

## THEORETICAL PAPER

## Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses

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doi: 10.1111/j.1365-2648.2008.04898.x**Abstract****Title.** Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses.**Aim.** The aim of this paper is to provide a theoretical framework of the initial role transition for newly graduated nurses who assist managers, educators and seasoned practitioners to support and facilitate this professional adjustment appropriately.**Background.** The theory of *Transition Shock* presented here builds on Kramer's work by outlining how the contemporary new graduate engaging in a professional practice role for the first time is confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural changes that are expressions of, and mitigating factors within the experience of transition.**Data sources.** This paper offers cumulative knowledge gained from a programme of research spanning the last 10 years and four qualitative studies on new graduates' transition.**Discussion.** New nurses often identify their initial professional adjustment in terms of the feelings of anxiety, insecurity, inadequacy and instability it produces. The *Transition Shock*© theory offered focuses on the aspects of the new graduate's roles, responsibilities, relationship and knowledge that both mediate the intensity and duration of the transition experience and qualify the early stage of professional role transition for the new nursing graduate.**Conclusion.** Transition shock reinforces the need for preparatory theory about role transition for senior nursing students and the critical importance of bridging undergraduate educational curricula with escalating workplace expectations. The goal of such knowledge is the successful integration of new nursing professionals into the stressful and highly dynamic context of professional practice.**Keywords:** acute care, adaptation, new graduates Registered Nurses, professional practice, reality shock, transition shock

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## Introduction

These are challenging times for new nursing graduates (NGs), the majority of whom make their initial transition to professional practice within the hospital environment. It has been claimed that <50% of practising nurses would currently recommend nursing as a career option (Heinrich 2001), while 25% would 'actively discourage someone from going into nursing' (Baumann *et al.* 2004, p. 13). It is not surprising, then, that 33–61% of new recruits in North America change their place of employment or plan to leave nursing altogether within their first year of professional practice (Dearmun 2000, Winter-Collins & McDaniel 2000, Advisory Committee on Health Human Resources 2002, Cowin 2002, Buchan & Calman 2004, Bowles & Candela 2005).

The importance of exploring the process of NG adaptation to professional practice in acute-care nursing relates to the ongoing challenge to healthcare institutions, schools of higher learning and policy-makers both to understand and respond to the issues that may be driving these energetic and motivated nurses out of acute care, or out of the nursing profession altogether. While it is clear that the journey of transition for the NG is often stressful, frustrating, discouraging and disillusioning, what remains unclear are the stages of that journey. *Transition shock* is presented here as the most immediate, acute and dramatic stage in the process of professional role adaptation for the NG. The design of this stage subsumes elements of transition theory, reality shock, cultural and acculturation shock, as well as theory related to professional role adaptation, growth and development, and change theory.

## Background

William Bridges (1980) begins his seminal dialogue on the concept of transition with this excerpt from *Alice in Wonderland*: "Who are you?" said the caterpillar... "I - I hardly know, Sir, just at present", Alice replied rather shyly, "at least I know who I was when I got up this morning, but I think I must have been changed several times since then"

(Carroll 1967, p. 47). Illustrated so poignantly here, transition represents that 'confusing nowhere of in-betweenness'

(Bridges 1980, p. 5) that serves as the channel between what was and what is. The 'in-between ness' that is the initial transition from student to professional practitioner is the subject of this paper.

The experience of transition to professional practice for the NG has been most notably and historically studied by Kramer (1974), who coined the term *reality shock* to

describe the discovery that school-bred values conflicted with work-world values. Disturbing discrepancies between what graduates understand about nursing from their education and what they experience in the 'real' world of healthcare service delivery leaves NGs with a sense of groundlessness (Duchscher 2001, 2003a, Delaney 2003). Once in the hospital environment, the new nurse is immersed in a firmly entrenched, distinctively symbolic and hierarchical culture that exposes them to dominant normative behaviours that have been described as prescriptive, intellectually oppressive and cognitively restrictive (Kramer 1966, Crowe 1994, Duchscher 2001). Mohr (1995) claimed that the hospital environment moves NGs away from the ideal of professional nursing practice adopted by them in their educational socialization process, and towards a more productivity, efficiency and achievement-oriented context that emphasizes institutionally imposed social goals. Resulting role ambiguity and the internal conflict that it precipitates have been cited as turning the creative energy of these new nurses into job dissatisfaction and career disillusionment (Gerrish 2000, Greenwood 2000, Winter-Collins & McDaniel 2000, Duchscher 2001, 2003a, Chang & Hancock 2003).

