Education*, 38(1), 24 – 30.
- Everett-Thomas, R., Valdes, B., Valdes, G.R., Shekhter, I., Fitzpatrick, M., Rosen, L.F., Arheart, K.L. & Birnbach, D.J. (2015). Using simulation technology to identify gaps between education and practice among new graduate nurses. *The Journal of Continuing Education in Nursing*, 46 (1)34 – 40.
- Faulk, D. R., Parker, F. M., & Morris, A. H. (2010). Reforming perspectives: MSN graduates' knowledge, attitudes, and awareness of self-transformation. *International Journal of Education Scholarship*, 7(1), Article 24.
- Ferrari, E. (2006). Issues of phenomenology for an undergraduate nursing dissertation. *British Journal of Nursing*, 15(3), 131 – 133.
- Fink, R., Krugman, M., Casey, K., Goode, C. (2008). The graduate nurse experience. Qualitative Residency Program Outcomes. *Journal of Nursing Administration*, 38(7/8) 341-348.



- Flood, A. (2010). Understanding phenomenology. *Nurse Researcher*, 17(2), 7 – 15.
- Gangstra, K., (2015). Nurse against nurse: Horizontal bullying in the nursing profession. *Journal of Healthcare Management* 60 (4) 249 – 257.
- Gelling, L (2015). *Qualitative research. Nursing Standard*, 29(30) 43 – 47.
- Gill, B., Deagan, E., & McNett, M. (2010). Expectations, perceptions, and satisfaction of graduate nurses. *Journal for Nurses in Staff Development*, 26(2), E11 – E17.
- Gobet, F. & Chassy, P. (2008). Towards an alternative to Benner's theory of expert intuition in nursing: A discussion paper. *International Journal of Nursing Studies*, 45 (9), 129 – 139.
- Goode C.J., & Williams, C.A. (2004). Post-baccalaureate nurse residency program. *Journal of Nursing Administration*, 34(2), 71 – 77.
- Griffin, A. E. C., Colella, A., & Goparaju, S. (2000). Newcomer and organizational socialization tactics: An interactionist perspective. *Human Resource Management Review*, 10(4), 453 – 474.
- Gruman, J. A., Saks, A. M., & Zweig, D. I. (2006). Organizational socialization tactics and newcomer proactive behaviors: An integrative study. *Journal of Vocational Behavior*, 69(1), 90 – 104.
- Halfer, D., & Graf, E. (2006). Graduate nurse perceptions of the work experience. *Nursing Economic\$,* 24(4), 150-155.

- Halfer, D., Graf, E., & Sullivan, C. (2008). The organizational impact of a new graduate pediatric nurse mentoring program. *Nursing Economic\$, 26(4)*, 243-249.
- Hansen, J. (2014). Nursing residency programs: Why now? *Journal for Nurses in Professional Development, 30(1)*, 47 – 48.
- Hart, Z.P., & Miller V.D. (2005). Context and message content during organizational socialization: A research note. *Human Communication Research, 31(2)*, 295 – 309.
- Hart, Z.P., Miller, V. D., & Johnson, J. R. (2003). Socialization, resocialization, and communication relationships in the context of organizational change. *Communication Studies, 54(4)*, 483-495.
- Heidegger, M. (1962). *Being and Time* (J. Macquarrie & E. Robinson, Trans.). Chicago: HarperOne (Original work published 1926).
- Hopkins, J.L. & Bromely, G.E. (2015). Preparing new graduates for interprofessional teamwork: Effectiveness of a nurse residency program. *Journal of Continuing Education in Nursing, 47(3)* 140 – 148.
- Institute of Medicine (2004), *Keeping Patients Safe: Transforming the work Environment of Nurses*. Washington DC: National Academies Press.
- Institute of Medicine (2010). *The Future of Nursing: Leading Change, Advancing Health*.
- Kaddoura, M. (2010), New graduate nurses' perceptions of the effects of clinical simulation on their critical thinking. *Journal of Continuing Education in Nursing, 41(11)*. 506-516.

