From Surviving To Thriving:  
Navigating the First Year of Professional Nursing Practice

Judy Boychuk Duchscher RN, PhD
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Dedication

This book is dedicated to all new nursing graduates and their devoted supporters for fueling the flame of caring, compassionate and committed competence that sustains the nursing profession.
Acknowledgements

I would like to thank all the family, friends, and colleagues who have sustained me through the stages of conceiving, developing, and building this theory of transition. While we all recognize the rudimentary need FOR support, what we do not always see clearly is how those whom we support hold US up.

My life changed when I began this journey in 1996. Along the way, I have had the absolute privilege of working with numerous new graduates who have not just blessed me with their insights but have led me to a professional ‘place’ where I know, without question, I belong. How ironic….given that belonging is the primary developmental objective of a newly graduated professional nurse. Perhaps it is simply a basic human need.

To my new graduate and student leadership team across Canada—quite simply, I owe you the latter years of my working life. You have nurtured my body by modeling for me how to rest, you have sustained my energy by renewing my faith in the power of the nursing collective, you have expanded my mind by challenging my assumptions and demanding reason and rationale for all I purport, you have balanced my life by reminding me how to work AND play (even together ☺), and you have touched my soul with your unflagging commitment to our future. I have never quite known how to thank you for the amazing gift you have been to me. I hope that hearing your ‘voice’ and seeing your early nursing experiences reflected in the words of this publication will, at least in part, compensate you for the sacrifice, risk and generous energy you have devoted to this work. Perhaps above all, I hope that you feel commensurately honored for the creativity, passion, creative intellect and faith you consistently demonstrate for this profession. I believe in ALL of you. Remember that you ARE the future. Without you we are but rafts afloat with neither oars to steer nor handles to hold—caught up in rapids that are as unforgiving as they are invigorating.

To my mentors, too abundant in collective spirit to do justice to individually—you know who you are—who have shown me ‘a way through the woods’, oftentimes equipping me with tools I didn’t even know I would need to forge my own path. Often, without my knowledge, you positioned yourselves behind me to catch me when I fell; walked ahead of me so I could see HOW you climbed and, when the brush was thick, cleared the way for me; stood by my side when the climb was particularly challenging so I could gain strength and courage from your presence; and surrounded me with your loving spirit when I inevitably and necessarily had to ‘go it alone’. When I think of you, I am reminded of the words of Bernard of Chartres—a 12th century French philosopher and scholar—who said that “we are like dwarfs on the shoulders of giants, so that we can see more than they, and things at a greater distance, not by virtue of any sharpness of sight on our part, or any physical distinction, but because we are carried high and raised up by their giant size.”
To my ‘funny’ brothers (Brian and Ron Boychuk of the ‘Chuckle Bros’ http://www.chucklebros.com/) for showing me how the use of humor can save us from the often relentless and confining clutch of ‘life’ – OURSELVES! I can see now how you provided our family with needed relief during life’s darker moments and for that I am truly grateful. Your continued support of my life, my work, and the painful but necessary growth these often demand in us, has been critical to my development. I treasure your unique influences in my life more every day.

To my parents, whose own struggles to provide a curious and convicted child with both vision and sight meant tremendous sacrifice and patience. Mom, thank you for doing all you could with everything you had. Dad, I have grown to love the ache that missing you brings.

Intentionally I end with gratitude for you Eldon. Your Divinely appointed presence in my life has allowed me to understand and fulfill my God directed purpose. You are my partner in every way—my lighthouse when dense fog clouds my vision, my reach when things seem beyond me, my strength when I have grown unusually weary, my spirit when circumstances leave me feeling hopeless, and my island when the waves of life threaten to drown me. I cannot imagine my life without you. Thank you for sharing both your strength and vulnerability with me. You have taught me how to love and what it means to be loved. That knowledge has transformed my life.

To He who Divinely appoints my life. . . .in everything I do, I hope to honor you.
Hillary Clinton had it right when she said ‘It takes a village’. BEING MENTORED MATTERS!!!! I cannot imagine how I might have written a cogent word that carried any hope of international impact without the tremendous support of my treasured colleagues around the globe.

It is appropriate to ‘start at the very beginning’ of my graduate journey, during which I was Blessed to cross paths with the following outstanding teachers, researchers and scholars: Dr. Karen Wright, Dr. Norma Stewart, Dr. Gail Laing and Dr. Debra Morgan (MN Studies—University of Saskatchewan, Canada); Dr. Joanne Profetto-McGrath, Dr. Olive Yonge and Dr. Flo Myrick (PhD Studies—University of Alberta, Canada). It is humbling now to reflect on the time I spent in their protected embrace as a young graduate and then doctoral student. I have often thought of the lessons they took the time and energy to teach me, despite being steeped in their own rigorous work and demanding schedules. As Joanne once said (actually it was more than once), ‘It took TWO to supervise YOU Judy!’ John Bunyon was credited with a notable quote, befitting my feelings toward these mentors: “You have not lived until you have done something for someone who can never repay you.”

Lynn Digney Davis, Chief Nursing Officer of the Saskatchewan Ministry of Health Nursing Secretariat is the epitome of a new graduate nurse champion! Lynn received Nursing The Future’s inaugural Torch Award for excellence in nursing leadership in recognition of her outstanding commitment to the advancement of new nurse issues. Without fail, Lynn has found a way to fund NTF annually, allowing us to take yet another step in supporting grads not only in her province but across North America. Nursing owes you a debt of gratitude Lynn and I owe you so much more.

Dr. Marlene Kramer, whose work in the 1960s pioneered this field of study, graciously honored my request to write the ‘Foreword’ for this book. It is truly difficult to express my gratitude for this act of support, and for the lifetime of contributions she has made, and continues to make to our global nursing community. Thank you Marlene for supporting me to join your original journey to give voice to the newest of our discipline.

Dr. Patricia Benner’s seminal body of work in the evolutionary skill acquisition and knowledge development continuum of practicing nurses changed our world in the 1980s. Her most recent publication, Educating Nurses: A Call for Radical Transformation has drawn our attention to the need for a reorientation in nursing curricula commensurate with our professional vision. Through this call to action, Dr. Benner invites us all to share in advancing nursing education, research and practice. Her willingness to support this body of work, and to graciously support my ongoing desire to pave a new way for the newest members of our profession, is truly humbling and inspiring.

I remember the first time I had the pleasure of meeting Dr. Marilyn Oermann. It was in Saskatoon, Saskatchewan during her visit to the University of Saskatchewan to work with our faculty on advancing our clinical education platforms. I was driving her to the airport and we stopped for lunch at a local hotel. In one hour, I felt more encouraged in my scholarly journey than I had in years prior. I have kept in touch with Marilyn for 10 years now and her support has never wavered….the spark of her positive nature and her professional encouragement have lit many a dark path for me over the years. Thank you Marilyn, over many miles and years, for ‘being there’.

Dr. Leanne Cowin came into my life in 2001 with the gift of her collegiality. Since that time, she has reached out to me as a mentor, colleague and friend on more occasions than I could possibly count. Leanne has supported and promoted my message about new graduate transition whenever, wherever and to whomever she could. She has successfully traversed our geographical distance in typical ‘Aussie’ style—with remarkable humor, humility, transparency, challenge, critique and above all acceptance. You have no equal in my books Leanne.

Finally, I would be remiss if I did not acknowledge my tremendously supportive colleagues in the Faculty of Nursing at the University of Calgary. Dean Dr. Dianne Tapp leads an outstanding and growing team of nurse educators, practitioners, administrators and researchers who are leaving a deep and enduring legacy for our profession. I am consistently impressed with the breadth and scope of their reach in our community and feel privileged to practice amongst them.
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I extend my heartfelt gratitude and profound respect to the following colleagues for their editorial contributions to this book:

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Preface

*From Surviving to Thriving – Navigating the First Year of Professional Nursing Practice* was originally published in 2006 through my organization *Nursing the Future ©*, selling over 5000 copies in Canada, the US and Australia from 2006-2011. In 2007, I completed my doctoral dissertation on the experience of professional role transition for the newly graduated nurse; this constituted my 4th serial study (3 qualitative studies of my own and the retrospective analysis of qualitative data from a study by Dr. Leanne Cowin in Australia) in this substantive area of research. At that point, I felt confident that my evolving findings had generated a grounded theory of transition for new nurses that I could stand behind. While the 1st Edition of this guide provided a solid framework to guide both new nurses and those who support them, it lacked the detail contained within my *Stages of Transition ©* and *Transition Shock ©* theoretical constructs and the strategies that arose both out of my research and through my work and consultation with thousands of novice and experienced nurses, managers and educators who seek to support new nursing graduates in professional role transition. These additional insights are offered in this 2nd Edition.

The response of the professional community to my work has inspired me to create a program of research that will further examine the professional role transition of new nurses and extend those insights to other disciplines. As of the writing of this 2nd Edition, I am leading one study exploring the experience of professional role transition for Accelerated Degree Nurses (prior non-nursing degree graduates) and another study of male nurses making their initial transition to professional nursing practice. As well, I am a Co-Investigator on a research team led by Dr. Janet Rankin (University of Calgary) to understand how the social construction of the contemporary nursing workplace influences the new graduate’s initial experience of nursing practice. Finally, alongside Dr. Jane Lemaire (Medicine) and Dr. Jean Wallace (Sociology) from the University of Calgary, I am exploring how physicians newly licensed for independent practice experience their initial professional role transition.

Once again, I have been truly blessed to work with a devoted team of new graduate nursing leaders, all of whom at the time of this writing have assisted me to build this resource for you. I would like to acknowledge their tremendous work in supporting their colleagues in transition, and being champions for the facilitation of a healthy professional role transition.

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1It is important to note that while my initial 4 studies were conducted with Registered Nurses in acute-care practice areas, this book and its contents have been exhaustively vetted by Practical Nurses in a variety of positions including student, new practitioner, practical nurse educators and managers. While the majority of new nurses (of all scopes) continue to make their initial transition to professional practice in acute-care, I took significant steps to ensure this book was edited by new nurses whose experiences of transition included rural, community and public health practice settings.
Preface

for new practitioners of nursing. It is with the deepest gratitude that I acknowledge Kandis Harris RN, BScN, MN(s), the National Leadership Director for Nursing The Future along with my thoroughly outstanding NTF New Graduate Leadership Team for the inspiration they have offered me for the past 12 years. Working with these young leaders has transformed me and allowed me to be all that I can be as a nursing leader. I am humbled to include myself among these brilliant minds, enduring spirits and compassionate souls. Finally, I have been blessed with committed support of numerous professional and personal mentors throughout my 32 year career. The 2nd Edition International Editorial Review Board includes many of those supporters and I am eternally grateful for the guidance and encouragement they offered me as I wrote this book.

Directly as a result of the selfless cumulative efforts of over 100 grassroots leaders, NTF continues to support nursing’s newest professionals as they strive to sustain their professional values at a time when everyone is being asked to ‘do more with less’, practice to a standard that honors the experiences of the patients, families and communities they serve, and fulfill their dual—and oftentimes competing—desire for a dynamic, challenging professional career and a quality personal life. We say it can be done—but we all need support to do it.

I challenge you to take what is offered in this resource and use it to challenge, confirm, validate, sustain or advance your experience AS a new graduate or your work WITH new graduates. I encourage my senior colleagues to look around them for that new nurse who is in need of encouragement, support and your experienced perspective. Equally, I remind all new graduates reading this book to be aware of the growing force of support that is yours if you can find the courage within to grab a hold of the out-stretched hand. We must ALL be within reach of the ‘other’ in order to create something stronger—in order to be more tomorrow than we are today. This is the legacy we are all privileged to leave.

The future is built by giving the next generation reason to hope.....

Judy E. Boychuk Duchscher RN, PhD
Founder and Executive Director
Nursing The Future ©
www.nursingthefuture.ca
Introduction

This book offers new nursing graduates, experienced nurses, managers, and educators a basis for understanding the issues inherent in making the transition from nursing student to professional practicing nurse in the contemporary healthcare climate. Please note that this book was written to reflect the collective experiences of new graduates and students from Canada, the United States, the United Kingdom and Australia. If a component of the text does NOT resonate with your geographical context, please keep this in mind. It was my intent that the book be as inclusive as possible without appearing biased to any one geographical location. I hope this is your experience in reading it.

The content in this book was reviewed by the NTF Canada Leadership Team, as well as numerous nursing students, newly graduated and experienced nurses and nursing leaders throughout North America, Australia and the United Kingdom. The knowledge used to develop and evolve the Transition Shock © model and the Stages of Transition © theory that frame this publication exists as part of the ongoing research and study program of Dr. Judy Boychuk Duchscher. The anecdotal evidence that substantiates these stages and the suggested strategies for a successful transition that are contained within this resource have evolved out of the experiences of new nursing graduates. A debt of gratitude is owed to the many new nurses who have contributed to our understanding of the struggles and triumphs experienced while making the transition to professional nursing practice.

This book has been licensed to Nursing The Future© by Dr. Boychuk Duchscher for limited production and distribution. Funds from the sale of these books are committed to providing resources and initiatives that support the professional role transition of new nurses and to developing new nursing leadership capacity.

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How Will This Book Help You?

This ‘survival guide’ (as my new grad leaders like to refer to it) will accompany you through the first 12 months of your journey into professional nursing practice. We know (because we’ve been there!) that there will be ups and downs during this initial year, but remember that you are NEVER ALONE. The numerous colleagues who have gone before you now embrace you with words of wisdom, smiles of encouragement, and the outreached hand of support. Nursing The Future, and all of your new graduate and experienced colleagues both in this organization and within your new practice settings, will be there for you any time you need them. Yes, there will be times of loneliness, painstaking growth and personal as well as professional change. But this will be balanced by many moments of comforting familiarity and thrilling success. You will learn that you can’t have one without the other - that when you are up to your eyeballs in one (either screaming YIKES or yelling YIPPEE), the other is on the horizon…and so it goes.

The book is divided into chapters: Chapter 1 provides an overview of the process of transition and offers you insights to consider PRIOR to graduating as a professional nurse. Chapter 2 introduces you to Transition Shock and walks you through the elements that both influence and are influenced by your initial entry into professional practice. This comprehensive section emphasizes the wholistic nature of transition and talks about why many graduates feel a sense of ‘shock’ when taking on the full weight of their professional nursing role for the 1st time. Unlike the extensive emphasis it assumes in this publication, thankfully this phase of transition is relatively short-lived ☺ and may be significantly muted for those who have strong supports during this time, have previous familiarity with the workplace in which they are transitioning, or whose life experience has afforded them relational, work and transition perspective through time-earned maturity.

Once over this initial ‘hump’, the remaining elements of the 1st Stage of Transition—DOING NURSING—unfold up to about 4 months after orientation is complete and the new nurse is ‘on their own’. Chapter 3 outlines this 1st Stage of Transition as a time of recognizing and accepting that life is different now that you are a practicing nurse. This is a time of focus for the new practitioner; doing what is required of you as a fully responsible and accountable nurse and ‘getting through your shift without killing anyone’ (not really, but this is how it feels…) is your primary objective. Chapter 4 follows with an overview of the 2nd Stage of Transition—BEING A NURSE—during which time there is an evolution in your perceptions of what nursing is and you strive to make sense of what has changed for you. This third chapter offers guidance on how you can fit what nursing ‘is’ into what you thought it ‘was’ and, perhaps more importantly, what you want it ‘to be’. We want you to know that you are not alone in what you are feeling or experiencing – contrary to the evidence that may overwhelm you during that 2nd Stage, YOU ARE NOT GOING CRAZY!
The 3rd Stage of Transition—KNOWING NURSING—or Chapter 5 of the book, accompanies you on what has by this point (we hope) become your ‘accepted’ career. It speaks about how you, now a more seasoned professional with an idea of what you want, can move forward in nursing while also moving nursing forward. It draws attention to the new perspectives you are gaining about healthcare as a system, and offers you ideas on how to pursue the path in nursing that can develop you professionally and satisfy you personally.

In TEXT BOXES enclosed with dark lines I have interspersed ‘famous’ quotations—some are intended to give you a much needed emotional break and some are intended to simply give you pause. As well, there are narratives (verbatim text from my research) that you will find in indented text with double quotation marks and italics. these are the words of new graduates JUST LIKE YOU who faced what you are facing and shared their experiences with me; now I am sharing them with you. Standards related to research ethics prohibit me from sharing the names of the individual/s from whom these narratives originate.

Each chapter culminates in a ‘review’ section at the end that is situated in summative commentary that highlights what I believe you:

1) NEED TO KNOW

2) NEED TO THINK ABOUT

3) NEED TO DO

Finally, there are numerous and extensive APPENDICES at the back of the book that offer tips on how to find the professional role that matches your aspirations and inclinations, strategies to cope with the first 12 months of your professional role transition, and resources that can assist you to advance both your career and the profession.

We offer you this resource in the hopes that it might help you to feel more understood and less overwhelmed.

So let’s begin…..
Foreword
Dr. Marlene Kramer

Years ago when Judy first introduced herself to me, she recounted her journey to secure a copy of my now-archived book *Reality Shock: Why Nurses Leave Nursing*. She talked about spending months scouring the bookshelves of her ‘senior’ colleagues and searching ‘used’ bookstores for a copy without success. I thought to myself, this nurse researcher is really serious about pursuing the work I had started on examining the trials and perils of new graduate nurses in their initial professional practice experience. Since then, I have tracked the progress and evolution of Judy’s research and am honored that she asked me to write the foreword for this book.

Nursing is the planned, scientific alteration of patients’ internal and external environments with the intent of placing them in the best possible situation for the laws of nature to act, thereby facilitating the healing process. Nightingale’s definition of nursing, based on the “environment as alterable medium” theory, served as a platform for two Institute of Medicine (IOM) reports that have captivated and revolutionized the health care industry and professions. The first IOM report, published in 1999 was entitled: *To Err is Human*, and described healthcare in US hospitals as unsafe, citing as many as a million people injured and 98,000 dying annually as a result of medical errors. (Subsequent studies in multiple countries suggest that the above statistics may have been largely underestimated). The 2003 IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* followed up on the initial report with identified solutions to environmental problems that threatened patient safety by effecting nurses and nursing care, and challenged the health care industry and professions to improve work environments of nurses. Most recently, the IOM has published a third report, *The Future of Nursing: Leading Change, Advancing Health* (2010) which emphasizes the close ties between nursing work and patient outcomes, recommending advancement in the education, practice preparation and utilization of nurses across all scopes of practice. Interestingly, the foreward pages of this latest report quote Goethe: “Knowing is not enough; we must apply. Willing is not enough; we must do”. I believe Dr. Duchscher’s book represents a living example of this vision as she makes the journey of professional role transition for new nurses ‘come alive’. Judy not only offers the newest members of our profession insights on what to ‘do’ to optimize this journey for themselves, but affords those of us who seek to support them a framework by which to do so.

Patient, family, clinical and organizational situations and interactions constitute the external environments of practicing nurses while the physical and emotional stress, loss of self-confidence and reduced self-esteem that result from the differences between the concept of nursing they learn in school and the concept of nursing demanded of them in hospital nursing practice constitute the nurse’s internal environment. My extensive research of magnet environments clearly demonstrates that the external environments within which nurses practice strongly
influence their internal environments. Although professional practice environments impact performance of all nurses and health care professionals, they have a profound effect on new graduates’ tolerance, motivation and ability to engage in safe practice. Structured support—usually in the form of Nurse Residency or Transition Facilitation Programs—that utilize evidence-informed approaches to alter both the internal and external environments may well be the most effective way to enhance the new graduate nurse’s role performance, provide job and professional practice satisfaction, and halt the flight of these aspiring professionals from the bedside and from the nursing profession.

My work in the 1960s was the first to explore the concept of reality shock in newly graduated nurses. Using reflective learning seminars, I sought to counter the negative socialization effects of the workplace on these newly graduated nurses’ internal environments. The four decades that have transpired since my original work have given way to tremendous change in our healthcare systems, particularly in hospital practice where most new graduates start out. Dr. Duchscher, in her work, has emphasized the direct and interactive impact of the external environment on new (or aspirant) professional nurses.