Existing knowledge suggests that NGs experience role performance stress, moral distress, discouragement and disillusionment during the initial months of their introduction to professional nursing practice in acute care. What remains less clear are the relationships between these experiences and the passage of time. While I found prior evidence on the experience of transition, no researchers seem to have extrapolated that knowledge to a formal framework for use in the development, implementation and evaluation of initiatives aimed at facilitating the NG transition. In my programme of research, I have sought to evolve further a substantive theory of role transition to professional nursing practice by distilling and distinguishing the salient, unavoidable and necessary aspects of transition into acute-care nursing from the more transient, context-related and yielding elements of transition for which support strategies can be effectively implemented.

## Data sources

The data sources culminating in the generation of this emerging theory originate from a 10-year programme of research encompassing four qualitative studies in the area of new graduate transition and an extensive literature review of the transition experience of the new NG. The initial study, conducted in 1998, consisted of a 6-month phenomenological exploration of five new nurses navigating their initial introduction to professional practice (Duchscher 2001,

2003a). The second study, conducted in 2001, extended over a period of 12 months and was an exploration of the experiences of four new graduates and five seasoned nurses. These graduates were studied as they integrated into an emergency room environment immediately after graduating from a Canadian undergraduate BScN nursing programme (Duchscher 2003b). The third study, conducted from November 2002 to November 2003, encompassed a retrospective analysis of qualitative data collected in a three-part Australian study examining graduate nurse self-concept and retention plans (Cowin & Hengstberger-Sims 2004). In the final study, I explored the transition journey of 15 newly graduated nurses over 18 months from June 2006 to December 2007 (Duchscher 2007). For this final study, I employed a generic qualitative approach to data collection (Sandelowski 2000, Caelli *et al.* 2003, Rolfe 2006), using a grounded theory process to guide the ongoing analysis and interpretation of the emerging data. Initial semi-structured interview templates were created for the 1, 3, 6, 9, 12 and 18-month data collection periods based on my previous programme of research on new graduate transition. These instruments were then modified as the data emerged. In addition, participants completed preinterview questionnaires and submitted monthly journals detailing their experiences. Finally, focused group discussions, informed and guided by prior interviews, journaling data and my ongoing study were conducted during identical time periods with a separate group of participants originating from the same nursing programme. A dynamic interplay between inductive and deductive processes permitted a fluid movement between data analysis and further data acquisition. Further to the research conducted, I have reviewed over 1000 publications related to new graduate transition, hospital nursing and trends in professional nursing practice, 387 of which have been directly related to the transition or integration of new nurses into work settings. The reviewed documents and publications were acquired from databases that included CINAHL Plus, Nursing and Allied Health Collection, MEDLINE® and PsycINFO.

## Discussion

### Experience of transition shock

Understood in the context of my research, the initial professional role transition of the NG consists of a non-linear process or journey that moves the new practitioner through developmental and professional, intellectual and emotive, skill and role-relationship changes, and contains within it experiences, meanings and expectations. Further to

this, the experience of transition is presumed to be influenced by developmental and experiential histories, and situational contexts that both prescribe and cultivate expectations about professional roles and responsibilities, work ethic and culture. The initial professional role transition experience of the NG is felt with varying intensity, is founded upon relatively predictable fundamental issues, and exists within individually motivated and fluctuating states of emotional, intellectual and physical well-being.

