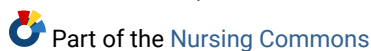Theses

2018

# Narratives of experience: Senior registered nurses working with new graduate nurses in the intensive care unit

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# Narratives of Experience: Senior Registered Nurses working with New Graduate Nurses in the Intensive Care Unit

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Submitted in fulfilment of the requirement of the Degree of
Master of Philosophy (Research)



School of Nursing

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December, 2018

# Declaration

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made.

The thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007, updated 2018). The proposed research study received cross-institutional approval from the relevant Ethics/Safety Committee, Approval Number LNR/16/SVH/170 and from the University of Notre Dame Australia Human Research Ethics Committee (EC00418), Approval Number 0172111S.

Signed:

Print Name:

Date:

# Acknowledgements

The completion of this inquiry would not have been possible without the generous support and encouragement of many people. To all those who supported me, both in my professional and personal life, I cannot thank you enough. I would like to extend a special thank you to the following people.

I would like to acknowledge the guidance and support of my supervisors, Associate Professor Joanna Patching and Dr Nerilee Torning. Their humour, academic insight and commitment bolstered me during this research journey. Nerilee, thank you for being a supervisor and friend. I would also like to thank Associate Professor Tracey Moroney, who was the first to hear my research idea and offered to be my supervisor. Jo, I'm grateful that when my supervisory team changed you 'took me on' and encouraged me when I was full of doubt.

I am especially appreciative to the participants in this inquiry. They permitted and trusted me to tell their story of experience, and without them, this inquiry would not be possible.

To my family and friends, thank you for understanding how difficult studying has been at times. I know I have been neglectful of our relationships, placing more emphasis on writing than enjoying your company.

I would like to dedicate this thesis to my partner, who recognises the importance of education and has supported me throughout the long research process. Also, for cooking most meals and feeding the cat during the past six months. I'm lucky to have such enduring loving support. The thesis is also dedicated to my mother, who raised a self-sufficient daughter. I hope this makes you proud.

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# List of Abbreviations

| | |
|---|---|
| ACCESS | Assistance, coordination, contingency, education, supervision and support |
| BOS | Burnout syndrome |
| CNE | Clinical nurse educator |
| CNS | Clinical nurse specialist |
| ECMO | Extracorporeal membrane oxygenation |
| ED | Emergency department |
| ICU | Intensive care units |
| NA | Narrative accounts |
| NAS | Nursing activities score |
| NASA-TLX | NASA task load index |
| NE | Nurse educator |
| NGN | New graduate nurses |
| NI | Narrative inquiry |
| NIMBY | Not in my back yard |
| NUM | Nurse unit manager |
| RN | Registered nurses |
| SRN | Senior registered nurse |
| SRQR | Standards for reporting qualitative research |
| TISS | Therapeutic intervention scoring system |

TL            Team leader

TPP           Transition to professional practice

VAD           Ventricular assist devices

# Abstract

The experiences and perceptions of New Graduate Nurses as they transition into professional practice and into intensive care units abounds in the literature. However, there is a dearth of literature exploring the experiences of Senior Registered Nurses who work with New Graduate Nurses in intensive care units.

The aim of this inquiry was to contribute to nursing knowledge by examining Senior Registered Nurses' stories of experience around the complexity of enabling development of New Graduate Nurses whilst working in clinical or team leading roles in the intensive care unit. Thus, allowing the Senior Registered Nurses' voice to be heard in the literature.

Narrative inquiry methodology, underpinned by Dewey's theory of experience, was used to examine the experiences of five Senior Registered Nurses in one Level 6 intensive care unit. This was achieved by engaging Senior Registered Nurses in individual conversations then co-composing the final individual narrative accounts with participants, whilst remaining immersed in the three-dimensional space of *temporality, sociality* and *place*. Thematic analysis methods were used to actively identify two overarching threads that resonated across all five narrative accounts.

The first thread, 'Reverberations', contained five minor threads: 'We Carry Them', 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'Enjoyable Moments' and 'Survival Mode'. The second thread, 'Caring', contained three minor threads: 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'.

Analysis identified Senior Registered Nurses' workload and level of patient surveillance increased when working with New Graduate Nurses in the intensive care unit, leading to perceptions of feeling stressed, pressured and overwhelmed. Yet an obligation prevailed to support and care for New Graduate Nurses, perceived by participant Senior Registered Nurses as not yet possessing the clinical skills to independently care for critically ill patients in the dangerous intensive care unit environment

There are significant implications for health care organisations to increase resources to alleviate Senior Registered Nurses' substantial workload and recognise their essential role

in supporting New Graduate Nurses while simultaneously sustaining quality intensive care unit patient care.

# Chapter 1: Introduction

In this chapter, a rationale for the inquiry and background information is presented to orientate the reader to the context. Narrative inquiry methodology is used to explore the phenomenon of interest. A statement of the problem, the inquiry puzzle and the inquiry's significance are presented. A succinct overview of each chapter is provided.

## 1.1 Background

Worldwide, the demand for registered nurses (RNs) is increasing to meet the needs of a growing number of patients with complex care needs. However, it is anticipated that this demand will not be met, with predicted RN shortfalls reported in developed countries. An undersupply (Marć, Bartosiewicz, Burzynska, Chmiel, & Januszewicz, 2018) of RNs and an ageing RN workforce that is close to retirement (Marc et al., 2018) is contributing to the demand. Reduced nursing school graduates (American Association of Colleges of Nursing, 2017), alternate emerging career opportunities (Robnett, 2006) and attrition of New Graduate Nurses (NGNs), those within their first year of practice, from the health care system (Hussein, Salamonson, Hu, & Everett, 2018) may also be contributing to RN undersupply.

Nursing shortages may be more pronounced in critical care areas, such as intensive care units (ICUs; Stone et al., 2006). The ICU working environment is affected by rotating shift patterns, the use of advanced technology, onerous workloads and the psychological burden from managing critical clinical situations (International Council of Nurses, 2006). It is recognised that caring for critically ill patients in an ICU is stressful (Saghafi, 2014), and as a result, RNs working in this environment may be more prone to burnout than RNs working in other clinical areas (Azoulay & Herridge, 2011). These factors may contribute to RN shortages in ICUs.

To address RN shortages in acute care hospitals, NGNs are now employed in highly specialised areas of nursing, such as ICUs (St Clair, 2013). The term NGNs is often cited in the literature together with *newly qualified nurses* (O'Kane, 2012), *newcomer nurses* (Tomietto, Rappagliosi, Sartori, & Battistelli, 2015) and *novice nurses* (Lavoie, Pepin, & Boyer, 2013). For the remainder of the thesis, the term NGN is used and is defined as

RNs within their first year of practice. Intensive Care Unit employment criteria based on previous nursing work experience in acute hospital wards are now less stringent owing to nursing shortages (Lavoie et. al., 2013). New Graduate Nurses may also be placed in ICUs, with organisations recognising that because of large numbers of critically patients being clinically managed outside critical care areas, NGNs should be provided an opportunity to learn essential knowledge and skills to assess and manage this cohort of patients, regardless of their location in the hospital (Lewis, 2011). This approach may result in reduced numbers of senior RNs (SRNs) caring for critically ill patients in ICU.

In ICUs, SRNs are an essential resource. They provide education, support and clinical development opportunities for NGNs as they commence their careers in ICU (Bortolotto, 2015; Travale, 2007). In this thesis, SRNs are described as RNs with at least five years of nursing experience. The term SRN is defined in more detail in the literature review chapter that follows. Advanced time management, critical thinking and clinical decision-making are essential nursing skills in the delivery of high-quality patient care in the complex, highly technological ICU environment. However, SRNs report NGNs' patient assessment skills and their ability to recognise clinical changes and patient deterioration as an area of concern (Hartigan, Murphy, Flynn, & Walshe, 2010; Hickey, 2009). Therefore, NGNs may inadvertently miss significant alterations in patients' clinical status (Levett-Jones et al., 2010). Consequently, NGNs require significant support and oversight from SRNs to ensure timely response from the appropriate health professional to ensure best possible patient outcomes.

The impetus for this inquiry arose from reflecting on my experiences working as an RN new to ICU. I required substantial support from SRNs to care safely for ICU patients, despite my years of previous experience as an RN. Years later, I was employed in the ICU in which this inquiry was situated. I progressed over time, from ICU RN, to team leader, then Clinical Nurse Specialist (CNS) and then to my current substantive position, Clinical Nurse Educator (CNE). Within my first year as CNE, I encountered an organisational change that affected ICU nursing practice: NGNs would be placed in ICU on their first 6-month rotation, as part of a 12-month Transition to Professional Practice (TPP) program. I wondered how SRNs might support first rotation NGNs to care for ICU patients, when NGNs would enter ICUs without independent clinical experience as an RN. Pragmatic advice was sought from other similar-sized health organisations in additional to searching the literature for evidence-based practice.

The literature describes the NGNs' experiences and perceptions of their transition into professional practice (Dyess & Sherman, 2009; Laschinger, Grau, Finegan, & Wilk, 2010; Ortiz, 2016; Parker, Giles, Lantry, & McMillan, 2014; Zinsmeister & Schafer, 2009) and their ICU orientation and induction programs (Bortolotto, 2015; Chestnutt & Everhart, 2007; Friedman, Cooper, Click, & Fitzpatrick, 2011). However, studies on the experiences of SRNs who work with NGNs (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012; Freeling & Parker, 2015; Hickey, 2009; O'Kane, 2012) are limited. No current research studies have exclusively examined the experiences of SRNs working with NGNs in ICUs.

Owing to the highly specialised nature of the ICU and idiosyncrasies of individual ICU milieus, a glossary is provided after Chapter 6 of this thesis. It explains the terminology that participants used when describing this inquiry's *place* (see the methodology section for an explanation of *place*). Additionally, to enhance the understanding of *place* for the reader, a photo of a patient in an ICU bed space is offered (see figure 1.1). The patient in the photo is obscured by specialised equipment necessary to support and aid recovery. Although the patient's family gave signed, informed consent, the consent form is not provided in the appendices of this thesis since redacting identifiers to ensure confidentiality resulted in an unreadable form. The consent form is stored with participant consent forms as detailed in section 3.10.5 Gaining Consent, and will be made available as required.

Comparing ICUs, both in Australia and globally, is challenging due to differences in hospital nursing structures, organisational and financial funding models and admitted patient cohorts. To ensure transparency, after the description of the inquiry's *place*, I present organisational and staffing features of this ICU and a brief description of the NGN orientation and induction program offered in the ICU in which this inquiry is situated.

## 1.2 Inquiry *Place*

The ICU context, or *place,* in which this inquiry was situated affected the experiences of SRNs working with NGNs. This ICU is situated in an Australian Level 6 metropolitan hospital. The intensive care service comprises two different specialities: a general/neuro/trauma and cardiothoracic ICUs. Although the medical team work across both specialities, RNs are predominantly assigned to one speciality and have independent

nursing rosters. However, ICU RNs work across the service as clinical and staffing activity dictates.

In this ICU, the nursing workforce is composed entirely of RNs. There are two ICU bed designations determined by the nursing intensity required to manage the patient (System Information and Analytics, 2018, p. 31). An 'ICU 1' bed is occupied by a patient whose care is provided by a nurse caring for only one patient. However, some of these patients may have nursing care delivered by an additional nurse, for example, a patient requiring extracorporeal membrane oxygenation (ECMO). An 'ICU 2' bed is occupied by a patient whose care is provided by a nurse caring for two patients (System Information and Analytics, 2018, p. 31).

During the week and within office hours, the ICU is supported by the following nursing positions: two Clinical Nurse Consultants (of which one is an equipment consultant), a Nurse Educator (NE), two CNEs and two Nurse Unit Managers (NUMs). When the NUM has designated non-clinical office days, a team leader (TL) is appointed. Routinely, the TL starts the shift without patient allocation, although it is expected that the TL would take a patient load if patient safety dictates, for example, if an unexpected urgent ICU admission occurs.

Registered nurses employed permanently in this ICU routinely manage mechanical ventilators, including adjusting ventilator settings, assessing patients' ventilation requirements and, suctioning and maintaining the airway (Chamberlain, Pollock, & Fulbrook, 2018). Additionally, RNs caring for high-acuity patients in this ICU possess the knowledge and skills to care for advanced technology, such as ventricular assist devices (VADs), ECMO and intraaortic balloon pumps (IABPs; see Glossary for details) and the ability to practice in specific nursing roles in emergency situations, such as ECMO cardiopulmonary resuscitation (E-CPR), cardiac arrest and open-chest resuscitation. As comparable with other Australian ICUs, in this ICU, it is standard practice for each specialist ICU RN to manage and care for the multiple and multifaceted needs of one critically ill patient. As opposed to the practice in some other countries, the intensive care nursing workforce is not supplemented by specialised healthcare practitioners such as dialysis nurses and respiratory therapists. Generally, one suitably experienced RN operates, manages and problem-solves all the invasive and technical devices necessary to provide organ support to a critically ill patient (Chamberlain, et, al., 2018).

Critically ill patient presentations to this ICU includes heart and lung transplantation, end-stage heart and respiratory failure and high-risk cardiothoracic surgery. Figure 1.1 illustrates the technological complexity of caring for an ICU patient in this unit. Routinely, SRNs, if not undertaking the TL role, may be allocated a patient load in addition to preceptoring NGNs or allocated the care of a high-acuity ICU patient. Rarely, when staffing numbers permit during periods of high patient acuity, the SRN may be placed in a *resource* role. The *resource* nurses do not start the shift with a patient allocation: They support other RNs with their workload, relieve staff for breaks and educate less-experienced members of nursing staff. The *resource* nurse role is made available on a shift-by-shift basis, decided by patient acuity, for example, two or more patients requiring ECMO across the service. The *resource* role differs from the ACCESS RN role. The ACCESS RNs (see Glossary) are recommended to be rostered according to a pre-determined (formula based) number to maximise safety and optimise ICU bed utility (Chamberlain, et, al., 2018). It would be a rare occurrence in this ICU to staff a *resource* nurse position.

**Figure 1.1: ICU Bed Space with Patient Obscured by Technology**

New Graduate Nurses enter this context as part of their TPP program. After a hospital-wide orientation and induction program, NGNs, on a six-month placement in ICU receive a three-day induction to ICU. The induction is led by CNEs and consists of ICU orientation, socialisation, introductory ICU nursing principles and the incorporation of simulation of introductory technical skills. After induction, NGNs are supernumerary, shadowing an experienced RN, predominantly an SRN, caring for an ICU patient over a predefined period. The supernumerary period lasts seven 8-hour morning shifts for a 'first

rotation' NGN and three 8-hour shifts for a 'second rotation' NGN. During this period, their SRN 'buddy' undertakes full responsibility and care of the patient. Each NGN works alongside their buddy, taking an incremental level of responsibility for the allocated patient over the supernumerary period. Once they complete the supernumerary period, NGNs are allocated a full ICU patient load. To provide ongoing support for NGNs, preceptors (in addition to their own allocated patients) are individually assigned to NGNs on a shift-by-shift basis, for a further six weeks. Throughout the preceptorship period, SRNs are typically allocated a patient load in addition to their preceptorship responsibilities. It is expected that by the end of the six month ICU placement, as part of the TPP program, the NGN be able to safely care for a mechanically ventilated patient; attending to all essential nursing care patient needs.

## 1.3 **Problem Statement**

New Graduate Nurses are commencing employment in ICUs, although evidence suggests that they do not possess the experience, clinical skills, knowledge or the confidence to work independently in an area affected by escalating levels of patient acuity and increasing workloads. New Graduate Nurses working in ICUs must have the clinical skills to recognise and resolve urgent emergency and emergent situations that occur unexpectedly to ensure patients' best possible outcomes. Additionally, the transition period may be affected by unhealthy and unsupportive workplace environments. Throughout this thesis, the NGNs' transition period will be referred to as the transition period.

Less-experienced nurses rely on SRNs for support, education and guidance to safely develop their clinical practice (Johnstone, Kanitsaki, & Currie, 2008). The support provided in the clinical environment is a significant factor in NGNs' professional, clinical and personal development. Although numerous studies examine the NGNs' experience transitioning into professional practice, fewer studies examine the SRNs' perspective of the NGNs' transition and no studies could be found that solely explore the experiences of SRNs working with NGNs in the ICU.

## 1.4 **Research Puzzle**

Qualitative research designs often commence with an initial research question that is designed more clearly as the research develops (National Health and Medical Research Council, 2018). Although this inquiry commenced with an initial research question, the inquiry does not pose a specific research question with a precise definition nor does it presents a research question with expectations of answers. Narrative Inquiry methodology frames a research puzzle, which carries with it a sense of searching and researching (Clandinin, 2013). This shift from research question to research puzzle allows such inquiries to make explicit that NI is different from other narrative methodologies (Clandinin, 2013).

Framing a research puzzle is part of the process of thinking narratively as well as an essential part of the inquiry design process. My thesis inquiry puzzle was, 'What is the experience of SRNs working with NGNs in the ICU?'

## 1.5 **Theoretical Perspectives**

Prior to starting this inquiry, it was essential to decide which research paradigm and methodology would best allow an exploration of my research puzzle. I wanted SRNs to have a voice, which to date has been silent in the literature with greater emphasis on the NGNs' experience, telling their [SRNs'] stories of experience to a wider readership. This inquiry's research puzzle would be best approached using Clandinin and Connelly's (2000) NI methodology since narrative inquirers recognise experience as a source of important knowledge and understanding. Narrative Inquiry methodology honours ordinary lived experiences and seeks to understand experience beyond the exclusive lens of the researcher (Caine, Estefan, & Clandinin, 2013).

Dewey's (1938) theory of experience is the philosophical underpinning of NI (Clandinin & Connelly, 2000). Dewey's criteria of experience—interaction and continuity—are enacted in situations, forming the keystone when attending to NIs' conception of experience. The NI dimensions of *temporality*, *place* and *sociality* form the NI three-dimensional inquiry space through which experience is examined. The understanding of experience occurs via a collaborative relationship between participants and researchers,

over time, in a place or places, and in social interaction in a specific social environment (Clandinin, 2013).

## 1.6 **Significance**

An increasing need for ICU services, combined with a shortage of ICU SRNs has been identified. Employing NGNs in ICU has been utilised as an option to meet this demand. However, NGNs may not have the clinical skills or experience to work in this highly specialised area. NGNs are reliant on the significant support provided by SRNs to work safely in the ICU.

As presented in the Literature Review in Chapter 2, studies specifically addressing this inquiry's research puzzle were not found, revealing a gap in the literature regarding the SRNs' experience of working with NGNs in the ICU. Since experiences are an important source of knowledge and understanding, it is essential to inquire into SRNs' stories of experience. Exploring SRNs' perceptions of working with NGNs may reveal interpersonal, workload, cultural and organisational factors that affect the health of work environments. The effect of NGNs on SRNs' working practices in the ICU may inform other ICU workplace issues, such as patient safety, staff satisfaction and staff retention— issues affecting all RNs.

## 1.7 **Structure of the Thesis**

In *Chapter 1*, background information informing the inquiry as well as the justification for the inquiry is presented. Included in this chapter is the rationale for choosing NI to explore the SRNs' experiences on working with NGNs in the ICU.

*Chapter 2* presents the systematized review of the literature review. This chapter commences with the background literature informing this inquiry. Although numerous studies examine NGNs' experiences, there is scant literature exploring the experiences and perceptions of SRNs working with NGNs in the ICU. This chapter details the search strategy used to guide the review and present the results. Then an extended review of literature informing this topic is presented. Lastly, the three studies that most aligned with search parameters are presented and critically evaluated, using the Standards for Reporting Qualitative Research (SRQR) (O'Brien, Harris, Beckman, Reed & Cook, 2014).

The inquiry's framework, NI methodology, is discussed in detail in *Chapter 3*. NI is philosophically underpinned by Dewey's (1938) theory of experience. Dewey's theory is described and correlated with NI. The methods used to explore this research puzzle are discussed chronologically to ensure transparency and trustworthiness of inquiry process. Mishler's (1995) method of 'Reconstructing the told from the telling', guided the development of the interim texts. Braun and Clarke (2006) present a method of thematic analysis that organises and describes field texts in rich detail via a six-phase process. This method was used to seek resonant threads across the narrative accounts (NAs).

*Chapter 4* presents the resonant thread findings, developed from the Nas. There are two overarching threads, each containing minor threads. The first overarching thread, 'Reverberations', contained the minor threads: 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'We Carry Them', 'Survival Mode' and 'Enjoyable Moments'. The second overarching thread, 'Caring', was informed by the minor threads: 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'. These threads are presented chronologically and are supported and illustrated by direct participant quotations from the Narrative Accounts

In *Chapter 5*, the threads that resonated across all NAs are discussed in detail with reference to similar studies in the literature and note disparities. Potential limitations of this inquiry are examined.

*Chapter 6* discusses recommendations for nursing practice and a conclusion. A glossary, reference list and the appendices complete the thesis.

In summary, this thesis explores the experiences of SRNs working with NGNs in the ICU via a qualitative NI methodology that honours the lived experiences of SRNs as an important source of understanding and knowledge. The findings of this inquiry lead to an enhanced understanding of the SRNs' experiences of working with NGNs, which can only benefit all RNs working in ICUs.

In the next chapter, the literature informing this inquiry is presented. After contextualising current nursing staffing shortages and NGNs' experiences of transition to practice, the more specific literature on SRNs' perceptions when working with NGNs serves as the foundation on which this study was built.

# Chapter 2: Literature Review

The following chapter presents a detailed description of the literature search methods and search results. A broad context of current global and local nursing staffing shortages in which NGNs commence practice, sets the stage for this inquiry. A systematized review of the literature was undertaken (Grant & Booth, 2009) and the results presented. Insights from NGNs' perspectives on commencement of employment, and the scarcity of literature on the SRNs' viewpoint of working with NGNs, provide the basis for the formation of this inquiry. As limited studies informing this inquiry were located via the search process, this chapter concludes with a critical evaluation of these studies, informed by the Standards for Reporting Qualitative Research SRQR (O'Brien, et., aL., 2014).

## 2.1 Background

Globally, the demand for RNs is increasing, with rising numbers of patients requiring hospital-level health care. Precipitating factors include increased growth and age of the population, and growing demand for high-quality, technologically advanced health care (International Council of Nurses, 2013; Robnett, 2006). Simultaneously, there is a global undersupply (Marć et al., 2018) and estimated predicated shortage of RNs, explained by unhealthy work environments (Ulrich, Lavandero, Woods, & Early, 2014) and an ageing RN workforce close to retirement age (Marć et al., 2018). Kramer and Schmalenberg (2008) defined a healthy work environment as, 'productive, able to give quality care, satisfying, and able to meet personal needs' (pp. 56–57). Reduced numbers of nursing school graduates, and emerging alternative career opportunities, also affect RN supply (Robnett, 2006).

The Australian hospital health care workforce is composed of a significant proportion of nurses (Australian Institute of Health and Welfare, 2010). They play an important role in the provision of patient care that is delivered collaboratively with other health care clinicians. However, under current practices, nursing shortfalls of over 85 000 by 2025 and nearly 122 000 nurses by 2030 (Health Workforce Australia, 2014, p. 17) have been estimated. Additionally, nursing turnover rates of between 15% and 45% have been reported in Australia, New Zealand, the United States and Canada (Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014).

Specialty care areas, particularly ICUs, may experience higher concentrations of nursing shortages (Stone, Larson, Mooney-Kane, Smolowitz, Lin, & Dick, 2006). Nursing work in ICU is both physically and mentally demanding. Nurses' working conditions are impacted by rotating shift patterns, excessive workloads and the psychological burden of managing critical clinical situations (International Council of Nurses, 2006), which may not be present in other specialty areas. An ageing workforce, high patient acuity, heavy workloads and turnover rates have been cited as possible reasons for shortages of ICU RNs (Travale, 2007).

The loss of nurses from the workforce has implications for both health care costs and efficiency, which may ultimately affect the quality of patient care (Duffield et al., 2014; Robnett, 2006). The capacity of nurses to provide quality health care is influenced by their practice environment, the hours of practice and the nursing skill mix (Twigg, Duffield, & Evans, 2013) These factors correlate with changes in the rates of adverse patient events (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, et al., 2014; Duffield et al., 2011).

Staffing, and specifically determining nursing skill mix in the ICU, is a multifaceted process. Matching the competencies of RNs available on a given shift with the needs of patients at multiple points throughout their admission is essential, because the condition of critically ill patients continuously fluctuates, often rapidly. It is crucial that nurse-staffing decisions consider more than fixed nurse-to-patient ratios and full-time equivalent nursing numbers. Staffing solely according to rigid ratios disregards variability in individual patients' needs and acuity, nurse competencies and the status of the ICU work environment (American Association of Critical-Care Nurses, 2016, p. 25). Therefore, throughout this inquiry skill mix is defined as the match between RNs' competencies in relation to the clinical needs of ICU patients, on any given shift.

Traditionally, ICUs employed RNs with at least a year of acute care ward experience, for example, medical-surgical (Morris et al., 2007). Despite critically unwell patients requiring the skill and experience of SRNs to ensure quality care, ICUs now employ NGNs without post-registration nursing experience (Chesnutt & Everhart, 2007; O'Kane, 2012; Proulx & Bourcier, 2008; Saghafi, Hardy, & Hillege, 2012; St Clair, 2013). This may be due to high nursing turnover rates and a shortage of RNs with ICU experience to fill ICU staffing vacancies (Bortolotto, 2015; Chesnutt & Everhart, 2007; O'Kane, 2012).

To maintain high-quality care for complex ICU patients, RNs provide education, support and clinical development opportunities for NGNs as they transition into ICUs (Bortolotto, 2015; Travale, 2007). Different terms are used in the literature to define an RN with experience, such as senior nurse (O'Kane, 2012), experienced nurse (Ballem & MacIntosh, 2014), seasoned nurse (Friedrich, Prasun, Henderson, & Taft, 2011), and expert nurse (Benner, 1982). For the purposes of this study, the term senior registered nurse (SRN) is defined as those nurses with a minimum of five years' nursing clinical experience who are currently employed. When referencing studies from the literature that use differing terminology, such as those mentioned above, the term SRN is used for consistency. If an author specifically defines an 'RN with experience' differently from the term SRN, the author's term and definition is stated for the reader and used in the review.

Regrettably, Duchscher (2008) suggests that SRNs may interact negatively with NGNs when they discover NGNs lack the knowledge, time and experience to perform clinical skills. NGNs may become disillusioned by the negative interactions, leading to their attrition from the workplace (J. Kelly & Ahern, 2009). Consequently, SRNs may become frustrated with the increased workloads associated with repeated cycles of recruitment, orientation and preceptorship of NGNs (Ballem & MacIntosh, 2014). Senior Rregistered Nurse burnout, dissatisfaction and turnover may result from SRNs' short supply, or when overstressed and overworked (American Association of Critical-Care Nurses, 2016), exacerbating nursing shortages. Therefore, it is necessary to inquire into the experiences of SRNs who work with NGNs in the ICU. The SRNs' experiences may reveal workplace, interpersonal and cultural factors that may affect SRN retention, workplace relationships, well-being and patient safety.

## 2.2 **Purpose**

A plethora of literature examines the experience of NGNs as they transition into professional practice: NGNs' perceptions and attitudes, experienced SRNs' perspectives of NGNs, descriptions of ICU NGN orientation programs and the experience of NGNs transitioning into ICU. The aim of this systematised review was to identify primary research literature specifically exploring SRNs' experiences related to working with NGNs in the ICU. This approach was undertaken recognising that although it includes elements of a systematic review process, the resultant output is not as rigorous as a full

systematic review. This approach is defended; for as a Master's thesis, resources were not available for a full review, such as two blind reviewers (Grant & Booth, 2009). However, as no studies have specifically addressed this review's aim, literature is critically evaluated that best aligns with this inquiry's research puzzle.

## 2.3 Search Terms, Databases and Limits

The literature search included published studies between January 2000 and November 2018. The terms, 'New Graduate Nurses,' 'newly qualified nurses,' 'new to practice nurses', 'expert nurses', 'senior nurse', 'critical care nurse' and 'intensive care nurse' were used in the initial search. The databases Cumulative Index to Nursing and Allied Health Literature Plus (CINAHL) with full text and Medical Literature Analysis and Retrieval System Online (MEDLINE) were used. The reference lists of relevant retrieved research articles were hand searched to identify other potential studies.

Databases were accessed through host systems at the hospital medical library and Notre Dame University library. Expanders, 'apply related words' and Boolean/phrases 'AND' and 'OR', were used to maximise search results. Owing to the limited number of studies revealed in the search, the CINAHL database search was repeated under the guidance of a research librarian. The search was expanded in CINAHL to search for both major and minor headings that included the terms 'Intra-professional Relations', 'Mentorship', 'Collaboration', 'Negotiation', 'Dissent and Dispute', 'Criticism', Work Experience' and 'Job Experience' (see Table 2.1). The terms were searched individually in Google Scholar to identify any other relevant research studies. Although it was recognised that searching in Google Scholar may not be reproducible by other researchers, this ad hoc means of searching may have revealed further relevant studies. The CINAHL database and reference list searches were guided by the PRISMA guidelines (Moher, Liberati, Tetzlaff, & Altman, 2010) and Kable, Pich and Maslin-Prothero's (2012) approach to documenting a search strategy for publication.

## 2.4 Inclusion and Exclusion Criteria

The review considered original qualitative and quantitative studies from the years 2000 to November 2018 that addressed the research puzzle, 'What is the experience of SRNs who work with NGNs in the ICU?' The inclusion criteria of this review sought original

research studies that reported the experience of SRNs' view of NGNs working in the ICU. Studies not situated specifically in the ICU context or that focused exclusively on the new graduate's or nursing student's experience of working in the ICU were excluded, since these studies do not directly provide insight into the current inquiry's research puzzle. Previously published specific literature reviews and systematic reviews were excluded since they were not original research studies. Studies published in a language other than English were also excluded.

## 2.5 **Search Process**

The results of the search revealed 145 articles, and these articles' abstracts were assessed and screened for relevance using the inclusion/exclusion criteria, with 118 abstracts being excluded. To increase the likelihood of identifying all relevant studies, a hand search of the reference lists of the 27 retrieved articles was conducted. This added two additional studies that were absent from the original search. One replication, one commentary, one editorial and a letter were excluded since they were not defined as original studies. The 25 remaining articles were read in full to determine relevance. Of the 25 articles, no identified studies exclusively addressed the purpose of the literature search. A summary of the literature search is presented (see Table 2.1).

**Table 2.1: Literature Search Summary**

| S. No. | Search Tem | Results |
|---|---|---|
| S1 | (MH "New graduate nurses") Or (MH "Novice Nurses") | 5881 |
| S2 | "newly qualified nurses" | 291 |
| S3 | "new to practice nurses" | 11 |
| S4 | S1 OR S2 OR S3 | 5993 |
| S5 | (MH "Expert Nurses") | 1710 |
| S6 | "senior nurse" | 320 |
| S7 | "critical care nurse" | 884 |
| S8 | "intensive care nurse" | 872 |
| S9 | S5 OR S6 OR S7 OR S8 | 3759 |
| S10 | (MH "Intra-professional Relations") OR (MH "Mentorship") OR (MH "Nurturing Behavior") OR (MH "Collaboration") OR (MH "Negotiating") OR (MH "Dissent" and "Disputes") OR ("Criticism") | 54326 |
| S11 | (MH "Work Experience") OR (MH "Job Experience") | 13512 |
| S12 | S10 OR S11 | 67010 |
| S13 | S4 AND S9 AND S12 | **145** |

Three studies partially met inclusion criteria, with none situated in Australia. Since none of the studies in the literature identified met all the inclusion criteria, the three studies that partially met the inclusion criteria (see Table 2.2) were critically evaluated.

**Table 2.2: Three studies Best Aligned with Inclusion Criteria**

| Author (Year), Country | Title | Design | Sample Size and Characteristics | Data Collection Methods | Findings | Limitations |
|---|---|---|---|---|---|---|
| Ballem and MacIntosh (2014), Canada | 'A Narrative Exploration: Experienced Nurses' Stories Of Working With New Graduates' | Narrative Inquiry | Eight RNs from four different nursing units (including critical care) across two hospitals. RNs had 5 years' experience and had worked with NGNs. Years of employment: 5–31. | Semi-structured interview | Three narrative themes: 'New Graduates Are Coming', 'Keeping Us On Our Toes' and 'Carrying The Load' | Nature of sample; all participants are comparable in terms of gender, culture and ethnicity. Data saturation was sought which does not align with narrative inquiry methodology. . |
| Baumberger-Henry (2012), USA | 'Registered Nurses' Perspectives on the New Graduate Working in the Emergency Department or Critical Care Unit' | Naturalistic-inquiry descriptive design | Thirty-one RNs aged 26–54 years, with 3–22 years' experience. All participants employed in emergency or critical care areas. Twenty-nine participants currently working with NGNs. | Focus groups | Two Themes: 'Lacking confidence' and 'Gaining Acceptance in the Unit Culture' | Literature search strategy not presented. Methods for identifying and developing themes not included. |
| O'Kane (2012), UK | 'Newly Qualified Nurses Experiences in the Intensive Care Unit' | Comparative qualitative study: two phases | Phase One: eight newly qualified nurse working in the ICU. Phase Two: seven senior nurses (band seven or above). | Phase one: semi-structured interview. Phase two: focus groups. | Four themes: 'Expectations', 'Challenges', 'Preconceptions' and, 'Support' | The underlying philosophy and/or methodology was not explicitly stated. Participants known to researcher. Methods for participant selection not described |

The three studies that were critically evaluated either presented an understanding of the SRNs' experience of working with NGNs in ICUs as part of a larger study (O'Kane, 2012) or included the ICU context in addition to other hospital clinical settings (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012). While O'Kane's (2012) study predominantly focused on the experience of NGNs working in the ICU, the NGN results were compared with the perspectives of the SRNs working with the NGNs in the ICU in the second phase of the study. Ballem and MacIntosh's (2014) study included SRN participants from a variety of hospital clinical settings, including critical care [ICU]. Baumberger-Henry's (2012) study explored the SRNs' perspective of the NGNs working in both the emergency and critical care [ICU] contexts.

## 2.6 **Extended Background Literature**

A discussion of the wider literature is presented as an extended background of the literature as no studies were found that met all the inclusion criteria. Then, the three studies that best aligned with the inclusion criteria are critically evaluated for their design and contribution to health care, education and nursing knowledge. The articles were critically evaluated using an approach guided by the Standards for Reporting Qualitative Research (SRQR) (O'Brien, et., al., 2014).

The SRQR is composed of 21 items developed by the authors via a rigorous synthesis of published guidelines and reporting standards and, expert consensus (O'Brien, et. al., 2014). The authors hypothesise that the use of the SRQR guideline will 'improve the transparency of all aspects of qualitative research by providing a clear standard for reporting qualitative research' (O'Brien, et. al., 2014, p. 1245). Although the 21 SRQR items reflect essential information for inclusion in a qualitative study report, they are not considered to be a way of rigidly standardising content. Individual studies' methodology, journal requirements, and authors' preferences may determine differences in organisation and sequencing than suggested in the SRQR. Journals' word restrictions and the authors' decisions to highlight certain components of a study might likely influence the author's capacity to fully explore all components in detail (O'Brien, et. al., 2014).

The following section discusses the wider literature. Following this, the three studies that best aligned with the literature review inclusion criteria are critically evaluated and presented.

Transition periods are often stressful times in nurses' careers, whether transitioning from NGNs into professional practice in the hospital context (Duchscher, 2009), staff nurse to CNE (Manning & Neville, 2009), RN to advanced practice nurse (Spoelstra & Robbins, 2010) or RN to family nurse practitioner (Poronsky, 2013). Literature concentrating specifically on role transition into ICUs covers both NGNs (O'Kane, 2012; Saghafi et al., 2012; St Clair, 2013) and experienced RNs (Farnell & Dawson, 2006; Gohery & Meaney, 2013).

Irrespective of the profession, no new graduate is able to demonstrate the same level of competency as a more accomplished and experienced colleague (Baumberger-Henry, 2012). New Graduate Nurses are required to possess necessary skills, such as critical thinking, deduction, communication and clinical knowledge, and to be able to apply knowledge to clinical practice (Berkow, Virkstis, Stewart, & Conway, 2009; Hartigan et al., 2010). However, NGNs enter nursing practice without the experience, expertise or confidence to work competently in a context that is affected by escalating levels of patient acuity and increasing workloads (Duchscher, 2008). New Graduate Nurses' perceptions of their transition into professional practice reveal concepts of transition shock (Duchscher, 2009), theory–practice gap (Gohery & Meaney, 2013), unsupportive work environments (Baxter, 2010), horizontal violence (Parker et al., 2014), lack of ongoing appraisals and timely feedback (Cubit & Ryan, 2011), poor socialisation (J. Kelly & Ahern, 2009) and lack of confidence (Faulkner, 2015). Therefore, NGNs are entering nursing practice in ICUs with limited clinical skills required for a highly specialised area and confronted by often unhealthy workplace environments.

Jacob, McKenna and D'Amore, (2014) examined SRNs' expectations of NGNs. Defining SRNs as 'nurse educators, nurse administrators, senior clinical nurses and key stakeholders such as Chief Nursing Officers, Australian Nursing and Midwifery Accreditation Council board members, and Nursing and Midwifery Board of Australia members' (p. 213), (Jacob et al., 2014) found that 57.4% of SRNs (n = 117) considered NGNs were prepared for the workforce, except in the attribute of leadership. Lofmark,

Smide and Wikblad (2006) study similarly found 75% or more of the SRNs (n = 136) rating NGNs as having a good or strongly developed ability to provide nursing care.

Berkow et al.'s (2009) study sought to isolate the specific competencies that comprise nursing preparation practice gap, while aiming to support nursing academics and hospital leaders to focus on key areas to bridge the gap collaboratively. From a potential pool of 53 000, frontline nurse leaders numbering 5 700 were surveyed, a 11% response rate. Frontline leaders in this study were defined as CNSs, educators, managers, charge nurses, nurse directors and staff nurses with more than two years of experience. Only 35% of respondents were satisfied with the ability of NGNs asking for assistance, with 28% thinking that NGNs could recognise unsafe practices in themselves and others. Respondents thought only 19% of NGNs could recognise changes in patient status (Berkow et al., 2009). Similarly, Kantar (2012) studied the perceptions of preceptors regarding the transition of NGNs from undergraduate to RN with critical care nurses comprising 40% of the study population (n = 21). Most preceptors (95%) in this study perceived that NGNs experienced difficulties in interpreting alterations in patients' health status because of disease processes.

Conversely, RN preceptors have reported that NGNs can independently perform basic skills, such as taking vital signs, hygiene, positioning and safety (Hickey, 2009). Adair, Hughes, Davis and Wolcott-Breci (2014) compare NGNs' self-assessment of their own skills with a skill competence demonstration and assessment by an expert RN. The expert RNs determined NGNs (n = 32) in this study were most comfortable in applying skills such as the application of pulse oximetry, hand washing techniques, demonstrated used of personal protective equipment, removal of indwelling urinary catheters, medication administration via subcutaneous and intramuscular injection, intravenous catheter removal and the administration of medication by intravenous push.

Regardless of the level of nursing experience, RNs' transition into the ICU context may be a difficult process owing to a lack of ICU-specific knowledge and skills, the technologically demanding nature of the environment and the intensity of care required by critically unwell patients (Farnell & Dawson, 2006; Gohery & Meaney, 2013; O'Kane, 2012). Although they may not be initially allocated a complex critically unwell patient, regardless of their level of general nursing experience, RNs new to ICU must have the clinical skills to recognise and resolve urgent and emergent situations that occur

unexpectedly (Chesnutt & Everhart, 2007). NGNs, despite possessing limited independent clinical experience when they enter nursing practice and specifically the ICU context, are often allocated an ICU patient soon after orientation (Chestnutt & Everhart, 2007). This is particularly challenging for NGNs given the difficulty of this transition for experienced nurses (Farnell & Dawson, 2006).

Critical thinking, time management and clinical decision-making are fundamental nursing skills in the delivery of high-quality patient care. Even more so, these skills are essential when caring for critically unwell patients in the complex, highly technological ICU context. However, NGNs' patient assessment skills and ability to recognise change and deterioration in patients have been reported by SRNs as an area of concern (Hartigan et al., 2010; Hickey, 2009). Nurse managers have reported that NGNs find critical thinking, associated with real-world demands, a difficult challenge (Chernomas, Care, McKenzie, Guse, & Currie, 2010; Clark & Holmes, 2007; Hickey, 2009). Hickey (2009) found more than 50% of SRN preceptors (n = 200) highlighted NGNs' critical thinking and time management skills as areas of weakness. NGNs' critical thinking is an area in need of development, with participants in Hartigan et al.'s (2010) study, reporting NGNs' hesitancy in clinical decision-making, despite often accurately judging and assessing clinical situations. Senior Registered Nurses report that NGNs also have trouble with organisation and time management skills (Chernomas et al., 2010; Clark & Holmes, 2007; Hickey, 2009). Therefore, many NGNs require support from SRNs when perform basic nursing skills.

Nursing is a profession that relies on the support provided by SRNs to educate less-experienced RNs in their clinical practice (Hautala, Saylor, & O'Leary-Kelley, 2007). The provision of support in a clinical environment continues to be a significant factor in RNs' clinical, professional and personal development (Gohery & Meaney, 2013; Hautala et al., 2007). What constitutes 'support' and why it is essential for NGNs is rarely defined in the literature. The complexity of support was highlighted when Johnstone et al. (2008) sought an operational definition of 'support' in addition to determining how much, for how long and when support should be given. Support was determined as aiding, strengthening and encouraging, thus enabling courage and confidence for safe, competent and effective practice (Johnstone et al., 2008). Johnstone et al. (2008) established that NGNs are often their own best sources of support with negative attitudes of staff towards NGNs being the most powerful barriers to obtaining support. Support was recommended

in the initial four weeks of NGNs' transition program and at the beginning of each ward rotation (Johnstone et al., 2008).

'Preceptor' is the term given to RNs who teach and support less-experienced nurses or NGNs in the clinical environment; SRNs often undertake the preceptor role. The role preceptors play in supporting the professional development of NGNs is widely recognised (Giallonardo, Wong, & Iwasiw, 2010; Sayers, DiGiacomo, & Davidson, 2011). Senior Registered Nurses support NGNs as they negotiate and transition into the complex reality of the busy clinical environment. The support of SRNs is essential as the NGNs advance along a scale of experience: from novices to experts (Benner, 1982).

Kantar (2012) explored the perceptions of preceptors regarding NGN practices during the first three months of transitioning into the acute care setting. Nearly 80% of these preceptors highlighted that NGNs required extra training in clinical procedures and technical issues once employed in clinical practice. Hickey (2009) sought to identify preceptors' views of NGNs' readiness for practice via the use of a specific set of criteria, determining the nursing skills that were most important for transitioning into practice. Hickey (2009) reported 63% of preceptors (n = 200) thought that NGNs required more assistance with the performance of skills than was expected. Research questions measuring critical thought processes in NGNs significantly determined only 13% of preceptors believed NGNs could set priorities most of the time and 47% only some of the time (Hickey, 2009, p. 38). Critical thinking was considered an important or very important skill when entering into professional practice by 93% of the study's respondents. The results from these studies may indicate that NGNs entering into higher acuity areas, such as ICU, may require even more assistance and training from SRNs to competently perform specific skills and establish appropriate clinical priorities.

Although preceptorship is essential to the NGN orientation, NGNs' experience the omission of preceptor allocation, allocation of multiple preceptors and allocated preceptors working on different shifts to them, and perceive varying standards of preceptor ability (Casey, Fink, Krugman, & Propst, 2004; Cubit & Ryan, 2011; Evans, Boxer, & Sanber, 2008). Johnstone et al. (2008) reported NGNs believed that they encountered inexperienced, unqualified and disinterested preceptors, which had a significant adverse impact on NGN confidence and perceived competence. It was hypothesised in Johnstone et al.'s (2008) study that the large number of part-time

preceptors, a poor skill mix and heavy workload issues influenced the lack of support that NGNs perceived.

Senior Registered Nurses' unprofessional behaviour and negative attitudes, such as being unwilling to support and having unrealistic expectations of NGNs, eye rolling, refusing to answer questions and making caustic comments were observed in some studies (Baumberger-Henry, 2012; Chernomas et al., 2010; Walker et al., 2013; Wolff et al., 2010). NGNs were perceived by some SRNs to demonstrate a poor work ethic and lack of commitment compared with SRNs (Chernomas et al., 2010; Wolff et al., 2010). Some SRNs were identified as being uncooperative and exhibiting difficult personalities when interacting with NGNs (Baumberger-Henry, 2012).

Senior Registered Nurses perceive preceptoring to be a complex and challenging experience (Carlson, Pilhammar, & Wann-Hansson, 2010). When RNs encountered time shortages owing to heavy workloads, preceptoring was considered stressful (Carlson et al., 2010; Yonge, Krahn, Trojan, Reid, & Haase, 2002). Hautala et al. (2007) found 83% of surveyed RNs (n = 65) reported mild to moderate stress when acting in a preceptor role since preceptoring required an increase in energy and time. Stress was related to the associated increase in workload attributed to the need to concurrently complete their own patient care duties while supporting, teaching and guiding the preceptees (Hautala et al., 2007).

Preceptors associate increased workload with the amount of time required to support preceptees (Hautala et al., 2007). However, to negate high workloads, preceptors (n = 13) in Carlson et al.'s (2010) study created time to successfully engage in a preceptoring role and endeavoured to reduce their feelings of inadequacy and stress. Strategies included the use of collegial support and cooperation to reduce workload, temporarily handing preceptorship responsibility to another RN and relying on medical support to provide education to the preceptees (Carlson et al., 2010). Despite feeling stressed owing to lack of time, preceptors attempted to hide these feelings from their preceptees. However, a rationale for hiding stress was not presented in the study.

Intensive Care Unit-specific orientation programs for NGNs (Bortolotto, 2015; Chesnutt & Everhart, 2007; Friedman et al., 2011; Kollman et al., 2007; Proulx & Bourcier, 2008; Seago & Barr, 2003; Welding, 2011) address NGNs' distinct learning needs while

addressing the need to improve patient safety in ICUs, provide quality nursing care, reduce nursing attrition and maintain RN staffing levels. These programs use a combination of ICU preceptors, structured clinical competence attainment and didactic education, to support the NGNs. However, none of the programs specifically addresses the experience of the SRNs who worked with the NGNs on the orientation programs. Conversely, the NGNs' experience of transitioning directly into ICU has been reported and encompasses NGNs': feeling overwhelmed (Lewis-Pierre, 2013; Saghafi, 2014; St Clair, 2013), challenged by the need to have advanced, effective communication skills (Lewis-Pierre, 2013; Saghafi, 2014); being fearful of making mistakes (Lewis-Pierre, 2013; Saghafi, 2014; St Clair, 2013) (Lewis-Pierre, 2013; Saghafi, 2014; St Clair, 2013) and possessing a desire to learn (Saghafi, 2014; St Clair, 2013).

In Australia, on completion of a Bachelor of Nursing degree, nursing students apply for registration with the Australian Health Practitioner Regulation Agency. Once registered, NGNs may commence their professional nursing careers by undertaking a TPP program. 'The TPP offers NGNs consolidated clinical support (including preceptorship) and education study days, which goes beyond standard orientation and induction of new employees' (Nursing and Midwifery Office, 2018, p. 2). Individual hospitals provide places for NGNs on TPP programs with the aim of supporting the NGNs as they transition from novices to competent nurses by providing a safe and supportive environment (Tuckett, Eley, & Ng, 2017). These programs are not mandatory nor offered by all employers. The TPP programs consist of a learning framework that integrates supernumerary time, clinical rotations, preceptorship, regular appraisals, education sessions and professional development days as well as socialisation support (Missen, McKenna, & Beauchamp, 2016; Tuckett et al., 2017). New Graduate Nurses employed on a 12-month TPP program 'rotate' through different clinical specialties, such as medical/surgical wards, critical care areas and palliative care. The duration of clinical rotations is often between three and six months (Missen et al., 2016). Before 2009, NGNs in the organisation in which this inquiry is situated were offered an ICU placement only on their final rotation. In 2009, the duration of rotations was changed from four to six months and NGNs were placed in the ICU as their first clinical rotation (Saghafi et al., 2012). The organisational change of practice that facilitated NGNs starting their career in the ICU as part of the TPP program initiated my interest in studying the experience of SRNs who work with the NGNs in the ICU.

The three articles that most closely aligned with the inclusion criteria are critically evaluated in the next section. The articles, 'A Narrative Exploration: Experienced Nurses' Stories of Working with New Graduates' (Ballem & MacIntosh, 2014), 'Registered Nurses' Perspectives on the New Graduate Working in the Emergency Department or Critical Care Unit' (Baumberger-Henry, 2012) and 'Newly Qualified Nurses Experiences in the Intensive Care Unit' (O'Kane, 2011) are critically evaluated for their design and contribution to nursing knowledge and health care. The critical review is guided by the Standards for Reporting Qualitative Research (SRQR) (O'Brien, et., al., 2014) (see Appendix A). These articles are presented in chronological order in the following section.

## 2.7 **Articles Aligned with Inclusion Criteria**

### 2.7.1 **'A Narrative Exploration: Experienced Nurses' Stories of Working With New Graduates' (Ballem & MacIntosh, 2014)**

The title of this study provides a concise description of both the study's nature and topic. The abstract provides a succinct overview of the study; however, the inclusion of the methodology may have strengthened the summary. The phenomenon studied was explicitly stated as being the SRNs' perspectives of their experiences working with NGNs. Research was reviewed that contained an understanding of SRNs' views and behaviours from the NGNs' perspective. This decision was defended; the authors found a dearth of studies specifically studying the SRNs' perceptions of working with NGNs. A search strategy summary is presented and includes terms and databases searched, allowing for search reproducibility.

Purposive sampling selected seven participants, with snowball sampling adding another participant. It was reported that no participants were excluded as all met inclusion criteria. Although a justification was provided for the use of purposive sampling, a defence of the use of snowball sampling was not presented. Although the specific type of purposive sampling was not stated, it could be hypothesised from data presented in the study that a stratified sampling was undertaken (Robinson, 2014). Participant SRNs had a minimum of five years' nursing practice experience and were currently employed in critical care, surgery, internal medicine and medical/surgery units, in two teaching hospitals in Eastern Canada. Participants were required to be currently working, or have worked, with NGNs within the past 18 months and willing to participate in an interview conducted in English.

However, in a table summary description of the participants, the authors include an additional description criteria, 'mentored graduates'. The term mentor is not defined. An alternate form of NI methodology than that used in the current study was employed to study the phenomenon. Data collection occurred via recording semi-structured interviews and the collection of observation field notes of participants' activities, as well as the researcher's personal thoughts.

Data saturation was complete after eight interviews; however, the concept of data saturation may not be congruent with NI methodology, aligning more closely with Grounded Theory (Varpio, Ajjawi, Monrouxe, O'Brien, & Rees, 2017). Core stories were crafted from each participant's transcribed interview. The core stories were searched for recurring patterns shared by more than one story (Polit & Beck, 2008). Data analysis was guided by Emden's (1998) analytic approach. The researchers state the credibility of the study was ensured with the core stories sent to the participants to check for accuracy. Although this process may reduce the risk of misinterpretation and misrepresentation, the use of member checking to increase credibility is debated in the literature (Varpio, et. al., 2017). The analysis of data in narrative inquiry is an interpretative act whereby the researcher actively constructs findings and conclusions. From this perspective, there may tension between researcher and participant if member checking of findings by the participant was disputed (Varpio, et. al., 2017). However, in this study, member checking was limited to the core stories.

Thematic analysis revealed three narrative themes describing the experience of SRNs working with NGNs: 'New Graduates are Coming', 'Keeping Us On Our Toes' and 'Carrying The Load'. Themes were elucidated with exemplars from the core stories. SRNs perceived NGNs to lack confidence, basic skills and critical thinking. The former's workload, stress and frustration increased when working with NGNs. Concerns were raised regarding patient safety, highlighting the perception of SRNs that NGNs do not have enough hands-on experience. Senior Registered Nurses responded to concerns regarding patient safety by increasing their knowledge of NGNs' patients, including any preparation required for procedures, preparation of intravenous medications and the presence of special lines. Despite the extra work that this entailed, SRNs obtained the additional patient information since they expected to be asked by NGNs, at any time during the shift, for assistance or advice.