In this new book, written specifically for newly graduated nurses transitioning from academia to their first employed professional practice experience, Dr. Duchscher summarizes the results of her 12 years of research. Through her direct observation of new graduates in clinical practice situations, countless interviews and focus groups, years of undergraduate teaching, and most recently through her experiences mentoring hundreds of new graduate leaders as part of her non-profit new graduate support network Nursing The Future, Dr. Duchscher has built a grounded theory that describes the journey of transition. This much needed explication is an outstanding contribution to our understanding of the difficulties and joys nurse graduates experience in their first year of practice. Of prime importance is that Dr. Duchscher’s work focuses on new graduates’ external as well as internal practice environments. Her theory is intended to help the new nurse gain ‘insight’ into the structures and processes that underlie the challenges they might be experiencing, while providing them with initiatives and approaches that can be used to alter BOTH of these environments.

A word to new graduates: This is not a dull, dry textbook. As you travel with Dr. Duchscher through your transition journey, you will encounter a delightful and very practical mix of theoretical concepts, enlivened and illustrated by quoted excerpts from practicing new graduates, light-hearted humor, as well as by parenthetical author feelings and comments. The very unusual first person insertion of the author’s experiences and comments offered by Dr. Duchscher not only brings her concepts to life, but creates a feeling of ‘oneness’ between new nurses everywhere and the author.

Through the understanding and subsequent framing of new graduates’ lived experiences, others who read this book will be in a position to assist newcomers to cope with the alterations of their internal environments while assisting them to adjust to, and perhaps even change, the
structures and processes in their external environments. Through a deep understanding of the transition journey lived by new grads, experienced nurses, clinical coaches, preceptors and mentors can facilitate the socialization and professionalization processes needed to support these aspiring professionals, their professional practice and the quality of care offered to the communities that nurses serve.

Marlene Kramer, PhD, RN, FAAN

About the Foreword Author:

Dr. Marlene Kramer received her BSN from St. Louis University in 1953, her MSN from Case-Western Reserve University (1958), and her PhD in education/sociology from Stanford University (1966). While at Stanford, she had the opportunity to study with Dr. Leon Festinger, father of the Cognitive Dissonance Theory that has become the major theory providing direction for coping with the “expectation-reality generated stress” encountered by nurses and other health care professionals in initial positions post graduation. She has held a variety of positions in Nursing Service and has been a member of the faculty of three Schools of Nursing: University of California in San Francisco, University of Connecticut, and University of Nevada, Reno where she was the first occupant of the Orvis Chair in Nursing Research. In the late 1960’s, Dr. Kramer tested the effects of an Anticipatory Socialization Program during academia, the first stage of professional socialization, on senior nursing students’ role conceptions. This study led to the publication in 1974 of her seminal work Reality Shock: Why Nurses Leave Nursing. From 1974 to 1979, Dr. Kramer received the first federally (US) funded research grant focused on empirical testing of programs designed to alleviate Reality Shock and assist new graduate nurses in making the transition from academia to acute care practice. This series of studies tested the effect of Reflective Seminars, Bicultural and Conflict Resolution training on new graduate nurses’ transition into practice, and resulted in two publications—Path to Biculturalism (1977) and Coping with Reality Shock (1979).

For the next 20 years, Dr. Kramer’s research focused on nurses’ work environments, and the effect that these have on nurses’ productivity, satisfaction with the work of nursing, and retention. The birth of the Magnet Hospital concept in the early 80’s provided the opportunity to conduct this extensive program of research in institutions of Excellence. Since 2000, Dr. Kramer and her colleagues at Health Science Research Associates have conducted a series of 8 studies in which they have identified 9 essential structures and 8 essential work processes that produce productive, healthy work environments and desired patient and nurse outcomes. Her current research program focuses on the impact of healthy work environments and Nurse Residency Programs on new graduate transition and integration into practice.
CHAPTER ONE

Student Nurse to Professional 101
Welcome To Nursing!

Accepting your 1st role as a professional nurse is the beginning of the next phase of ‘the rest of your life’! Isn’t that how the saying goes? It is, without a doubt, one of the most exciting times of your life!!! Having said that, I’ll bet there is also a place, deep in the pit of your stomach that turns at the thought of graduating—that feels nervous and strangely anxious about what’s ahead. That is likely because you are not entirely sure what it will be like to practice as a ‘real’ nurse and you may not know who you will be working with, if you will be able to work well together, or even if you will find the work you are looking for. You may not really have a good sense of what will be expected of you as a new nurse, what unit or institution you will be employed by, or what the differences will be working as a professional compared to working as a student. This guide is intended to respond to those concerns with insight about this experience AND to offer you hope and support as you make your way into the profession of nursing.

“It would be nice to sort of be able to talk with [someone] to say ‘is this where you’re at or am I really not getting this’ or ‘okay this is normal and this is how we sort of go about this’. I worry that [other] new grads usually by this point are functioning completely independently and effectively and efficiently and I’m sort of back here stumbling through the motions.”

To begin, anytime someone makes a ‘change’ from what they know to what they don’t know or are not completely familiar with, they experience a transition—a journey from what was to what is. It is not so much the actual CHANGE (motivating event or ‘catalyst’) that challenges us, but the process of MAKING THE CHANGE that the situation motivates—that’s transition. Transitions are considered passages or movements from one state or condition to another and they can profoundly influence and alter the lives of the individuals involved as well as their significant others (friends, family and co-workers). Transitions usually begin with events that create instability and make change necessary—graduating as a nurse and moving from being a nursing student to being a fully responsible professional nurse IS such an event.

“It hasn’t sunken in yet actually. Like I was amazed the other day because I took my shoes to work and I could actually leave them there. Like I have a locker and I can leave my stuff there and it’s hard to get used to the fact that this is kind of a permanent thing. That it’s not a 4 month rotation or four week rotation or a three month rotation or whatever.”

—I attribute my success to this –
I never gave or took any excuse.
- Florence Nightingale

Chapter One
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Making the transition from being a student to being a ‘real’ nurse is rewarding and exciting. At the same time however, it can be frightening, lonely and overwhelming as the realization dawns that you are responsible for what happens with the patients under your care, and that you are essentially ‘on your own’.

“I like to think of myself as a competent [person]. I do like to think that I do have some degree of competence. Now going into this profession, one shift is never like the other. You have to be prepared for whatever can be thrown at you and like I’ve told my co-workers, for me it seems like whenever it rains, it pours for me meaning that when one thing goes wrong or one admission comes in, I get three. And it’s almost like it’s harping on my confidence a little bit right now. It’s kind of breaking it down and I’ve never felt like that before so maybe I’m questioning this position I’m thinking to myself can I do this? And that’s new for me ‘cause up to this point it has been ‘how am I going to do this? Now it’s ‘CAN I do this at all?’

We want you to know that you are NOT alone – that every other nursing student who has ever graduated goes through a similar process of adjustment. Have patience and know that you WILL get through this experience and you will become the professional nurse you have always wanted to be.

But let’s not get too far ahead of ourselves. As Julie Andrews’ character Maria sang in The Sound of Music, “Let’s start at the very beginning….a very good place to start”!

**Prior to Graduating**

“You know they talked a lot about it in school and I always thought ‘Uh, whatever’. I thought you know that’s common sense but it’s not really when you think about it… Like they did ask us questions in school about ‘OK, you have this patient, this patient, this patient. Who do you go to first?’ Those kinds of questions. And I just thought she’s [faculty] the meanest woman in the whole world. She just wants to trick us! But you know what? I think we needed more of that cause you need that once you’re there. I think that’s why I found her a difficult teacher is cause she’s teaching you things that you really needed to know. You needed to know those things to be on the ward and to be by yourself and it just seemed like a lot when you were in that class. You thought, ‘Oh like you ask too hard questions’. We shouldn’t be knowing these things but you should and I’m glad that she did talk about things. Like she did talk about someone

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1In North America, the word ‘cause acts as an abbreviation of the word ‘because’. The Australian equivalent would be ‘coz’.

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**Whatever my individual desire were to be free, I was not alone. There were many others who felt the same way.**

-Rosa Parks
coming with this and this, what do you think they’re diagnosis is going to be. And you know she wanted you to analyze the situation and through that know what steps you should take and I never really realized it then but now I’m like ‘Oh’. If only I’d paid attention to what she was saying to me.”

My research, the numerous conversations I have had with leading scholars on the subject of nursing, and my long history teaching nursing and working with newly graduated nurses has taught me that the process of ‘socialization’ into the profession begins LONG BEFORE you enroll in a nursing education program. For instance, can you tell me you haven’t seen episodes of ‘ER’, ‘Scrubs’, ‘Grey’s Anatomy’ or ‘Nurse Jackie’ before or during your education? And we all know that these shows give people impressions about what nursing IS and what nurses DO. We also know, and you have likely learned over time that not all of these impressions are accurate. Some students go into nursing because they have experience with a family member who is a nurse and they admire that individual for the work they do, or even just ‘like’ them personally and associate who they ARE with what they DO. Some students have had experiences with the healthcare system prior to entering school, either as a young patient or as the family member of someone struggling with a health challenge—they see a role for themselves in making a difference in the lives of individuals in need. Finally, there are the encounters with experienced nurses that you have throughout your education; some of those encounters have likely inspired you to be better than you currently are, while some may have made you wish you had never started……these experiences are not new, nor unique to the nursing profession. Sad to say, but human nature can, on occasion, be strangely disappointing.

“Disappointed I would say is the biggest thing because you have an expectation that you’re going to graduate and become a nurse. You’re going to buy a nice house. You’re going to drive a nice car. You know everything’s going to be dandy and then you get out and you have a bunch of older nurses that it feels like they hate you, you know, where they’re ready to run you off the floor you know. You realize that you owe $40,000.00 in student loans and you can’t get your new house. You can’t get your new car. You know, it’s a disappointment.”

Some people reasonably assume the healthcare system will always need nurses and further, that employability as a nurse is a relatively timeless certainty. And finally, some individuals (like me!) see nursing as a rewarding, dynamic, flexible, mobile career that can take you ANYWHERE and allow you to do almost ANYTHING (my experience tells me that’s TRUE!). All of these experiences breed expectations and they don’t call them ‘lasting impressions’ for nothing!
So, chances are there were very personal reasons that grounded your decision to enter nursing. Those reasons may well have influenced:

1) what you chose to study (the subjects you wrote about in your papers for instance),
2) the area of practice you are seeking as a professional (hospital, community, or public health),
3) how you see your role in relation to other healthcare providers (how nurses relate to other healthcare providers and the relative autonomy, respect and acknowledgment they are afforded),
4) and how you ‘want’ to practice in relationship to your patients, the communities you serve and the profession as a whole (hands on direct care, nursing education, research or administration for instance).

It is important that BEFORE YOU GRADUATE you take time to explore the reasons why you wanted to be a nurse in the first place, how those reasons might have changed, and how your reasons might be challenged or supported by the roles you are anticipating to assume as a practitioner in the ‘real’ world. This reflection will help you to prepare to practice in an area that is compatible with those expectations. Case in point—if you enjoy working in high intensity, rapidly changing situations you may want to choose a busy medical-surgical hospital unit as your initial practice experience. Conversely, if you like to teach, work to develop programs and initiatives or provide international healthcare relief, you may want to consider a community, public or international placement. As well, this kind of self-knowledge can alert you to the potential incompatibility of your goals and expectations with the jobs for which you are applying. For instance, if you enjoy rapidly changing situations but you have a history of a stress-induced ailment, you may want to choose an initial practice context that has lower stress, or you may want to consider casual or part-time work in acute-care after graduation so you can control your hours and workload intensity during your initial adjustment to a professional practice role.

“Well maybe because when you're a student, you know you've like a maximum of three people to take care of ever as a nursing student, and then you come out and you've got ten. Like ten is a big difference you know, and plus, on top of that, like those three you care for from what 7:00 in the morning till 2:00 in the afternoon, you barely make it to post-conference. Now I'm working shifis with ten other nurses and as students you really helped each other out like you know you've
been friends. You’ve been together for four years and now I get out to the unit and nobody wants to help me it seems like and yeah, it’s different. It’s just so different. By the end of the day I can’t even think straight or stand up anymore. It’s just I’ve been run off my feet every day.”

Despite these suggestions, the reality is that you might not always HAVE a choice about where you work initially. While you may want to work in surgical acute-care or public health initially, the positions available to you may be in long-term care or medicine. Or, there may be personal circumstances (a desire to stay close to family, children or a spouse) in your life that require you to remain in the area where you graduated, limiting your options for employment. You may also feel anxious about leaving your education-based hospital experience behind too soon AND the acute-care job market may be more open to novice practitioners than other agencies (more experienced nurses often seek the less physically demanding work found in homecare, community or public health). So despite the anxieties that come with acute-care nursing, you may choose to ‘start’ your professional career there, branching out later in your career to community, public or home health positions. Remember—this is a CAREER and you WILL get where you want to go—it just might not be immediately!

Regardless of WHERE you choose to nurse at the start of your career, or WHAT role you take on as a new nurse there are certain elements of BECOMING a nurse that are common to the vast majority of graduates.

He knows nothing; and he thinks he knows everything. That points clearly to a political career.

-George Bernard Shaw

What’s the Deal with Transition?

“I might as well start by telling you that it’s the hardest thing I’ve ever had to do was to make the transition from going to school to practicing in the real world. Everyone told me everything is going to come together. But that’s something I have learned—I had to experience it for myself.”

As we talked about above, the transition from being a student to being a fully responsible, accountable professionally practicing nurse is one of the most anticipated moments of a person’s career. The fact that we are formally ‘ending’ one phase of our professional socialization and moving into another assumes a certain degree of change—changing roles, responsibilities, relationships and knowledge. With these changes come additional or different pressures,
expectations and challenges. It is what you have prepared for throughout your education, but when it actually happens, it often hits you like a wet towel across the face.

“Hmm. Strange. I don't really feel like I am done [school]. Like I walked to work one morning and as I was walking I was thinking 'I'm getting paid to do this' cause it was like I was still in clinical and you know like I know it's different. I mean there's a little bit of financial freedom now, which is nice. I can actually do things that I enjoy. But yeah it's very strange to all of a sudden be done and it's like the thing is, I found this especially when we first got out of school. You build up for years and there's this huge excitement of graduating and then you have your first shift and your first you know all these firsts. All at once.”

Newly graduated nurses usually begin the process of professional role transition once they formally leave the safe and predictable confinement of their nursing education program. In fact, some have described the 1st year of professional nursing practice as ‘an obstacle course,’ with the graduate experiencing their work as overwhelming, primarily because of expectations of employers (and graduates themselves) that they will ‘hit the ground running’. There may be individuals with whom you work that do not appreciate, or have clearly forgotten the struggles of starting out as a new professional. These individuals may give you the impression that you should be functioning more like a experienced nurse rather than at the level of a graduate nurse.

“I feel like yes I am ready. I've been through my school. If there's something I don't know, I have all the textbooks. I have people to ask. I mean I know that there's so much learning yet and it's still to come and that I'll feel more comfortable with more experience. But at a new grad level I'm ready. You know I can work as a new graduate.”

As a new grad, you recognize that things are ‘different’, but you may not yet be sure exactly what that means. To begin, you may be experiencing total and independent responsibility for your own life for the first time, managing your own money and caring for your own home (complete with cleaning, laundry and shoveling walks ☺). You may be paying your own rent or mortgage now, maybe paying off the loans you accumulated during your education, and trying to figure out how you are going to pay your VISA with your MASTERCARD so you can afford that long-anticipated vacation that doubles as a reward for all your hard work in school!
Chapter One

“Well I think that it’s just a lot of what people tell me—you know like ‘You’re done school’, or ‘welcome into the real world.’ Like that’s always what I’ve heard and I just think ‘Yeah like now I have to start paying those bills and I have to start paying back that student loan’ and you know like things can start moving now.”

Perhaps you are looking to live apart from friends who have served as your roommates throughout college or university. If nursing is your 2nd professional diploma or degree, you may have children or a spouse (or perhaps aging parents) who have been ‘patient’ with your absence the past couple of years and now expect you to be there for and with them. It doesn’t take long for you to begin to wonder what happened to the ‘time off’ from life’s stresses that the end of this long study period was expected to produce!

“I really didn’t think it was going to be that different. But it was a big change going from a student to actually having to be there doing things. It is big change and it’s really overwhelming. Kind of like you know happy about it one minute and bawling about it the next. You’re just not sure what to think.”

All of these issues bring with them unexpected, and perhaps even disappointing reminders that life is complicated—that hard work doesn’t always ‘pay off’ immediately, or even in the way that we thought it would, or think it should. It’s a strange juxtaposition—graduating and getting back into your ‘real’ life—it has its joys AND its challenges. Now, just managing your relationships with, and responsibilities to family, friends and significant others while trying to navigate a work schedule, get to know new colleagues, re-establish a personal life, figure out who you ARE when you aren’t studying, and understand what it means to BE a professional nurse consumes your energy and time—you just exchanged one set of challenges for what almost seem like GREATER challenges!!

We’re not lost! We’re just locationally challenged.

- John Ford

“I just find for me, I’m not at the point where I’m confident in my abilities yet and I feel like I just want somebody to reassure me that ‘Yes, that’s right Barb’ You can do that’. It’s like a continual. It’s always and it’s in almost everything. I feel like I just want to know that my clinical judgments, my clinical assessments, that they’re correct. That I’m not missing something and that because I want to be competent and safe….I just want to make sure. It’s like back to the word scary like it’s just kind of scary to be making those decisions.”

“I am feeling increasingly confident in my nursing abilities everyday but feeling like I am failing at life. Graduating was supposed to mean I was going to get my life back but I can’t seem to find the balance. I work and sleep, and everything else seems so hard to incorporate.”
TAKE A BREATH……you’ll land on your feet!!! This is simply a period of time where you are learning how to balance the personal with the professional as you explore the new dimensions of your life separate from being a student.

What Factors Influence a New Nurse’s Transition Experience?

My research has consistently revealed that new nurses leave their basic nursing program with the ability to apply a critically thoughtful and reflective approach to their practice as nurses, but within weeks of being introduced into the ‘real’ world, their practice becomes more about doing than knowing. While this often corrects itself over time, there are factors contributing to this ‘back peddling’ in the new graduate’s initial few months of practice:

1) the majority of graduates transition into professional practice through the dynamic, fast-paced and relatively unforgiving environment of acute-care;

2) acute-care patients are more clinically complex and generally sicker than ever;

3) the care resources available to nurses have not kept pace with the demands of nursing work;

4) new nurses are not entirely prepared to work in ‘teams’, therefore their comfort level with and knowledge of task delegation, supervision of unlicensed staff and workload collaboration with nursing and allied health colleagues is extremely limited;

5) students are not consistently expected to integrate population health indices in their patient/client care (i.e. the majority of acute-care admissions are geriatric patients yet the issues related to gerontology—for instance the propensity for dehydration in the elderly—are not comprehensively considered in the daily care planning of the aged acute-care admission);

6) the education of nurses has advanced in the direction of a primary health care focus, while the environment within which new practitioners work remains based upon a biomedical ‘illness’ model of care that focuses nursing work on ‘doing’ rather than ‘knowing’; AND

7) the varying scopes of practice of nurses, and the emphasis on power rather than value sets nurses up to compete rather than collaborate on ways to optimize the care of their patients.

The nursing profession expects much from its members. I have always been an acute-care practitioner (except for several stints up north and some community development projects) and have worked as both a direct-care nurse and a clinical educator. I would always tell my students that nursing in acute-care will ask you for everything you have; then when you feel you have given everything you could possibly give, it will turn around and ask for more. I can completely appreciate how difficult it is for the experienced practitioner to sustain their passion and energy AND instill hope in others while working in a system that:
In short, like I said before, it’s COMPLICATED!!! Making the transition to professional practice can feel as though you walked out of your education and into some sort of MAN- whole that someone forgot to cover!
Just Before The Earth Moves

Prior to the onset of the transition shock experience there are often feelings of elation, excitement and anticipation; after all, you have worked so hard and sacrificed so much to get to this point. We are often somewhat idealistic during our educational preparation. As a nursing educator, I can’t imagine teaching you only what nursing IS without teaching you what it COULD BE. Having said that, I think it is my sense that the greater the anticipation of being able to enact ALL the values that you held dear in your education, the more susceptible you are to the range, overwhelming intensity and labile nature of the experience of professional role transition (moving into the ‘real world’ of practice). The degree to which you experience transition shock, and the relative skills you have to manage that experience depends to a large degree on previous life experience, the maturity of your coping skills, how quickly you are expected to get ‘up to speed’, how much and the nature of the support that exists in your new workplace, and how DIFFERENT the world of work is from what you experienced as a nursing student.