- Keller, J.L., Meekins, K., & Summers, B.L. (2006). Pearls and pitfalls of a new graduate academic residency program. *Journal of Nursing Administration*, 36(12), 589 – 598.
- Kelly, J., & Ahern, K. (2008). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing*, 18(6), 910 – 918.
- Klein, H. J., Fan, J., & Preacher, K. J. (2006). The effects of early socialization experiences on content mastery and outcomes: A meditational approach. *Journal of Vocational Behavior*, 68(1), 96 – 115.
- Klingbeil, C., Schiffman, R., Ziebert, C., Totka, J.P., Schmitt, C.A., Doyle, L., Stelter, A., V. Stonek, A.V., Ke, W., Johnson, N. (2016). Transition of Experienced and New Graduate Nurses to a Pediatric Hospital. *Journal for Nurses in Professional Development* (32) 4, 198-204.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advance Nursing*, 21(5), 827 – 836.
- Komaratat, S. & Oumtanee, A. (2009). Using a mentorship model to prepare newly graduated nurses for competency. *Journal of Continuing education in Nursing*, 40(10). 475-480.
- Kovner, C. T., Brewer, C. S., Fairchild, S., Poornima, S., Kim, H., & Djukic, M. (2007). Newly licensed RNs' characteristics, work attitudes, and intentions to work. *American Journal of Nursing*, 107(9), 58 – 69.

- Kovner, C.T., Djukic, M., Fatehi, F.K., Fletcher, J. Jun, J., Brewer, C. Chaacko, T. (2016). Estimating and preventing hospital internal turnover of newly licensed nurses: A panel survey. *International Journal of Nursing Studies* 60 (2016) 251–262.
- Kramer, M. (1974). *Reality Shock*. St. Louis: C. V. Mosby Company.
- Kramer, M., Halfer, D., Maguire, P., Schmalenberg, C. (2012). Impact of healthy work environments and multistage nurse residency programs on retention of newly licensed RNs. *Journal of Nursing Administration*, 42(3). 148 – 159.
- Krozek, C. (2008). The new graduate RN residency: win/win/win for nurses, hospitals and patients. *Nurse Leader*, 6(5). 40-44.
- Krugman, M., Bretschneider, J., Horn, P.B., Krsek, C.A., Moutafis, .A. & Smith, M.O. (2006). The national post-baccalaureate graduate nurse residency program: A model for excellence in transition to practice. *Journal for Nurses in Staff Development*, 22(4), 196 – 205.
- Laschinger, H.K.S., Cummings, G., Leiter, M., Wong, C., MacPhee, M., Ritchie, J., Wolff A., Regan S., Bruning A.R., Jeffs, L., Young-Ritchie, C., Grinspun D., et al. (2017). Starting Out: A time-lagged study of new graduate nurses' transition to practice. *International Journal of Nursing Studies* 57 (5) 82–95
- Laverty, S.M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3).

- Lavoie – Tremblay, M., Viens, C., Forcier, M., Labrosse, N., Laliberte, D., & Lebeuf, M. (2002). How to facilitate the orientation of new nurses into the workplace. *Journal for Nurses in Staff Development*, 18(2), 80 – 85.
- Leonard, V.W. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.) *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness*. (pp.43 – 63). London: Sage Publications.
- Letourneau R., M. & Fater, K.H. (2015). Nurse residency programs: An integrative review of the literature. *Nursing Education Perspectives*, 36(2), 96-101.
- Li, Y. & Jones, C.B. (2013). A literature review of nursing turnover costs. *Journal of Nursing Management*, 21(3).405 – 418.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Inquiry*. Beverly Hills CA: Sage
- Lopez, K.A., & Willis, D.G.(2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726 – 735.
- Magill, F.N. (1990). *Masterpieces of World Philosophy*. New York: Harper Collins.
- Marin, K.A., & Rotondo, E.K. (2017). Rumination and self-reflection in stress narratives and relations to psychological functioning. *Memory*, 25 (1).
- McConnell-Henry, T., Chapman, Y., & Francis, K. (2011). Member checking and Heideggerian phenomenology: A redundant component. *Nurse Researcher*, 18(2), 28 – 37.