Caring for both the NGNs' patients and their own was exhausting and stressful for SRNs. The importance of NGNs asking questions was discussed, yet NGNs' questions were thought to interrupt the SRNs' ability to concentrate on their own patient care. Although SRNs encouraged NGNs to ask questions and supported them with their workload, questions increased the SRNs' feelings of pressure during periods when they already had high workloads.

The SRN participants were verbally supportive of NGNs, actively supporting NGNs to ask questions, assisting them with new clinical skills and helping them when they were overwhelmed. However, the SRNs' stories were not always supportive, with reports of annoyance with NGNs who did not ask questions, follow suggested advice or take initiative. Recommendations for nursing practice were discussed and included: prolonged mentorship and support programs, protected time for mentoring and the recognition and acknowledgement of SRNs' workloads when working with NGNs. No researcher biases or conflicts of interest were reported. The nature of the participant sample with all participants comparable in terms of gender, ethnicity and culture could be considered a limitation of the study. The inclusion of male participants and those of a non-Caucasian background may have resulted in different study findings. Additionally, there was a difference in nursing education attainment which may also lead to differences in lived experiences with NGNs. The authors provide a description of study participants, including whether they had mentored a new graduate nurse. The term mentor is not defined in the article and may have different connotations in different health settings. Consequently, the implications of one participant potentially having a different skill set to other participants on the findings of this study is unable to be ascertained.

Implications for nursing practice from this study included the increase in awareness and acknowledgement of SRNs' workload when working with NGNs. Suggested future directions included examining the nurse managers' role in retaining NGNs, studying factors that contribute to discord in SRN and NGN perceptions of support and conducting similar research in alternate nursing workplaces, such as community settings, rehabilitation centres and nursing homes.

## 2.7.2 'Registered Nurses' Perspectives on the New Graduate Working in the Emergency Department or Critical Care Unit' (Baumberger-Henry, 2012)

The title includes a concise description topic of the study and defines it as being qualitative. The study sought to gain an understanding of SRNs' perspectives of NGNs working in the emergency department (ED) or ICU. However, the title and stated aim differs from the aim described in the abstract; which is to describe work relationships with NGNs in the ED or ICU. This may lead to confusion regarding the phenomenon under investigation. Regardless, the aim does suggest the need for a qualitative approach. Related literature is used to provide motivation and background for the study; however, there is a broad statement suggesting that despite all that is known about NGNs, there is scant literature regarding the perceptions of SRNs working with NGNs in the ED or ICU. This is statement cannot be confirmed as accurate as a search strategy is not presented and is therefore not reproducible. The inclusion of a literature search strategy may have been excluded with the findings and discussion prioritised, due to strict word limits placed on journal articles. The study's framework was described as a naturalistic-inquiry descriptive design. However, the research paradigm is not stated thus there is missed opportunity to evaluate both the fidelity of the underlying methodology to the research question and methods and, the rigor and trustworthiness of the study (O'Brien, et. al., 2014).

Participants were enrolled in a Masters degree program at a metropolitan university in a mid-Atlantic region of the United States. Recruitment methods were not stated and therefore unable to be assessed. Participants were aged 26–54 years, having 3–22 years of experience in an ED or an ICU area. The majority were currently working with NGNs. All participants were employed in trauma centres and community and inner-city hospitals.

The researcher's assumptions were bracketed with the stated aim of ensuring accuracy and eliminating bias (Lincoln & Guba, 1985) before data collection occurred. Discussions with focus groups were conducted using a semi-structured interview guide. Six discussions with focus groups were conducted, with a purposive sample of 3–10 SRNs in each group. Relevant information regarding the context in which data collection occurred is not described so readers do not have opportunity to understand possible influences on data collected, such as location of the focus group or person/s conducting the focus groups (O'Brien, et. al., 2014).

The discussions with focus groups were audiotaped and transcribed by the researcher. Although the author states the participants' responses and content was extracted for meanings and consistency, which led to pattern and major theme identification., the method for identifying and developing themes is not included in the article. It was explicitly stated that data saturation was achieved. No further information regarding data analysis is provided. The method of data analysis is congruent with the research question; however, an important omission is the lack of evidence regarding the study's auditability, confirmability and creditability.

The findings and discussion are reported in the results section of this study. Although many journals require separate reporting of findings and discussions, it has been argued that reporting of these essential study elements remain at the discretion of the study author (O'Brien, et. al., 2014). Two themes were identified and extracted from the data: NGNs lacking confidence and gaining acceptance in the unit's culture. The themes were described with exemplars from the focus groups. However, the findings supported literature showing that in emergency situations, the NGNs' inexperience led to interruptions in the workload of SRNs, requiring SRNs to assist NGNs' manage their workload. In certain emergency situations, SRNs were obliged to take over the care of the NGNs' patients. New Graduate Nurses were perceived to lack confidence, had concerns with basic skills and time management, were fearful and lacked the ability to think critically. Additionally, SRNs directed incivility and belittling and toxic comments towards NGNs. Although SRNs were not proud of this behaviour, the participants acknowledged that this behaviour existed.

Limitations of the study were not explicitly presented in the study article. There is scant information regarding the characteristics of the participant group, specifically gender or ethnic background. Participants with differing characteristics may have offered different perceptions of the phenomenon under study.

Implications for practice were presented and included the recommendations that: NGNs receive a minimum orientation of six months in specialty areas followed by six months of mentoring; NGNs be given a sense of community in a professional environment, free of discourteous behaviour; and NGNs be encouraged and nurtured to ask questions with the aim of overcoming their fear of asking questions and being perceived as burdensome.

### 2.7.3 'Newly Qualified Nurses experiences in the Intensive Care Unit' (O'Kane, 2012)

The phenomenon of interest under study is the experience of NGNs starting their career in ICUs from the perspective of NGNs and ICU SRNs. The objectives stated were three-fold: to explore NGNs' experiences of commencing their career in ICUs; to discuss areas affecting NGNs' induction into ICUs; and to compare similarities and differences between NGNs' and SRNs' opinions of the phenomenon. Related literature is used to provide motivation and background for the study; notably, there is little research studying NGNs in the ICU, and therefore, this study fills a gap in the literature. However, the basis of this broad statement is difficult to critique as a description of the methods and terms used to conduct the literature review is not provided.

The author states a comparative qualitative approach was used to study the phenomenon however an explicit statement of the underlying philosophy and/or methodology was not provided; therefore, it is difficult to determine the researcher's values, beliefs and experiences regarding this research problem. This has implications for readers when critiquing the methodology and results, as researcher's views and beliefs can be said to influence the interactions the researcher has with participants (Kuper, Reeves, & Levinson, 2008). Although in the abstract the author of this research states a comparative qualitative approach was used, the aim and methods of the research suggests the use of a phenomenological approach. It is unclear whether the author is using a comparative research method as the research design or as a data analysis tool to evaluate similarities and differences as part of a within-case comparison, as a phenomenological approach (Mills, 2008).

The study was situated in a 13-bed ICU in a large teaching hospital in West Yorkshire, England. Eight NGNs participated in phase one, with seven SRNs involved in phase two. There were two participant groups, NGNs and, SRNs defined as 'band 7 or above' [Ward Manager/Ward Sister/Charge Nurse/Nurse Manager/Clinical Ward Nurse Lead] (O'Kane, 2012, p. 45). NGNs were defined as those employed in ICU for less than one year. Both phases used purpose sampling; however, the recruitment process was not stated. The two populations of nurses are not described further than their years of experience. Whether this impacts the results of the research cannot be ascertained. It could be postulated that if phase one nurses had been exposed to difference in nursing

undergraduate education and had clinical exposure to intensive care as part of their education, then there is a possibility of differing participant experiences and therefore, results.

The researcher describes two phases of the research. Phase one consisted of asking the newly qualified nurses questions derived from the literature review. These questions were semi structured in nature; however, they are not provided therefore congruence between the research aim, methodology and methods is difficult to evaluate. The lack of theoretical discussion in this research may reflect on the quality of the research. Kuper, et. al. (2008) suggest, from a pragmatic viewpoint, qualitative research presented in health profession specific journals tend to emphasise results that relate to practice. Whereas, theoretical discussions are published elsewhere.

Pilot testing the research questions ensured rigour, although one participant was used in this process. Phase two used themes and clusters from phase one to conduct a focus group with senior nurses. The author states the finding from each group were compared but this process is not articulated in the article.

The researcher referred the findings from phase one and two back to the literature. Although this approach informs the reliability of the research, it adds to the lack of clarity regarding the main aim of the research.

Data analysis was described; early data analysis was informed by Morse and Field (1995) and, Colaizzi's (1978) seven-stage theoretical framework (Polit & Beck, 2008) was employed in later analysis. Although not explicitly stated, the use of Colaizzi's (1978) framework suggests the researcher employed a phenomenology methodology. Nonetheless, Hallet (1995) suggests that if a framework is used to analyse data to discover the essence of a phenomena, the phenomenology changes from a philosophical approach to a method (Flood, 2010).

Post analysis, four major themes with associated clusters and sub-clusters were identified. These were illustrated with exemplars from the semi-structured interviews and focus groups. Participants validated the findings via member checking. Although this may add rigour and credibility to the analysis and increase participant involvement in the research, there is debate in the literature regarding this process. Lewis (2009) argues member checking, particularly the concepts of checks and balances used to correct errors and

eradicate the likelihood of misrepresentation, is historically embedded in positivism and post-positivism.

New findings from this study highlighted: NGNs had trouble with time management, decision-making and socialisation, NGNs pose burnout risk to their SRN preceptors; a lack of ward experience can lead to NGNs' inability to manage time, prioritise and learn basic skills without ICU monitoring; and SRNs' concerns regarding competency-based practice is leading to a generation of task-orientated nurses. An unawareness of competency-based practice leading to an inability to record, retain and recognise legalities involving competencies was highlighted.

Limitations were acknowledged; the participants were known to the researcher, potentially affecting the credibility of the results. The researcher balanced this against SRNs supporting the research process and participant comfort with a familiar researcher. However, this cannot be assumed as hegemony may exist between different nursing grades and reporting lines and could have an impact on the data collection process. The study was recognised as being small in scale. Auditability was described. However, there was minimal evidence regarding the rigour of the study; fittingness, confirmability and credibility were not explicitly stated. Trustworthiness, credibility and transferability of this research is difficult to assess as detailed information regarding the research paradigm, selection of participants, interview questions and the researcher's reflexivity is not richly discussed in the article.

Implications for health professionals are as follows: The findings of this study offer support for ICU being a good learning environment for NGNs on the provision that NGNs are provided necessary support. Despite initial anxiety, NGNs coped well with the ICU pressure. However, the SRNs found the integration of NGNs in the ICU environment challenging. The SRNs recommend that NGNs should have ICU experience as a student, yet recognised this is not always possible. A lack of ward experience was perceived by SRNs to influence NGNs' ICU nursing. New Graduate Nurses required sufficient support to have a beneficial and pleasant ICU working environment. The SRNs were aware of their support role. It was recommended that NGNs be supported with two preceptors.

Although a plethora of literature has examined NGNs' experience when transitioning into professional practice, fewer studies have focused on SRNs' experience of working with

NGNs during their transition. Further, studies exclusively focusing on the experience of SRNs who work with NGNs in the ICU were not located in the literature. The three studies selected for review presented an understanding of the SRNs' experience on working with NGNs in ICUs: either as part of a larger study (O'Kane, 2012) or, on including the ICU context with other hospital clinical areas (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012).

The findings of these three studies concluded that SRNs working with NGNs in the ICU context are generally supportive of NGNs. Senior Registered Nurses supported NGNs by encouraging them to ask questions and helping them with their nursing tasks, despite an associated increase and interruption of their own workload. However, SRNs perceived the increase in workload related to supporting NGNs as a source of stress and frustration, with SRNs exhibiting negative behaviours towards NGNs. The studies highlighted additional concerns regarding the NGNs' lack of ward experience, which could hinder their ability to develop in ICUs, and patient safety in the ICU context, owing to lack of clinical experience.

The literature review identified gaps in the existing literature. The 'voices' of SRNs' who work with NGNs in the ICU has been silent in the literature, with a greater emphasis on the experiences of NGNs. This current study intends to add to nursing knowledge by telling the stories of SRNs' experiences. The aim in giving a voice to SRNs working in the ICU is to have them narrate their own stories (Wang, 2017b) of experience rather than to understand their experience from the NGNs' perspective. Inquiring into the SRNs' stories may reveal organisational, interpersonal and cultural factors affecting staff retention, patient safety and the maintenance of healthy workplaces.

The next chapter presents the underlying thinking and subsequent actions of this inquiry's approach to the NI methodology. A Deweyan (1938) view of experience forms the foundation of Clandinin and Connelly's (2000) NI methodology. Narrative Inquiry guides the phases of this inquiry's method. The method is presented with detailed transparency, ensuring auditability and credibility of the inquiry process.

# Chapter 3: Methodology and Methods

> Narrative inquiry is a way of understanding experience. It is collaboration between researcher and participants, over time, in a place or series of places, and in *interaction* with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that made up people's lives, both individual and social (Clandinin & Connelly, 2000, p.20).

A research paradigm guides a study's construction and choice of appropriate methodology and method. Elements of a paradigm include ontology, epistemology and methodology. In this chapter, this inquiry's qualitative paradigm, NI, is presented. Qualitative research methodologies and methods are applicable to nursing research, being congruent with the researchers' aims of exploring and presenting knowledge generated from experience and interactions with participants (Holloway, 2005). Narrative Inquiry's philosophical underpinnings, methodology and the methods used to generate and analyse the field notes (data) are described and discussed in detail. First, Dewey's (1938) understanding of experience is presented as it underpins Clandinin and Connelly's (2000) NI methodology. The researcher's reflexive stance, position and justification are offered followed by an explanation of the NI methods used.

## 3.1 Philosophical Underpinning: Dewey

John Dewey (1859–1952), a philosopher, psychologist and educational reformer, was integral to the foundation of the philosophical movement, Pragmatism. Dewey developed a philosophy of education to meet the needs of the changing democratic society in the 20th century. Dewey's goal was to promote human interests by creating a society of informed and engaged inquirers (Gouinlock, 2018). In his concise statement, 'Experience & Education', Dewey (1938) detailed his theory of experience.

Dewey's (1938) theory of experience and the philosophy of Pragmatism are fundamental to the ontology and epistemology of NI. The philosophical movement of Pragmatism seeks thought and the meanings of conceptions through their practical applications. Pragmatism is a tool for guiding action and solving problems and as a means of action (James, 1975; Pragmatism, n.d.). The pragmatist views experience as, 'always more than

we can know and represent in a single statement, paragraph or book. Every representation, therefore, no matter how faithful to that which it tries to depict, involves selective emphasis of our experience' (Clandinin & Rosiek, 2007, p. 39)

Dewey's (1938) theory of experience asserts that experience and education are inextricably linked. Dewey writes, 'Every experience lives on in further experiences' (p. 27). This concept of *continuity* of experience describes how every experience modifies the person who has undergone, and been acted upon, by the experience. This modification affects the quality of subsequent experiences, whether one wishes it or not (Dewey, 1938). An educative experience is one that is conducive to physical, intellectual and ethical growth. Conversely, a miseducative experience is one that effects or distorts the growth and responsiveness of further experiences, thus limiting the possibility of having richer experiences in the future (Dewey, 1938).

Dewey's (1938) principles of *continuity* and *interaction* are central to the constitution of experience. Dewey's first principle, *continuity*, was depicted through a narrative continuum. Clandinin and Connelly (2000) describe this continuum: 'Wherever one positions oneself in that continuum – the imagined now, some imagined past, or some imagined future – each point has a post experiential base and leads to an experiential future' (p. 2). Dewey's second principle, *interaction,* was described by Clandinin and Connelly (2000), 'People are individuals and need to be understood as such, but they cannot be understood only as individuals. They are always in relation, always in a social context' (p. 2).

Dewey (1938) comprehends the concept of *situation* to be intertwined with the principle of *interaction.* People live in a world, meaning that they live in a series of *situat*ions. Therefore, interaction indicates the relationship of the individual with objects and other people. Further, the principles of *continuity* and *interaction* are intertwined: 'They intercept and unite. They are, so to speak, the longitudinal and lateral aspects of experience' (Dewey, 1938, p. 44). Dewey refers to a 'changing stream that is characterised by continuous interaction of human thought with our personal, social and material environment' (Clandinin & Rosiek, 2007, p. 39).

Transforming the commonplace term, *experience*, into a term of inquiry; Dewey (1938) influenced the researchers Clandinin and Connelly (2000). Dewey's views of experience

formed the conceptual framework from which Clandinin and Connelly (2000) explored educational experience.

## 3.2 **Narrative Inquiry Methodology: Clandinin and Connelly**

Jean Clandinin and Michael Connelly (2000) are educational researchers who held a narrative view of experience based on Dewey's (1938) principles of experience. They established NI as a research methodology, writing a definitive guide explaining NI theory by creating a contextual definition of NI. Clandinin and Connelly (2000) show what NIs 'do' by 'using storied examples from NIs that address a range of research concerns' (p. xiii).

Stories are the way in which people create meaning in their lives and gain each other's support in establishing their lives and their communities (Clandinin, 2007). Stories are created by people in a particular place at a particular time while engaging in a particular experience (Clandinin, 2007). Polkinghorne (1988) describes narrative as being a 'kind of organizational scheme expressed in story form' (p. 13) that 'organizes events and human actions into a whole' (p. 18). To study narrative is to study the ways in which people experience the world (Connelly & Clandinin, 1990).

As a research methodology, NI is distinct both methodologically and ontologically from research practices that use stories as data [field texts] or view story and narrative as representational forms, as structure and as content analysis, or treat stories as the studied phenomenon. Narrative Inquiry is different from types of narrative analysis used in other methodologies, such as linguistic, structural and visual analyses. Stories and narratives are used as data in methodologies such as ethnography, case study and phenomenology, in addition to being used as forms to represent findings and results of studies. However, NI is a methodology with distinct differences from other uses of narratives in research studies (Caine et al., 2013).

In NI, the term narrative refers to the structured characteristics of experience to be studied as well as the method of inquiry for its study (Connelly & Clandinin, 1990). Therefore, it is equally accurate to refer to 'narrative inquiry' as it is to state, 'inquiry into narrative' (Connelly & Clandinin, 1990, p. 2). This delineation is preserved, defining inquiry as 'narrative' and the phenomenon as 'story' (Connelly & Clandinin, 1990, p. 2). People, by nature, lead 'storied lives and tell stories of those lives' (Connelly & Clandinin, 1990, p.

2). Narrative Inquiry researchers provide descriptions of lives, gather and tell stories of lives and compose narratives of experience.

Underpinned by a Deweyan view of experience, NI begins and ends with respect for the ordinary lived experience (Clandinin & Connelly, 2000). Ontology, 'the study of being' (Crotty, 1998, p. 10), is concerned with the nature of reality. Dewey's (1938) ontology is transactional, implying that the 'ideal for inquiry is not to generate an exclusively faithful representation of a reality independent of the knower' (Clandinin & Rosiek, 2007, p. 39). Narrative Inquirers seek to generate a new relationship between a person and their environment, their social interactions and world (Clandinin & Rosiek, 2007). Thus, 'Our representations arise from experience and must return to that experience for their validation' (Clandinin & Rosiek, 2007, p. 39). A pragmatic ontology of experience places emphasis on both the temporal nature of knowledge generation and on *continuity*.

The individual's experience is the starting point for NI (Clandinin & Rosiek, 2007). However, NI explores institutional, societal and cultural narratives within which an individual's experiences are, 'constituted, shaped, expressed and enacted – but in a way, that begins and ends that inquiry in the storied lives of the people involved' (Clandinin & Rosiek, 2007, p. 42). Through the study of a person's experience, NI researchers seek to enhance and transform the experience for other readers and themselves (Clandinin & Rosiek, 2007).

Attending to the phenomenon of experience begins at the outset, and continues throughout the NI. 'Narrative inquirers understand experience as a narratively composed phenomenon' (Clandinin, 2013, p. 16). Epistemology focuses on the nature and forms of knowledge and the ways in which knowledge can be acquired and communicated to others (Cohen, Manion, & Morrison, 2011, p. 6). From an epistemological perspective, this NI research employs Clandinin and Connelly's (2000) three-dimensional NI space, which is discussed next and is referred to throughout the inquiry. The researcher 'thinks narratively' by considering the phenomenon under inquiry through the commonplaces of *temporality*, *sociality* and *place*. By thinking narratively, the researcher, 'highlights the shifting, changing, personal, and social nature of the phenomenon under study' (Clandinin, 2013, p. 38). Engaging in NI requires the researcher to think within the three commonplaces of NI throughout the stages of the inquiry: framing the research puzzle;

negotiating relationships with the participants; navigating entry to the research field; composing the field texts; and composing the research text (Clandinin, 2013).

## 3.3 Three-Dimensional Narrative Inquiry Space

Drawing upon Dewey's (1938) principles of experience—*continuity*, *interaction* and *situation* (Clandinin & Rosiek, 2007)—and adopting Schwab's (1978) term *commonplaces*, a metaphor of a three-dimensional space was developed. Connelly and Clandinin (2006) identify, 'three commonplaces of narrative inquiry – temporality, sociality and place – which specify dimensions of an inquiry space' (p. 479). The three commonplaces were imagined as a checkpoint, a means to direct and reorient attention when conducting an NI. The three commonplaces provide a conceptual framework for NI.

### 3.3.1 Temporality

Inquirers attending to the temporal dimension consider that the people, places, things and events being studied have a past, present and future. Events under inquiry are in temporal transition (Connelly & Clandinin, 2006). Entities do not exist in one singular moment, independent from their past and their influence on the future (Clandinin & Connelly, 2000; Clandinin, 2013). The importance of the temporality dimension in NI originates from philosophical views of experience, highlighting:

> As with all the particular narratives (experiences and actions) in which we consciously participate, to live this story is to tell it, to ourselves and possibly to others; and in this case to retell it again and again, revisiting it as we go along. (Carr, 1991, pp. 95–96)

When NI researchers attend to the dimension of temporality, they are attuned to both the participant's and their own lives. Attention is drawn to the temporal nature of places, things and events when engaging in the inquiry (Clandinin, 2013). In keeping with the temporal commonplace, NI frames a research puzzle rather than research questions and expectations of solutions. This puzzle is accompanied by a 'sense of a search, a "re-search", a searching again' (Clandinin & Connelly, 2000, p. 124). Narrative Inquiries conveys 'more of a sense of continual reformulation of an inquiry than it does a sense of problem definition and solution' (Clandinin & Connelly, 2000, p. 124).

### 3.3.2 Sociality

Narrative Inquiry researchers simultaneously attend to the personal and social conditions. The personal conditions of both the inquirer and the participant are defined by Connelly and Clandinin (2006) as being 'the feelings, hopes, desires, aesthetic reactions, and moral dispositions' (p. 480). Social conditions are deemed to mean the individual's context, including the environment, surrounding factors and forces, existential conditions and people (Connelly & Clandinin, 2006). Personal conditions can be internal or external. Inquirers turning internally focus on personal conditions, such as aesthetic reactions, emotions and moral responses; those turning externally attend to what is occurring, to the people and occurrences in our experiences (Clandinin, 2013).

Another aspect inherent in the *sociality* commonplace is the relationship between inquirer and participant, an important component in NIs. Connelly and Clandinin (2006) write, 'Inquirers are always in an inquiry relationship with participants' lives. We cannot subtract ourselves from [the] relationship' (p. 480). Narrative Inquiry researchers create research texts, which account for who they are in the study as well as who they are in relationship with the participants. This aspect of the *sociality* commonplace pays attention to the relational ontology of NI.

### 3.3.3 Place

The third commonplace is that of place or a sequence of places. Place is defined as 'the specific concrete, physical, and topological boundaries of place where the inquiry and events take place' (Connelly & Clandinin, 2006, p. 480). Recognising that events 'take place some place' (Connelly & Clandinin, 2006, p. 480) is the crux of this commonplace. When NI researchers write for others about the relevance of their work, they need to acknowledge the impact and qualities of place, on the study. The specificity of place is crucial for NI researchers because they consider stories, people and places to be intricately connected (Clandinin, 2013).

## 3.4 **Entering the Midst**

Working in the three-dimensional space, NI researchers are always *in the midst*, located in and, transecting, the dimensions of *temporality*, *sociality* and *place* (Clandinin & Connelly, 2000). Entering research relationships can be formed in the midst of

professional and personal lives; organisational or university narratives; and cultural, political and social narratives (Clandinin, 2013). When the participants' and researchers' lives intersect in the midst, they are shaped by the inquiry's attendance to the, 'past, present, and future unfolding social, cultural, institutional, linguistic, and familial narratives' (Clandinin, 2013, p. 43). Meeting in the midst occurs when researcher and participants meet at the beginning of the inquiry and while acquiring and negotiating field texts; researchers leave the midst on writing the research texts [theses]. Final research texts can refer to a variety of documents, such as academic publications, theses and dissertations; however, hereafter, the final research text is referred to as the 'thesis'.

## 3.5 **Field Texts**

Field texts are co-compositions that reflect the experiences of the participants and researchers and can include transcripts, documents, artifacts, photographs, field notes and journals. These co-compositions may direct the diverse ways in which theses represent the retold stories of experience (Clandinin, 2013). Clandinin and Connelly (2000) use the term 'field texts' rather than the term 'data', 'to signal that the texts we compose in narrative inquiry are experiential, intersubjective texts rather than objective texts' (Clandinin, 2013, p. 46). Throughout this thesis, the term 'field texts' is used, replacing the term 'data'. If the term 'data' is used specifically by another author, the term field texts is placed in square brackets as an explanation.

Howe and Moses (1999) discuss the ownership of field texts, suggesting consideration especially 'when the ownership passes from the participants to the researcher, and with what constraints, requirements, conditions and powers over the use and dissemination of the findings placed upon the data [field texts] by the participants' (p. 43). If inquirers respect the dignity of the participants, then there is need to treat participants as equals not as subordinates to the researcher (Cohen et al., 2011). This is particularly important since NI attends to relational aspects in all phases of the research; hence, field texts and interim texts were co-composed and negotiated throughout this inquiry.

## 3.6 **Telling and Living**

Connelly and Clandinin (2006) state that there are different approaches to co-composing field texts: *telling* and *living*. When considering the three-dimensional space at the outset

of the NI, the researcher can either consider the life as lived in the past, *telling*, or *living* the life under study as it occurs, *living* (Kim, 2015). Narrative Inquiry researchers may begin with either telling or *living*, yet most predominately begin with *telling*. One of the main ways of *telling* is storytelling.

In NIs focused on *telling*, the most commonly used starting point is conversation. Clandinin (2013) suggests allowing a space where both participants' and inquirers' stories can be created and heard. The conversations are marked by their equality, allowing participants the flexibility to introduce additional topics and set direction. Since conversations entail listening, inquirers may probe deeper into the story, resulting in a more extensive representation of experience. Probing occurs in an environment of mutual trust, whereby the inquirer cares about the experience described by the participant (Clandinin & Connelly, 2000).

In contrast to *telling*, Connelly and Clandinin (2006) suggest a more time-consuming, intensive method begins with *living* alongside participants who are in the midst of their lives. *Living* field texts are the researcher's observations and/or participants' observations (Kim, 2015). Connelly and Clandinin (2006) assert that although riskier for the inquirer owing to participant control over the aspect of *living*, it is rich with intellectual potential and interest. Researcher–participant relationships that are focused on *living* alongside the participant may be more intense and intimate than those that begin with *telling* (Connelly & Clandinin, 2006). If the researcher shares similar experiences with participants in the inquiry, empathy and close relationships may develop.

Although this is a *telling* inquiry, I also live alongside the participants. Although I did not collect field notes since I lived alongside the participants, our shared knowledge of the commonplaces of *place* and *sociality* gave me unique insight into the co-composed narrative accounts (NAs). Further, I will continue to live alongside the participants after this NI thesis is written. Regardless of the beginnings, whether *telling* or *living*, NI researchers work collaboratively with the participants in the three-dimensional space. Narrative Inquiry researchers find ways of understanding participant experiences, as well as their own experiences, as they endeavour to co-construct experiences established through the process of relational inquiry (Connelly & Clandinin, 2006). To better understand their own experiences, researchers may engage in a process of critical self-reflection throughout the inquiry.

## 3.7 **Reflexivity**

Being reflexive and demonstrating these reflections in the thesis are considered a key element of ethical, qualitative research (Bishop & Shepherd, 2011). 'Reflexivity requires critical self-reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process' (Finlay & Gough, 2008, p. ix). Although researchers may be honest in their reflexive accounts, there are factors that may not be immediately discernible by inquirers or may be distorted by temporality. Therefore, reflexivity occurs before, during and after an experience, as a form of continuing self-analysis and political awareness, often documented in a researcher journal (Lahman, Geist, Rodriquez, Graglia, & DeRoche, 2011). Since NI is attentive to the relational aspects of the methodology, a reflexive approach is essential as it:

> notices the reactions to a research situation and adapts in a responsive, ethical, moral way, where the participant's dignity, safety, privacy, and autonomy are respected. Additionally, the researcher pays special attention to the possible power imbalances between the researcher and the participants. (Lahman et al., 2011, p. 1403)

Narrative Inquiry researchers co-compose numerous field texts with the participants. What is eventually shared in this thesis comprises only some of these field texts. The process of negotiating and co-composing the interim NAs with participants, the researcher's analysis and the searching for resonant threads, through to the writing of the thesis, requires attention to the three-dimensional space. Some stories, characters and contexts will interweave and interconnect, while others will remain singular and incongruent. Elliot Mishler (1924–2018), a significant contributor to the field of NI, suggested, 'Narrative inquirers need to make visible in their research texts the process(es) by which they chose to foreground particular stories' (Clandinin, 2013, p. 50).

Analysis of the field texts occurred within the three-dimensional space. Interim texts 'are partial texts which are open to allow participants and researchers opportunities to further compose storied interpretations and to negotiate the multiplicity of possible meanings' (Clandinin, 2013, p. 47). The interim research texts were 'open' to participants since they allowed further negotiation regarding unfolding threads of experience; this process was essential when writing the thesis. The process of shaping and analysing the field texts into interim and thesis occurred in two stages: co-composing the NAs and the search for resonant threads. As detailed in the next paragraph, Mishler's (1995) 'reconstructing the

told from the telling' (p. 95) was employed to compose the tentative NAs. Braun and Clarke's (2006) thematic analysis method was used to seek resonant threads across the final negotiated NAs.

Mishler's (1995) method of 'reconstructing the told from the telling', guided the development of the interim texts. In Mishler's (1995) article, 'Models of Narrative Analysis: A Typology', the models are ordered in a series of 'sets'. The first set focuses on the 'correspondence between the temporal sequence of actual events and their order of presentation in the text or discourse' (p. 90). In this 'set', analysis places the 'told' into a temporal order or a reordered storyline. Participants may not always tell stories of experience in a temporal or conceptual order, deviating from storylines and making general comments that do not have clear temporal signposts (Kim, 2015; Mishler, 1995). By rearranging the 'told' from the conversations into chronological or thematically coherent stories, the researcher reconstructs a story from the '*tellings*'. The reconstructed story becomes, 'the narrative for further analysis' (Mishler, 1995, p. 95).

Thematic analysis is a method of identifying, analysing and reporting threads (themes) across the NAs. Focusing on the particular plotlines of the individual NAs, 'resonant threads or patterns' (Clandinin, 2013, p. 132) are sought across the NAs. The plotlines, which weave and thread over time and place through the participants' NAs, are termed 'threads' (Clandinin, 2013, p. 132). Metaphorically, the NAs are laid alongside one another, searching for 'resonances or echoes that reverberated across accounts' (Clandinin, 2013, p. 132). These resonant threads convey an important meaning about the field texts in relation to the research; representing a degree of patterned meaning or response across the five NAs (Braun & Clarke, 2006).

Thematic analysis is not a linear process but one more recursive in nature. It is a process that develops over time with movement back and forth between the phases. Teachers and researchers in qualitative psychology, Braun and Clarke (2006) present a method of thematic analysis that organises and describes field texts in rich detail via a six-phase process: familiarising yourself with your data [field texts], generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report [thesis] (p. 87). A summary of the six-phase process is presented in the appendices (see Appendix B). Braun and Clarke's (2006) thematic analysis approach aligns with NI methodology owing to the recursive nature of the analysis process. The backwards and

forwards movement through the phases echoes the commonplace of temporality with its sense of continual searching and reformulation.

Narrative Inquiry research texts do not presume to provide answers to the research puzzle in the thesis. Narrative Inquiries are less concerned with generalisability and more concerned with a deeper understanding of the research puzzle (Tolley, Ulin, Mack, Robinson, & Succop, 2016). Rather, stories of experience are presented so that readers may 'rethink and reimagine the ways in which they practice and the ways in which they relate to others' (Clandinin, 2013, p. 51). By presenting the findings of the NI in a narrative format, readers 'can access rich layers of information that provide a more in-depth understanding of the particulars of the participant's points of view' (Wang & Geale, 2015, p. 195).

Josselson (2007) proposes that there is an inherent ethical conundrum in narrative research. The narrative researchers have a dual role—they are in a research relationship with the participants but also in a professional role within the academic community. Relational ethics requires a responsibility towards dignity, respect, cultural awareness, reflexivity, well-being and confidentiality of the participants (Josselson, 2007; Lahman et al., 2011). These responsibilities may create tensions with the academic obligations of analysis and interpretation, accuracy and publishing of the thesis (Josselson, 2007; Park, Elly, Vera, David, & Joanne, 2016). Balancing both ethical and academic responsibilities simultaneously was challenging. Rather than attempting to untangle and resolve tensions that occurred during this NI, they were acknowledged and made visible in the thesis (Clandinin, Murphy, Huber, & Orr, 2010; Huber, Clandinin, & Huber, 2006; Josselson, 2007). Tensions encountered in this NI, such as level of smoothing requested by a participant, use of pseudonyms, inclusion of research processes in the NAs and inclusion of one participant's career trajectory, are discussed throughout section 3.10 Methods.

## 3.8 Researcher's Position

I chose NI methodology because I consider life to be interpreted and experienced by people via *interactions*, in a constantly changing complex world (Cohen et al., 2011; Tuli, 2011; Wang, 2017b). I focused on the phenomenon of lived experience and the individual's development of knowledge via experience. In this NI, I sought to honour the experience of the SRNs who work with NGNs in the ICU, focusing on SRNs' lived

experience, via the telling of stories as an important source of knowledge and understanding.

The relationship between participants and inquirers may add richness and depth to the narrative field texts and potentially lead to deeper insights into the context under inquiry (Tuli, 2011). The pre-established professional relationship between the participants and me allowed a greater understanding of the commonplaces of *place* and *sociality* as explained in section 3.6 Telling and Living.

My personal and professional experience highlights that as 'narrative inquirers we work within the space not only with our participants but also with ourselves' (Clandinin & Connelly, 2000, p. 61). Consequently, throughout this inquiry, to ensure transparency, my voice is made visible and integral to the story. Clandinin and Connelly (2000) state, 'It is impossible (or if not impossible, then deliberately self-deceptive) as researchers to stay silent or to present a kind of perfect, idealized inquiring moralizing self' (p. 62). The inquirers' voice has been made visible in other NI research texts (Lindsay, Schwind, Papaconstantinou, Smye, & Cross, 2016; Wang, 2017a).

## 3.9 **Justification**

To justify an NI, Clandinin and Caine (2012) suggest 'responding to the questions of "so what?" and "who cares?"' (p. 174), in three ways: personally, practically and socially or theoretically. These justifications were imagined at the outset and revisited throughout the inquiry during the composition of the tentative NAs and thesis.

Personal justification was demonstrated through my reflexive stance. Inquirer reflexivity does not consider research neutral in relation to values or ethical conduct to be simply a matter of complying with a predetermined set of rules. Hammersley and Traianou (2012) suggest that reflexivity highlights the 'value-rich' rather than 'value-neutral' nature of social research. Reflexive judgement must be applied to the whole research context, 'including the identities of the researcher and of the researched, and the forces, of various kinds, operating upon and within the situation' (Hammersley & Traianou, 2012, p. 34).

Since NI is an ongoing reflexive methodology (Connelly & Clandinin, 2006), I considered my interest in, and relationship to, the inquiry through a 'Narrative Beginnings Account' (see Appendix C) and reflexive journal. Narrative inquirers begin their research

journey by inquiring into their own stories of experience. Engaging in autobiographical NI, inquirers frame their own narrative beginnings. My 'narrative beginnings account' made 'evident the personal, social, and political contexts that shaped our understandings' (Clandinin, 2013, p. 55). Processes, ideas, tensions and dilemmas were contemporaneously recorded in the confidential, reflexive journal (Clandinin, 2013).

Practical justification was evidenced by the discovery of a gap in the literature exploring SRNs' experiences of working with NGNs in the ICU. In response to the 'so what' question, I contemplated issues of equity and social justice (Clandinin & Caine, 2012). In the absence of the SRNs' voice, I considered, 'alongside participants, how their and our experiences might be shaped differently in the future' (Clandinin & Caine, 2012, p. 174). Providing insight into the SRNs' experiences through stories told and shared, readers of this research may in future desire to tell and share their own stories.

The final justification required a consideration of social or theoretical justifications. Social justification can be thought of in two ways, 'theoretical justification as well as social action and policy justification. Theoretical justification comes from justifying the work in terms of new methodological and disciplinary knowledge' (Clandinin & Huber, 2010, p. 436). Social justification was demonstrated through giving voice to the SRNs and making visible their stories of their experience, working with NGNs in the ICU context (Clandinin & Huber, 2010). Additionally, theoretical justification was determined via expanding nursing disciplinary knowledge resulting from the findings of this inquiry and presenting NI as an appropriate methodology when inquiring into SRNs' experiences.

## 3.10 **Methods**

In the following section of this chapter, I present and describe the methods used when generating and analysing the field texts co-composed with the participants of this current inquiry. I make visible aspects such as relational considerations, ethical tensions and participant collaboration to ensure absolute process transparency.

### 3.10.1 Receiving Ethical Approval

Inherently collaborative, NI is a relationship-focused methodology, whereby ethical considerations are commonly viewed as responsibilities negotiated throughout the phases of the inquiry. Narrative Inquiry researchers consider ethical research relationships to be

ones that show awareness: of respect, the negotiation required with participants regarding the collaborative nature of the research and the trust formed between inquirer and participant (Clandinin, 2006; Connelly & Clandinin, 1990). Therefore, ethical considerations beyond those required by institutional human research ethics committees become important (Clandinin, 2013). Additional ethical considerations result from the NI perspective of the researcher arriving in the midst of participants' lives, requesting participant help to understand the research puzzle (Josselson, 2007). This stance guides ethical dilemmas that may occur during the ongoing relational aspects of the research processes (Clandinin & Connelly, 2000; Clandinin, 2006). This inquiry received ethics approval from a metropolitan Level 6 hospital (Health System Planning and Investment Branch, 2018) Human Research Ethics Committee, reference number LNR/16/SVH/170 (see Appendix D) and received cross-institutional recognition of this approval from the University of Notre Dame, Australia.

### 3.10.2 Enrolling Participants

A research advertisement was displayed on ICU notice boards (see Appendix E). Screening occurred when potential participants contacted the inquirer in person. The inclusion criteria were: SRNs were permanently employed in the ICU; they had worked with NGNs within the last three months; and they were willing to give written and informed consent and participate in and observe the inquiry protocol. As this inquiry had an ideographic approach (Robinson, 2011) a participant sample size of between four to eight participants was proposed. This number of participants allowed for individual participants to have a locatable voice within the inquiry whilst allowing for intensive analysis of each participants' narrative account (Smith, Flowers, & Larkin, 2009).

When potential participants approached me, I gave an overview of the inquiry, a hard copy of the participant information guide (see Appendix F) and the consent and form of withdrawal of participation (see Appendix G). I felt it important to discuss the relational and collaborative nature of NI methodology early in the enrolment process. Although I would continue to work alongside the participants throughout the inquiry period, the potential participants and I would be in an inquiry relationship, co-composing the NAs. I was transparent regarding the relational aspects of the NI, since it may have affected potential participants' willingness to participate. They were encouraged to ask questions, ensuring full understanding of the inquiry methods.

A purposive sampling strategy was employed. All five potential participants who showed interest in the project met inclusion criteria and were enrolled, with none being excluded or withdrawing. Consequently, the sample had demographic homogeneity (Robinson, 2014). All participants were female, anglophone and Caucasian, with an average 13 years of nursing experience in this ICU. The sample size allowed scope for developing resonant threads across the narrative accounts, whilst preventing the inquirer from being submerged in field notes (Robinson & Smith, 2010).

### 3.10.3 Maintaining Confidentiality

Confidentiality protected the participants' right to privacy by the nondisclosure of information that may have identified them (Cohen et al., 2011). Although aware of who had provided information, I did not share this publicly. Field texts, NAs and the thesis were safeguarded to protect participants' confidentiality (Josselson, 2007). I maintained confidentiality by using pseudonyms, omitting time and dates in the NAs, participants' review of their tentative narrative accounts and storing a pseudonym for participant identifier on one non-networked, password-protected computer.

To ensure confidentiality, the use of pseudonyms is often appropriate in research texts; however, the imposition of biomedical human research principles on participants may remove autonomy (Lahman et al., 2015). The use of pseudonyms seems at odds with some participants' desire to use their own names. I took a responsive approach, creating pseudonyms with participants rather than automatically assigning pseudonym names that I selected. To remain attentive to the participants, I chose human names rather than numeric identifiers (Lahman et al., 2015). Since I was unable to predict whether participants may want to choose their own pseudonyms or allow me to choose them, I made these options available on the consent form. The five participants requested that I choose their pseudonym. However, as detailed later in the chapter, one participant negotiated an alternate pseudonym post reading their tentative NA.

All proper names were changed because participants may be identified via association (Josselson, 2007). Pseudonyms replaced names of participants' family members, friends or colleagues. Specific places and education programs were obscured. However, Poland (2001) warned 'Removing too much identifying information could compromise future researchers' ability to contextualize the testimony of the respondents adequately as a basis

for analysis' (p. 634). In this inquiry, contextual information remained intact as a way of understanding the commonplace of *place*. The participant's NAs contained specific details regarding lengths of time and dates. These details were 'blurred' in the final NA to protect participant confidentiality. As an example, the phrase, 'She had been in the hospital for many years' was used rather than the specific number of years mentioned by the participant, attending to NI's commonplace of *temporality*.

The tentative NAs were negotiated, providing an opportunity for participants to highlight any concerns regarding confidentiality. One participant requested that I change their assigned pseudonym to one of their choosing. Another insisted I leave information regarding their career in their NA. I had concerns this information could potentially be attributed to the participant; however, the participant argued the information was essential to the story of experience. The concerns were acknowledged and resolved and are discussed in more detail later in the chapter.

### 3.10.4 Locating Conversations

Staying true to the collaborative nature of NI, I aimed for the meeting places to be mutually decided. I emphasised with participants that they were doing me a favour; therefore, anywhere they chose to meet, be it a café, their home or the workplace, would be suitable. However, all participants asked what would be convenient for me, when negotiating where to meet. In each case, I emphasised that the choice of location was their decision. I took this approach because I wanted a convenient and comfortable location for the participants, seeking to reduce possible tensions in the research process (McDowell, 2001). Additionally, I sought an equitable relationship with the participants during the conversations. However, Hunter (2005) counters this view, suggesting research situations were synonymous with participant anxiety.

Some locations may be more prone to interruptions and distractions than others. I was conscious of the fact that if the participants chose a noisy location, the quality of the digital audio recording may be negatively affected, potentially affecting the quality of the research transcripts (Mero-Jaffe, 2011). Chosen for its unobtrusive size, longevity of recording time and quality of recorded sound, the digital audio recorder had been pre-checked for functionality, clarity of recording and power life. This ensured the conversation was recorded clearly and without unnecessary interruptions.

All participants chose to meet in the ICU, either before or after a shift. I found it intriguing that all participants preferred to meet at work. Herzog (2005) suggests that the chosen setting of the conversation 'is not only a technical matter of convenience and comfort but should be examined within the social context of the study being conducted' (p. 25). The participants' choice was respected. They were not asked to explain their decision. I wondered whether the ICU location was simply convenient to the participants and therefore a pragmatic choice. Thinking temporally back to this time, I wished I had asked participants to discuss their decision. On the day of conversation, I chose the location in the ICU. The variable nature of the activity in the ICU and the need to protect the confidentiality of the participants meant I could not pre-book a location. We were meeting 'in the midst' of our working lives. To ensure privacy and confidentiality, I chose rooms without windows and with lockable doors, which were co-located with the ICU but away from the clinical area.

I believed the participants were giving me a *gift* of their time and stories of experience. 'It is useful to conceptualize the interview [conversation] as a *gift* of time, of text, and of understanding, that the interviewee gives to the interviewer' (Limerick, Burgess-Limerick, & Grace, 1996, p. 458). Although I felt comfortable when requesting this *gift*, I did feel a strong sense of obligation towards the participants. I was aware that I wanted to value their *gift* and do it justice. This feeling of obligation permeated the inquiry from the moment that the participants showed willingness to participate. Therefore, in the spirit of hospitality, the participant was asked whether the space was suitable before entering the room. I deliberately let the participant enter the room first and choose where to sit. I did this to acknowledge the agency of the participant and to 'disrupt conventional notions of power in the interview relationship' (Limerick et al., 1996, p. 458).

### 3.10.5 Gaining Consent

Informed consent is the foundation of ethical behaviour because it respects the rights of individuals to exercise control over their life and make decisions for themselves (Howe & Moses, 1999). The principle of informed consent originates in the individuals' right to self-determination and freedom (Cohen et al., 2011). Self-determination requires participants to evaluate the risks and benefits before consenting. The right to participate also infers the right of refusal and the right to revoke consent after the research has commenced (Cohen et al., 2011). Since NI is a collaborative methodology, informed

consent and the right to revoke consent was sought iteratively throughout the research process. None of the participants chose to revoke consent.

Iterative consent is a dynamic process, with the inquirer committed to obtaining ongoing consent rather than seeking a one-off consent at the start of the research project. The inquirer seeks confirmation from participants at different research points to confirm that they still wish to be involved as well as regarding the use and naming of information within the field texts. Iterative consent may prove challenging if participants change their minds about the use or naming of field texts (Lahman et al., 2015). However, this did not occur in the current inquiry and hence did not need to be addressed.

Narrative Inquiry is a relational and collaborative methodology, requiring the inquirer to gauge participants' comfort levels with all facets of the study. Process responsiveness is a comprehensive ethical stance committing the inquirer to a reflexive practice (Lahman et al., 2011). This was demonstrated when: negotiating entry to the field and creating relationships with participants, negotiating meeting times and places to hold conversations, co-composing the NAs and seeking participant consent to present the NAs in the thesis.

The inquiry's protocol was reiterated with the participants before the consent form was signed. To ensure informed consent, the participants were given the opportunity to ask questions regarding the inquiry's aims, methods and potential risks, including their right to refuse and withdraw without prejudice. The consent form was signed and a copy given to the participant. The researcher's copy was stored in a locked desk drawer within a locked office. All participants signed the consent form immediately before individual conversations commenced.

### 3.10.6 Conversations with Participants

In qualitative research, there are three main types of interview: structured, semi-structured and unstructured interactive interviews (Corbin & Morse, 2003). The difference between these interviews is the degree to which the participants of the interview have control over content and process (Corbin & Morse, 2003). The unstructured interactive interview may also be referred to as narrative interview, open-ended interview or as interview as conversation (Clandinin, 2013; Corbin & Morse, 2003). Clandinin (2013) suggests interview as conversation predominates in NI since it

makes space for both the participant and inquirer to create and hear each other's stories. Riessman (2008) suggests two active participants co-construct narrative and meaning. The aim of NI is to create richly detailed accounts of experience rather than general statements or short answers. Therefore, in this NI inquiry, I chose to engage in conversation because not only did this reflect the experience of co-composing stories with the participants but also aligns most closely with NI methods.

Research conversations often start with what Spradley (2016) calls a 'grand tour question' (p. 62). By asking the participants to tell me a story of their experience, they determine where to begin, elements to include or exclude, the order in which elements are included and how much detail they wish to share (Corbin & Morse, 2003). Although the participants were central to the process of telling their stories, I played a role in the conversation via the use of focused listening and responding (Ritchie, Lewis, Nicholls, & Ormston, 2013). I did this by giving my full attention to the participant, trying not to analyse conversation content or consider whether it aligned with other participants' stories.

Valuing the participants' *gift*, I anticipated that I might need a 'conversation guide' when engaging with the participants in conversation. The use of a conversation guide (Chase, 2011; Liamputtong, 2013; Wang, 2017a) is intended to prompt the inquirer's engagement with the narrators' story of experience and track progress through the conversation, discovering the rich and varied complex elements of each story (Chase, 2008; T. Kelly & Howie, 2007). The guide was brought to all conversations; however, it was only used during the first conversation. During the first conversation, I found the guide to be distracting and I realised that I was being less attentive to the participant. In subsequent conversations, I was more focused on its presence than being fully attentive to the participant. When this occurred, I discarded the guide and allowed the conversation to flow naturally.

Corbin and Morse (2003) explore four phases of unstructured interactive interviews [conversations] as a way of explaining that conversations, when held in a caring and sensitive manner, present an opportunity for reciprocity and psychological risk mitigation. The four phases of conversation are: *pre-interview*, *tentative*, *immersion* and *emergence*. In the following paragraphs, my experience of each of the phases is described.

It is during the *pre-interview* phase when the participants and inquirer establish a degree of comfort and trust. This initial period is important and should not be rushed, setting the tone for the forthcoming conversation (Corbin & Morse, 2003). Although I believe I had created a degree of trust with the participants in my substantive role of ICU CNE, establishing comfort and trust in my additional role as inquirer was important. This was done by: reiterating the purpose of the conversation, ensuring that concerns or questions about the research protocol and confidentiality had been resolved and ensuring that the consent form was signed. During this phase, iterative consent was sought to digitally audio record the conversation. Participants were reminded that they were free to withdraw from the research at any time, without consequence.

Additionally, a degree of 'small talk', light, agreeable, and safe verbal conversation (Flemming, 2018), precedes the formal start of the recorded conversation (Corbin & Morse, 2003; Johnson & Rowlands, 2012). The content of the small talk in this NI differed between participants. Some discussed their workday or events in their home life, while others chatted about personal lives or shared recent photos taken on mobile telephones. However, one participant told me a poignant personal story of own experience with digital audio recorders. This story, associated with the research topic, extended well beyond what would be considered 'small talk'. On hearing the story, I realised the reason that the participant was so insistent that I ensure that the audio recorder was turned on and recording correctly. I was humbled and grateful that she trusted me and took time to share such a personal story. Her insistence in ensuring the digital audio recorder was capturing her story was indicative of both her care and collaboration throughout our research relationship.

It is during the *pre-interview* phase that the basis for reciprocity is established. Corbin and Morse (2003) suggest 'An interview [conversation] is an exchange. The participants sometimes share intimate information, but the researcher gives something in return…' (p. 342). An overt discussion or mention of reciprocity between the participants and me did not occur during the *pre-interview* phase. However, during other stages of the conversations, participants sought reciprocity via asking questions and, as an inquirer conscientious to relational responsibilities, I provided answers once the conversations had concluded (Corbin & Morse, 2003).

Corbin and Morse (2003) suggest that the *pre-interview* phase gradually merges into the conversation; however, the transition between the two phases is not always perceptible. In this inquiry, this did not occur. With all participants, I clearly stated that I would turn on the digital audio recorder, transitioning the *pre-interview* phase into the *tentative* phase. Turning the digital audio recorder to 'record' mode was the point at which the interview transitioned to the *tentative* phase.

The *tentative* phase is a period where participants build trust in the inquirer. Corbin and Morse (2003) state, 'There may be some testing of interviewer response as participants wonder what and how much can be told' (p. 342). As participants told their stories, they not only took their own emotional responses to what was being shared into account but also my verbal and non-verbal cues as the inquirer. Participants may adjust their stories but as trust develops, more of the story unfolds. I believed that eye contact, facial expressions and body language of the participants were ways in which trust was confirmed (Johnson & Rowlands, 2012). Usually, the slow unfurling of participants' experiences leads to the *immersion* phase. However, in this inquiry the *tentative* phase rapidly progressed to full *immersion*. It could be conjectured that trust between inquirer and participants was pre-existing or that participants were keen to share their stories of experience.

