

The current global shortage of nurses is unprecedented, with demands for full-time nursing professionals growing faster than the rate at which new nurses are graduating from educational institutions (Barney, 2002; Purnell, Horner, Gonzale & Westman, 2001; Shields, 2004). The challenge of replacing nurses who have left the workplace, and a desire for knowledge about the resources required to support those just entering it are motivating healthcare institutions and nursing leaders to explore exactly what constitutes a quality work environment (Buerhaus et al., 2007; Coomber & Barriball, 2006; Lin & Liang, 2007; May, Bazzoll & Gerland, 2006). Growing rates of seasoned nurse attrition are resulting in the replacement of highly competent and experienced practitioners with newly graduated nurses (NGs) who have neither the practice expertise nor the confidence to navigate a clinical environment burdened by escalating levels of patient acuity and subsequent nursing workload intensity (Roberts & Farrell, 2003; Taylor, 2002). Compounding this human resource management crisis is evidence of a disorientating, discouraging and ultimately exhausting initial work experience for young nurses that is resulting in high levels of NG burnout within 18 months of their introduction to professional practice (Cho, Laschinger & Wong, 2006; Laschinger & Leiter, 2006).

This paper presents the results of a research study that revealed a staged experience of transition occurring over the initial 12 months of an introduction to professional practice for NGs. Inherent within this initial role transition were processes that progressed these novice practitioners through increasing levels of knowledge and broadening scopes of practice, and contributed to the ongoing development of their personal and professional selves. It is intended that the model of transition stages offered here be used as a guide by clinical educators, unit managers and hospital administrators who are recruiting, orientating, mentoring and seeking to successfully integrate this newest generation of nurses into their workplace.

Background to the Research

The experience of *transition* for the NG entering professional practice, while not completely separate from the constructs of *socialization* and *professionalization*, is differentiated here as the process of making a significant adjustment to changing personal and professional roles at the start of one's nursing career. Understood in the context of this research, transition for the NG consists of a nonlinear experience that moves the new practitioner through personal and professional, intellectual and emotive, skill and role relationship changes and contains within it experiences, meanings and expectations. While it is reasonable to presume an individualized and thus peculiar nature to the experience of NG transition, the first 12 months of work experience encompass a complex but relatively predictable array of emotional, intellectual, physical, sociocultural and developmental issues that in turn feed a progressive and sequential pattern of personal and professional evolution.

This research employed a generic qualitative approach of interpretive inquiry, using foundational knowledge on the NG's introduction to the workplace to frame an exploration of the process of transition that occurs over the first 12 months of practice. Fourteen female graduates who originated out of the same 4-year baccalaureate undergraduate nursing program were purposefully selected from two major cities in Canada. Research strategies included a demographic survey at the start of the research, six face-to-face interviews at 1-3-6-9-12-18 month periods followed, in the initial two cases, by focus groups with a different set of participants located in the second major city, preinterview questionnaires requesting the completion of a process-revealing exercise such as letter writing, collage construction or picture drawing, monthly journals and ongoing email communication with all participants over the 18 months.

Conceptual Framework of Transition Stages

Transitions have been defined as passages or movements from one state, condition or place to another "which can produce profound alterations in the lives of individuals and their significant others and have important implications for well-being and health" (Schumacher &

Meleis, 1994, p.119). The process of transition to professional practice in nursing graduates has been reported most notably in the work of Marlene Kramer (1974). According to Kramer, the experience of role transformation from student to staff nurse evolves in a fairly predictable pattern, moving the novice from an initial *honeymoon* phase where graduates are excited and exhilarated at having arrived at a long-awaited goal, through a *shocking* assault on their professional values that leaves them disorientated and disillusioned, through to the *recovery* and *resolution* phases earmarked by a return of a sense of balance (Kramer & Schmalenberg, 1978).

Dearmun (2000), Duchscher (2001), Ellerton and Gregor (2003), and Kelly (1998) provide the next level of formalized analysis of NG transition stages that informed this author's research. Remarkably similar thematic conclusions were presented that reflected the prior workings of Bridges (1991), Kramer (1974) and Benner (1984). Dearmun and Duchscher both claimed that the initial 3 months of NG transition is consumed by an adjustment to new roles and responsibilities, an acceptance of the differences between the theoretical orientation of their education and the practical focus of their professional work, and the NGs' integration into an environment that emphasizes teamwork as opposed to individually-based care provision. A further finding was that a significant change in the graduates' perception of their experience is noted at approximately 5-7 months, propelling them to yet another stage of greater consolidation and meaning making (Duchscher). In all of the research reviewed on NG transition stages, varying degrees of attention were paid to the emotional impact of the transition on the NG and its significance to the NG's ability to advance through the stages. With the exception of some of Kramer's work in the 1960s, none of the studies mentioned above have formally acknowledged the significance of either developmental or sociocultural origins to, nor physical expressions of role transition stress for NGs. Finally, few studies since Kramer have distilled out the nuances of the transition experience at various stages or sought to clarify the relationship of the stages of growth and change in the NG to the passage of time.