It was not uncommon in my research, nor is it in my ongoing work with nursing students and new graduates, to hear them using words, phrases or expressions such as ‘terrified’ and ‘scared to death’ when referring to their transition experience.

“As a student moving into the ‘real world’ in a few short months, I have recently (during the past month) become scared, anxious, and hesitant regarding graduation. It has occurred to me that it will be the first time I will encounter this degree of responsibility, accountability, and change.”

New graduates claim that relentless anxieties are routine during the initial weeks of being on their own (usually after orientation is complete and they are given the full weight of responsibility for a nursing workload). It is ‘normal’ for you to have some anxieties around your ability to perform with confidence and competence as a new graduate, and it is normal for you to be unsure about how to interact with new colleagues. I also believe that how you experience your introduction to professional nursing work significantly influences how you come to view your professional capacity, the path you feel you CAN take in nursing and the confidence with which you deal with the evolving stages of professional role transition. The workplace where you first experience nursing as a fully accountable professional nurse is critical to your progression – so think about this as you begin.

“If I think we’re just trying to put everything together of what we learned in school and trying to think back on things and… you go through a lot of; ‘Should I do this, should I not be doing this, should I go back to school’…I found I was very hard on myself. Very critical of what I was doing and wanted to quit a few times. I think it really makes a difference on where you start and how you’re experience is at that time. It changes your opinion of nursing.”
For many newly graduated nurses, the experience of transition shock feels ‘like I just jumped into the deep end of the pool’. While we assume that ALL graduating nurses are prepared to practice as beginning nurses (that IS the purpose of the rigorous evaluative expectations of your educational colleges and the reason for your national qualifying examination), some new nurses (like other new professionals) are not ready to jump into their practice with both feet.

“I think you’re trying to understand who you are as a nurse in those first 6 months… I think you discover which kind of nurse you want to be like cause you see others and you try and follow somebody that you want to see as a role model.”

For many, there is a lack of awareness regarding the toll this initial transition may take on their personal energy and time, and on their evolving professional identity. Although most graduates anticipate some adjustments to their professional work situation as they leave school and move into practice, prior to this transition you probably rarely doubted your choice of career nor did you likely question the investment of the years of study that were required of you. No doubt, you expect to be met by a welcoming collegial environment, and afforded a workload that is challenging but achievable; more an extension of the roles and responsibilities you have grown accustomed to as a senior student. It is common for new nurses to anticipate the thrill of actualizing the professional role to which they have earned a title, and it is also normal to expect a certain level of recognition for the knowledge you have acquired and the commitment you have already made to the profession. These are very reasonable expectations.

“You know all of those feelings are just overwhelming you and you don’t know what’s going on, you just have too many feelings. But now that…we’re all calm and doing okay, now we can look back and see all the stuff that we’ve done and learned.”

What I would like to do now is to review the experience of transition shock, offering some insights into why the experience plays out the way it does. You may relate to all or just some of the elements of the experience and likely at varying levels of intensity when compared to your fellow colleagues going through this transition. I can tell you that the experience of transition shock is not linear, and not necessarily similar in the way it is expressed or managed from person to person. I can also tell you that the personal and professional adjustments of this period have been found to affect graduates most intensely in the first 1–4 months post-orientation (the time after which workplace orientation processes and additional induction learning has taken place and after the new nurse had been teamed up with a senior qualified nurse for the purposes of learning expected routines, roles and responsibilities). I would anticipate the adjustments to vary according to your own personal history, coping mechanisms, support systems, co-existing life issues and stress resilience levels.

Any transition serious enough to alter your definition of self will require not just small adjustments in your way of living and thinking, but a full-on metamorphosis.

-Martha Beck
Foundational Elements of Professional Role Transition for New Nurses

There are foundational intersecting elements that feed into your initial experience in the workplace: 1) stability, 2) predictability, 3) familiarity, 4) consistency and 5) success. It is important to say at the outset that the underlying issue here is ‘control’ – having an environment that is stable, predictable, familiar and consistent that in turn allows one to feel successful speaks to our innate desire to control what happens to us, including when it happens, how it happens, and with whom. These elements, when in ‘order’ put us in the driver’s seat of our own life. The challenge with a major change like professional role transition is that much is happening that is outside of our control—leaving us stranded on this island of uncertainty—and we consume a lot of our energy just trying to get things BACK to ‘normal’. Often times our limited knowledge of what is ahead translates into ‘let’s get things back to the way they WERE’ as we recognize this way of being and know how to cope with it—it’s comfortable. But, often without realizing it, doing just that prevents us from moving ahead to what is beyond that which we currently know, making it hard for us to accept, adjust, adapt, and ultimately grow.

I hope now you can see why it is SO important to understand the foundational elements that feed into a new nurse’s sense of control—success in making a healthy professional role transition with the least amount of resistance DEPENDS on this knowledge!

Quality Workplace Factors for New Nursing Graduates©
So, let’s talk about each of these elements as they relate to how you evolve as a new nurse. Strategies to address some of the issues related to these elements will be waiting for you at the end of the chapter!!

**STABILITY** as used here refers to how steady the circumstances and situations are for you during your transition experience; essentially, stability refers to that which is unlikely to change or ‘deteriorate’. If we think about you as a PERSONAL being, this translates into having a POST-GRADUATION life that you recognize as similar to what life was like BEFORE your transition to professional practice took place. Now, there are individuals who thrive on chaos (hhhhmmmmm, well, I don’t really know too many who truly thrive on chaos outside of the fact that it can be motivating and exhilarating for limited periods of time and may be familiar if one was exposed to chaos a lot as a child…) and therefore they may have more well developed skills to cope with instability in their life. But stability is the quest of the human ‘being’—it is a fundamental feature of ‘homeostasis’, which even from a purely bio-physiologic perspective is something all humans seek. I mean seriously, have you been to an amusement park lately? The roller coaster is an AWESOME ride—it’s exciting and scary in a safe sort of way. But I couldn’t stay on it all day—I want to get my feet back on the ground or the shifts in equilibrium just disorientate and nauseate me.

“My 1st 6 months were horrible. Absolutely horrible….it was just the whole confidence, being in a new place,…not knowing what to do as a nurse cause I’m just starting out and just the situations that I don’t know—that you get put into and you’re not confident and you don’t know what you’re doing.”

When it comes to your LIFE, you might want to spend some time thinking about how stable your current life situation is as you enter this significant change. If you are a student about to graduate, you might want to think about how many decisions you can ‘put off’ until you have experienced the initial 6 months of your transition so that those personal changes don’t contribute unnecessarily to your transition stress. When you are considering all the changes you are anticipating, remember that POSITIVE changes are still changes—moving, purchasing a home or car, getting married. While these are clearly exciting and wonderful events in your life that will bring you much joy, remember that they will also consume your energy and contribute to ‘instability’ in your life. Just keep in mind that if you CAN delay other MAJOR decisions until you have been working for at least 6 months, it will allow you to conserve needed energy that may get you through the initial stress of this life change.

*If the people who made the decision were the people who also bore the consequences of the decisions, perhaps better decision would be the result.*

- John Abrams
Now, as for the change that you can’t control……life has its way with us more often than not and controlling change is not always possible. Sometimes you simply have to roll with it. In such cases, simply being aware that you ARE experiencing instability in your relationships, your financial situation, your living arrangements or other areas of your life will be a step toward managing your stress during transition.

So what about you as a PROFESSIONAL—how do you manage the level of stability in the workplace? The factors feeding instability in the workplace are less likely to be ‘in your court’ as they say – you may not have as much control over these factors, but you DO have some control over whether or not you choose to be employed there and ultimately, we all have control over how we RESPOND to what is happening around us.

To begin, ASK QUESTIONS!!!! For instance, when you meet key individuals with whom you may be working in the near future (and you should ALWAYS meet with the manager, the clinical educator and several nurses—senior and junior—in the area to which you are seriously considering working), think about questions you might ask them:

- how many nurses have left in the past year and for what reasons;
- what kinds of staffing levels do they maintain (what is the nurse-patient ratio, how often are nurses called in on overtime and how much sick time does the unit manage on a weekly basis);
- how long is the average length of stay for patients on this unit/in this health center; on average, what is the ‘census’ of the unit (how many beds are full on average each day OR how many clients will I be expected to visit each day and what is the region/part of the city I will be responsible for OR how many programs will I be given responsibility for);
- what is the level of acuity of the patients (how SICK are the patients on the unit—how is that measured and if patients deteriorate over the course of a shift, what adjustments need to be made for this change in the workload of the nurse);
- what kinds of social activities do they organize for their staff (how ‘social’ the staff are often tells you a lot about how ‘happy’ they are working there – even high workloads can be managed if staff work together and enjoy each other);
- how much time does the manager spend interacting with staff;
- what are the opportunities for continuing education (when was the last educational session for nurses, how many attended, were they replaced to attend the session, and what was the session about);
- do they employ support staff (housekeeping, unit clerks, porters) after 4pm;
- do people enjoy working there (are there ‘humour boards’ or cartoons scattered about the unit/workplace, do they have a social committee and when is the last event they organized);
- what does a typical day look like for a nurse in this workplace;
• on average how many breaks do the nurses actually take each day; AND
• how do staff collaborate on the provision of care (how do Registered Nurses and Licensed or Registered Practical Nurses\(^3\)/Certified Nurses Aides discuss and distribute the care required from their team during a shift.

These questions can be asked as you meet with different people in your workplace (remember to pose varying questions to nurses on the unit—not just the manager, educator, coordinator or charge nurse). Another strategy is to ask similar questions to different people and see if the responses vary. These questions can give you insight into how ‘stable’ the unit is to which you are thinking about going. It is not necessarily that what you hear will STOP you from going to that unit (TRUST ME – there are pros and cons to EVERY place of employment and there is NO workplace Nirvana!!), but the answers might prepare you for some of the checks and balances you will need to put in place for yourself during your transition to that unit.

I need to make a comment at this point about the ‘clinical’ stability of the patient demographic you choose to care for as a new nurse. My research in the emergency department was particularly enlightening for me around this. New nurses, though often highly intellectually competent and skilled, have had very little experience witnessing acute decompensating patterns of change in patients that are associated with high levels of risk (likelihood of catastrophic outcome). The new nurse’s ability to recognize subtle changes in a patient’s clinical condition is significantly limited by their inexperience (remember at the beginning of the book when I was talking about the fact that MOST nursing knowledge comes from dealing with increasingly complex situations—as they say, “there’s nothing like experience”).

“Some of the new grads have come to me now and said, ‘I don’t know what we were thinking, we don’t even know where we are as nurses and here we are in an emergency department where you’re expected to know and do and anticipate’, and like they said they’re so tired of learning they just want to catch up to what they’ve learnt instead of cramming all of this information in and not really being able to digest it….It’s such a different focus, emergency though you know….it’s just their [new grads] problem solving skills aren’t there. They get stuck and they can’t move forward. And they’re not able to change quick.”

This lack or absence of ‘tacit’ knowledge may render the patients, new practitioners and their colleagues vulnerable. If you add to this mix the highly unpredictable (rapidly changing situations that cannot be anticipated), unfamiliar (the potential for numerous clinical conditions being presented), inconsistent (the variation in clinical presentations of a given condition) and emotionally charged (patients whose health may be threatened or families

\(^3\)Practical Nurses are variably referenced as Licensed or Registered, according to geographical location. For the purposes of clarity, this nursing scope of practice will be referred to dually as Licensed/Registered Practical Nurse or as LPN/RPN in this publication. Specific reference will be made to Enrolled Nurses and Registered Psychiatric Nurses when appropriate.
who are often in crisis) context of high acuity practice areas such as the emergency room and critical care, you have a potentially volatile environment with a high risk for an unhealthy, ineffective and potentially unsafe transition.

While there are always exceptions to the rule, my experience as a critical care nurse who started in ICU after only one year of nursing experience, and my research and work with numerous new graduates inspires me to caution others regarding the practice of hiring new graduates into high acuity environments (particularly emergency) right out of school. The stability of the patient population you are going to care for as a new nurse is very important to your professional development.

“I just found it interesting that one of the new grads said that one of her co-workers upstairs…got to spend the whole year and learn who she was as a nurse and that was something that the new grads in emerg didn't get to do. She said you get to mature as a nurse for that 1st year as to who you are and what it is you really want to do with all this knowledge…get to learn about yourself as a nurse.”

“I could see us hiring them as new grads and then not setting foot in our department for 6 months to a year…Send them out to different areas to work for 4-6 weeks as a buddy and just learn the process and MI's and what kind of care there is…Send them to neurology and get them used to seeing…normal to abnormal or abnormal back to normal…and getting that kind of ground under them.”

Remember that your primary task as a new practitioner is to develop (NOTE TO SELF: this does not say ‘HAVE’):

- a strong base of organizational skills, time management competence;
- foundational skills in the assessment of the ‘normal—abnormal’ continuum (be that clinical pathophysiology or community and relational dynamics);
- the capacity to prioritize and delegate;
- cultural and social knowledge related to working on a team and working with this team;
- an understanding of how expectations of a graduate nurse differ from those of a senior student;
- the ability to balance your personal and professional life (or actually FIND your personal life again….);
- the flexibility to navigate the circadian and lifestyle flux that is synonymous with shift work; AND
- an understanding of how to collaborate and consult with allied health professions (physicians, social workers, physio).
With respect to your ‘thinking’ during the early stages of transition, it is important to remember that you may **NOT** always be expressing your true thinking **CAPACITY** initially as much as you may be revealing the natural limitations in your thinking **CAPABILITY** during what is a very stressful time in your professional development. Remember, you are thinking about many things during your transition—clinical scenarios you have never seen before, changes in your personal life, additional professional responsibilities, increased performance expectations, pressures of accountability and the potential for and implications of error—to name just a few.

**GO EASY ON THE SELF CRITICISM – it takes a long time to become an expert!**

Now there may be individuals around you who will give you the impression that you are not functioning to specifications—that you should know more, that your education was inadequate, or that if you had paid more attention in class you wouldn’t be in this pickle ☺. But there are just as many who would suggest that if you were orientated longer, had a more committed mentor or a 12-month residency program you would not experience the stress of transition. No doubt there are shreds of truth to all of these claims. But those who play the blame game, pitting your education against your workplace, do little to solve the problem.

Transition to professional practice continues to exist today in a similar fashion to when Dr. Marlene Kramer talked about reality shock in the 1970s largely because **THERE IS NO NIRVANA**. From an educational perspective, no nursing program worth its salt would educate students for what the workplace is really like without also preparing them to elevate the standards to which we are able to practice as nurses. That is the objective of a rigorous nursing education. Conversely, there are FEW workplaces whose orientation, transition facilitation, staff integration strategies and practice environments could live up to the ideals represented...
by the largely ‘theoretical’ foundations of nursing education. The IDEAL, in either nursing education or the healthcare system simply doesn’t exist, though ‘magnet care environments’ \(^9\) strive to achieve optimum practice contexts for nurses. That is not to say that the majority of healthcare systems OR the educational program from which you graduated are failures if they have not achieved this level of excellence, but rather that ‘excellence’ is a continuum and most educational programs and health institutions/centers fall somewhere in the middle—there is room for improvement but they are doing what they can with the resources they have. In the end, we are all obligated to push the boundaries of what we are capable of in order to produce a contemporary context of nursing education, clinical practice and healthcare delivery that is everything it CAN be.

SUCCESS for a new nurse is not that mysterious and, to be honest, similar to that sought by all nurses. You want to leave work MOST DAYS having:

- **not killed anyone ☺**;
- **learned** something new;
- **contributed** something significant;
- **fulfilled** the needs of the majority of those under your care;
- **enjoyed** a sense of cohesion with the physician, nursing and allied health colleagues you work alongside;
- **functioned** collaboratively with those you have called upon to assist in the plan of care;
- **been empowered** by your leadership to make decisions appropriate to your level of knowledge, skill and experience; AND
- **been supported** to create and advance new ideas that optimize the level of nursing practice in your healthcare community.

The difference with a newly graduated nurse is that ‘being successful’ is critical to a healthy and progressive movement through the various stages of early professional development. Unlike their more experienced colleagues, new nurses don’t have the well-honed skills that allow them to easily navigate (or recover from) threats to their as yet fragile sense of professional identity. I would suggest it takes at least a year to mature one’s construct of what a nurse is, what a

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\(^9\) The American Nurses Credentialing Center (ANCC) MAGNET RECOGNITION PROGRAM\(^\text{®}\) is characterized by practice environments in which nurses work with other nurses who are clinically competent; nurse-physician communication and work is collegial/collaborative; interdisciplinary relationships are promoted and facilitated; autonomy and clinical decision making in nursing practice is supported; nurse managers are supportive; nurses control their own practice; there is support for foundational and ongoing education; staffing is adequate; and nurses work in a culture where concern for patients is paramount (see also Kramer M, Schmalenberg C. [2002]. Essentials of magnetism. In McClure ML, Hinshaw AS, eds. Magnet Hospitals Revisited: Attraction and Retention of Professional Nurses. Washington, DC: American Nurses Association, p. 25-59.)
nurse does, how a nurse interacts with colleagues and where nursing fits on the professional continuum and within the overall healthcare ‘machine’. As much as I would like to say it no longer exists, there remains a hierarchy in healthcare and naming it is a starting point for determining how to function within it while at once considering how you can change it where necessary. Failing to provide the new professional with a graduated, success-oriented initiation to practice is ‘preparing them for failure’. My experience with new nurses over the years, and with senior nurses wounded by their early professional experiences, tells me that the successful introduction of a newly graduate nurse into the profession is FOUNDATIONAL to the success of the profession as a whole.

A final word about progress—SMALL STEPS WIN THE RACE!!!!!!!!! A professional career is a marathon, not a sprint. You CAN be and WILL be that expert practitioner you came into nursing wanting to be, but expertise takes time, struggle, and painstaking growth. Beverly Sills reminds us “there are no shortcuts to any place worth going.”

Try to stay grounded in the fundamental objectives of a newly graduated nurse:

- Gaining a sense of the roles and responsibilities of a graduate nurse;
- Creating a workload organizational system that works for you;
- Learning how to manage your time within a GRADUALLY increased workload complexity;
- Learning the routines of your workplace;
- Seeing and experiencing a variety of ‘normal’ and ‘abnormal’ situations under contained conditions;
- Debriefing with a trusted experienced colleague, nursing educator, or mentor about clinical situations to gain a depth of understanding of ‘clinical patterns’ and the relationships between those patterns and the judgments that arise out of them;
- Gaining confidence in performing the fundamental skills required of a nurse in the setting where you work (the competencies of an expert nurse are not singular ‘skills’ or ‘tasks’ performed in isolation, but a complex and layered portfolio of roles and responsibilities enacted in an infinitely varied set of sequences and combinations and under dynamic, fluid and often intense and risk-laden conditions);
- Assessing patients or practice situation of increasing complexity and varying levels of stability;
- Learning how to work ON a team—and learning ABOUT your team;
- Getting to know the dynamics of your workplace—what is ‘nursing’ to your colleagues and how is nursing valued within your institution and community;
- Gaining a balance between your personal and professional life;
- Learning who you ARE when you are not consumed by studying and academic deadlines; AND
- Learning to have FUN again!
At this point, it is worth reinforcing the need to SLOWLY INCREASE the level of clinical complexity, intensity and scope of your nursing practice. Success is not as likely if you are placed in situations that are beyond your capacity—this practice could be unnecessarily counterproductive in the long run. While it may be tempting to jump into clinical practice areas that are demanding and high paced, your practice is best served with a strong foundation and strategic approach to growing your nursing skill and experiential knowledge prior to engaging in high level and critical impact decision making and clinical problem solving under conditions of duress. IF you are interested in high acuity practice (for example ICU or ER), meet with the manager or educator in that practice area and determine the skills, knowledge and experience that would best prepare you for that career path (See Appendix Working in High Acuity). Advance your skill portfolio and consider making the first step toward that career after a year of ‘getting your feet wet’. MAKE A CAREER PLAN that lands you in the area you really want to be within 2 years post-graduation and you will enter that area with a much greater sense of confidence, competence and clarity.

There is a final element that I did NOT include in the overall schemata but that I would like to make note of here. At the risk of being redundant, that element is FREQUENCY, FREQUENCY, FREQUENCY. The more OFTEN you are exposed to stable, predictable, familiar and consistent elements in your personal and professional life immediately after you graduate, and the more gradually you advance the complexity, intensity and scope of your practice by monitoring your developing competence and confidence, the more likely you are to successfully progress THROUGH transition shock, and subsequently through the anticipated stages of professional role transition.