In the *immersion* phase, the conversation does not always follow a predictable linear configuration. Participants may talk about topics unrelated to the research topic or they may move back and forth in time and between experiences. They may at times pause to collect their thoughts or contradict themselves. These contradictions and pauses do not necessarily negate the story being told. They may be an indication that the participants are reflecting and trying to make sense of significant experiences in their lives, providing a new clarity that may not have been visible previously (Corbin & Morse, 2003). Conversations can vary in length and perceived quality because some participants may naturally be better able to convey or express themselves via storytelling while others may just limit themselves to the facts: 'First this happened, then this, then that' (Corbin & Morse, 2003, p. 343). The conversations in this inquiry lasted between 30 and 55 minutes, with some participants speaking almost without break while others required probing questions and prompts to encourage conversational flow. The variable linear flow and length of the conversations was not reflective of the rich nature of the participants' storytelling.

Participants may be distressed while telling stories that provoke strong emotion. Researchers can give the participant the choice of regaining composure, changing the topic or ending the conversation. Regardless of the option chosen, the ethical and relational responsibilities of NI should constrain the researcher from leaving a participant in a state of distress (Corbin & Morse, 2003). Leaving a participant in emotional distress after a conversation without sufficient support or appropriate safeguards is immoral (Smith, 1992). I did not sense distress from the participants at any stage in the conversations. Two participants demonstrated concern, wanting to know whether their stories were useful to me as an inquirer. Another participant seemed apprehensive, worrying that she mumbled too much and went off on tangents. In each of these cases, the cause of the concern was discussed and remediated by both the participant and inquirer.

In the fourth and final phase of *emergence*, conversation shifts back to less emotional and sensitive levels, although the topics discussed may be just as relevant. During this phase, the researcher may provide advice, validation or information (Johnson & Rowlands, 2012) to the participant without interrupting or influencing the storytelling flow. Since conversations involve collaboration between the participant and the researcher, Johnson and Rowlands (2012) argue that the researcher should engage in reciprocity. Researchers may share with the participant their own beliefs, feelings and reflections on the topic of conversation. Reciprocity occurred throughout some of the conversations, and once some of the conversations had ended and the audio recorder turned off. I was asked my thoughts on the NGNs, such as whether I thought they should 'come to ICU'. I spoke to some participants, explaining my thoughts and experiences as well as sharing knowledge of existing ICU transition/education models.

As part of the *emergence* phase, both the participant and inquirer negotiate an exit to the conversation while achieving a level of comfort before parting (Booth & Booth, 1994). Limerick et al. (1996) suggest that research participants are active collaborators in creation of knowledge and that neither the participant nor inquirer is without power during the interview process. 'Contrary to traditional perspectives on interviewing, the researcher does not always control the closure of an interview, even after a winding down-period' (Limerick et al., 1996, p. 456). Although the researcher may attempt to exit the interview, the participant may actively resist the suggestion. One participant seemed to

resist ending the conversation. After asking whether they had anything else to add, the participant replied, 'no,' yet continued to emphasise areas she had covered previously.

Ethical considerations are just as essential at the conclusion of the conversation as they are at the start. Corbin and Morse (2003) remind us 'Qualitative interviews can be very demanding of researchers. They become involved in the story and research out of empathy to participants. In a way, they become part of the story' (p. 344). Returning the conversation to an emotional level that is less intense before ending the conversation is recommended (Corbin & Morse, 2003). Josselson (2007) advises ending the conversation positively, recognising that in some ways the ending of the interview is somewhat like ending a process in psychotherapy, where it, 'becomes important for both people to voice how they felt about the experience and to note its meaningfulness' (p. 544). I ended the conversations by thanking participants for their *gift* of time and experiences shared, and turning off the digital audio recorder. After turning off the recorder, I reminded the participants that I would be writing their tentative NAs and that they would receive a copy. I sought iterative consent to meet with them, after they had time to read and review their account; continuing the co-composition of their final NA.

### 3.10.7 Reflecting on Conversations

Although conversation skills may be taught in the classroom in disciplines such as social work, psychological counselling and nursing, and then subsequently transferred to research interviewing, 'Interviewing [conversation] skills seem to develop with experience' (Corbin & Morse, 2003, p. 347). As a novice researcher, I was concerned that I may not have had the required conversation skills and I wanted to ensure that I respected the *gift* that I had been given. My concerns originated from my perceived lack of experience, since I had not engaged in research conversations before commencing this NI. However, I had engaged in specific education and professional practice over my career, with a focus on debriefing, active listening, appraisal delivery and feedback skills.

Novice researchers may engage in first conversations that are awkward, with interjections and questions that interrupt storytelling flow owing to researcher uneasiness with silences and pauses. Inadvertent questions may disrupt the flow of participants' thoughts and feelings (Holloway & Freshwater, 2007). I perceived the first participant conversation to be interrupted and non-linear. I rationalised that this may have been because of the

nervousness that the participant and I both exhibited. After reflecting on the first conversation and after reading the interview transcript, I adjusted subsequent conversations, interjecting less often, using questions differently and limiting 'talking over' participants. My experience mirrored the views of Corbin and Morse (2003) who suggest novice researchers can learn from initial conversations. When the participant had left and I was alone, I turned the digital audio recorder back on and recorded my immediate reflections of the conversation process, including my own discomfort on certain aspects of my actions as a novice researcher in the conversation as well as reflections on experiences raised by the participants.

### 3.10.8 Transcribing Conversations

The audio-recorded conversations and my post-conversation verbal reflections were uploaded as digital files to my password-protected computer. The files were sent by 256-bit SSL encryption to a service that specialises in academic, government and legal transcriptions. The audio files were treated in the strictest confidence, with an assurance that all transcription staff and contractors had signed the company's confidentiality agreement. On receiving the transcribed files, I saved and named these using the participant's pseudonym.

I requested a legal hearing, strict verbatim transcription service. This type of transcription included every sound and vocalisation, such as 'umms' and 'aahs', interruptions when they occurred and interviewer interjections. I considered this form of transcription valuable in ensuring accuracy when composing the NAs and when seeking resonances across NAs during analysis. Additionally, Halcomb and Davidson (2006) state that the 'Existence of verbatim transcripts can be beneficial in facilitating the development of an audit trail of data [field texts] analysis by supervisors or independent persons' (p. 40)

Once I received the transcript, I checked for transcription errors to ensure accuracy of the transcript. This involved listening to the audio recording while simultaneously reading the transcript. This was a lengthy process and involved listening to sections of transcripts many times. The transcription service had highlighted (via time stamps) potential inaccuracies or audio that was less clear in transcription. The highlighted sections were listened to repeatedly until transcription accuracy was ensured. However, several

potential inaccuracies could not be resolved by this method and were highlighted for review and consideration by the individual participants.

Owing to the use of terms, acronyms and jargon highly specific to the ICU context, there were unavoidable errors in the transcript. My in-depth knowledge of the ICU context and medical acronyms ensured errors were noted and resolved. For example, VLAD was changed to LVAD and VECMO was changed to V-A ECMO (see Glossary).

### 3.10.9 Composing Interim Field Texts

Working within the three-dimensional NI space, field texts are embedded within the research relationship. Either alone, or with the participants, field texts are shaped into interim research texts. Composing interim research texts allows inquirers to continue to engage in relational ways with the participants, offering opportunities to co-compose and negotiate meanings. The process of returning interim texts to the participants, for further engagement and negotiation of unfolding narrative threads of experience, is a central component of the composition of research texts in NI (Clandinin, 2013).

My field texts were the recorded digital audio files of conversations (including my Narrative Beginnings Account and my reflections post conversations), my reflexive journal and notes taken during meetings with my supervisors. By reading and re-reading the field texts, I formed an initial perception of what was contained within the texts, in relation to the three-dimensional NI space.

### 3.10.10 Composing Tentative Narrative Accounts

Narrative Inquiry researchers frequently engage in writing a variety of interim texts (Clandinin, 2013; Clandinin & Connelly, 2000). These texts exist between the field texts and the final thesis. They are shared, negotiated and co-composed with participants. I chose to name the interim texts, 'tentative NAs'. Clandinin (2013) used this term, when showcasing exemplars of interim texts, in the textbook, Engaging in Narrative Inquiry.

After resolving errors in the transcripts, I started to compose the tentative NAs. I then began the process of listening to the audio of the conversation while reading a hard copy of each transcript. The purpose of listening to, and hearing, each person's digital audio transcripts while reading the transcript was to facilitate immersion in the field notes and start the process of analysis (T. Kelly & Howie, 2007; Kim, 2015; Law & Chan, 2015).

Thinking temporally about the conversations between the participants and me, the backwards and forwards processing that occurred allowed me to better understand the participants' stories of experience and of the context in which it was situated. Lugones (1987) explored concepts of 'worlds', how 'We inhabit "worlds" and travel across them and keep all the memories' (p. 14). Lugones (1987) suggests that it is possible to move into and between worlds as our lives unfold. '… As we "'world'-travel across "worlds" we construct images of who we are and what we are about as well as images of who others are and what they are about' (Clandinin, 2013, p. 59). I wanted to '"*world*"-*travel*' (Lugones, 1987, p. 11) to the time and place where the conversations had occurred.

Working within the three-dimensional space, I made comments in the margins of the hard copy of the transcript, writing down my thoughts regarding *temporality, sociality* and *place*. When re-reading the transcript, I was attentive to other characters and stories that I had not listened to as carefully on the initial reviews. These components were highlighted in the margins as possible plotlines and narrative threads.

Following Mishler's (1995) 'Models of Narrative Analysis: A Typology', I used the 'Reconstructing the Told From the Telling' (p. 95) method and began writing tentative NAs for each participant. Since the conversations with the participants were not always linear, with participants telling stories that zig-zagged depending on what was being perceived as important at that one moment (Kim, 2015), I reordered the storylines from the *tellings* gained in the conversations with the participant into coherent tentative NAs. I did this by using a temporal and thematic grouping in a way that I hoped would make sense to both the participant and reader. The effects of *place* on the narrative and the complexity, contradictions, tensions, possible plotlines and emotion inherent to each participant's story were captured in the tentative NAs (Law & Chan, 2015). Relational aspects between the participant and me were made visible throughout the accounts. To remain immersed and engaged in the conversation, I chose to type each of the participant's words, rather than copying and pasting sections of transcript into the tentative NAs. As a researcher, I found this to be another way of remaining attentive to participants' stories of experience. Since NI begins and ends with respect for the lived experience, the NAs predominantly consisted of participants' own words. The reconstructed NAs at this stage were still tentative. Eventually, after further collaboration with participants, the NAs became the 'narrative(s) for further analysis' (Mishler, 1995, p. 95).

After composing each tentative NA, I reread each individual account. By *world-traveling* back to the time of conversation, it became apparent that meanings that had appeared clear at the time of conversation were now ambiguous. Additionally, there had been errors in the transcript, marked by time stamps, that could not be resolved through repeated listening to the digital audio files and reading of the transcripts. I was also concerned that despite using pseudonyms to maintain confidentiality and defining information such as career length, previous place of work and qualifications broadly, readers might be able to deduce the participant's identity. Concerns within the account were highlighted using red text.

Downey and Clandinin (2010) reveal the importance of understanding narrative coherence when progressing from field texts to interim accounts and the thesis. It is tempting to compose 'smooth' texts, intimating lives that are also narratively coherent and smooth. Narrative smoothing is a method used by researchers to make participants' stories coherent and interesting to the reader (Kim, 2015). Alternatively, narrative smoothing can be considered problematic since this method involves acts of omission. For example, narrative smoothing might involve the selective reporting of field texts or the removal of context owing to the researchers' assumption that what was apparent to them will also be apparent to readers (Kim, 2015). Clandinin (2013) suggests that NI researchers need to make visible the ways in which researchers and participants, successfully and sometimes not so successfully, struggle for coherence. In the composing and co-composing of the interim NAs and thesis, researchers must, 'make visible the multiplicity, as well as the narrative coherence and lack of narrative coherence, of our lives, the lives of participants, and the lives we co-compose in the midst of our narrative inquiries' (p. 49).

### 3.10.11 Reviewing Tentative Narrative Accounts with Participants

Being mindful of how relational ethics permeates NI, I had extended invitations to each participant to continue to collaborate and to co-compose their final NA (Clandinin, 2013). Clandinin and Connelly (2000) articulate a poignant moment in NI—the experience of sharing research texts with the participants. From their own experience, they suggest that there is always concern that sharing the research text will alter the working relationship between the participant and researcher. Fear behind the concern may originate from losing a research site, to the research document possibly upsetting the participant or losing a

friendship or respect between participant and researcher. The sense of continually moving backwards and forwards between living in the midst of, and being in, the field, field texts and the research texts is present in NI. Awareness of these considerations returns NI researchers back to the ongoing negotiation of relationships with participants. Knowing the participants personally and professionally, I was anxious about sharing the tentative NAs with the participants because I wanted to represent their experiences accurately in the accounts (Clandinin, 2013).

When each tentative NA was complete, I printed a hard copy that contained a cover page with the participant's pseudonym and returned it personally to the participants to continue the co-composition of their accounts. All participants requested a hard copy of their individual tentative NAs, rather than a soft copy. After giving them their copy, I suggested a time and date to meet again to discuss their tentative account. I expressed my desire for them to read the tentative NAs and note any concerns, misrepresentations, errors or requests to add or clarify information contained in the account. I emphasised that I valued their story of their experiences and wanted to represent it accurately.

Guided by Clandinin (2013), I had a copy of the tentative NA identical to the one that I had given each participant. The use of red text to highlight sections about which I was unsure gave a sense of its 'in-the-making' format. All participants had bought along their copy of the tentative account to the meeting. I read the entire tentative account with each individual participant, noting the sections that I thought were unclear, asking the participant to clarify and confirm my interpretations. I had a pen and made immediate changes to my hard copy as they were suggested by the participant. I incorporated all the marked suggestions in their copy of the account. I made a point of asking whether I had accurately represented their experiences in the tentative NAs. Each participant had the opportunity to continue the conversation, adding other stories to their narrative. I explicitly asked whether they wanted to add anything else. None wished to discuss other stories.

When co-composing the NA, minimal narrative smoothing (see section 3.10.10) was used. I removed some repeated utterances, such as 'um, um, um' from participants' quotations. A participant requested that I change 'At least if they've done some ward work, then they're learning time management and about drugs and, and, and, um, yeah' to 'At least if they've done some ward work, then they're learning time management and

about drugs'. I acquiesced for two reasons: Since we were co-composing the account, I felt a relational ethical obligation to honour her request, and I believed that it did not alter the meaning or context of the statement.

Reading excerpts of transcripts may be embarrassing and discomforting for participants (Hagens, Dobrow, & Chafe, 2009; Mero-Jaffe, 2011). Of interest, all participants, including myself as the inquirer, voiced or felt discomfort at the poor grammar reflected in our speech patterns in the tentative NAs. During our meeting, some participants expressed their discomfort, saying 'Do I really sound like that?' One participant requested that I 'smooth' one section of text to counteract the perception of poor grammar. The participant SRNs made comments and suggestions and highlighted perceived errors in their individual tentative NAs. I was appreciative of their time and attention to detail, believing it to be evidence of the truly collaborative nature of the NAs' co-composition.

During this stage, a participant requested that I change her pseudonym to another since it might be attributed to her by deductive reasoning. The participant elected to use a pseudonym of her choosing. This pseudonym was changed in all research texts and field notes. Another participant was unable to provide clarity to a section of transcript. Although the meaning had seemed clear during the conversation, neither the participant or myself could provide adequate clarity to this section of discussion. I made the decision to remove these sentences from the tentative NAs.

One participant queried why I had included certain descriptions of the research process in the tentative account. Once I explained that I thought they were evidence of participant trust, collaboration and a 'flat' power differential, the participant agreed to their inclusion in the NAs. The same participant, after reviewing her stories, chose to change some phrases to more accurately represent her meaning. When we were sitting together in a locked and private office space, she shared some of her reflections when reading the tentative account. She realised that when talking about the NGNs, she collectively called them, 'they'. She had written in the margins, 'They [nurses] doesn't sound good'. It seemed to concern her that she spoke of the nurses collectively—that maybe this was disrespectful. Nonetheless, this quotation remained unchanged in the NAs. One participant, on reading and affirming the account, commented that it captured her experience correctly. She thanked me for writing the account, wished me well and offered encouragement regarding the completion of the thesis.

The final participant raised an ethical tension. I was uncomfortable with some sections of this participant's story since I thought it possible that readers of the NAs may be able to identify the participant via deductive reasoning. Kaiser (2012) discusses the confidentiality risks associated with conducting research within a group or community. Owing to unique occupational, geographical and other characteristics, social groups can be identifiable to outsiders. In addition, members within these groups may be able to recognise themselves and others in final research accounts (Kaiser, 2012). I felt that some plotlines within this participant's story might reveal the participant's identity. Conversely, the plotline seemed essential when thinking about the commonplaces of *temporality* and *place*. When the participant and I sat down to continue the co-composition of the tentative NAs, we discussed this tension. The tension was negotiated from my perspective as a researcher wanting to ensure the participant's confidentiality and from the participant's perspective, who felt that her career trajectory, although potentially an identifier, was an important aspect of her story and gave insight into her experiences. After much reflection, I chose to respect the wishes of the participant and honour her narrative authority. I included this plotline in the final NAs (see Kath's NAs).

### 3.10.12 Composing my Narrative Beginnings

The 'Narrative Beginnings Account' (see Appendix C) allowed me to consider myself in relation to the research phenomena, participants and research literature (Clandinin & Caine, 2012). I chose to write my autobiographical NA in the form of a 'Narrative Beginnings Account' much later in the research process. This delay was owing to the time taken to ponder and resolve the puzzle of how to compose my account and where my account might be made visible in the thesis.

Ultimately, I chose to self-interview. World travelling back to when I started my postgraduate study, I recollected some of the questions I had been asked by my supervisors. I answered these remembered questions aloud, digitally recording my response. The digital file was sent to the same transcription service to be transcribed verbatim. Using the three-dimensional approach, along with Mishler's (1995) 'Reconstructing the told from the *telling*', I sought potential plotlines as I wrote my own 'Narrative Beginnings Account'.

This inquiry's *place*, the ICU, is integral to the participants' and my stories. Each ICU has its own culture and its own area of medical speciality and is situated in its own organisational and political milieu. The specificities of this ICU affect, and are integral to, the stories that the participants and I told. Therefore, these were made visible in the thesis (see section 1.2).

### 3.10.13 Analysing the Narrative Accounts

The participants' finalised co-composed NAs were the source of the 'narrative(s) for further analysis' (Mishler, 1995, p. 95). Narrative Inquiry methodology begins and ends with respect for ordinary lived experience. Since NI researchers study experience as story, I chose to leave the NAs 'whole' (see Appendix H), respecting and honouring the participants' voices and stories of experiences (Wang, 2017b). I did not recreate the stories of the participants or use other narrative representations once I had completed the thematic analysis.

There are numerous methods of analysing field texts, although Gergen (2004) suggests an 'analytical method of deconstructing stories into coded piles' may challenge the research's aims (p. 272). Narrative Inquiry research texts do not present final answers to research questions in the thesis. However, I did aim to present to readers of the thesis the SRNs' stories of experience so that they may engage the readers, encouraging a reimagining and a reconsideration of the ways in which they practice (Clandinin, 2013).

Thematic analysis was employed to identify and analyse the resonant threads. An active participant in the process, I sought to present a rich thematic description of the threads. The threads within the NAs were identified inductively. A semantic approach was adopted, with threads identified 'within the explicit or surface meanings of the data [field texts]' (Braun & Clarke, 2006, p. 84). There was a progression in the analytic process: from a description phase, whereby the threads were organised and summarised to show patterns in the semantic content, through to an interpretation phase, where the significance of the threads and the implications and broader meanings were placed in relation to the existing literature (Braun & Clarke, 2006).

The thematic analysis process used in this research was guided by the six phases method outlined by Braun and Clarke (2006). These phases are titled: *Familiarising yourself with your data* [field texts], *Generating initial codes*, *Searching for themes*, *Reviewing themes*

[threads], *Defining and naming themes* [threads] and *Producing the report* [thesis] (Braun & Clarke, 2006, p. 87). The analysis followed a recursive approach, with movement through the phases happening in a 'back and forth manner'.

In phase one, *familiarising yourself with the data*, I immersed myself in the NAs. The immersion was a time-consuming process of reading and re-reading the NAs and *world-traveling* back to the time and place where my conversations with the participant occurred. During this phase, I hand wrote notes in the margins of the hardcopy of the individual NAs, noting an initial list of ideas and points of interest. In practice, I had already started contemplating some initial thoughts and possible threads since this phase was similar to the process used when writing the tentative and final NAs.

The second phase, generating initial codes, involved the creation of initial plotlines from the NAs. The plotlines identified aspects of the NAs that resonated when considering the phenomenon under inquiry. There was a systematic approach taken to each NA. At this stage, I had moved back to a soft copy of the NAs. Each line of text was read and potential plotlines were inserted in the margins. The plotlines were systematically organised into groups, with verbatim field texts extracts exemplifying each plotline. Each section of verbatim field tests was identified with the participant's name and line numbers from the NAs. The verbatim extracts use this referencing and are presented in the Findings and Discussion Chapters. This was a manual process; software was not used because of the time required to learn to use a software program effectively and accurately. I created as many plotlines as possible so as not to limit potential threads and retained as much of the surrounding field text extracts that I considered relevant to maintain context. As noted by Braun and Clarke (2006), field texts contain inconsistencies, and 'It is important to retain accounts that depart from the dominant story in the analysis' (p. 89). The tensions and inconsistencies were not 'smoothed' in the analysis process.

Phase three, searching for themes [threads], began when I had collated and created plotlines across all NAs. The focus of analysis moved back to a broader view. The plotlines and relevant field texts extracts were sorted into potential threads. The plotlines were combined and reduced and were placed into electronic textboxes, which allowed the creation of an initial thread map. This thread map made visible the relationships between plotlines, threads and overarching threads. A revisit of the field text extracts was required to ascertain whether the threads should be discarded, separated, merged or refined (Braun

& Clarke, 2006). This phase ended with a collection of potential threads and overarching threads, along with the NA extracts that supported them.

Phase four, reviewing the themes [threads], involved a refinement of the threads, which occurred in two levels. The first level of refinement occurred when all the collated extracts for each thread were read and consideration was given as to whether they formed a consistent pattern. Since the threads were consistent with the NA extracts, a similar process was repeated for all the NAs. The NAs were reread to determine whether the potential thread map truthfully echoed the meanings in the NAs. The re-reading allowed for missing additional NAs extracts within threads to be reviewed and new plotlines to be added. The reviewing and refining process continued until there was a robust thread map (Braun & Clarke, 2006).

Phase five, defining and naming the themes [threads], involved defining and refining each thread and then writing a detailed analysis of each thread and overarching thread. Each thread's NA extracts were organised into an internally consistent and coherent account, with accompanying analysis. The analysis also identified the story that each thread told and considered how it fits into the broader discussion being told in relation to the research puzzle. At the end of this phase, there was a clear definition of each thread, along with a sense of how they resonate across all NAs.

The final phase, 'producing the report' was writing the thematic analysis for the thesis. Selected vivid and compelling quotations from the NAs (Braun & Clarke, 2006), which captured the essence of the thread, were related back to the analysis, to the research puzzle and to the literature. These vivid examples provided evidence of the threads' prevalence within the NAs to convincingly illustrate the analysis in relation to the research puzzle (Braun & Clarke, 2006).

I was confident I had completed the collection of field texts, and co-composed and negotiated the NAs with the participants as guided by Clandinin and Connelly (2000). I then transparently analysed the NAs following Braun and Clarke's (2006) thematic analysis approach. The completed NAs are presented in Appendix H; I finalised phase six by producing this thesis.

In the next chapter, the findings are presented in the form of main overarching threads containing minor threads that add depth of meaning to the main threads. Each thread is further elucidated using participant quotations from the NAs.

# Chapter 4: Inquiry Findings

In this chapter, a discussion of the resonant major and minor threads from the conversations with the SRNs is presented. Two main threads resonated across the narrative accounts, revealing the experience of SRNs working with NGNs in the ICU. These threads are: 'Reverberations' and 'Caring.' Each of the main threads contains several minor threads that contributed additional layers of meaning. The threads are presented as a network diagram (see Figure 4.1).
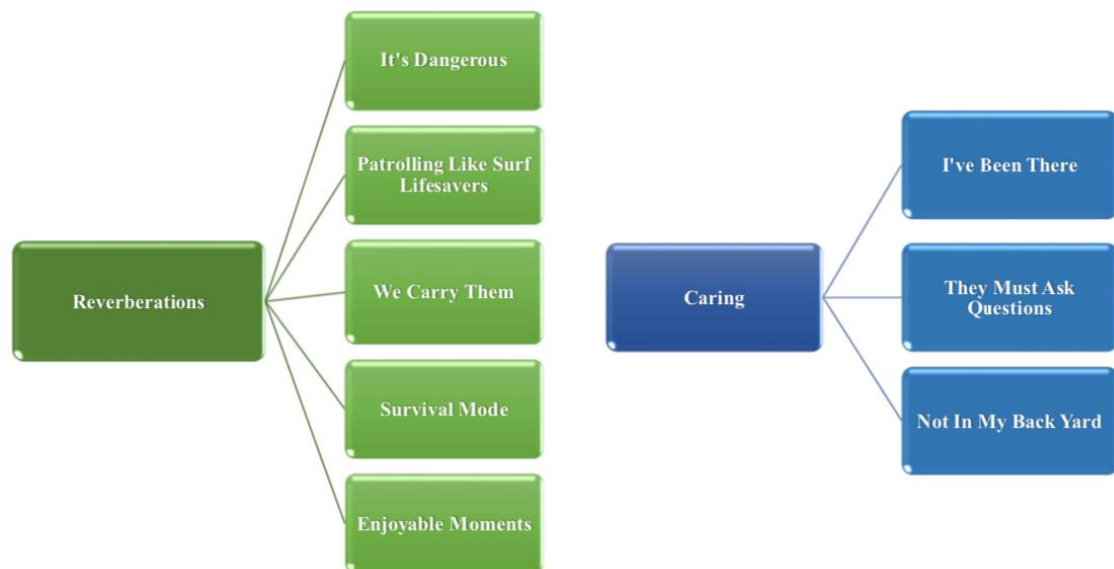


**Figure 4.1: Thread Network**

The first thread, 'Reverberations', reveals the SRNs' perceptions of the impact of working with NGNs in the ICU. 'Reverberations' contains the minor threads: 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'We Carry Them', 'Survival Mode' and 'Enjoyable Moments'. The second thread, 'Caring', portrays the SRNs' positive intentions towards the NGNs. 'Caring' contains the minor threads: 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'. The presentation of these threads is illustrated and supported with participant quotations from the narrative accounts.

## 4.1 Reverberations

The SRNs reported that the placement of NGNs into the ICU affects SRNs' capacity to fulfil their patient care and team leading roles. The meaning of 'Reverberations' is to have

a continuing or prolonged effect ('Reverberate,' 2011). Therefore, this thread represents the continued or prolonged effect that supporting NGNs to transition into professional practice in ICU has on the SRNs. Participant SRNs commented that the ICU working environment is demanding, emotional and stressful and the presence of the NGNs exacerbated this situation. It is important to highlight the SRNs' descriptions of the context in which this current inquiry was situated to appreciate the reverberations of the NGNs' presence:

> The patients are a lot sicker now. And we have heaps more specialised equipment and that now. We can have three or four ECMOs at once. And patients that normally would've just died on the table, now they bring them out. (Kylie, L. 128–130)

The SRNs described a busy ICU environment where the high acuity of patients requires SRNs to participate and make rapid decisions in clinical emergencies:

> Yeah, it's full on, working in ICU, especially in this ICU. It's very busy. (Camilla, L. 229)

> There's plenty of things that can go wrong very quickly, and that's the nature of this place that makes it scary. (Kath, L. 315–316)

New Graduate Nurses enter this highly complex context that ultimately leads to 'reverberations' experienced by SRNs. These reverberations are felt particularly after the supernumerary period is complete and NGNs are counted in the ICU nursing staffing numbers. Sarah, a preceptor for NGNs, describes one experience of this process, highlighting the effects on the SRN once the NGN has a patient load:

> As soon then as they have their own patient and you have your own patient, it kind of changes. It becomes a lot more intense or a lot more stressful, I think, probably for both of you because you can't watch what they're doing … even if you have a kind of quiet patient, you're still busy with your own patient and they're [NGN] a bit lost. (Sarah, L. 15–19)

The participant SRNs describe how NGNs, having limited independent nursing practice, required support when performing basic nursing care and extensive support when caring for ICU patients needing advanced nursing interventions. Senior Registered Nurses stated NGNs were unprepared for the high acuity and fast pace of the ICU and hence the impact this has on the SRN:

I think some of them are absolutely stunned. They're like deer in the headlights when they come here. They—it's—it's confronting. If you've never been to ICU, you come here, you hear all the alarms, you see all the machines and you go like, 'Oh. My. God. What am I supposed to do? Where do I start? I don't know what that machine does. I don't know anything about this?' (Camilla, L. 219–223)

They haven't even got sort of the basics—I know when I was a new grad even like priming a line or shaking up an antibiotic, things like that was anxiety enough <laughs>. No time management. And, then they're put with this patient that's got like five or six infusions going at once and, you know BiPAP or ventilators, instead of just getting that basic down to patient care or the basics of time management. All that first, especially if they haven't worked in a nursing home or anything, … I just think it's way too much overload. (Kylie, L. 113-118)

The SRNs considered NGNs to be task focused, dependent on adherence to clinical policies and procedures, and reliant on guidance from more experienced nursing staff. Although SRNs readily supported and educated NGNs, they reported that the amount of direction required to provide safe patient care was significant and added to the SRNs' already demanding workload: 'It's a busy enough, stressful job as it is, to have people that are just thrown in and don't know' (Kylie, L. 109–110).

New Graduate Nurses can feel overwhelmed with the demands of working in ICU, and SRNs can feel overwhelmed when trying to support them. When talking broadly about their work experiences, the SRNs spoke of their requirement to attend to the complex needs of ICU patients' families. When considering their work with NGNs, families were interwoven into the *sociality* and *place* commonplace of this inquiry. In the current inquiry, SRNs discussed the negative behaviours of families towards NGNs, when families recognised the NGNs' level of experience, and the ways in which this ultimately affected the SRNs:

Their family are demanding, and the new grad who has very little experience is being asked these questions that they really don't know the answers to and [are] expected to do things that they really might not have the expertise to do. (Sarah, L. 142–145)

As advanced beginners, NGNs are required to rapidly integrate new concepts and skills into ICU clinical practice. Experience with specific repeated clinical scenarios helps NGNs reinforce knowledge and skill integration (Benner, 1982). However, ICU

environments can be highly unpredictable. ICU patients are often unstable and require continuous assessment and interventions, including the use of advanced medical technology. The SRNs were aware of the gap between theory and skills learned at university and the reality of patient care delivery in the ICU (Welding, 2011). As one SRN said, 'Their clinical skills are at the beginning, and so it's very hard in a place that's quite dynamic and quite, um, full-on I guess' (Lisa, L. 24).

### 4.1.1 It's Dangerous

The minor thread titled 'It's Dangerous' describes the SRNs' perceptions of NGNs as possessing basic nursing skills in a high-acuity clinical environment that requires advanced time management, patient assessment and critical thinking skills. Critically ill patients often deteriorate rapidly and require immediate assessment, diagnosis and appropriate interventions and therapies. The diagnostic and treatment interventions are technologically advanced and this technology continues to rapidly evolve. The gap between the skills and competencies possessed by NGNs and the ICU patients' clinical requirements concerned SRNs: 'Sometimes, it's very difficult to find a patient for a new grad to look after. Because of a lack of skills' (Camilla, L 22–23).

The SRNs also relayed a feeling of concern regarding potential adverse complications associated with patient care in the ICU, recognising that the ICU was a dangerous place and more so for NGNs, who were still acquiring the skills necessary for the environment and patient acuity: 'It's not good for them [NGNs], I don't think, this environment. You just can't afford—I can't afford to trust them, their skill and their knowledge. 'Cause I—you just can't. It's too dangerous' (Kath, L. 382–384).

Owing to their lack of clinical experience, NGNs may have rarely participated in real-life emergency scenarios and thus may be ill-prepared for emergency situations when immediate nursing interventions are required. This poses a potentially dangerous situation for both NGNs and patients. When such events occurred, SRNs reported that they rapidly intervened to ensure NGNs' critically ill patients were appropriately treated. These essential interventions caused reverberations, further defining the situation as 'It's Dangerous'. The resulting impact often interrupted SRNs' work and added to their workload. Participants described experiences when NGNs were allocated ICU patients who clinically deteriorated. Senior Registered Nurses perceived NGNs did not often

possess skills to recognise clinical deterioration and were unable to rapidly provide essential nursing care, requiring SRNs to urgently intervene to prevent the patient experiencing dangerous, life-threatening sequelae:

> These people [ICU patients] just deteriorate, and you then are putting out a fire. And it's emotional for the new grad [NGN] because often when it gets to that point you—there's only so much talking you can do <laughs>. You've almost got to push them out of the way and just sort the problem out and explain it afterwards. So, it's stressful for you, it's stressful for the patient importantly and it's stressful for the new grad [NGN]. Ah, and that can happen frequently here, unfortunately. (Kath, L. 321–327)

Senior Registered Nurses' oversight of the nursing care provided by NGNs was deemed essential by the participants in ensuring patient safety and preventing possible iatrogenic complications and their sequelae. The NGNs' lack of knowledge of, and inconsistent application of, evidence-based nursing procedures created an element of danger. Sarah recalls that an NGN, who had a patient with a central venous catheter, appeared unskilled with the nursing care required, making it a potentially dangerous and life-threatening situation for the patient:

> Well, one new grad on a couple of occasions let the CVC [central venous catheter] disconnect from—without clamping it, so obviously risk of air embolism but it went the other way ... —there was blood came out rather than air going in. New grad's upset because she got blood on the sheets, but it's like that's not the problem here at all ... so anyway, this girl goes off crying and I can't—I don't want to then turn around and be, and say this happened, you know, in a stern sort of way or like reaffirm her mistakes. I just kind of let it lie for a day and then went and said ... 'I think you need to look at this, and do you understand the importance of this?' Because, the first time it happened I thought okay, good, she would've learned her lesson now and that's not going to happen again, but then it happened again and then it's just like, oh my god, how—you know? That's so scary to me ... when you're new, I think it's just so easy to make mistakes. (Sarah, L. 38–61)

The SRN participants perceive the ICU clinical environment to be dangerous; the placement of NGNs in this environment made the environment increasingly hazardous. Patients required constant monitoring and assessment and immediate interventions are often necessary to remediate sudden deterioration. To ensure the best outcome for critically ill patients, SRNs provide oversight of NGNs and their allocated patients,

intervening as needed to ensure patients receive high-quality, timely care. The second minor thread, 'Patrolling Like Surf Lifesavers', describes the oversight aspect of the main theme of 'Reverberations'.

### 4.1.2 Patrolling Like Surf Lifesavers

'Patrolling Like Surf Lifesavers' describes the surveillance methods described by participant SRNs to ensure NGNs deliver safe patient care and minimise errors. However, because of the high-acuity clinical environment and increased workload, SRNs often considered their ability to engage in surveillance of the NGNs' work inadequate. The analogies to watching, 'to keep an eye', 'having eyes in the back of their heads' and 'helicopter parent', were used by SRNs to describe how they felt on facilitating patients' safety:

> You're managing the unit, and so you're managing sick people and keeping an eye—it's almost like you're putting out fires. That's your role [as a team leader]. And the thing with new grads is there isn't a fire yet. You're making sure they don't start one, with all due respect. (Kath, L. 131–134)

Aware of the danger in NGNs functioning in a role for which they lack knowledge and experience, SRNs described surveillance as looking after two-year-olds and requiring eyes in the back of their heads. The SRNs spoke of the need to evaluate and assess patients regularly to ensure the care NGNs were providing addressed their patients' often fluctuating, clinical needs:

> You—you cannot trust … And you have to go and check over and over and over again. (Camilla, L.48–49)

> You just have to try and hover. You're like a helicopter parent to these toddlers. (Camilla, L.64–65)

> You just constantly have to be awake and alert and patrolling. Like, I feel like I'm on Bondi Beach sometimes <laughs>, you're just up and down, up and down, up and down. (Kath, L. 342–343)

However, owing to workload issues, it was not always possible for SRNs to maintain the level of surveillance they perceived necessary to keep patients safe and prevent errors. Senior Registered Nurses felt NGNs may be unaware of signs of deterioration in the

critically ill or may lack the knowledge or experience to safely and rapidly deliver multimodal nursing care:

> So, yeah, it again goes back to having eyes in the back of your head. But I don't have eyes in the back of my head <laughs> obviously <laughs> so unfortunately sometimes people do deteriorate. (Kath, L. 328–330)

> If you can't get there because of—you become busy, then it's um—I don't know, sometimes mistakes happen … It's not good that they happen, but they do … But sometimes you can't be everywhere. (Lisa, L. 123–126)

The minor thread 'Patrolling Like Surf Lifesavers' describes the SRNs' surveillance as they attempt to minimise errors while supporting NGNs in the ICU. The next minor thread 'We Carry Them' under the overarching thread 'Reverberations' describes the SRNs' increased workload associated with keeping NGNs safe in the dangerous ICU environment.

### 4.1.3 We Carry Them

Within the overarching thread 'Reverberations' is the third minor thread 'We Carry Them'. This thread describes SRNs' workload concerns, such as staffing resources, concurrent roles, breaks and time constraints. Staffing resources were perceived by SRNs as being inadequate to meet workload demands. The dual role of supporting NGNs while concurrently delivering nursing care to an allocated patient, or being TL, created additional work for SRNs. The SRNs described workplace strategies to manage increases in workload. However, this did result in feelings of 'carrying' the NGNs.

Staffing levels affected SRN workload. Inadequate skill mix was perceived as an important factor in excessive workload demands. The SRNs actively advocated with managers to increase staffing and ensured that NGNs were not allocated patients outside their scope of practice and competence:

> We don't have any resource nurses, yeah. And, you really have to fight sometimes to have two nurses on fresh ECMO, and if you have those two nurses then things are unbelievably better, but if you don't have them, you know, the new grads a lot of the time they can just sing [manage on their own]... You do really try to get around to them, but I don't know. But like, most of them do very well at the same time. It's just kind of like a bit of an element of an accident waiting to happen. (Sarah, L. 154–159)

Senior Registered Nurses described how these additional roles contributed to increased workloads for them. Educating less-experienced staff, acting as a resource nurse, being a member of the Code Blue team and preceptoring NGNs were common additional roles, especially if the SRN was allocated a lower acuity ICU patient:

> In fact, those days are the busiest days 'Cause you're kind of helping everyone else and the new grads, and then you're looking after your own patient as well when you have the time, you know? (Sarah, L. 359–361)

The SRN participants often acted in concurrent roles of TL and resource nurse because of a lean nurse-staffing model. This was a further addition to SRNs' workload when working with NGNs:

> You often as a new-in charge find yourself being the—you're actually the resource nurse, so if we don't have enough staff to have two nurses on the ECMO, you are the extra staff on the ECMO, and you cover all the breaks, and you're trying to support the new grads. (Sarah, L. 151–154)

Although SRNs acknowledge the preceptor role was essential to support and develop NGNs, they also perceived it as a significant addition to SRN workload. A feeling of responsibility and pressure accompanied the role particularly when SRNs were allocated a high-acuity patient load in addition to preceptoring responsibilities: 'It's time-consuming preceptoring, making sure that everything is done. It's quite a lot of pressure because you do take responsibility of, you know, what they do. You have to' (Camilla, L. 23–25).

The increased workload associated with ensuring the delivery of safe patient care while supporting an NGN resulted in frustration and guilt when SRNs were unable to complete their work to a satisfactory standard:

> There is just so many things to do. If you want to look after your patient properly and do all the things that you're supposed to do during the day and look after the patient like would be your own family member, to do that detail, then how on earth do you find a couple of hours during that shift to teach the new grad? I just don't know. I just don't know. (Camilla, L. 182–186)

Participant SRNs reported that they often delayed or cut their breaks short to ensure patient safety and placed the needs of team members, including NGNs, before their own.

The SRNs reported self-denial, demonstrated 'We Carry Them', ensuring NGNs on the shift received allocated breaks at appropriate times, while maintaining adequate skill mix to ensure patient safety:

> You don't get breaks because you're too worried about the patient's safety. So, you might just …sit down at the desk and eat your food there, hopefully, or have two minutes—go and heat up for food in the microwave and run back. It's crazy sometimes. (Camilla, L. 128–131)

Despite the extra work associated with supporting NGNs, SRNs still actively encouraged NGNs to clarify concerns and seek clinical advice and provided learning opportunities. Moreover, the SRNs often helped NGNs with their nursing work in addition to their own responsibilities, further demonstrating the extra workload the SRNs carried. However, time constraints associated with their individual workloads affected their ability to support and carry the NGNs consistently. Owing to high patient acuity in the ICU, SRNs reported difficulty in finding time to care for their own patients while preceptoring an NGN:

> If they have to take a central line out, they've never taken a central line out. To have that time to show them where they find the... policy from, do the procedure, like explain the whole thing. It's a lengthy thing to do if you … look at the policy, explain the procedure, do the procedure together and then have some sort of ... feedback at the end of it … 'you did great, next time you have to remember to do that, well done'. (Camilla, L. 167–171)

Nevertheless, SRNs used a variety of strategies to ensure that they were doing their best to ensure they were supporting and supervising NGNs while the latter were practising within their scope:

> A couple of weeks ago I had to take a patient as an in-charge. So, I was in-charge, but I had to take a patient because we were too tight across the floor and because …. The only other person that could've doubled say, was a new grad, but I couldn't let her double because it would've been too much for her. (Sarah, L. 200–203)

Another approach was to replace the NGN with a more appropriately skilled RN from an adjacent ICU pod, reallocating the NGN to a more appropriate patient and receiving a more senior nurse in return. The SRNs advocated for the NGNs, ensuring they were not

nursing outside their scope of practice. This meant an appropriately skilled RN was caring for a high-acuity patient. However, this was still, at times, interpreted as 'carrying' the NGN, because there was often additional work involved, negotiating the change in patient allocation: 'You need to replace them with, you know, an agency nurse or someone doing overtime. And it's frustrating and time consuming trying to organize that' (Camilla, L. 119–121).

The practice of reallocating an NGN to a patient whose clinical care needs matched the skill set of the NGN was perceived to increase ICU patient safety. Maintaining patient safety within the ICU was at the forefront of SRNs' priorities. Since working in the ICU environment requires clinical judgement, rapid decision-making and the use of complex technology, SRNs supported NGNs' nursing work despite the associated workload burden. The following minor thread 'Survival Mode' in the overarching thread 'Reverberations' describes the emotional and psychological reverberations felt by SRNs working with NGNs.

### 4.1.4 Survival Mode

'Survival Mode' represents SRNs' enduring capacity to work in the ICU clinical environment, recognised as being a particularly stressful area of nursing (Burgess, Irvine, & Wallymahmed, 2010). Survival is defined as, 'the state or fact of continuing to live or exist, typically in spite of an accident, ordeal, or difficult circumstances' (Survival, n.d.). Participant SRNs described negative emotional and psychological symptoms, such as stress, guilt and pressure, when working with NGNs in this environment.

The SRNs felt responsible to ensure potential errors by NGNs were noticed and rectified before patient harm occurred. This responsibility caused considerable stress for the SRNs as the thought of an error causing patient harm or the loss of life affected the SRNs: 'Terrible! It's a huge responsibility. Absolutely massive' (Camilla, L. 71). Further, 'But when it's really busy, then there's the capacity for something to go wrong—and then I'd feel terrible' (Kylie, L. 222–223).

Senior Registered Nurses in this inquiry used the metaphor of a juggler to describe how they manage their stress when required to balance caring for ICU patients while supporting NGNs: 'Stressfully. I don't know. I don't know how you manage it. Just try

the best you can. Just juggle I … I try to keep as much of an eye as I can on them' (Sarah, L. 81–83).

The SRNs revealed that during periods of increased patient acuity and workload or when more than one NGN was rostered on the same shift, they could not maintain a high level of NGN supervision. This created concern and feelings of guilt because SRNs were acutely aware of their role in preventing and reducing errors and iatrogenic patient complications. Senior Registered Nurses felt a sense of personal responsibility when other nurses raised concerns regarding an NGN's nursing practice. Sarah communicated an experience, saying:

> And you hear things back from other nurses … They're like, 'By the way, this happened', and … you just feel guilty that it happened 'Cause they're upset, the new grad's upset, you're upset. I'm wondering 'is this my responsibility that the new grad just did that? (Sarah, L. 32–35)

However, the overwhelming sense of ensuring patient safety and NGNs' integrity meant the SRNs worked in what they called 'Survival Mode' to try to ensure nothing went wrong. Guilt also occurred when SRNs were balancing simultaneous duties and thus were not able to complete tasks to a perceived high standard. While SRNs felt pressure when working with NGNs, they acknowledge that NGNs and patients' families also felt pressure. The SRNs normalised ICU as a pressured environment:

> I think there's the pressure on—I feel the pressure on myself. I feel like as a—as a team, there's pressure on the other nurses that are there, which leads to sometimes not as good care for the patient. But … also the patient's family. (Kylie, L. 19–22)

The SRNs in this inquiry experienced extreme pressure during the 'buddy' period when preparing NGNs for independent practice:

> You feel under pressure in the first week to give them as much preparation as possible, so they'll be able to take their own patient the following week, but obviously, you can't give them enough, and you can't cover everything that's going to happen and a lot of what you tell them they've forgotten again anyway, so you feel like you're telling them over and over and over and then they've got their own patient. (Sarah, L. 21–25)

Senior Registered Nurses also felt pressure when supporting NGNs emotionally and picking up additional patient workload owing to NGNs not being accredited for certain

nursing practices (giving cytotoxic medications and continuous renal replacement therapy [CRRT]). ICU patient acuity contributed to the stress, guilt and pressure felt by SRNs and, feeling a sense of responsibility for the NGNs and at times their patients, added to this pressure:

> Yeah, it's horrible. I used to cry even before I got here … and then just get my shit together. I mean, excuse me, get my act together. And walk through the door and hold my breath for eight hours. (Kath, L. 217–219)

Participant SRNs described how they thought and dreamt about work when they were at home. Although several SRNs had learned techniques over the years to separate work and home life, others still regularly 'took work home.' SRNs 'coped' with the demands of working in ICU in a variety of ways—they drank alcohol at home to 'wind down' after a shift, attended counselling to deal with emotional issues regarding complex patients and talked with colleagues or family members:

> burned out sometimes. Oh, it's good, like, I enjoy it, but you're just busy. I take lots of it home. I know I don't—I try not to, like, too much but yeah, you definitely take it home. (Sarah, L. 372–374)

> [talking] just allows you to—to get it out of your system, to flush it out because some things just don't leave you. I think everyone takes a chunk of you and you can't escape that. (Kath, L. 187–189)

The minor thread 'Survival Mode' describes SRNs' negative feelings when working with NGNs in the highly stressful ICU environment. However, the following final minor thread 'Enjoyable Moments' acknowledges that SRNs also experience positive reverberations.

### 4.1.5 Enjoyable Moments

'Enjoyable Moments' describes the SRNs' positive experiences on working with NGNs. Teaching NGNs encouraged SRNs to refresh their clinical knowledge and update their practical skills. The SRNs worked in an environment where all staff were encouraged to learn and share knowledge, from NGN to SRN. The ICU clinical environment acknowledged the contribution of all health care team members. Moreover, SRNs felt a sense of pride and satisfaction when NGNs exceeded their expectations and when NGNs

acknowledged and were thankful for their support. Senior Registered Nurses in this inquiry described how they found NGNs' questions often personally beneficial for lifelong learning:

> Sometimes it keeps your brain going with the questions they ask you. Makes you think about why you're doing things or that you don't. And then sometimes they might ask me something I don't actually know, so then I have to go look it up. So, in that way it's beneficial. (Kylie, L. 262–265)

The questions NGNs asked challenged SRNs' practices and thought processes, and the latter received the questions positively. The SRNs also described feelings of satisfaction and enjoyment teaching NGNs:

> Well they challenge your thinking, I suppose, so you have to kind of think about why they asked that question or whatever…. Yeah, what way are you teaching them, yeah. I think definitely, I like teaching new grads and teaching or doing skills or whatever you're doing … you have to kind of brush up on things yourself because otherwise what are you telling them, you know? (Sarah, L. 218–222)

> Now that I'm more senior and am able to explain concepts in a basic way 'cause I understand them. I quite enjoy it, and I think they [NGNs] get a bit of enjoyment after having learned new things that are quite technical. I think cardiothoracic is technical, but it's plumbing. You know, it is quite basic, and if you can find a way to explain something that's technical in a very basic way um, it's quite satisfying, I guess. And seeing someone understand that… quite a nice little moment sometimes. (Kath, L 356 –361)

Senior Registered Nurses in this inquiry were receptive to expanding their knowledge and as well as using the opportunity to teach NGNs, they also recognised they could learn from NGNs: 'It was a very basic thing that quite a junior person [NGN] taught me something and I was like, "Wow, that's really awesome to know. I wish <laughs> I'd known that ten years ago"' (Kath, L. 289–291).

The SRNs felt a sense of pride and accomplishment when NGNs progressed in their nursing practice. Occasionally, NGNs exceeded SRNs' expectations by exhibiting critical thinking and clinical insight beyond what was normally expected from NGNs. Additionally, SRNs felt rewarded when recognised and appreciated for the support they had provided to the NGNs:

Some of the new grads are brilliant and they ask you a question and they just bowl you off your feet 'cause they're so far ahead of where you think that they should be or— that's really good. (Sarah, L. 214–216)

It's like a win because when you see a new grad developing, you're proud of them, so it's nice. (Sarah, L. 212–213)

When they're at the end of their rotation they come, and say, <mock tearfully> 'Oh you were my preceptor. I remember the first day with you'. It comes at the end, I think. When they say that and go, 'Thank you for your support. I was always able to come and talk to you'. (Camilla, L. 141–144)

The final minor thread 'Enjoyable Moments' in the overarching thread 'Reverberations' describes the SRNs' descriptions of the positive aspects of working with NGNs in the ICU. The following section describes the second main resonant thread in this Findings Chapter, 'Caring', and its supporting minor threads, 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard.'

## 4.2 Caring

The major thread 'Caring' represents the nurturing culture by the SRNs towards NGNs. The concept of caring was multifactorial. Although SRNs had contradictory feelings regarding the decision to place NGNs in ICU as part of the TPP program, they felt an obligation to professionally, clinically and psychologically support the NGNs and were personally invested in their clinical and professional career development. The SRNs also recognised the impact of the ICU environment on the NGNs, the steep learning curve that the NGNs faced during their six months placement, and the ramification of potential errors being contributing factors to NGNs feeling overwhelmed and stressed.

The SRNs voiced their commitment to supporting the NGNs in integrating new knowledge and skills, support seen as being necessary to ensure the delivery of safe patient care. The demonstration of caring extended beyond providing clinical support and education. Senior Registered Nurses spoke of their genuine interest in the NGNs as individuals. The SRNs created rapport with NGNs and established relationships that encouraged NGNs to be open about their feelings and experiences:

> Some of them might not start out good, but then they're nurtured…I was nurtured, and I stayed. It can be a positive, a very positive experience hopefully. (Kylie, L. 270–271)

> I think you can try and make them feel comfortable.... You've got to talk to them and communicate with them and, um, kind of get an understanding of what they understand... Rather than looking at what they can't do, kind of working through what they want to learn. (Lisa, L. 88–91)

Although NGNs entered professional practice competent in basic nursing skills, SRNs reported that NGNs in ICU still required significant direction from more experienced nurses. Additionally, SRNs reported NGNs did not possess the advanced nursing skills necessary to work independently in ICU. Senior Registered Nurses considered it vital to change this potentially negative situation into a positive one. Therefore, SRNs strived to educate NGNs by providing resources such as ICU-specific education days, nursing in-services and ICU-specific competencies. The SRNs took opportunities to personally educate NGNs: 'If I come in and it's reasonably quiet, I will try and give the new grad something challenging so that I can support them and try and teach them something' (Sarah, L. 167–169).