*Transition shock* emerged as the experience of moving from the known role of a student to the relatively less familiar role of professionally practising nurse. Important to this experience for the NG is the apparent contrast between the relationships, roles, responsibilities, knowledge and performance expectations required within the more familiar academic environment to those required in the professional practice setting (see *Transition Shock Model*© in Figure 1). For participants of this research, the experience of transition shock felt 'like I just jumped into the deep end of the pool'. Participants seemed ill-prepared for the toll this initial transition would take on both their personal energy and time and on their evolving professional self-concepts. Although they anticipated that some adjustments to their professional work situation would be necessary, prior to the transition they never doubted that their choice of career and the investment of the years of study that this required would be affirmed through a positive work experience: a welcoming collegial environment, a moderately challenging but easily achievable extension to the roles and responsibilities to which they had grown accustomed, the thrill of actualizing the professional role to which they had earned the title, and the fulfilment of being recognized for the knowledge they had acquired and the commitment they had made to caring for others.

Although this process was neither linear nor prescriptive, the personal and professional adjustments evolved and progressed most intensely through the first 1–4 months postorientation (the time after which workplace orientation processes and additional induction learning had taken place and after the new nurse had been teamed up with a senior qualified nurse for the purposes of learning expected routines, roles and responsibilities). At the termination of this postorientation period, the exhaustion and isolation that both fed and resulted from the disorienting, confusing and doubt-ridden chaos that represented their new-found reality motivated a deliberate withdrawal from the intensity of the shock period. The participant expressions of this transition shock experience are presented here as emotional, physical, socio-cultural and -developmental, and intellectual (see *Transition Conceptual Framework*© in Figure 2).



Figure 1 Transition Shock Model.

*Emotional*

The range, overwhelming intensity and labile nature of the emotions expressed by participants during this initial stage of transition was truly impressive. Using words and phrases or expressions such as ‘terrified’ and ‘scared to death’, these participants claimed that relentless anxieties were routine during those initial weeks. Although one might expect some trepidation concerning skill-level competence and the establishment of new collegial relationships in an NG professional, these data demonstrated that the stability, predictability, familiarity and consistency of both the introductory clinical experiences and the individuals with whom the graduates interacted significantly influenced their responses to the existing role transition stress. The majority of the graduates in this research could feel their anxiety ‘dancing on the edges of my words and memories’, displaying overwhelming, and at times physically and psychologically debilitating, levels of stress during the initial 1–4 months postorientation. This more traumatic adjustment often correlated with inadequate and insufficient functional and emotional support, lack of practice experience and confidence, insecurities in communicating and relating to new colleagues, loss of control over

and lack of support for the enactment of their professional practice values and anticipated roles, physical, emotional, and intellectual exhaustion, and unrealistic performance expectations by the institution, their colleagues and the graduates themselves.

Not uncommonly, participants described *dominant* nurses with whom they were required to interact as inadvertently challenging both the process and content of their practice foundation. At times, these challenges were perceived as intentionally seeking to diminish the already negligible level of confidence with which they were working. Conversely, some participants poignantly revealed the transforming capacity of both supportive statements and displays of acceptance by senior colleagues on the development of their evolving professional self-concept and on their ability to pass through the particular moment and keep going. Interestingly, several participants over the 10-year study period used the metaphor of *drowning* when both describing and visually representing the overwhelming experience of the first 1–2 months of transition. In the most recent study, startling pictures were drawn and collages designed that clearly illustrated the loss of control and