Several remaining authors have more peripherally enhanced our understanding of the phases and stages of transition for the NG (Brown, 1999; Casey, Fink, Krugman & Propst, 2004; Chang & Hancock, 2003; Goh & Watt, 2003; Ross & Clifford, 2002; Schoessler & Waldo, 2006; Tiffany, 1992). Issues commonly cited as troublesome for NGs at various points in time throughout the initial 12 months relate to a lack of clinical knowledge and confidence in skill performance, relationships with colleagues, workload demands, organization and prioritization as they relate to decision making and direct-care judgments, and communicating with physicians. While many of these studies measured or identified particular concerns at points in time (e.g., scheduled testing by instrument, interview or focus group), few gave insight into what aspects precipitated their occurrence or supported their presence, precisely when the issues originated, or what factors may have impeded or mediated the resolution of those issues. The *Stages of Transition Model* © that resulted from this research is inextricably linked to the author's 10 year history of study and research in the area of the new nurse's professional role transition. The intent of this particular arm of the author's grounded theory research program was to further examine, build upon and mature aspects of the NG's transition experience into acute care such that an accurate overall representation of this experience and the processes encompassed within could be confidently introduced into the scholarly community.

Stages of Transition

The initial 12 months of transition to professional acute-care practice for the graduates of this study was a process of *becoming*. Both a personal and professional journey, participants evolved through the stages of *doing*, *being* and *knowing*. The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. While this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. Further to this, data manifested ongoing, but

transient regressions precipitated by the introduction of new events, relational circumstances and unfamiliar or complex practice situations or contexts into the graduates' assumed location on the transition continuum that is represented by the stages model presented here.

Doing

The initial period of professional role transition for these acute-care nurses encompassed approximately the first 3-4 months of the study. All participants had undergone a period of orientation prior to the study commencement and were working > 50% maximum hours on varying acute adult and pediatric medical surgical units in different hospitals, as well as one who worked in a neonatal intensive care unit. The majority had been hired into temporary part-time or casual positions but were working full-time hours, and 30% of the participants were shared (e.g., float position) between 2-5 different units on an ongoing basis. None had yet written their RN qualifying examinations and all were therefore working under the probationary title of Graduate Nurse. The initial transition from a structured life that was known, relatively predictable and often mastered into a new set of expectations and responsibilities that were at best semifamiliar but not fully understood posed numerous challenges to both their personal and professional selves. While initially curious and excited to tackle the challenge of managing the transition from student to professionally practicing nurse, the participants quickly realized that they were quite unprepared for the responsibility and the functional workload of their new roles:

It's strange. I don't really feel like I am finished school. Like I walked to work one morning and as I was walking, I was thinking, "I'm getting paid to do this," because it's like I was still in school. And then, within my orientation week I was told that the staff had just run off this nurse who wasn't doing very well. They told me that they had made it so miserable for her that she would leave....and I think they were proud of it – that they had gotten rid of her. I think its maybe to maintain quality control but it's definitely one of my fears that I won't be accepted. That if I am failing they won't come along side me, but will show me the door.

The vast majority of these NGs entered their professional transition with expectations and anticipations that were more idealistic than they were realistic. Not uncommonly, they blamed the

shocking disparities between what they had anticipated regarding their roles as nurses, and what they were being expected to do in the “real” world on their lack of educational preparation. Even when asked, none of the participants at this stage had considered the culpability of their workplaces in failing to prepare them for, or gradually introduce them to the roles and responsibilities of a fully practicing nurse. They readily identified surprise at the intense and heavy workload of ward nurses, struggled with the non-nursing duties they were expected to assume, and ultimately expressed disappointment at the low value placed on their contribution to assigned units and nursing’s contribution to institutional operations in general.

This first stage of entry into professional practice was marked by a tremendous intensity, range, and fluctuation of emotions as graduates worked through the processes of discovering, learning, performing, concealing, adjusting and accommodating. Within several weeks of being hired, these novices were afforded full patient loads equal to their senior nursing counterparts, but without reasonable access to expert counsel or practice support. None of the participants in this study was formally mentored, and the clear majority went from “buddy” experiences to full responsibility without graduated progression.