Senior Registered Nurses in this inquiry viewed the support provided by the entire ICU nursing team as being an essential concept when caring for NGNs. When SRNs were busy with critically unwell patients, other members of the ICU nursing team included in this team approach supported the NGNs:

> I quite enjoy taking new grads [NGNs]. I think the most important thing that you can teach them really is that they're not alone and we work as a team. And when they're in trouble or don't understand something, we don't expect them to understand, or know what to do. But we do expect them to stick up their hand up and recognize when their patient needs extra hands. That's the most important thing, and for anyone really, but particularly new grads who might think that they are—are being judged for their skills when really, they're not. They're just here to learn. (Kath, L. 362–368)

> We have a good team in that there are other nurses … they [NGNs] can ask, and they know they can ask anyone. (Sarah, L. 84–86)

Senior Registered Nurses highlighted how it was difficult for them to care for and support NGNs during periods of increased patient acuity and workload. In these situations, the ICU nurse diverted their focus from the NGN to their own patient's requirements:

> Like we always work as a team to try and incorporate the new grads because they aren't stand-alone members of staff on their own. They can't be because they just don't have the experience and it's just not fair to—and that's how they suffer when we're really busy because—because the team then that is trying to support them kind of falls apart a bit because we're too busy. (Sarah, L. 254–254)

The caring exhibited by SRNs was reflected in their recognition of the importance of initial professional nursing experiences. The SRNs wanted NGNs' placement in ICU to be positive and beneficial: 'It might affect the rest of their nursing career. It's a pivotal thing, your first experience when you come out, whether you enjoy it' (Kylie, L. 29–31).

Care shown by the SRNs towards NGNs was multifactorial in nature in the major thread 'Caring'. The following minor thread 'I've Been There' describes the reflective practice of SRNs towards NGNs.

### 4.2.1 I've Been There

Throughout the narrative accounts, the SRNs personally reflected on their own experiences of being an inexperienced RN working in ICU. It was through the lens of their own experiences that SRNs gained insight into the experience of NGNs and showed empathy, motivating their care of NGNs. The minor thread 'I've Been There' exemplifies this aspect of care by the SRNs towards the NGNs. The participants in this inquiry had a variety of nursing experience before being employed in this ICU. Some SRNs had placements in ICU as NGNs, others had commenced in ICU soon after entering professional practice, while others had years of ward experience before being employed in the ICU. Kath's reflection on her experiences provided her insight to further support and care for the NGNs currently working in ICU:

> I liked intensive care, but I felt that it was out of my depth. I just wasn't experienced enough to come back here … I would've liked to have come straight here, but there's just, it was too stressful for me to—I think I probably would quit, to be honest. It was just every day coming to work here was so stressful. I liked it, but the stress was—was

um, you know, unfair on myself and everyone around me really, I think. (Kath, L. 70–78)

Reflecting on the level of support provided by RNs when the SRNs first worked in ICU influenced the care they currently showed towards the NGNs. Senior Registered Nurses remembered their inexperience when reflecting upon their introduction to ICU nursing:

I feel sorry for them because I was there and I know what it's like. (Kath, L. 135)

I don't just want them [NGNs] to like go home feeling that they did a bad job or that they're really stressed out, whatever, so I try to probably—yeah, I probably do try and teach them. I don't know if it's got to do with my experience or what. I suppose it does, yeah, I suppose everything's got to do with your own experience. (Sarah, L. 313–316)

Yeah… I think I didn't have a lot of experience, but I knew I didn't have a lot of experience. I was always asking questions…. It affects the way I teach in that I remember the stress, you know, and I remember the, like, it's fun as well. It's very …there's adrenaline out of being involved in an emergency kind of situation. (Sarah, L. 308–311)

In addition to affecting the way SRNs cared for NGNs in ICU, their previous experiences of working in the ICU altered the way SRNs communicated with NGNs:

I think that new grads do have a lot of—everybody's very friendly and chatty, and I think that this unit now, makes it easier for new grads to go through things … with their staff members. I think it's—I don't think it's too bad at all really, better when I was here. (Kath, L. 208–211).

Senior Registered Nurses were aware of unproductive communication styles and actively sought to minimise toxic interactions. This was considered important in an environment considered dangerous. The SRNs were acutely aware of the stressful nature of the ICU and the ways in which individuals coped under intense pressure. They acknowledged that NGNs were still learning to manage the effects of pressure on themselves and others. The SRNs' previous experiences and reflections of working in ICU influenced the way in which they approached the establishment of healthy working relationships with NGNs:

I don't mean to be intimidating to—to people. I don't want people to think that I intimidate them. Because that—you know that doesn't really solve anything. Just makes you look like a scary senior nurse and I—I don't want that. (Lisa, L. 132–134)

Senior Registered Nurse participants' insight into their own experience influenced their feelings about NGNs entering professional practice with ICU as their first placement. One participant, when an NGN, had been placed on rotation in two acute hospital wards before commencing her third rotation in ICU:

> And look, I was a new grad, and I ended up staying on after my new grad. But I would've just shit myself coming … [as a first rotation NGN]. It would've just—I don't know. They're very brave. (Kylie, L. 119–120)

Remembering their own experiences of being an inexperienced RN in the ICU, the SRNs sought to actively support NGNs. To enable support and care, SRNs relied on the NGNs' capacity to articulate concerns and questions. The following minor thread 'They Must Ask Questions' describes this resonant finding.

### 4.2.2 They Must Ask Questions

This minor thread describes SRNs actively encouraging NGNs to ask questions, raise concerns and seek advice so they could optimally care for the NGNs. The SRNs believed NGNs' capacity to provide safe and timely care to ICU patients depended on their ability, willingness and comfort in asking questions. Senior Registered Nurses reported an inability to adequately support NGNs' workload, educate them or prevent potential patient error if they were unaware of NGNs' concerns or queries. The SRNs' capacity to care for NGNs diminished if the NGNs' did not communicate their concerns. Their care towards the NGNs was demonstrated by their personal investment in the NGNs' professional and clinical development.

The NGNs' questions alerted SRNs to potential patient safety concerns. When occupied with other responsibilities in the ICU, SRNs were dependent on NGNs to alert them to changes in patients' physiological status:

> The nurse [NGN] yelled out my name in an urgent tone. I turned to see an ICU patient sitting in a chair. The monitors were flashing red and sounding their alarms. I noticed that the patient's blood pressure was extremely low … I remember thinking, 'Thank goodness, they recognized the problem and asked for help.' But I also wondered what might have happened, if they hadn't? (Inquirer in conversation with Kath, L. 307–313).

Participant SRNs raised concerns regarding their perception of NGNs' lack of experience in decision-making skills, time management and setting of clinical priorities in the ICU. In view of NGNs' lack of experience, and to maintain high-quality patient care, SRNs expected NGNs to ask questions when they were unsure or the patient's clinical condition had changed, so SRNs could provide education, advice, direction and support. One participant gave an example verbalising and reinforcing the need for NGNs to ask questions: 'You can ask questions as many times as you want to. I'm happy to explain same thing numerous times. I'd rather have you asking questions than not asking questions and not knowing what's going on' (Camilla, L. 55–57).

The SRNs reinforced with NGNs the necessity of seeking advice, additional education and support when unsure of aspects of patient care. Asking questions gave opportunities for SRNs to support NGNs in adjusting patient care priorities and provide advice when there were gaps in knowledge:

> And I always say that as well to new grads, you know, 'Just ask'. Like, you try and reaffirm it like, 'Ask questions, ask anyone. It doesn't matter. Just ask the question rather than doing something dangerous'. (Sarah, L. 86–88)

The SRNs emphasised a heightened need for NGNs to ask questions during busy shifts, since they were less likely to be able to provide surveillance to either the ICU patients or the NGN. The Senior Registered Nurses explained to NGNs that the potential consequences of not asking questions were dire: 'You might lose a life in ICU. That's the reality' (Camilla, L. 69–70).

Participant SRNs revealed that the content of NGNs' questions offered an insight into how individual NGNs were progressing clinically as well their understanding of the rationale behind clinical interventions: 'to know that they're actually thinking about what they're doing, … They've been shown how to do it and are just doing it but, not actually understanding why they're doing the things they're doing. Processing' (Kylie, L. 216–219).

Concerningly, SRNs suggested that some NGNs seemed reluctant to ask questions, postulating that avoidance of asking questions may be used to obscure knowledge deficits. Participant SRNs also wondered whether NGNs were scared to ask questions, suggesting that families present in ICU may also contribute to NGNs' reluctance to ask questions:

Well, the reality is that...they don't always ask, you know. They're too embarrassed to own up...not knowing something that they think they should know. Um, and you discover later on, when things go wrong, that they had no idea really and they didn't come and ask you. (Camilla, L. 61–64)

Some of them are quite fearful, and instead of saying 'Oh look, I don't know what I'm doing,' or 'I'm out of my depth here', or 'I need some help'. I think some people try and hide that. And they're the dangerous ones, and they're the ones you've got to try and find and keep a close eye on so that they don't accidentally start fires. (Kath, L. 139–143)

if family work out that they're a new grad. Some family can be very funny about that, and that makes things <sighs> then they get all nervous. (Kylie, L. 267–269)

The SRNs actively tried to establish caring, open and supportive professional relationships with NGNs as a way of encouraging NGNs to ask questions when they felt hesitant:

You, kind of have to tune into them a bit and, and try and connect to them and make them feel comfortable. So that if there is an issue that they don't understand, that they come and ask. And never be afraid to ask because it's—it's better to ask and learn than to not say anything and kind of blindly work your way through it. (Lisa, L. 72–75)

Participants recognised the resulting tension in balancing the competing demands of patient care and providing NGNs with answers. Since SRNs needed to ensure NGNs were delivering high-quality patient care, they actively encouraged NGNs to ask questions and raise concerns. However, there was an associated increase in SRNs' workload resulting from the questions and concerns, which they perceived as a contributor to feelings of increased stress. Despite the additional workload and stress, SRNs endeavoured to communicate openly and respectfully with NGNs. Although they were required to answer questions and provide advice, they expressed frustration with questions they perceived at times as being indiscriminate. The SRNs became tired when asked to educate NGNs or answer recurring questions regularly; this was more pronounced when more than one NGN was rostered on the same shift. There was a sense of frustration from the participating SRNs when NGNs did not ask questions or integrate offered advice into patient care. Nonetheless, SRNs recognised their frustration and modified their

behaviour: 'There's no point in being degrading or—know what I mean? Like, that's not gonna solve anything' (Lisa, L. 80–81).

The SRNs exemplified their care of NGNs by their encouraging NGNs' to ask questions, seek advice and raise concerns despite the resultant increase in workload. The ability of NGNs to deliver safe, well-timed and quality patient care was dependent on their willingness and comfort in highlighting their knowledge gaps. The SRNs' care of NGNs diminished if the NGNs' did not communicate their concerns. The next thread, 'Not In My Backyard', describes the SRNs' recommendation that NGNs gain experience in the broader acute hospital environment before entering ICU.

### 4.2.3 Not In My Backyard

The colloquial phrase 'not in my backyard' and its acronym NIMBY refer to the response of local people to perceived detrimental development projects in their neighbourhood, such as jails or large apartment buildings. It is considered a "predictable and sometimes appropriate response to inappropriate development or development that has been undertaken without adequate community engagement" (Cohen, 2016). The participant SRNs expressed a tension between supporting NGNs in ICU whilst believing it would be better that TPP experience to be gained elsewhere.

The SRNs in this inquiry demonstrated their care towards NGNs by being personally invested in the clinical and professional development of NGNs. The participant SRNs had insight into NGNs' needs based on their own experiences and recognised that they had a pivotal role in supporting NGNs' TPP. However, they recognised that there was a disconnect between the theory and skills learned during undergraduate study and the reality of caring for patients in the ICU environment: 'Because they're fresh from the Uni. They haven't got the skills' (Camilla, L. 73–74).

The participant SRNs believed that NGNs needed to gain nursing experience as an RN, ideally before entering ICU. The SRNs stated two reasons supportive of this opinion: NGNs needed to embed basic nursing skills before working in a high-acuity clinical area such as the ICU, and their nursing career may be negatively affected by a lack of broader hospital nursing experience. Senior Registered Nurses perceived this experience would be best provided by a less acute clinical area. Thus, the phrase 'Not In My Backyard' describes the final minor thread in the major thread of 'Caring'.

The SRNs were concerned about the NGNs' minimal independent nursing experience. Participant SRNs considered the ICU to be an overwhelming and stressful environment; particularly for the NGNs. Therefore, they perceived it as an unsatisfactory clinical area for NGNs to gain confidence in clinical decision-making and embed newly acquired nursing skills and knowledge. The SRNs reported that NGNs were task-oriented, still learning how to set priorities and manage their time. Although deemed competent to practice by the registration authority, NGNs were still learning aspects of basic patient care:

> like washing the patient say, or, you know, making sure they have their teeth cleaned. Just those little things that can make a difference to the [ICU] patient. Because here even—you still have to do all that. (Lisa, L. 185–188)

The NGNs experienced a steep learning curve when starting in ICU. They integrated basic nursing skills acquired at university while rapidly learning the skills and knowledge to safely care for high-acuity ICU patients. The SRNs were concerned about the expectations placed on NGNs after the 'buddy' period was complete and the impact this had on skill acquisition:

> I just think because they haven't looked after anyone and then you're expecting them to look after people in ICU and things—like, some things just get … along the way like washing, bowels, things that are really important on the ward—maybe kind of get lost a bit in ICU because there's other things that take over in their [patient] priorities. (Sarah, L. 446–449)

> You feel um, like it's a bit of a waste coming … straight out of Uni because like they're just learning basic things still and a lot of the stuff that we do there is so technically orientated that, um, they're almost skipping quite a few steps in terms of patient care. (Kath, L. 348–351)

The SRNs in this inquiry argued that NGNs should not be placed in ICU on a first rotation because of the disconnect between the basic skills possessed by the NGNs and the advanced nursing interventions required by critically unwell patients. The Senior Registered Nurses perceived they were not given adequate resources, such as time and supernumerary staff, to ensure first rotation NGNs were adequately supervised and given ongoing in situ clinical education, to reduce the risk of patient care errors: 'I don't know

if we should ever have first rotation new grads in ICU... I think that's dangerous' (Camilla, L. 71–72).

In addition to sensing that the placement of NGNs in the ICU on (especially) a first rotation may have negative implications for ICU patients, the SRNs were concerned about the negative effect on the NGNs, demonstrating their care towards the NGNs': 'It's—it's overwhelming. I think some of them are just paralysed with fear and take forever to learn things' (Camilla, L. 223–224).

Participants revealed their care towards the NGNs by speaking of the emotional impact the ICU environment had on NGNs, as demonstrated by NGNs' tears and speaking openly about feeling stressed. The NGNs' stress levels and feelings of being overwhelmed affected them as well as SRNs:

> Yeah. It's horrible to think that anyone went home and, upset—like after a shift; even if you're not team leading. Like you want people to go—you want everyone to feel okay with their work. You, kind of just have to accept that new grads are going to feel really stressed... I hate to see them like staying late or feeling really stressed, and they do. They tell you that they feel so stressed. (Sarah, L. 320–324)

The SRNs participants postulated that that if NGNs gained ward experience in someone else's 'back yard' prior to working in ICU, then both the SRNs and the NGNs would feel less stressed. There was a discrepancy between participants, as to whether NGNs should work in the ICU in their first year. Some participants felt the ICU was an unsuitable environment for any RN without at least a year of experience in an acute hospital ward. Others believed a placement in ICU may be appropriate as a second rotation. However, the participant SRNs' emphasised this was on the provision that adequate resources were provided to ensure continuous NGN supervision and support and that NGNs should have gained six months of nursing experience on a lesser acuity ward: 'get all second rotation rather than first rotation—I think that would be ideal' (Camilla, L. 196).

The SRNs, demonstrating their investment in the NGNs' clinical development, strongly emphasised the importance of NGNs gaining clinical experience in the wards, as they perceived ward-specific skills would enhance the NGNs' nursing practice in ICU. A lack of ward experience was viewed potentially as an impediment to NGNs' clinical and professional development in ICUs. Senior Registered Nurses declared ward experience

gave the NGNs a global view of the hospital, which was not possible if clinical experience was exclusively obtained in ICU. Experienced gained exclusively in ICU was viewed as a potential hindrance to overall hospital awareness. The SRNs considered acute hospital wards an ideal environment to gain confidence in providing essential basic nursing skills, such as time management, prioritising, patient assessment and patient hygiene provision:

> basic things like that that you might've picked up on a more—a less critical area like a ward, is a really good thing to have under your belt, in terms of confidence and patient safety. (Kath, L. 390–392).

When assessing and monitoring patients, RNs working in acute hospital wards do not generally have access to the technology available in ICU. Participants suggested that working in the wards enabled the NGNs to learn and embed essential 'head to toe' patient assessment skills without relying on invasive technology. Participant SRNs wondered whether NGNs who had exclusively worked in ICUs were denied an opportunity to learn these skills:

> You have to actually use your stethoscope yourself. You have to count their [the patient's] respirations. You have to feel their pulse. You have to um, do a manual blood pressure. You have to talk to them. You have to reassure the relatives and then you have to build a case and take it to the doctors and explain it in a clinical and professional way. I think that's a really important skill to have. Rather than, you know—I mean I see X-rays ordered well before a stethoscope has even touched a patient here [in ICU], which is handy, but um, you know, it's really important to be able to clinically assess your patient. (Kath, L. 433–439)

The SRNs suggest NGNs' knowledge of the patient's entire hospital journey in addition to how ICU integrated with the wider hospital was affected by their minimal ward experience:

> I definitely think they should find out how a hospital works and have a bit of respect for the patient that you've just discharged to that unit. You know, appreciate what the patient's about to walk into as well. There's a big change between ICU and the ward. (Kath, L. 446–448)

Senior Registered Nurses in this inquiry highlighted that NGNs were challenged by their lack of awareness of the global hospital environment, resulting in a lack of knowledge

regarding outside influences, which can affect nursing care in ICU. The SRNs exhibited their care towards the NGNs, recognising that their future clinical careers may be affected by their reduced exposure to ward nursing.

This chapter presented the findings of this inquiry via threads. Two main threads resonated across the SRNs' narrative accounts: Reverberations and Caring. Contributing additional layers of meaning to the overarching thread of 'Reverberations' were the minor threads: 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'We Carry Them', 'Survival Mode' and 'Enjoyable Moments'. Further, the main thread 'Caring' was informed by the minor threads 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'.

The SRNs in this inquiry described reverberations when working with NGNs in the ICU. Participant SRNs depicted ICU as a dangerous place, with critically ill patients requiring constant observation and assessment of all relevant clinical data to ensure the instigation of rapid interventions and advanced technological therapies. However, NGNs possess basic nursing skills and remain reliant on SRNs to provide education, advice and surveillance, when caring for high-acuity ICU patients. Senior Registered Nurses described the added workload when monitoring NGNs' patients for clinical changes and the requirement to initiate rescue therapies when patients deteriorated. Additionally, SRNs provided surveillance of NGNs' nursing care, ensuring patient safety and preventing possible iatrogenic complications and their sequelae, and supported them with their workloads. Thus, working with NGNs contributed to SRNs' perceived excessive workload demands in ICU. Workload demands contributed to SRNs' emotional and psychological symptoms, such as stress, guilt and pressure.

However, SRNs described Enjoyable Moments when working with NGNs. Educating NGNs refreshed SRNs' clinical knowledge and encouraged them to update their practical skills. The SRNs felt a sense of pride and satisfaction when NGNs exceeded their expectations, when NGNs acknowledged and were thankful for their support and when NGNs stated they enjoyed their rotation in the ICU.

The sense of caring shown towards NGNs was evident in the SRNs' reflective practice. Participant SRNs comprehended the NGNs' experience through the lens of their own experiences, showing empathy, and their experiences motivated their care of NGNs. The SRNs own experience influenced the education, communication and support they

provided NGNs. The Senior Registered Nurses actively sought to minimise toxic interactions, establishing healthy working relationships within the team. The SRN participants encouraged NGNs to ask questions, raise concerns and seek advice since NGNs' capacity to provide safe and timely care to ICU patients depended on asking questions. The SRNs in this inquiry actively tried to establish open and supportive professional relationships with NGNs, encouraging hesitant NGNs to ask questions.

Despite SRNs having insight into NGNs' needs and recognising their essential role in supporting NGNs' TPP, SRNs believed that NGNs needed ward nursing experience before entering ICU. The SRNs noted two reasons: NGNs needed to embed basic nursing skills before working in a high-acuity clinical area such as the ICU, and their nursing career may be negatively affected by a lack of broader hospital nursing experience. The Senior Registered Nurses recommended NGN foundational experience would be best provided by an area less acute than ICUs.

Although new theory generation was beyond the scope of this thesis, development of a model, reflective of the SRNs' experiences related to working with NGNs in the ICU showing the intertwining nature of the threads, bounded by the commonplaces of *temporality*, *sociality* and *place*, warrants further investigation. In the following chapter, this inquiry's findings are discussed in view of existing theory and literature.

# Chapter 5: Discussion

This current inquiry employed NI methodology when exploring five SRNs' experiences working with NGNs in the ICU. Braun and Clarke's (2006) thematic analysis was used to seek resonant major and minor threads across the narrative accounts to explain the SRNs' experiences. Two major threads were found, the first being 'Reverberations', containing five minor threads, 'We Carry Them', 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'Enjoyable Moments' and 'Survival Mode', and the second being 'Caring', containing three minor threads, 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'. In this chapter, a discussion of the threads is presented sequentially and relevant literature reported. Concluding remarks include recommendations for practice.

The major thread 'Reverberations' represented the prolonged and continuing effect SRNs experience when working with NGNs in the ICU. The ICU clinical environment was described by SRNs as being busy and stressful, with high-acuity patients' illness trajectories requiring the integration of constantly evolving advanced medical technology. The SRNs' descriptions of working in the ICU as being demanding, emotional and stressful mirrored those by other authors who describe a highly stressful and pressured environment (Gohery & Meaney, 2013; Khan, Jackson, Stayt, & Walthall, 2018; Moss et al., 2016). The ICU clinical environment is compounded by multiple nursing role assignments (Matlakala, Bezuidenhout, & Botha, 2014), complex technology (Wung et al., 2018) and challenging nursing routines associated with direct patient care such as: managing end-of-life care issues, prolonging life by use of mechanical support, performing cardiopulmonary resuscitation, participating in post-mortem care and supporting families (Mealer et al., 2012). Patients admitted to the ICU require the support of many life-sustaining medical devices and interventions; they are the most critically ill and complex patients in a hospital setting (Kruer, Jarrell, & Latif, 2014). Additionally, nursing management of ICU patients requires extensive knowledge and experience to safely and efficiently use continually evolving technologically advanced medical devices (Wung et al., 2018). New Graduate Nurses enter this multifaceted environment as part of their TPP, causing the 'Reverberations' experienced by the SRNs who work alongside them.

Participant SRNs perceived that NGNs were inadequately prepared for clinical practice in ICUs. In the minor thread 'It's Dangerous' SRNs raised concerns regarding NGNs' clinical practice, including their slow work pace, individual task focus and an inability to recognise and respond to patient deterioration. This finding is consistent with those of researchers who reported SRNs considered NGNs to be inadequately prepared for the demanding pace of acute clinical environments (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012). Ballem and MacIntosh (2014) recruited participants from five clinical environments, including critical care [ICU] nursing units, and Baumberger-Henry (2012) included SRN participants from emergency and critical care units [ICU]. In the study by Baumberger-Henry's (2012) it was determined that NGNs did not possess the required nursing skills to safely and independently work in critical care areas, such as the ICU and the ED.

The major thread 'Reverberations' and the minor thread 'It's Dangerous' highlighted the participant SRNs' perception that NGNs were not adequately prepared for the ICU clinical environment. The SRNs in this current inquiry considered NGNs to be task focused and dependent on SRN guidance, support and education to safely care for critically ill patients. Globally, the shortage of ICU RNs has impelled ICUs to employ NGNs and junior nursing staff, necessitating more supervision and support from SRNs (Department of Health, 2004). A North American report found 23.3 % of NGNs were working in critical care areas 6.5 months' [average] post registration (National Council of State Boards of Nursing, 2018). Critical care areas in this report were defined as ICU, CCU, step-down units, paediatric or neonatal ICUs, EDs and post-anaesthesia recovery units (National Council of State Boards of Nursing, 2018). The findings of this study align with those of another (O'Kane, 2012), with participant SRNs suggesting that NGNs should gain student experience in ICUs. However, it is recognised in these studies, that student placement in ICU may not always be possible.

As discussed in the minor thread, 'It's Dangerous', SRNs perceived the NGNs as not having the advanced clinical skills required in ICU to be able to recognise and, rapidly intervene and care for a deteriorating patient. However, it has been asserted that the aim of universities is to prepare nursing students for generalist nursing clinical practice and not speciality practice, such as the ICU (Swinny & Brady, 2010). Placing NGNs in ICUs has implications for nursing education and emphasises the need to expose nursing students to critical care settings as part of their curriculum and clinical placements.

Providing pre-registration ICU education helps prepare NGNs to care for critically ill patients (Department of Health, 2004). Since significant numbers of critically unwell patients are clinically managed outside dedicated ICU facilities (Lewis, 2011), graduating nurses should possess the skills and knowledge to assess and manage critically ill patients, regardless of their location within the hospital.

Studies exploring nursing students' experience of ICU clinical placements have been presented in the literature (Doucette, Brandys, Canapi, & Davis, 2011; Vatansever, Nursel, & Neriman, 2016). Vatansever et al. (2016) studied the experience of 18 first-year nursing students in one Turkish university hospital ICU. The ICU was reported to be a stressful and overwhelming place to learn and practice nursing skills. This finding was supported by Doucette et al. (2011); however, the authors reported participant students developed coping mechanisms to overcome psychological and physical challenges of ICU nursing. When considering the stressful nature of the environment and the student's limited autonomy in the ICU compared with that in clinical wards, Vatansever et al. (2016) recommended the ICU clinical environment may be better suited to nursing students who were close to graduation.

Despite the reported benefits of providing pre-registration ICU nursing education, such as learning the skills to assess and manage critically ill patients (Department of Health, 2004), and enhancing recruitment to critical care areas such as ICU (Swinny & Brady, 2010), there are difficulties when supporting nursing students in ICUs. Providing clinical placements for increasing student numbers placed increased pressure on RNs to provide good quality supervision in clinical environments (Mould, White, & Gallagher, 2011). Concerns raised by SRNs associated with supporting nursing students in ICUs include balancing time for patient care with teaching and inadequate staffing levels (Carlson et al., 2010). Henderson et al. (2010) highlighted that SRNs have a dual role: They ensure the delivery of high-quality care for patients and concurrently supervise nursing students. The double functions are demanding and stressful because of the pressure of clinical commitments, such as simultaneously providing support for NGNs and lack of time for educational opportunities, and reflects the findings of this study from the themes 'We Carry Them' and 'Survival Mode'.

The SRN participants in this current inquiry raised concerns that first rotation NGNs entered ICU without the required skills to safely care for critically unwell patients. The

participants suggested nursing skills and knowledge learned during undergraduate study did not prepare the NGNs for the reality of working in ICUs. This finding was reported in the minor thread 'Not In My Backyard' of the major thread 'Caring'. This finding is at odds with that of Williams and Palmer, (2014) who report ICU placements during undergraduate study provide nursing students the skills to assess and manage critically ill patients. Gallagher, Rice, Tierney, Page and McKinney (2011) stated findings from an evaluation of a two-day critical care course for nursing students. The authors reported that 89.6 % of student participants (n = 182) perceived their level of confidence increased when caring for critically ill patients and 88.2% of participants believed their knowledge and skills had improved. However, this study reported limitations and did not assess students' actual ability. Therefore, the nursing students' perceptions of increased skill as it relates to demonstrated competence could not be established. This reflects the findings of this inquiry, where the SRNs perceived NGNs as not possessing required skills, however actual competence was not measured. Further research is indicated, measuring whether clinical skills and knowledge taught in undergraduate education are associated with demonstrated ICU clinical competence and preparedness for practice.

The minor thread 'It's Dangerous' in the major thread 'Reverberations' described the SRNs' perception of NGNs' possession of basic nursing skills and knowledge in an area that required competence in advanced time management, patient assessment and critical thinking skills, and the ability to instigate timely and vital therapeutic interventions. The perceived gap between the NGNs' skills and knowledge and the requirements of critically ill ICU patients concerned the SRNs. In the current inquiry, SRNs reported feeling pressured and stressed in their accountability for ensuring ICU patients' high-quality, safe and timely care. The participants felt a personal responsibility to ensure NGNs did not make errors in patient care since the former were acutely aware that such mistakes could have negative outcomes for patients. Ballem and MacIntosh (2014) explored the perceptions of SRNs working with NGNs in different work environments, including an ICU. They reported a similar finding, with SRNs feeling the constant burden of being responsible for, and watchful over, NGNs.

During periods of increased activity, SRNs reported a reduced ability to provide patient and NGN surveillance, perceiving the reduced surveillance as a potential patient safety issue. This finding was described in the third minor thread 'Patrolling Like Surf Lifesavers' within the major thread 'Reverberations'. A seminal US report articulated the

importance of RNs in patient safety (Committee on the Work Environment for Nurses and Safety Board on Health Care Services, 2004). Published by the US Agency for Health-Care Research and Quality, it identified multiple threats to patient safety, including inadequate training and insufficient supervision. Significantly the report identified that RNs play an essential role in patient safety, providing the most direct care, observing for clinical changes and initiating rescue interventions (Twigg, Duffield, & Evans, 2013). The importance of RNs to patient safety is additionally emphasised by data from the Joint Commission on the Accreditation of Health Organisations database on sentinel events. Sentinel events defined as 'any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a person or persons, not related to the natural course of the patient's illness' (Hoonakker et al., 2011). Over a seven-year period, 1995–2002, 19% of total errors reported identified RN staffing levels as one of the four causative factors. Other factors were inadequate staff orientation and training, competency assessment and a breakdown in communication (Committee on the Work Environment for Nurses and Safety Board on Health Care Services, 2004).

An important finding described in the minor thread 'Patrolling Like Surf Lifesavers' within the major thread 'Reverberations', is the SRNs in this current inquiry recognised their significant role in the surveillance, intervention and rescue of ICU patients from harm. However, participant SRNs reported they often did not have the nursing resources to adequately provide surveillance to NGNs in the ICU. Twigg et al. (2013) supported this finding, stating patient safety, 'can only be realised if there are sufficient nurses to provide appropriate care' (p. 544). Additionally, Peet, Theobald, & Douglas, (2019) assert that the capacity for nursing surveillance may be unravelled by the context in which the RNs practice; recognising the political and social tensions inherent in everyday nursing practice 'have a profound impact on patient care' (p. 2931).

Senior Registered Nurses in this current inquiry reported that NGNs' lack of experience in providing nursing care in the ICU created additional workload challenges for the SRNs. The minor thread 'We Carry Them' in the major thread 'Reverberations' highlighted factors such as staffing resources, time constraints, reduced break time and concurrent roles that contributed to SRNs' workload concerns. The SRNs felt an obligation to provide safe and high-quality patient care in addition to supporting NGNs. Participant SRNs reported they delayed and went without meal breaks to ensure adequate patient surveillance; they answered numerous requests for guidance and information by NGNs

and worked with them to ensure NGNs completed all their nursing tasks promptly. When patients deteriorated, SRNs rapidly intervened, often taking full responsibility for the NGNs' patients in addition to their own responsibilities. These interactions increased the workload of SRNs, who reported feeling tired when required to continually support NGNs.

The NGNs impact on SRNs' workload, as discussed in the threads, 'Survival Mode' and 'We Carry Them' and concerns regarding NGNs preparedness to work in a Level 6 ICU as represented in 'Not in My Backyard', may be exacerbated by organisational factors inherent in *sociality,* specific to this *place.* Although this inquiry was not specifically examining either the organisational or ICU context features that might impact the SRNs' experience, the context in which this inquiry was located did not align with standard six of the ten standards inherent to the ACCCN workforce standards for intensive care nursing (Chamberlain, et, al., 2018). The ICU in this inquiry does not roster a pre-determined number of ACCESS RNs to optimise patient safety or maximise ICU bed utility, which may contribute to the SRNs' perceived workplace stress and, specifically their perceived increased workload when working with NGNs (Chamberlain, et, al., 2018).

In response to requests from the Australian intensive care nursing profession, the Australian College of Critical Care Nurses (ACCCN) sought to develop a robust evidence based position statement on the ICU nursing workforce. The aim was to 'develop standards that defined a safe and sustainable intensive care nursing workforce to ensure the best outcomes for critically ill patients' (Chamberlain, et, al., 2018. p. 293). Post a systematic review of the literature and further evidence review, analysis and grading of included studies, all ten draft standards were deemed to be supported by a body of evidence of at or above grade C. The draft of the standards was reviewed by professionals and consumers, including relevant advisory panels. The guidelines were appraised using the AGREE II instrument by eight nursing clinicians, who were not involved in the standard's development from the Intensive Care Services Network, Agency for Clinical Innovation, New South Wales, Australia (Chamberlain, et, al., 2018).

It has been reported that increases in patient acuity and health care costs associated with providing care for sicker patients place substantial financial pressure on acute care hospitals. Health care providers are often asked to provide the same level of care with fewer resources (Duchscher & Cowin, 2006). New nurses are entering professional practice in clinical areas affected by unparalleled workload expectations and high levels of stress (Duchscher & Cowin, 2006). Senior Registered Nurses who work in these areas are exhausted, which ultimately affects their capacity to mentor and act as role models to NGNs (Ballem & MacIntosh, 2014). Senior Registered Nurses in this current inquiry recognised preceptoring was essential to the support and development of NGNs; however, they also perceived preceptoring to increase their workload. This finding is similar to the findings of Shermont and Krepcio (2006), who sought to evaluate the turnover rates in three inpatient surgical units at a US children's hospital. The authors acknowledged the burden placed on the role when preceptors were required to assume TL responsibilities or take a patient allocation in addition to their preceptor responsibilities.

High workload is an identified major concern in health care, particularly in ICUs, (Hoonakker et al., 2011) and a significant job stressor reported by ICU SRNs (Kiekkas et al., 2008). The SRNs in this inquiry described increased workloads when working with NGNs in the ICU. The thread 'We Carry Them' within the overarching thread 'Reverberations', supports the findings of Ballem and MacIntosh (2014), whose theme, 'Carrying the Load' reports SRNs were stressed, overwhelmed and exhausted when carrying a greater workload while working alongside NGNs.

High workloads can have negative consequences for ICU nurses, including burnout syndrome (BOS), which in turn, is associated with decreased well-being and quality of patient care, and increased fiscal costs associated with turnover rates and absenteeism (Embriaco et al., 2007). Intensive Care Unit patient care is affected by high nurse workload, resulting in poor patient outcomes, complications and increased mortality (Gurses, Carayon, & Wall, 2009). These outcomes may be related to the lack of time to perform vital patient care tasks. Given the evidence of high workloads on ICU nurses and patients, it has been considered important to examine workload dimensions, such as time pressure and physical, mental and emotional workloads (Carayon & Alvarado, 2007), in addition to examining the methods employed to measure workload (Hoonakker et al., 2011).

Workload can be difficult to define and conceptualise particularly when considering global differences in the staffing, management and financing of ICUs. Workload has been defined as the 'momentary relative capacity to respond' (Lysaght, Hill, Dick, Plamondon, & Linton, 1989, p. 204) and 'a multidimensional and complex construct, that is affected by external task demands, environmental, organizational and psychological factors, and perceptive and cognitive abilities' (Weinger, Reddy, & Slagle, 2004, p. 1419). Developments in treatments available for critical illness have altered the types of patients being admitted to ICUs with more elderly patients, those with pre-existing chronic disease and greater severity of illness being admitted (Carmona-Monge, Rodríguez, Herranz, Gómez, & Marín-Morales, 2013). The nursing care required by these ICU patients, and consequently the ICU nurses' workload burden, is directly influenced by the use of increasing numbers of therapeutic interventions (Carmona-Monge et al., 2013). Additionally, RNs with limited independent nursing experience post registration are commencing their professional careers in ICU (Bortolotto, et. al., 2015). These NGNs require significant support from SRNs to ensure they are adequately supported; increasing the workload of the SRNs (Ballem, 2014). Measuring ICU nursing workload may be equally difficult considering the patient and operator approaches available (Hoonakker et al., 2011). Patient-based workload measures only consider characteristics such as the number of patients, nurse-to-patient ratio, patient acuity and time. Conversely, operator-based workload measures consider nurse characteristics, including their interaction with the working environment (Carmona-Monge et al., 2013).

For decades, attempts have been made to demonstrate ICU cost–benefit ratios via a variety of tools designed to measure severity of patient illness in addition to the true cost of ICU nursing workload. Miranda, Nap, de Rijk, Schaufeli and Iapichino (2003) developed the Nursing Activities Score (NAS), validated in a study of 99 ICUs across 15 countries. This tool measured additional nursing activities, such as care of relatives and administrative tasks, and found these to account for 60% of average nursing time. The Nursing Manpower Use (NEMS) tool was developed from a more complicated tool, the Therapeutic Intervention Scoring System (TISS; Reiss Miranda, Moreno, & Iapichino, 1997). Carmona-Monge et al. (2013) sought to determine the workload relationship between the NAS and the NEMS in addition to their ability to measure the staffing needs in the ICU and whether it was appropriate to meet the needs of the patients (Carmona-Monge et al., 2013). The authors determined a strong association between measurements

despite the NEMS being based on the critically ill patient's therapeutic interventions and the NAS attributing greater specific weighting to standard independent activities of ICU nursing care. However, it was noted that the main difference between the tools was in the determination of staffing levels. Estimated nursing staffing needs through the NAS were significantly higher than through the NEMS, since the former assesses nursing activities extending beyond those associated with patient severity or therapeutic interventions. Carmona-Monge et al. (2013) remarked that in both cases, regardless of the tool used, estimated staffing needs established through the tools were higher than currently provided in the ICU in which their study was situated.

Hoonakker et al. (2011) sought to apply the NASA task-load index (TLX) tool, developed to measure aviation workload (Hart, 2006), to health care with the aim of examining ICU nurses' workload. Data were collected from 17 ICUs in seven US hospitals. Hoonakker et al. (2011) concluded the NASA-TLX is a valid and reliable tool to measure nurse workload in ICUs. The authors established the tool was easy to administer and complete, allowing researchers to measure different dimensions of ICU nursing workload. The dimensions included mental, physical and temporal demands. This study was unique because it studied both patient and operator dimensions of workload. Workload tools, such as those described, could be used to measure SRN's workload. Initiatives to reduce the risk of BOS, address perceived staffing concerns and trial different NGNs' orientation, induction and supernumerary models, could employ the NEMS, TISS or NASA-TLX as a pre-and post-intervention measure of SRNs' workload when working with NGNs in the ICU. This proposition is discussed in more detail in the recommendations chapter.

The degree to which SRNs in the thread 'Survival Mode' within the major thread 'Reverberations' reported feeling worried, stressed, irritable, pressured and tired when working alongside NGNs in the ICU is of concern since these symptoms may be indicative of chronic stress. Senior Registered Nurses in this inquiry described negative emotions, perceiving they were unable to provide an acceptable level of patient care. Huntington et al. (2011) in their study of RNs in Australia, New Zealand and the United Kingdom (n = 7604) working predominantly in acute hospital facilities (n = 3975) reported similar findings and suggested their findings may be consistent with the definition of burnout. The term burnout is defined as a psychological syndrome that occurs in response to chronic stressors and exhibits as 'emotional exhaustion,

depersonalization and reduced personal accomplishment' (Maslach, 2003, p. 12). Burnout is not uncommon in ICU RNs with Merlani et al. (2011) reporting 28% of RNs (n = 2415) in their study of 2 996 ICU caregivers in 74 Swiss ICUs, exhibited a high degree of burnout. Consequences of burnout to nursing staffs' health manifest clinically and include insomnia, irritability, tiredness, emotional instability, eating problems and headaches (Poncet et al., 2007). Senior Registered Nurses in this current inquiry reported similar symptoms, such as irritability, tiredness and emotional instability. The SRNs also reported a potential new finding—they drank alcohol to wind down after a shift and as a coping mechanism.

Burn Out Syndrome is the result of chronic stress, yet Merlani et al. (2011) reported high stress levels did not always correlate with high burnout. Merlani et al. (2011) hypothesised being burned out may reduce stress resistance thus contributing a 'vicious cycle wherein the role of each factor might be confounding' (p. 1144). It has been suggested that burnout may not be gender specific (Merlani et al., 2011) but linked to the individual health care worker's psychological and empathic traits and whether individuals have self-caring support systems that mitigate the detrimental effects of stress (Azoulay & Herridge, 2011). Although SRNs in this current study reported findings of feeling pressured, stressed and overwhelmed, they also described positive moments and recognised beneficial aspects of working with NGNs in the ICU. This inquiry's finding is supported by that of Azoulay and Herridge (2011) who reported SRNs' individual traits may provide a degree of mitigation for both stress and burnout.

The findings of this current inquiry report participant SRNs [with an average 13 years of experience at this inquiry site], despite feeling overwhelmed, stressed and pressured, have an enduring capacity to work in the ICU environment. Burgess et al. (2010) support this finding, reporting that although the ICU workplace is an area susceptible to staff turnover and nursing shortages some RNs thrive in the high-stress ICU environment, maintaining their interest and desire to work despite the inherent stressors. The ability to thrive in a stressful environment could be explained by individual SRN's possession of inherent resiliency, resiliency being a 'multidimensional characteristic that allows an individual to thrive when faced with complexity and high rates of change' (Moss et al., 2016, p. 373). The current inquiry's findings are also supported by Mealer et al. (2012), who report the presence of resilience in a subsection of ICU nurses was associated with a significantly reduced rate of BOS and symptoms of depression and anxiety. Resilience has been

reported as playing a role in establishing healthier psychological profiles of ICU nurses, acting as a safeguard against burnout (Charney, 2004; Chlan, 2013; Mealer et al., 2012). Resilience can be learned with psychologists identifying factors that promote resilience, such as family relationships, external support systems and individual temperaments (Mealer et al., 2012). Personal qualities, such as the ability to engage the support of others, faith, optimism, altruism, the belief that stress can be strengthening, and striving towards personal goals, are also associated with resilience (Charney, 2004; Hoge, Austin, & Pollack, 2007; Luthar, Cicchetti, & Becker, 2000; Mealer et al., 2012). The personal qualities and factors associated with resilience reflect this current inquiry's findings as described in the major thread 'Caring'. The SRNs reported: engaging the support of the ICU nursing team to overcome stressful situations, providing support to NGNs despite the associated increase in workload and moderating their communication and interactions with NGNs when under pressure, and through reflection on their own ICU experiences, showed empathy to NGNs working in the ICU.

As presented in the final thread 'Enjoyable Moments' within the overarching thread 'Reverberations', SRNs in this current inquiry described positive experiences related to working with NGNs in the ICU. Although literature describing the experiences of SRNs working with NGNs in the ICU is limited, the available literature describes positive aspects of working with NGNs. Ballem and MacIntosh's (2014) study reported SRNs were motivated by the presence of NGNs to refresh their nursing skills and knowledge, thus keeping their personal nursing practice current. Further, SRNs in Baumberger-Henry's (2012) study recognised that NGNs completing orientation in critical care areas such as ICUs had positive benefits on individual SRN's workload and general staffing levels. The current study presents new findings, with participant SRNs articulating feeling proud of NGNs when they progressed clinically and professionally in the ICU. The SRNs communicated their sense of satisfaction when NGNs voiced their gratitude and thanked the SRNs for their support while on ICU placement.

Despite SRNs in this current inquiry reporting NGNs' nursing skills were at a basic entry level in an area that required advanced nursing skills, and despite the impact this had on their workloads, SRNs were supportive of, and exhibited care towards, NGNs, as described in the overarching thread 'Caring'. This finding of the concept of caring was supported by studies (Ballem & MacIntosh, 2014; O'Kane, 2012) that reported SRNs eased the transition of NGNs into professional practice and were cognisant of their role

obligations to be supportive of NGNs. However, SRNs in this inquiry explicitly commented that NGNs were considered a part of the team, and despite the associated increased workloads and levels of stress and pressure associated with working with NGNs, actively cared for and supported the NGNs. The SRN participants recognised that initial experiences in nursing could have a profound effect on NGNs' future careers and therefore tried to ensure that NGNs' ICU experiences were positive.

However, these findings are at odds with studies (Baumberger-Henry, 2012; Duchscher, 2009; Johnstone et al., 2008; Laschinger et al., 2010; Parker et al., 2014) that described the unsupportive behaviours SRNs exhibited towards NGNs. The discrepancy in findings might be explained by differences in workplace culture, leadership qualities and available resources between the sites in which the studies were situated. Additionally, the capacity of individual RNs, nursing units and organisations to engage with NGNs, support their ongoing education and provide resources to gradually assume full RN responsibilities and expectations may affect SRNs' behaviours towards NGNs. Regardless of the rationale for the behaviour, Baumberger-Henry (2012) emphasised that SRNs who ignore or remain silent when witnessing SRNs' nonconstructive interactions with NGNs legitimise this unsupportive behaviour.

This current inquiry's findings discussed in the thread 'I've Been There' within the overarching thread, 'Caring' aligns with that of another study (Ballem & MacIntosh, 2014) describing the reflective practices of SRNs towards NGNs. These findings highlight that SRNs support NGNs as they transition into professional practice. The SRNs in both studies personally reflected on their own experiences as new RNs working in an acute care hospital. Their reflection enhanced their empathy towards NGNs and their willingness to support NGNs' workload in addition to their own and to provide emotional support. The SRNs' reflections on their previous disparate early experiences in the ICU motivated them to ensure the NGNs' ICU experience was positive. Evidence that SRNs continued to reflect on their practice was apparent in the findings and has been supported by Hodges, Troyan & Keeley's (2010) study, which suggests that RNs should continue to reflect and critically appraise their practice because reflection leads to an increased capacity to support colleagues to remain in the adverse, complex and unpredictable health care system.

The participant SRNs, as discussed in the thread 'They Must Ask Questions', within the major thread 'Caring', highlighted the importance of NGNs asking questions and seeking advice from more senior colleagues when they recognised limitations in their knowledge and skills. The SRNs perceived that when NGNs did not ask questions or seek advice, there was an increased potential risk of patient errors. This finding was supported by Baumberger-Henry's (2012) study seeking to explore RNs' perceptions of NGNs working in an emergency or ICU area. The author commented that 'Not asking means that the possibility of causing an error is high' (p. 301). The SRNs in the current inquiry believed that NGNs might conceal their level of knowledge and inexperience and at times were reluctant to seek advice. The SRN participants were concerned about this behaviour because the time-constrained environment of this inquiry's context meant that if NGNs did not ask questions or were not transparent about their level of knowledge, SRNs would not be able to amend their workload to provide the necessary NGN support and education. This perception regarding NGNs affected the SRNs, particularly if they were in the TL role, because the role requirement obliged them to ensure overall patient safety and staff support.

The Senior Registered Nurses postulated NGNs' embarrassment, fear and presence of patients' families underpinned their reluctance to seek SRN advice and ask questions. This finding is supported by studies that report on the presence of NGNs in the ICU from either the NGN or SRN perspective. Saghafi et al. (2012) reported NGNs attempted to hide their ICU nursing inexperience from patients and families, believing their inexperience might influence the level of patient trust in their capacity to implement patient care. Baumberger-Henry's (2012) study suggested NGNs' desire to be autonomous prevented them from asking SRNs questions. These findings are concerning, because SRNs recognise their obligation to teach NGNs but are constrained if NGNs do not ask questions, attempt to obscure their level of knowledge or are not aware of their knowledge gaps. Workload demands can limit the SRNs' capacity to undertake vigilant surveillance of NGNs and ICU patients. Senior Registered Nurses rely on NGNs to raise concerns regarding their patients' condition so that they can provide support, advice and clinical interventions in a timely manner, thus ensuring patients receive best possible nursing care. However, if NGNs do not ask questions or vocalise their concerns, both NGNs and ICU patients receive less than optional support.

The thread 'Not In My Backyard' in the overarching thread, 'Caring' examined the SRNs' belief that the NGNs' lack of ward experience and knowledge of how the wider hospital worked in conjunction with the ICU restricted their ability to work in the ICU environment. The ability to clinically assess patients without the use of monitors or advanced technological equipment was perceived by SRNs as being a skill more readily gained in hospital wards. Since SRNs were quick to take over the care of the deteriorating patient, something that may not readily occur in a hospital ward, participant SRNs suggested that NGNs may have fewer opportunities in ICUs, unlike in lesser acuity clinical areas, to gain skills such as accountability and responsibility. This finding was mirrored in O'Kane's (2012) study where SRNs' perceived the lack of NGNs' ward experience 'was a potential hindrance to nurses' development in ICU' (p. 49). Correspondingly, in O'Kane's (2012) study, SRNs identified that experience in a clinical area without monitoring and technology gave NGNs an opportunity to gain basic assessment skills. Further, ward experience was thought to encourage NGN skills such as, 'accountability, responsibility, and the ability to prioritize' (p. 49).

Within the overarching thread, 'Reverberations', SRNs in the current inquiry, described the hectic, stressful, dangerous nature of the high-acuity ICU environment in the thread 'It's Dangerous' and the pressure and added workload required to support NGNs while sustaining high-quality, safe patient care in the threads 'Survival Mode' and 'We Carry Them'. The participant SRNs perceived the NGNs' nursing skills as being inadequate to meet the needs of critically unwell ICU patients. The SRNs recommended that because of the nursing skill and experience mismatch between NGNs and ICU patients' requirements, first rotation NGNs should not be placed in ICU on a TPP program. However, SRNs' views differed in this regard. Some suggested that NGNs should not work in ICUs until they had practiced for a year in a clinical ward area whereas others proposed that NGNs be allocated a rotation in ICUs after a six-month placement in a clinical ward area, provided the SRNs were given adequate resources to sufficiently support the NGNs and their allocated patients. Similar concerns were raised by SRNs in Baumberger-Henry's (2012) study regarding the placement of NGNs in critical care areas with SRNs stating problems with, 'time management and basic skills, fear, and inability to think critically' (p. 301). A participant in Baumberger-Henry's (2012) study stated, 'I don't believe graduate nurses should be in the emergency department or intensive care

unit. It's this constant stop go, stop go, and a lot of people don't have the basic down at that point' (p. 301).

Nursing staff shortages and high levels of intention to leave rates are a global concern, especially in highly specialised environments such as ICUs. There has been a significant change in nursing culture in recent times with ICUs now offering orientation and transition programs to NGNs (Bortolotto, 2015; Friedman et al., 2011), often with the intended aim of ameliorating staffing shortages. Programs to successfully familiarise NGNs with the ICU and increase staffing levels have been shown to be cost effective, despite the financial resources required to run the program (Bortolotto, 2015). The SRNs in the current inquiry supported the development of NGNs and recognised their crucial role in supporting NGNs' transition into professional practice. However, they also reported in the minor thread 'We Carry Them' within the major thread, 'Reverberations', difficulty in consistently supporting NGNs because of skill mix and workload concerns. This finding is concerning since Hussein et al. (2018) reported that NGNs' intention to stay is directly related to their not being placed in clinical situations beyond their individual capability. Additionally, NGNs' intention to remain in critical care areas produced two significant and independent predictors: high satisfaction with unit orientation score and high satisfaction with clinical supervision. Previous research also confirms that NGNs who feel better supported are more likely to be satisfied and indicate an intention to stay in their current critical care area (Parker et al., 2014).

However, these studies did not evaluate the perceptions and experiences of SRNs who play a vital role in orientating, inducting and clinically supporting the NGNs. If a perceived effective critical care unit orientation and clinical supervision increases NGNs' intention to remain in critical care areas (e.g., ICUs), addressing the challenges experienced by SRNs, as reported in the findings of this inquiry, associated with providing support in areas affected by increased admission rates, patient acuity and complexity is warranted (Hussein, et. al., 2018). The SRNs' capacity and willingness to provide clinical supervision to NGNs working in ICUs deserves further investigation.