Categories of Influence in the Experience of Transition

Through my research I have been able to generate 4 core categories that I suggest influence, and are influenced by the professional role transition of the new nurse. I have identified these core categories as: 1) roles, 2) relationships, 3) responsibilities, and 4) knowledge. I am choosing to talk about these four categories within the transition shock phase of your experience because I believe that WHICHEVER of these core categories, or elements within them, afford you the LEAST amount of stability, predictability, familiarity and consistency are areas in which you may want to FOCUS your coping STRATEGIES. If you can understand what IS or what MIGHT challenge your transition experience, you will be more likely to successfully resolve the challenges and minimize the intensity and duration of your transition shock experience.
Roles. As a new nurse, you can’t help but notice a subtle but distinct change in your overall role from one of dependent learner to one of independent practitioner and interdependent collaborator. While you may have enacted some of your professional ‘roles’ as a student (care provider, advocate, counselor, teacher to name a few), the change in accountability and responsibility for the process and outcome of those same roles as you enter the world of professional practice can alter your perception of them. They can take on a relative ‘unfamiliarity’ that is surprising to a lot of graduates—things you did with relative ease prior to graduating ‘look’ different through the lens of your new credentialing. Suddenly (and sometimes VERY suddenly), the safety net of faculty or preceptorial collaboration and consultation is no longer available and even the permission not to know because ‘I’m a student’ is no longer an acceptable fall back (although ‘I’m a grad nurse’ can have a similar effect during those months prior to national licensure). The weight of the ultimate responsibility can strangely alter your perceptions and interpretations of situations that are really quite similar to those you dealt with as a student. This contributes to role stress and can weigh heavily on you.

Role stress turns into role strain when you are unable to reconcile for yourself or others what role you are assuming (are you a student or a professional nurse). I recall a graduate who had previous experience as a unit clerk, porter and nurses aide—ALL on the unit to which she was planning to transition. As she was completing her senior nursing practicum in that unit, there was significant role confusion not only for her but for the unit staff who continued to consult her for issues that were more about the OTHER roles she had assumed and not commensurate with her role as a nursing student. While still a student, she pursued a creative solution of distinguishing what role she was engaging in by wearing colored uniforms (for example a red uniform indicated to staff that she was in the role of a nursing student and a white uniform indicated she was in the role of a nurse’s aide). By virtue of this creative strategy the graduate prevented role stress from extending to role strain. The staff became accustomed to her categorizing system and in the end her transition was relatively uneventful. Hey, whatever WORKS!!!!

It is possible that you could experience something similar if you practiced as a Licensed/Registered Practical Nurse or Enrolled Nurse (UK) in a particular practice area and then return there as a Registered Nurse—the point is that if your ‘formal’ title, and therefore your ROLE changes you should expect a period of adjustment for you and those you work with. This includes those of you who might have worked as a nursing student, or had educational experiences on the unit to which you are now transitioning. It is not uncommon, and I suppose not unexpected, for your nursing colleagues to feel somewhat ‘familiar’ with you because you have been ‘around’ them already; perhaps even forget you are a new grad. This can lend itself to unrealistic expectations on the part of the staff and is something that should be discussed (YOU might have to bring it up!) during the first several days of your new role. The best approach is good communication and transparency, particularly with those you are working alongside, as to what roles and responsibilities you are assuming at any given time. Patience with yourself and others will put you ahead of the game as well ☺.
I believe that students who experience a capstone practicum on the unit to which they will be transitioning, or who take employment in that unit prior to graduating as a new nurse can significantly reduce overall transition shock. Having said that, there is something quite phenomenal that occurs for even those graduates that they don’t expect; the nurses with whom they worked collaboratively as a senior student (maybe even just a short week ago) appear to treat them differently. Sometimes your status as a new nurse in the eyes of your experienced colleagues is ENHANCED and the new role feels empowering, while sometimes the more senior nurses’ expectations rise more RAPIDLY than the confidence you have in your new position, rendering you vulnerable to feelings of inadequacy and incompetence. My research was not clear on this, but it was consistent—something changed. It is hard to know if this ‘change’ was in the receptivity of senior co-workers to the new nurses altered role designation, or if the change was in the self-perceptions of the graduates themselves; but an adjustment to new role expectations was necessary by all. Along these lines, the challenge of returning to a unit where you were previously a senior student may result in staff expecting you to know more than other new graduates and assuming that you require less orientation or transition support. This may not be a fair assumption and I encourage you to discuss this potential issue with your manager, educator and practice area manager prior to employment.

Finally, the roles you will be assuming in this newest chapter of your life are as PERSONAL as they are PROFESSIONAL. The fact is that family (parents, spouses, children) and friends KNOW you graduated and now THEY have changing expectations of you. It might be something as simple as no longer being able to ‘escape’ the clutches of unwanted social invitations by saying ‘I have to study’ or something as complex as trying to explain to your 4 year old daughter how your mind, body and soul have been depleted by the past 3 years of school and that you need to rest awhile; your child who simply wants your attention believes all that celebrating that occurred for graduation was reason to believe YOU’RE BACK!!!!

I recently had someone approach me to ask if I was going to write a professional role transition guide for the family and friends of new graduates!!! I actually thought that was quite an insightful query as graduates sometimes forget that they are not necessarily the only ones who ‘graduated’ from this chapter in their lives. Those who have ‘stuck by you’ during the challenging times are ALSO experiencing a transition of sorts—it may be that they have ‘buffered’ aspects of their own lives in order to give you space to study, or ‘put off’ advancements they have wanted to pursue in order to be the stabilizing force you required during your education. It may even be that they sacrificed material purchases or the even more precious commodity of ‘time’, in order that you could pursue your dream.

I am NOT suggesting that these individuals have a malicious intent….but if aspects of your life (and the lives of those around you) had to undergo change to accommodate this educational ‘hiatus’ then it is really only reasonable for there to be some expectation that it will change ‘back’ to the way they were BEFORE you took your education ‘break’. BRACE YOURSELF for this possibility. First of all, as the saying goes, ‘you can never go back’....
and this educational experience has likely changed you fundamentally. It is hard to imagine watching life being born and ending; seeing for yourself how the homeless navigate the streets at night; holding a heart in your hands (literally); or playing a game with your 10 year old pediatric oncology patient while his chemo is running and NOT find your perspective about life transformed. Be prepared for the experience of re-entering a life that looks different than it did before you started school. Friends you had before may not understand why or how you’ve changed and your relationships with them may need some tweaking. Sadly, there may be relationships that you will simply outgrow and you may find yourself needing to move on. As much as you have gained during your education, there is a sense of loss as well—knowing this gives you permission to grieve what you have left behind as you move forward with the next chapter of your life. For parents to whom you now owe money in student loans, spouses whose social lives have been a series of lonely nights, children who have been inordinately patient with your ‘neglectful absence’, and friends who ‘put up’ with your theorizing and stories of calamity, sacrifice and growing pains simply WANT YOU BACK. You can’t blame them! Their demands on your now ‘free’ time may be premature for where you are actually at emotionally, physically and socially. You may find it stressful and challenging in the early months after graduation as you come to realize that the next level of your education has just begun and it is taking more out of you than you originally thought it would.

If you can, sit down with those individuals in your life and explain beforehand what they can expect from you as a newly graduated professional nurse (and perhaps in the years to come you can give them my Professional Role Transition Support Guide for People Who Love Their Nursing Graduate And Want Them Back). Outline for them the challenges you may be facing over the initial 12 months so that you might stem the tide of expectation at least for the first stage of your transition (up to 4 months post orientation). In the end, you may simply have to apologize for your ‘absence’ and let it go; many graduates say that friends and family simply don’t understand what they are going through during the initial transition to practice.

Spending time with other new graduates (come and find us at www.nursingthefuture.ca or access a regional or local new nurse support network where you work) may take on an important role in sustaining your sense of normalcy and reminding you that it’s not just YOU that is experiencing this disconnect! Hey, you might even be able to swap strategies that can help you cope with misinformed but well-meaning supporters!

**Responsibilities.** This is a big one! If there is anything that knocks a new graduate off their ‘axis’ it is likely the sense of responsibility they feel as a new practitioner. It seems to change the way they see everything in their professional world—the knowledge that you are now RESPONSIBLE for judgments that arise from that knowledge, decisions that arise from those judgments, and the impact and influence of the outcomes of your judgments and decision on people’s LIVES—can initially feel overwhelming. It is something you get accustomed to but it takes time. That is often the reason why, even in areas that you felt confident as a senior student, there is a relative DROP in confidence as a practicing nurse. The weight of
responsibility can cloud your vision such that what was previously quite comfortable and familiar to you becomes partially or sometimes completely unrecognizable. Like when your patient requires a top up of morphine for 7/10 pain and you have to give him an intramuscular injection because his PCA (that’s patient-controlled-analgesia for those of you who have been in a community placement for the last year 😊) is interstitial and you know you need to get his pain under control before you can start another line—and you need to ACT NOW! Somehow your skill proficiency in IM injections—and you were the recipient of the North American Intramuscular Injection Excellence Award for heaven’s sake—is UNAVAILABLE to you now and you are shaking as you draw up the medication because you know the patient’s wife will want to be present while you administer it and you think she will clearly see how incompetent you are (not that you actually ARE incompetent, but that is how you FEEL)!

“Some things go so fast though I can’t even process them….Like it’s so fast that I can’t even process some stuff and it takes like 5 or 6 times to catch it all. It’s just going so fast.”

You know what? You’ll give the injection after which you will come back to the nursing station and sit down because the post-adrenaline jitters are upon you, and you will realize that you AND your patient (AND his wife) are FINE! And the next time you have to deal with a similar situation it will be much easier. And so it goes……this is the experiential knowledge that is nursing practice in the ‘real’ world.

Now the responsibilities related to your performance at work are only one piece of this puzzle. Other responsibilities that new professionals are often dealing with include, but may not be limited to:

1) Developmental responsibilities
   a. moving out of home;
   b. managing finances for the first time;
   c. learning how to live independently from family;
   d. making major purchases (cars, homes); AND
   e. figuring out how to pay for them 😊.

2) Relational responsibilities
   a. marriage;
   b. divorce (it is amazing how one major change gives way to another);
3) **Work responsibilities**
   a. completing routines and tasks on time (many which you have never experienced prior to employment such as transcribing physician orders, administering intravenous narcotics or chemotherapy, intracranial pressure or hemodynamic monitoring, sexually transmitted infection notification);
   b. communicating certain information to the ‘right’ people while NOT communicating certain information to the ‘wrong’ people (socially constructed power structures); AND
   c. learning which decisions and judgments are appropriate for a new graduate level of knowledge and when consultations with senior nursing staff or physicians are necessary.

4) Learning about and enacting **professional responsibilities**
   a. involvement in professional associations and unions (rights vs obligations of the profession);
   b. knowledge of and respect for unit culture and power/authority hierarchy (who to go to about what);
   c. intra-disciplinary relationships (working collaboratively with varying scopes of practice within the nursing discipline);
   d. generational dynamics (how to approach a baby boomer about a change you think needs to be made, or how to delegate to an Xer);
   e. interdisciplinary collaboration (when to consult pharmacy, physiotherapy or social work); AND
   f. leadership, collaboration and delegation/assignment (learning who on your team is capable of doing what, how to assign tasks to more established nurses who ask if you need help, how to share a workload by collaborating with your nurse partners for that day, or how to delegate to an unlicensed healthcare worker who is 20 years your senior).

**Relationships.** The relationships nurses engage in with one another both determine and reveal the ‘culture’ of the nursing profession. They say that one can learn much about a society by the way it treats its most vulnerable members. With this in mind, many would claim that nursing has some work to do…
A significant challenge to ‘belonging’ is that it is often determined not by ourselves, but by OTHERS (those individuals with whom we seek to belong). The need to fit IN to a social structure assumes acceptance by the ‘other’—and that is not completely within the control of the individual looking to fit in. Unless of course, that person doesn’t CARE if they fit—in which case the concept of belonging is somewhat mute.

So assuming that the newly graduated nurse WANTS to fit in (HELLO!!! Of course you do!!!), there is a degree of vulnerability involved in that objective. How far will a new nurse go to be accepted by the individuals who represent their professional ‘social structure’? The answer is sometimes quite far…..which speaks less to the constitution of the new nurse and more to the power of professional enculturation or our general need as human beings to belong. Being on the periphery, or ‘marginalized’ as a new professional is fundamentally inconsistent with the developmental need to be accepted as a new professional. Enculturation is defined as the process by which a person learns the requirements of the culture into which they seek acceptance. It is the process by which they come to understand and ultimately choose to adopt, challenge or reject the values and behaviors considered integral to that culture. Successful enculturation results in the inductee becoming ‘competent’ in the language, values and rituals of the dominant culture.

Becoming part of any cultural group involves socialization; the gradual but deliberate shaping of an individual over time by exposing them to cultural norms, customs, values, traditions, social roles, symbols and languages. There is an inherent assumption in socialization that the inductee will share the values of the dominant cultural group. While there are many traditional values of the nursing profession that the majority of nurses would likely agree are worthy of preserving, there are certain social customs, roles or ways of relating within the profession that could use ‘a hot bath and a clean shave’☺. Just because we’ve always done something a certain way doesn’t make it the ‘best’ way or even the ‘right’ way. But tradition is steeped in a long history of ‘doing it this way’ and not likely to change easily or quickly. A few questions for anyone engaging in debate or critique are:

"The guy at the convenience store is the only one who understands me."
1) Do I have enough information about why this particular situation is the way it is currently to even critique it? Is there more than one way to approach this?

*Note to self:* There’s ALWAYS more than one way to approach ANYTHING. GET MORE INFORMATION FROM ALL THE PEOPLE INVOLVED.

2) What is my plan of challenge/critique?

*Note to self:* YOU CATCH MORE FLIES WITH HONEY THAN YOU DO WITH VINEGAR – people respond better when you can appeal to what works for them and not just what works for you.

*Appended note to self:* THIS IS THE WAY IT IS FOR A REASON—DO I KNOW THE REASON?

*Final note to self:* THERE IS ALWAYS A PROCESS TO FOLLOW IF YOU WANT TO BE HEARD—WHAT IS THAT PROCESS IN THIS SITUATION?

3) Does my plan consider the other person(s) involved?

*Note to self:* It might sound cliché, but usually the BEST solution to any problem or issue is not YOURS or THEIRS, but OURS.

**Knowledge.** It really is one thing to ‘know’ something as a student and then to ‘know’ that SAME THING as a fully accountable and responsible professional.

“I think so because, I mean, your ideals are what you hope for, you know, you’re thinking of how great it’s going to be and stuff and that’s always good to try and achieve those goals and things. But…it’s really tough when you think nursing is going to be one way and it ends up another so, in a way, yeah, what we learned in nursing wasn’t necessarily applicable to what we really have to do. Cause it’s not, even in terms of the big huge care plans we have to do in fourth year. Like I, I realize in first, second, and third year we have to do those big care plans to really learn and figure out, you know understand practice and organization and stuff but in your fourth year you do these huge care plans and you know everything about your patient and you have a really good idea of what you’re suppose to do the next day after you go in. And then, when you’re a nurse, you have sixteen patients, you know the top layer and you have to learn to nurse off of that. You have to learn your priorities by reading two sentences on their diagnosis and what operation they had and that’s it. And you have to learn how to make judgments and how to organize your care in a split second and that’s something that we weren’t taught in nursing. That is something we had to learn in the real world and that was really tough. Cause you really have to learn how to prioritize your care and who you’re going to look at first and who’s the most important—in minutes.”

It is as if at times the knowledge that you had developed a relative comfort with as a student is unavailable when you most need it (which is usually in circumstances where you are under pressure, exhausted and distracted by your transition experience!!!). I want to be clear that this intellectual ‘black hole’ into which your mind seems to have fallen as a new graduate is often
not as much about you ‘forgetting’ what you knew, and it doesn’t necessarily mean that you
are incapable or incompetent. I would suggest that what it generally means is that what you
knew ‘before’ your mind, body and soul were consumed with transitioning into the roles and
responsibilities of a professional practitioner, has receded into the less accessible areas of your
cognitive control and requires more energy and intent to bring it back to the FRONT of your
thoughts—often having to make its way through the rather gooey mixture that represents the
OTHER thoughts that are monopolizing your mind (if you still don’t ‘get’ that, you need to
re-read the initial 40 pages of this book…. ☺).

This is why I believe it is important to limit the level of EXPECTATION related to critical
practice judgments and decisions that you are required to make and focus more on:

• taking in knowledge about your work environment and workplace routines (learning
  how to work nights for instance);
• familiarizing yourself with the common clinical presentations of your patient
  population or the situated concerns of the communities for whom you are
  responsible;
• getting to know who your colleagues are and how they work so that you can work
  more easily WITH them;
• experiencing what it is like to have a patient rapidly decompensate or even die on
  your shift; AND
• learning what you need to do in those uncomfortable patient situations that you
  didn’t learn in school, like having to inform the spouse of a 56 year old man that
  you diagnosed with a sexually transmitted infection that she needs to be tested for
  genital herpes!

Much of this knowledge will be NEW to you! While you undoubtedly have a strong base of
science and theory from which your colleagues and patients/clients will surely benefit, it is in
the application of theory to countless combinations of variables that makes nursing practice
so consistently complex, often unpredictable and always dynamic. As the saying goes: ‘there’s
nothing like experience’…..

As has been outlined for you in the previous pages, knowledge of nursing theory and
science related to normal and abnormal processes (biophysical, psychosocial, cultural
or sociopolitical) is ESSENTIAL to practicing as a nurse. But as a professional, there is
knowledge related to workplace dynamics, professional roles and responsibilities, performance
expectations and inter-professionalism that exceeds what you can be afforded in the
relatively ‘sheltered’ experience of your education. There are few (if ANY) professionals,
regardless of discipline, who ‘waltz’ into their new practice environments. It simply is not
possible to prepare you for all the computations of issues, clinical presentations or dynamics
that play out in real life in the few short years that represent your education. Even if we
COULD prepare you, do you REALLY want to spend 10 more years in school??
“And you know all the senior nurses after that happened…said, ‘oh, yeah when you have an abdominal pain in a male you always rule out a Triple A [abdominal aortic aneurysm] and then you go with whatever’. Not once have I heard that before. Not once….And that’s the first thing that the paramedics teach…treat everyone with abdominal pain as a triple A. Not once in my whole entire stint of being in the ER have I heard that out of anybody’s mouth.”

I would like you to consider ‘reprogramming’ your idea of the contemporary nursing workplace; it is really the NEXT level of your education and builds upon the foundational knowledge you have acquired in your ‘basic’ program. To think otherwise is to misrepresent the dynamic and fluid nature of the human experience of health and illness and to under-appreciate the all encompassing essence of the nursing discipline: interactions with human beings from all walks of life, throughout the lifespan and in all situations and dimensions of their health or illness experience. Further, to think about your educational program as your time of ‘learning’ and professional practice employment as ‘working’ is unfair to YOU as well as to your practice. It sets up a polarizing experience when you get into practice and you see how much much you have yet to learn. There is the potential, if you think of your educational program as completely responsible to prepare you for EVERYTHING that might happen in practice, to blame your education for the discrepancies between what you were taught WOULD happen and what you find IS happening for you as a new practitioner. Though I don’t know too many nursing programs that would claim they have the ‘perfect’ approach to comprehensively preparing their graduates, I also don’t know ANY workplaces that can lay claim to the perfect orientation or transition program for the new nursing professional. What we need to recognize is that both education and the healthcare sector have room to grow such that the ‘gap’ between them is lessened over time. While I recommend you wait until you have been in practice for a year (to gain a balanced perspective on your situation), be sure to provide both your educational program and your workplace with formal feedback on what might enhance a smoother transition to practice for the new graduate of nursing in your region.

“It seems like it’s flown by but I’m at like such a different place than I was a year ago when I look back and like I still feel kind of anxious looking back you know. I just feel like I was kind of thrown in there and flying by the seat of my pants and all of a sudden you’re responsible and it’s just huge, huge, huge stress—huge, huge pressure and it’s…like it feels like it wasn’t that long ago but at the same time it does. Like I think the changes have been pretty subtle along the way but still a year’s made a big difference. I hear that some places do a years worth of kind of orientation and buddying and that kind of thing and like when I did my buddy shifts—I did about a months worth full-time buddy shifts and at the time it was like, OK, I just want to be on my own but now I think ‘If it was maybe more of a gradual time it would have been better.’”
NEED TO KNOW

- **Transition shock** occurs within the initial weeks to months of entering professional practice and results from an ‘alarming’ realization that the roles, responsibilities, knowledge and relationships you are engaging in as a new nurse are more challenging, dynamic and intense than you had expected.

