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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 6: Recommendations and Conclusion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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