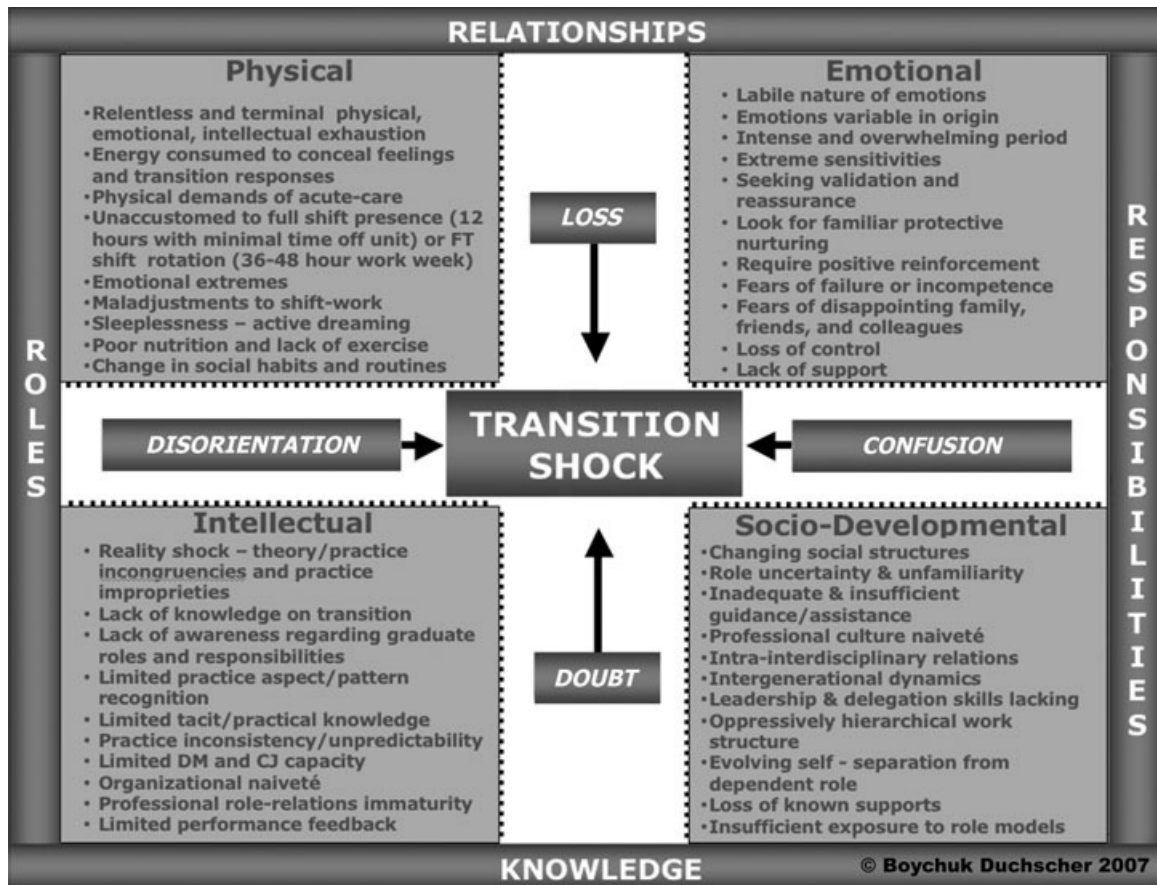


Figure 2 Transition Conceptual Framework©.

subsequent powerlessness associated with the transition shock experience.

The energy being consumed by their attempt to stabilize the emotional roller coaster on which they found themselves motivated a predictable but nevertheless remarkable exhaustion in all participants by the third to fourth month of transition. The primary fears for the new graduates during this stage of their transition were: (1) being 'exposed' as clinically incompetent, (2) failing to provide safe care to their patients and inadvertently hurting them and (3) not being able to cope with their designated roles and responsibilities. The dreaded outcome was rejection by their peers as valued and contributing members of the professional community. New graduates went to great lengths to disguise their feelings of inadequacy from their new-found and reverently esteemed colleagues.

The loss of the support system that the NGs employed during their undergraduate education was intensely felt. Not having immediate access to previous educators or peers to provide intellectual counsel, emotional support, or practice consultation and feedback potentiated the novice practitioners' feelings of isolation and self-doubt. Many of their new

graduate colleagues were working different shifts, were employed in other institutions, or had moved to rural or distant geographical locations. Access to a support network of peers and colleagues was identified as an important link to the ongoing professional development of those who had even minimal access to it, and sorely missed by those who did not. Finally, many graduates expressed struggles with maintaining the practice intentions and standards that they had consolidated during their education. The majority of NGs shared feelings of frustration and guilt about their inability to enact the practice principles they believed were a basic requirement of their professional role. There was a sense of culpability for the perpetuation of substandard practice that served as a powerful but insidious role transition de-stabilizer.