The ideal length of ICU orientation programs has not been established in the literature, although many authors describe programs lasting 12 to 26 weeks (Bortolotto, 2015; Friedman et al., 2011; Proulx & Bourcier, 2008). Suggested supernumerary periods for NGNs differ in the literature. O'Kane (2012) recommended NGNs should receive an

eight-week supernumerary period, supported by two preceptors irrespective of experience. Atherton and Alliston (2011) reported a 10-week supernumerary period for NGNs entering the department of critical care medicine on a nursing entry to practice program. Commenting on the Australian experience, Missen, McKenna and Beauchamp (2016) reported that NGNs in one regional ICU were supernumerary for the entire three-month rotation. In comparison, these programs differ significantly from this inquiry's *place*. In this context, the organisation offers an orientation program comprising of a three-day induction with CNEs, then one-week supernumerary for first rotation NGNs and three days for second rotation NGNs. The NGNs are subsequently enrolled in an ICU specific, three-day didactic 'Introduction to ICU' course.

The workload and pressures experienced by the SRNs, as described in the minor threads, 'We Carry Them' and 'Survival Mode', relate specifically to working with the NGNs in ICU, however there may be organisation wide factors impacting these findings that should be considered. There is current Australian research examining the NGNs' perceptions of practice environments and clinical supervision and, how these variables influenced NGNs' intention to stay in non-critical and critical care areas post their TPP program (Hussein et al., 2019). However, there is a dearth of literature exploring the organisational and contextual factors that influence ICU SRNs' capacity to support NGNs and, their own workload during the orientation and supernumerary period. This may be an area suitable for further investigation.

Best nursing practice in ICU endeavours to counteract and reduce the severity of complications associated with critical illness. Senior Registered Nurses working in ICU carefully observe and clinically assess ICU patients and on interpreting all available data instigate timely and appropriate interventions and therapies (Adam, 2017, p. 54). However, NGNs possess basic skills and are reliant on SRNs to provide education, advice, and surveillance when managing high-acuity patients in critical care areas such as ICUs (Baumberger-Henry, 2012). The Dreyfus Model of Skill Acquisition suggests that during the acquisition and development of skills, an individual progresses through five levels of proficiency: novice, advanced beginner, competent, proficient and expert (Benner, 1982). Benner's (1982) study confirmed the model can be applied to nurses when acquiring clinical nursing skills. NGNs are classified as advanced beginners since they experience every clinical situation as a multitude of competing tasks, all of which seem of equal priority (Benner, 1982). Although NGNs are deemed competent by the

higher education institution to be registered by Australian Health Practitioner Regulation Agency, when performing basic nursing skills, they continue to require support and assistance from experienced RNs. Senior Registered Nurses in ICUs play a vital role in the clinical development of NGNs as they transition into professional practice and gain experience.

## 5.1 Limitations

Limitations of qualitative studies may occur in the lack of congruence between philosophical underpinnings, methodology and methods, potentially limiting the trustworthiness of the research. The visibility of researcher reflexivity throughout this thesis, together with the inclusion of the researcher's Narrative Beginnings Account in the appendices (see Appendix C), demonstrated that congruence was maintained within this Narrative Inquiry.

The limitations of Narrative Inquiry methodology, as used in this inquiry, are those inherent to immersion in the three-dimensional Narrative Inquiry space. Therefore, this inquiry was limited to the stories of experience told by five participants in one specific place. There is no claim to generalisability of findings. As Narrative Inquiries are less concerned with generalisability and more concerned with a deeper understanding of the research puzzle, the presentation of an examination of the SRNs' stories of experience may encourage readers to rethink and reimagine SRNs' practice in the ICU. Thus, contributing to nursing knowledge in this speciality area.

The relationship between inquirer and SRN participants in this current inquiry, despite acknowledging the relational ontology of NI, may be considered a potential limitation. Although my knowledge of the ICU *place* may have encouraged rich and detailed conversations, I was actively aware that my concurrent role as CNE in the context in which this inquiry was situated, may have influenced my interpretations. Although my reflexivity was visible throughout the thesis, my worldview is not dissimilar to that of the SRN participants and my embeddedness in the inquiry context may have unintentionally constrained some active analysis processes. However, I sought to ameliorate this by presenting the participants' complete narrative accounts to allow readers to consider their own interpretations of the SRNs' stories of experience.

Narrative inquiry methodology explicitly acknowledges that there is no final story, or final telling and 'no one singular story we can tell. We realize that this is not going to be satisfying for those who want to see truth, or accuracy and verifiability of data' (Clandinin, 2013, p. 205). The stories told by participants were not narratively smoothed and their inherent tensions and contradictions were made apparent.

# Chapter 6: Recommendations and Conclusion

The aim of this inquiry was to contribute to nursing knowledge by examining SRNs' stories of experience whilst working with NGNs in the ICU. Thereby, allowing the SRNs' voice to be heard in the literature. Senior RNs in ICUs play a vital role in both the clinical and professional development of NGNs as they transition into professional practice and gain experience in the ICU. As discussed in *Chapter 3* there were two major inquiry findings. The major thread, 'Reverberations', contained five minor threads: 'We Carry Them', 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'Survival Mode' and 'Enjoyable Moments'. The second thread, 'Caring', contained three minor threads: 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'. Based on these findings and those from the literature, as discussed in *Chapter 5,* this Chapter presents recommendations for nursing practice.

Nursing leaders in the organisation and at local levels need to recognise and acknowledge the increased workload associated with working with NGNs. Senior Registered Nurses, in this inquiry as described in the minor threads, 'We Carry Them' and 'Survival Mode' and other literature (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012; O'Kane, 2012), have reported feeling overwhelmed and stressed when working with NGNs in the ICU. The SRNs in this inquiry sought recognition from managers regarding the amount of work involved in supporting NGNs while safeguarding patient safety in the ICU. Ballem and MacIntosh (2014) suggest performance reviews are an ideal opportunity for nurse managers to acknowledge the SRNs role and associated increased workload in educating, supporting and guiding NGNs as they gain experience in the ICU. Favourable frequent informal feedback from nursing managers has been directly associated with lower turnover intentions in a study of home nurses (Van Waeyenberg, Decramer, & Anseel, 2015). This strategy could be implemented in clinical contexts such as ICUs, where time restraints and shift patterns may influence the scheduling of formal feedback sessions with SRNs. Managers' acknowledgement and appreciation of the essential role SRNs play in the support of NGNs working in the ICU environment may contribute to lower turnover intention rates.

In the period 1995–2005, two-thirds of root causes of sentinel events were related to communication issues (Joint Commission on Accreditation of Healthcare Organizations, 2003). The SRNs concerns regarding NGNs' ability, comfort in and willingness to ask questions was presented in the thread, 'They Must Ask Questions'. The SRNs reported that if unaware of NGNs concerns regarding their patient care they were less able to adequately support NGNs' workload, provide education or prevent potential patient error. Indirectly, high nursing workloads may affect patient safety because of its negative effect on communication, decreased staff motivation and job satisfaction and increased rates of burnout (Hoonakker et al., 2011). RNs making decisions regarding patient allocation on a regular basis should be enabled and empowered to make decision about those allocations and adjust them as required to match the skills and knowledge of the RN to the patient's care needs. Additionally, patient allocation decisions should be made and adjusted to meet the changing needs of the patient and safe practice (Penoyer, 2010)

Hospitals need to invest in creating environments supportive of SRNs' workload, including through sufficient staffing, managerial support and recognition of SRNs and by maintaining healthy relationships between SRNs and other health care workers (Olds, Aiken, Cimiotti, & Lake, 2017). Given the findings of this inquiry, reported in the minor threads 'We Carry Them' and 'Survival Mode' and other studies (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012; O'Kane, 2012) regarding the negative impact of high ICU nursing workload, particularly amongst SRNs, it is recommended that the physical, mental and emotional workloads, including time pressures, be measured regularly. This recommendation is highlighted by others, suggesting appropriate nursing staffing levels be based on total patient acuity instead of absolute patient numbers and rigid nurse-to-patient ratios that disregard variability in individual patients' needs and acuity, nurse competencies and the status of the ICU work environment (Kiekkas et al., 2008; Nurses, 2016). The NASA-TLX, NEMS and TISS tools that measure ICU nurses' workload could be easily applied as part of a larger quality improvement initiate, seeking to create healthier ICU workplaces with manageable workloads and decreased incidence of BOS. ICUs which are considering practice changes such as employing NGNs as part of a TPP program or recruiting NGNs immediately post registration, may consider the workload measurement tools as a pre-and post-intervention measure of SRNs' workload when working with NGNs in the ICU.

The SRNs in this inquiry reported in the minor thread 'Survival Mode' symptoms that might reflect the definition of BOS, such as irritability, tiredness and labile emotions. Burn Out Syndrome could be considered a significant quality improvement target, since it can lead to increased rates of intention to leave, absenteeism and resignation (Aiken et al., 2012; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004). Nonetheless, factors that contribute to increased rates of burnout, such as ICU patient mortality and length of stay (Merlani et al., 2011), conflict (Poncet et al., 2007) and increased workload (McManus, Keeling, & Paice, 2004; Moss et al., 2016) are complex issues and may prove difficult to address.

Strategies to prevent and treat BOS in critical care areas, such as the ICU, can be divided into two streams: interventions that focus on improving the ICU environment, and interventions that support clinicians in coping with their environment (Moss et al., 2016). Improvements to the ICU environment might be guided by the recent American Association of Critical-Care Nurses (2016) statement. The statement set six standards for establishing and sustaining healthy work environments: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition and authentic leadership (p. 10). Mealer et al. (2012) used a resilience conceptual framework, informed by Dennis Charney's (2004) work identifying 10 psychological characteristics of resilience that can be learned through cognitive behavioural therapy (Milne, 2007). The 10 characteristics described by Charney are: be optimistic, develop cognitive flexibility, develop a personal moral compass or shatter-proof set of beliefs, be altruistic, find a resilient role model in a mentor or heroic figure, learn to be adept at facing your fears, develop active coping skills, establish and nurture a supportive social network, keep fit and have a sense of humour and laugh frequently (Milne, 2007, p. 5). Resilience may act as a protective mechanism to reduce and prevent symptoms of BOS associated with working in a stressful ICU clinical environment. In this inquiry, the stressful environment was further impacted by the 'Reverberations' experienced by SRNs when NGNs entered the clinical context. Since resilience can be learned, educational and support programs focusing on these 10 characteristics may result in decreased rates of BOS, improved work satisfaction and healthier work environments and potentially decrease ICU nurse turnover rates and attrition from the workplace (Mealer et al., 2012).

Health care organisations must consider educating ICU SRNs, as part of a wider interdisciplinary ICU team, in recognising BOS risk factors and providing support when

staff seek assistance (Moss et al., 2016). Intensive Care Unit SRNs and other members of the ICU team could consider maintaining their physical health and emotional coping mechanisms, building personal resilience. There are several strategies that ICU SRNs and the health care organisation might consider when building resilience. Burgess et al. (2010) suggested removing stressors (as able) through active planning and using positive reframing as a way of thinking about the stressor from a different perspective. Regular interdisciplinary meetings to discuss difficult patient cases, debriefing, staff support groups, clinical supervision and staff education in communication, negotiation and conflict resolution are methods that have been suggested to help create healthy workplaces (Chlan, 2013; Levy, 2004; Mealer et al., 2012).

Providing networking and educational opportunities for SRNs to discuss and exchange ideas with other SRNs and preceptors as protected time away from the clinical context and the associated workloads may result in improved job satisfaction and a more positive experience for other SRNs in similar roles (Goss, 2015; Sandau, Cheng, Pan, Gaillard, & Hammer, 2011). Since SRNs have a significant role in the development of NGNs, nurse managers and organisational leaders should ensure and encourage this cohort of SRNs access to education and forums that specifically address these aspect of their role (Baxter, 2010). Education focusing on adult learning theory and principles, evaluation and performance management strategies, approaches to giving and receiving constructive feedback, advanced communication techniques and negotiating skills would be extremely beneficial in providing the tools SRNs require when supporting NGNs in the ICU. Particularly during clinical situations, for which the NGNs were often unprepared, involving rapidly deteriorating, critically ill patients, as presented the thread, 'It's Dangerous'.

There may be opportunity for SRNs who work in this inquiry's' *place* to continue to tell stories of their experiences to others interested in this puzzle. The major thread 'Caring' and the minor threads, 'I've Been There', 'They Must Ask Question' and 'Not in My Back Yard' highlight the SRNs' investment in NGNs' careers.  This may present a unique opportunity for SRNs' to share experiences and make visible the capacity of SRNs to care for NGNs despite the perceived overwhelming, pressured and stressful environment of ICU.

Diagnostic and treatment interventions are more technologically advanced, patients have increasingly complex health conditions, there is high RN turnover and economic resources are progressively more restricted, leaving little room for planned or spontaneous opportunities for professional development (Bjørk, Torstar, Hansen, & Sandal, 2009). Research studies (Aiken et al., 2008; Bjørk et al., 2007) emphasise the importance of continuous education and its effect on RN recruitment and retention (Hansen, Gundersen, & Bjørnå, 2011). Senior Registered Nurses, including other relevant staff such as CNEs, NEs and nursing managers, need to be given sequestered time to adequately develop and evaluate nursing orientation and induction programs with a focus on education and organisation theory and predefined measures of efficacy, including the cost-effectiveness of supernumerary time and impact on SRNs workload. Engagement with stakeholders is an essential aspect of these processes. Consideration could be given to university academic lecturers and course coordinators being more actively involved in clinical practice, with potential mutual benefits for both undergraduate nursing programs and the clinical workforce. University nursing faculty input on developing and evaluating orientation and preceptor programs may assist nursing educators and managers in developing evidence-based programs, which better support SRNs and NGNs, while expanding faculty's understanding of the complexity and constraints of clinical environments such as ICUs (Mårtensson, Engström, Mamhidir, & Kristofferzon, 2013). This could lead to improved undergraduate preparation of nursing students whom may ultimately enter professional practice in the ICU as a NGN.

There are constraints when comparing ICUs, both globally and internally, owing to differences in hospital nursing structures, organisational and financial funding models and admitted patient cohorts. However, further research into the optimal length of NGNs' orientation, induction and supernumerary periods, with a focus on both SRNs and NGNs experiences of the process, and potential effect on patient safety and outcomes may be advantageous to the ICU nursing community. Paradoxically, the current inquiry's findings suggest that SRNs who work with, and preceptor, NGNs experience higher workloads and levels of stress, factors that influence higher levels of BOS and intention to leave rates. Further research on the experience of SRNs who work with NGNs in the ICU may prove beneficial to the understanding of the broader impact of NGN ICU orientation and induction and supernumerary programs.

Concerns were raised by SRNs in this inquiry and other studies (Baumberger-Henry, 2012; O'Kane, 2012) regarding NGNs' basic level of knowledge and experience limiting their ability to care for critically unwell patients. The participant SRNs postulated, as discussed in the minor thread, 'Not in My Backyard' that a lack of ward experience and knowledge of the wider hospital could negatively affect NGNs' development. Well-resourced orientation and induction and supernumerary programs, offering didactic education, supported clinical experience, graded entry to nursing responsibility and achievable workloads, could be considered by nursing management. Fiscal restraints and decreased managerial recognition of the benefits of extended, well-resourced orientation, induction and supernumerary programs may affect an individual ICU's ability to provide NGN orientation programs that both support NGNs and the SRNs' workload and the ability to provide safe and effective care. To resolve the tension between the need to increase ICU RN staffing numbers, yet provide a healthy working environment that minimises the loss of SRNs from the ICU, an alternate NGN ICU orientation and induction model could be offered.

As suggested by SRNs in this current inquiry, in the minor thread, 'Not in My Backyard', RNs with one year's nursing experience in an acute hospital environment could be actively recruited and welcomed into the ICU on a 12-month transition to an ICU program. Building on skills and experience established and gained in the wards as part of a TPP program, SRNs may be more readily able to provide the support and education required to support novice ICU RNs while lessening their overwhelming workload. Providing time and resources for NEs to develop a program and establish robust evaluation tools, including workload tools such as the NASA-TLX, NEMS and TISS would enable the program's effectiveness to be measured and critiqued. Possible beneficial outcomes may include a reduction in SRNs' workload, resulting in the retention of SRNs in the ICU; a decreased rate of perceptions of being overwhelmed and pressured; and a cohort of RNs with suitable experience from which to offer permanent ICU employment.

Despite all the information available about NGNs, there is a dearth of information regarding the experiences of SRNs who work with NGNs in the ICU. In the current health care environment, it may not be possible to limit ICU employment to RNs with nursing experience. However, the need to create and sustain healthy ICU working environments is essential. Managerial recognition of, and strategies to reduce, SRNs' workload when

working NGNs; well-resourced, designed and evaluated orientation, induction and supernumerary programs that recognise the role and workload of SRNs when supporting NGNs and other nursing staff new to ICU nursing practice; and SRN-specific education and support programs that teach BOS recognition and the attainment of resilience may improve the health of the ICU workplace environment. Additionally, from an organisational perspective, the cost effectiveness of other forms of support, such as ACCESS RNs, to address the imbalance between required and available surveillance and support for NGNs caring for critically ill patients in the ICU, should be considered.

Senior Registered Nurses' stories of their experiences when working with NGNs in the ICU has been silent in the literature with greater emphasis on the NGNs' experience. This inquiry contributes to current nursing knowledge, making visible and adding new insight into the SRNs' experiences when working with NGNs in the stressful, complex and specialised ICU environment. Readers of this current inquiry are invited to immerse themselves in the three-dimensional space; opening up new possibilities for different stories of SRNs' experiences with NGNs in the ICU to be lived and told.

# Glossary

ACCESS RNs: '"on-the-floor" Assistance, Coordination, Contingency (for a late admission on the shift, or staff sick mid-shift), Education (of junior staff, relatives, and others), Supervision and Support' (Chamberlain, D., Pollock, W., & Fullbrook, P., 2018, p. 297). ACCESS nurses are staffed in addition to rostered bedside nurses, Nurse Unit Managers (NUMs), shift leaders, educators, specialist clinical nurses and support staff (non-nursing). There are similar roles with varying names and descriptions used in Australian ICUs, for example, 'resource nurse' and 'float nurse' (The Workforce Advisory Panel, 2003).

BiPAP: BiLevel Positive Airway Pressure is a form of non-invasive ventilation using a fitted facemask (Sanchez, Smith, Piper, & Rolls, 2014). BiPAP is increasingly used as an adjunct to optimal medical therapy in the treatment of acute respiratory failure in critical care areas and specialised respiratory ward areas.

Code Blue: hospital-wide medical emergency. The Code Blue team consists of ICU nursing and medical staff rostered on shift. When a Code Blue alert is activated, two RNs [one SRN and an RN] and an ICU registrar] attend the patient. The ICU RNs, rapidly reallocate their ICU patient load to other RNs on shift, for attending to the Code Blue emergency. In patients who have a cardiopulmonary arrest up to 10 days following cardiac surgery, open-chest resuscitation may be performed. SRNs in this ICU have the ability to assist ICU doctors to perform the re-sternotomy and resuscitation algorithm.

CNE: The Clinical Nurse Educator delivers and evaluates clinical education programs within the ICU. The CNE supports clinical procedure skill development, delivers informal education to the individual, orientates and preceptors staff new to ICU, provides clinical education in the ICU and provides support for quality improvement initiatives and clinical policy development (Industrial Relations Commission of New South Wales, 2017).

CNS: Clinical Nurse Specialists are RNs who have undertaken additional study in their specialty area and/or have worked in the specialty area for a predetermined number of years. The CNS role holds additional responsibilities, such as leadership, education,

quality improvement activities and clinical resource support for other interdisciplinary health care staff.

CRRT: Continuous Renal Replacement Therapy is indicated when ICU patients experience acute renal failure refractory to medical intervention or disease process. Indications include fluid overload, electrolyte and metabolic imbalance and 'dialyzable intoxications' (Pannu & Gibney, 2005, p. 1). It is normally intended to be a 24-hour-per-day therapy.

CVVHDF: Continuous Veno-Venous Haemo-DiaFiltration is a mode of CRRT. It is also known colloquially as, 'the filter' or 'dialysis'.

Data extract: refers to an individual section of narrative data, which has been identified within, and extracted from, the NAs (Braun & Clarke, 2006). Data extracts exemplify a plotline.

Dialysis: see CVVHDF.

ECMO: ExtraCorporeal membrane oxygenation is a device, similar to cardiopulmonary bypass. ECMO can provide prolonged cardiac and respiratory support for patients with refractory cardiopulmonary impairment. In the adult population, it is often used for patients who cannot be weaned from cardiopulmonary bypass or as a therapy for patients with end-stage heart and/or lung failure (Gaffney, Wildhirt, Griffin, Annich, & Radomski, 2010). In speciality hospital centres (such as this inquiry's site), ECMO can also be inserted during cardiopulmonary arrest. This is known as E-CPR. When predominantly providing cardiac support, by draining blood from a large vein and returning oxygenated blood to a large artery, the term VA-ECMO is used. VV- ECMO is used to support lung function with blood drained from a large vein and returned to a large vein.

Field: In NI, the 'field' refers to the 'ongoing relational inquiry space' (p. 45) that is negotiated between participant and inquirer (Clandinin, 2013).

Field Texts: In NI, the narrative inquirers' term for data (Clandinin, 2013).

IABP: IntraAortic Balloon Pump is a widely used mechanical haemodynamic assist device for patients requiring cardiac support (Thiele et al., 2013). The IABP has a long cylindrical balloon, which is inserted into the descending aorta. It rapidly inflates during

diastole and deflates during systole. This action increases coronary blood flow and oxygenation and decreases the workload of the heart (Patel & Gruberg, 2010). It is often called a 'balloon pump'.

ICU: The Intensive Care Unit is a separate and self-contained section of the hospital, overseen by Intensivists. It is staffed and equipped to manage patients with life-threatening health conditions. An ICU provides special expertise and capabilities for the support of vital health functions, utilising the skills of medical, nursing and interdisciplinary staff proficient in the management of these health conditions (Nickson, 2016). Intensive Care Units s normally have a higher ratio of nursing staff, one nurse to one patient.

Intensive Care Units are also known as intensive treatment units, critical care units or intensive therapy units. They may be divided into areas of specialty, such as cardiothoracic, neurological, trauma or general ICUs. The ICU in this research study is a cardiothoracic referral centre, supporting inter- and intra-state hospitals, within a larger ICU service. It has service capacity to care for patients requiring complex cardiothoracic procedures and interventions, such as heart and lung transplantation, ECMO and mechanical cardiac assist devices.

Intubation: is a procedure whereby a flexible tube, normally made of plastic, is inserted into the trachea to maintain an open airway. It is a procedure often used in the critical care setting to facilitate mechanical lung ventilation and prevent aspiration in the critically unwell and/or sedated patient (Schiffman, 2018). Patients who are intubated require constant one-to-one RN observation and interventions.

NGN: New Graduate Nurse is defined as a newly qualified RN, practising in their first year of nursing.

NUM: Nurse Unit Manager of ICU is an RN in charge of the ICU. Their responsibilities include but are not limited to: directing and supervising nursing activities; appraising and counselling nursing staff; allocating and rostering nurses; and assisting in the development and/or implementation of innovative nursing practice (Industrial Relations Commission of New South Wales, 2017).

Phenomenon: 'An observable fact or event, an object or aspect known through the senses rather than by thought or intuition' (Phenomenon, n.d.).

Plotline: the essence, or main point, of a story.

Pragmatism: a philosophical movement 'marked by the doctrines that the meaning of conceptions is to be sought in their practical bearings, that the function of thought is to guide action, and that truth is pre-eminently to be tested by the practical consequences of belief' (Pragmatism, n.d.).

RN: A Registered Nurse is a nurse who has completed a 3-year nursing degree from a higher education institution or equivalent, or from a recognised hospital-based program, and is registered as a nurse with the Australian Health Practitioner Regulation Agency.

SRN: A Senior Registered Nurse has undergone additional training and supervision, which enables them to assume the ICU nursing TL role, in the absence of the NUM. SRNs report directly to the NUM. For the purposes of this study, SRNs have a minimum of five years' ICU experience and have worked with an NGN in the three months before enrolling in this NI.

Story: a person's single account or description of past events and actions in their life. In this research, stories were conveyed via conversation and assumed to be accurate and not deliberately 'made up' (Emden, 1998). 'Story' is the phenomenon under inquiry (Connelly & Clandinin, 1990, p. 2).

TL: Team Leader is the RN in charge of ICU, when the NUM is off duty or engaged in other responsibilities.

Threads: an NI term for themes. 'A theme captures something important about the (narrative) data in relation to the research question, and represents some level of patterned response or meaning within the data set' (Braun & Clarke, 2006, p. 32). Threads are plotlines of the individual NAs that resonate across all NAs (Clandinin, 2013).

TPP: Transition to Professional Practice programs offer newly qualified registered nurses 'consolidated clinical support (including preceptorship) and education study days, which goes beyond standard orientation and induction of new employees' (Nursing and Midwifery Office, 2018, p. 3). The programs are often one year in length and offer clinical

placements of varying lengths in clinical areas in a hospital. NGNs in this study have six-month placements in two hospital areas. The TPP program was previously known as the New Graduate Program, Transitional Support Program or New Graduate Nurse Program

Tube: see intubated.

VAD: Ventricular Assist Device is a miniaturised, continuous flow centrifugal pump, which is surgically inserted into the left ventricle to provide haemodynamic support. Patients with end-stage heart failure refractory to optimal medical treatment, who meet specific criteria, may be suitable for this type of support. The VAD pulls oxygenated blood through the pump, pushing it into the ascending aorta. When the blood reaches the ascending aorta, it flows to the body (HeartWare, 2018). The insertion of a VAD allows most people with end-stage heart failure to have improved quality of life and survival rates (Slaughter et al., 2013). When inserted in the left ventricle, it is called a left ventricular assist device, or LVAD.

'Working with': This phrase encompasses the variety of interactions that occur between the SRNs and NGNs within the ICU. For example: working on the same shift; providing education or clinical support; having preceptor or supernumerary supervisor responsibilities; providing appraisal feedback to nursing educators and managers; ensuring nurses are practising within their scope of practice; and assuming responsibility for the nursing care of other RNs' patients during meal breaks, emergencies and education periods.

# References

Adair, J., Hughes, L., Davis, S., & Wolcott-Breci, M. (2014). Comparing new BSN RN self skills assessment to actual skills demonstration. *Journal of Professional Nursing, 30*(2), 180–184. doi:10.1016/j.profnurs.2013.09.009

Adam, S., Osborn, S., & Welch, J. (Eds.). (2017). *Critical care nursing: science and practice.* Oxford, United Kingdom: Oxford University Press.

Aiken, L., Clarke, S., Sloane, D., Lake, E., & Cheney, T. (2008). Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration, 38*(5), 223–229. doi:10.1097/01.NNA.0000312773.42352.d7

Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R., McKee, M., . . . Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *British Medical Journal, 344*, e1717. doi:10.1136/bmj.e1717

Aiken, L., Sloane, D., 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. *Lancet, 383*(9931), 1824-1830. doi:10.1016/S0140-6736(13)62631-8

American Association of Colleges of Nursing. (2017). Nursing faculty shortages [Fact Sheet]. Retrieved from https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Faculty-Shortage.

American Association of Critical-Care Nurses. (2016). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence*. Retrieved from https://www.aacn.org/WD/HWE/Docs/HWEStandards.pdf

Atherton, S., & Alliston, S. (2011). Caring for carers in critical care. *Kai Tiaki: Nursing New Zealand, 17*(10), 12-13. doi: 10.1177/0969733009351950

Australian Institute of Health and Welfare. (2010). Australia's health 2010: The twelfth biennial health report of the Australian Institute of Health and Welfare. Retrieved from http://www.aihw.gov.au/

Azoulay, E., & Herridge, M. (2011). Understanding ICU staff burnout: The show must go on. *American Journal of Respiratory and Critical Care Medicine, 184*(10), 1099-1100. doi:10.1164/rccm.201109-1638ED

Ballem, A., & MacIntosh, J. (2014). A narrative exploration: Experienced nurses' stories of working with new graduates. *Western Journal of Nursing Research, 36*(3), 374–387. doi:10.1177/0193945913502131

Baumberger-Henry, M. (2012). Registered nurses' perspectives on the new graduate working in the emergency department or critical care unit. *Journal of Continuing Education in Nursing, 43*(7), 299. doi:10.3928/00220124-20111115-02

Baxter, P. E. (2010). Providing orientation programs to new graduate nurses: Points to consider. *Journal for Nurses in Staff Development, 26*(4), E12–17. doi:10.1097/NND.0b013e3181d80319

Benner, P. (1982). From novice to expert. *American Journal of Nursing, 82*(3), 402–407. doi:10.2307/3462928

Berkow, S., Virkstis, K., Stewart, J., & Conway, L. (2009). Assessing new graduate nurse performance. *Nurse Educator, 34*(1), 17–22.doi:10.1097/01.NNE.0000343405.90362.15

Bishop, E. C., & Shepherd, M. L. (2011). Ethical reflections: Examining reflexivity through the narrative paradigm. *Qualitative Health Research, 21*(9), 1283–1294. doi:10.1177/1049732311405800

Bjørk, I. T., Hansen, B. S., Samdal, G. B., Tørstad, S., & Hamilton, G. A. (2007). Evaluation of clinical ladder participation in Norway. *Journal of Nursing Scholarship, 39*(1), 88-94. Retrieved from doi:10.1111/j.1547-5069.2007.00149.x

Bjørk, I. T., Tørstad, S., Hansen, B. S., & Samdal, G. B. (2009). Estimating the cost of professional developmental activities in health organizations. *Nursing Economics, 27*(4), 239. Retrieved from https://www.researchgate.net/publication/26811849_Estimating_the_Cost_of_Professional_Developmental_Activities_in_Health_Organizations

Booth, T., & Booth, W. (1994). The use of depth interviewing with vulnerable subjects: Lessons from a research study of parents with learning difficulties. *Social Science & Medicine, 39*(3), 415–424. doi:10.1016/0277-9536(94)90139-2

Bortolotto, S. J. (2015). Developing a comprehensive critical care orientation program for graduate nurses. *Journal for Nurses in Professional Development, 31*(4), 203–210. doi:10.1097/NND.0000000000000139

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi:10.1191/1478088706qp063oa

Burgess, L., Irvine, F., & Wallymahmed, A. (2010). Personality, stress and coping in intensive care nurses: A descriptive exploratory study. *Nursing in Critical Care, 15*(3), 129–140. doi:10.1111/j.1478-5153.2009.00384.x

Caine, V., Estefan, A., & Clandinin, D. J. (2013). A return to methodological commitment: Reflections on narrative inquiry. *Scandinavian Journal of Educational Research, 57*(6), 574–586. doi:10.1080/00313831.2013.798833

Carayon, P., & Alvarado, C. J. (2007). Workload and patient safety among critical care nurses. *Critical Care Nursing Clinics of North America, 19*(2), 121–129. doi:10.1016/j.ccell.2007.02.001

Carlson, E., Pilhammar, E., & Wann-Hansson, C. (2010). Time to precept: Supportive and limiting conditions for precepting nurses. *Journal of Advanced Nursing, 66*(2), 432–441. doi:10.1111/j.1365-2648.2009.05174.x

Carmona-Monge, F. J., Rodríguez, G. M. R., Herranz, C. Q., Gómez, S. G., & Marín-Morales, D. (2013). Evaluation of the nursing workload through the Nine Equivalents for Nursing Manpower Use Scale and the Nursing Activities Score: A prospective correlation study. *Intensive and Critical Care Nursing, 29*(4), 228–233. doi:10.1016/j.iccn.2013.03.003

Carr, D. (1991). *Time, narrative, and history*. Retrieved from https://hdl-handle-net.ipacez.nd.edu.au/2027/fulcrum.0g354f50j

Casey, K., Fink, R., Krugman, M., & Propst, J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303–311. doi:10.1097/00005110-200406000-00010

Chamberlain, D., Pollock, W., & Fulbrook, P. (2018). ACCCN Workforce Standards for Intensive Care Nursing: Systematic and evidence review, development, and appraisal. *Australian Critical Care, 31*(5), 292-302. doi: 10.1016/j.aucc.2017.08.007


Charney, D. S. (2004). Psychobiological mechanisms of resilience and vulnerability: implications for successful adaptation to extreme stress. *Focus, 161*(3), 195–391. doi:10.1176/appi.ajp.161.2.195

Chase, S. (2008). Narrative inquiry. Multiple lenses, approaches, voices. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative materials* (3 ed., pp. 57-94). Thousand Oaks, California: Sage.

Chase, S. (2011). Narrative inquiry. Still a field in the making. In N. K. Denzin & Y. S. Lincoln (Eds.), *Sage handbook of qualitative research*, (4 ed., pp. 421–434). Thousand Oaks, California: Sage.

Chernomas, W. M., Care, W. D., McKenzie, J. A., Guse, L., & Currie, J. (2010). 'Hit the ground running': Perspectives of new nurses and nurse managers on role transition and integration of new graduates. *Nursing Leadership, 22*(4), 70–86. doi:10.12927/cjnl.2010.21598

Chesnutt, B. M., & Everhart, B. (2007). Meeting the needs of graduate nurses in critical care orientation: Staged orientation program in surgical intensive care. *Critical Care Nurse, 27*(3), 36–40. doi:27/3/36 [pii]

Chlan, L. L. (2013). Burnout syndrome among critical care professionals: A cause for alarm. *Critical Care Alert, 21*(9), 65–68. Retrieved from https://www.reliasmedia.com/articles/64302-burnout-syndrome-among-critical-care-professionals-a-cause-for-alarm

Clandinin, D. J. (2006). Narrative Inquiry: A Methodology for Studying Lived Experience. *Research studies in music education, 27*(1), 44-54. doi: 10.1177/1321103X060270010301

Clandinin, D. J. (2007). Starting with Living Stories. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology* (pp. 247-250). Thousand Oaks, California: SAGE Publications, Inc. Retrieved from http://methods.sagepub.com/book/handbook-of-narrative-inquiry.

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Walnut Creek, California: Left Coast Press.

Clandinin, D. J., & Caine, V. (2012). Narrative inquiry. In A. Trainor & E. Graue (Eds.), *Reviewing qualitative research in the social sciences* (pp. 166-179). New York, New York: Routledge.

Clandinin, D. J., & Huber, J. (2010). Narrative inquiry. In P. L. Peterson, E. L. Baker, & B. McGaw (Eds.), *International encyclopedia of education* (3rd ed.). Retrieved from
http://ipacez.nd.edu.au/login?url=https://search.credoreference.com/content/entry/estiee/narrative_inquiry/0?institutionId=1939.

Clandinin, D.J., & Connelly, M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco, California: John Wiley & Sons.

Clandinin, D. J., Murphy, M. S., Huber, J., & Orr, A. M. (2010). Negotiating narrative inquiries: Living in a tension-filled midst. *The Journal of Educational Research, 103*(2), 81-90. doi:10.1080/00220670903323404

Clandinin, D. J., & Rosiek, J. (2007). Mapping a landscape of narrative inquiry: Borderland spaces and tensions. In D. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a methodology*. doi:10.4135/9781452226552

Clark, T., & Holmes, S. (2007). Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies, 44*(7), 1210–1220. doi:10.1016/j.ijnurstu.2006.05.010

Cohen, S. (2016). The Not in My Backyard Syndrome and Sustainability Infrastructure. Retrieved from https://www.huffpost.com/entry/the-not-in-my-backyard-sy_b_8910632?guccounter=1

Cohen, L., Manion, L., & Morrison, K. (2011). *Research methods in education* (7th ed.). London, United Kingdom: Routledge.

Committee on the Work Environment for Nurses and Safety Board on Health Care Services. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academies Press.

Connelly, M., & Clandinin, D. (2006). Narrative inquiry. In J. L. Green, G. Camilli, & P. Elmore. (Eds.)*, Handbook of complementary methods in education research* (3rd ed., pp. 477–487). Mahwah, New Jersey: Erlbaum.

Connelly, M., & Clandinin, D. (1990). Stories of experience and narrative inquiry. *Educational Researcher, 19*(5), 2–14. doi:10.3102/0013189x019005002

Colaizzi, P. (1978). Psychological Research as the Phenomenologist Views It. In Valle, R.S. & King, M. (Eds.), *Existential Phenomenological Alternatives for Psychology*. New York: Oxford University Press.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics. *Qualitative Inquiry, 9*(3), 335–354. doi:10.1177/1077800403009003001

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, Sydney: Allen & Unwin

Cubit, K. A., & Ryan, B. (2011). Tailoring a graduate nurse program to meet the needs of our next generation nurses. *Nurse Education Today, 31*(1), 65–71. doi:10.1016/j.nedt.2010.03.017

Department of Health. (2004). The recruitment and retention of staff in critical care. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4083568.pdf

Dewey, J. (1938). Experience and education. New York, New York: Kappa Delta Pi.

Downey, C. A., & Clandinin, D. J. (2010). Narrative inquiry as reflective practice: Tensions and possibilities. *Handbook of reflection and reflective inquiry* (pp. 383-397). Boston, Massachusetts: Springer.

Doucette, E., Brandys, D., Canapi, B., & Davis, A. (2011). The intensive care unit as an untapped learning resource: A student perspective. *Dynamics, 22*(1), 19–23. Retrieved from http://search.ebscohost.com.ipacez.nd.edu.au/login.aspx?direct=true&db=rzh&AN=104822386&site=ehost-live&scope=site

Duchscher, J. B. (2008). A process of becoming: the stages of new nursing graduate professional role transition. *Journal of Continuing Education in Nursing, 39*(10), 441–450. doi:10.3928/00220124-20081001-04

Duchscher, J. B (2009). Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing, 65*(5), 1103–1113. doi:10.1111/j.1365-2648.2008.04898.x

Duchscher, J., & Cowin, L. (2006). The new graduates' professional inheritance. *Nursing Outlook, 54*(3), 152–158. doi:10.1016/j.outlook.2005.04.004

Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M., & Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research, 24*(4), 244–255. doi:10.1016/j.apnr.2009.12.004

Duffield, C., Roche, M., Homer, C., Buchan, J., & Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across countries. *Journal of Advanced Nursing, 70*(12), 2703–2712. doi:10.1111/jan.12483

Dyess, S. M., & Sherman, R. O. (2009). The first year of practice: New graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing, 40*(9), 403–410. doi:10.3928/00220124-20090824-03

Embriaco, N., Azoulay, E., Barrau, K., Kentish, N., Pochard, F., Loundou, A., & Papazian, L. (2007). High level of burnout in intensivists: Prevalence and

associated factors. *American Journal of Respiratory and Critical Care Medicine, 175*(7), 686–692. doi:10.1164/rccm.200608-1184OC

Emden, C. (1998). Conducting a narrative analysis. *Collegian, 5*(3), 34. doi:10.1016/S1322-7696(08)60299-1

Evans, J., Boxer, E., & Sanber, S. (2008). The strengths and weaknesses of transitional support programs for newly registered nurses. *Australian Journal of Advanced Nursing, 25*(4), 16–22. Retrieved from https://www.researchgate.net/publication/242184761_The_strengths_and_weakn esses_of_transitional_support_programs_for_newly_registered_nurses

Farnell, S., & Dawson, D. (2006). 'It's not like the wards'. Experiences of nurses new to critical care: A qualitative study. *International Journal of Nursing Studies, 43*(3), 319–331. doi:10.1016/j.ijnurstu.2005.04.007

Faulkner, J. (2015). *New nursing graduates' relationships with experienced nurses in practice: an integrative literature review* (Master's thesis, University of Victoria, Victoria, Canada). Retrieved from http://hdl.handle.net/1828/6059

Finlay, L., & Gough, B. (Eds.) (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford, United Kingdom: Blackwell Science

Flemming, C. (2018). *The serious business of small talk: Becoming fluent, comfortable, and charming*. Oakland, CA: Berrett-Koehler

Flood, A. (2010). Understanding phenomenology. *Nurse Researcher, 17(2),* doi:10.7748/nr2010.01.17.2.7.c7457

Freeling, M., & Parker, S. (2015). Exploring experienced nurses' attitudes, views and expectations of new graduate nurses: A critical review. *Nurse Education Today, 35*(2), e42–49. doi:10.1016/j.nedt.2014.11.011

Friedman, M. I., Cooper, A. H., Click, E., & Fitzpatrick, J. J. (2011). Specialized new graduate RN critical care orientation: Retention and financial impact. *Nursing Economics, 29*(1), 7–14. Retrieved from http://search.ebscohost.com.ipacez.nd.edu.au/login.aspx?direct=true&db=rzh&A N=104814678&site=ehost-live&scope=site

Friedrich, L. A., Prasun, M. A., Henderson, L., & Taft, L. (2011). Being a seasoned nurse in active practice. *Journal of nursing management, 19*(7), 897-905. doi:10.1111/j.1365-2834.2011.01294.x

Gaffney, A. M., Wildhirt, S. M., Griffin, M. J., Annich, G. M., & Radomski, M. W. (2010). Extracorporeal life support. *British Medical Journal, 341*, c5317.

Gallagher, P. J., Rice, B., Tierney, P., Page, K., & McKinney, A. (2011). An evaluation of a critical care course for undergraduate nursing students. *Nursing in Critical Care, 16*(5), 261–269. doi:10.1111/j.1478-5153.2010.00442.x

Gergen, M. (2004). *Narrative analysis*. Retrieved from http://methods.sagepub.com/book/narrative-analysis. doi:10.4135/9781412985246

Giallonardo, L. M., Wong, C. A., & Iwasiw, C. L. (2010). Authentic leadership of preceptors: Predictor of new graduate nurses' work engagement and job satisfaction. *Journal of Nursing Management, 18*(8), 993–1003. doi:10.1111/j.1365-2834.2010.01126.x

Gohery, P., & Meaney, T. (2013). Nurses' role transition from the clinical ward environment to the critical care environment. *Intensive and Critical Care Nursing, 29*(6), 321–328. doi:10.1016/j.iccn.2013.06.002

Goss, C. R. (2015). Systematic review building a preceptor support system. *Journal for Nurses in Professional Development, 31*(1), E7–E14. doi:10.1097/NND.0000000000000117

Gouinlock, J. (2018). John Dewey. In *Encyclopaedia Britannica*. Retrieved from https://www.britannica.com/biography/John-Dewey

Grant, M., & Booth, A. (2009). A Typology of reviews. *Health Information and Libraries Journal, 26,* 91-108. doi:10.1111/j.1471-1842.2009.00848

Gurses, A. P., Carayon, P., & Wall, M. (2009). Impact of performance obstacles on intensive care nurses' workload, perceived quality and safety of care, and quality of working life. *Health Services Research, 44*(2p1), 422–443. doi:10.1111/j.1475-6773.2008.00934.x

Hagens, V., Dobrow, M. J., & Chafe, R. (2009). Interviewee transcript review: Assessing the impact on qualitative research. *BMC Medical Research Methodology, 9*(1), 47. doi:10.1186/1471-2288-9-47

Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary? *Applied Nursing Research, 19*(1), 38–42. doi:10.1016/j.apnr.2005.06.001

Hammersley, M., & Traianou, A. (2012). *Ethics in qualitative research: Controversies and contexts*. Retrieved from http://methods.sagepub.com/book/ethics-in-qualitative-research-controversies-contexts.

Hansen, B. S., Gundersen, E. M., & Bjørnå, G. B. (2011). Improving student supervision

in a Norwegian intensive care unit: a qualitative study. *Nursing & health sciences, 13*(3), 255-261. doi: 10.1111/j.1442-2018.2011.00609.x

Hart, S. G. (2006). NASA-task load index (NASA-TLX); 20 years later. In *Proceedings of the Human Factors and Ergonomics Society Annual Meeting, 50* (9), 904–908. doi:10.1177/154193120605000909

Hartigan, I., Murphy, S., Flynn, A. V., & Walshe, N. (2010). Acute nursing episodes which challenge graduate's competence: Perceptions of registered nurses. *Nurse Education in Practice, 10*(5), 291–297. doi:10.1016/j.nepr.2010.01.005

Hautala, K. T., Saylor, C. R., & O'Leary-Kelley, C. (2007). Nurses' perceptions of stress and support in the preceptor role. *Journal for Nurses in Staff Development, 23*(2), 64–70. doi:10.1097/01.NND.0000266611.78315.08

Health System Planning and Investment Branch. (2018). *NSW health guide to the role delineation of clinical services*. Retrieved from http://www.health.nsw.gov.au/

Health Workforce Australia (2014). *Australia's future health workforce - nurses' overview report*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8 C16AACA257D9500112F25/$File/AFHW - Nurses overview report.docx

HeartWare. (2018). What is a VAD? Retrieved from https://www.heartware.com/patients-caregivers/what-vad

Henderson, A. J., Alexander, H., Haywood, A., Stapleton, P., Cooke, M., Patterson, E., . . . Creedy, D. K. (2010). Promoting and providing expert guidance in work-intensive clinical settings. *Vocations and Learning, 3*(2), 141–156. doi:10.1007/s12186-010-9036-3

Herzog, H. (2005). On home turf: Interview location and its social meaning. *Qualitative Sociology, 28*(1), 25–47. doi:10.1007/s11133-005-2629-8

Hickey, M. T. (2009). Preceptor perceptions of new graduate nurse readiness for practice. *Journal for Nurses in Staff Development, 25*(1), 35–41. doi:10.1097/NND.0b013e318194b5bb

Hoge, E. A., Austin, E. D., & Pollack, M. H. (2007). Resilience: research evidence and conceptual considerations for posttraumatic stress disorder. *Depression and Anxiety, 24*(2), 139–152. doi:10.1002/da.20175

Holloway, I. (Ed). (2005). *Qualitative research in health care*. Maidenhead, United Kingdom*:* McGraw-Hill.

Holloway, I., & Freshwater, D. (2007). Vulnerable story telling: Narrative research in nursing. *Journal of Research in Nursing, 12*(6), 703–711. doi:10.1177/1744987107084669

Hoonakker, P., Carayon, P., Gurses, A. P., Brown, R., Khunlertkit, A., McGuire, K., & Walker, J. M. (2011). Measuring workload of ICU nurses with a questionnaire survey: The NASA Task Load Index (TLX). *IIE Transactions on Healthcare Systems Engineering, 1*(2), 131–143. doi:10.1080/19488300.2011.609524

Howe, K. R., & Moses, M. S. (1999). Chapter 2: Ethics in educational research. *Review of Research in Education, 24*(1), 21–59. doi:10.3102/0091732X024001021

Huber, M., Clandinin, D. J., & Huber, J. (2006). Relational responsibilities of narrative inquirers. *Curriculum and teaching dialogue, 8*(1/2), 209. doi:10.1080/00220670903323404

Hunter, S. (2005). Negotiating professional and social voices in research principles and practice. *Journal of Social Work Practice, 19*(2), 149–162. doi:10.1080/02650530500144709

Huntington, A., Gilmour, J., Tuckett, A., Neville, S., Wilson, D., & Turner, C. (2011). Is anybody listening? A qualitative study of nurses' reflections on practice. *Journal of Clinical Nursing, 20*(9-10), 1413–1422. doi:10.1111/j.1365-2702.2010.03602.x

Hussein, R., Salamonson, Y., Hu, W., & Everett, B. (in press). Clinical supervision and ward orientation predict new graduate nurses' intention to work in critical care: Findings from a prospective observational study. *Australian Critical Care*. doi: 10.1016/j.aucc.2018.09.003

Industrial Relations Commission of New South Wales. (2017). *Public Health System Nurses' and Midwives (State) Award*. Retrieved from http://www.health.nsw.gov.au/careers/conditions/Awards/nurses.pdf.

International Council of Nurses. (2013). The Global Shortage of Registered Nurses: An Overview of Issues and Actions. Retrieved from www.ners.unair.ac.id/materikuliah/shortage.pdf

International Council of Nurses. (2006). The global nursing shortage: Priority areas for intervention. *Global Nursing Review Initiative*. Retrieved from http://www.who.int/workforcealliance/knowledge/resources/icn_nursesretention/en/

Jacob, E. R., McKenna, L., & D'Amore, A. (2014). Senior nurse role expectations of graduate registered and enrolled nurses on commencement to practice. *Australian Health Review, 38*(4), 432–439. doi:10.1071/AH13216

James, W. (1975). *The meaning of truth*. Cambridge, Massachusetts: Harvard University Press.

Johnson, J. M., & Rowlands, T. (2012). The Interpersonal dynamics of in-depth interviewing. In J. Gubrium, J. Holstein, A. Marvasti, & K. McKinney (Eds.). *In The SAGE handbook of interview research: The complexity of the craft.* (pp. 99-104) doi:10.4135/9781452218403

Johnstone, M.-J., Kanitsaki, O., & Currie, T. (2008). The nature and implications of support in graduate nurse transition programs: an Australian study. *Journal of Professional Nursing, 24*(1), 46–53. doi:10.1016/j.profnurs.2007.06.003

Joint Commission on Accreditation of Healthcare Organizations (2003). *Hospital accreditation standards*, Oakbrook Terrace, Illinois: Joint Commission Resources.

Josselson, R. (2007). *Handbook of narrative inquiry: Mapping a methodology*. Retrieved from http://methods.sagepub.com/book/handbook-of-narrative-inquiry.

Kable, A. K., Pich, J., & Maslin-Prothero, S. E. (2012). A structured approach to documenting a search strategy for publication: A 12 step guideline for authors. *Nurse Education Today, 32*(8), 878–886. doi:10.1016/j.nedt.2012.02.022

Kaiser, K. (2012). Protecting confidentiality. In J. Gubrium, J. Holstein, A. Marvasti, & K. McKinney (Eds.). *The SAGE handbook of interview research: The complexity of the craft*. (pp. 457-464). doi:10.4135/9781452218403

Kantar, L. D. (2012). Clinical practice of new nurse graduates in Lebanon: Challenges and perspectives through the eyes of preceptors. *Journal of Continuing Education in Nursing, 43*(11), 518–528. doi:10.3928/00220124-20120801-62

Kelly, J., & Ahern, K. (2009). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing*, 18(6), 910–918. doi:10.1111/j.1365-2702.2008.02308.x

Kelly, T., & Howie, L. (2007). Working with stories in nursing research: Procedures used in narrative analysis. *International Journal of Mental Health Nursing, 16*(2), 136–144. doi:10.1111/j.1447-0349.2007.00457.x

Khan, N., Jackson, D., Stayt, L., & Walthall, H. (in press). Factors influencing nurses' intentions to leave adult critical care settings. *Nursing in Critical Care*. doi:10.1111/nicc.12348

Kiekkas, P., Sakellaropoulos, G. C., Brokalaki, H., Manolis, E., Samios, A., Skartsani, C., & Baltopoulos, G. I. (2008). Association between nursing workload and mortality of intensive care unit patients. *Journal of Nursing Scholarship, 40*(4), 385–390. doi:10.1111/j.1547-5069.2008.00254.x

Kim, J.-H. (2015). *Understanding narrative inquiry: The crafting and analysis of stories as research*. Thousand Oaks, CA: Sage.

Kollman, S., Liedl, C., Johnson, L., Elwood, T., Mundy, L., & Shue, J. (2007). Rookies of the year: Successfully orienting new graduate registered nurses to the cardiovascular surgical intensive care unit. *Critical Care Nursing Clinics of North America, 19*(4), 417–426. doi:10.1016/j.ccell.2007.07.007

Kramer, M., & Schmalenberg, C. (2008). Confirmation of a healthy work environment. *Critical Care Nurse, 28*(2), 56–63.

Kruer, R. M., Jarrell, A. S., & Latif, A. (2014). Reducing medication errors in critical care: A multimodal approach. *Clinical pharmacology: Advances and applications*, 6, 117-126. doi:10.2147/CPAA.S48530

Kuper, A., Reeves, S., & Levinson, W. (2008). Qualitative Research: An Introduction to Reading and Appraising Qualitative Research. *British Medical Journal, 337(7666),* 404-407. doi:10.1136/bmj.a1035

Lahman, M. K., Geist, M. R., Rodriguez, K. L., Graglia, P., & DeRoche, K. K. (2011). Culturally responsive relational reflexive ethics in research: The three Rs. *Quality & Quantity, 45*(6), 1397–1414. doi:10.1007/s11135-010-9347-3

Lahman, M. K., Rodriguez, K., Moses, L., Griffin, K., Mendoza, B., & Yacoub, W. (2015). A rose by any other name is still a rose? Problematizing pseudonyms in research. *Qualitative Inquiry, 21*(5), 445–453. doi:10.1177/1077800415572391

Laschinger, H. K. S., Grau, A. L., Finegan, J., & Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing, 66*(12), 2732–2742.

