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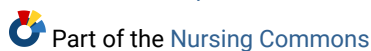
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Narratives of experience: Senior registered nurses working with new graduate nurses in the intensive care unit

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Chapter 1: Introduction

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

1.1 Background

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

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

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

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

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

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

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

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

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

1.2 ***Inquiry Place***

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

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

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

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

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

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



Figure 1.1: ICU Bed Space with Patient Obscured by Technology

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

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

1.3 Problem Statement

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

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

1.4 Research Puzzle

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

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

1.5 Theoretical Perspectives

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

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

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

1.6 Significance

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

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

1.7 Structure of the Thesis

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

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

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

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

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

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

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

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