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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 2: Literature Review

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

2.1 Background

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

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

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

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

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

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

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

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

2.2 **Purpose**

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

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

2.3 **Search Terms, Databases and Limits**

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

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

2.4 **Inclusion and Exclusion Criteria**

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

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

2.5 **Search Process**

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

Table 2.1: Literature Search Summary

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

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

Table 2.2: Three studies Best Aligned with Inclusion Criteria

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

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

2.6 Extended Background Literature

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.7 Articles Aligned with Inclusion Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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