The discovery that all was not as they had expected it would be sent the NGs of this study into a flurry of learning and subsequent performing. Understanding what was expected of them, doing it well, and completing their tasks on time was their primary concern. The reasoning behind this focus became clearer upon hearing that numerous graduates were chastised by select senior coworkers on the unit, or called at home after their shift because of something they had forgotten to do. Uncertain of who they could trust with their profound vulnerabilities, and driven by an understandable but impressive need to belong, these graduates went to great lengths to disguise their emotions from colleagues and worked to conceal any feelings of inadequacy.

Because so much of what they were experiencing was new to them, the functional learning curve that dominated this stage of transition was steep for all participants. As a result,

what had in many become a solid professional identity by the end of their undergraduate years was fracturing under the weight of performance anxiety and self-doubt; these graduates felt stressed “about absolutely everything.” The new practitioners’ adequate and sometimes advanced entry level skill and knowledge were constantly challenged by their wavering confidence, their limited experience with the application of that skill and knowledge, and a lack of predictability of and familiarity with the many variations in clinical contexts. The relentless requests to assist with, or perform procedures for which the graduate had little or no reference caused significant levels of anxiety. Yet again, these situations posed a high level of risk to graduates of being exposed as incompetent and subsequently reducing their credibility in the eyes of their colleagues.

During this initial stage of their transition, the new nurses in this study felt able to reasonably manage a workload that consisted of a nurse-patient ratio of less than 1:8 but were often left caring for anywhere between 8-16 adult patients without consistent support from another Licensed Practical Nurse (LPN) or RN. High levels of stress were associated with: caring for patients who were clinically unstable; being expected to multitask (i.e., answering phones, speaking with physicians, processing orders, dealing with multiple patient and family issues concurrently) while providing direct care to patients (i.e., starting IVs, dispensing medications, performing dressing changes); caring for patients who were critically ill or dying; or dealing with families who had numerous questions or demands. Many examples were given of graduates whose need to intently focus on every detail of their role prevented them from hearing or seeing much of what was going on around them. As a result, graduates universally expressed anxieties around “missing something” or inadvertently and unintentionally bringing harm to someone under their care as a result of their ignorance or inexperience.

Not uncommonly, participants’ descriptions of clinical situations exposed a prescriptive approach to their thinking. One participant suggested that this early practical application of their knowledge was akin to “being in a private little bubble and things are going on all around me and

I cannot hear them, I cannot see them.” The limits to their problem-solving and subsequent clinical judgments were not surprising, given that they had never actually seen or had an opportunity to work through many of the scenarios they were being presented with. Strategies to manage complex clinical scenarios seemed unavailable to their minds that were consumed with completing tasks and routines within the rigid timeframes imposed by the structure of the units where they worked. It was understood that failure to adjust to or comply with existing routines could garner exclusive attention; an outcome that conflicted with the developmental task of “fitting in” to their dominant professional culture.

Contributing to their stress was the expectation that they would delegate appropriate tasks and responsibilities to other licensed and non-licensed personnel, many of whom were older in age and far advanced in clinical experience and practice seniority to them. Further to this, participants found themselves frustrated by what they perceived as archaic ways of thinking about nursing by some of their more senior colleagues, and expressed disappointment regarding the rigid and distracting allocation to their role of non-nursing tasks. While these graduates felt the immediate need to accommodate “what” was being practiced without asking “why,” they would later identify these issues as primary factors contributing to their lack of professional fulfillment in an acute-care nursing role:

I was so focused on knowing the routine, knowing what I’m doing, getting things done, knowing the way different nurses like things done, knowing where I fit in, what I’m supposed to be doing, when I’m supposed to be doing it. I had total tunnel vision. I was just focused on getting the job done and getting out of there on time. Then I would go home and I would feel guilty for not being more.

It is important to mention that during this stage of their transition, the graduates’ overall energy was being necessarily divided between the demanding professional adjustments cited above and parallel, but no less significant sociocultural and developmental changes occurring in their broader lives. These young women were experiencing varying but nonetheless acute changes to established life-pattern routines such as changed living arrangements, terminated or advanced

intimate relationships, and the acquisition of unprecedented debt through the purchase of cars and homes; all serving as both exciting distractions and unexpected burdens. Concurrently, these normally high-spirited young nurses were adjusting to intimidating levels of clinical responsibility, navigating new professional associations while struggling to let go of long-standing personal relationships that no longer fit with their evolving selves, seeking acceptance into a tradition-bound and hierarchical nursing culture, and adjusting to the physical demands of intensive, alternating and sometimes unpredictable or inflexible day/night shift schedules. It was in the context of undergoing this tremendous inventory of developmental change that these nurses were making advanced clinical judgments and practice decisions for which they felt minimally qualified and completely responsible. They were exceptionally hard on themselves when they felt they had failed to identify or appropriately intervene in a changing clinical situation regardless of competing demands. Further to this, in spite of the fact that many of the situations in which they were placed were beyond their intellectual or practical capability, their behavior was consistently self-deprecating.