*Physical*

The physical response of the NGs to the transition shock experience was grounded in the all-encompassing energy being consumed just trying to perform in their new role at the level expected of them, without revealing how difficult

1 this was for them. Changes to established life-pattern rou-  
 2 tines such as modified living arrangements, terminated or  
 3 advancing intimate relationships, and the acquisition of debt  
 4 through the purchase of cars and homes served as both  
 5 exciting distractions and unexpected burdens to these  
 6 already disoriented graduates. In addition to undergoing  
 7 personal and developmental changes, these young profes-  
 8 sionals were being expected to make advanced clinical  
 9 judgments and practice decisions for which they felt mini-  
 10 mally qualified but completely responsible. The strain of this  
 11 new level of professional accountability was heightened  
 12 by unclear practice expectations from managers and  
 13 colleagues, inaccurate assumptions by the graduates of what  
 14 a 'successful' transition would look like, unanticipated role-  
 15 relationship struggles with colleagues, the physical demands  
 16 of adjusting to shift work, and a virtual absence of nor-  
 17 malizing feedback on which to base their experience and  
 18 their role transition progress. Fed by doubts and insecurities,  
 19 these new practitioners seemed unable to control the  
 20 relentless debriefing of their practice actions and decisions.  
 21 They all described spending their waking hours thinking  
 22 about what had transpired on their last shift and preparing  
 23 for what might happen on their next one. Sleep time was  
 24 consumed by dreams about work, bringing about a state of  
 25 'perpetual work' that contributed significantly to their  
 26 growing exhaustion.

### 27 *Sociocultural and developmental*

28 For the young adults in this research, the transition shock  
 29 experience was, in large part, about finding their way in a  
 30 world for which they had been prepared but were not wholly  
 31 ready. The disconnection between who they were as women  
 32 and young professionals and who they thought they were  
 33 supposed to be as nurses, the behaviours they witnessed in the  
 34 role models that surrounded them and how the realities of the  
 35 practice environment facilitated, supported, reinforced,  
 36 challenged or censored professional codes of behaviour  
 37 dominated this initial transition period. During the first  
 38 4 months, the primary sociocultural and -developmental  
 39 tasks for these new graduates appeared to be finding and  
 40 trusting their professional selves, distinguishing those selves  
 41 from the others around them, being accepted by the larger  
 42 professional nursing culture, balancing their personal lives  
 43 with their professional work, and finding a way to meld what  
 44 they had learned during their undergraduate education with  
 45 what they were seeing and doing in the 'real' world. Rela-  
 46 tionships with colleagues were critical forecasters of the  
 47 transition shock experience.

48  
 49 Functioning within a hypersensitive and self-critical state,  
 50 the graduates felt any and all tremors of disapproval,

disrespect or doubt as they did likewise of acceptance, praise  
 or simple encouragement. Regardless of the reasons, most  
 participants alluded in some way to a desire to be included in  
 the 'clique' that constituted the culture of their nursing unit.  
 All spoke of wanting, but not adequately receiving, both  
 affirming and critical feedback from either their senior  
 colleagues or those they perceived to be in an evaluative  
 role, such as managers and educators. In the absence of  
 formal feedback, these novice practitioners looked for other  
 indicators by which to measure the safety, competence and  
 relative progression of their practice. A strong theme during  
 the initial 4 months of their introduction to professional  
 practice was the evolution of a more mature, professional  
 sense of self. This developmental change was both exciting  
 and daunting to these young women, dictating modifications  
 to established relationships with friends and family, and  
 transforming the way in which they viewed themselves. A  
 number talked about 'growing up', and reflected on their  
 struggle to renounce the safety and security of a more  
 protected, comfortable routine and less responsible way of  
 life.

Graduates spent a good part of the initial transition period  
 trying to discern their nursing role in relation to others. It was  
 commonly asserted that 'being a student, you are doing all  
 the different roles, so that when you come out you're a little  
 bit confused'. During the initial several months, the NGs  
 found themselves distracted by the focus on tasks relative to  
 the other nursing responsibilities with which they associated  
 their professional role, such as patient advocacy, teaching  
 and counselling. An underdeveloped level of organization and  
 a desire to fit into the culture of the units where they worked  
 fostered a focus on completing their tasks 'on time' (e.g.  
 charting and other paperwork, answering phones, ordering  
 tests) rather than spending quality time with patients and  
 families.