Lavoie, P., Pepin, J., & Boyer, L. (2013). Reflective debriefing to promote novice nurses' clinical judgment after high-fidelity clinical simulation: A pilot test. *Dynamics (Pembroke, Ont.), 24*(4), 36–41. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24616950

Law, B. Y., & Chan, E. A. (2015). The experience of learning to speak up: A narrative inquiry on newly graduated registered nurses. *Journal of Clinical Nursing, 24*(13–14), 1837–1848. doi:10.1111/jocn.12805

Levett-Jones, T., Hoffman, K., Dempsey, J., Jeong, S. Y. S., Noble, D., Norton, C. A.,... & Hickey, N. (2010). The 'five rights' of clinical reasoning: An educational model to enhance nursing students' ability to identify and manage clinically 'at risk' patients. *Nurse Education Today*, *30*(6), 515–520. doi:10.1016/j.nedt.2009.10.020

Levy, M. M. (2004). Caring for the caregiver. *Critical Care Clinics, 20*(3), 541–547, xi. doi:10.1016/j.ccc.2004.03.013

Lewis, J. (2009). Redefining qualitative methods: Believability in the fifth moment. *International Journal of Qualitative Methods, 8(2). doi:10.1177/160940690900800201*

Lewis, R. (2011). Learning the 'smart' way... Results from a pilot study evaluating an interprofessional acute care study day. *Nurse Education Today, 31*(1), 88–93. doi:10.1016/j.nedt.2010.04.001

Lewis-Pierre, L. (2013). *Workplace readiness of new ICU nurses: Perceptions of managers, educators, preceptors, and new RN graduates.* (Doctoral dissertation). Retrieved from https://www.researchgate.net/publication/261831618_Workplace_Readiness_of _New_ICU_Nurses_A_Grounded_Theory_Study (3572923)

Liamputtong, P. (2013). *Research methods in health: Foundations for evidence based practice*. Melbourne, Australia: Oxford University Press.

Limerick, B., Burgess-Limerick, T., & Grace, M. (1996). The politics of interviewing: Power relations and accepting the gift. *International Journal of Qualitative Studies in Education, 9*(4), 449–460. doi:10.1080/0951839960090406

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lindsay, G. M., Schwind, J. K., Papaconstantinou, E., Smye, V., & Cross, N. (2016). Autobiographical reflections on what it means to experience disruption. *Reflective Practice, 17*(5), 583–591. doi:10.1080/14623943.2016.1184635

Lofmark, A., Smide, B., & Wikblad, K. (2006). Competence of newly-graduated nurses: A comparison of the perceptions of qualified nurses and students. *Journal of Advanced Nursing, 53*(6), 721–728. doi:10.1111/j.1365-2648.2006.03778.x

Lugones, M. (1987). Playfulness, 'world'-travelling, and loving perception. *Hypatia, 2*(2), 3–19. Retrieved from https://www.jstor.org/stable/3810013

Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543–562. doi:10.1111/1467-8624.00164

Lysaght, R. J., Hill, S. G., Dick, A., Plamondon, B. D., & Linton, P. M. (1989). *Operator workload: Comprehensive review and evaluation of operator workload methodologies.* Retrieved from http://www.dtic.mil/dtic/tr/fulltext/u2/a212879.pdf

Manning, L., & Neville, S. (2009). Work-role transition: From staff nurse to clinical nurse educator. *Nursing Praxis in New Zealand, 25*(2), 41–54. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/19928650

Marć, M., Bartosiewicz, A., Burzynska, J., Chmiel, Z., & Januszewicz, P. (in press). A nursing shortage: A prospect of global and local policies. *International Nursing Review*. doi:10.1111/inr.12473

Mårtensson, G., Engström, M., Mamhidir, A.-G., & Kristofferzon, M.-L. (2013). What are the structural conditions of importance to preceptors' performance? *Nurse Education Today, 33*(5), 444–449. doi:10.1016/j.nedt.2012.04.015

Maslach, C. (2003). *Burnout: The cost of caring*. Los Altos, CA: ISHK.

Matlakala, M., Bezuidenhout, M., & Botha, A. (2014). Challenges encountered by critical care unit managers in the large intensive care units. *Curationis, 37*(1), 1–e7. doi:10.4102/curationis.v37i1.1146

McDowell, L. (2001). 'It's that Linda again': Ethical, practical and political issues involved in longitudinal research with young men. *Ethics, Place & Environment, 4*(2), 87–100. doi:10.1080/13668790124226

McManus, I., Keeling, A., & Paice, E. (2004). Stress, burnout and doctors' attitudes to work are determined by personality and learning style: A twelve year longitudinal study of UK medical graduates. *BMC Medicine, 2*(1), 29. doi:10.1186/1741-7015-2-29

Mealer, M., Jones, J., Newman, J., McFann, K. K., Rothbaum, B., & Moss, M. (2012). The presence of resilience is associated with a healthier psychological profile in intensive care unit (ICU) nurses: Results of a national survey. *International Journal of Nursing Studies, 49*(3), 292–299. doi:10.3928/00220124-20111115-02

Merlani, P., Verdon, M., Businger, A., Domenighetti, G., Pargger, H., & Ricou, B. (2011). Burnout in ICU caregivers: A multicenter study of factors associated to centers. *American Journal of Respiratory and Critical Care Medicine, 184*(10), 1140–1146. doi:10.1164/rccm.201101-0068OC

Mero-Jaffe, I. (2011). 'Is that what I said?' Interview transcript approval by participants: An aspect of ethics in qualitative research. *International Journal of Qualitative Methods*, *10* (3), 231–247. doi: 10.1177/160940691101000304

Mills, M. (2012). The SAGE Encyclopedia of Qualitative Research Methods. In L. M. Given (Ed.), Comparative Research. Thousand Oaks, California: SAGE Publications. Retrieved from https://methods.sagepub.com/reference/sage-encyc-qualitative-research-methods. doi:10.4135/9781412963909

Milne, D. (2007). People can learn markers on road to resilience. *Psychiatric News, 42*(2), 5. doi:10.1176/pn.42.2.0005

Miranda, D. R., Nap, R., de Rijk, A., Schaufeli, W., & Iapichino, G. (2003). Nursing activities score. *Critical Care Medicine, 31*(2), 374–382. doi:10.1097/01.CCM.0000045567.78801.CC

Mishler, E. G. (1995). Models of narrative analysis: A typology. *Journal of Narrative and Life History, 5*(2), 87–123. doi:10.1075/jnlh.5.2.01mod

Missen, K., McKenna, L., & Beauchamp, A. (2016a). Graduate nurse program coordinators' perspectives on graduate nurse programs in Victoria, Australia: A descriptive qualitative approach. *Collegian, 23*(2), 201–208. doi:10.1016/j.colegn.2015.03.004

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2010). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *International Journal of Surgery, 8*(5), 336–341. doi:10.1016/j.ijsu.2010.02.007

Morris, L. L., Pfeifer, P. B., Catalano, R., Fortney, R., Hilton, E. L., McLaughlin, J., . . . Goldstein, L. (2007). Designing a comprehensive model for critical care orientation. *Critical Care Nurse, 27*(6), 37-60. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18032685

Morse, J. M., & Field, P. A. (1995). *Nursing research: The application of qualitative approaches.* Cheltenham, United Kingdom: Nelson Thornes.

Moss, M., Good, V. S., Gozal, D., Kleinpell, R., & Sessler, C. N. (2016). An official critical care societies' collaborative statement: Burnout syndrome in critical care

health care professionals: A call for action. *American Journal of Critical Care, 25*(4), 368–376. doi:10.1016/j.chest.2016.02.649

Mould, J., White, H., & Gallagher, R. (2011). Evaluation of a critical care simulation series for undergraduate nursing students. *Contemporary Nurse, 38*(1–2), 180–190. doi:10.5172/conu.2011.38.1-2.180

National Health and Medical Research Council. (2018)). *National Statement on Ethical Conduct in Human Research*. Retrieved from https://nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018 - block-views-block-file-attachments-content-block-1.

National Council of State Boards of Nursing (2018). 2017 RN practice analysis: Linking the NCLEX-RN examination to practice: U.S. and Canada. Retrieved from https://www.ncsbn.org/12095.htm

Nickson, C. (2016). ICU design and staffing. Life in the fast lane. Retrieved from https://lifeinthefastlane.com/ccc/icu-design-and-staffing/

NIMBY (n.d.). In *Dictionary.com.* Retrieved from http://www.dictionary.com/browse/nimby

Nursing and Midwifery Office. (2018). 2019 *Graduate nursing and midwifery transition to professional practice handbook.* Retrieved from https://www.health.nsw.gov.au/nursing/employment/Pages/Recruit.aspx

O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine, 89*(9), 1245-1251. doi:10.1097/ACM.0000000000000388

O'Kane, C. E. (2012). Newly qualified nurses' experiences in the intensive care unit. *Nursing in Critical Care, 17*(1), 44–51. doi:10.1111/j.1478-5153.2011.00473.x

Olds, D. M., Aiken, L. H., Cimiotti, J. P., & Lake, E. T. (2017). Association of nurse work environment and safety climate on patient mortality: A cross-sectional study. *International Journal of Nursing Studies, 74*, 155–161. doi:0.1016/j.ijnurstu.2017.06.004

Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence. *Nurse Education in Practice, 19*, 19–24. doi:10.1016/j.nepr.2016.04.001

Pannu, N., & Gibney, R. N. (2005). Renal replacement therapy in the intensive care unit. *Therapeutics and Clinical Risk Management, 1*(2), 141–150. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18360553

Park, E., Elly, P., Vera, C., David, M., & Joanne, M. (2016). Ethical tensions as educative spaces in narrative inquiry. *Forum Qualitative Social Research, 17*(2). Retrieved from https://www.researchgate.net/publication/299670058_Ethical_Tensions_as_Educative_Spaces_in_Narrative_Inquiry/download

Parker, V., Giles, M., Lantry, G., & McMillan, M. (2014). New graduate nurses' experiences in their first year of practice. *Nurse Education Today, 34*(1), 150–156. doi: 10.1016/j.nedt.2012.07.003

Patel, N. D., & Gruberg, L. (2010). Intra-aortic balloon pump counterpulsation. In A. Jeremias & D. L. Brown (Eds.), *Cardiac intensive care* (2nd ed., pp. 570–578). Philadelphia, PA: Saunders.

Peet, J., Theobald, K., & Douglas, C. (2019). Strengthening nursing surveillance in general wards: A practice development approach. *Journal of Clinical Nursing, 28,* 2924-2933. doi: 10.1111/jocn.14890

Penoyer, D. A. (2010). Nurse staffing and patient outcomes in critical care: A concise review. *Critical Care Medicine. 38*(7), 1521-1528. doi: 10.1097/CCM.0b013e3181e47888

Phenomenon. (n.d.). In *Merriam-Webster.com*. Retrieved from http://www.merriam-webster.com/dictionary/phenomenon

Poland, B. D. (2001). *Handbook of interview research*. doi:10.4135/9781412973588

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins.

Poncet, M. C., Toullic, P., Papazian, L., Kentish-Barnes, N., Timsit, J.-F., Pochard, F., . . . Azoulay, E. (2007). Burnout syndrome in critical care nursing staff. *American Journal of Respiratory and Critical Care Medicine, 175*(7), 698–704. doi:10.1164/rccm.200606-806OC

Poronsky, C. B. (2013). Exploring the transition from registered nurse to family nurse practitioner. *Journal of Professional Nursing, 29*(6), 350–358. doi:10.1016/j.profnurs.2012.10.011

Pragmatism. (n.d.). In *Merriam-Webster.com*. Retrieved from http://www.merriam-webster.com/dictionary/pragmatism

Proulx, D. M., & Bourcier, B. J. (2008). Graduate nurses in the intensive care unit: An orientation model. *Critical Care Nurse, 28*(4), 44–52. doi:28/4/44 [pii]

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1), 25-41. doi: 10.1080/14780887.2013.801543

Robinson, O. C. (2011). The idiographic/nomothetic dichotomy: Tracing historical origins of contemporary confusions. *History and Philosophy of Psychology, 13(1),* 32-39. Retrieved from https://scholar.googleusercontent.com/scholar?q=cache:j48l6qbr20EJ:scholar.google.com/+idiographic+and+nomothetic&hl=en&as_sdt=0,5

Robinson, O. C., & Smith, J. A. (2010). Investigating the form and dynamics of crisis episodes in early adulthood: The application of a composite qualitative method. *Qualitative Research in Psychology, 7*(2), 170-191. doi:10.1080/14780880802699084

Robnett, M.K. (2006). Critical care nursing: wowrkforce issues and potential solutions. *Critical Care Medicine*, *34*(3), S25-31. doi:10.1097/01.CCM.0000203087.42439.53

Reiss Miranda, D., Moreno, R., & Iapichino, G. (1997). Nine equivalents of nursing manpower use score (NEMS). *Intensive Care Medicine, 23*(7), 760–765. doi:10.1007/s001340050406

Reverberate. (2011). In *Collins English Dictionary - Complete and Unabridged*. Retrieved from https://www.thefreedictionary.com/reverberate

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, California: Sage.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. Thousand Oaks, California: Sage.

Saghafi, F. (2014). *The journey from new graduate to proficient nurse in the Intensive Care Unit: A descriptive phenomenological study* (Doctoral dissertation, Australian Catholic University, Sydney, Australia). Retrieved from https://researchbank.acu.edu.au/theses/466/

Saghafi, F., Hardy, J., & Hillege, S. (2012). New graduate nurses' experiences of interactions in the critical care unit. *Contemporary Nurse, 42*(1), 20–27. doi:10.5172/conu.2012.42.1.20

Sanchez, D., Smith, G., Piper, A., & Rolls, K. (2014). *Non-invasive ventilation guidelines for adult patients with acute respiratory failure: A clinical practice guideline*

(Version 1). Retrieved from https://www.aci.health.nsw.gov.au/networks/intensive-care/intensive-carmanual/statewide-guidelines/non-invasive-ventilation-guidelines

Sandau, K. E., Cheng, L. G., Pan, Z., Gaillard, P. R., & Hammer, L. (2011). Effect of a preceptor education workshop: Part 1. Quantitative results of a hospital-wide study. *Journal of Continuing Education in Nursing, 42*(3), 117–126. doi:10.3928/00220124-20101101-01

Sayers, J., DiGiacomo, M., & Davidson, P. M. (2011). The nurse educator role in the acute care setting in Australia: important but poorly described. *Australian Journal of Advanced Nursing. 28*(4), 44-52. Retrieved from http://ezproxy.uws.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2011365160&site=ehost-live&scope=site

Schiffman, G. (2018). Endotracheal Intubation. Retrieved from https://www.medicinenet.com/endotracheal_intubation/article.htm

Schneider, Z. (2012). Critically reviewing research. In Z. Schneider, D. Whitehead, G. LoBiondo-Wood, & J. Haber (Eds.), *Nursing and midwifery research: Methods and critical appraisal for evidence-based practice.* (pp. 285-315). Chatswood, Australia: Mosby.

Schwab, J. J. (1978). *Science, curriculum, and liberal education: Selected essays.* Chicago, IL: University of Chicago Press.

Seago, J. A., & Barr, S. J. (2003). New graduates in critical care. The success of one hospital. *Journal of Nurses in Staff Development, 19*(6), 297–304. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15027345

Shermont, H., & Krepcio, D. (2006). The impact of culture change on nurse retention. *Journal of Nursing Administration, 36*(9), 407–415. Retrieved from https://journals.lww.com/jonajournal/Abstract/2006/09000/The_Impact_of_Culture_Change_on_Nurse_Retention.7.aspx

Slaughter, M. S., Pagani, F. D., McGee, E. C., Birks, E. J., Cotts, W. G., Gregoric, I., . . . HeartWare Bridge to Transplant, A. T. I. (2013). HeartWare ventricular assist system for bridge to transplant: combined results of the bridge to transplant and continued access protocol trial. *Journal of Heart and Lung Transplantation, 32*(7), 675–683. doi:10.1016/j.healun.2013.04.004

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London, United Kingdom: Sage.

Smith, L. (1992). Ethical issues in interviewing. *Journal of Advanced Nursing, 17*(1), 98–103. doi:10.1111/j.1365-2648.1992.tb01823.x

Spoelstra, S. L., & Robbins, L. B. (2010). A qualitative study of role transition from RN to APN. *International Journal Nursing Education Scholarship, 7*(1), 1-20. Retrieved from http://scholarworks.gvsu.edu/kcon_articles/19

Spradley, J. P. (2016). *The ethnographic interview*. Long Grove, Illinois: Waveland Press.

St Clair, M. (2013). New graduate nurses' experiences of transition during orientation into critical care (Doctoral dissertation). Retrieved from https://dc.uwm.edu/etd/378/

Stone, P. W., Larson, E. L., Mooney-Kane, C., Smolowitz, J., Lin, S. X., & Dick, A. W. (2006). Organizational climate and intensive care unit nurses' intention to leave. *Critical Care Medicine, 34*(7), 1907–1912. doi:10.1097/01.CCM.0000218411.53557.29

Survival. (n.d.). In *OxfordDictionaries.com*. Retrieved from https://en.oxforddictionaries.com/definition/survival

Swinny, B., & Brady, M. (2010). The benefits and challenges of providing nursing student clinical rotations in the intensive care unit. *Critical Care Nursing Quarterly*, 33(1) 60-66. doi:10.1097/CNQ.0b013e3181c8df7c

System Information and Analytics. (2018). *Bed Type Code Set Update from 1 July 2018*. (16/4437). Retrieved from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2018_029.pdf.

Thiele, H., Zeymer, U., Neumann, F.-J., Ferenc, M., Olbrich, H.-G., Hausleiter, J., . . . Empen, K. (2013). Intra-aortic balloon counterpulsation in acute myocardial infarction complicated by cardiogenic shock (IABP-SHOCK II): Final 12 month results of a randomised, open-label trial. *Lancet, 382*(9905), 1638-1645. doi:10.1016/S0140-6736(13)61783-3

Tolley, E. E., Ulin, P. R., Mack, N., Robinson, E. T., & Succop, S. M. (2016). *Qualitative methods in public health: A field guide for applied research*. Hoboken, NJ: Wiley.

Tomietto, M., Rappagliosi, C. M., Sartori, R., & Battistelli, A. (2015). Newcomer nurses' organisational socialisation and turnover intention during the first 2 years of employment. *Journal of Nursing Management, 23*(7), 851–858. doi: 10.1111/jonm.12224

Travale, I. L. (2007). Computer-assisted instruction for novice nurses in critical care. *Journal of Continuing Education in Nursing, 38*(3), 132–138. doi:10.3928/00220124-20070501-02

Tuckett, A., Eley, R., & Ng, L. (2017). Transition to practice programs: What Australian and New Zealand nursing and midwifery graduates said. A Graduate eCohort Sub-Study. *Collegian, 24*(2), 101–108. doi:10.1016/j.colegn.2015.10.002

Tuli, F. (2011). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences, 6*(1). 97-108. doi:0.4314/ejesc.v6i1.65384

Twigg, D., Duffield, C., & Evans, G. (2013). The critical role of nurses to the successful implementation of the National Safety and Quality Health Service Standards. *Australian Health Review, 37*(4), 541–546. doi:10.1071/AH12013

Ulrich, B. T., Lavandero, R., Woods, D., & Early, S. (2014). Critical care nurse work environments 2013: A status report. *Critical Care Nurse, 34*(4), 64-79. doi:10.4037/ccn2014731

Vahey, D., Aiken, L., Sloane, D., Clarke, S., & Vargas, D. (2004). Nurse burnout and patient satisfaction. *Medical Care, 42*(2 Suppl), II57. doi:10.1097/01.mlr.0000109126.50398.5a

Van Waeyenberg, T., Decramer, A., & Anseel, F. (2015). Home nurses' turnover intentions: The impact of informal supervisory feedback and self-efficacy. *Journal of Advanced Nursing, 71*(12), 2867–2878. doi:10.1111/jan.12747

Varpio, L., Ajjawi, R., Monrouxe, L. V., O'Brien, B. C., & Rees, C. E. (2017). Shedding the cobra effect: Problematising thematic emergence, triangulation, saturation and member checking. *Medical Education, 51*(1), 40–50. doi:10.1111/medu.13124

Vatansever, N., Nursel, V., & Neriman, A. (2016). Intensive care unit experience of nursing students during their clinical placements: A qualitative study. *International Journal of Caring Sciences, 9*(3). Retrieved from https://search-proquest-com.ipacez.nd.edu.au/openview/59702b68f84540cf2b1613c59eb0b1a4/1?pq-origsite=gscholar&cbl=1606338

Wang, C. C. (2017a). Chinese nursing students at Australian universities: A narrative inquiry into their motivation, learning experience, and future career planning.

(Doctor of Philosophy), Edith Cowan University. Retrieved from http://ro.ecu.edu.au/theses/1949

Wang, C. C. (2017b). Conversation with presence: A narrative inquiry into the learning experience of Chinese students studying nursing at Australian universities. *Chinese Nursing Research, 4*(1), 43–50. doi:10.1016/j.cnre.2017.03.002

Wang, C. C., & Geale, S. K. (2015). The power of story: Narrative inquiry as a methodology in nursing research. *International Journal of Nursing Sciences*. 2(2). 195-198. doi:10.1016/j.ijnss.2015.04.014

Weinger, M. B., Reddy, S. B., & Slagle, J. M. (2004). Multiple measures of anesthesia workload during teaching and nonteaching cases. *Anesthesia & Analgesia, 98*(5), 1419–1425

Welding, N. M. (2011). Creating a nursing residency: Decrease turnover and increase clinical competence. *Medsurg Nursing, 20*(1), 37–40. Retrieved from https://www.researchgate.net/publication/50905927_Creating_a_nursing_reside ncy_decrease_turnover_and_increase_clinical_competence

Williams, E., & Palmer, C. (2014). Student nurses in critical care: Benefits and challenges of critical care as a learning environment for student nurses. *Nursing in Critical Care, 19*(6), 310–315. doi:10.1111/nicc.12053

The Workforce Advisory Panel. (2003). ACCCN ICU staffing position statement (2003) on intensive care nursing staffing. Retrieved from https://www.acccn.com.au/documents/item/20

Wung, S., Malone, D., & Szalacha, L. (2018). Sensory overload and technology in critical care. *Critical Care Nursing Clinics of North America, 30*(2), 179–190. doi:10.1016/j.cnc.2018.02.001

Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002). Being a preceptor is stressful! *Journal for Nurses in Professional Development, 18*(1), 22–27. doi:00124645-200201000-00005

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 Professional Development, 25*(1), 28–34. doi: 10.1097/NND.0b013e318194b58c

# Appendices

## Appendix A: Standards for Reporting Qualitative Research: A Synthesis of Recommendations (O'Brien, et. al., 2014, pp. 1247-1248).

| No. | Topic | Item |
|-----|-------|------|
| | **Title and abstract** | |
| S1 | Title | Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended |
| S2 | Abstract | Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions |
| | **Introduction** | |
| S3 | Problem formulation | Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement |
| S4 | Purpose or research question | Purpose of the study and specific objectives or questions |
| | **Methods** | |
| S5 | Qualitative approach and research paradigm | Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/interpretivist) is also recommended; rationale[b] |
| S6 | Researcher characteristics and reflexivity | Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability |
| S7 | Context | Setting/site and salient contextual factors; rationale[b] |
| S8 | Sampling strategy | How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale[b] |
| S9 | Ethical issues pertaining to human subjects | Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues |
| S10 | Data collection methods | Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale[b] |
| S11 | Data collection instruments and technologies | Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study |
| S12 | Units of study | Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results) |
| S13 | Data processing | Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts |
| S14 | Data analysis | Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale[b] |
| S15 | Techniques to enhance trustworthiness | Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale[b] |
| | **Results/findings** | |
| S16 | Synthesis and interpretation | Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory |
| S17 | Links to empirical data | Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings |
| | **Discussion** | |
| S18 | Integration with prior work, implications, transferability, and contribution(s) to the field | Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field |
| S19 | Limitations | Trustworthiness and limitations of findings |
| | **Other** | |
| S20 | Conflicts of interest | Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed |
| S21 | Funding | Sources of funding and other support; role of funders in data collection, interpretation, and reporting |

# Appendix B: Phases of Thematic Analysis (Braun & Clarke, 2006, p. 87).

| Phase | Description of the process |
|---|---|
| 1. Familiarizing yourself with your data: | Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas. |
| 2. Generating initial codes: | Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. |
| 3. Searching for themes: | Collating codes into potential themes, gathering all data relevant to each potential theme. |
| 4. Reviewing themes: | Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis. |
| 5. Defining and naming themes: | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme. |
| 6. Producing the report: | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. |

## Appendix C: Narrative Beginnings Account

I started my nursing career um, on a new graduate program. I was very lucky. I, ah, was interviewed and then selected um, to be employed on a year-long program in a big tertiary teaching hospital. I had graduated with a diploma of health science in nursing from a big university in the town in which I live. So, I consider myself very lucky that I got that new graduate program ah, which was a yearlong. Um, it's a very long time ago now and I don't have a lot of memories of what happened in that year. I think most of my memories regard ah, feelings, how I felt, the um - the transition shock, um, how upsetting it was and lack of knowledge, some of the situations I found myself in, all of which I remember quite clearly. But um, other aspects like who my educators were, the NUMs, even some people that I worked with um - escape me now.

My final rotation was an acute aged care and gastro ward and we had a lot of cardiac arrests and medical emergencies. I remember being quite stimulated, not enjoying, but being challenged by those situations. Around the same time ah - ah, somebody I went to university with um, was now a paramedic and he came in and said, "Look, if you enjoy this kind of work why don't you consider leaving nursing and become a paramedic?" Um, so I did. Um, I joined the ambulance service for two years and in those days, it was a little bit different. You - you worked through levels. You worked up through levels, one which was like probationary, up to level three, and you could stay at level three, but then you had to be selected and undergo further training to become a paramedic. So, I got to level three.

I then decided that I really missed the team environment um, of nursing and working in a big hospital and amongst a team and getting to follow patients through a little bit more. And at the time I had a friend who was a doctor and he said, "Why not try intensive care? It's very similar to what you're doing now, but in the safety of a hospital um, and you may, looking forwards, appreciate this when you're 40 years old." So once again I changed direction and went to work in a private ICU which I enjoyed, but I'm not sure that that environment and that team were right for me.

And then there were quite a few traumatic events happen in my own personal life. I moved to a country town and worked in emergency and ICU there for one year and then decided to go and live in England. So, I worked over there for, I think it was four or five years;

predominantly in ICU. Um, and because I had a passport I wasn't restricted to one hospital. I could work agency and work um, in a lot of different hospital ICUs um, and that could be a choice I could make on a day to day basis.

I realised I was ready to come back to Australia and asked a lot of the Australians um, especially those from Sydney, "where was a good place to work?" Overwhelmingly the hospital in which I work at now, came up as being a - a place to work at. Um, and I always enjoyed cardiothoracic ICU nursing, so it seemed the right fit. I knew um, from reputation that um, the hospital I work at um, does cardiothoracic but it also does um, heart and lung transplants, so that made me quite nervous but at the same time it was a challenge and I thought it could be a place to go. So, I worked there as agency and then as part-time and then as full-time.

After working there um, for a long-time I realised the patients were so challenging. Um, it wasn't like any other ICU that I'd worked in anywhere in London, or in the country or in Sydney. I realised I - I needed to know a lot more. Um, it was incredibly challenging um, and at the time there was a very different culture. I remember going home and crying in the car for 20 minutes thinking, "I'm never going to be the kind of nurse they need me to be." Um, so knowing that I needed to know more, I did a postgraduate certificate in critical care. It was around the time that we started doing more work with ventricular assist devices, so it was a unique environment: transplants; and mechanical assist devices. Even though it was a small unit, it was very fast. I'd never experienced anything like it and I'd come with years of ICU experience before I came into this place.

Um, after doing the course I became a team leader and then eventually a clinical nurse specialist, and then the educator in ICU. Someone at the time suggested I might like to try becoming the afterhours educator for the hospital. Um, I was - discussed it with the um - the head of that department and before I knew it um, was given ah, the position of afterhours educator, which I absolutely loved. But at the same time, I was removed from a team. I was floating around the hospital helping each individual ward and I really missed working as a part of a team and I - I really missed intensive care.

So, I was part-time afterhours educator and part-time CNS in the ICU um, and I'd - I'd done that for quite a while. And then the - the role of educator became vacant. So, in that period there'd been um - it had been unfilled um, so…. I think I made a mistake. The

person that suggested it, had been the educator, but had resigned from that role for a couple of years, if I remember correctly? Um, and so the - the position had been temporarily filled by a number of people, when they eventually um, decided to interview for a permanent person. So even though relatively, I was inexperienced in education um, and to some extent even leadership, I thought I might try it because I really enjoyed education. And to my surprise, received the permanent position. Um, which when I first started, I remember it being quite a shock. Because um, I think the only advice I was given, was by my direct manager saying, "Make it your own."

I hadn't really, in any of my career, experienced um, an educate - an educator that I can remember. That could be my - my bad memory. It could've been my relationship with them, but I just don't remember a strong role model other than the one that suggested that I become the afterhours educator and - and she hadn't been in the role for a number of years. So really, um, when they said, "Make it your own," I really <laughs> had no idea where to start. But I guess with my recent study in critical care I knew - I knew I needed to know more. I needed to know the theory of adult education and the principles; how to relate it back to nursing, and how to embed all those principles into day to day practice.

Um, around the time that I started, I was immediately having to orientate and induct new people into the ICU. And - and there was a book of clinical competencies but a guide as to how to orientate and induct, seemed to live, really in the corporate memory of the colleagues that preceded me. So, one of the first things I did, was work with a lot of those people; to try and write down, and structure what the unit thought orientation and induction should be. Which was timely, I guess, because at the same time, the organisation decided to change how new graduates and the new graduate program, would be structured.

So, the hospital, ah, and the education department um, decided to change the rotations from, I think three rotations of four months each, all in different clinical areas, to just two rotations, of six months. The - the first time the hospital directed that New Graduate Nurses um, straight out of university, would be entering um, our intensive care unit which is a quaternary level ICU. That rose - that - that would – created, apprehension. From my own experience and that of others, it was a very dynamic, stressful um, but highly specialised intensive care to work in and, I really couldn't picture, understand why, or

how, we would um, bridge New Graduate Nurses, straight from university in - into that kind of area?

I think a lot of the senior nurses, just through conversations and relationships and talking, um, said the same thing? There was a degree of bewilderment, um, but genuine concern for these nurses as well, because they all remembered how they felt when they started in nursing, let alone nursing in an ICU. Um, so the senior nurses and management got together and structured a program. And ah, we ah, evaluated that program. And the statements that were coming from the senior nurses um, I felt personally, were quite profound and touching. Genuine - genuine concern for the New Graduate Nurses and, what we were asking them to do and, how they were coping with that situation.

I genuinely wonder how the senior nurses do it? We're a unit, even though we're a quaternary level, high acuity unit, we don't have any um, extra resources. We have a free team leader but we don't have access nurses. Um, we are genuinely at um, full capacity. We don't have a standalone MET team. So, if we have to run to a cardiac arrest (so the ICU is the code blue team) or we do ECMO-CPR, um, use the Lucas, people are off the floor. We have to then flex, to support the patients that are there. Our senior nurses team-lead. Some of them do the roster. Like I said, they're on the code blue team. Um, they're preceptoring. They're buddying. Um, they're completing competencies. They're in clinical lead roles. They are teaching. They're ensuring patients remain safe.

At the time, I knew I had to - well, I didn't have the experience. I hadn't started - I don't think I'd started my um - my masters of education? So, I really looked to the literature to see if anybody else had done this before. And the literature was quite overwhelming about the experience of new graduates, but there was very little out there about um, how experienced nurses work with new grads in the ICU. There were examples of programs, but they were all pretty much from America or Europe, so didn't entirely relate to the - the resources and the environment um, that we were working with. Um, so I guess we, my fellow educator and I, sort of got through orientating. But the idea that there was not a lot in the literature about the experience of senior nurses working with new grads um, along with the statements they'd made in this evaluation, stuck in my mind. And I thought if there was a gap in the literature, it should be really worth investigating.

Um, so my idea was to try and take all of these words - these stories that these seniors were telling and hopefully put it out there. I didn't know where 'there' was, but I hoped somebody would listen ah, because what - their concern and their ongoing experience seemed worthy of listening to, and seemed worthy of support. Um, but I wasn't sure if people truly were listening um, so I spoke to my colleague who had a PhD and she suggested we could start looking at this, but she started asking me questions like, "what is your research question?"

I really didn't know what she was talking about, so um, I arranged an introduction to one of the professors at the local university and arranged an appointment with her to see if she could work with me, because she'd done similar work, but from the perspective of - of new grads, in the past. She suggested I do a master of research or philosophy where I would be taught the basics of research. Um, my assignments um, would then form the - the basis of my thesis. Um, so having in this time finished my masters of education, I just jumped two feet into a master of research.

Um <pause> and so it - it gave me an opportunity to really clarify um, what my research question was um, and it gave me a chance to - to talk about what the aim of my research was, and it really came down to the fact that um, the seniors were working alongside these very inexperienced and um, nurses in an environment um, that required dynamic critical judgment and thought and interventions, in one of the - the most acute ICUs in the country, and um, they were doing it with very little extra resources, very little time for orientation and preceptorship and education.

Um, we understood a bit more how the New Graduate Nurses were coping with that, both from literature and from their evaluations um, but there really wasn't anything other than the stories the nurses were telling about their experience and what it meant for them. Um, so I felt very strongly that I would like to - to give voice to what they were saying and for someone else, the 'other person', I - I don't know who that is, hopefully management, but I'm not under any illusion that what I'm going to do is going to change the world, but I just hope somebody will listen to their stories um, and that change will come from um - from reading their experience.

I really do wonder how the senior nurses do it day in and day out? I mean I certainly know how I feel or did feel as a clinical nurse specialist. As an educator, I'm slightly more

relieved because I only get allocated impatient responsibility um, in an emergency such as staff members calling in sick and not being able to replaced or unexpected admissions, things like that. So, I don't have a generally have a patient load, so I can hover, and teach and support, with too many other responsibilities.

Um, but we're a unit that takes ECMO and we can have multiple ECMO in the unit, balloon pumps, ventricular assist devices. We do transplants; we have people coming in um, pre-arrest or post-arrest. Um, very few of our patients are considered HDU. Um, if they are, they're the sort of patients, like a routine post-op CAGS [coronary artery bypass grafts] or AVR [aortic valve replacement] um, that's being sent to the ward um, the next day. But that day if they're considered HDU they'll be ah, transferred to the ward and then a new admission will come in. Um, we do dialysis. Patients will have inhaled nitric oxide, balloon pumps, pulmonary artery catheters. Um, they're sort of normal interventions for our unit. Um, there can be the massively bleeding patient. Um, we do open chests in the unit.

Ah, we support rotating staff from other areas, that are coming um, for the experience of ICU. Plus, we support postgraduate courses, such as the ICU course and the cardiothoracic course. So, the senior nurses ah, really do have a huge responsibility um, for a lot of things. But patient safety, I guess, is foremost. So, in an environment like that, that's loud and busy and fast and acute, um, with ever-changing technologies and trial devices and treatments that we're doing - I guess the environment is so important when we - when we talk to them, and about what they do, and what their experience is.

Um, so I really do wonder, "what it means for them to be working alongside the new graduates and supporting them?" Um, 'Cause the feedback from the new graduates is that they feel overwhelmingly supported. So, something is happening. But I just don't know what it means? What the experience of the senior nurses is? Um <pause> is it causing stress? Is it taking a toll? Are there things that we could be doing better? Um, there's a lot of um - unknowns in all of that. So, I'm just - I hear the stories that the - the seniors tell of what they wish for; how things could be different. So, I'm just very keen to - to talk about that experience um, the stories that they tell of their experience um, and share it with the wider community. That was - that was my desire, on starting on this process of inquiry.

# Appendix D: Ethics Approval

Human Resources Ethics Committee approval

21 July 2016

Ms Susan Whittam
Intensive Care Services

Dear Susan,

**SVH File Number: 16/116**
**Project Title: Narratives of Experience: Senior Registered Nurses Working with New Graduate Nurses in the Intensive Care Unit**
**HREC Reference Number: LNR/16/SVH/179**

Thank you for your e-mail, dated **20 July 2016**, responding to issues raised regarding the above project, which was first considered by the HREC Executive on **5 July 2016.**

Based on the information you have provided and in accordance with the NHMRC National Statement 2007 and NSW Health Policy Directive PD2010_055 'Ethical and Scientific Review of Human Research in NSW Public Health Organisations', this project has been assessed as low/negligible risk and is therefore exempt from full HREC review.

Hospital HREC (EC00140) has been accredited by NSW Ministry of Health as a Lead HREC under the model for single ethical and scientific review and Certified by the NHMRC under the National Certification Scheme. This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice.* No HREC members with a conflict of interest were present for review of this project.

This project meets the requirements of the National Statement on Ethical Conduct in Human Research. I am pleased to advise that the Committee at an Executive meeting on **19 July 2016** has granted ethical and scientific approval of the above **single centre** project.

You are reminded that this letter constitutes *ETHICAL* and *SCIENTIFIC* approval only. You must not commence this research project at a site until a completed Site Specific Assessment Form and associated documentation have been submitted to the site Research Governance Officer and Authorised. A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Please note that it is not considered best practice to store research data on personal hardware. No identifiable participant data can leave a site. There always needs to be data security measures in place and a clear plan for permanent destruction of data needs to be adhered to at completion of the project.

The project is approved to be conducted at

If a new site(s) is to be added please inform the HREC in writing and submit a Site Specific Assessment Form (SSA) to the Research Governance Officer at the new site.

The following documents have been approved:

- Protocol, Version 1, dated 18 July 2016
- Participant Information Sheet and Consent Form, Version 1, dated 20 July 2016
- Advertisement, Version 1, dated 19 July 2016

The Low and Negligible Risk Research Form (LNRF) reviewed by the HREC was LNRF**AU/6/9B27212**

Please note the following conditions of approval:

- HREC approval is valid for **5 years** from the date of the HREC Executive Committee meeting and expires on **19 July 2021**. The Co-ordinating Investigator is required to notify the HREC 6 months prior to this date if the project is expected to extend beyond the original approval date at which time the HREC will advise of the requirements for ongoing approval of the study.

- The Co-ordinating Investigator will provide an Annual Progress Report beginning in **July 2017**, to the HREC as well as a Final Study Report at the completion of the project in the specified format.

- The Co-ordinating Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project and any complaints made by participants regarding the conduct of the project.

- Proposed changes to the research protocol, conduct of the research, or length of approval will be provided to the HREC Executive for review, in the specified format.

- The HREC Executive will be notified, giving reasons, if the project is discontinued before the expected date of completion.

- Investigators holding an academic appointment (including conjoint appointments) and students undertaking a project as part of a University course may also be required to notify the relevant University HREC of the project. Investigators and students are advised to contact the relevant HREC to seek advice regarding their requirements.

Please note that only an electronic copy of this letter will be provided, if you require the original signed letter please contact the Research Office and we will be happy to provide this.

Should you have any queries regarding this project please contact the Research Office, Ph: (02) 8382-4960 or by E-mail:                    The HREC Terms of Reference, Standard Operating Procedures, *National Statement on Ethical Conduct in Human Research* (2007) and the *CPMP/ICH Note for Guidance on Good Clinical Practice* and standard forms are available on the Research Office web-site to be found at:

Please quote **SVH File Number: 16/116** in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely,

**HREC Executive Officer**

TRIM REF: D/2016/53536

# Appendix E: Research Advertisement

## PARTICIPANTS NEEDED FOR RESEARCH

### Are you a senior ICU nurse who works with New Graduate Nurses in the ICU?

Seeking senior ICU nurse volunteers to take part in a research study. This study seeks to understand the experiences of Senior Registered Nurses who work with New Graduate Nurses on a Transitional Support Program, in the Intensive Care Unit.

You would be asked to participate in a conversation style, one-on-one interview. Your participation would involve *one* session (about *60* minutes long). After the researcher has written your tentative account, you will have an opportunity to re-compose the account.

For more information about this study, or to volunteer for this study, please contact:

*Susan Whittam*

This study has been approved by the _____ Research Ethics Committee (HREC) - No. 16/116

| Susan Whittam Or Email: | Susan Whittam Or Email: | Susan Whittam Or Email: | Susan Whittam Or Email: | Susan Whittam Or Email: | Susan Whittam Or Email: | Susan Whittam Or Email: |
|---|---|---|---|---|---|---|

# Appendix F: Participant Information Sheet

## Participant Information Sheet

| | |
|---|---|
| **Title** | Narratives Of Experience: Senior Registered Nurses Working With New Graduate Nurses in the Intensive Care Unit. |
| **Protocol** | 1 |
| **Principal Investigator** | Susan Whittam |
| **Supervisors** | Associate Professor Tracey Moroney, Dr Nerilee Baker |
| **Location** | |

## Part 1     What does my participation involve?

### 1     Introduction

You are invited to take part in this research project, which is called Narratives Of Experience: Senior Registered Nurses Working With New Graduate Nurses in the Intensive Care Unit. You have been invited because you responded to the research recruitment poster and meet selection criteria.

This Participant Information Sheet tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
• Understand what you have read
• Consent to take part in the research project
• Consent to be involved in the research described
• Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

## 2    What is the purpose of this research?

The research project seeks to understand the experiences of Senior Registered Nurses (SNRs) who work with New Graduate Nurses (NGNs) on a Transitional Support Program (TSP), in the Intensive Care Unit (ICU). There is ample literature describing the NGN experience, however there is gap in literature addressing the experience of the SRN working with the NGN. Therefore, the significance of this study is that it will describe the experience of the SRN working with NGNs in ICU. Understanding the experience of the SRN working with NGNs in the ICU may reveal workplace, interpersonal and cultural factors that may affect staff retention, workplace relationships and wellbeing.

The results of this research will be used by the researcher Susan Whittam to obtain a Master of Philosophy (Research) degree from Notre Dame University, Sydney.

## 3    What does participation in this research involve?

Consent form will be signed prior to any study assessments being performed and you will receive a copy of your consent. The research project involves a one-on-one, conversation-style interview. The interview will be audio taped. It is estimated that the interview will take no longer than one hour and will take place at a mutually convenient location. You will be asked to tell a detailed story of your experiences working with New Graduate Nurses in the Intensive Care Unit.

The researcher will then analyse the conversation and write a tentative narrative account. This will be sent to you via email and given to you as a hard copy. If you wish, you may re-compose this tentative Narrative account with the researcher. There will be no out of pocket expenses if you choose to participate in this research project. There will be no reimbursement or payment for participating in this research project.

There are no costs associated with participating in this research project, nor will you be paid.

## 4    Other relevant information about the research project

This research study will involve 4-8 participants at

## 5    Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with professional staff or your colleagues at

## 6    What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research. The significance of this project is that it will describe the experience of the SRN working with NGNs in ICU. Understanding the experience of the SRN working with NGNs in the ICU may reveal workplace, interpersonal and cultural factors that may affect staff retention, workplace relationships and wellbeing.

**7      What are the possible risks and disadvantages of taking part?**

If you become upset or distressed as a result of your participation in the research project, the research team will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge. This service can be contacted by calling 1800 8187 28 or (02) 82479191 or via www.accesseap.com.au

**8      What if I withdraw from this research project?**

If you do consent to participate, you may withdraw at any time.  If you decide to withdraw from the project, please notify a member of the research team before you withdraw. A member of the research team will inform you if there are any special requirements linked to withdrawing.  If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form which will be provided to you by the research team.

**9      Could this research project be stopped unexpectedly?**

This research project may be stopped unexpectedly for a variety of reasons. These may include reasons such as the primary researcher withdrawing from studying at the University of Notre Dame,

**10     What happens when the research project ends?**

You will receive a copy of your individual tentative account and be given an opportunity to recompose this account.  Once the information from this research project has been analysed, a summary of the results can be emailed to you at your request.  You can expect to receive this summary in two years.

## Part 2    How is the research project being conducted?

**11      What will happen to information about me?**

By signing the consent form you consent to the research team collecting re-identifiable data about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential.

A document that identifies you with your pseudonym will be kept on a password protect computer in a locked office and not removed from the                                        Only the principle investigator will have access to this document. This document will be the only way in which you can be re-identified. This document will be deleted at the end of the research study.

Audio data collected during the conversational style interview, will be encrypted and sent to an Academic Transcription service for transcription. The audio data will not contain any identifiers. Transcribed coded data will be kept on the researcher's password protected, non-networked computer during the period of analysis and writing of the final results.  After this time the coded data will be transferred to the School of Nursing, Notre Dame University. Non-identifiable data will be stored at the School of Nursing, for a minimum period of 5 years, as required by the University Of Notre Dame. After this time it will be deleted according to the School of Nursing's protocols.

Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law. The personal information that the research team collect and use is your name and pseudonym.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission. Confidentiality will be maintained by use of a pseudonym.

In accordance with relevant Australian and/or New South Wales privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored.  It will be disclosed only with your permission, or as required by law.

**12      Complaints and compensation**

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible.  You will be assisted with arranging appropriate treatment and support.

**13      Who is organising and funding the research?**

Susan Whittam is conducting this research project, under the supervision of Associate Professor Tracey Moroney and Dr Nerilee Baker.

Notre Dame University and                                        , may benefit financially from this research project if, for example, the project assists Notre Dame University and : in any commercial enterprise.

You will not benefit financially from your involvement in this research project even if, for example, knowledge acquired from your information proves to be of commercial value to Notre Dame University and                         /

In addition, if knowledge acquired through this research leads to discoveries that are of commercial value to the researchers or their institutions, there will be no financial benefit to you or your family from these discoveries.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

## 14    Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).
The ethical aspects of this research project have been approved by the HREC of ·
       ; Reference No. 16/116.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

## 15    Further information and who to contact

The person you may need to contact will depend on the nature of your query.  If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on (02) 8382 3501 or any of the following people:

**Research contact person**

| Name | Susan Whittam |
|---|---|
| Position | |
| Telephone | |
| Email | |

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

**Complaints contact person**

| Name | Research Office Manager |
|---|---|
| Position | |
| Telephone | |
| Email | |

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

**Reviewing HREC approving this research and HREC Executive Officer details**

| Reviewing HREC name | |
|---|---|
| HREC Executive Officer | |
| Telephone | |
| Email | |

**Governance Officer Contact**

| Position | Research Governance Officer |
|---|---|
| Telephone | |
| Email | |

# Appendix G: Consent and Withdrawal

## Consent Form and Form for Withdrawal of Participation

<div style="border: 1px solid black; padding: 20px;">

### Consent Form

| | |
|---|---|
| **Title** | Narratives Of Experience: Senior Registered Nurses Working With New Graduate Nurses in the Intensive Care Unit. |
| **Protocol Number** | 1 |
| **Principal Investigator** | Susan Whittam |
| **Supervisors** | |
| **Location** | |

#### Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I have agreed to one of the following options:

☐ That the researcher will use a pseudonym of my choosing to ensure my name and any other identifying information will be made confidential; or

☐ That the researcher will choose a pseudonym on my behalf, to ensure my real name and any other identifying information will be made confidential.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____

Signature _____ Date _____

#### Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Consent and form for withdrawal 20160720 v1

</div>

# Form for Withdrawal of Participation

| | |
|---|---|
| **Title** | Narratives Of Experience: Senior Registered Nurses Working With New Graduate Nurses in the Intensive Care Unit. |
| **Protocol** | 1 |
| **Principal Investigator** | Susan Whittam |
| **Supervisors** | |
| **Location** | |

## Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my routine care, or my relationships with the researchers or Notre Dame University,

Name of Participant (please print) _____

Signature _____ Date _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher must provide a description of the circumstances below.

## Declaration by Researcher[†]

I have given a verbal explanation of the implications of withdrawal from the research project and I believe that the participant has understood that explanation.

Name of Researcher (please print) _____

Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

## Appendix H: Participants' Narrative Accounts

This inquiry's puzzle was exploring the experiences of SRNs working with NGNs in ICU. As detailed in the Methodology Chapter, the individual NAs were negotiated and co-composed with the participants, whilst remaining attentive to the three-dimensional NI space. The NAs are presented chronologically for the reader.

Before presenting the NAs, a brief overview of the five participants is offered. The participants were SRNs who were currently employed in the ICU in which this inquiry was located. All five SRNs were female and had an average 13 years' experience working in this ICU, at the time of conversation. All had worked with an NGN within the immediate three months prior to the NIs commencement. Each SRN had completed an ICU-specific post-graduate qualification.

### Lisa's Narrative Account

After Lisa had volunteered to be a participant in my research project, we discussed when and where we might meet. I offered to hold the taped conversation at a time and place that was convenient for her, for example in her home, or at a café. Lisa however, wanted to meet at a time and place that was convenient for me. After reiterating that the time and place was for her to decide, Lisa decided to conduct the taped conversation at work. Lisa asked the taped conversation to be conducted after her shift had finished.

On the day on the taped conversation, Lisa had been allocated a patient admitted to the ICU post cardiac arrest. The patient was receiving intra-aortic balloon pump therapy, was coagulopathic and was requiring multiple inotropes. In the hours leading up to the taped conversation, the patient had been transported to and from the radiology department for a brain CT scan.

Lisa commented, "it's been one of those busy days, but it's, um, yeah. It's tiring, but it's been good."

The activity in the ICU on the day of the conversation meant that the taped conversation was held in the CNE / CNC office, behind a locked door. Even with the door closed, the noise of the unit, alarms, conversations, clinical waste bins being moved, permeated the

office. Lisa entered the office first and chose to sit in my chair at my desk. I sat opposite her, at a colleague's desk. I welcomed and thanked Lisa for her valuable time.

I started our conversation by reiterating the purpose of the research and asked if she had any final questions or concerns regarding the research topic or her involvement. After signing the consent and giving Lisa a copy, I turned on the recorder.

I started the conversation with Lisa, saying, "what I'm interested in is your particular experience working with new grads in the ICU."

Lisa responded by saying, "Their clinical skills are at the beginning and so it's very hard in a place that's quite dynamic and quite, um, full-on I guess. You kind of have to carry them a lot of the time which brings extra workload for yourself, and you can really only give them simplistic patient, and even then it can be hard."

After talking to Lisa, I learned that she defined 'simplistic patients,' as straightforward post-operative patients. Patients who follow standard pathways being "extubated and then the next day drains out and to the ward but as the years go on the patients are actually getting more, um, complicated in the sense that you don't see that straightforward case come through like you would see ten years ago, where you'd be bang, bang, bang and drains out and off to the ward."

Lisa explained that in her role of Team Leader in the ICU, it's quite hard to allocate a simplistic patient to the new graduate nurse, as the patients are becoming more complicated. She described how even extubated patients may require dialysis, or intra-aortic balloon pumps or have Ventricular Assist Devices insitu. She suggested that these patients are not ideal for New Graduate Nurses, as they haven't completed their associated competencies and may not have adequate supervision. On any one shift staffing may be limited so that the new graduate nurse may be allocated two patients. Although the allocated patients would be categorised as less acute, within the 8-hr shift period, the patients may be discharged to the ward, and then the new graduate nurse could be required to take a new admission to the ICU.

As a team leader in the ICU, Lisa believed that she had to have an understanding of what was going on with each patient. She was then required to gauge the level of knowledge and skill of each new graduate nurse, "some of them come in, and they're over-confident,

some of them come in, and they're, um, overwhelmed." When there weren't many senior nurses on a shift, she was very busy going around to each bed space making sure that every nurse was keeping on top of what they had to do, "otherwise they might have problems and call out, 'I'm sinking.'"

When not acting as the Team leader for the shift, Lisa was allocated a patient in the ICU. I was interested in how she cared for her patient while continuing to teach and support a new graduate nurse. She laughed when she said, "So, I guess when you are out in the unit, and you've got a patient...hopefully, the new grad's got a nice easy patient and that it's um, so that you get time to give them a bit of space and let them try and work things out. But also come around and ask them if they need a hand as well."

When I asked Lisa if she was able to do that most days, she replied, "not much." When her workload was increasing, and she was preceptoring a new graduate nurse, Lisa said she would say to the new graduate nurse, that she wouldn't be able to "teach today <laughs> and um, yeah. Come, you know, if you've got any questions, maybe I can tell you what to do or don't be afraid to ask another senior member."