Being

The next 4-5 months of the NGs' postorientation (PO) transition experience was marked by a consistent and rapid advancement in their thinking, knowledge level and skill competency. Concurrently, this stage sparked disconcerting doubt in the participants regarding their professional identity by challenging pregraduate notions of nursing and exposing the inconsistencies and inadequacies in the healthcare system. As one participant articulated:

The reason I'm finding this part of the transition to be the most difficult is because the excitement about being done and the shock that I was in has worn off. I feel as though I'm on a raft that is drifting farther and farther away from the shore (my safety net of being a student or a new grad). And I'm floating toward an island where the experienced nurses are but I keep losing sight of them due to all the waves.

The high degree of frustration and subsequent energy consumption that characterized the prior stage of their transition continued at a slower, but nonetheless relentless pace. To cope with the ongoing drain on their resources, many of these graduates sought refuge in their personal lives, separating themselves from their work environment (e.g., refusing overtime) and putting a distance between themselves and their colleagues (e.g., choosing to forego staff functions). Fundamental to this stage was an increased awareness of themselves professionally, an exploration of the role of the nurse relative to other healthcare professionals, and a fundamental search for balance between their personal and professional lives. During the initial half of this stage (between 3-5 months PO) the participants became increasingly comfortable with their roles and responsibilities as nurses. This comfort permitted them, during the latter half of this stage, to begin a concerted examination of the underlying rationale for nursing and medical interventions and the appropriateness and effectiveness of the healthcare system. Scrutinizing the practice context and its relationship to the graduates' professional role aspirations would take on more importance during the final stage of their transition. During the course of this second stage, the participants would disengage, question, search, reveal, recover, accept and ultimately re-engage in their chosen career; the difference was that this time it would be on their terms.

As one participant suggested, the initial segment of this second stage found these nurses "caught up in a turn." There was awareness that something was different but they would spend several months struggling with the changes brought about by their commitment to become a "real" nurse. They grieved the loss of what had been while not entirely sure they were ready for the leap into what was. Many questioned why they had left the comforts of their established school routine only to expose themselves to a daily onslaught of daunting responsibility that left them feeling perpetually incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless. This downward spiral motivated a protective withdrawal from their surroundings as they attempted to recover a sense of control over their lives. They expressed a strong desire for

clinical placements that offered them stable patient situations and several of the participants changed to casual employment status so that they could choose the hours they would be required to work. Most had tired of the constant “newness” and were looking to escape the barrage of learning, growing and changing; they wanted to be surrounded by familiarity, consistency and predictability.

Participants’ sense of self-trust was tenuous during the initial phase of this stage and many sought validation for their decision-making and clinical judgments from senior coworkers whose level of practice they respected and admired. Unlike the first transition stage, where they required more prescriptive directives about what should be done in particular clinical situations, participants were now expressing more of a desire for clarification and confirmation of their own thinking and acting. Knowing they could make decisions and implement nursing actions that were not only safe and appropriate, but astute, was important to their wavering confidence. Not uncommonly, during the initial several months of this second stage (approximately 3-6 months PO) graduates were placed in leadership positions (e.g., put in charge of units, students, or made responsible for orientating new staff) that they consistently deemed as inappropriate and unsafe. A relatively disturbing finding was the frequency with which the graduates were placed in clinical situations beyond their clinical competence, cognitive or experiential comfort level. Over 30% of participants with less than 5 months of experience were either requested to go to, or simply assigned shifts in an observation unit. All of them expressed significant discomfort at these requests, though the majority felt either too new to make demands about their placements or interpreted the appeals for advanced responsibility as a statement of confidence in their abilities, making it difficult to refuse the requests.

The start of this stage was a delicate time for the NGs as the desire to both hold on and let go were equally strong leaving them conflicted, confused and sending discordant messages to those around them. Concurrently, these NGs identified overly vigilant supervision of their

practice as a display of doubt in their abilities, while at once expressing feelings of abandonment when left without experienced nurses to reach out to in situations that were unfamiliar, unexpected or unstable. The peak of this struggle for most in the study occurred at around 5-7 months when a crisis of confidence, mitigated by the intersection of insecurities regarding their practice competency and their fear of failing their patients, colleagues and themselves motivated a renewed commitment to maturing their practice that would carry them through the next several months. Over the course of the remainder of the second stage the graduates would find more middle ground, claiming less often that “the good days are great and the bad days are horrible”; an increasingly moderate perspective on their professional experiences became evident. Having been previously frustrated by their perceived lack of progress, the graduates relaxed into a more comfortable space that permitted the mild angst that came with what they did not know to coexist with the growing confidence in what they did know.