- While you may be optimally **prepared** to practice as a new nurse by your educational program (you know what it means to ‘do’ nursing), it is likely not possible to be entirely ready to face the challenges of ‘being’ a fully responsible and accountable practitioner until faced with situations that demand these.

- Transition shock is not only **intellectual** (knowing something ‘theoretically’ is different than applying that theory in the ‘real world’), but it is **cultural** (understanding what nursing is in relation to other professional roles in practice), **social** (there are certain ‘unwritten’ rules related to the relationships between nurses and between nurses and other professionals that can’t be ‘taught’), **physical** (plain and simply: nursing is HARD WORK most days as it includes a lot of physical effort—lifting, moving, walking, bending), **emotional** (we often deal with individuals and communities at the intersections of ‘health’ and ‘illness’, during times of vulnerability and in situations of despair or desolation and that takes its toll on practitioners emotions), and **spiritual** (it is not uncommon for nurses to be in demanding dilemmas that profoundly challenge their professional and personal ethics and make them question their own, others or the healthcare system’s moral underpinnings, resulting in disconnections or disharmony between the nurse’s sense of ‘self’ and ‘other’).

- New graduates need to surround themselves with people and situations that are 1) **consistent**, 2) **predictable**, 3) **stable**, 4) **familiar**, and that support 5) **success**.

- IT TAKES at least 6 months to find your sea legs as a new nurse!!!

- Initial integration into practice **TAKES practice**—find a **SAFE ENVIRONMENT** to practice your fundamentals so that within the first few months you can ‘lift your gaze’ beyond **WHAT** you are doing to explaining **WHY** you are doing it—**don’t expect yourself to be thinking too much about WHY you are doing what you are doing for at least the first 4 months**, particularly if there are many new situations to which you are exposed. Your primary goal will be to figure out what is expected of you and to learn to fulfill your roles and responsibilities ‘without killing someone’ 😊.
NEED TO THINK ABOUT

- Where is the **SAFEST** place for you to make the transition to professional practice (ask the following questions related to your plans)?
  - Did you have experience in this area during a capstone practicum?
  - Is there an adequate orientation?
  - Will they assign you a mentor?
  - Can you work days for the first month after orientation?\(^{10}\)
  - What kind of support\(^ {11}\) is offered to you as a new graduate?
    - Orientation and specialty certification;
    - Preceptorship;
    - Mentorship;
    - Supernumerary work;
    - Residency/Internship; AND
    - Transition Facilitation Coordinator

- Does the place you are thinking about initially working provide:
  - **Consistency**—are you going to be working with similar staff, consistent patient presentations/diagnoses?
  - **Predictability**—do you know when, where and with whom you will be working, or can you predict with some certainty the kinds of patients you will be seeing?
  - **Familiarity**—do you know where to find what you need when you need it, have you been with these staff before, have you worked with these particular routines before, and is there another new grad you can team up with to transition with you? AND
  - **Stability**—how stable is your life? Do you have a consistent shift that you can predict and therefore plan around, are your patients at high risk of decompensating on a regular basis, is the staff turning over a lot, and is there a strong sense of support on the unit you are going to?

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\(^{10}\)This may not be required for all graduates but many new nurses struggle with the circadian rhythm challenges of working nights and can further exhaust you. As well, nights are notoriously ‘short staffed’ (there are no physicians making rounds, no diagnostic testing outside of emergent issues, etc.) and patients are encouraged to sleep, which makes caring for them less demanding but also reduces the availability of assistance from colleagues.

\(^{11}\)All of the programs identified here vary in structure and format but all have the intent of supporting the new nursing graduate to gain experience with the routines and responsibilities of their new role, gain some familiarity with the staff they will be working with, progress SLOWLY in accepting greater breadth and scope of responsibility as a professional, and feel supported to grow at their own pace.
on the unit you are going to.

• Are you likely to be **successful** as a new nurse in this unit/center or are there situations (clinical or relational) of **high risk** that make your success less likely?

• What strategies have you used to **successfully manage stress** in the past? (i.e. exercise, journaling, socializing with friends, going for coffee with good buddy)?

• What **negative outcomes of stress** have you experienced in the past? (i.e. irritable bowel syndrome, increased drinking, drug abuse, difficulty with anger)?

• What is going on in your **LIFE** that might influence your work transition?
  o How can you stabilize the relationships in your life?
  o What major financial decisions (moving, buying a home or car) can you delay for 6 months?
  o What can you do to balance the intensity of the initial few months of transition (physical exercise, social activities, relaxation strategies)?
  o How will you **PLAN** for this balance ahead of time?
  o What do your friends, spouse, parents, children **NEED TO KNOW** about this phase of your career that will make it easier on you and them?
  o Who are the individuals to whom you go to for support? Will they be available to you?
  o What nursing peers can you routinely network with for support? When and where will you meet?

**NEED TO DO**

1. **Understand transition shock**;
2. **Know the limits of your practice** capability during this period of transition;
3. Remember that you need **CONSISTENCY, PREDICTABILITY, STABILITY, and FAMILIARITY** to be **SUCCESSFUL**;
4. **Find a unit/center/community that will support you** to progress slowly into your roles and responsibilities as a newly graduated nurse (i.e. **SHOP AROUND!!!!**);
5. Determine what **level of patient is appropriate for you to care for** during your initial transition (REMEMBER: stable, consistent, predictable, familiar);
6. **Know your BOUNDARIES** (i.e. if someone asks you to care for a patient, or go to a unit that you feel is beyond your knowledge or experiential comfort level, **JUST SAY NO!!!!** If you feel ‘reduced’, ‘belittled’ or ‘coerced’ by your colleagues response, SAY “I sense that you don’t agree with my decision, but I know this is in the best interests of the patient/the workplace/my coworkers” and approach your mentor, educator or manager at the next most appropriate time—that might be at the end of the shift—to discuss your concerns);
7. Meet with your manager, educator and mentor EVERY SHIFT for the first two weeks POST-ORIENTATION and then EVERY SET OF SHIFTS for a month after that:
   a. discuss how the shift went
   b. outline what went WELL and what CHALLENGED you and why
   c. formulate a plan together to deal with the challenges next time AND
   d. modify the transition support as your needs change or are revealed;

8. Inform colleagues, family, friends, children, spouses and parents of the POTENTIAL challenges you will be dealing with during the initial couple of months after you begin working as a new nurse (AFTER orientation):
   a. exhaustion (sleep a lot but don’t feel rested—sleep is consumed with dreaming about work),
   b. fear of failure (more defensive than usual or sensitive to critique/comments; tendency to ask questions repeatedly),
   c. performance anxiety (avoiding particularly difficult/new skills, avoiding patients who are ill and/or experiencing physical symptoms of anxiety such as sweating, racing heart, shortness of breath or inability to think/concentrate before or during a task),
   d. labile emotions (laughing one minute, crying the next—easy to provoke to tears or anger at work OR at home), AND
   e. low self-confidence (seem to react rather than respond to comments and many comments taken ‘personally’; may need unusual levels of affirmation or reassurance);

9. Be AWARE of how you COPE with stress—prepare for stress during these initial months by PLANNING activities that relieve stress OR/AND avoid, delay, or resolve whatever stressors you can (i.e. if money worries stress you, try to put off major purchases until you have the energy to cope); AND

10. Plan to get as much sleep as you can—IF you choose to take sleeping aides, first talk with a Nurse Practitioner or Physician. While the ‘odd’ Gravol™ or glass of wine might seem like a benign strategy to help you get through those nasty ‘all night self-debrief sessions’ that seem to haunt you after a shift, this kind of coping behavior on an ongoing basis should trigger an alarm for you. The line between healthy and dysfunctional coping is sometimes about the length of time you remain in ‘coping’ mode and whether or not that coping strategy starts to adversely affect other aspects of your life. YOU’RE A NURSE—you’d think you would know when you have crossed that line. But BEWARE—it CAN sneak up on you so if you feel yourself

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If you do not have a formal ‘mentor’ assigned to you, take an experienced nurse with whom you have a good working relationship into the meeting with you and debrief with them after the meeting to determine if you understood what was said the way they understood what was said.
sliding down the ‘other’ side of that slippery slope (i.e. someone comments about your unusual behavior or expresses concern about what they think are unhealthy habits you have adopted), reach out to another grad or trusted friend for support, or visit your primary care practitioner or even the occupational health nurse in your workplace. Any issues you share related to your health will be held in CONFIDENCE—these supportive health professionals are there to help you manage your stress appropriately and help you get back on track!
Stage 1
Professional Role Transition

DOING
Some Things Come in Waves (like nausea 😊)….. Transition Comes in STAGES

The transition into practice for the first 12 months after nursing school is a process of becoming a professionally practicing nurse. As with most journeys, it isn’t a straight line from novice to expert, but more of a winding road, full of twists and turns, detours, and the occasional pothole 😊. To be clear, this critical life experience will be very unique to every individual so I cannot tell you exactly what your transition will look like. I can, however, give you a sense of the experiences that the majority of new graduates who have gone on this journey go through1 so that you can:

1) **begin to prepare** for your own transition by putting checks and balances in place for the possible challenges ahead, and

2) **know that you are NOT ALONE**—or in technical terms, ‘normalize’ your experience so that you do not get stuck thinking ‘Am I the only one who is struggling?’

Trust me…..we ALL struggle with major transitions in our lives.

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**It is my daily mood that makes the weather. I possess tremendous power to make life miserable or joyous. I can be a tool of torture or an instrument of inspiration, I can humiliate or humor, hurt or heal. In all situations, it is my response that decides whether a crisis is escalated or de-escalated, and a person is humanized or de-humanized. If we treat people as they are, we make them worse. If we treat people as they ought to be, we help them become what they are capable of becoming.**

- J.W.Goethe

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At this point, I believe it is prudent to remind you about the importance of **FAMILIARITY, CONSISTENCY, PREDICTABILITY and STABILITY** in your personal AND professional life during the next 6 months. As Michael Moncur’s saying goes, ‘life is what happens to you while you are making other plans’. The message is that while we strive to plan, organize and direct our lives (which is not such a bad idea as ideas go), by doing so we often fail to leave enough ‘space’ for:

1) new events (moving, getting married or divorced, buying a car or a house, or **starting a job as a new nurse**);

2) complicated relationships (conflicts in the workplace with co-workers, starting or ending personal friendships or intimate relationships); and

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1For an overall perspective on the Stages of Transition journey of the new nurse, please see the **Conceptual Model of Transition Support** in the Appendix of this book.
Accommodating

As a result of the pressures to meet deadlines constructed by the unit or institution within which you are working, you may feel the need to accommodate practices you see in more experienced staff without necessarily critiquing those practices for their soundness. Sometimes this happens without you even realizing it (I mean REALLY—you are BUSY TRANSITIONING!!!!), but then again, sometimes you may find yourself accommodating substandard practice because to NOT do so might be perceived as an indirect challenge or criticism of your colleagues. Although new nurses understandably feel an immediate need to adjust their practice to what may be accepted unit practices, many later identify discrepancies in standards of practice as primary factors contributing to their lack of professional fulfillment in their nursing role.

“I was so focused on knowing the routine, knowing what I’m doing, getting things done, knowing the way different nurses like things done, knowing where I fit in, what I’m supposed to be doing, when I’m supposed to be doing it. I had total tunnel vision. I was just focused on getting the job done and getting out of there on time. Then I would go home and I would feel guilty for not being more.”

“I’ve never had anyone’s blood sugar who was critically low before so I asked one of the more experienced nurses, ‘Okay, what’s the next step—like who do I call and what do I get ready and what will they probably order?’ I would say I was slow—slower than them.”

“Blood—well I’ve given it a few times but I had to give a chemo drug for the first time and so I was thinking back to my orientation in the classroom: ‘Okay, what do I need to do? What do I need to check?’ So yeah it just took me 5-10 minutes to review everything, get things ready and go over in my head what I’m going to do and then going in and doing it.”

In part, this accommodation may be warranted as nurses with years of experience performing particular skills or making certain decisions and judgments repeatedly acquire ‘tacit’ knowledge; a deep sense of ‘know how’ that comes through repeated success in dealing with varied clinical situations. Such expert knowers not only ‘see’ what others do not (relying on a deep knowledge that comes from a subconscious synergy of the senses), but ‘know’ intuitively WHAT to do, WHEN and HOW to do it, and WHY they are
doing it. Invariably, the new nurse watches the application of this knowledge with awe wondering, “How did he know that?” or “Will I ever be able to practice like that?” Indeed you will, but that kind of knowledge development takes time, practice experience and circumstance. You cannot even buy that kind of experience…..

“For me, this is what made my first few months BLOW SO SOOOO much…if you have really good role models in your workplace, you still sort of feel like a bag of dirt. But you really feel like a big bag of dirt when these nurses act like they came out of nursing school this way! It’s just nice to know that these role models once felt like I do now….”

I would be remiss if I did not speak to the frustration and disappointment some new nurses describe when they see what they believe to be archaic ways of thinking about, or practicing nursing by their experienced colleagues. This includes the rigid allocation of ‘tasks’ that may be arguably outside of the job description of a professional nurse (i.e. emptying dirty linen bags or cleaning patient rooms after discharge). Notwithstanding the need to perform whatever tasks ensure the health and care of patients/clients (i.e. sterilizing a vaginal speculum at 0200 hours on a weekend when central supply is not in the hospital because you are admitting a rape victim OR cleaning an observation room after you have urgently transferred a more stable patient to accommodate a transfer from critical care), it IS important that we ensure full application of each team member’s skills, knowledge level and practice capacity.

As a nursing graduate, you may struggle with the expectation that you assign or delegate tasks and responsibilities to other licensed and non-licensed personnel, many of whom may be older and have more clinical experience or work seniority than you.

“What overwhelms me the most? Definitely being incompetent. Feeling like I’m not prepared to handle the patient load and delegating when I don’t even know what

4It is important to understand the distinctions between ‘assigning’ and ‘delegating’. Assigning care implies that you are collaborating with another healthcare professional who is licensed and works within a scope of practice for which they can be held accountable. If, in this case, you are ‘assigning’ care, it is assumed that you are transferring responsibility for that care to the individual to whom you are assigning the task (in other words, they are responsible). Conversely, delegation encompasses requests for the performance of a task for which the individual to whom the skill or task is being delegated is NOT licensed and therefore is NOT able to be held ultimately responsible for the performance of that skill within their professional scope. In this case, YOU (the delegator) retain responsibility for the performance of that skill or task.

If you can’t live through adversity, you’ll never be good at what you do. You have to live through the unfair things, and you have to develop the hide to not let it bother you and keep your eyes focused on what you have to do.

- Maurice “Hank” Greenberg
to delegate cause I don’t know what should be done. Where I work we have really
delineated roles but sometimes I find it hard to give other people direction. Sometimes
it’s hard for me….Especially if they’ve been there longer than I have, it’s kind of tricky
because we were expected to do all of the care for our patients as students so when we
take on the RN role we do everything for the patients that we have been assigned.”

**Pride is concerned with who is right. Humility is concerned with what is right.**

- Ezra Taft Benson

While it may be initially difficult to consider having to ‘tell’ someone what needs to be done, it is often more a matter of APPROACH than substance (you know what they say: *it isn’t WHAT you say but HOW you say it that matters…..or put another way, people may not always remember what you did or even what you said, but they will always remember how you made them feel…..*). I have provided some ideas in the Appendix on how to approach these sensitive situations, but here is a summary:

1) **Use ‘I’ more than ‘YOU’** – I was hoping I might get some assistance to bathe this individual this morning – would you have time? OR I am new to collaborating on workload – how would YOU recommend we work with this group of patients/clients? OR I have never partnered with a practical nurse except when I was a student – can you help me understand how our roles work together on this unit?

2) **Listen CAREFULLY** to the other person – understanding is crucial – My first thought is that we should do ____ - what do YOU think we should do in this situation? OR Have you seen this happen before? What would you do in this situation? OR How would you approach this?

3) **Avoid judgmental statements** – You didn’t ask me OR I wouldn’t have pulled that dressing off the way you did OR You were so unsupportive to me in that situation. Instead, **stay with YOURSELF**, and offer insight into how it felt or what you are thinking: When you didn’t ask me for my opinion, I felt invisible OR I wondered why you removed that dressing when you did – I know you had your reasons and I want to understand so that I can learn OR When we were in the room with that patient, you seemed impatient with the way I was taking out those staples – it didn’t feel very supportive.

4) **Use QUESTIONING with HUMILITY whenever possible!** I call this ‘The Columbo Approach’ (OK, that might be ‘dating’ me but *Columbo*™ was a popular television drama from the 1970s whose main character was a private detective. For more insight into his approach to inquiry, go to http://johncaswell.posterous.com/columbo-questions-and-the-semantic-answering). In approaching ANY situation, if you can change a ‘statement’ into a ‘question’ that implies a level of humility in your own understanding, it can smooth the edge off statements that might be perceived, however unintentional, as judgmental, accusatory or even confrontational. Try this instead: “I noticed when we were in that situation that you didn’t ask me what I thought – would you mind if I shared that with you now?” OR “I noticed that you removed that dressing without gloves and I am not accustomed to that – can you tell me why you would
do that so I can learn?” OR “When I was removing those staples, I felt you being a bit impatient with me. Was I doing it incorrectly or is there a way you would have done it differently?”

5) **UNDERSTAND** what the roles and responsibilities are of the ‘other’ nursing and allied health personnel you are working with. Ask THEM what the relationships are in the workplace, look at any role descriptions the manager or educator might have, or spend time BUDDYING with each of those individuals so you get a sense of what their days consist of.

During this first stage of transition, your overall energy is usually divided between demanding professional adjustments as discussed above, the broader issues related to the ‘culture’ within your workplace (working with people who have individual ways of thinking, behaving and relating with others) and changes in your own personal life.

Your life, and reactions TO your life, may be labile and ‘extreme’, so be aware that your response to situations in MANY facets of your life may have as much to do with the stage of transition you are in as the situation itself!

“It's up and down depending on the day. Some days I'm fine and it's like 'This is great!', and other days it's like 'Wow, I've got to look for another job' or 'Maybe this isn't for me'. I just thought this is where I want to be and I was so excited when I got hired and I was like 'YES, this is where I'm going to be!' Then it was like 'Well maybe this isn't where I want to be and if it's not, then where do I want to be...like where do I belong? Where should I go?' Like if I thought this was where I wanted to be and it's not working, then now what do I do now? So I don't know. It's kind of confusing at times, but overall I am enjoying it—it just has hard moments.”

“I try to remember that it's just a job. It's not my life and it shouldn't be my life but I don't know. It's hard. It is. Yeah. Yeah but it's only been a month and I just hope it's going to get easier. I hope it doesn't get any worse....To tell you the truth I really expected it to be easier and when it was hard, I was surprised when I found it difficult. I mean it's so naïve of me.”
“Work is very, very stressful right now. It’s been causing me so much grief. We’re really busy and we have some really sad, sad cases right now that I’m having a hard time dealing with it….I’m having a hard time separating myself from it, so like I can’t sleep. I’m dreaming. And then outside of work I’ve been really busy too so I just feel like my head’s been spinning. It’s still good days bad days so it just sort of depends on what is going on in the unit that day. Some days, I just come home saying, ‘I have to find a new job because if it’s causing this much, like leakage into my personal life, then I’m going to burn out in no time, or else I have to learn how to separate myself better.’ So…it’s been tough.”

You may have just moved out ‘on your own’, decided to end an intimate relationship (they often say that one major change begets another), or START one (getting married is a common experience for young graduates). Now that you are making all this money☺you may decide this is a good time to purchase that new car or home you have always wanted (really, that makes sense now that you are a working professional!!!). Stress comes in a variety of forms, but remember that even ‘good’ stress is still STRESS!

“I feel it’s harder to get things done just because I want to escape from work and get out of the city and see things but then I feel so disorganized in my life when it comes to things like laundry and dishes and all that stuff that builds up when I’m at work and I don’t want to spend my day off doing that stuff. When I’m not at work, I really need that escape. I feel I need that but at the same time I think that may be contributing to the overwhelming feelings cause my personal life is so disorganized.”