"Even though you're preceptoring, we're kind of all preceptoring the new grads… So at least, you know, they don't feel alone – to, um ask."

"I think it can be a bit overwhelming in the big picture. But some of them handle it, and some of them don't."

Lisa spoke of the responsibility of being a team leader and how it affected her, "I think sometimes maybe you get a bit grumpy with it all or a little bit stressed." When I asked Lisa if it worried her that some New Graduate Nurses were overwhelmed, she said, "well a little bit because I think that... could turn them off nursing. When they might be good nurses."

Throughout our 50-minute conversation, Lisa spoke of trying to connect with the New Graduate Nurses. She laughed as she said, "maybe it's the mother in me. … you can't be mean to them. Like what's going to achieve? You know you are not going to achieve anything. They're only a little bit older than my daughter, so you kind of have to tune into them a bit and, and try and connect to them and make them feel comfortable. So that if there is an issue that they don't understand, that they come and ask. And never be afraid

to ask because it's – it's better to ask and learn than to not say anything and kind of blindly work your way through it."

"I think that most of them go away feeling reasonably happy with their experience. Some of them come back."

It seemed important to Lisa that the New Graduate Nurses were happy with their experience in ICU and would apply for permeant positions in the unit, once they had completed their new graduate transition program. "There's no point in being degrading or – know what I mean? Like, that's not gonna solve anything. You may as well at least ask them, what they're thinking, as well if you've got time. Like 'what do you think we should do?' And, making them feel comfortable I think. So - yeah. But I don't mind teaching them different things, and It's good for me to practice remembering."

When I asked Lisa if she had an experience working with a new graduate nurse, that where she had thought, "ooh maybe I could have done that differently?"

Lisa responded, "Well, I think, as a senior nurse you can always learn how to be better. I guess after many years, things come naturally. I think you can try and make them feel comfortable. …. You've got to talk to them and communicate with them and, um, kind of get an understanding of what they understand... Rather than looking at what they can't do, kind of working through what they want to learn about and get, ah, more skill in."

Taking Lisa back to the start of her career, I asked her how long she had been in the ICU? Lisa laughed and asked if I was going to write that down. Lisa explained that she didn't know. She stated she had been in the hospital for many years and had worked in the cardiac unit for a few years before doing a university course. Being a hospital trained nurse, Lisa completed additional subjects which resulted in her receiving a degree in nursing.

I questioned, "so, how did you come ICU?" Lisa explained how she was required to do a secondment in ICU as part of her university course.

"I thought this was…seemed like a good place to work. So, once I finished the course, I applied to come here. So, I'm still here."

When I asked Lisa to reflect on her time in the ICU, she felt that there had been big changes, "one of the main ones is the introduction of new grads. They even tried to bring enrolled nurses in there for a little bit".

I wanted to confirm that I had understood her correctly and asked whether she meant New Graduate Nurses straight out of university. She confirmed this and said it was a big change from previous practice.

When I asked Lisa what she thought about New Graduate Nurses being employed in ICU, straight from university, she responded "well I think it's a bit scary for them. I think it's a bit too visually - oh I don't know. …. I think that that it can be a bit overwhelming…" I asked Lisa if it worried her that the new graduated nurses were overwhelmed. She responded, "well a little bit because I think that that can turn then off nursing when they might be good nurses."

I asked Lisa to clarify a concept she had raised earlier in the conversation, regarding relying on and trusting the new graduate nurse to ask questions when they were unsure. Lisa responded, "the overconfident mightn't ask, and the under-confident mightn't ask…you have to kind of work with them and see …. where they're at. It's your job to make sure they are feeling comfortable and that they are getting their work done... so it's - it's not easy, but you've got to do it."

When asked, "what happens if you don't 'do it'?" Lisa stated, "oh the patient might crash, or they might learn. They might just work it out." I asked Lisa what might happen if she was unable to 'get there and see how they're doing?'

Lisa responded, "Um, ooh, I don't know. You could ask them at the end of the shift. Or, um, every hour on the hour. Or …just be sure that they – you're keeping up, 'do you need a hand with something? I s-s'pose if you can't get there because of – you become busy, then it's um – I don't know, sometimes mistakes happen. … Like I think mistakes – mistakes happen. It's not good that they happen, but they do. They happen... I shouldn't say that sometimes mistakes happen. And it's not good that they happen. But sometimes you can't be everywhere, and I like to come home from work and think that I worked as best I could for the situation, um, but, you know sometimes mistakes happen. It's not good."

I asked Lisa to reflect on her early career on the wards and her first experiences of working in ICU. "Do you think your experiences coming here impact maybe the way you teach or think about new grads?"

"Probably. Yeah. …… I don't mean to be intimidating to - to people. I don't want people to think that I intimidate them. Because that – you know that doesn't really solve anything. Just makes you look like a scary senior nurse and I – I don't want that. Yeah…. It's like life. Like if you want to be an ogre, then you aren't gonna have any friends. If you want to talk to people and, you know, make people feel comfortable that they can come and ask you something that you can help them – I feel good that I could help them if I can. Sometimes they have to work it out. If it's a reasonably simplistic issue but – yeah you try to make them feel – as long as there's not too many of them. You know, as long as you don't have to do it all of the time … I guess educating does – like I like it, but it does become tiring as well I think. Whereas today was quite good cause I was just in there and I can just get on with what I've got to do."

As a clinical nurse educator, I have my own rationale and insight as to why it can be tiring to educate at times, but I was interested in Lisa's perception, so I asked, "why do you think it's tiring sometimes to educate all the time?"

"Cause it's – mentally tiring. On your brain. Yeah. Explaining stuff and going through stuff and – and, um, yeah. It is mentally draining I think. And you do come home being tired."

Lisa had previously explained to me that even though it could be very busy at work, it was often busier at home. I wondered out loud, "how does that work then if you go home tired?" Lisa replied, "Oh Michael's pretty good, so its umm it's like everything, isn't it? You've gotta work as a team; otherwise, it won't work. You know what I mean? And I know like – I could say that I don't want new grads here. And - and – because it's more work for people like myself. But it's …. what's happening. Yeah. I can't see them say – 'Cause once they start something …it doesn't change."

I wondered what Lisa thought about New Graduate Nurses starting their career in ICU. She reflected to when she was a beginning practitioner, "See, I probably was always a keen nurse so maybe if I could have perhaps come earlier than I did. … I just think they should do their new grad around the hospital. And then if they want to come, then at least

after a year, where they're used to working with patients, used to working with drugs, use to communicating and talking about problem solving and time managing and things that – then come into this environment."

"If it's busy and they've got a patient that is fairly stable and then they, say, the patient deteriorates a little bit, and they need – so you've kind of got to step in then, get on with doing stuff that's required that they just haven't got the concept of doing it because they've never been exposed to it. At least if they've done some ward work, then they're learning time management and about drugs."

"There are nurses that have come that are switched, ready to go – and even though they're confident, they ask as well. And yet sometimes there'll be other nurses that will just kind of make it work, where it's a little bit over their understanding but – yeah. I think they're good. Like they're good after a bit of time."

"The challenge is teaching them the new equipment that we use learning dialysis, learning how to understand the balloon pump or the VAD. I thinks it's good that we have the [Education Day program] I think, - for people like that coming through and the [Introduction to ICU program]. I think that they're all good courses to provide for the nurses here, so – I think that that helps too"

Lisa changed the trajectory of the conversation to ask me directly how new graduates nurses were selected to work in ICU for 6 months on their first rotation out of university. I explained that I believed that the nurses were interviewed at a hospital level first and were then chosen to work in ICU. Lisa asked, "Like I could say it's too much for us but will it – will – would what we say mean anything?" I responded by saying, "I'm not sure. I think it might be a chat for another time." Lisa laughed and said, "Do you know what I mean? Like if we – if you…"

I remained attentive to what Lisa was saying. I wondered out loud, "I think it's really interesting that you're saying; correct me if I'm wrong but, maybe if they came with a year of experience?"

"Experience. Yeah. Just at time management and I think it's good to learn out there about the hospital, where everything's located and what you've got to do and talking to your patient and – yeah all that. And also learning the basics of nursing too – like washing the

patient say, or, you know, making sure they have their teeth cleaned. Just those little things that can make a difference to the patient. Because here even – you still have to do all that, as well as lots of other things go on as well, so, just learning probably time management."

"It's a big thing, time management. Yeah. Do I like having the new grads? Sometimes. Sometimes not <laughs>. But I think it's the way it's heading so you, have to work it out."

"I do like working out there. I do like it. Maybe I've been here too long sometimes because you must never become complacent, I think because it's - it's too unpredictable. You have to keep your standards – all the – all the time. And that does become tiring but like it's - it's not a bad place to work in nursing. When you look at the other things that go on in the unit besides new grads. Maybe a year out in the world of the hospital and then come into ICU? I think that they'd be a little bit more mature. And, more confident in themselves to ask the questions that they don't know."

"…. It's – it's hard. But I – if they go away with a positive feel from the unit and not feel, that they never want to step foot in it again – then I think it's been ok."

"Overall, I think it's – I do think it's a bit premature. But I - at my level I can't change that. But I – I do think that perhaps a year of being out there and working in the wards and learning a bit more about how a hospital works, bringing with it a bit more confidence and a little bit more maturity as well – to - to set foot in intensive care. But do my best to make them feel comfortable."

**Camilla's Narrative Account**

When planning when and where we would conduct our taped conversation, I offered to meet Camilla at a time and place that was convenient for her. After discussing the possibility of me meeting her at her home, Camilla proposed that this would be too noisy and that we might just talk about things other than the research topic. She ultimately decided that it would be most convenient for her to come into work an hour or so early, and conduct the conversation before her shift. To protect her privacy and to ensure that we would not be interrupted, I arranged access to an empty office that was located close to the ICU.

I had known Camilla socially and professionally for an extended period of time. I wondered if being friends and colleagues might influence the conversation. We started our conversation with Camilla showing me photographs of an event that had recently happened in her life. After talking and laughing about the photos, at one point we simultaneously mentioned the need to stop talking and start the taped conversation; a coincidence that made both of us start laughing again. This moment was reassuring to me as a researcher because it demonstrated that Camilla had the capacity to separate friendship from work relationships and participate equally in the research. I explained the purpose of the research and asked if there were any concerns or questions. After signing the consent, and the digital audio recorder had been turned on, I thanked Camilla for being involved in the research. I started the conversation by asking her what it was like for her as a senior nurse, working with new grads 'out on the floor'; the daily reality?

She sighed and said, "it can be challenging at times, especially if we've got more than one new grad on a shift. Just purely because the skill mix ain't great, you know, most of the time. Sometimes, it's very difficult to find a patient for a new grad to look after. Because of a lack of skills. Also, it's time consuming preceptoring, making sure that everything is done. It's quite a lot of pressure because you do take responsibility of, you know, what they do. You have to. I just try to remember what it was like when I was newly qualified nurse and how patient people were with me. Because, you know, I've been in the same situation".

Knowing that Camelia was born overseas, I took Camilla back in time to when she first started studying to become a registered nurse. She described the practice of the university

in her country of origin; all undergraduate nursing students choose a specialty at the start of their three and a half years of training. Camilla said she knew she wanted to do acute care nursing, therefore had she had months of experience working in placements in ICU, Emergency department or operating theatres. Soon after graduation, Camilla moved to another country and immediately started work as a new graduate nurse in an intensive care unit. She reflected on this and stated, "so, you know, I've been there. So, I have to support them."

I asked her if her experiences as a student and new graduate nurse in ICU affected the way in which she managed things, out on the floor with the new grads. Camilla sighed again, "Has to. Um I'm sure it does. …I'm just not very familiar with the training that the new graduates go through at the moment. But it seems to be much more, sort of theory based. Rather than practical. Some of them seem to be quite new with not much knowledge when they reach us." I asked if she could give me an example of that. "Well, it's just the basic things like priming an IV giving set might be a task. Or taking a blood pressure or ECG. Very basic tasks. And then it becomes very task orientated, you know, rather than seeing a bigger picture,... they just seem to do one little bit here and there. And not joining the dots together really."

Many years ago, Camilla and I had been talking and I remembered her describing what it was like to work with New Graduate Nurses. Her description had resonated with me and now years later, I had the opportunity to ask her if she remembered saying, "Having new grads is like looking after two year olds. You have to have eyes in the back of your head."

"Well it is," said Camilla. "It is like that. You – you cannot trust. And you have to go and check over and over and over again," she said emphatically. "Some of them are quite good. But most of them are not. So yeah, a little bit like toddlers. Turn your eyes and, you know, things are not done or missed or, you know."

"Patient's got no blood pressure. No-one's too worried about it. Because they don't know the implications."

Camilla spoke of how she interacted with New Graduate Nurses and her belief "that there's no silly questions." Camilla then imitated talking to a new graduate nurse, "you can ask questions as many times as you want to. I'm happy to explain same thing

numerous times. I'd rather have you asking questions than not asking questions and not knowing what's going on."

She continued, "so, you have to keep the communication open and hope that they, you know feel supported and feel safe to, you know, ask silly questions."

I was interested in Camilla's experience of new grads asking questions and asked her to explain how that actually occurred on a shift, "Well the reality is that...they don't always ask, you know. They're too embarrassed to own up...not knowing something that they think they should know. Um, and you discover later on, when things go wrong, that they had no idea really and they didn't come and ask you. So, you just have to try and hover. You're like a helicopter parent to these toddlers, and you've just got to try to figure out what's going on … on an hourly basis …walk to the bedside, ask 'what's going on?' Have a look at the chart, what things have been done, what's not done? You know, ask them, 'what are you planning to do next? What things do you still need to get done today?' It's full on."

I asked Camilla, 'what happens if they don't ask the question?" Camilla responded, "You might lose a life in ICU. That's the reality." When I asked her how that made her feel, she said with emphasis, "Terrible! It's a huge responsibility. Absolutely massive. I don't know if we should ever have first rotation new grads in ICU…. I think that's dangerous."

When I asked her why, Camilla answered, "Because they're fresh from the Uni. They haven't got the skills. They don't recognise these things. They need to go and practice somewhere first. Unless they are an exceptional individual and have done all their placements in …really busy units or ICU or ED or something like that. They need to practice just normal things. Just, you know, giving medicine, learning medicine, you know? It might take them an hour to do 8 o'clock medication in the morning, and you just don't have that amount of time in ICU most of the time. You've got five minutes to do your drugs, then you move on to the next thing. And you're constantly multitasking and – they just - they can't because they're doing one task at the time. And slowly. And I think wards are perfect for practicing, you know, doing obs. and doing IV antibiotics and priming lines and stuff like that. Assessing the patient."

I listened to Camilla as she described her varied responsibilities within the ICU. As a senior nurse, Camilla may be allocated the responsibility of caring for the most complex,

critically unwell patient in the ICU. At other times, she may be the team leader for the shift; or be the preceptor for a new graduate nurse. I wondered if the role she was allocated on any given day changed the way in which she worked with the new graduated nurse.

"Well, it just depends on the day really. You know, often being in charge you are so busy just organising staffing, organising patient flow that you don't actually get to have much time with a new grad, unfortunately. Uh, lucky for the first …few weeks, they've got a preceptor so you can rely on a preceptor to keep an eye on the new grad. So… I think I definitely give them more support if I'm looking after a patient and there's a new grad working next to me or I'm preceptoring them. You have more time to do that hopefully. And hopefully, you've been given a patient who is a little bit less busy so that you have time to walk over to the other bedspace and...go through things together".

I listened as Camilla defined a busy patient, "for me a busy patient is probably someone with dialysis or ECMO … unstable, multiple inotropes...needing constant attention." I stated that I believed that we often had patients like she had just described. Camilla agreed and said, "We are a very busy unit."

Camilla explained that each patient in the ICU has a nurse who is allocated to care for them. It is the role of the team leader, to allocate the registered nurses to the patients. Camilla explained her decision-making process when she is assigned the team leader role for the shift, "Well it so depends on who I need to allocate. Like there are course students, there is new grads, there are people who have got certain skills to look after certain things like ECMO. So, I think …first you have to sort out, do you have enough nurses to look after ECMO and LVAD patients? Do that first then you go to the other end of the spectrum and have a look at …. who would be suitable for that new grad to look after? How long have they been here? Can they look after a ventilated patient? Is there a stable ventilator patient that they could look after? And, you know, go from there. …Once…they've been with us for three or four months then you've got a little bit more flexibility, but you still can't allocate someone with a dialysis machine, anyone, you know, very unstable. So, it limits the possibilities and, you know they often end up looking after the same patient, the whole week. Because there is no-one else for them to look after. So, it must be quite hard for them as well. But I suppose they do come to ICU … as a new grad to learn sort of basic ICU skills…. They're not expected to look after

complicated, intensive care patients. But we haven't got those not very complicated patients very often."

I listened to Camilla as she spoke of her frustration working with New Graduate Nurses, "We're not given the tools, you know, to cope with it. You're stretched to the limit.... sometimes …if the skill mix is bad, and you haven't got any sort of stable ICU patients for the new grad to look after, you just have to not give them a patient. You need to replace them with, you know an agency nurse or someone doing overtime. And it's frustrating and time consuming trying to organise that. You just hope that when you're coming on and you're in charge that …things like that would have been thought about by the previous team leader or NUM. But often you come on, and you realise that, hey, hang on, I've got two new grads on. I can't give a patient for them, because there's no-one for them to look after. And then … then and there, you start sorting it out and liaising with the other intensive care, 'is there anyone there who can look after? Can we swap nurses around? Who can stay back and do overtime?'"

Camilla spoke of how she might be the only senior nurse on an evening shift or night shift with no-one else who can be a team leader, "You don't get breaks because you're too worried about the patient's safety. So, you might just … sit down at the desk and eat your food there, hopefully, or have two minutes – go and heat up your food in the microwave and run back. It's crazy sometimes." I asked Camilla what would happen she took her full break away from the floor, "I don't know. I don't want to think about it. … sometimes you just have to liaise with the in-charge at the other intensive care unit and …hand over to them.. say, 'I'm going for half an hour.' If they call you, run."

When I listened to Camilla tell her stories, I wondered how experiences like these affected her, Camilla laughed when she said, "I don't take anything personally anymore. I used to get terribly, um, … I don't take things personally and get frustrated. But now I just …always try to do my best and …too bad if that's not good enough. I know that I've done my best and you hope for the best."

I acknowledged Camilla's stories of her experiences sounded challenging. I wondered if Camilla had had rewarding experiences with new grads, "Yeah. When they're at the end of their rotation they come, and say, <mock tearfully> 'Oh you were my preceptor. I remember the first day with you'. It comes at the end, I think…When they say that and

go, 'thank you for your support. I was always able to come and talk to you.' But that's how you get feedback if you get feedback really. I do like teaching, and I do like working with new grads … because I've been there."

I asked Camilla to recall a particular experience with a new graduate nurse. I asked her, as she recalled this experience, to consider if she would do anything differently? She sighed and said, "I'd just like to have more time to spend with them somehow... to be available to give more support. Um, so I don't know how, how I could change that. Um, I suppose … as a team leader trying to be better at allocating new grads and the preceptor so that the preceptor would have the time to help the new grad. I think that would be one way to do it. … Or be more available for the new grads. I try to do that but there's always room for improvement, I think."

"It would be nice to get proper feedback from the new grads at the end of their rotation." At this point, Camilla directed the conversation back to me and stated, "you probably get it from them when you do the... the end of rotation feedback. You know they might tell you something, what it was like and you know, it would be nice to get that; maybe on minutes of the meeting or something?"

"Get something back, you know, especially if it's positive feedback." <laughs>

I sensed this was important to Camilla, so I asked her, "Why is that important?"

"Because we don't hear anything really ever. You know there is no rewards in this job. Really it would be nice to get some words, I think."

I acknowledged her viewpoint by saying, "I think you may be right."

I wanted to confirm that I understood correctly. Did Camilla believe that time was the important resource she could have to support new grads? "Yeah. Absolutely."

When she talked about providing support, Camilla suggested, "You know, it's often just doing …simple things… If they have to take a central line out, they've never taken a central line out. To have that time to show them where they find the …policy from, do the procedure, like explain the whole thing. It's a lengthy thing to do if you … look at the policy, explain the procedure then do the procedure together and then have some sort of …feedback at the end of it….'you did this great, next time you remember to do that, well

done.' And that can be an hour thing to do. And just to have the time to do things like that. Or just generally …sit down and have a look at the patient. 'Tell me about your patient what kind of patient do you have today?' And then maybe do a head to toe assessment with that …patient. I think that would be so valuable. You would learn so much as a new grad if someone did take the time and go through that with them."

We then spoke of why Camilla believed she didn't have the time. She laughed and said, "Because unless it's the first couple of days, and you're buddying the new grad, you have your own patient workload."

"As a senior nurse you never, hardly ever, have the really quiet patient. You always have the sick patient of the unit, just because of the patient acuity and the skill mix. You just always end up with someone quite sick. And there is just so many things to do. If you want to look after your patient properly and do all the things that you're supposed to do during the day and look after the patient like would be your own family member, to do that detail, then how on earth do you find a couple of hours during that shift to teach the new grad? I just don't know. I just don't know."

As we talked, Camilla revealed other resources available, "Well it depends on what day of the week and what time of the week it is…. during the weekdays, educators, NUMS you can ask people to come and help you. But they might have other things to do too."

Asking if other people help, Camilla stated, "Absolutely. Yeah, I think there is quite good teamwork, and there is a number of people who will always jump in, and they just see, and they realise what's going on, and they jump in. And I've never ever got a problem saying to someone that, 'I'm too busy. Could you walk over there and have a look at what's going on because I haven't been there for hours and I don't know if she needs something, or he."

I asked Camilla what might she do if she had the power to change things? Camilla laughed and said, "get all second rotation rather than first rotation – I think that would be ideal. And have maybe a longer period when they start in ICU with a buddy without a patient workload. And we try to do that, you know, if it is possible. We see how they go and give them more buddy days if we can. But it would be nice if they got like a couple of weeks buddying rather than having a patient on the next week."

"It would be nice to have more time to go through things…. There's probably as many ways of preceptoring and buddying a new grad as there are nurses. …Would be a good idea to give some sort of guidelines on how to preceptor or buddy a new grad. Like, I try not to intervene too much. I just try to be available and stop if things are going wrong. And just be an available resource hovering behind their back all the time. And just let them try to make decisions, try to learn, do things explain. And I'm just the walking, following, helper. You know? I don't know if that's the right way to do it. …. Sometimes I feel some nurses when they are buddying with a new grad, the new grad just ends up doing little things or just watching. I don't think that's the way to learn, to be honest, in ICU. You need to be hands on."

"But more time, more resources and less acute patients, please. There are things that you can't change, you know. But if they had a little bit better basic skills when they came here, that would be nice. Or should it be compulsory that they have to have an acute area rotations during their Uni? If they want to come to ICU as a new grad? Could that be something that we request, that we only get new grads who've had, let's say, an ICU rotation previously."

Camilla questioned the process of recruitment, saying, "I don't know how you do the selection process. I don't know how they select the new grads to the rotations. I don't know. I don't know what the process is."

Camilla explained the difference experience would make, "Well they would already have basic skills and understanding of what kind of environment ICU is. I think some of them are absolutely stunned. They're like deer in the headlights when they come here. They – it's – it's confronting. If you've never been to ICU, you come here, you hear all the alarms, you see all the machines, and you go like, 'Oh My God. What am I supposed to do? Where do I start? I don't know what that machine does. I don't know anything about this?' It's – it's overwhelming. I think some of them a just paralysed with fear and take forever to learn things."

"It's also like emotional things like patients dying, and they might never ever have seen anyone that sick really. Um, dealing with the relatives who are extremely stressed because their loved one is, you know, in intensive care unit. You know, just things like that. You know, no life experience. They're often young. Not all new grads are young. But they're

often 20 something. Yeah, it's full on, working in ICU, especially in this ICU. It's very busy."

**Kylie's Narrative Account**

When arranging a time, date and place, with Kylie, to record our conversation, I was aware that she seemed mindful of my schedule. Kylie had asked me, "what would be good for you?" I reiterated that she was doing me a favour and that I could meet her at a time and location of her choosing. She chose a time and date; arranging to meet in our workplace, before the start of her rostered shift.

Unfortunately, Kylie needed to reschedule our appointment for medical reasons. A second time and date was arranged to coincide with another one of Kylie's rostered shifts in the ICU. We met in a location close to the ICU, in a private room with a locked, closed door. The room had a desk and chair and a lounge. I let Kylie enter first and asked if the space was suitable. Kylie sat down first, at one end of the lounge. I chose to sit at the opposite end. I showed Kylie the recorder that I planned to use to record our conversation, and asked permission and gained her consent to record our conversation. I then reiterated the purpose and background of the research project and asked if Kylie if she had any questions or concerns. I reminded her that she would receive a copy of the Tentative Narrative Account and have opportunity to make amendments. Kylie chose not to choose her own alias; she then signed the research consent.

I started the conversation by thanking Kylie for spending time with me. I then asked Kylie to describe the gritty, day to day reality of being a senior nurse working with New Graduate Nurses in the Intensive Care Unit.

Kylie responded, "I think there's the pressure on - I feel the pressure on myself. I feel like as a - as a team, there's pressure on the other nurses that are there, which leads to sometimes not as good care for the patient. But … also the patient's family. You're taken away from that, helping with the family and supporting the family. So, your whole role is sort of affected, and you're not able to do it to the best of your ability. And especially also with junior staff, very sick patients and then you need to find overtime. You can … feel the guilt of not being able to get <laughs> staff on the next shift. Then while you're looking for that then yeah, I feel guilty that I'm not being able to help the new grad nurse or the junior nurse, and then I feel bad for the patient, and it sort of <laughs> becomes a roll-on effect. Then if something is to go wrong that I haven't picked up, then it sort of comes back on me.

"Yeah, I feel bad for the new grad nurse. Especially if it's the first rotation and it might affect the rest of their nursing career. It's a pivotal thing, your first experience when you come out, whether you enjoy it. Um, but also everyone else around them, do you know I mean, it puts pressure, added pressure on them. Cytotoxic medications, you know, certain things that they can't do. Like, the other evening I had to do like five cytotoxic medications, and it took up a good two hours. By the time I went around, and I didn't get dinner till like quarter to 10 'Cause I was the only team leader that was on."

I repeated Kylie's words back to her as a question, "Not getting dinner?"

"No, not till quarter to 10. And then it was me, and Lucy was the only team leader down the other end, and we were both alternate running for arrests. She went to two arrests, so then when she was gone, I was helping across the floor – and I had junior staff. It was really very unsafe. I didn't feel comfortable. And then I went home that night, and you can't switch off. You think, 'oh god, is there something that didn't get done?'"

Kylie asked me, "you know what I mean?"

I agreed that I did know. I started to ask Kylie whether the situation she just described, regarding availability of senior staff happened frequently, when she interjected, "That's the first time that's been that bad. But there was only another senior nurse rostered with me, but then he was off sick. So, if he had been there, then I would've had at least someone to bump off."

I was interested in Kylie's description of her experience when she went home and couldn't 'switch off,' so I asked her how she felt she went home.

Kylie explained, "I find it difficult to get to sleep, you know. You worry about things and …" Kylie paused, and we were both quiet for a minute.

To encourage flow in the conversation, I thought back to back to Kylie's suggestion of her being responsible if something goes wrong. I asked her if she remembered any experiences when errors had happened.

"Um, not off the top of my head. But <sighs> you're busy off doing other things. You don't get around to see if there could be errors there that you haven't been able to pick up on. Not being able to get around to them as an in-charge. To get around and know what's

going on with every patient too can be a bit of a problem if you've got really busy – sick patients and junior staff. Then I'm fighting for all overtime for the night shift. You know, I don't get to go and then it's like 8 o'clock at night before I've actually got a grasp of what's actually going on the floor <laughs>."

I was interested in how Kylie defined a busy shift. I asked her, "what a busy shift like that might mean and what kind of patients do you have?"

Kylie laughed and asked me directly, "Do you know what I mean?"

I agreed, "yeah, I do."

Kylie continued, "And I don't feel that is supported by the management. They just go home and say, "Yeah, well, you find the staff," and um, when it's known during - like, in the morning- how bad the staff is, and then you have to wait to look for overtime until 5 o'clock, you're waiting for the agency which almost never turn up. I've got in trouble for ordering overtime before The NUM's come back at 5 and said there's no - because you know what I mean, like – you just get yourself into strife. I just feel they just wash their hands and say <laughs> 'see you later,' or they apologise and say, 'oh sorry, it's going to be bad.' Like, that shift, that one shift, a few weeks ago was so bad. If something went wrong, you know? It was terrible."

"Even for Lucy down the end, like, it's wrong. It's so bad. And I didn't put in an incident report because I was over it by the time I left. I did speak to the manager about it, but really".

Reflecting on the experiences Kylie was describing, I asked, "it almost sounds as like you're doing a few jobs all at once. You're organizing staff, but you're trying to manage the floor, but you're also the arrest team?"

Kylie laughed and said, "Yeah. Just, yeah."

I started to ask Kylie another question, but she interrupted, "And so really. I say I feel sorry for myself because it puts pressure on myself. But then, it puts pressure on the new grad, puts pressure on new staff; if there's a dying patient and you're not able to um, you know, nurture the family. Then that can have ramifications on how they deal with their grief later on. You know, if there's a post-transplant that's in theatre and you haven't been

able to get out to see the patient's family, and they're all there stressing, and then they come in, and they're all angst up. Sometimes you forget. Try not to, but, you know, when you're super busy like that, so it affects everything really."

To this point in our conversation, Kylie had seemed to be discussing her role as a team leader. I wondered about the other roles Kylie undertook as a senior nurse in the intensive care unit. I asked her, "so what happens when you're out on the floor, maybe in your preceptoring role? What's it like for you working with new grads when you're in that role?"

Kylie clarified, "So, in the buddy?"

I agreed but suggested, "or working just alongside them?"

Kylie stated, "So I don't – I don't mind it at all when I'm buddying with them, and we're working together. Sometimes, um, I don't really mind it when we're working next-door as long as you don't get a busy patient."

"But, you know, someday is like any other day when your minds not on it. <Laughs> You might, but um, I don't really mind in that - in that situation. But I just think when you're in charge, and you've got a whole lot of junior staff on, it makes it very difficult. And I don't think it's looked at, you know. I don't know, it's not the rostering thing. I admire the people that do the rosters, but sometimes it's just bad."

"Yeah. And there's different new grads. There's ones that are quite capable from earlier on and then, there are others that struggle and sometimes those ones that struggle get a bit of trouble from other staff members. That doesn't do much good for their confidence. They're not bullied, but they're um, you know, no-one wants to work with them or whatever - roll their eyes when you -<laughs>."

I asked Kylie, "Why do you think that might be?"

"Probably because they're stressed and they're – and they're frustrated as well. I think there's a lot of frustration around nurses because it's a busy enough, stressful job as it is, to have people that are just thrown in and don't know. And, it's no fault of their own, but I think it's - I don't think it's a good idea putting first rotation new grads in ICU."

I responded, "Yeah. Why? Why is that?"

"Because they haven't even got sort of the basics – I know when I was a new grad even like priming a line or shaking up an antibiotic, things like that was anxiety enough <laughs>. No time management. And, then they're put with this patient that's got like five or six infusions going at once and, you know BiPAP or ventilators, instead of just getting that basic down to patient care or the basics, time management. All that first, especially if they haven't worked in a nursing home or anything, while they're - I just think it's way too much overload."

"And look, I was a new grad, and I ended up staying on after my new grad. But I would've just shit myself coming <literally>. It would've just – I don't know. They're very brave."

When I asked Kylie if she had worked in this ICU as a new grad, she confirmed that she had, "on my third rotation."

I wondered out loud, "so was it different back then when you did it?"

Kylie explained, "Um, well, we didn't come on the first rotation. I did surgical, and then I came, and that was frightening enough. <laughs> But there were a lot of really good staff that I felt really supported when I was a new grad."

I asked Kylie, "do you think over time the acuity has changed at all?"

She answered, "Yes. The patients are a lot sicker now. And we have heaps more specialized equipment and that now. We can three or four ECMOs at once. And patients that normally would've just died on the table, now they bring them out and - Which is a good thing but, yeah, patients are a lot sicker. If I had to work full time I couldn't do it <laughs>, It would be too stressful."

I wondered if Kylie's experience as a new grad in this ICU influenced her now?

"Yeah. Look, I try my hardest to be nicer, to be supportive and that and just feel really bad when I'm put in a situation where I can't do, you know, I don't - I'm not doing the best for the new grad. And then it puts a lot of pressure on me if I've got junior staff as well as the new grad and if something goes wrong, it's going to come back and bite me."

I asked Kylie, "has that happened or - "

Kylie laughed and said, "it hasn't happened yet touch wood."

I responded to Kylie by repeating her own words, as a question, "we do get a lot of other junior staff?"

Kylie said, "Yeah. Thank goodness it hasn't happened yet."

At this point in the conversation, I wondered what Kylie would do, if she "had the ability to change anything? What would 'you' do differently being a senior and a team leader out the floor with New Grads?"

Kylie responded, "Ideally there wouldn't – there would not be more than one on the floor at a time. There would have to be at least another couple of senior staff that you could, you know, fall back on. Ideally not have first rotation. I don't know why the hospital does that really? Like, come here first and then go to palliative care. Like, what's the rationale behind that?"

Kylie laughed when I said, "I'm not sure."

She continued, "It would be nice if they were buddied with a nurse for longer, I think if we had the ability. Do you know? And have – I would like – it's hard because of the rostering, but the same buddy and have a longer buddy period; where they're actually together."

Interested in Kylie's suggestion, I asked, "But you, you are one of the people that buddies … the new nurses?"

Kylie agreed, "Yeah."

I wasn't sure I understood Kylie's perceptive, so I posed the question, "Is that something that you would like to do, spend a really long period working with them?"

Kylie laughed and said, "So yes."

She laughed again, "Yes and no. Um, I don't know."

Kylie then posed a question to me, "It's a week isn't it, they get? Is it a week?"

As different rotations get different supernumerary, and buddying periods, I suggested, "it's not a long time."

Kylie kept talking, "Yeah, a week. I reckon they need <sigh> though it might be punishing. I think they need a whole roster buddied because sometimes they're not given the advantage of having a difficult patient. Everyone then, when they've only had that one week, everyone will give them an extubated patient. So, they never really get in that buddy period, a post-op. Do you know? I think they need quite a few post-ops working with someone to get the gist. And it is – as allocating, I have done it myself where you want to try less pressure on yourself; giving them an easier patient, extubated patient. But if you've got the ability and it's quiet, I would give them a post-op with someone I know could watch out for them… but yeah, I think that's a problem that happens."

"They're only buddied for one week, and then they're given all the easy patients, and then … they're here for a couple of months, and they've hardly had any post-ops, and then it's - then you're stuck. They're expected to take them, and you're really busy with other things, and you don't really have the time to spend with them. I don't know."

Kylie looked directly at me and asked, "Do you agree?" She laughed.

I responded, "I've got some thoughts on the matter. Talk to you about it after." This made Kylie laugh.

Interested in Kylie's comment regarding her experience allocating patients to New Grads, I asked, "If you are a team leader and you have new grads on the floor, and you said before, we've got VADs and dialysis and ECMO, and we're a transplant unit as well. How do you go about allocating new grads and junior staff to the kind of patients we have?"

Kylie sighed, "I guess it depends on what their skill mix is there. Like, obviously, I can't give them a VAD. We can't have dialysis. Um, and sometimes they have to have a sick transplant with all the immunosuppression and, you have to go and do their – all their cytotoxic stuff. And the medications in itself is a lot for me sometimes. So, the medications – medication time, sometimes that can be really off-putting for the - really hard for them to -. It's probably not a nice thing to give them, but them sometimes there's no choice."

"And then especially if we've got dialysis and there's a lot of junior staff that aren't dialysis accredited. You know, we had like four in the unit… a month or so ago and 'oh I can't take dialysis,' <laughs> 'I can't do this. I can't do that.' And it's not their fault, but you know. And then you get frigging agency staff that are high dependency. They can't do anything either, so then you've got to – and there are certain ones that we get that you have to watch like a hawk because they make errors."

I wanted to share with Kylie, my experience of working in the unit; explaining that despite working in this ICU for many years, I felt that I was still learning the subtleties of our patients. I laughed and admitted I was still learning how to talk to irate surgeons and physicians.

Kylie responded, "Oh, that's the other thing for some <laughs> like, I haven't had a problem with anyone, but I've had junior staff tell me that they've been, or even junior team leaders, tell me they've been told off by certain [surgeons]. Which is really not very nice. If they did it to me, I'd just give it back."

Referring to the new grads, I commented, "I wonder, they're not only learning technical skills, they're learning professional relationship skills …"

"Yeah. And there's a big problem with how all the new doctors that come through, no one introduces themselves either. They don't even introduce themselves to the team leader, so it must be frustrating for the junior nurse as well, I imagined. I don't know."

Changing the direction of the conversation, I commented to Kylie, "There's something you said before, and I wanted to ask you about it. Um, oh, that was it. You said you really rely on the new nurse to ask when something's going wrong?"

Kylie responded, "Mm. Yeah. And most – the majority of them do, but there are some that don't."

I asked Kylie why it was important to her, "that they ask the question if they're unsure?"

Kylie explained, "Because <sighs> for one, that anxiety of, 'oh my god, is something going to come back and bite me?' Do you know what I mean? As a lead, 'Cause I'm sort of in charge, responsible and supposed to know what's going on. But to know that they're actually thinking about what they're doing, and not just doing things that are sort of –

They've been shown how to do it and are just doing it but not actually understanding why they're doing the things they're doing. Processing."

I queried, "So what happens then if they don't ask questions?"

Kylie laughed and said, "Oh like it's not so bad when it's not busy because we go around and check on them. But when it's really busy then there's the capacity for something to go wrong – And then I'd feel terrible."

I share with Kylie my experience, "I look around some days, and I have to admit that I'm terribly worried. I don't know where to go first. I almost have to triage it in my head – 'who's got the sickest patient and where should I invest my time?'"

Kylie responded, "And you know, they might be scared themselves, like petrified, and they don't want to look like they don't know what they're doing. And I guess, they might think, 'Oh, that person's 'oh no,' she might be a bit scary. I don't want to go ask her a question.' I think that I'm quite approachable, hopefully."

I shared with Kylie an experience I had had with a new grad. "I was out on the floor doing something, and I heard my name being called. I looked around and saw a very low MAP. The poor young nurse was frozen. They, at least they, recognized that was a problem, which was good, but beyond that, they didn't know how to react or what to do. I was relieved, I guess, that they noticed a low MAP, but they had no idea what to do next."

Kylie explained a situation she had experienced, "So, inotrope bags running and they're not having the foresight to hang another bag, and you have like no blood pressure while they're having difficulty priming and doing a new bag."

When I asked, what happened to the patient, Kylie said, "Hypotensive, really hypotensive, had to have Aramine. And another thing, an LVAD patient had a drain put in, and I was making my way around; trying to get – to know what to do. Anyway, the patient was hypotensive. I said, 'Well, make sure we check the BP – the arterial line up there,' but it wasn't a good trace. I said, 'Let's do a Doppler thing, and then I'll come back, 'but of course while I was away, they were still trying to find the pulse, the MAP. The cardiothoracic surgeon went off their tree. 'What's going on here? Why hasn't the patient had a blood pressure,' rah-rah-rah, like really a bit inappropriate. And I love the cardiothoracic surgeon, but it was just that they were like yelling and there was a lot of

hoo-ha-ing and then 'Cause the drain had only just gone in, and they were worried that they had perforated something, so that was a bit stressful too."

"I shove them down when they happen because you sort of – you very much just black them out. Suppress them. <laughs> But look, I'm not perfect myself, and people here do things sometimes."

When I asked Kylie how long she had worked here, she suggested that it had been close to two decades. But she had worked in other areas during that time. Despite not working full time hours, Kylie felt that she was, "On the pulse. But always it's an environment - every time I come here I learn something more, do you know what I mean? Sorry about boasting about it."

I laughed and asked Kylie, "What keeps you here?"

Kylie said, "To tell you the truth, I really love it. I do. I really love it but some days like when I have shifts like that when you just don't feel supported – when you are on with a good crew it's lovely and it's rewarding most of the time. But sometimes it's a very thankless job."

I posed a question to Kylie, "Do you think there's any positives working with new grads that start off here?"

Kylie responded, "There is because sometimes it keeps your brain going with the questions they ask you. Makes you think about why you're doing things or that you don't. And then sometimes they might ask me something I don't actually know, so then I have to go look it up. So, in that way it's beneficial. It's just be nicer if it was – if they didn't come here on the first rotation. For them as well."

"It's stressful on them, and it's stressful on us and stressful on everyone. Especially if family work out that they're a new grad. Some family can be very funny about that, and that makes things <sighs> then they get all nervous."

"Some of them might not start out good, but then they're nurtured…I was nurtured, and I stayed. It can be a positive, a very positive experience hopefully."

Kylie's words reminded me of something she had said earlier, and I was keen to know more, "I hope I'm not putting words in your mouth, but you said sometimes they're really stressed?"

Kylie clarified, "The new grads?" I nodded.

"Yeah <sighs> can see that they're stressed and especially at the end of their shift. That's why I ask everyone... if they're all right."

"And then if it's really busy and I haven't been able to get around and help them, then that makes me feel bad. Then I feel guilty."

"Like, I'd only use to be able to go home, and you have a drink and wind down <, but now I'm just too tired. I just want to go to sleep 'Cause I know I've got to get up in the morning. I go to bed and I, just like – my head just goes round and round and round while I'm driving home and I go, 'Oh shivers, did I do that?' Have to quickly ring work <laughs>."

I asked Kylie, "Do you call work sometimes?"

She replied, "I do, I do, and say, 'oops, I don't think I did that.'

**Sarah's Narrative Account**

Sarah and I arranged to meet before her afternoon shift. I had been given access to the ICU registrar's office; a private space with a locked door that is located close to the ICU. After I reiterated the aim of the research, we signed the research consent forms. I made sure Sarah was happy to have our conversation recorded, and I turned on the recording device.

I thanked Sarah for spending time chatting with me and started the conversation by recapping her role in the ICU. Sarah is a senior registered nurse in the ICU who is nominated by the nurse unit manager (NUM) to be in charge of shifts. She also preceptors new members of ICU nursing staff in addition to being allocated to patient care. I was interested in, "what it was like for you out there, that day to day reality, I guess?"

Sarah responded, "I think usually when you start with a new grad, on their first couple of days it's kind of fine because they're – it's almost like having a third-year student ...... if it's their first rotation and they haven't done another rotation anywhere else .... The first day you'll just talk about things, and the next day you'll try and give them more responsibility, and I try to kind of sit back and encourage them to make their own decisions and everything. And that's all fine over their first week or however long they're buddied but almost as soon then as they have their own patient and you have your own patient it kind of changes. It becomes a lot more intense or a lot more stressful I think, probably for both of you because you can't watch what they're doing and then – and you don't really know what they're doing and usually even if you have a kind of quiet patient you're still busy with your own patient and they're a bit lost, I suppose."

"You feel under pressure in the first week to give them as much preparation as possible, so they'll be able to take their own patient the following week, but obviously, you can't give them enough, and you can't cover everything that's going to happen and a lot of what you tell them they've forgotten again anyway, so you feel like you're telling them over and over and over and then they've got their own patient."

"Sometimes it feels quite dangerous really because you kind of feel like they don't really know what they're – like, they don't really have a clue."

Sarah explained the trajectory of allocating patients to new grads in the ICU, "Okay, they're getting on okay. They've got a couple of discharges and then suddenly you're like, well it would be great if they took a tube, but they're taking a tube practically unsupervised, well, half supervised kind of if you have the time, and then doing things that – or not doing things they should be doing but you just don't have time to properly – I don't know… And you hear things back from other nurses … They're like, "By the way, this happened," and … you just feel guilty that it happened 'cause they're upset, the new grad's upset, you're upset. I'm wondering is this my responsibility that the new grad just did that?"

I was interested in knowing more about what Sarah meant when she said, 'you hear something happened,' and asked her if she could remember and give me an example?

"Well, one new grad on a couple of occasions let the CVC disconnect from - without clamping it, so obviously risk of air embolism but it went the other day where it is - there was blood came out rather than air going in. New grad's upset because she got blood on the sheets, but it's, like that's actually not the problem here at all, but then new grad goes off crying not because anyone gave out to her, it was just because she was upset and obviously, she's upset."

"I remember, you know, my first week in ICU I wasn't a new grad, but I wasn't that long in either. I was still in my first year of nursing, and I was so nervous I pulled the trolley, and the whole drawer came out that had all the vacutainers and everything, and they all went all over the floor, and there was this big huge bang and whatever, and you'd be just mortified, you know, or if a patient dropped their blood pressure suddenly you blame yourself, whereas now you think that - obviously you know what the things are going on in ICU and you don't panic about them the way you did when you were a new grad, but when I was a new grad, I don't know, I blamed everything that went wrong with my patient on myself."

I asked Sarah where she had worked as a new grad nurse, and it was explained that she had worked in another country. She was technically a new grad, but it was called something different and the system worked differently. At this point in the conversation, Sarah took me back to the previous topic we had been discussing.

"So anyway, this girl goes off crying and I can't – I don't want to then turn around and be, and say this happened, you know, in a stern sort of way or like reaffirm her mistakes. I just kind of let it lie for a day and then went and said … 'I think you need to look at this, and do you understand the importance of this?' Because, the first time it happened I thought okay, good, she would've learned her lesson now and that's not going to happen again, but then it happened again and then it's just like, oh my god, how – you know? That's so scary to me... when you're new, I think it's just so easy to make mistakes."

I was interested in what was happening to Sarah at the time the incident occurred, wondering if she had a patient of her own?

Sarah wasn't sure where she was, "I had a patient, or I was relieving for breaks for someone else, or I was on my lunch or I was gone somewhere completely different. It just happened."

Sarah then explained that you can be allocated to swap for breaks with a new grad. "You go over, and you say, 'Is everything ok? Do you need anything?' And they just say, 'No,' and then you have a quick look and you see what they're doing, and you might notice something that they need to do, so you might remind them to do it, and they'll say, 'okay, okay, yeah, yeah, yeah, yeah. Yeah ok.' What can you do?"

"It's very hard if they don't want to ask a question or if they do and you're busy with another patient."

As I listened to Sarah say she might be busy with another patient, when she was supporting a new grad, I wondered if she could, "describe a normal sort of patient for you?"

"Oh, you could have anybody … but you wouldn't obviously be given an ECMO patient or anything, but you could be given anything else really. They try not to give out like a really busy patient, but often times it doesn't matter or they'll give you someone maybe who's getting discharged, so you could be taking out drains, taking out lines, handing over to the ward, doing paperwork, getting that person all ready to do, just actually discharging them and physically being off the floor, so then the new grad is just left with their patient."

I probed Sarah, asking how she managed that? Sarah laughed and said, "Stressfully. I don't know. I don't know how you manage it. Just try the best you can. Just juggle I … I try to keep as much of an eye as I can on them and then to be like, 'okay, you need to do this, this, this, this, this and let me know if you have any trouble with any of it.' I suppose we have a good team in that there are other nurses that will – you know – they can ask, and they know they can ask anyone. And I always say that as well to new grads, you know, 'just ask.' Like, you try and reaffirm it like, 'ask questions, ask anyone. It doesn't matter. Just ask the question rather than doing something dangerous.' So yeah, I suppose they …. They just ask other people."

I wondered what might happen if the new grads don't ask the questions. Whilst I was asking this question, Sarah, anticipating what I was asking, spoke over me and finished the question, saying 'if they don't find me?"

She answered the question, "I don't know, because you worry that something really big could happen, but at the same time, I can't remember anything really big every happening." Sarah reflected back to the story she had told me earlier, "You know, like I mean if that patient had got an air embolism, something big would've happened, but they didn't…. I've never seen anything huge …. well, like a patient dying or something because of it but see; you don't know then. You don't know about line sepsis and all of these things… I've seen drains come disconnected and things like that. I've seen self-extubations, a couple of them, with new or junior staff…"

At this point in the conversation wondered if the ramifications of mistakes were the patient potentially at risk of dying the impact this might have on her. I asked Sarah, "Do you find yourself worrying a bit when you're out on the floor working alongside or with new grads?"

"I find when I was starting to team lead I used to worry so much about the new grads. Because I used to feel like that they were just so – under so much pressure because suddenly when you're team leading you're like kind of – you've got an insight into everyone's work, so you know exactly how the new grads are feeling because they're coming to you with their problems or whatever, so I used to feel really burdened by trying to support them. So, there could be three new grads on a shift, and I'd be trying to help – or two new grads on a shift."

At this point, Sarah asked me a direct question, "They'd never be three new grads on a shift really, would there?"

Sarah continues, "I'd be trying to help them, teach them, mind them so that they're not going home upset, you know, debrief with them if there's something happened, and then I'd go home, and I'd be like, oh my god. I just feel like I spend all my time on new grads, and your sick patients – as a team leader, I felt that I wasn't even getting to see, because I was spending so much time with probably the less acute patients but because they had new grads and then – and then I felt guilty that I wasn't supporting the senior nurses who had sicker patients. But I think I've gotten over that a bit or maybe …maybe I just…. I don't know how that doesn't feel like it's much of an issue anymore."

"I know that in that time……there was one particular new grad who was just very – you know, she told me herself that she went home and cried most evenings after work and all this sort of stuff, so – so I knew that she was under a lot of pressure. And she told me that her partner had told her that she had changed since she started in ICU because she spends all her time studying when she's not at work and like that, she comes home crying every day, and she's blamed everything on herself, never left work on time, and that was at the same time that I was a new team leader, so I think yeah, maybe that didn't help either."

Immediately I asked Sarah, "how does that make you feel, hearing that?"

"Oh just guilty. I felt like I could put myself in her shoes because I'd kind of been there, but at the same time, when I was a new grad or when I was first in ICU, I always felt very supported really. I didn't ever really feel that I was on my own, whereas I think some of them probably sometimes do. You know, they're working evening shifts with sick post-ops. Post-ops bleed, and they do funny, and there's no educators around, and the staff are more skeleton and out could have all sorts going on…. Where I worked probably wasn't the same acuity as here anyway."

I wondered how Sarah personally defined the acuity in ICU. She responded, "Huge, like well on the cardiothoracic side we could have long termers. What happens is we have patients who are really, really, really sick, maybe have V-A ECMO, on multiple, multiple inotropes and as soon as their ECMO is out they go down the line to being a less acute patient and then suddenly it's maybe not new grads straight away but new starters and then new grads looking after them, and they're still hectically crazy patients. Like, you're

running for your whole eight hours, even as a senior nurse. You could be so busy with that patient because even if they might not have ECMO in, they're still very sick. Now they're really deconditioned they're probably awake as well now, so they are more demanding themselves. Their family are demanding, and the new grad who has very little experience is being asked these questions that they really don't know the answers to and expected to do things that they really might not have the expertise to do. And sometimes we have so many other sick patients on the unit that the new grad doesn't really have anyone to turn to because the senior nurses are too busy with the ECMOs or whatever, so I find that the juniors kind of have to look after one another sometimes…Someone who started six months ago is looking after the new grad because the senior nurses are …and the team leader sometimes doesn't know what's going on with the new grad or that junior nurse because she's too busy trying to help the senior nurses with the fresh ECMO that's bleeding and, you know, you often as a new-in charge find yourself being the – your actually the resource nurse, so if we don't have enough staff to have two nurses on the ECMO, you are the extra staff on the ECMO, and you cover all the breaks, and you're trying to support the new grads."

I acknowledged what Sarah was saying by repeating, "spare staff." She continued, "We don't have any resource nurses, yeah. And you really have to fight sometimes to have two nurses on fresh ECMO, and if you have those two nurses then things are unbelievably better, but if you don't have them, you know, the new grads a lot of the time they can just sing…. You do really try to get around to them, but I don't know. But like, most of them do very well at the same time. It's just kind of like a bit of an element of an accident waiting to happen."

Listening to Sarah tell her story, I reciprocally started explaining how I felt sometimes when I start my shift as the CNE and during handover realise that there are patient's with VADS, dialysis, and IABPs. Sarah quickly responded, "Well, sometimes we've had to send new grads to the other ICU because we don't have anything we can give them because our acuity's too high."

I questioned how Sarah managed that if she was in charge? How did she allocate?