An essential element to the NGs recovery during the latter part of this stage was the time they spent reacquainting themselves with personal aspirations that had been subverted to the consuming process of their professional growth. Less cognitive, physical and emotional energy was needed to manage the now familiar nursing procedures and clinical situations. Participants required less energy to debrief about work, affording them more time to adjust to and accept the changes to their personal and work-life schedules and enjoy their new-found liberation. Within several months (i.e., at approximately 6-8 months PO) a rejuvenated spirit would reawaken a tempered interest in learning that would have them starting to seek out challenges to their thinking, putting themselves in new and unfamiliar practice situations and planning more long-term career pathway options.

Knowing

The third and final stage of the new graduates’ initial 12 months of practice was focused on achieving a separateness that both distinguished them from the established practitioners

around them and permitted them to reunite with their larger community as professionals in their own right. Dialogue revealed that the majority of graduates harbored some apprehension about moving out of the learner role into one which they believed would hold greater expectations and a reduced margin of error allowance. During this final stage of their initial professional role transition experience graduates continued the recovery they had started during their second stage. Some participants were experiencing a shift in their primary supportive relationships from non-nursing pregraduate friends and family members to coworkers and nursing colleagues, while others were crystallizing intimate relationships through engagements and weddings. There was a sense, particularly during the initial months of this final stage that the graduates just wanted to coast; they were content to “get up and go to work and come home to my life.... my eyes and ears are open, but my mouth is closed.” Especially toward the latter half of this stage, increasing time would be spent exploring and critiquing their new professional landscape and graduates would begin to take notice of the more troubling aspects of their sociocultural and political environments.

While participants identified themselves as only moderately stressed at both the 9 and 12 month study time periods, the factors contributing to their level of stress had changed from their individual capacity to cope with their roles and responsibilities to frustrations in dealing with the system (i.e., institution or healthcare) at large. An overwhelming majority of the participants offered disconcerting descriptions of nurses as “being at the bottom” of the hierarchy of authority and power. A growing discontent with what they perceived as professional devaluing would culminate in yet another, though much less dramatic reduction in their momentum. For many, this served as the point of origin in their search for professional fulfillment outside of their existing acute-care bedside role.

By the 12th month study marker all graduates had reached a relatively stable level of comfort and confidence with their roles, responsibilities and routines. Many spent time

“comparing” their practical skill level and cognitive prowess with the newest graduates entering their clinical environments, making mention of the differences they noticed between themselves and their new graduate colleagues:

Perhaps I noticed such a difference because I reported off to a new grad. And the contrast between our reactions is what made me realize I have changed. I watched as her eyes became bigger and bigger as I gave report. She almost started panicking before I was even done and stated she felt really overwhelmed. I remember exactly how she felt, but I was surprised (and relieved) that I no longer felt this way about work.

Further to this, being able to answer questions rather than simply ask them, and being able to assist others with their workloads were both identified as notable signs of their progress. Several participants suggested that these changes were attributed to advancements in their organization and prioritization, while others claimed that “all of a sudden you look back and its like how did I get from there to here, because it’s gradual and it happens without your realizing it.” As another participant stated, “you know it could be exactly the same scenarios but my ability to cope has changed,” illuminating the grounded perspective expressed by the whole of the study group at this final stage.

Discussion and Recommendations

Bridges (1991) claimed that prior to embarking on a transitional process individuals must recognize in themselves a need for change. This “defining moment” for the NGs of this study was dually *developmental*, because many of them were experiencing total and independent responsibility for their lives for the first time, and *situational* as they explored the new dimensions of their professional roles separate from being students. These young professionals generally have limited practical nursing experience, lack social and developmental maturity and struggle with basic clinical and work management skills such as communicating with and delegating to others and balancing time with responsibilities and tasks.

What has been demonstrated by the model presented here is that the measures undertaken to address the issues inherent in the NG's initial period of introduction to professional practice are sensitive to time and the relative position of the NG on the continuum of his or her individual transition experience. As outlined above, new graduates begin with a rather prescriptive and linear approach to both their thinking and their practice (Duchscher, 2003). While they are adjusting to changing roles, routines, responsibilities and relationships NGs require all their energy and focus for each separate task at hand (e.g., giving medications, speaking with physicians, performing a dressing change). As Benner (1982) so clearly articulated, "the heart of the difficulty that the novice faces is the inability to use discretionary judgment" (p. 403), which mitigates against a successful linear application of theory to clinical practice. The limited capacity for multitasking and the challenge inherent in higher-order decision-making that requires the melding of variant sources and levels of information-complexity make functioning in the dynamic environment of acute care exceedingly difficult for the NG (Ferguson & Day, 2004; Roberts & Farrell, 2003; Taylor, 2002). Allowances should be made for a reduced workload and the NG should be given dependable access to a consistent seasoned clinical colleague who is also afforded work relief, who is being compensated for and educated about their advanced leadership role, and with whom the NG has a trusting relationship. It is unreasonable to expect undergraduate educational institutions to prepare graduates to competently perform all of the skills required by a contemporary acute-care workplace. It is therefore essential that during their orientation period NGs be allowed to repeatedly practice the multitude of nursing and transfer of function skills required by their transitioning unit. Supernumerary staffing arrangements allow the NG to take advantage of the varying needs by staff for the performance of skills in a range of clinical situations. The novice can then perform and further learn required skills under the watchful eye and skillful preceptoring of many different clinical experts while serving to offset the unit workload. This inadvertently cultivates an environment of teamwork amongst the staff and satisfies the much sought after sense of belonging for the NG.