Relating to other professionals within the clinical environ-  
 ment was an energy-consuming adjustment. Struggling with  
 moderate to low levels of self-confidence, these young nurses  
 found it intimidating and ultimately devaluing to interact  
 with both senior physicians and nurses whose behaviour  
 reinforced hierarchical rather than collegial relationships.  
 Many described an oppressive hierarchy amongst the nurs-  
 ing staff, and passive-aggressive styles of communication  
 between nurses and physicians. In a related finding, consid-  
 erable stress was involved in supervising, delegating and  
 providing direction to other licensed and non-licensed  
 personnel, many of whom were senior to the NGs in both  
 practice experience and age. The graduates claimed that they  
 had never been prepared to take on those roles or allowed to  
 practise them during their undergraduate education.

*Intellectual*

The introduction of the graduates to their new professional practice environment began with some form of orientation to the workplace, their nursing role and the context within which they would be practicing. During this early period, graduates maintained their high level of energy, eager and inspired by an exciting anticipation of finally being able to practise independently; being in a learning role was familiar to them and they held a curious fascination about what lay ahead. Most of the graduates identified this 'next step' as similar to the increase in challenge they had long experienced when moving from one student clinical rotation to another. Additional role expectations were interpreted as a more advanced conceptual application of that which they already knew and as similar to the graduated progression, which had been required of them as students from year to year. Still not feeling the full weight of their professional responsibilities or nursing workload during this orientation period, the clear majority of the study participants were shocked by the change they experienced once orientation was completed and they were 'on their own in the real world'. The experience was rapidly and abruptly transformed from one of excitement and wonder to one of overwhelming fear, doubt and all-consuming stress.

Some of the difficulty in making the switch from partial to full responsibility for these graduates lay in the approach of senior nurses, clinical educators and nurse managers to orientation. The majority appeared to have a limited understanding of the relative inflexibility of the NG practice capabilities and expected that they would be able to manage the workload of a seasoned practitioner within several weeks. Further to this, no one mentioned to these participants that they would experience a transition, nor accounted for that experience either in the content or process of their professional initiation. Many of the 'buddy' experiences (i.e. often two 12-hour days and two 12-hour nights where a seasoned nurse and NG are paired up with a common workload) were based on workload division rather than on a preceptor-based tacit knowledge-transfer model. The availability of and ongoing access to seasoned nursing practitioners varied considerably in this research. More often than not, graduates did not reach out to their senior counterparts because the workloads of the staff to whom they were expected to turn were as demanding as their own. The feeling that they were burdening these already-taxed practitioners, combined with the potential threat to their self-confidence and ultimate acceptance by their colleagues should they be exposed as ignorant or inexperienced, served as critical deterrents to their reaching out for assistance when they needed it.

Without exception, graduates who self-reported that they had secured an employment position within which they were

expected to relieve permanent staff on a variety of nursing units (i.e. *floating* or *casual relief* positions) described that experience as extending, intensifying or delaying progression through their transition experience, and they suggested that this work arrangement should not be considered when introducing NGs to professional practice. For the novice practitioner, 'it's like a new job every time you go somewhere new'. The primary issue related to floating was the lack of consistency in both the staff to whom the graduates looked for mentorship and collegial support, and the patients for whom they were caring. The influence of these inconsistencies was further aggravated by a lack of predictability in their assignments, which prevented them from anticipating and thus preparing for the unit-related issues, clinical knowledge expectations and practice requirements of the area to which they were going.

During the transition shock period, the new nurses were able to manage reasonably a workload that consisted of a nurse-patient ratio of less than 1:8, a relatively controlled, balanced and stable level of acuity in their patients, and practice assignments that gave them seasoned practitioner-assisted decision-making and clinical judgment. Several graduates claimed that they were 'slower' than their colleagues in making decisions and completing their daily routines. Much time was being spent 'thinking back' through what was for them relatively linear and prescriptive theory and instruction from previous undergraduate or current institutional educators. Frequent concerns were expressed about whether or not they were doing what was expected or what would be considered safe, and whether or not they would be able to notice that which was outside of the norm, given the intensity of their focus and the boundaries of their practice experience. A relatively disturbing finding from graduates going through this initial transition shock period was the frequency with which they expressed concern about being placed in clinical situations beyond their cognitive or experiential comfort level. Over 30% of those in the final study were either requested to go to or simply assigned shifts in an observation unit. Some spoke up, stating their discomfort and even identifying to the scheduler the perceived impropriety of such an assignment. Others felt either too new to make demands about their placements, or interpreted the work placement as a statement of confidence in their abilities, making it difficult to refuse the request.