If you are a ‘mature’ student, perhaps completing nursing subsequent to working within another field or line of work, you have likely sacrificed family time or suspended what might have been a stable income, to move in this professional direction.

“You know, it is a lot of work just trying to remember everything and I have kids at home. This is just one part of my life but it’s consuming right now and I find it hard to balance everything. I don’t have the time I thought I was going to have and the kids want me, and there are meals to get ready and I can’t always ask [husband] to step in for me—I think he is tired of that actually. It’s not that I stress totally about work, it’s just that it’s EVERYTHING—all together, that seems a bit much right now.”

“It looks like dinner, sleep and sanity are not to be.”
Further to this, individuals who have chosen nursing as a second career may have to balance child-care and family responsibilities within an often condensed and intense period of study. While graduation can be a welcome relief from the burdens of balancing multiple roles and pressures, returning to such a ‘full’ life (children awaiting your attention now that you are ‘free’ and spouses expecting you to assume prior roles within the family) while navigating the stresses of transition can be daunting.

The changes that come with completing your education and moving into professional practice can be as stressful as they are exciting! Particularly when, at the same time you are: adjusting to intimidating levels of professional responsibility, trying to get a sense of what it is like to work with other professionals on a team, struggling with what appear to be changing relationships with individuals you knew ‘as a student’, and seeking acceptance into a tradition-bound and somewhat hierarchical nursing culture.

“I know I could ask someone else to do it. That’s one problem I have though. I have a hard time delegating things especially to senior nurses because I feel this is my job. I should do it. But I need to ask someone else to do it and I’m a little hesitant because I guess I feel a little bit inferior. I know I shouldn’t but I do because I’m new and they know what they’re doing and they would have had it done and I don’t.”

“When I was a [senior student] we got along great. She orientated me. She was great. And now that I’m an RN I have a hard time saying, ‘Can you do this’ cause I feel like she’s looking at me like ‘Oh you think you’re so high and mighty’ and I’m not trying to act like that and I hope I’m not acting like that but you just really think in the back of your head that they’re thinking that— I’ve never heard anyone say that but I’m just always behind and I don’t like asking people to do things. I don’t know why. I’d just rather get it done myself.”

Then there are the physical demands of adjusting to intense, alternating, and sometimes unpredictable or inflexible day or night shift schedules without the advantage of ‘breaks’ that used to come in the form of pre and post conferencing with your instructor!

“Oh there’s definitely no routine. Not with shift work. It seems like I have complete opposite schedules to friends that are up here and that when you do want to go for coffee or you do want to go out that it just seems like you never have the same day off.”
Yeah it definitely takes the routine out for sure. And maybe that’s why it makes it a little bit harder to adapt to. I don’t think I always deal with change very well.”

NOW you realize for the first time what it means to work THROUGH a complete shift and the energy it consumes can take you by surprise. When you think about taking responsibility for significant clinical judgments and practice decisions when so much else is going on, you are feeling the full weight of Stage One transition. I encourage you to go a bit easy on yourself. It has been my experience that despite the fact that many of the responsibilities you are charged with as a new nurse, as well as some of the new clinical situations in which you may find yourself in, may be beyond your intellectual or practical familiarity (and maybe even capability), that you tend to blame YOURSELF for ‘missing’ something or failing to identify or appropriately intervene in a changing clinical situation.

“IT’s just still like the uncertainty and the second guessing and then the wanting or needing or reassurance that sometimes I feel like I can’t just go and do something. I always want to make sure that I’ve checked or that I am doing the right thing. That I am making the right decisions for this patient. And I wonder ‘Is there something more that I should be doing?’”

“I still kind of worry about missing something….being detrimental to my patient. I don’t know how to keep all that stuff in my head and how to pass everything on. I can’t remember everything and, you know, I try to keep notes for the day but there’s always something….not knowing the answers and maybe I’ll do something wrong or forget to do something and cause a patient harm.”

Seriously, the workload of a nurse challenges even the most experienced practitioners, so go easy on yourself.....
NEED TO KNOW

- This stage is all about CHANGE—if you are familiar with the workplace to which you will be transitioning (i.e. you have worked there before when you were a student or you completed a final practicum there), the intensity and duration of this stage may be reduced.
- During the course of the initial 3-4 months of practice, you will be:
  1) **Adjusting** to new roles, responsibilities, relationships (both personally and professionally) you are also adjusting to expectations that you will apply the knowledge you have come to know theoretically from your formal education at the same time as you are learning the NEW knowledge that comes with working as a professional nurse in practice. Adjusting takes time!
  2) **Accommodating** new routines for practice that may be embedded in prescribed timelines and strict policy guidelines and different than what you knew as a student (BID medications may be given at 1000/1600 instead of 0800/1400 **OR** all patients being seen in clinic for a suspected STD must be seen by a Nurse Practitioner for sexual counseling **OR** female nurses are NOT to do perineal care on incarcerated male patients). While you may have options or choices related to the practices you adopt as your own, and while some established ways of practicing can be challenged using current evidence or your prior experience, there will be certain policies and procedures that you will simply have to accept as ‘the way we do things here’. In fact, you may find yourself in situations where you will see practices that you DO NOT feel able to accept (i.e. substandard, unethical or illegal) but that are being adopted by those around you—maintaining or adhering to a professional standard of practice is always a decision!
  3) **Learning** new skills, roles, responsibilities and clinical knowledge that relates to a specific area of practice. It can feel like EVERYTHING is new when you start out in professional practice; even OLD feels NEW when you have to take responsibility for it!!
  4) **Performing** skills, tasks and procedures can feel daunting; even those you have expertly performed before can take on a different level of complexity when the context within which you are performing is intense, dynamic and unfamiliar. Knowing that YOU are responsible and accountable now for your actions (or inactions) can be intimidating. For instance, being charged with the decision about WHAT and HOW MUCH narcotic to give your methadone patient **WITHOUT** ‘consulting with your instructor’ can feel overwhelming the first few times. Don’t forget that there is ALWAYS another nurse you can check with—even
if you have to page a supervisor, text a peer or call a friend or another nurse at home from your workplace!

5) **Concealing** your level of insecurity, your fears of inadequacy or your feelings of anxiety from the experienced colleagues around you is normal; after all, you want to FIT IN and be accepted by them as a practicing colleague! Depending on the support you have received from your manager, educator, preceptor or mentor, and depending on the availability of open and accepting co-workers, you may feel more or less comfortable asking questions, thinking ‘out loud’, or sharing your concerns, ideas, practice decisions and clinical judgments as a new nurse. Remember, it is ALWAYS better to be CAUTIOUS and prevent an error than be OVER CONFIDENT and have to correct your mistake! If you feel unable to ask questions when you need to, or if you do not have access to an experienced colleague for consultation as a new nurse—you are in an UNSAFE WORKPLACE and should be addressing this with management as soon as possible. While it is normal to find yourself in the rare position of having to respond to a situation for which you are ill prepared or inexperienced, being PLACED in these situations consistently (i.e. frequently feeling ‘over your head’) is **NOT ACCEPTABLE**. If your manager or clinical educator are unable to reconcile this situation to your satisfaction, and if you do not have access to, or perhaps do not feel comfortable approaching a workplace union/labour representative⁵, you should seriously consider alternate employment. In such circumstances **YOU** and those under your care are in danger…..

• This stage is **EXHAUSTING**—physically, emotionally, intellectually and spiritually—and may leave you terminally tired by the end of the 4 months. Initially you will be sustained on the pure, raw excitement of graduating and the ‘nervous’ energy of being a new professional. Over time though (usually as you approach the 2nd stage of transition), you may find yourself demonstrating signs of energy depletion that include:
  o feeling tired despite prolonged sleeping periods;
  o poor quality sleep due to dreaming about work;
  o disengaging with friends and family;

⁵For graduates working in ‘unionized’ professional environments, it is important to appreciate the distinctions and differences between unions and professional regulatory organizations. **Unions** function to advocate for the socioeconomic interests of their members, lobbying on behalf of nurses with regard to their salaries, conditions of work including professional practice environments, and safety in the workplace. **Professional regulatory organizations** are primarily focused on the protection of the public by setting requirements to enter the profession and establishing and enforcing standards of practice. There are situations in which these separate organization overlap in the mutual interests of patient safety, quality work environments and promoting excellence in nursing practice.
• You may experience **dichotomies** (things that go “WHAAAAAT???”) in your practice:

1) **caring dichotomy**—you find yourself caring for patients efficiently (with a focus on the workplace) rather than effectively (which would be a focus on the patient’s *needs*) as you had come to expect during your education;

2) **quality dichotomy**—instead of witnessing, or personally providing compassionately competent care that speaks to the needs of patients and their families (again, something you were taught you would be doing), you find yourself and your colleagues maintaining and supporting the powerful structures, hierarchies and ordered routines of the institution where you are working;

3) **dependency dichotomy**—while wanting to be perceived as an independent, capable practitioner by your colleagues (isn’t that the goal of every new professional?), you frequently need to reach out to others for assistance, exposing your ‘newness’ and perhaps even your lack of knowledge and skill;

4) **practice dichotomy**—you begin to see the differences between what you were taught in school and what is actually practiced in the clinical setting; this results in confusion, frustration and sometimes a need to determine who or what ‘failed’ to prepare you for these discrepancies;

5) **focus dichotomy**—you feel guilty about the fact that your focus is often about how a situation will impact **YOU** (how you will be perceived or judged in that situation) instead of only how it impacts on your patients and their families (that isn’t ‘selfish’ in a new professional, it’s normal);

6) **experiential dichotomy**—while you understand that experience is key to your progress as a professional (and the means by which you acquire the respect, mutual recognition, acceptance and independence all professionals desire), you have little control over how you get that experience.

**THESE** are the things that keep you up at night, with your mind racing as it tries to ‘understand’ how things that don’t GO together, ARE together…. 
NEED TO THINK ABOUT

- How can you plan for familiarity, consistency, predictability and stability in your personal life and professional workplace during this first 4 months?
- What major decisions can you postpone until the 2nd stage?
- How do you normally cope with stress?
- Are you at risk for substance abuse—if so, how can you prepare for/manage this risk?
- How can you relieve your stress—can you plan ahead of time to take several mini-vacations or ask for 3 spa treatments as a graduation present and book them for 1-2-3 months post orientation?
- How can you plan with parents, siblings, children, friends or spouses to do what needs to be done in your personal life while you experience this transition in your professional life?

NEED TO DO

1. Ask to be assigned a consistent preceptor during the initial 4 months of your employment who has volunteered for this advanced teaching role and received some kind of preparation that includes knowledge of the stages of transition.

2. Find a mentor who can offer support and encouragement over the next couple of months. If you are not assigned a mentor, ask the manager or educator who might be a good 'match' for you OR make the effort to connect with a senior nurse in your workplace who gives you an indication of acceptance (i.e. perhaps they say 'Hi', or smile at you—ask them to go to coffee and talk to them—you will know whether or not they are interested in supporting you). Keep searching until you find someone to support you in the workplace (it doesn't have to be someone you work with, but it would help if they were a nurse). It is generally a good idea to find a mentor who shares your scope of practice; they are most likely to understand the challenges of your role. Having said that, I have had numerous professional mentors in my career! Sometimes all we need is a good listener, someone who is willing to support and encourage us or someone who can lift us to higher ground when we feel like we are drowning.

3. Request a predictable schedule or 'staffing line' so you can learn the practices and particularities of a consistent group of co-workers as well as experience the scope of clinical presentations related to the patient/client population you will be caring for in your work.

4. Gradually and slowly advance your skills and ask your supervisors to limit the level of complexity of patients you are assigned for the first 4 months. Gradually increase...
the complexity of your patient load over the initial year of practice.

5. Give your close friends and family a **copy of your shift schedule** and try to plan time to socialize, time to be alone, and time to do personal errands.

6. Provide **guidelines** to family and friends regarding **WHEN** to call you, particularly if you are working nights (i.e. call NO EARLIER than 2 hours before the start of your shift and NO LATER than 1 hour after you arrive home from your shift).

7. Make your **meals the DAY BEFORE** your shift.

8. Arrange to **meet with your mentor/support person after EVERY set of shifts** for the first 2 months—then meet with them every month for several months—then as needed.

9. **DON’T WORK OVERTIME** or if you have to, **LIMIT** the overtime shifts.

10. Try to find consistent part-time or full-time work where you can work with the same colleagues and patient population. **Don’t FLOAT** if you can avoid it—if you HAVE TO FLOAT, limit yourself to 2-3 units.

11. Negotiate your **orientation schedule** with your educator (see Appendix VI).

12. Organize **debriefing sessions** with a friend or peer after every set of shifts.

13. Don’t plan any activities **the day AFTER a stretch of shifts**—sleep in, do your laundry, vacuuming and dishes, and CHILL!!

14. Find a way to **work off your stress** (i.e. meditate, do yoga, exercise).

15. **Talk to other new graduates** who are going through the same thing you are!

16. **Keep a journal** of all the things that well went during each shift. Jot down positive feedback you receive from co-workers or patients. It is so easy to focus on what went wrong or how you have to improve that it can be easy to forget what you are excelling in. Staying positive and consistently focusing on what went well during these first few months will increase your confidence as a new practicing nurse.

17. **Get together with your nursing friends or other new graduated nurses!** Go for coffee and discuss or vent about your experiences as a new graduate nurse. You will be surprised that you are really NOT as alone as you might feel.
Stage 2
Professional Role Transition

BEING
“I have thought of the many other things that have happened in my life but so far this has been the most difficult time in my life. Surviving the first six months. And I don’t know if I really communicated to you how stressful it was. I like to think I did in my journals and in our interviews, but it was stressful on so many levels. On every level and like I said, it’s stressful now, my career is stressful now but in a very different sense. In that I know that I’m going to survive the day, whereas before I literally didn’t know if I was going to survive the day. I honestly wasn’t sure.”

Can you BELIEVE you made it through the 1st stage of transition….essentially unscathed! WOOHOO!!!!!!

If you are simply ‘reading ahead’ in hopes of finding out what happens during the next stage, READ ON DUDE!!!! The good news is that you are moving from SURVIVAL mode to THRIVING mode as a new nursing professional!!

The next 4 to 5 months of your post-orientation transition experience will be marked by a consistent and rapid advancement in your thinking, knowledge level, skill competency and….BEST OF ALL, your confidence.

You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You are able to say to yourself, ‘I have lived through this horror. I can take the next thing that comes along.’ You must do the thing you think you cannot do.

–Eleanor Roosevelt

“And I’ve definitely learned a lot more about time management. Like if I need to give somebody this med and I need to flush their catheter I need to grab them a gown, so I’ll do it all at once. Where as before I’d be in and out of the room four times to do all these things. But now, I can think better in my head and I’m like ‘OK, I’ve got to do all this before I go in’.”

“I’d probably say [the biggest change is] the confidence. Just being confident in my knowledge and what I know, and confident that I know where to get the answers
or who exactly to go to instead of going to ten different people. Just being more confident in myself and my knowledge so I know when I need to do something. I'm not always second guessing what I'm doing."

“Yeah, I think it’s getting better. It feels better because I’ve had situations where I have picked things up and then I feel like, ‘Yeah, I went to school to learn how to do this and I will recognize these things’.”

Just a word of caution here—while the 2nd stage is not as ‘daunting’ as the 1st, this stage can spark disquieting doubt regarding your professional identity and purpose.

“The reason I’m finding this part of the transition to be the most difficult is because the excitement about being done and the shock that I was in has worn off. I feel as though I’m on a raft that is drifting farther and farther away from the shore (my safety net of being a student or a new grad). And I’m floating toward an island where the experienced nurses are, but I keep losing sight of them due to all the waves.”

Perhaps it is all the ‘waves’ that make the initial part of this stage so challenging. To date, the transition has been dominated by physical adjustments to the hours and demands of work (particularly if you are working shifts in a hospital environment); emotional ups and downs brought on by the anxieties of practicing ‘on your own’ or taking responsibility for practice (in particular, skills and decisions) that you had significant support for when you were a student; and intellectual strain from having to THINK ABOUT EVERYTHING with a level of intensity that can be more draining than invigorating.

“I was doubting myself. Everything was happening so fast….I felt like I was on the edge and was losing control. I thought maybe these feelings and these emotions were going to overcome me and I wouldn’t be able to get out. It felt like I was drowning….It seems that there is always something new and it’s always stressful to be doing things for the first time, figuring out the process, making sure I do it right. Do these feelings of anxiety every go away? When does this job get less trying? I guess some things are becoming repetitive, but it will feel a lot better when I can attack more things with confidence and not fear.”

Now your energy is going more (or additionally) to the social (establishing relationships with colleagues, adjusting to individual personalities in the workplace, and reconfiguring a personal life while being a working professional), cultural (understanding how ‘power and influence’ are exercised in your workplace and who the formal and informal leaders are), and political (determining what control you have over your practice and how to use that power to ‘get’ what you need for those under your care) aspects of your life as a nurse. These are elements of your day-to-day functioning as a professional that you might not have NOTICED before. Now
that you are able to ‘lift your gaze’ from the more immediate tasks before you, you will start to notice what is going on AROUND you.

Take note that the need to coexist in all 6 of these spheres (physical, emotional, intellectual, social, cultural and political) at the SAME TIME accounts for the majority of energy consumption during this stage. As one new grad put it: “This is why you are SO SO utterly bagged and tired in this stage”.

“I get the bigger picture a little bit more now. Not always, but I know where I want to be and I’m still not there yet but I feel like, ‘OK, at least I know more how to get there.’ Just even knowing and feeling more comfortable with other staff, like the physicians, and knowing them more…it’s not so lonely.”

“Lately, patients have been driving me CRAZY (participant emphasis)!! Demanding, rude, ungrateful. Some days I come home and wonder what the common belief is as to the nurse’s role. Because let me tell you I feel like a waitress not making tips. I need to start sticking up for myself a little more, but I am quite unfamiliar with how to be confrontational.”

You may find yourself challenging pre-graduate notions of nursing and you might even notice inconsistencies and inadequacies in the health care system. This can be very disruptive to the impressions of nursing that you had come to believe when you were still a student. One of my research participants articulated it as follows:

“I like the nursing aspect of it, it’s not stressing me out much anymore. It’s other things now. It’s the politics…everyone’s burnt out. I’m not even focusing on myself and my skills anymore, it’s my surroundings and just the atmosphere.”

This can be a stage of significant ‘flux’ for new nurses—a time of ‘awakening’ to all that IS and all that IS NOT. Restoring a sense of equilibrium is the name of the game in this stage, marked by: 1) searching, 2) questioning, 3) doubting, 4) examining, and 5) revealing.

“Like in the real world you are understaffed and you are working hard. It was a real eye opener to me. You know, the things that go on and the things that they let fly. Like do you know that now we have patients in the hallways on our units? I had a patient in the T.V. room the other day. Like this is the real world and welcome to it, you know? You’re nursing someone in the T.V. room today! It’s a bit bizarre. It’s
just we’re full to the max mostly with medicine on a surgical unit and we have these surgeries that the surgeons don’t want to cancel so we take our least sick patient and put them in, well we could put them in the equipment room or in this case the T.V. room, and you nurse them there and hope nothing goes bad ‘cause you don’t have any suction, you don’t have any oxygen. So you put a note on the door saying ‘Patient Room. Please don’t enter.’ I just think it’s crazy. Like I just couldn’t believe it when they were asking us to do this. I thought are you nuts? Like on a general day I take care of ten patients. I can’t take care of twelve or thirteen patients! That’s too many—there’s a lot going on. And the other thing that happens is if we need a bed early in the morning, the patients that are being discharged later that day have to get out of that room and go sit in the T.V. room until someone can come pick them up. But they’ve just had surgery, they’re in pain and maybe they would like to rest for another three hours until their husband can come pick them up, you know? But we need that bed, we need it cleaned, we have a fresh O.R. coming in so, ‘Pack up your stuff cause you’re in the T.V. room.’ I feel like the hospital is being run a bit more like a business than a caring community. It’s really business-like so whoever is making these decisions obviously has no idea what goes on in a nursing unit.”

Searching

The confusion, doubt, frustration and anxiety that characterized the initial stage of your transition will continue at a slower, but seemingly relentless pace.