Prolonged orientation periods (12-24 weeks) that are grounded in a balance of classroom theory and clinical practice wean the graduate into the rigors of being a fully responsible and accountable professional practitioner (Cowan & Duchscher, 2007). Graduates require consistency, predictability, stability and familiarity in their initial clinical practice situations for at least the first 4 months. Floating NGs between more than two units, expecting NGs to orientate students and other new staff, implementing rapid-turnover shift schedules for graduates or requiring them to work excessive overtime, putting new hires in charge of units, or rotating inexperienced nurses into high-acuity observation subunits are all practices that should be avoided during the initial stages of professional role transition as they may contribute to an unsafe environment for patients and staff.

As graduates advance through the stages of transition, their needs necessarily change. During the second stage of transition, the NGs of this study had in many ways advanced through Benner's (1982) novice level of competence and into the stage of an advanced beginner. In general, the NGs' comfort with the routines of their unit and their familiarity with roles and responsibilities that have been established by virtue of the experience they have gained over the initial months of their transition serve as a foundation from which they can draw to both predict and respond to presenting situations. While the graduate will likely be comfortable with more common events that consist of stable client presentations and consistent relationships and expectations, placing graduates in complex and rapidly changing situations may illicit feelings of "terror in which they recognize that they are in over their heads and lose all capacity to plan or act" (Benner, p. 57). What is needed at this point in the transition experience is a process whereby graduates can be permitted to relax and enjoy their hard-earned comfort level while being challenged to slowly advance their thinking and practice within the safe confines of a mentored relationship.

After approximately six months of graduated and facilitated clinical learning, the graduate is ready to be introduced to more unstable patient populations (e.g., step-down or observation

units) assuming the close availability of seasoned staff (e.g., not scheduled as the sole nurse in high-acuity units or left alone during breaks without readily accessible clinical back-up). At this point, NGs should be assisted in making, and taking responsibility for increasingly complex decisions and judgments related to changing patient situations with the coaching of advanced clinicians. Advancing the graduate beyond their capacity (e.g., ACLS, Charge Nurse Training) would be easy to do at this stage, but could prove counterproductive in the long run. These new professionals have been through a significant growth experience and need time, particularly during the initial several months of the second stage of transition (4-6 months) to recover their sense of balance and restore their depleted energy reserves. Encouraging the graduate to pursue personal enhancement activities and “settle” their lives outside of nursing will set the stage for a more longterm commitment by the graduates to their work environment.

During the final stage of transition (8-12 months) the graduate maintains a variable tension between a contented enjoyment of his or her work and the inherent tendency toward mobility and career advancement that is characteristic of this generation (Duchscher & Cowin, 2004). Mentors and managers working with NGs would be well-served to join with them in formulating a two and 5-year career trajectory that addresses their most immediate plans and supports, both educationally and organizationally, their projected professional aspirations. It is in this stage that NGs are seeking to establish a separateness that both distinguishes them from and permits them to unite with the practitioners in their larger community and develop a sense of agency that permits them to see the potential for and process of making sustainable change within a bureaucratic system (Benner, Tanner & Chesla, 1996; Pask, 2003). The awakening of this insight should be part of the evolving relationship between a mentor and a more senior graduate and considered a healthy, essential step in the NGs sociodevelopmental maturity.

New graduates will likely express some discontentment about the encroachment of work on their personal lives; a concern that may be exacerbated if the NGs did not receive reasonable support early in their transition. Experiences of being restrained in the enactment of their

professional role, growing frustration with the apparent complicity of their colleagues to the improprieties of the practice environment, and the feelings of powerlessness that these issues may engender in NGs should be considered a natural part of their professional development. It is possible that the deleterious influence of these factors on the NG's sense of agency may be muted by opportunities to actualize some form of change in the unit or the institution during the latter half of this stage (10-12 months). Having an institutional or region-wide, rather than a unit-based approach to advancing the career pathway of a NG, and being open to challenge and change at all levels of the organization are not only desirable attributes of the contemporary workplace but may well determine the recruitment and retention capacity of all future health human resource institutions.

