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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 4: Inquiry Findings

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

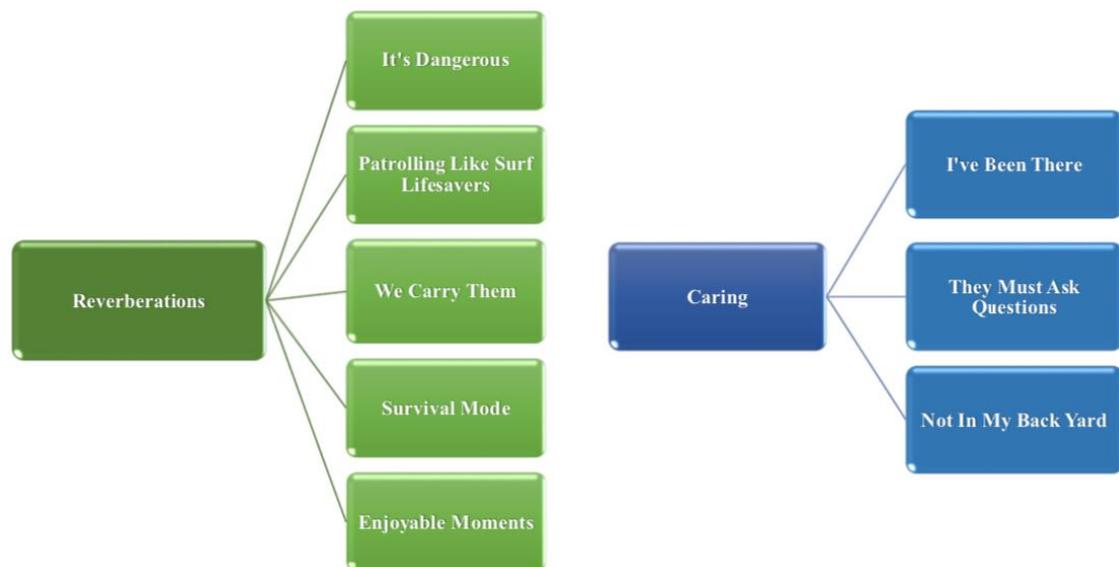


Figure 4.1: Thread Network

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

4.1 Reverberations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.1.1 It’s Dangerous

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

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

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

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

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

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

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

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

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

4.1.2 Patrolling Like Surf Lifesavers

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

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

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

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

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

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

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

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

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

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

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

4.1.3 We Carry Them

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.1.4 Survival Mode

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.1.5 Enjoyable Moments

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

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

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

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

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

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

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

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

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

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

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

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

4.2 Caring

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

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

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

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

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

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

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

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

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

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

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

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

4.2.1 I've Been There

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2.2 They Must Ask Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2.3 Not In My Backyard

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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