“I’m exhausted. You hear people say, ‘Well I work a week of twelve hour shifts’ but you could never do that in nursing. By the end of four [shifts] I’m either one of two ways: I feel like I could go on forever working those twelve hours because you’re in that routine, you’re totally switched around; or I could sleep for two days because I’m so exhausted….I think it’s the mental part. The thinking—you’re so busy doing stuff, trying to remember the numbers, trying to remember this, do that, did I do that? It’s just more mental exhaustion is what it is.”

Feelings of ‘energy drain’ are common during this period. Truth be told, it may be that you are just noticing your lack of energy now, but the 1st stage of transition was more likely where it was depleted. While it can be frustrating, I have come to believe that the exhaustion felt by new nurses at this stage is a normal and healthy part of the disengagement process. The exhaustion essentially FORCES you to make the separations necessary to gain back your equilibrium and in doing so, motivates the creation of a larger ‘whole’ that can encompass the multiple and complex dimensions of real life.

“I value my personal life over my work—that’s changed. Sometimes I get frustrated because nursing should be my career and I like to believe that it is my career but sometimes it is just a job. Some days I go in and it is just a job—sometimes you’re
1. Why did I go into nursing at all?
   - It is normal to feel a lack of confidence in yourself. This is still a time of learning and you may not yet be sure of what you offer to this profession when compared to those you see around you—do not forget the unique gifts that YOU bring to your work that NO ONE else does and value them!

2. Am I capable of reaching the level of expertise I see in my experienced colleagues and mentor(s)?
   - Witnessing what may appear to be innate and seemingly ‘effortless’ abilities and skills in your experienced colleagues becomes the yardstick against which you measure your own, as yet unrefined, fluctuating and often tenuous abilities—this can undermine your confidence and is not a realistic comparison.
   - You may draw relationships between your ‘confidence’ and your ‘competence’, thinking that because you do not feel CONFIDENT that you are not COMPETENT—remember that these are NOT always directly linked and that it takes time for you to build both competence and confidence.
   - Frequent debriefing with your mentor, an experienced colleague or just someone you TRUST that understands your experience is essential to cultivating a ‘truthful’ perspective about nursing work.

3. Will I ever experience the professional respect that I feel I deserve?
   - Claiming your ‘rightful place’ on the healthcare professional continuum is an ongoing process. This struggle may be particularly evident:
     a. within institutions or unit cultures that are more hierarchical;
     b. where nurses of varying levels of responsibility do not act collegially or collaboratively;
     c. when nurses and physicians do not work together as a collaborative professional team;
     d. if nurses are not valued for their knowledge, practice skill, clinical judgment and decision making.
   - Everyone deserves to be respected by others for the unique knowledge, skill and character that they bring to the care of their patients/clients but oftentimes the respect we REALLY want and need is from ourselves—this is where you should focus your attention.

4. Will my life ever be well balanced?
   - You may well be exceptionally tired at this stage and this exhaustion can feed your doubt. Be sure to ‘ground’ the questions and doubts you might have during this stage in the knowledge that things always look different when you have a good sleep (or perhaps several weeks of good sleeps in your case).
   - You WILL achieve the balance your experienced colleagues seem to have and some day, you too will be able to come to work and banter about how your
weekend went without even THINKING about all the work that lies ahead until you have to do it ☺.

5. **Who am I as a nurse?**
   - It is normal to compare yourself to other nurses within and outside of your own scope of practice—we often ‘measure’ ourselves against others like us, particularly when we are new.
   - At this point in your transition, you have seen enough to come to some conclusions about what you DO and DO NOT want to see in YOUR practice; you are starting to crystallize your own professional identity.
   - It is in this 2nd stage that you make decisions about ‘what does it mean to be a Registered Nurse, Licensed/Registered Practical Nurse, Enrolled Nurse or Registered Psychiatric Nurse’ and how will I honor those credentials?

**Doubting**

You may find that your sense of self-trust is fragile during the initial phase of this 2nd transition stage. It is common to seek validation for decision-making and clinical judgments from experienced coworkers whose level of practice you respect and admire.

“I think it’s coming, but I don’t feel like I have proven anything to anybody yet at work. I feel like they still look at me as the little grad nurse that asks so many questions and needs so much help. And I feel like even in the last month that I have learned a lot and changed a lot and I had a lot of light bulbs go on and I think I’m asking a lot less questions and requiring a lot less help. But I still feel like people… I don’t know how to explain it and I can’t really think of anything to prove it, but I don’t think they respect me yet as a nurse.”

“I was asked by my mentor, ‘Well why would you do it that way?’ and I said, ‘Well, _told me that this was the way we do it and I agree with her and I believe this is what we should do’, and she was quite, well I mean it was a Monday morning after all, but she was quite short with me and I think it’s because she doesn’t trust me as a nurse. I’m just the silly young grad nurse that she doesn’t trust and she didn’t believe that I knew what I was talking about. Whereas I think if I was a senior nurse she wouldn’t have questioned it. So it just made me feel like I was going backwards again and it was like, ‘Oh you still don’t respect me as a nurse. I still need to work on you.’*chuckles*”
Unlike the 1st transition stage where you called upon your colleagues for more prescriptive directives about “what should I do” in particular clinical situations, you are now able to generate ideas or strategies for addressing clinical challenges you face and are looking more for clarification, confirmation or validation of YOUR thoughts and actions.

“I don’t have to consciously think as much about doing some of the care. I can think beyond that. You’ve worked with enough of the nurses to get a feel of everybody’s personality and what they do, and I’ll ask some nurses, ‘Why do YOU do this when this other nurse DOESN’T do this?’”

“Yeah, before when I was asking questions, I didn’t care. I was like ‘I need to know this. I don’t want to hurt my patients’. I just needed to get this done quickly because I had so much to do. Whereas I think I have a little bit more time now. Rather than running to someone and saying ‘Give me a quick answer’ I look it up and do it myself. I think I’ll earn a little more respect doing that.”

Knowing you can make decisions and implement nursing actions that are not only safe and appropriate, but astute and thoughtful is important for your confidence. This is where the feedback from colleagues is particularly helpful so do not be afraid to ask for it!! For instance, you might ask your preceptor/mentor, “I wondered what your impressions were of my decision in this case. Is this a decision you would have made?” OR “What did you think about how I approached that situation? Were my nursing actions the best in that case or would you have done something different? Can you explain the thinking behind your own decision in that situation?”

“I think I’m much more thorough and also more focused on what’s important. Also just understanding—you know you sort of get the routine down so you know what to expect and then that helps you in your preparation and then you start thinking, ‘OK, what are the usual orders for that? Well these orders aren’t really fitting so maybe I should call the doctor and make sure that they don’t want antibiotics or want the morphine or whatever’. I think I analyze more and the whole critical thinking you know, like what am I prioritizing, instead of just starting at room number one and working down to room number ten, it’s ‘OK, who do I need to see first? How can I organize my morning? Who has 08:00 meds? Or you know, ‘This person didn’t have a very good night’ or ‘This person might need something for pain so I’ll go see them first’. I think I have gotten a lot quicker at things like processing orders. Like we do all of our own orders so trying to find things in the computer before it was like, I don’t even know where to look. Whereas now it’s like I know I’ve entered it before. I know I can be a little bit faster—I mean I’m still slow compared to most of the nurses but I’m faster than I was. It sounds silly but at the time when you’re doing it for the first time, you forget all these little tiny things whereas now it’s just like “finger snap” ‘OK, we should just do it’. It’s being comfortable I guess *laughs*, you know?”
It is important to note that during the initial several months of this 2nd stage, it may be tempting to accept leadership positions. For example, managers and educators who witness the increased level of comfort and confidence that accompanies this next stage may take this as a cue that you are ‘ready’ to be put in charge of units or students, or made responsible for orienting new staff. A consistent but disturbing finding in my research was the frequency with which new grads were placed in clinical situations beyond their clinical competence, cognitive or experiential comfort levels.

“I'm scared of the same things I've always been scared of. I'm always scared that I will miss something or something will happen and I won't pick up on it. Or that I'll get in over my head and not recognize it.”

A significant percentage of participants in my research have claimed that prior to five months of experience, they were either requested to go to, or were assigned shifts in an observation unit. This caused significant discomfort but these new grads: 1) felt too ‘new’ to make demands about where they were being asked to work, 2) did not want to disappoint the manager, educator, or senior colleague making the request, or 3) interpreted the appeals for advanced responsibility as a statement of confidence in their abilities. All of these situations made it difficult for them to refuse the requests.

“Well, here I am in obs [observation unit] AGAIN! I don't really feel I should be in here seeing as I have never been orientated to obs. This is the second time they've put me in here but the first time there was much confusion and they shipped me to [somewhere else] after report. I mentioned that I thought I should get some training but that sort of seemed to fall on deaf ears....I don't understand how they can justify an unsafe situation by saying 'Oh you're only the 2nd nurse so you won't have to give meds'. HELLO, people are not put in obs because of the meds they're on, it's because of their increased acuity. Something I don't feel I am qualified at doing with my present level of experience!"

While it may be hard to say ‘no’ to such an offer as it may represent positive affirmation of your growth, it is essential that you CAREFULLY weigh this decision against the risk accepting this opportunity may hold for you and those under your care. Remember what I said before—it takes a CAREER to make an expert nurse!!

“I feel like the staff have accepted me, which is great, but with that I feel as though they forget that I am still a new grad. There are many things which I have still not done and many others that I have very limited experience with.”

_The key to realizing a dream is to focus not on success but significance - and then even the small steps and little victories along your path will take on greater meaning._

-Oprah Winfrey
While it is obvious relatively early in this stage that you are ‘on your way’ (WOOHOO!!!!), it can also be a vulnerable period in your professional role transition. Though there is a relative comfort and familiarity that comes with working in one place consistently for the initial 6 months, think carefully about moving on too quickly. You will continue to develop your fundamental professional skills for at least the first 12 months of practice, and making a change prematurely can set you back.

“Oh, I feel like I'm back to the beginning right now. I left a job where I knew for the most part what I was doing, I knew what to expect, I knew how the ward worked and now I'm kind of back to square one and it's frustrating. I really feel that I don't know what I'm doing. You know, I have some general experience with surgeries so I don't feel like I'm that far behind but in terms of routines on this ward and the nurses here are very strict with how things are done and what's done. So being new again is really hard. I feel like I'm back to square one. I feel like I'm a new grad again, and I've been out six months, you know? Like it's tough. And then you feel incompetent like I'm getting all those feelings again.”

It is my sense that the experience of stability, consistently, familiarity and predictability may be as important in this stage as they were in the prior months of your transition—but for different reasons. In the early months of transition, you are sustained by the excitement of graduating; you can deal with almost ANYTHING!!! That may not be the case after several months of learning new roles and responsibilities, dealing with inconsistent, unpredictable and sometimes unstable situations, and working hard to establish that all important, but usually hard-earned professional credibility. I liken this stage of your transition to how it feels AFTER a CODE (forgive me here, but I AM a cardiovascular critical care nurse so my experiences reflect this), where the adrenaline that got you THROUGH the experience (a.k.a. Stage 1 transition) is still running through your veins causing a sense of hyper-vigilance and an accelerated level of energy. Eventually that adrenaline level DROPS (a.k.a. Stage 2 transition) and you feel shaky and drained. This ‘shakiness’ is another reason why you need consistent and predictable assignments with an ‘appropriate’ level of challenge. Depending on how smooth your journey was through Stage 1 and transition shock3, you may feel more or less depleted at this point. Remember that the only solution for depletion is regeneration—give yourself permission to COAST!

3As previously identified, Transition Shock© is a component of the 1st stage of transition—to review, re-read Chapter 2 or review the Stages of Transition Model© in Chapter 3.
“Comfort, confidence, level of responsibility and just, I think the personal and professional growth that you go through. You do a lot of changing. Things are a lot different. You’re not living that student lifestyle anymore. You’re not always worried quite as much about money and you can spend it on that or you can do this. And you have to be more responsible. I think there are definitely changes. It’s a lot different having days off or having a week off. You can do a lot more things. And I think I’m still searching for some stuff to do constructively in my time off.”

The period of 4-8 months post-orientation is a delicate balance of wanting to hold on to what ‘was’ because it seems safe and comforting (mostly because it is recognizable), while being equally aware that in order to move beyond who you ARE to who you could BECOME, you need to let go and trust in the process of development. At this point you need to be willing to keep walking even though you might be unsure of what is ahead.

“I just loved it. Every day I enjoyed going. If I had to work four nights in a row, I wasn’t worried about it, you know, I just really liked the work. But now it’s a different story. I just don’t know. And partially it’s because it’s new and I just don’t feel as confident. But nursing in general, I mean, I still do love nursing, I just don’t love my job right now.”

“It was a bit scary for me to admit that I was so uncertain about my career choice. It feels so silly to go to school for so long, and then once being finished, saying ‘I don’t know if this is for me’. It’s like I should have thought of that before it started….I’m so uncertain as to what I think about nursing and where I’m at right now, that I need to wait until I have some definitive thoughts and feelings before I make any decisions.”

Unlike the initial months of transition where you felt reassured by the presence and oversight of your experienced colleagues, this stage of transition is about transferring your dependence on others to a reliance on yourself; you need to know you can trust your own abilities, skills, assessment capacity and practice competence. Therefore, overly attentive ‘supervision’ of your practice by well-meaning mentors or supervisors may now be interpreted as a display of doubt in your abilities. The peak of this struggle usually occurs around 6-8
months when a crisis of confidence results from the intersection of your remaining insecurities about your practice competency, the need to become more independent, and fears you might have of failing your patients, colleagues and yourself if you are unable to meet expectations (your own AND others).

“It’s odd how I work a 3 day stretch and however those days went often reflects my attitude on my days off. If work is going good, I am in a good mood to experience the rest of my life. If work didn’t go well, it affects my social life, my relationships with family and friends. It is the difference between me achieving productivity in my personal time or wasting it laying on the couch hung-over and dreading the next stretch of work. It shouldn’t have this much control over my life. Work is supposed to be a significant portion of my life, but the key word is ‘portion’. I am feeling the same way I felt when I started; unable to keep up with everything occurring around me, patients unsatisfied with their care, families asking me questions I can’t answer, coworkers having to take the brunt of the extra work needing to be completed and physicians intimidating me more than ever. It is not that I never began feeling comfortable in my work. There were a couple of amazing months where I felt comfortable in my position, confident in my problem solving skills, aware of my new time management skills, and proud of my assessment skills and detective work when issues came up. Now I feel I am back to square one wondering where those months of experience disappeared to. Questioning if that comfortable feeling was a figment of my imagination.”

“I remember that I was emotional because nursing wasn’t how I wanted it. You know, like I had this dream of like the perfect house and all this money—that was the thing, money. I always was excited about that and being able to take trips, you know, plan a family and stuff and then of course the first six months you have so many other things you have to do and so what you think as soon as you start nursing is, ‘I’m going to be out there and, yada, yada, yada’, but it doesn’t happen and it was hard fitting into ‘the circle’ at work for the first little bit so that was difficult. And then being new I didn’t know my rights as an employee. I wanted to quit after like the first six months ‘cause I just thought, ‘This isn’t what I wanted’. But my mom made me stay. And I’m glad she made me stay. I went to go see a counselor and she

4See Stages of Transition Model© in Chapter 3.
said, ‘You know, like you’re only in the first six months’ so my mom made me stay and I thank her for making me stay. But I would also say if you ever came in contact with someone that wanted to be a nurse, to encourage them to really meditate and think on if that’s what they really wanted and if they can come across experiences to make that decision ‘cause it’s a long road to walk down and then find out that it’s not right for you.”

This is a relatively precarious time in your growth; you can feel impatient with your colleagues ‘watchfulness’ while at other times you feel like you have been abandoned if they leave you alone in unfamiliar, unexpected, or unstable situations. It is difficult to prescribe a workable solution to this predicament because it is one of those ‘darned if you do and darned if you don’t’ situations. I have always believed that respectful honesty and dignified transparency are the best approaches so I would suggest you sit down with your preceptor/mentor and let them know EXACTLY what we talked about above. Thank them for their vigilance and let them know it is not about THEM but about YOU—that in order for you to move forward, they need to let go of you a bit. If you are NOT comfortable saying this, approach your educator or manager for confidential advice on how to handle the situation. Finally, if your preceptor/mentor IS that watchful, you may want to start the conversation with, “I have noticed that you are still very watchful of my practice and I wonder if perhaps you have concerns about what I’m doing or the way I’m doing it? I have SO appreciated your support and guidance, but thought I would ask if you think I am ready to do more on my own?”

“I had a senior nurse helping me with some work today—she watched over my shoulder constantly and made me nervous. I know that I take longer at doing everything—a few minutes longer at drawing up a medication, a few minutes longer to chart, etc. She was always one step ahead of me, pointing out what I needed to do before I could do it myself—that just made me fumble a little more!”

Examining

Somewhere around 6-8 months something changes and the remainder of this stage is about finding some ‘middle ground’ between your past experience as a student, with the primary goal of learning about nursing, and your current experience as a professional applying what you have learned to your practice.

“For the most part I think that’s been really a conscious decision especially about the anxiety. It’s just like ‘that’s enough’. You know what I mean? I’m usually OK now with just leaving it or I’ll just, you know, tell [my boyfriend] ‘this happened and it was really hard’ but then that’s it and I go to sleep. It’s not looming over my head or anything, like ‘did I make any mistakes? I don’t usually think that so much anymore. It’s sort of just like, ‘OK, I did my best that day or I made sure everything was done and what didn’t get done well…I’ll just have to let that go because there’s nothing I can do about it now.”"
Growing into your new identity as a nurse may well depend on your ability to engage in a critical but fair examination of your experience to date. There will come a time (likely during this stage) when you become acutely aware of the differences in what you are actually doing as a nurse relative to what you were educated or prepared to do. That’s a big one.

“It’s definitely not what I thought it would be. I mean by the time I was done school I thought I knew what it was going to be, but when I started, I have no idea what I thought nursing was….I can remember learning the principles of sterile technique in school. Now I’m standing here watching an experienced nurse pull off a dressing with no gloves, and slap another dressing back on the incision without even cleaning it, and I don’t say anything.”

It is advisable that you consult with ‘wise elders’ who themselves have wrestled with issues like this over the course of their career (and EVERYONE has). As I said earlier, a defining moment in any professional’s life is when they come to realize that THERE IS NO NIRVANA.....that reality is NEVER ideal, but that we are all obligated to get as close to it as we can. You may struggle with ‘what to do’ when witnessing substandard practice in a colleague—what you choose to do is a critical decision in your developing professional identity—choose carefully.

It is very strange that the years teach us patience—that the shorter our time, the greater our capacity for waiting.

-Elizabeth Taylor

“...basically told myself that it was OK if I didn’t meet all of those standards. There is just so much to learn that it’s impossible...to do it all as well as you would like to. I don’t know if that’s really good, but that’s where it is. There’s definitely the temptation to become complacent when you say, ‘Well, I’ve been managing OK.’”

Professionals working on the edge of people’s lives the way that nurses do quickly learn that there are ‘lines’ we must NOT cross when things get hairy (and believe me, things will get hairy). The lines that distinguish good practice from bad practice cannot be BOLDED and ITALICIZED for emphasis like I have done here! The knowledge of which I speak (the real life application of theory and knowledge that we call tacit knowledge) is subtle and more grey than it is black and white. Much of what we learn as nurses is accomplished.
through thinking-in-action⁵ (a.k.a. thinking DURING practice) as through a critically
reflective debriefing process AFTER practice.

“Yeah, I think a little more about it [things I'm doing], like 'I don't think that's a
good way to start an IV [intravenous]'. You know, once you watch those really skilled
nurses put some of these IVs in, you're like, 'Yeah, that's a lot different than the way
this other person does it', and that must be working because people seem to come to
her for IVs. So yeah, you can judge a little more.”

Everything that we do as nurses can likely be done better, and each day is a new day that holds
possibility for progress and advancement. The new graduate needs to understand that while
no practice is perfect, we continuously STRIVE to optimize our care, clinical decisions and
judgments; this implies an ongoing intentional synergy between what we THINK and what
we DO.

“I really think it all goes back to the workload. You become exhausted…even myself,
I never wanted to start doing this ‘cutting corners’ thing. You find yourself doing
that and that's not nursing. …You've been running around all day, your back is
sore, you're exhausted. This patient is a sit-down lift…it is a good idea to get her
up into the chair at least once during the day but you don't. That's cutting corners.”