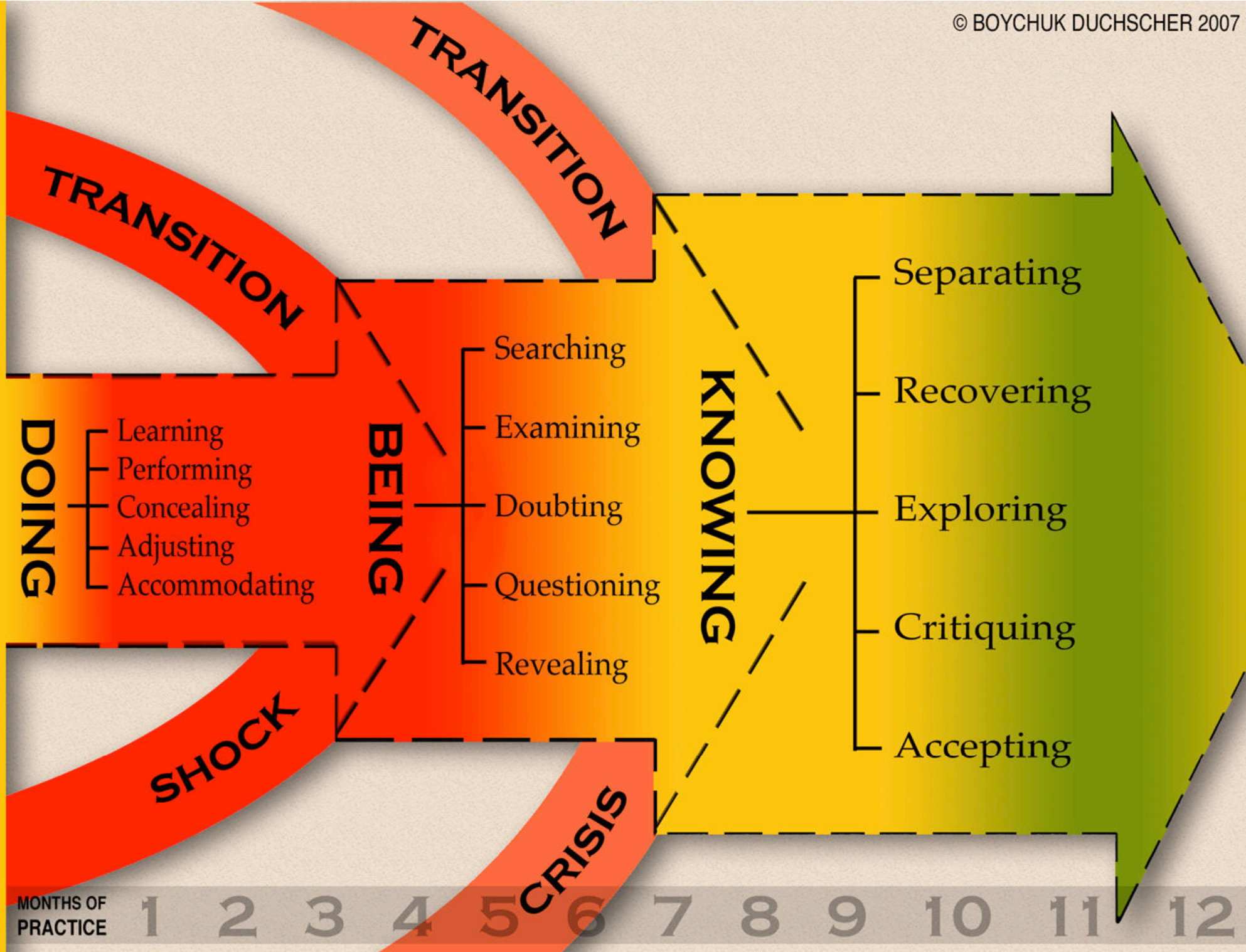
References

- Barney, S.M. (2002) The nursing shortage: Why is it happening? *Journal of Healthcare Management, 47*(3), 153-155.
- Benner, P. (1982). From novice to expert. *American Journal of Nursing, March*, 402-407.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley Publishing.
- Benner, P.A., Tanner, C.A., & Chesla, C.A. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer Publishing Company.
- Bridges, W. (1991). *Managing transitions: Making the most of change*. Reading, MA: Addison-Wesley.
- Brown, P.L. (1999). Graduate nurses: What do they expect? *Kansas Nurse, 74*(5), 4-5.
- Buerhaus, P.I., Donelan, K., Ulrich, B.T., Norman, L., DesRoches, C., & Dittus, R. (2007). Impact of the nurse shortage on hospital patient care: Comparative perspectives. *Health Affairs, 6*(3), 853-862.
- Casey, K., Fink, R., Krugman, M. & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6): 303-311.
- Chang, E., & Hancock, K. (2003). Role stress and role ambiguity in new nursing graduates in Australia. *Nursing and Health Sciences, 5*, 155-163.
- Cho, J., Laschinger, H.K.S., & Wong, C. (2006). Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Nursing Leadership, 19*(3), 43-60).
- Coomber, B., & Barriball, K.L. (2006). Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. *International Journal of Nursing Studies, 44*, 297-314.