- McKenna, L., Brooks, I., & Vanderheide, R. (2017). Graduate entry nurses' initial perspectives on nursing: Content analysis of open-ended survey questions. *Nurse Education Today, 49*(2), 22-26.
- Merton R. (1957) *Social Theory and Social Structure*. Free Press,
- Mitus, J.S. (2006). Organizational socialization from a content perspective and its effect on the affective commitment of newly hired rehabilitation counselors. *Journal of Rehabilitation, 72*(2), 12 -20.
- Munhall, P.L. (2007). *Nursing Research: A Qualitative Perspective*. Boston: Jones and Bartlett Publishers.
- Mooney, M. (2007). Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nursing Practice, 13*(2), 75 – 80.
- Nesler, M. S., Hanner, M. B., Melburg, V., & McGowan, S. (2001). Professional socialization of baccalaureate nursing students: Can students in distance nursing programs become socialized? *Journal of Nursing Education, 40*(7), 293 – 302.
- Newhouse, R. P., Hoffman, J. J., Sulflita, J., & Hairston, D. P. (2007). Evaluating an innovative program to improve new graduate nurse socialization into acute healthcare setting. *Nurse Administrator Quarterly, 31*(1), 50 – 60.
- Paley, J. (1996). Intuition and expertise: Comments on the Benner debate. *Journal of Advance Nursing, 23*. 665 – 671.
- Parsons, K. (2010). Exploring how Heideggerian philosophy underpins phenomenological research. *Nurse Researcher, 17*(4), 60 – 69.

- Perry, B. (2009). Being an exemplary role model: It begins with an optimistic attitude. *Journal of Nurses in Staff Development*, 25(5), 242 – 248.
- Pittman, P., Herrera, C., Bass, E. & Thompson, P. (2013). Residency programs for new nurse graduates: How widespread are they and what are the primary obstacles to future adoption? *The Journal of Nursing Administration*, 42(11) 597 – 602.
- Price, S. L. (2009). Becoming a nurse: A meta study of early professional socialization and career choice in nursing. *Journal of Advance Nursing*, 65(1), 11 – 19.
- Rantanen, A., Pitkänen, A., Paimensalo-Karell, I., Elovainio, M., Aalto, P., (2016). Two models of nursing practice: a comparative study of motivational characteristics, work satisfaction and stress. *Journal of Nursing Management*, 24(2): 261-270.
- Rashotte, J., & Thomas, M. (2002). Incorporating educational theory into critical care orientation. *The Journal of Continuing Education in Nursing*, 33(3), 131 – 137.
- Reddish, M. V., & Kaplan, L. J. (2007). When are new graduate nurses competent in the intensive care unit? *Critical Care Nurse Quarterly*, 30(3), 199 – 205.
- Reece, S., Cooke, C., Polivka, B., Clark, P. (2016). Relationship between mock code results on medical-surgical units, unit variables, and RN responder variables. *MED-SURG Nursing*, 25(5). 335 – 340.

- Reinsvold, S. (2008). Nursing residency: reversing the cycle of new graduate turnover. *Imprint* 56(1). 25 – 29.
- Reising, D. L. (2002). Early socialization of new critical care nurses. *American Journal of Critical Care Nursing*, 11(1), 19 – 26.
- Richards, L. & Morse, J.M. (2007). *A User's Guide to Qualitative Methods*. 2<sup>nd</sup> ed. London: Sage Publications.
- Rodwell, J. & Demir, D. (2012). Psychological consequences of bullying for hospitals and aged care homes. *International Nursing Review*, 59(4).
- Rush, K.L., Adamack, M., Gordon, J., Lilly, M. & Janke, R. (2013). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies*, 50, 345–356
- Ruth-Sahd, L.A. & Hendy, H.M. (2005). Predictors of novice nurse use of intuition to guide patient care decisions. *Journal of Nursing Education*, 44(10), 450 – 458.
- Ryan, F., Coughlan, M., Cronin, P. (2007). Step-by-step guide to critiquing research. Part 2: qualitative research. *British Journal of Nursing*, 16(12). 738-744.
- Saks, A.M., & Ashforth, B. E. (1997). Socialization tactics and newcomer information acquisition. *International Journal of Selection and Assessment*, 5(1), 48 – 61.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27 – 37.