**Implications for nursing**

The transition shock experienced by NGs when they enter practice as fully functioning professionals contributes to the

1 stress and strain of this initial socialization period. Building  
2 on Kramer's (1974) earlier work in this area, transition shock  
3 moves us beyond an understanding of the graduates'  
4 responses to their new reality as being primarily about a  
5 gap between what they were taught in their undergraduate  
6 education and what they come to know in their work world.  
7 My research demonstrates that the NG engaging in a  
8 professional practice role for the first time is confronted  
9 with a broad range and scope of physical, emotional,  
10 sociodevelopmental and -cultural and intellectual changes  
11 that are both expressions of and mitigating factors within the  
12 experience of transition. These factors may be further  
13 aggravated by antecedents related to unfamiliar and chang-  
14 ing personal and professional roles and relationships,  
15 unexpected and enhanced levels of responsibility and  
16 accountability that are unable to be afforded to the graduates  
17 during their student experience, and expectations that they  
18 will apply to everyday practice situations clinical knowledge  
19 that has often been untried, is contextually unrecognizable or  
20 is simply unknown.

21 The element of surprise is an important contributing factor  
22 in the experience of transition shock. While growing evidence  
23 now exists about the effect of various orientation and transi-  
24 tion facilitation programmes on the role socialization process  
25 of the NG (Ward & Berkowitz 2002, Bowles & Candela 2005,  
26 Beecroft *et al.* 2006, Newhouse *et al.* 2007), there is no  
27 literature beyond Kramer's (1974) work that demonstrates a  
28 relationship between formal pregraduate transition prepara-  
29 tion and the experience of moving into a professional nursing  
30 practice role. The limited scope of knowledge about profes-  
31 sional role transition in undergraduate nursing theory may be  
32 contributing to students' unfamiliarity with and lack of  
33 preparedness for what awaits them after graduation.

34 There is an advancing movement towards the development  
35 and enhancement of workplace orientation and transition  
36 facilitation programmes for NGs (Beecroft *et al.* 2004,  
37 Marcum & West 2004, Gazza & Shellenbarger 2005, Halfer  
38 2007, Newhouse *et al.* 2007). Although many of these  
39 programmes recognize the issues inherent in the early  
40 experience of the NG, few incorporate formal transition  
41 theory into the content, structure or process of their  
42 programmes. My research suggests that it is important to  
43 further enhance NG orientation programmes by including  
44 knowledge about professional role transition. Such a  
45 programme would encompass knowledge (e.g. theory taught  
46 in creative and interactive ways that accommodate varying  
47 learning styles and modes of knowledge transmission) and  
48 practice (e.g. role playing or contextually based learning  
49 scenarios that engage both novice and seasoned practitioners)  
50 related to the stages of transition and the experience of

transition shock (e.g. what to expect and when); intergener-  
ational and inter/intraprofessional communication (e.g. work  
ethic and style differences as well as role distinctions);  
workload delegation and management (e.g. delegating to  
individuals older and more experienced than oneself and  
prioritizing the competing demands a full workload); lifestyle  
adjustment (e.g. financial management and adjustments to  
working alternating shifts), change and conflict management  
(e.g. dealing with loss and change and navigating evolving  
relationships with family, friends and colleagues); unit-  
specific skills (e.g. special nursing and medical procedures  
and emergency protocols); and professional roles and respon-  
sibilities (e.g. working with physicians, seasoned nursing  
colleagues and multiple disciplines).