- Cowin, L., & Duchscher, J.E.B. (2008). Transitional programs. In Chang, E. and Daly, J.,(Eds) *Transitions in Nursing: Preparing for Professional Practice (2nd ed)*. NSW, Australia: Elsevier Australia.
- Dearmun, A.K. (2000). Supporting newly qualified staff nurses: The lecturer practitioner contribution. *Journal of Nursing Management*, 8, 159-165.
- Duchscher, J.E.B. (2001). Out in the real world: Newly graduated nurses in acute care speak out. *Journal of Nursing Administration*, 31(9), 426-439.
- Duchscher, J.E.B. (2003). Critical thinking: Perceptions of newly graduated female baccalaureate nurses. *Journal of Nursing Education*, 42(1), 1-12.
- Duchscher, J.E.B., & Cowin, L. (2004). Multigenerational nurses in the workplace. *Journal of Nursing Administration*, 34(11), 493-501.
- Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *Journal of Continuing Nursing Education*, 34(3), 103-107.
- Ferguson, L.M., & Day, R.A. (2004). Supporting new nurses in evidence-based practice. *Journal of Nursing Administration*, 34(11), 490-492.
- Goh, K., & Watt, E. (2003). From 'dependent on' to 'depended on': the experience of transition from student to registered nurse in a private hospital graduate program. *Australian Journal of Advanced Nursing*. 21(1): 14-20.
- Kelly, B. (1998). Preserving moral integrity: A follow-up study with new graduate nurses. *Journal of Advanced Nursing*, 28(5), 1134-1145.
- Kramer, M. (1974). *Reality shock: Why nurses leave nursing*. St. Louis: C.V.Mosby Company.
- Kramer, M., & Schmalenberg, C. (1978). *Bicultural training and new graduate role transformation*. Wakefield, MA: Contemporary Publishing, Inc.
- Laschinger, H.K.S., & Leiter, M.P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/engagement. *Journal of Nursing Administration*, 36(5), 259-267.

- Lin, L., & Liang, B.A. (2007). Addressing the nursing work environment to promote patient safety. *Nursing Forum*, 42(1), 20-29.
- May, J.H., Bazzoll, G.J., & Gerland, A.M. (2006). Hospitals' responses to nurse staffing shortages. *Health Affairs*, 25, w316-w323.
- Purnell, M.J., Horner, D., Gonzalez, J., & Westman, N. (2001). The nursing shortage: Revisioning the future. *Journal of Nursing Administration*, 31(4), 179-181.
- Roberts, K., & Farrell, G. (2003). Expectations and perceptions of graduates' performance at the start and at the end of their graduate year. *Collegian*, 10(2), 13-18.
- Ross, H., & Clifford, K. (2002). Research as a catalyst for change: The transition from student to Registered Nurse. *Journal of Clinical Nursing*, 11, 545-553.
- Schumacher, K.L., & Meleis, A.I. (1994). Transitions: A central concept in nursing. *IMAGE: Journal of Nursing Scholarship*, 26, 119-127.
- Schoessler, M., & Waldo, M. (2006). The first 18 months in practice: A developmental transition model for the newly graduated nurse. *Journal for Nurses in Staff Development*, 22(2), 47-52.
- Shields, M. & Wilkins, K. (2006). *Findings from the 2005 national survey of the work and health of nurses*. Statistics Canada: Ottawa, ON.
- Taylor, C. (2002). Assessing patient's needs: Does the same information guide expert and novice nurses? *International Nursing Review*, 49, 11-19.
- Tiffany, J.C. (1992). What to expect from your first year of nursing practice. *NSNA Imprint*, 39(1), 33-37.

O
R
I
E
N
T
A
T
I
O
N



- DOING**
- Learning
 - Performing
 - Concealing
 - Adjusting
 - Accommodating

- BEING**
- Searching
 - Examining
 - Doubting
 - Questioning
 - Revealing

- KNOWING**
- Separating
 - Recovering
 - Exploring
 - Critiquing
 - Accepting

MONTHS OF PRACTICE 1 2 3 4 5 6 7 8 9 10 11 12

TRANSITION STAGES MODEL