- Santucci, J. (2004). Facilitating the transition into nursing practice: Concepts and strategies for mentoring new graduates. *Journal for Nurses in Staff Development, 20*(6), 274 – 284.
- Seron, C., Silbey, S.S., Cech, E., & Rubineau, B. (2015). Persistence is cultural: Professional socialization and the reproduction of sex segregation. *Work and Occupations, 43*(2). 178 – 214.
- Shipman, D (2014). The lived experience of transitioning to a new graduate nurse following a pre-licensure hospital-based externship experience. Dissertation. ProQuest.
- Smedley, A. M. (2008). Becoming and being a preceptor: A phenomenological study. *The Journal of Continuing Education in Nursing, 39*(4), 185 – 191.
- Spetz, J., Harless, D., Herrera, C., & Mark, B. (2013). Using minimum nurse staffing regulations to measure the relationship between nursing and hospital quality of care. *Medical Care Research and Review, 70*(4), 380–399
- Speziale, H.J.S., Streubert, H.J., Carpenter, D.R. (2011) *Qualitative research in Nursing*. Lippincott, Williams & Wilkins: Philadelphia.
- Spoelstra, S. L., & Robbins, L. B. (2010). A qualitative study of role transition from RN to APN. *International Journal of Nursing Education Scholarship, 7*(1), Article 20.
- Stasser, P.B. (2005). Competency-based occupational health nurse orientation. *AAOHN Journal, 53*(8), 337 – 339.

- Taylor, H. R., Wescott, E., & Bartlett, H. P. (2001). Measuring the socialization of graduate and diplomate nurses using the Corwin role orientation scale. *Journal of Advance Nursing*, 33(1), 20 – 28.
- Theisen, J. L., & Sandau, K.E. (2013). Competency of new graduate nurses: A review of their weaknesses and strengths for success. *The Journal of Continuing Education in Nursing*, 44(9). 406-414.
- Thomka, L. A. (2001). Graduate nurses' experiences of interactions with professional nursing staff during transition to the professional role. *The Journal of Continuing Education in Nursing*, 32(1), 15 – 19.
- Trowler, P.R., & Knight, P.T. (1999). Organizational socialization and induction in universities: Re-conceptualizing theory and practice. *Higher Education*, 37(2), 177 – 195.
- Tuttle, M. (2002). A review and critique of Van Maanen and Schein's "Toward a theory of organizational socialization" and implications for human resource development. *Human Resource Development Review*, 1(1), 66 – 90.
- Van der Zalm, J.E., & Bergum, V. (2000). Hermeneutic-phenomenology: Providing living knowledge for nursing practice. *Journal of Advance Nursing*, 31(1), 211 – 218.
- Van Manen, M. (1990). *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. Albany, New York: State University of New York Press.

- Van Maanen, J.,(1976). *Handbook of Work, Organization, and Society*. Chicago: Rand McNally College Publishing Company.
- Van Maanen, J., & Schein, E. (1979). *Toward a Theory of Organizational Socialization*. Greenwich Connecticut: JAI Press Inc.
- Vivilaki, V., Johnson, M. (2008). Research philosophy and Socrates: Rediscovering the birth of phenomenology. *Nurse Researcher*, 16, 84 – 92.
- Walker, W. (2007). Ethical considerations in phenomenological research. *Nurse Researcher*, 14(3), 36 – 45.
- Wareing, L. (2011). Workplace mentor support for foundation degree students: A hermeneutic phenomenological study. *Journal of Clinical Nursing*, 20(3-4), 545-554.
- White, A., Brannan, J., & Wilson, C.B. (2010). A mentor-protégé program for new faculty, part 1: Stories of protégées. *Journal of Nursing Education*, 49(11), 601 – 607.
- Whitehead, L. (2004). Enhancing the quality of hermeneutic research: Decision trail. *Journal of Advance Nursing*, 45(5), 512 – 518.
- Wilson, J.L. (2016) an exploration of bullying behaviors in nursing: A review of the literature. *British Journal of Nursing*, 25(6). 303-306.
- Woodall, T. (2000). Clinical expertise: A realistic entity or a phenomenological fantasy? *Journal of Neonatal Nursing*, 6(1), 21 – 25.
- Wu, D., Luo, Y., Xinyu, L. (2017). Correlation between critical thinking disposition and mental self-supporting ability in nursing undergraduates: A cross-

sectional descriptive study. *The Journal of Nursing Research*, 25 (1). 68-75.