In conjunction with important theoretical knowledge and  
practical experience, it is suggested that institutions accom-  
modate an evolving programme of mentorship between new  
and seasoned practitioners in the workplace (Thomka 2007).  
The successful integration of novice nurses into their  
collegial network is a primary developmental task of this  
socialization period (Etheridge 2007, Newhouse *et al.* 2007).  
Appropriate mentorship supports that allow for changing  
roles and relationships between mentor and mentee, and that  
correlate with the evolving stages of transition are more  
likely to meet the dynamic needs of graduates and may  
enhance the job satisfaction of seasoned professionals (Rowe  
& Sherlock 2005, Coomber & Barriball 2006, Glasberg  
*et al.* 2007).

In seminal research that explicated the evolving skill  
acquisition and competency in nurses as they gained  
increased levels of practice experience, Benner (1982; see  
also Benner & Wrubel 1982) established that novice nurses  
think and act differently from their seasoned counterparts.  
More contemporary authors have provided ample evidence  
that the critical thought and subsequent clinical judgment of  
the NG lacks the depth and breadth that comes with  
experience (Taylor 2002, Welk 2002, Roberts & Farrell  
2003). I found similar evidence about the initial transition  
shock experience of the NG entering professional practice  
during my research and made apparent the importance of  
purposefully and slowly graduating the clinical responsibility  
and practice autonomy of these novices. My evidence is clear,  
particularly the data that arose out of the emergency room  
research, that choosing to deploy NGs to acute-care units  
that require rotations through an observation or step-down  
unit, placing new nurses in permanent floating positions (i.e.  
relief teams), or staffing high acuity practice areas (i.e.  
emergency room or critical care) with graduates directly out  
of undergraduate nursing programmes are decisions that  
should be undertaken judiciously, taking into consideration

## What is already known about this topic

- These are challenging times for new nursing graduates, the majority of whom make their initial transition to professional practice within the hospital healthcare environment.
- Kramer's concept of reality shock, based on research from the 1960s, continues to serve as the construct upon which our understanding of the initial transition to professional practice for new nurses is based.
- The contemporary environment within which the newest nursing graduates are making their transition has changed dramatically in the past 20 years to one where acute care is intense, highly dynamic and laden with stress and excessive workload demands.

## What this paper adds

- *Transition shock* is presented here as the most immediate, acute and dramatic stage in the process of professional role adaptation for the new nurse.
- The concept of *transition shock* builds on elements of transition theory, reality shock, cultural and acculturation shock, as well as theory related to professional role adaptation, growth and development, and change.

## Implications for practice and/or policy

- Understanding the initial stage of role transition for newly graduated nurses will assist managers, educators and seasoned practitioners to appropriately support and facilitate this professional adjustment.
- Healthcare institutions, schools of higher learning and policy-makers need both to understand and respond to the issues that may be driving these energetic and motivated nurses out of acute care, or out of the nursing profession altogether.

the understandably precarious nature of the NGs' cognitive processing ability during the early stages of their professional socialization period. New graduates should be initially (during the first 12 months of practice) placed in consistent and relatively stable clinical settings, be encouraged to increase their exposure to advanced clinical scenarios gradually and strategically, be given regular and frequent feedback that reinforces and redirects their developing skill and knowledge, be offered opportunities for the safe sharing of work experiences with NG peers as well as seasoned colleagues, and be encouraged to collaborate on the devel-

opment or enhancement of approaches that optimize their learning environment and quality work experience.

## Conclusion

Transition shock represents the initial reaction by new nurses to the experience of moving from the protected environment of academia to the unfamiliar and expectant context of professional practice. The evolving theory presented here depicts the initial 3–4 months of professional role transition for the newly graduated nurse as a process of adjustment that is developmental, intellectual, sociocultural and physical and which is both motivated and mediated by changing roles, responsibilities, relationships and levels of knowledge in the personal and professional lives of the new professionals. This theory suggests that educational institutions and industry employers should focus on providing preparatory theory about role transition for senior nursing students, facilitating educational clinical placements that more appropriately prepare graduates for the dynamic, highly intense and conflict-laden context of professional practice, expand and extend workplace orientations to offer an alternating balance between theoretical knowledge and clinical skill practice, and provide structured mentoring programmes that foster healthy partnerships both between seasoned and novice nursing practitioners and between nurses and their multidisciplinary care delivery partners.

## 7 Author contributions

Xxxxxx.

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