"You just try to – if, say, on the other hand, if I come in and it's reasonably quiet, I will try and give the new grad something challenging so that I can support them and try and

teach them something. But if it's busy you just allocate for yourself, and you put the new grad on probably the easiest patient and also beside someone who can give them some support – or you tell them, 'you ask this person if you need help' and you tell that person, 'you need to mind the new grad 'cause I'm too busy' and that's kind of the way I do it."

"I just allocate as best I can. And you know, make sure that if you do have a resource, you put someone as resource who's is willing to help new grads or you know, you don't give the resource position to someone who isn't doing to do anything for the night, 'cause you need that person to be like your resource as well as the whole floor, if that makes sense."

I wondered what Sarah meant when she said, and she gives a less busy, less acute patient to the new grad? She explained, "Someone who's waiting for the ward, extubated, preferably not on, not bleeding or not on anything crazy or like a simple post-op. You know, if you can get them extubated early in the night and then the new grad can just kind of deal with whatever's going on. You want to give them as little as possible to deal with."

Listening to Sarah explain, I was interested if this was always achievable. "Sometimes we only have really sick patients to give them, and you can't put them – you know, your least sick patient might be a person in the side room, but that person needs to be able to relieve dialysis or needs to be VAD accredited … We've had that as well, a lot of VAD's that the patient themselves aren't sick but the new grad can't take any VADs, so you can't give them a VAD at all….they can't swap breaks with VADs, and they can't swap breaks with dialysis, so sometimes you'd give the patient – a new grad a patient and you just say, 'you just go on a break whenever you want, and I'll cover your break', because the new grad is kind of not useful enough to you in a break swapping."

I asked Sarah, "so, what does that mean for you as team leader then if you're swapping for the breaks?" I listened as she laughed and responded, "ah, it means you don't really get a break… I definitely think …if you're in charge you take nothing like your break, your allocated break, like the break you're supposed to take, and you …just forget completely. If it's night time you can forget about having a dinner and you forget about everything. You might get a break at 5 o'clock in the morning or, you know, really late once everyone else is back and once everything's kind of settled, but that's the time

usually that there's some sort of an admission or something ridiculous. But it's not always like that either. It's just sometimes.

I asked Sarah "how do you feel at the end of shift if you're not having breaks?"

"Sometimes exhausted. Sometimes really grateful…. a couple of weeks ago I had to take a patient as an in-charge. So, I was in-charge, but I had to take a patient because we were too tight across the floor and because …. The only other person that could've doubled say, was a new grad, but I couldn't let her double because it would've been too much for her but between two new grads and a new starter they just sort of just managed their stuff because I was too busy. And they did so well, and I just came back up and kept checking on things, and they were doing gases, and they were doing…. And you know, you go home and you're proud of them like 'cause you're just like, oh they're amazing 'cause – and you just tell them, you know, this is what has to happen because you only have one patient in ICU and sometimes you have two patients but very rarely, some people become very tunnel visioned and they can't see what's going on outside of – so you kind of just have to say to them, you know, 'I need you to pitch in now tonight and just get all this stuff done and we'll get through it together', kind of thing. So then sometimes you're just really happy like for them. It's like a win because when you see a new grad developing, you're really proud of them, so it's nice."

"And some of the new grads are brilliant, and they ask you a question, and they just bowl you off your feet 'cause they're so far ahead of where you think that they should be or – that's really good."

When I asked Sarah if she ever found herself learning from the new grads via some of the questions they ask, she responded, "Well they challenge your thinking, I suppose, so you have to kind of think about why they asked that question or whatever…. Yeah, what way are you teaching them, yeah. I think definitely, I like teaching new grads and teaching or doing skills or whatever you're doing, new starters or new grads. You have to kind of brush up on things yourself because otherwise what are you telling them, you know?" Sarah laughed and said, "you have to tell them the truth!" She laughed again, "As opposed to lies."

Listening to Sarah, I wondered how she taught on a busy shift if she wasn't having break, and she was 'brushing up on her own knowledge.' "I don't know. I suppose I try and do

as much of that when you're quiet, as you can. Sometimes you just don't have time to – or you just like, maybe, send someone else in their direction. If you see someone else that's not that busy, you could just say, 'can you just do over there and explain that stuff because I don't have time?' If you're a team leader – like, when I'm on the floor myself I usually can find the time you know. I'll - if I have my own patient, well, depending on what the patient is, obviously, but usually, I can find the time to explain something to them if they ask me a question.

When I asked Sarah how she 'found the time,' she told me, "I don't know, abandon your own patient for a while?"

"Just abandon your own patient for a while. I know I can get things done quite quickly if I put my mind to it. I know that if someone else can just keep an eye on my patient for 10 minutes, I can get back and do everything else. Whereas the new grads, sometimes it takes them half an hour to do a blood gas. So, I find that they're quite slow. Or you might say to them, 'are you going to do that CVAD dressing?' and come back an hour later and it's still not done. Whereas If it's my work I know I can - how quick I can get things done. So, it's easier to balance your time.

I wasn't sure at this point if I had understood Sarah correctly, so I queried what she had told me and asked her to clarify, "it sounds like either you're making time or stepping away from your own patient to give them time, to…."

Sarah agreed and said, "I think that's kind of part of your job, isn't it?"

"Stepping away from your own patient but someone else, I suppose can keep half an eye on your patient."

I asked Sarah if she meant that if someone needed help, the team became involved and patients and staff shuffled around.

"I think that's – I think we have to. Like we always work as a team to try and incorporate the new grads because they aren't stand-alone members of staff on their own. They can't be because they just don't have the experience and it's just not fair to – and that's how they suffer when we're really busy because – because the team then that is trying to support them kind of falls apart a bit because we're too busy. So, then the new grad sort of has to get on with it. Then I think the poor doctors get a bit of the brunt of it as well

'cause if the new grad doesn't have anyone else to ask and they have the sense to ask the question, they'll go to the doctor. But it could be something that some of us might never ask a doctor, and the poor doctor's a bit flustered with all these silly questions. But that new grad is better than the one that doesn't ask the question."

Sarah explained that the new grads "can't put things together, you know, 'Cause that's just experience really – so they don't even know there's something wrong sometimes, you know, or they – or they can't problem solve things on their own. She continued, "they still don't know the right question to ask or the right pathways to try and figure it out themselves."

Again, I wanted to clarify that I understood, and queried, "you have to almost learn how to ask questions?"

"Yeah. You have to learn because you might not realise the implications of some things until you have more experience."

I asked Sarah if she could give me an example of what she meant.

"Things like dropping your own outputs anyway or, you know, between high lactate to high CVP, all those kind of things, or low CVP, kids like, new grads don't know anything about those things really, you know, and they – and they – I'm sure they lean after their 6 months here or whatever but at the start of that they won't see those things. They won't even – they don't even know what a CVP is let alone what the numbers mean, or …you know, or a high CVP, like a rising CVP in a transplant or something. They won't - someone who's more experienced will have flagged that way earlier than a new grad who'll just stay writing it down for hours and hours and hours and not really make any connection with it. And sometimes the doctors are too busy. Like they're with an ECMO that's bleeding, that's whatever, and the new grad's just sitting over there writing in their obs every hour. Patient hasn't – doesn't really look like their changing or anything, so they're – so it could be hours before anything's actually really flagged."

I was attentive to what Sarah was saying. When she mentioned the doctors, it was a timely reminder. I was curious to more about something she had mentioned, so I queried, "Do you find as a senior nurse the doctors will help with the new grads?"

"Um not really. I think as a senior nurse the doctors kind of um fob off new grads a little bit or – because the new grad could be on the right direction but the doctor it'll be like, 'oh what are they on about?' and kind of maybe not pay too much attention or they'll say, 'oh yeah, we'll get there in a while', but then they might not get there …'cause they'll push them down the priority list of problems 'cause it's probably something that doesn't really need to be solved as urgently as something else."

At this point Sarah paused, remembering another experience, "You know if you're up and down on noradrenaline like crazy – kind of means you need more filling but new grads will never understand that, so they might be struggling, struggling, struggling with their inotropes but they might not know, even tell that to anyone, or to, you know ask the question."

"You'll be like, 'oh just tell the doctor.' Or, I'll do that as well. I'll sort it out for the new grad. If I see a problem, I'll go to the doctor 'cause I know that I can explain it maybe a bit better than they can or whatever."

Attentive to what Sarah had been telling me, I wanted to clarify that I understood, so questioned, "there's a lot for them to learn and it's not always the technical skill?"

Sarah said, "Yeah, exactly. They can learn those technical things quite quickly – well – ish. But then they might not know like why they're doing things at the same time. They just sort – they learn to do it, but then if some step of it goes wrong, they don't really have any troubleshooting behind it or don't ever do any problem-solving for that because they don't really know why they're doing things. So, it's all just experience really, but then they fall down in the fact that we don't have – they don't have enough supervision a lot of the time."

As I listened to Sarah's story, I was interested in the premise that she felt she didn't have a lot of experience before she started working in ICU. Taking Sarah back to this time in her career, I asked her, "do you think that affects the way you work or teach now?"

"Yeah… I think I didn't have a lot of experience, but I knew I didn't have a lot of experience. I was always asking questions…. It affects the way I teach in that I remember the stress, you know, and I remember the, like, it's fun as well. It's very …there's adrenaline out of being involved in an emergency kind of situation and I know they find

that fun as well, so they find things fun that we find boring now, because we're dealing with bigger things…. I know that they're having fun too, but I don't just want them to like go home feeling that they did a bad job or that they're really stressed out, whatever, so I try to probably – yeah, I probably do try and teach them. I don't know if it's got to do with my experience or what. I suppose it does, yeah, I suppose everything's got to do with your own experience."

I wanted to clarify an impression that I was gaining as I listened to Sarah tell stories of her experience. I asked her, "It sounds like it affects you a little bit when you know that they're going home and they're stressed and …"

Sarah interrupted me at this point, saying, "Yeah. It's horrible to think that anyone went home and, upset-like after a shift; even if you're not team leading. Like you want people to go – you want everyone to feel okay with their work. You kind of just have to accept that new grads are going to feel really stressed…. I hate to see them like staying late or feeling really stressed, and they do. They tell you that they feel so stressed. Our little one says that she shakes if she gets sent down to the [another ICU] and she says, 'I shake for my whole shift.' She doesn't feel that she gets the same support down there that she gets with us. Oh, but that's because she doesn't know people as well. She doesn't feel like she has the same people to ask questions to and whatever."

I was interested in Sarah's ideas on how she would do things differently if she could? Sarah immediately responded, "just more nurses."

"Maybe longer – give them longer time. It's hard because you can't waste two nurses on them. Actually, I do find that when I'm buddying after a while, you sort of do let them like have the run of things yourself and you end up being a resource for the rest of the floor as opposed to just being their buddy."

Then they stopped and asked me a direct question, "is it buddy, when you work alongside with somebody?"

I answered her question. Sarah then regained her train of thought, "Yeah, when they're supernumerary and then they're preceptored afterwards, but I suppose maybe preceptored for longer. So that they're actually …the responsibility of somebody else for longer. But that's really stressful then on the nurse – on the preceptors because you're trying to do

your own job and keep an eye on someone else's job at the same time. So, it's quite stressful without a resource. You see, you really need senior resource nurses."

Sarah compared a previous unit to one where she currently worked, "you'd have the in-charge of the shift, say like a team leader, I suppose would be the same equivalent but there'd always be at least one if not two other team leaders as resource nurses on that shift and they would never have a patient. So, there's the difference in staffing between that unit and this unit is like huge really. And then those team leaders would be going around and like, they had educators and stuff as well, but those team leaders would be going around, and they'd be doing skills and teaching, and …the most junior nurses would often get the most acute patients because they could have a really senior buddy to work with them all the time. So, it was just different. Think here, because of our acuity and lack of resource nurses; you end up giving the easiest patients to the new grads."

"You know, the discharges to the wards – they get a lot of discharges, and then until they unless they're on evening shifts, they don't really get post-ops as such. Might just spend the whole day with one extubated patient…"

Out loud, I tried to collate the different roles, Sarah undertook in the ICU, "As a senior nurse, you're in-charge, or you're taking a patient, or you're preceptoring.. What else do you do, 'cause that sounds like a lot?"

"Teach I suppose, resource. Resource for other people. If you have an extubated patient who's kind of able to plod along themselves, you're definitely resource. In fact, those days are the busiest days 'cause you're kind of helping everyone else and the new grads, and then you're looking after your own patient as well when you have the time, you know? 'Cause that's the same patient that a new grad would be so busy with all day long and you hardly look at them because you're running around doing everything else – going to code blues."

I really wanted to clarify that I'd understood what Sarah had just told me, "do you as a senior ever just take one patient and that's it? It just sounded as if most days you almost do two jobs. I'm not sure if that's what you mean?"

"Yeah. I think you do. If your patient is really sick, you might get to stay with them for the whole day, but usually, you're... No. Because as soon as you've extubated your patient

really, you're helping other people as well. You rarely go to a bedspace and don't move for the rest of the day."

I wondered how this made Sarah feel? "Ah. Burned out sometimes. Oh, it's good, Like, I enjoy it, but you're just busy. I take lots of it home. I know I don't – I try not to, like, too much but yeah, you definitely take it home. You sit in bed, and you're finishing nights, or after my second night last week, I woke up at whatever time, 0100 and then I was trying to get back to sleep, but I was sitting at the nurses' station at work, and all the beeping was going on, and everything was – there's those things going on, but every time I tried to close my eyes I could just see myself sitting at the nurses' station. I couldn't get away from it for ages, so I think that's taking it home."

I acknowledged that Sarah was saying. I shared a similar story in response, "every now and then, when I'm in the grocery store, and I hear alarms – I startle. Like it's an arrest. It's funny."

"Oh, we've had really bad, you know, everyone's had those really bad ones where you think you're on ECMO or, you think there's a dialysis machine right bedside you in bed, and you can actually see it. You feel like you can see it, mm."

At this point in the conversation, I repeated a statement that Sarah had made; but posed it as an open question, "so, if we had access nurses?"

"Yeah. I think having access nurses would make a huge difference."

"I know the after-hours educator is here. Like they're in the hospital, and they come up sometimes at night-time. They always seem to just fly through, and kind of that's it. There's not really much intervention with her or much interaction, but if you had somebody who maybe was just for new grads 'cause I think you guys…". At this point, Sarah again directed the comment towards myself, "there's too much going on with new starters, everyone else. I mean it's new grads, new starters and then the education of all the other nurses that are already there for however many years, so I think new grads if they had maybe just their own person in like - within the hospital …. That just looked after them and worked, actually worked with them."

"Not come in and say, 'is everything okay?' because they're just going to say, 'Yeah.' It's like a facilitator of the students. The students just want that person to be gone as soon

as possible. They just tell whatever they can tell them to get rid of them, you know, but if you had someone who actually came and just did a whole shift with them. And not in the first week that they're there. Like three months later."

I queried that Sarah was suggesting that someone from outside ICU could be a support for the new grads.

"Yeah. But I suppose that person though, would have to be ICU trained or have experience in ICU to be able to properly, um, what's the word, like for them to benefit really from it because they have to be able to teach them the ICU stuff."

"They go to a lot of education. You know, the [introduction to ICU course] that they do, education in the evenings…. I wish as well that we had more access to what they're doing or if we knew that they were being educated in because a they could be getting great education down there that we don't know about, so then you are afraid to give them things that are over their heads or to try and teach them things that are over their heads, but maybe they're getting this education… they go off every – or however many evenings a week and we never know what they do."

At this point, Sarah and I talked about the all the education the new grads received at a hospital level, throughout their one-year transition program. I explained that the CNE's would know topic being presented and who was delivering the session, but that we didn't attend the education.

"Yeah. Yeah. Yeah. I know, but I think some …. You'd obviously know more about it than we would, but on the floor, I think we don't really know anything about what they get taught down there, you know? It'd be good to link what they're doing somewhere else with what we're doing. I don't know."

"And their skills as well… I don't know how to explain it. Like I know they should have access to educational stuff and I'm sure they – and I'm sure that's what they're doing in their – in those weeks that they go down as well, like it's helping them for their preps – their prep for doing those skills, but sometimes it feels like they don't have any prep for those skills. You know, they' re kind of trying to do them but they're just doing them with the experience that they are getting every day rather than actual…. They should be able to learn stuff for those skills or study stuff for those skills or whatever. I don't know. So,

I'm trying to give them articles, or I try to give them, show them, where to get stuff, but I don't know."

I sensed that this bothered Sarah. "Well, I'd like to be able to – I don't know how to explain what I'm trying to say, 'cause I'm not able to formally educate anyone, and I don't have enough resources to properly explain things to people without teaching them out of my head."

"But I feel like if they had an ICU book…. Do they have ICU like workbooks, aside from their skills, but do they have stuff that teaches them things?

At this point in the recorded conversation, I discussed, from my perspective and knowledge as the CNE in the ICU, the information that's provided in the orientation package and as part of the [introduction to ICU education program]. Sarah remembered that she presented on the [introduction to ICU education program]; its purpose to provide the theory to support the completion of skills, by the new grads. Sarah articulated that she felt the new grads should have "more than just a skills book." She felt that there should be a resource available that could be access by both senior staff and new grads so that, "everyone'd be reading off the same page."

"It's really hard. I think it's stressful for them and it's stressful for us, and I don't really know the solution of …..."

Sarah stopped talking at this point, so I asked the question, hoping to better understand her perspective, "In that, they need to learn so much and be taught so much?"

"I just think because they haven't looked after anyone and then you're expecting them to look after people in ICU and things - like, some things just get lost and - along the way like washing, bowels, things that are really important on the ward - maybe kind of get lost a bit in ICU because there's other things that take over in their priorities."

Listening closely to Sarah's story, I wondered out loud if new grads, "come with those skills or that's something that they learn on the ward?"

Sarah clarified my question, "as in come from college with them?" "Yeah" I responded.

"I don't really think so. I don't really think anyone comes from college with good skills in even just how weird it is to wash another person. Like I don't mean that in a bad way but it is. As a young person that's a really weird thing to do, like in your mind. But when you get used to it then you just - you love it you know, and you take pride in doing it. But feeling weird about it and then the patient's got a breathing tube and central line and chest drains and a catheter an all these things that you're afraid to you know, and it just must be so hard for them."

Sarah's story reminded me of a situation I had had as a new grad; I shared this with her, "I remember being a new grad and my very first day, walking into a room, a bed of four, and I didn't even know how to say hello to those people. I had to put my shoulders back and take a big deep breath and …."

Sarah responded, "Yeah. I know. Exactly. How do you know to say hello to them? See, that's – sorry this is the other part of the new grad thing that I didn't explain. With the way, we do our training is – our last year is nine months of continuous placement, so that kind of is my new grad so that I had all that done and then I went and did…. You are the washer for those nine months. You're the person who does the washing and the obs. and the… You do medications under supervision, but that's kind of it. So, I think you get … we get more … they probably haven't had as much time on the floor doing those kind of personal – those kind of just basic things as what I had."

"So, it's hard. And they're trying to learn about inotropes!"

I commented, "It's a huge jump."

"And in fairness to them they do – they do so well considering how actually big it is. But it's just in the - I suppose in the first couple of weeks; especially, a couple of months for some of them, or their whole placement for some of them, is so stressful, I think."

Sarah and talked about how each new grad seemed quite different. I mentioned that some of the new grads want to come back to ICU and seemed suited to this environment. Sarah responded, "Oh, they're brilliant. I think by the end of their placement, a lot of them want to come back, you know. There's only…. Really one person I know, that was like, "No, I can't. I can't go back to ICU."

I asked Sarah how she felt when she heard that "some of the new grads were coming back?"

"Oh, I'm happy enough. I think experience out of here is good too though, for people. Same as I don't think anyone should just be in the emergency department for their whole … without ever having experience anywhere else. I think a mix is good just for, having a wider view of things they get there. Over those six months, if they do their first six months with us, they get another six months on the ward, at least that's something for them."

I asked Sarah to consider the new grads that have six months elsewhere and then come to ICU.

"Yeah. They're usually a little bit better. Well, not better, I shouldn't say better. It's usually a little bit less stressful for them because they're kind of know the hospital already and know the med chart and know [the electronic patient system] and know all those kind of little things…. And they'll have experience with putting rapid responses and talking to doctors. They'll just have a little bit more, and they know the hospital a bit better. … there's not as much new things for them, but then sometimes they probably think …. I was going to say maybe they just don't ask questions then if they think that they know it all already from being [elsewhere]. I think it's all quite overwhelming here no matter where you come from."

I repeated the statement Sarah had just made, "It's overwhelming coming here." I asked Sarah her whether she thought it was for anybody. She clarified my question, by asking if I meant, "overwhelming coming – starting in this ICU?" I agreed that this is what I meant.

"I think it is for anybody…. I think maybe just ICU in general. This ICU is hectic <laughs> and I can't compare it to any other one in Australia 'cause I've never worked in any of them in Australia, but I think all ICUs are … There's a lot to learn, you know. And all ICUs are probably very specific. They do things a certain way, so even if you had experience in ICU, moving ICU is probably kind of overwhelming 'cause everyone's going to be quite regimented in the way they do things. But yeah, this hospital is like, hectic. The [other ICU] is just full of patients who are just quite scary even to experienced nurses a lot of the time and [this ICU] is like full of really, really, really sick people. But

then we also have the best doctors probably. Well, we have very experienced doctors anyway, as far as I can see, so that helps you know."

"you get that support, and all the staff are quite experienced and, well not all the staff. But there's a lot of experienced staff that have dealt with the things that this hospital throws at them. It's mad."

"It's probably a really good place for a new grad to learn though, at the same time. I don't know. I don't know what to do with new grads."

I asked Sarah, "What would you like to do if you had all the power in the world?"

She laughed, "I don't know if I'd stop them coming. I think I'd just resource the place better in terms of staffing. Like, have more staff available to them or specific staff for them. Or, maybe …a workbook or a folder that was just available on the floor that we can just pull to teach them things, with systematic stuff that's for the patient. I think that the [bedside folders] that we have... To teach them a regime of things. Yeah, just more time, I suppose. More time to give them and more …just resources. It's just about staffing, isn't it?"

I wanted to make sure I had really heard and understood what Sarah had told me, so I summarised some points that she had made and repeated them back to her, so she could confirm or clarify. My understanding was: sometimes she was really busy and found it really stressful. Sometimes she didn't get breaks. But despite this, her focus was still on supporting the new grads.

Sarah agreed, "I'd say to other staff that aren't new grads or aren't new starters, 'okay, your patient's fine, so you're going to go now and you're going to have to go and help everyone else. Whereas I kind of have that maybe a bit in me anyway. I suppose I'm bossy as well, I think. So, I won't just sit there if I see things going on that could be done better. I'll say, 'oh no, look, do it this way,' or, 'this is what needs to be done.' So I suppose that's - if you can turn a blind eye and just sit there and do your own work and whatever, then you wouldn't have as much focus on like trying to support them or whatever."

"But if you can't turn a blind eye, then I don't know. I don't see how you can be any other way except for trying to support them. For me, it's just more staff. To have that resource

person, but as soon as you have that, the worker will do so much better. You really can see the difference. The whole environment is very changeable anyway, you know. It's probably always going to be stressful because if you had 25 beds, you'd fill 25 beds and if you had 30 beds you'd fill 30 beds. Someone will always ring in sick even if you have a resource person and then two people ring in sick, and suddenly you're down. …. So even if you plan to have those things sometimes you just won't have them."

"I don't know if there's much of a solution really, but I think just longer support for them, a longer period of transition is probably what they need."

**Kath's Narrative Account**

Kath requested that we meet at our workplace, either before or after a shift, as it was more convenient for her. We had looked at her shifts to find a suitable day and time and had settled on a particular date. Unfortunately, Kath was unable to make the appointment due to unexpected overtime. The ICU had unplanned admissions, and there were staff shortages. Kath volunteered to do a double shift, which meant she was unable to make the appointment.

We made another appointment. Again, there were unplanned admissions combined with staff shortages and skill mix concerns. Kath again agreed to do overtime and missed our appointment. Our third meeting was also cancelled due to Kath forgetting the appointment date. She was apologetic and explained that she had childcare issues – her normal babysitter had cancelled.

We rescheduled again, and on our fourth attempt, we were able to meet before an evening shift. We meet in an office adjacent to the ICU. The office contained of two desks and, when the door was shut, there was complete privacy. Although, the general activity of the unit could be heard through the door. I started the conversation by showing Kath the recording device, and I explained the purpose of the research project. Kath didn't have any questions or concerns regarding the research and signed the consent form.

Kath was insistent that the recorder be checked and that I was sure it was working and recording her words. Kath surprised me by sharing a very personal family story. The very poignant story explained why she was very aware of the recorder and her concern that it was recording accurately. I felt very moved by what she told me and humbled that she had chosen to share something so personal with me. There was a level of care and attention to detail, regarding the research process, displayed by the participant that I appreciated.

This is why I formally started our conversation by saying, "I will check to see that that's recording, after what you've just said." I continued, "Thank you for coming in. So, I guess we just talked about why I'm doing this, so what I'm really interested in is … what it is like for you to work with new grads out on the floor? … That nitty-gritty experience?"

I sensed that Kath had really thought about her experiences before our conversation, because she spoke for some time, saying, "Yeah. Oh well, it's very stressful really, … because … you don't really know what you're working with, to be honest. You haven't had a chance to … well, you know that they've come straight from Uni. They may have no experience, or they may have had worked in nursing homes or whatnot through their nursing degree to keep them cashed up. So that's good sometimes, and you never know how enthusiastic they've been in their practicals and … during Uni time. Sometimes they, you know, get good placements where they are allowed to get experience and sometimes they have none."

"I certainly know when I came out of Uni, I had very, very little experience… When I came here as a New Grad. I had already worked on two other wards, or one other ward, I think. I was still terrified here, still really learning, you know, how to prime a line properly, and – and things like that, let alone … you have zero experience in terms of ventilation and … really critically unwell patients. And I know I relied heavily on my seniors then and from my point of view I knew that whenever I had no idea what was going on or had questions or was unsure about something, I had no hesitation whatsoever in asking my seniors what I should do or what was going on, 'am I doing the right thing' and I never took any chances."

"And now, as a senior looking back on these people coming through, that's something that you look for. That's the most important thing to look for in these New Grads is 'are they going to ask me questions?' Do they know their limitations? Are they focused on this day and this unit and this time, because they have no idea what's around the corner? Um, and that's the scary part. It's not about how much you know. They can read. They can have a photographic memory of every textbook they've ever read. Doesn't mean anything once you're on the floor and things can change very quickly in this unit, in cardiothoracic care."

"And so, you rely on their adult skills really more than anything; to put their hand up and come and find you because you can't be everywhere at once. Um, and usually you know what you try and do is … allocate them to a patient that is appropriate. And that's very difficult sometimes because obliviously you can't give them gadgets such as LVADs or balloon pump or CVVHDF and usually the easiest gadget you give them is a ventilator, which is scary."

I acknowledged what Kath had been saying. There was a pause in the conversation. I was interested in Kath's nursing experience before she started working in ICU. I wondered out loud, "I didn't realise…for some reason, I thought you'd come from a [cardiothoracic surgical ward]. I didn't realise you'd started here?"

Kath responded, "Oh as a New Grad I worked here for, ah – I can't remember how long, about four months maybe? But I went to an [acute Aged Care] ward, so that was quite a nice, kind of easing into nursing generally. There was good basic nursing, you know, pressure area care and lots of drugs, but all oral drugs mainly."

At this point I shared with Kath that my early career had been similar; I had done a New Grad rotation in the [acute Aged Care] ward. Kath responded, "Yeah, it was a good start. I actually really like it to be honest. And now I came here, and it was just like the other end of the world, buts that's cool. I mean just learn something new and -."

I interrupted Kath at this point to clarify her timeline, "and you stayed here or you went away and –."

Kath explained, "I went to a [Surgical] ward to complete my New Grad course and then, ah, didn't really know where to go. I liked intensive care, but I felt that it was out of my depth. I just wasn't experienced enough to come back here. Um, so I went to a [cardiothoracic] ward and worked there for a few years. Then I did a cardiothoracic course and then came to a cardiothoracic intensive care, which I thought was a natural progression." Kath laughed.

I responded with a questioning prompt, "Rather than maybe straight here?"

"Yeah. I would've liked to have come straight here, but there's just, it was too stressful for me too – I think I probably would quit, to be honest. It was just every day coming to work here was so stressful. I liked it, but the stress was – was um, you know, unfair on myself and everyone around me really, I think."

I wanted to confirm what Kath had said, so I asked, "so as a New Grad you were really stressed?"

Kath responded with, "Mm."

I asked what stressed her. "Oh, just the responsibility of these people that I really – you know – I knew how to work an [infusion pump] and turn infusions up and down and stuff, but really I had no basis or grounding on the big picture of what was happening with these people, and I was constantly just relying – I felt like just a monkey just pressing buttons with no basic understanding of what was happening, so ah, just wasn't ready to stay here. Even if it was learning on the job, I just didn't think it was – I just – it was too much for me."

Kath laughed when she stated, "But I like it now."

I wondered what was different for Kath, between then and now? Kath replied, "Oh I've just got a lot – I did the course, so I have a much more in-depth knowledge about cardiothoracics and a lot more - more – a lot more experience with cardiothoracic patients and … the common things that go wrong and what to look for and easily spot a deteriorating patient way before they're anywhere near deterioration, if you know what I mean?"

I confirmed for Kath that I did know what she meant. She kept speaking, "And, ah, just a lot more confidence in being able to – I think that I learned that from the [cardiothoracic] ward … where you have to use your skills to look after people. You have to be able to walk into a room and be able to look at each patient and have a good idea of what – what their – if they're okay or not. And I think once you can feel confident in that kind of area, then you can have more confidence in your skills and then bring it to a more critical area, like here."

I was interested in Kath's insight into her own experience. I asked her, "Do you think that that experience affects the way you work with New Grads now?"

"Yeah. I think working on a ward makes a big difference because you know where that – if they've come from a ward you've gotten a basic idea of what – how they're thinking in terms of time management and what's important and what's not. I think the focus on the ward is a lot more task orientated."

"And, I think sometimes it's important to bring to their notice this is much more about the patient, and you might not give their medications on time if the person next to you is deteriorating, and you need to give somebody a hand. It's a lot more about patient focus

– and that is really important. Yeah. And also, the difference between here and the ward also is when the doctors want something done they want it done now, not like, you know, give 100mls of fluid and, you go to your lunch break and then come and do it. You do it, you do it now, and I think that's another thing that some of these New Grads kind of don't really get when they've come from the ward. But they pick it up quickly, hopefully."

I was interested in Kath's nursing career progression, asking her, "It's a big change isn't it, over a career. Being a New Grad here and then now you are a team leader and a preceptor?"

"Yep. Yeah, no, it's good. It's been a nice progression through my career, I think. I really enjoy where I am at the moment. Kind of has its ups and downs being a senior person, but I think I'm in a good spot at the moment because – well, a while there I was going to quit, 'Cause it was just all too stressful, and, you know, this unit is particularly emotional at times and sometimes you just feel like you can't – you don't get time to come up for air and – before you're back in with some other battle. But, ah – I think having kids helps a little bit 'Cause you kind of have to change your focus when you go home and find new – other things to do and laugh and yeah, it's nice. It helps me a lot."

At this point, there was a pause in the conversation. I asked Kath, "you're a team leader, and you're a preceptor, and you're a senior out on the floor. Do you think working with New grads changes, when you're in those different roles?"

Kath was unsure of what I meant and asked me, "Say that again?"

I laughed and responded, "I'm not really sure what I just said." I rephrased the question for Kath, "You're a team leader, so working with the New Grads when you're in that role is that different to being a preceptor working with a New Grad or …"

Kath interrupted, "Oh yeah, definitely, being a team leader. You're managing the unit, and so you're managing sick people and keeping an eye – it's almost like you're putting out fires. That's your role. And the thing with New Grads is there isn't a fire there yet."

Kath laughed then continued, "You're making sure they don't start one, with all due respect." And I feel sorry for them because I was there and I know what it's like, but you don't really – the thing I find most difficult to come to terms with and the thing that I find

most difficult to negate is how do they feel about their role? Do they understand their role? Do they understand their scope? Do they understand how dangerous this place is?"

"It's very difficult to figure that out with some of these people because they do live - some of them are quite fearful, and instead of saying, 'Oh look, I don't know what I'm doing,' or, 'I'm out of my depth here,' or, 'I need some help,' I think some people try and hide that. And they're the dangerous ones, and they're the ones you've got to try and find, and keep a close eye on, so that they don't accidentally start fires. So, you can give them a very stable patient, but often those stable patients are the ones you really have to focus on because, you know, they have - you have to make sure that their respiration stays good and they do their physio, and they cough up their sputum plugs because those stable ones can all of a sudden deteriorate and end up having to be tubed and I think that's something that happens a lot here."

"Patients who are getting better are given to the less senior people, often new grads, and they - they stay in intensive care longer because of that. And, as a team leader, it's important to go and find - keep an eye on these new grads ah, and say, 'Right, you know, you need to do physio with these people. It's not just the physio's job. You need to get them deep breathing. You need to get on top of their pain,' and it's very basic stuff, but it makes a big difference. Especially with our transplant patients who are elderly, some of them, our older transplants. Prime example's a gentleman we had here a couple of weeks ago. He had a [lung operation]. You know, we - really important to get on top of his physiotherapy early um, and get him moving early because he was very frail and we had a really small window opportunity to get it right, and unfortunately we didn't, and um, you know, he did deteriorate, ended up being re-tubed and ended up passing away."

"That's the real criteria of people, that you really have to keep an eye on um, and it's difficult when you have to allocate a new grad to someone like that because the next patient's got a balloon pump, the next patient's got dialysis and blah-blah-blah, and um, as my role as a team leader in looking after these people is - is constantly keep an eye on a - you know, keeping ahead of the game. And if you've got a busy shift because there is a sick person, then sometimes you don't go near them, and you've got to trust the person next to them, their preceptor or whoever, to help them, and that doesn't always happen. But, thankfully around here it does most of the time because we've got really awesome

staff. But it's a lot of pressure, and sometimes you go home thinking yeah, I know I didn't do a very good job today, but that's all you can do."

I was responsive to Kath's perception that all her attention is with the sick patient. I wondered how she personally defined a sick ICU patient?

"Oh, someone who is deteriorating or needs – or is not necessarily deteriorating but very critically unwell, needs a lot of inotropes, things are changing, so you have to maybe start dialysis or, you know, a lot of physical tasks need to be done and so your attention is drawn to that patient to help the nurse there 'Cause they need help. Because that patient - their deterioration needs to be stopped and you need to act quickly, so that's what I mean."

Listening to Kath tell her story, I was interested in how she managed her work life balance. I asked her, "You've mentioned a couple of times, it's really hard to come from all of this, and then go home. How do you manage that …?"

Kath responded, "Oh you've just got to go through it in your head and um, over the years I've just got better at it, I think."

"I used to drink a lot." Kath laughed and continued, "I used to talk to my partner about it. I don't do that as such anymore because I find the conversation – sometimes I just want to get it out and not have anything come back." She laughed again.

"My partner works in [a hospital] also, and sometimes I think about that; whether I should be discussing these things. But I tend to just let it go now, just to – or talk to my colleagues about it. Ah, have had some counselling with various – with some patients because some things I just couldn't get away from. Kept haunting me. Um, and just allows you to – to get it out of your system, to flush it out because some things just don't leave you. I think everyone takes a chunk of you and you can't escape that. It's just finding a way to fill in that chunk with something else."

Kath laughed and continued, "I don't know, I just ah – Like I said, my kids help, 'Cause you just have to focus on something else. You know, I have no choice. I think also in the last year or two we've just got a really good crew at the moment, who are quite sensible and very talkative and you know, respectful."

I wanted to clarify who Kath meant, so I asked, "Do you mean New Grads?"

"No, sorry I mean senior staff and up and coming [senior staff]. I find the last two years of [staff doing the postgraduate ICU nursing course] are really awesome, and they're a lot more – they're a different generation I think. They talk a lot more about their emotions and stuff, which I don't think we ever really used do very well on this unit. I think there was a bit of a kind of a <sigh> 'What's the word?' Like everyone just dealt with it themselves here as it was almost part of your job and part of the pride of working here as you know, 'can we cope with this?' But in actual fact, we just can't. And ah, I've been really thankful to have this new crew come through and – it's been easier to deal with these horrible situations, I think."

I wondered aloud to Kath; it seemed that she had experience dealing with difficult situations and support from colleagues? I asked her "how do you think New Grads cope with that?"

"Exactly. I don't know <laughs> to be honest. I don't know. I'm just trying to think if things have changed since I was a new grad, or not, 'Cause I was just so inexperienced that <laughs> I probably had no idea what was going on most of the time anyway. I think that New Grads do have a lot of - everybody's very friendly and chatty, and I think that this unit now, makes it easier for New Grads to go through things themselves - with their staff members. I think it's – I don't think it's too bad at all really, better than when I was here."

Kath laughed again while she emphasized, "definitely."

At this point in the conversation, I shared with Kath my experience of starting employment in the ICU, "When I first started here I had a few years of ICU experience, and yet I'd never experienced anything like this: ECMO and VADS and balloon pumps and open-chests and things. I used to go home and cry in the car."

Kath responded, "Yeah, it's horrible. I used to cry even before I got here." We both laughed, as Kath finished her story, "and then just get my shit together. I mean, excuse me, get my act together. And walk through the door and hold my breath for eight hours."

"Anyway. I like - I love working here. It's a good place. You know you do good things… It's a good team. You've got a good team of doctors that you trust, and you have to trust them, otherwise you - I wouldn't be able to work here. Trust in terms of belief that they

have the right morals and values and um, ah, goals for these people, realistic - realistic goals. Sometimes not so realistic but, you know, the patient's interest at heart and that's - that's why I am able to do what I do. Because if I didn't trust or believe in these Consultants, I wouldn't work here because you know when it all goes … the things we do to these people to keep them alive, it's almost - you know, if there wasn't the word "hospital" written on the front of the building we'd be up for blood torture. 'Cause, you know, it all works out well when they get transplanted, or they get better and leave. But when they don't, and you look back on the way - the - the - the things you've had to do to them, you just think, 'Wow, that's ah - that's not right,' <laughs>. Not right in terms of it's just - they've had a horrible time in the last month or two of their life.

"All with good intentions and the hope of better days, but when those better days don't come it's - it's a really difficult - I find that really difficult. That's probably the most difficult thing I find in this unit; when they pass away and you just look back on the life that they've had for the last month and think, 'Wow, that wasn't nice.'"

"We do extraordinary things to keep them alive, but they're all invasive things."

I asked Kath, "If you're the team leader and we've got patients that are that sick with the extraordinary mechanical devices and things that we can use here, how do you manage when you might have two new grads on the floor?"

Kath replied immediately, "Oh you just have a bad day. I mean you've just got to run. You've just got to be - have eyes in the back of your head. I always tell my new grads if I - if I feel that I don't have a lot of support, then I will definitely tell the new grads that it's going to be a busy shift. And I might be busy, but I'm always here to help them. And if they have any questions, they are to find me. It doesn't matter if I'm busy or not, that I'm here for them as well. And I try and keep an eye on them, and I help them where I can. I also brief the whole team usually if - if we're going to have a day where I know we're going to be busy. I usually brief everybody and say, 'Look, you know, we're all in it together. We've got to keep an eye on each other. I'm going to be busy. Can you please help me um, 'Cause you've got to work as a team?' But it's stressful. It's really stressful when you find that you have to allocate your easier patients to a new grad then - then they technically aren't necessarily going to be an easy patient now - for you - for me. So, you

know, it just makes my job harder, but it is part of the job, so you just have to deal with it."

At this point in the conversation I asked Kath to expand on her phrase, "you have to have eyes in the back of your head."

Kath sighed and started talking, "Ah, because your focus is often in another direction <laughs>. Um, again patients who are needing tasks done or nurses that need help, um, more senior nurses, that is. Ah, so you have to be on the lookout in all directions regarding the new grads and making sure that they're not letting things slide; not taking much notice of inotropes or - I had a situation the other night where I had a new grad in the side room. A patient was on a little bit of Noradrenaline, and they were in the main unit talking to other nurses. The alarms were all going off, and I had to go and find them and say 'Look at that. What are you doing about it? Why are you 10 meters away talking to other nurses?"

"'Cause, first of all, Noradrenaline is a dangerous drug and whatever the patient's on - I have my own policy that if you have a patient on more than three mls an hour, then you don't leave the room in the side room. Or, never too far away from the alarms at least. So, that's an example of a person that I've picked up who I - I can't trust. Um <laughs> so, unfortunately - whenever this person is on I always, you know, have to swing past them and their patient and have a look at things and ah, make sure that there's enough Noradrenaline in their bags. They've got enough, inotrope backup, enough - that everything's - everything is right. I have to look after the patient like they're my patient."

Knowing that Kath isn't always the team leader on the shift; that she will take a patient load, I wondered what it was like working next to a new grad?

Kath laughed and said, "Ah, well, you – I mean I always just butt in and help, and it's a natural ability to be nosy."

I laughed as well, and Kath continued, "I mean everything's a teaching opportunity, isn't it? So, you know, if you're next to someone who's learning, then, as a senior person, it's your job, I think to help them learn."

"And it's for the safety of the patient. Ah, so you just help and keep an eye on things and teach them. You know, last night, we had … a relatively experienced person whose chest

drain was full, and I pointed it out to them, and they said, 'oh yeah, I've got another 30 mls, 'and I went, 'Yeah, no."

"Are you kidding?" I said as a joke. Anyway, they just looked at me, and I went, 'Well, seriously, you should never let your drain get that full.' So it's a constant learning thing. Everybody's learning, and I learnt something the other day, um – oh, forgotten it, unfortunately, <laughs> Ah bugger it.."

We both laughed, and Kath said, "that would've been a good think to talk about. Anyway, it's gone."

I laughed and teased Kath, saying, "You learned it well."

"Yeah. Oh, I was very surprised. It was a very basic thing that a quite a junior person taught me something and I was like, 'Wow, that's really awesome to know. I wish <laughs> I'd known that ten years ago."

Kath paused and said, "I can't remember what the question was now but … it's being next to a New Grad?"

I agreed that was what we had been talking about and Kath continued, "I think they need support as well. I mean they – I think they want to be taught, well, most of the time."

Kath and I then spoke of her role of preceptoring New Grads in the ICU.

"I think the difference between good new grads and - I mean, there's good and bad. But, the ones that you can trust are the ones that are looking for learning experiences; looking to learn all the time, not just looking because they've been rostered on today and this is their job to be in this unit. That's the difference between people who, you can um - who will - who will learn and will grow into excellent cardiothoracic nurses. They're looking for opportunities and ask questions when they don't understand. They're the people that you really enjoy working with and, who learn the most because they want to learn and are interested. 'Cause it's a privilege to work here really, I think."

Listening to Kath speak about New Graduate Nurses, reminded me of a recent experience. I think it had been Kath's phrase, "eyes in the back of your head" and having to trust people to ask for help when they were unsure. My experience involved a new grad on the

floor. The nurse yelled out my name in an urgent tone. I turned to see an ICU patient sitting in a chair. The monitors were flashing red and sounding their alarms. I noticed that the patient's blood pressure was extremely low. The patient's eyes were closing. I was concerned that the pressure was so low that if I didn't intervene quickly that the patient could be pre-cardiac arrest.

I remember thinking, 'thank goodness, they recognized the problem and asked for help.' But I also wondered what might have happened, if they hadn't?'

I shared this experience with Kath. She reacted, "Or if they're talking to somebody down a couple of bed spaces away? There's plenty to learn around here, and there's plenty of things that can go wrong very quickly, and that's the nature of this place that makes it scary. Things change quickly, and sometimes you can predict them. Sometimes you can't as a senior person. So, the New Grads have got no hope, because they don't have any experience. That's what makes it scary as a senior because you can't really rely on their – you can't rely on their experience 'Cause they don't have any."

I was intrigued as to how the senior's 'managed' so I asked Kath that question, "Well it's very difficult to manage that. Sometimes it's not managed very well at all. These people just deteriorate, and you then are putting out a fire. And it's emotional for the new grad because often when it gets to that point you – there's only so much talking you can do <laughs>. You've almost got to push them out of the way and just sort the problem out and explain it afterwards. So, it's stressful for you, it's stressful for the patient importantly, and it's stressful for the new grad. Ah, and that can happen frequently here, unfortunately."

"So, yeah, it again goes back to having eyes in the back of your head. But I don't have eyes in the back of my head <laughs> obviously <laughs> so unfortunately sometimes people do deteriorate."

I acknowledged what Kath was telling me, "Yeah. As you know, I work Monday to Friday and do the occasional overtime…"

"But Monday to Friday there's NUMs and educators and CNC's around. So, what happens after hours when you're managing all of this …."

Kath interjected, "Oh well, I – You just don't get a break as a team leader. You're constantly on the lookout, even on nightshift. I won't go to my break if I'm leading until everyone's had their break. Which is fine, but you just have to be constantly – especially on night shift 'Cause you've got a Registrar, but they're half asleep sometimes <laughs>. Sometimes we get a new bunch and ah, again, it's almost like having a new grad if you've got a new doctor as well. You just – you don't know what they're like and you've got to learn to trust them and know - figure out their skill level and their experience."

"You just constantly have to be awake and alert and patrolling. Like, I feel like I'm on Bondi Beach sometimes <laughs>, you're just up and down, up and down, up and down."

Kath laughed when I commented that, "It's a really good way of putting it."

She commented, "That's what your job is really, isn't it, as a team leader?"

At this point, I asked Kath to explain her experience of preceptoring a new grad and wondered if she had ever preceptored a new grad straight out of university?

"Ah – oh, it's quite – it's like [pause] <sigh> you feel um, like it's a bit of a waste coming straight here as a - those people straight out of Uni because like they're just learning basic things still and a lot of the stuff that we do there is so technically orientated that, um, they're almost skipping quite a few steps in terms of patient care. You wonder what they're like when they hit the wards after being here for six months. Their time management, I'm sure, will be like being a new grad from Uni straight over again. Because the set of skills that you need for the ward and the set of skills you need here are completely different, so it's a big jump for them."

"And ah, but I quite like it now that I'm more senior and am able to explain concepts in a basic way 'Cause I understand them. I quite enjoy it, and I think they get a bit of enjoyment after having learned new things that are quite technical. I think cardiothoracic is technical, but it's plumbing. You know, it is quite basic, and if you can find a way to explain something that's technical in a very basic way um, it's quite satisfying, I guess. And seeing someone understand that… quite a nice little moment sometimes."

"I quite enjoy taking new grads. I think the most important thing that you can teach them really is that they're not alone and we work as a team. And when they're in trouble or don't understand something, we don't expect them to understand, or know what to do.

But we do expect them to stick up their hand up and recognize when their patient needs extra hands. That's the most important thing, and for anyone really, but particularly new grads who might think that they are – are being judged for their skills when really, they're not. They're just here to learn."

There was a pause in the conversation, so I asked Kath, "If you had all the power in the world to make any change you wanted to make, what would you do?"

Kath questioned, "in terms of new grads…?"

I confirmed this is what I mean.

Kath started talking, "Um, well, I think for new grads, to be useful in this unit, I think a bit of experience elsewhere would be beneficial for them. I still think we should have new grads here. I just think straight out of Uni is just silly because you tend - I tend to treat them like they're stupid. I - I know it's bad, but you have to treat them like they're stupid in terms of not being - speaking to them in a disrespectful way, but like speaking to them, like they know nothing. I think that that's not good for their ego or their career in terms of esteem and confidence when they're used to being treated like they know nothing. And, that happens for months here."

"I mean, there was a new grad the other day who I thought, 'Oh you've been here for a month now.' They said, 'Oh actually, I've been here for five months.' <Laughs> I was like, oh god, they must've learned something by now. And they had, but yeah, <sighs> - it's not good for them, I don't think, this environment. You just can't afford - I can't afford to trust them; their skill and their knowledge 'Cause I - you just can't. It's too dangerous. Um, so I think if I had a magic wand, it would be nice to have new grads that have a little bit more experience in terms of, you know, just drugs, giving drugs, dispensing drugs, um, and patients. You know, how to deal with a patient, how to recognise a patient who's a difficult personality or hypoxic."

"That's really important in this area, but some people will just think, "Oh this guy's just not very nice." Well, no <laughs> he's got not enough oxygen in his brain - in his system. So, you know, little basic things like that that you might've picked up on a more - a less critical area like a ward, is a really good thing to have under your belt, in terms of confidence and patient safety."

"So that would be my thing, to have new grads, but not straight out of Uni. Maybe, at least one rotation somewhere else would be <sighs> ah, beneficial for everyone. And I think; also it's better for them because I'm quick to jump in and take over. I'm quick to jump in and help fix things. That doesn't happen on a ward. So, once they leave here, the responsibility really is on them. I think a lot of responsibility the new grads have in this unit is taken away from them, because I - we don't trust them necessarily, and that changes when you go to the ward. You are given, four to six patients and you have to - no-one else is watching over your shoulder. You're it."

Having not worked on the wards for a very long time, I asked Kath, "the new grads don't have the ready access to the doctors, do they, like they do down here?"

Kath confirmed, "No. That's right. Or even, you know, their team leaders. I can't find a nurse anywhere on some of those wards <laughs> sometimes, let alone a team leader. That's setting themselves up to fail really. That would be my magic wand."

I asked Kath, "is there anything thing else you wanted to add, what it's like working with them or."

Kath stated, "just stress – just really stressful. But a challenge and sometimes, some days are good. Some days are bad. I just also wish that our powers that be, that my managers would listen to our appraisals a little bit more carefully of these people because I don't really think they do. I don't think that's relevant to your study, but anyway."

I commented, "I think, yeah, that's a different conversation. But um, I think you're right with some of our new grads, do stay on after their new grad rotation."

Kath responded, "Mm. I think that's – I think that's another subject but, yeah, that's – I don't think it's right."

I was intrigued as to why Kath thought that, so I questioned, "Why is that?"

"I don't think that the – I think they should get experience in the ward first. Yeah. How a hospital works. It should be compulsory before you come back here."

Interested in what Kath was saying, I repeated her words, "to get ward experience?"

Kath affirmed, "Oh yeah, absolutely. You get a set of skills that you'll never get here."

I wondered if Kath's early career had influenced her beliefs. I asked her, "you think that because that's how you did your career or?"

"Um, yeah. And not because I did it that way. I've learned things. I - you can pick a patient from a mile away that is not doing well. That's because you've had to look after these people. And get doctors' attention, and they sit there for an hour or two while people kind of fart arse around or whatever. And you have to be there. And you have to hold their hand. And you don't have Midazolam, and you don't have Propofol. And ah, you have other patients that you have to deal with as well and time manage and learn to speak to medical people in a professional and ah, urgent way and get their attention. And learn how to speak the language um, to get people's attention, rather than just putting your hand up and letting everybody else deal with it. Or ordering a chest X-ray or getting, you know, a really senior doctor at the click of your fingers."

"You have to actually use your stethoscope yourself. You have to count their respirations. You have to feel their pulse. You have to um, do a manual blood pressure. You have to talk to them. You have to reassure the relatives and then you have to build a case and take it to the doctors and explain it in a clinical and professional way. I think that's a really important skill to have. Rather than, you know - I mean I see X-rays ordered well before a stethoscope has even touched a patient here, which is handy, but um, you know, it's really important to be able to clinically assess your patient."

"Mm. And I think we rely a lot on monitors here. What if the monitor's wrong? I mean you should be able to look at your patient and go, 'I don't actually believe that. I don't think that. That doesn't make sense to me,' because you've already looked after someone like that without a monitor. I think it's a really important skill."

I wanted to confirm that I had understood Kath correctly, so I asked, "so new grads should go out and spend a couple of years on the wards and then come –".

Kath interrupted, "I definitely think they should find out how a hospital works and have a bit of respect for the patient that you've just discharged to that unit. You know, appreciate what the patient's about to walk into as well. There's a big change between ICU and the ward. I think if you've worked on the ward you know what - it helps you in your care for your patient. Especially our long termers who are, you know, used to hitting the buzzer and having someone there 10 seconds later. That's not just going to happen on

the ward and um, I don't know, I think it helps to have a preparation to help your patient do better on the ward. But also, to know what a patient goes through on the ward. Some of these nurses have no idea. It's funny - oh it's not funny, but when we get sent to the wards, you know, once or twice a year and stuff, we all hate it because we have to work so hard <laughs> which is the bottom line <laughs>".