Xiaowei, S., Brinthead, T., & McCree, M. (2017) Understanding the influence of self-critical, self-managing, and self- assessing self-talk on performance outcomes in a public speaking context. *Imagination, Cognition and Personality*, 36(4). 356 – 378.

Yu, M. & Kang, K.J. (2016) Factors affecting turnover intention for new graduate nurses in three transition periods for job and work environment satisfaction. *Journal of Continuing Education in Nursing*, 47(3). 120 – 131.

Zinsmeister, L. B., & Schafer, D. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development*, 25(1), 28 – 34.

## CURRICULUM VITAE

Jennifer J Hostutler

### Licensures and Certifications:

	<b>Type of Licensure or Certification</b>	<b>Licensing or Certifying Organization</b>
Current Licensure Type and State	RN OHIO	Ohio Board of Nursing
Current Certification	CS-BC	American Nurse Credentialing Center
	CCRN	American Association of Critical Care Nurses
	ACLS	American Heart Association

### Education:

<b>Date of degree completion</b>	<b>Institution &amp; City, State</b>	<b>Degree</b>	<b>Major</b>
April 2018	Indiana University Indianapolis, Indiana	PhD	Major – Nursing Minor – Education Technology
May 1996	Kent State University Kent, Ohio	MSN	Nursing
December 1991	Kent State University Kent, Ohio	MPA	Public Administration
May 1985	University of Akron Akron, Ohio	BSN	Nursing

Full-time Professional Work Experience:

Dates of Employment	Institution & Job Responsibilities	Position
August 2017 to present	<p>Cleveland State University</p> <p>Coordinate and teach the senior level critical care lecture and sophomore level nursing theory class for the basic and accelerated BSN programs.</p> <p>Member of baccalaureate curriculum and evaluation committee.</p> <p>Member of baccalaureate course coordinator committee.</p> <p>Primary Investigator for "Palliative Care in the Critical Care Unit"</p>	Assistant Professor
June 2011 to June 2017	<p>Kent State University-Stark Campus</p> <p>Coordinate and teach the senior level critical care nursing class. Course responsibilities include:</p> <ul style="list-style-type: none"> <li>• Working with the clinical site to arrange for clinicals: ensuring site, state and federal requirements are met</li> <li>• Obtaining security clearance/access for students</li> <li>• Personal orientation to computer charting, medication administration procedures, equipment, and policies</li> <li>• Reserving rooms for pre and post conference</li> <li>• Maintaining site required documentation</li> <li>• Monitoring students during clinical experience <ul style="list-style-type: none"> <li>○ Making student assignments</li> <li>○ Assisting students to apply classroom discussion to clinical experiences</li> <li>○ Assisting students to develop critical thinking</li> <li>○ Monitoring and assisting with medication administration</li> <li>○ Monitoring and assisting with</li> </ul> </li> </ul>	Lecturer

	<p>procedures and treatments</p> <ul style="list-style-type: none"> <li>• Coordination with other critical care instructors</li> <li>• Review and selection of new textbook</li> <li>• Preparation of all lectures, exams and simulations</li> <li>• Delivery of all lectures, exams and partial simulations</li> <li>•</li> </ul>	
August 2010 to May 2011	<p>Ahuja Medical Center</p> <p>Developed/created education department for new hospital.</p> <p>Developed and implemented on-boarding and orientation for all nursing staff.</p> <p>Developed and implemented quality improvement programs for the nursing units.</p> <p>Assisted with development of policies and procedures, process flows, and nursing standards.</p> <p>Provided ongoing educational support for nursing staff.</p> <p>Assisted with development of financial monitoring at unit level.</p> <p>Developed and implemented monthly Nursing Grand Rounds.</p> <p>Assisted with development of "Transition to Nursing Bridge Orientation Program".</p> <p>Key</p> <p>Member of committees planning for Stroke and Chest Pain Certification and Magnet Designation.</p>	Education Coordinator, CNS
January 2008 to August 2010	<p>Robinson Memorial Hospital</p> <p>Worked as a float RN in critical care division.</p> <p>Assisted with education and orientation programs.</p> <p>Coordinated research project on nurses' knowledge of heart failure.</p> <p>Served as interim director for 6 months.</p>	RN Interim Director, Telemetry and Critical Care

