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

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The University of Notre Dame Australia

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

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<td>1. Familiarizing yourself with your data:</td>
<td>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</td>
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<td>2. Generating initial codes:</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</td>
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<td>3. Searching for themes:</td>
<td>Collating codes into potential themes, gathering all data relevant to each potential theme.</td>
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<td>4. Reviewing themes:</td>
<td>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.</td>
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<td>5. Defining and naming themes:</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</td>
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<td>6. Producing the report:</td>
<td>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.</td>
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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’re 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/6/9827212

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 5 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) 6382-4960 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
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 a 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.

Participant Information Sheet 20160720 V1
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.accessappl.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 number].

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) 8362 3501 or any of the following people:

**Research contact person**

<table>
<thead>
<tr>
<th>Name</th>
<th>Susan Whittam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td></td>
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<tr>
<td>Telephone</td>
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<td>Email</td>
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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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Research Office Manager</th>
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<tr>
<td>Position</td>
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<td>Telephone</td>
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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**

<table>
<thead>
<tr>
<th>Reviewing HREC name</th>
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<tr>
<td>HREC Executive Officer</td>
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<td>Telephone</td>
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**Governance Officer Contact**

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<th>Position</th>
<th>Research Governance Officer</th>
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<td>Telephone</td>
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Participant Information Sheet 20160729 V1
## Appendix G: Consent and Withdrawal

### Consent Form and Form for Withdrawal of Participation

**Consent Form**

<table>
<thead>
<tr>
<th>Title</th>
<th>Narratives Of Experience: Senior Registered Nurses Working With New Graduate Nurses in the Intensive Care Unit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol Number</td>
<td>1</td>
</tr>
<tr>
<td>Principal Investigator</td>
<td>Susan Whittam</td>
</tr>
<tr>
<td>Supervisors</td>
<td></td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th>Name of Participant (please print)</th>
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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
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</table>

### 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.

<table>
<thead>
<tr>
<th>Name of Researcher† (please print)</th>
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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

† 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 20150720 v1
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 Whitlam

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 ___________________________

1 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.

Consent and form for withdrawal 20160720 v1
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 intravenous 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 permanent 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 immunsuppression 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?”


“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?”

“How quick I can get things done. So, it’s easier to balance your time.

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

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‘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 l - 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>”.