<p>June 2004 to March 2009</p>	<p>Akron General Medical Center</p> <p>Coordination of on-boarding and orientation for new employees in the nursing department.</p> <p>Ongoing support throughout orientation period of new nursing hires into the critical care areas.</p> <p>Coordination of education needs for management and staff in the ED, MICU/SICU, PACU, OR, hemodialysis, radiology and neuroscience units.</p> <p>Responsible for monitoring and evaluating on-going quality improvement programs in above units.</p> <p>Assisted with community outreach programs.</p> <p>Assist with employee incentive programs.</p> <p>Key member of committees responsible for successful Joint Commission Accreditation and Chest Pain Center and Stroke Certifications.</p> <p>Leader in the hospital-wide implementation of Relationship-Based-Nursing.</p> <p>Lead unit-based research projects and developed unit-based evidence-based-practice opportunities in critical care units.</p> <p>Developed and implemented Certification Study programs.</p>	<p>RN Instructor/ CNS</p>
<p>June 2001 to present</p>	<p>Eagle Education</p> <p>Provide continuing education for health care professionals in the form of self-study modules and seminars. Also provide staff development services for institutions and disease management programs for patients and families. Assist in development of marketing programs as well as community outreach programs.</p>	<p>Executive Director</p>
<p>August 1996 to May 2001</p>	<p>The University of Akron</p> <p>Courses taught - Critical Care, Nursing of the Older Adult, Senior Practicum and</p>	<p>Visiting Professor</p>



	<p>Leadership. Responsibilities included instruction in lecture, seminar, learning lab and clinical; student advising; interaction with area hospitals for integration of clinical experiences. Committee responsibilities included: junior and senior level committees, chair of Undergraduate Curriculum Committee, co-chair Sophomore Revision Committee.</p>	
<p>May 1990 to April 1997</p>	<p>Summa Health System</p> <p>Staff nurse coverage in the Critical Care Division. Primary duties included assisting the Administrative Director of Critical Care. Special projects have included: coordinating and preparing the operating and capital budget for the critical care division, maintaining on-going analysis of budget variances and developing corrective plans, revising the policy and procedure manual for emergency department, revising the performance appraisals for managers and nurses, implementing a new product capital equipment evaluation process, standardizing equipment between St. Thomas and City Hospitals, assisting in implementing a chest pain center and patient classification system in the emergency department, assisting in the implementation of unit-based quality improvement, assisting in development of the nursing senate, assisting in project enhancement teams and redesign projects, assisting in the development and implementation of leadership training for the management staff, and ongoing staff development services, completion and publication of research project on patient satisfaction in the emergency department.</p>	<p>Special Projects Coordinator - RN</p>
<p>May 1989 to May 1990</p>	<p>Cleveland Clinic Foundation</p> <p>Staff RN in the Neurosurgical Intensive Care Unit</p>	<p>RN</p>

August 1985 to May 1989	Akron General Medical Center Clinician I in the Intensive Care and Coronary Care Units. Served on Policy and Procedure Committee and Unit Councils.	RN-Clinician I
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Part-time Professional work experience:

Dates of Employment	Institution & job Responsibilities	Position
September 2011 to present	Affinity Medical Center Critical Care RN, CNS Educator Assist with education and training of nursing staff	CNS/RN
September 2004 to May 2006	Malone College Instructor in the School of Nursing. Courses taught: Critical Care, Junior Level Medical-Surgical Course, Leadership, Senior Practicum and Research	Instructor
September 2003 to December 2003	The University of Akron Clinical instructor for junior level med-surg class	Clinical Instructor
January 2003 to May 2003	Faculty- Kent State University Clinical instructor for sophomore med-surg class.	Clinical Instructor
Summer 1991 Summer 1992	Sea World of Ohio Arura Ohio Provided first-aid treatment to sick or injured employees and guests, maintained employee medical files and performed employee health screenings, taught CPR, first aid and water safety. Assisted in maintaining Occupational Health and Safety Administration (OHSA) compliance.	RN

July 1990 to December 1990	Meridia Heart Institute Helped to implement a nationwide five-year heart attack risk study in the Cleveland area	Internship
November 2001 to July 2003	Hospice Care Center/Visiting Nurse Worked with hospice patients in the care center and in the home care settings	RN
May 1998 to December 2000	Akron General Medical Center Staff nurse - per diem float	RN
July 1997 to August 1998	Mercy Medical Center Staff nurse- critical care per diem float pool	RN

Honors and Awards:

Date	Name of award/recognition	Institution/Organization Name, Location
December 1993	Induction: Sigma Theta Tau	Nursing Honor Society Delta Omega Chapter
Spring 2014	Nominated: Distinguished Teacher Award	Kent State University Stark Campus
Spring 2016	Induction: Golden Key International Honour Society	International Honor Society

Unfunded Research:

A Comparison of Patients' and Nurses' Perceptions of Patient Needs and Satisfaction in the Emergency Department – completed February 1998

Preceptors Experience with New Graduate RNs in the ICU research site:

Cleveland Clinic Foundation – completed May 2011

POST: Measurement Tool for Cardiac Intervention Patients – research site:

Akron General Medical Center

Nurses Knowledge of Heart Failure research site – Robinson Memorial Hospital

Socialization of New Graduate RNs into the Critical Care Setting ongoing –

Dissertation at Indiana University School of Nursing

Peer Reviewed Publications:

Hostutler, J.J. (1996). A better way to select medical equipment *Nursing*

*Management*, 27(6). 32M to 32P.

Hostutler, J.J., Taft, S.H., Snyder C. (1999), "Patient needs in the emergency

department: Nurses' and patients' perceptions" *Journal of Nursing*

*Administration*, 29 (1). 43 – 50.

Non-Peer Reviewed Publications

Hostutler, J., Kennedy, MS., Mason, D. Schorr, TM. (1999). Nurses as leaders;

then and now. American Journal of Nursing, 99(10), 36 – 38.

Hostutler, J., Kennedy, MS., Mason, D. Schorr, TM. (1999). Nurses as leaders;

then and now. American Journal of Nursing, 99(12), 36 – 38.

Hostutler, J., Kennedy, MS., Mason, D. Schorr, TM. (2000). Nurses as leaders; then and now. American Journal of Nursing, 00(2), 34 – 36.

Hostutler, J.J. (2000). Cosmetic Surgery and the Elderly. Aging. Salem Press

Professional Presentations:

How to Form a Graduate Student Organization

NAGPS National Conference, March 1989

Norman University; Oklahoma City, Oklahoma

Legislative Updates"

NAGPS Midwest Regional Conference, November 1991

Southern Illinois University; Carbondale, Illinois

Health Care Reform and Nursing

Graduate Research Colloquium, April 1994

Kent State University; Kent, Ohio

Getting Started in Research

Sigma Theta Tau Research Day, May 1995

Youngstown State University; Youngstown, Ohio

## Research in the Clinical Setting

Nursing Research Day, November, 1995

Summa Health System; Akron, Ohio

## Comparison of Nurses' and Patients' Perception of Patient Needs and Satisfaction in the Emergency Department

MNRS Research Conference, April, 1996

Detroit, Michigan

## Comparison of Nurses' and Patients' Perception of Patient Needs and Satisfaction in the Emergency Department

Sigma Theta Tau Research Day, April 1996

University of Akron; Akron, Ohio

## Understanding Fluid and Electrolyte Balance

Seminar for Eagle Education, Summer 2001

## Understanding Pain and Pain Management

Seminar for Eagle Education, Summer 2001

## Geriatric Emergencies

Dallas, Texas. Primedia Education, August 2001

## Critical Discussions

Tallmadge, Ohio End of Life Seminar March 2015