“I feel I have really grown in my skills, knowledge and confidence as a nurse, but there
is always so much more to know and do to gain comfort as you become a competent
nurse. Getting over that hump of being terrified each time you set foot on the ward
for a new shift has allowed me to feel comfortable in what I am doing and to ask
questions when I am not sure. I think the old saying 'practice makes perfect' does not
apply to the career I have chosen, because there are so many ways to do things and so
many practices that change with time, you really never become the perfect nurse. I
have given up on that goal. I think it is safer to say 'practice makes you more efficient.'”

Find someone (or MORE THAN ONE because different mentors connect with you on
different issues) you can trust to help you negotiate the minefield that comprises the daily
issues and clinical situations about which we make nursing judgments and decisions. This stage
is about struggling with self-doubt and “it's like night and day walking onto a shift knowing I can
completely trust the nurses I am working with and go to them for help.”

THOUGHTS become ACTIONS that can have life altering consequences for those under
our care. Nobody can nurse well in isolation.

MA: Basic Books, Inc.
“Some affirmation would have been nice. That’s something that I’ve noticed we don’t do well. I don’t know if it’s nurses in general but on our unit they don’t compliment each other very well. Like sitting you down and saying, ‘You know you did a very good job’. I haven’t had that. I mean they do write people up, when someone isn’t doing well, and I don’t think it’s necessary. I would like to see them make an effort when a new grad makes a good decision to say, ‘You know, that was the right thing to do’, because you need it. You can’t always rely on your self-talk to pull you through.”

Revealing

As you progress toward the latter part of the 2nd stage of transition, all that has been revealed to you over the past 6-8 months stimulates an increasingly moderate perspective on your professional experiences; there will be less HIGHS and LOWS and more ‘neutral’ days (seriously, who can sustain those kinds of highs and lows!!!!). Having been previously frustrated by your perceived lack of progress, you might find yourself relaxing into a more comfortable space that permits the mild angst that comes with revelations about what you DO NOT KNOW to co-exist with the growing confidence in what YOU DO KNOW. You begin to gain trust in yourself.

“I think relying on yourself and trusting yourself go hand in hand because if you don’t trust yourself, if I don’t trust my own judgment, I’m never going to be able to say, ‘Oh that’s the right choice’. I’ll always be like, ‘Oh I better ask somebody else’. So I think it’s very important. And I think in order to move on I need to trust myself, or I don’t think I would ever move on. Even if it’s that I’m going to screw up and it’s going to be OK.”

You might feel a bit detached from your surroundings (friends, colleagues or even yourself) as you find your way through this stage. This is a normal response as you locate that middle ground we spoke about earlier.

“I can just prioritize what I need to do. It doesn’t bother me as much and I just do what I need to do or what I have to do and then delegate what I need to delegate and get everything done. Then hopefully by the end of the day everything is done, and I can go home. Life used to revolve around work so much and I felt almost depressed in those first few months. [My husband] was gone and I was starting this new job and it felt like that was all I did—I went to work and came home and prepared to go back to work again. But I was switching over and having trouble sleeping and dreaming about work and just everything revolved around work. But it doesn’t anymore. I still don’t sleep wonderful the night before but I can sleep OK between shifts and I don’t lose sleep afterwards thinking ‘Oh what did I miss? What did I do wrong? What should I have done differently?’ I can go out and have a life and not worry about work.”
Pages 105 to 114 not available in this preview.
Stage 3
Professional Role Transition

KNOWING
NOW THIS IS MORE LIKE IT......

Having survived the physically, emotionally, intellectually and spiritually exhausting period that encompasses the first several months of transition, and having hopefully found a restorative balance during the subsequent ‘mid-year’ transition stage (2nd), I anticipate you have arrived at the final leg of your initial professional role transition journey.

“There’s not as much worry or fear really. Like in the beginning there was a lot of fear of the responsibility I had, of the decisions I had to make, of what was riding on me I guess. Just like all of a sudden having, you know, the full patient load and all these things and you know, parents asking questions. Just everything. It was like, ‘I’m not going to be able to keep up’ or ‘I’m going to miss something important’. Whereas now, I can plan better and look ahead and sort of, ‘OK, what can I do to help the night staff out today?’”

“It’s weird, like it just was, it was, it was, you know, just kind of rolling along thinking it is, it is, it is and then, all of a sudden I realized ‘Hey, it’s not so bad anymore.’ I don’t even remember the month it would’ve been. And in some ways it almost feels like it’s just been getting better for a long time.”

When I say ‘final leg’, I do so with the full knowledge that the socialization to professional practice as a nurse is called a CAREER and it happens over a lifetime. I have been nursing for 32 years and something new is always coming my way; most times that is because I invite it in. On occasion, however, it creeps in like a dense and strange smelling fog (like out of a Stephen King movie), finding its way under my door despite strict instructions to STAY AWAY ☺.

“It still comes and goes too and like I’ve said before, I’ll have a day that’s bad and you feel like ‘Oh, I haven’t even made any progress’. I’m giving report and they’ll ask me a question and it’s, ‘Of course, why didn’t I think of that?’”

Whether it is viewing our profession with a different lens, or simply watching the discipline grow as the world changes, being a professional is a work in progress.
Your role as a new nurse, developmentally speaking, is to achieve a relative uniqueness that both distinguishes you from the established practitioners around you, and allows you to work interdependently amongst them within a community or on a team of professionals. It is normal to harbor some apprehension about moving out of the learner role and into a role that holds greater expectations for performance and a narrower margin for error.

“How I define good days has changed. A good day before was surviving to the end, feeling that everything was done. I knew what tasks I needed to do and I had the list in my head so I could check another thing off this list and so I wouldn’t get caught not doing something. Now I don’t even look at time…as long as I can get done what I need to get done I’m ok.”

“That first period, the first three months where a time for was debating whether or not this is the profession for me. I was doubting myself; I was doubting my skills; I was doubting everything that I had learned in nursing. It started to progress a little bit, but then I had a little stint again at about the 6 month mark where again, the stress, the overwhelmed feelings, like just everything seemed to be piling up and it felt again like ‘I don’t know about this’. But now I would say probably within the last month it’s been feeling really good. I actually don’t dread going to work and I don’t lose sleep over it.”

“A friend of mine bought me a name tag and it says ‘Jenn, RN’ and once I actually felt comfortable in that role, I started wearing it but I didn’t start wearing it until about probably a month ago. Ever since I’ve been wearing that name tag I’ve had, and again it might just all be in my head, but their respect level and the physicians approaching me have been a lot more respectful. I don’t know if it’s just because of the RN behind my name. Because I know before with my other nametag, they would actually ask ‘Who’s the RN down here’. But now they look at my name tag some of them even call me by my first name and, oh yeah, it’s been very different.”

During this final stage of your initial transition to professional practice, you will continue the recovery you started during the 2nd stage, but this time you will be engaging with a more future-oriented set of priorities.

“The future, according to some scientists, will be exactly like the past, only far more expensive.

-John Sladek

“Like I said from the beginning, things are so much better. I know I’ll never forget how hard it was because I still bring it up and even some of the girls that I’m friends with now were the ones that were kind of rough on me in the beginning and I still
bug them about it because I don’t want them to forget. I want them to realize that they need to accept new students and new nurses, and that people who are new to the unit need to be welcomed and accepted.”

This stage is about settling into a deeper understanding of what nursing IS and who you ARE as a practitioner within the larger discipline. It is a time of 1) exploring, 2) separating, 3) critiquing, 4) recovering, and 5) accepting.

Exploring

The detachment from work (and sometimes from life around you) that may have settled in during the latter part of the 2nd stage continues through the early months of this 3rd stage. You may simply want to “get up, go to work and come home to my life...eyes and ears open, but mouth closed”.

“I guess I thought it was going to be the big defining career. My kids would be like, ‘My mom is a nurse’. But that’s not how they introduce me, because it’s not how people see you. You know, people see you as [given name] you know? I wrote a letter to my Mom awhile back because I was frustrated—for a couple of weeks it had become just a job and I think it was mostly because of the people I worked with, ‘cause to them sometimes it IS just a job and so you fall into the same rut as them. So I was frustrated and my Mom said ‘Well you just have to stick it out. You know, you just need to stick it out and maybe this isn’t where you’re going to be for the rest of your life and that’s OK because nursing is so diverse’. I know I won’t be here [name of workplace] forever because I enjoy it but it doesn’t energize me all the time to go to work. I don’t get all excited. I want to be in a job or a career where I do the foot-work but I also want to be part of a committee to make the unit better.”

As is alluded to in this narrative, more time may now be spent exploring and critiquing your new professional landscape and taking stock of the more disquieting aspects of your socio-professional, cultural and political work environments.

“I think…it’s a little bit of everything and I think I need a break. Badly. Like I think I need to just get away and not worry about it and not have staffing call four times a day for overtime. Like I said, I use to see my job as an extension of myself and now it’s just something I do and that I’m competent at it. And I know that Reality is a crutch for people who can’t cope with drugs. -Lily Tomlin
makes me probably not as caring as I'd like to be but I guess that's just how I've dealt with the fact that I don't want to be there. Right now I don't see a lot of other options for myself. Like I use to think that...it was like I would do this for a while and then I would try this, and this, and this, and this and now I'm just like, I don't know. It was suggested that maybe trying a different hospital might be better because I guess things are different at [this other hospital] and there's a lot of the crap going on at [this hospital] that doesn't happen there and that might be worth a try. I don't know. I just feel like, it's only been 8 months and I'm kind of stuck between a rock and a hard place—what do you do really?

Your level of stress during this stage can vary considerably, but the factors contributing to your stress have likely changed from a focus on your individual capacity to cope with new roles and responsibilities, to feelings of frustration in dealing with the system at large (i.e. the workplace, institution or healthcare in general). An overwhelming majority of participants in my studies over the past 12 years took note at this stage of their position of power and authority relative to others, with many identifying nurses as “being at the bottom of the pile”. Some were understandably disturbed by this perception.

“I wish I could say that work is going great. I wish I could say that nursing is everything I ever thought it would be and more. But I can't. Sometimes it takes an army of courage to drag myself from my oh so comfortable bed to that stressful place. I feel like I am back at square one wondering where those nine months of experience have gone. I was feeling so good a couple of months ago and it's like I don't even remember that feeling. I wonder, 'Could I be experiencing burnout?'”

Growing discontent with what you might perceive as professional devaluing can motivate another, albeit less dramatic reduction in your momentum. In my research, for those making their transition in a hospital environment, this peak (really the peak of a chronic level of discontent) ultimately served as a tipping point that started them searching for professional fulfillment beyond the role of an acute-care bedside nurse.
At this point in your professional journey, you can expect a change to occur in your primary support relationships. Prior to graduating, you most likely relied on non-nursing friends, pre-graduate student peers and family members for support. Now, you may see your support relationships shifting to current coworkers and experienced nursing colleagues. It is important to recognize that any change brings about both gains and losses; you must be willing to shed the ‘old’ in order to make room for the ‘new’.

“I think one thing that has really helped me is having a sounding board with my colleagues who can say, ‘That’s normal’. It’s having great relationships with all the staff members, and going out together and socializing; it’s like a family you know? We get along and we really try to help each other out, work as a team, back each other up. I’ve gotten to know some of them a lot better too and they genuinely care about their co-workers. So some of us are friends outside of work so I think it’s good.”

This does not mean that ALL past relationships will go by the wayside, but that your relationships may be altered somewhat in form and purpose. You may start to notice that your new multidimensional life (personal and professional) has relative components (for instance there may be your ‘professional nursing’ life, your ‘creative photography’ life, your ‘family’ life, your ‘social’ life) into which some relationships fit while others do not. Many new nurses, particularly younger graduates, may make crystallizing commitments with partners at this stage such as getting engaged, getting married or taking steps to cohabitate if they haven’t done so earlier in their transition process. For grads of 2nd degree programs or for those with established families of their own, this stage creates space (time and energy) for reinvesting in family connections or time honored traditions, engaging in a partner’s career or a child’s activities, or thinking about where your personal and professional lives are going or what they might ‘look like’ in the future.

“I find it very stressful at times and there’s a lot of things that bother me about it like not being able to complete my work and be satisfied with my job all the time. But I don’t think I’ll ever do anything else and if I do, it would just be temporarily. Like I might take some time off to have children some day but I’d always go back. Even
Pages 121 to 134 not available in this preview.
Appendices

I. TRANSITION SHOCK Summary
II. DOING Summary
III. BEING Summary
IV. KNOWING Summary
V. Conceptual Model of Transition Support
VI. Senior Practicum/New Nurse Transition Schedule
    Transition Program Content
    1-4 Weeks
    5-8 Weeks
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VII. Finding the Right Job
VIII. Working on a Team
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XI. Workload Distribution/Collaboration/Delegation
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    Organizing
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XVII. CODES and Rapid Response Teams
XVIII. Death of a Patient
XIX. Nursing in Rural or Remote Areas
XX. Working in High Acuity Areas
XXI Generational Workplace Ethics/Behavior
RESPONSIBILITIES – Issues

- **Connecting with other disciplines** collaboratively and autonomously for the first time
- **Integrating into an established healthcare culture** that has its own hierarchy about which you may be unfamiliar
- **Taking on additional responsibilities** such as delegation, collaborative care planning, leading, and making decisions and clinical judgments
- **Managing ongoing personal responsibilities** with family, friends, or partners

RESPONSIBILITIES – Strategies

- **Understanding that it takes time to establish yourself as a leader in patient care planning and directing.** While you have often been expected to plan, direct, and evaluate significant patient care initiatives, you have likely NOT been fully responsible for the outcomes. But rather, you have been closely guided in the development, conduct, and evaluation of those initiatives by experienced faculty or practicing nurse colleagues. Further to this, many new nurses are expected to work alone on relatively highly acute units with little or no consistent access to experienced preceptors or mentors. **WATCH and LISTEN** – spend time with an established nurse who has the kind of leadership attributes that YOU respect (i.e. organized, respectful, collaborative, etc.). Ask to SHADOW someone in charge and get a sense of HOW they enact their leadership characteristics.

- **Delegating to other practitioners.** You may be expected to delegate roles and tasks to individuals who may be older in age and more experienced and this can be a significant stressor. This stress may cause you to take on tasks you would otherwise delegate to others, thinking that this will allow you to avoid having to deal with this uncomfortable responsibility. **Guidance and modeling** on how to approach staff to whom you must delegate, but to whom you must also look to for information about your patients or for experiential knowledge is available so **ASK YOUR MANAGER OR EDUCATOR** about
Understand that delegation and workload sharing are **DIFFERENT**; delegating is about YOU being responsible for asking someone to do something 'on your behalf' (for which you remain partially responsible) versus workload sharing, which would be where 'licensed' caregivers (Registered Nurses, Registered/Licensed Practical Nurses, Enrolled Nurses, Physicians, Dieticians, Social Workers, Occupational and Physiotherapists, etc.) collaboratively decide who is the BEST individual/s to care for WHICH patients/communities/situations and how best to work TOGETHER to accomplish what needs to be done.

- **Making independent decisions and clinical judgments.** You may be unprepared for, and experientially incapable of making complex patient care decisions in clinical/care situations with which you have little or no experience. Mentoring is valuable relative to this responsibility and learning occurs OVER TIME. Again, be aware of decisions being made by others (all team members) and 'go to school' on WHAT they decide, HOW they decide it, WHO they collaborate with, and WHEN they reach out for assistance from others. It is always a good idea to ask questions and seek someone else’s opinion on a decision you are making—over time, you will feel more confident making decisions on your own. Expertise TAKES TIME!!

- **Balancing multiple responsibilities.** There is ALOT going on for you during your transition to professional practice. Depending on the scope of responsibility, nurses carry varying roles and are afforded different levels of
decision-making and judgment responsibilities. Being introduced into your roles and responsibilities SLOWLY and sequentially is most effective so try to negotiate this gradual integration with your manager and educator. If you can spend time ‘buddying’ with other healthcare professionals with whom you are to work (other nurses, support staff, other professional practitioners) you will have a sense of what THEY do relative to YOU; this allows you to take on only responsibilities that are YOURS to assume! There is enough work for everyone ☺

• **Familiarizing yourself with practice contexts.** Being introduced into a professional practice role is often daunting when you feel completely responsibility for the outcome of practice decisions you may never have made before. Access to a practitioner who has experienced the issues you are experiencing and worked through them over time can demonstrate for you how to balance all the roles and responsibilities—even if you are in a rural or remote area or you are the ONLY nurse practicing in that center at any given time, make sure you have access to a senior practitioner by phone! As well, try to transition into professional practice transition in a familiar environment (i.e. take opportunities to do senior practicum rotations where you want to be employed) and try to remain in the area to which you initially transition for one year post graduation. It may be tempting to ‘leave’, particularly if you are struggling in your workplace, but remember—EXPECT to struggle—this is a MAJOR CHANGE in your life and there WILL be times of struggle. Changing your place of employment (unless you are being bullied and are unable to resolve the abusive situation)
will only mean that you need to go through this AGAIN. The challenge with painstaking growth is that if we don’t grow from it in one situation, ‘life’ will introduce it again….and again….until we learn whatever lesson it is trying to teach you. You have a LIFE TIME of work ahead—don’t rush through your experiences!

**ROLES – Issues**

- **Adjusting to additional roles** with primary responsibility for treatment plans for patient treatment plans/multidisciplinary leadership roles/collaboration on and implementation of appropriate physician requests (a.k.a. ‘orders’)

- **Coping with role stress** particularly when roles are blurred, unclear or inappropriate for one’s level of experience, knowledge or skill capacity

- **Learning ‘new’ roles** related to specific workplace expectations, routines, and relationships that may be compounded by an overwhelming sense of responsibility for one’s actions

**ROLES – Strategies**

- **Experiencing varying levels of stress.** Role stress is high particularly during this first stage. The impact of this stress on your development depends on your perceived intensity of the stress, the supports and resources available to you as you navigate the environment (i.e., available colleagues and peers as well as prior and suggested coping mechanisms), your ability to experience success in your new role, consistency and predictability within the workplace, and the time and opportunity you have to learn the roles, skills, routines, tasks and practices expected.

- **Progressively integrating into the role of a nurse.** Nurses function in varying but intense, dynamic and highly demanding contexts. New nurses, because of their limited experience in a variety of practice settings, should not be expected to make high-level clinical decisions or judgments unless provided with access to experienced collegial collaboration. Remember that much of your energy is being consumed by simply adjusting to a new reality that is both personal and professional. Expectations of performance without the provision of adequate support may result in unsafe practice situations that may go undetected by colleagues. The new professional’s need to belong and feel
affirmed is highest during the initial months of their transition. As a new grad, you are developing a new professional identity during the first 12 months of practice and what you come to learn about yourself and others during the early stages of your transition will influence your experience for the remainder of your transition, possibly crystallizing your impressions of the profession as a whole. **Organize to be mentored** by an experienced practitioner who is as accepting and embracing as they are competent. That may mean you need to find someone who is an EXPERT practitioner to show you the skills you need to be proficient at, but a different individual to encourage you, listen to your concerns, challenges, and anxieties, support your ideas and strategize with you on how to accomplish the career path you have planned for yourself.

- **Clarifying roles and responsibilities.** Role blurring and confusion (i.e., what does the social worker do and what do I do in this family crisis situation?) may be more prevalent if you have NOT been orientated (i.e., spent time shadowing colleagues in other disciplines as well as unit clerks, porters, nursing coworkers) to the roles and practices of your intra/professional colleagues. Spend time talking with and **shadowing** ALL colleagues with whom you will be working (including lab and pharmacy staff, your nursing partner [for LPN/RPN/Enrolled Nurses this would be an RN], nurse practitioners, physicians, receptionists, unit clerks, porters, allied health professionals and collaborating centers/organizations) so that you know WHAT they do, WHEN they do it and HOW to connect with them for support in your community or institution.
New Graduate Stages of Transition

STAGE 1 - DOING

LEARNING

- At this stage you will be most comfortable in the learning role and least comfortable applying that knowledge—you will most likely feel insecure about what you know because the situations may ‘look’ different than they did when you were a student.
- You will likely feel more comfortable with theory – you may find that you ‘default’ to theory when stressed because it is safe and familiar. Remember, it isn’t as much WHAT you say or know as HOW you say or present that knowledge that people respond to. Consider using the following statements when responding to your colleagues:
  1. That is such a great point. Can you show me what you mean?
  2. Thank-you so much for pointing that out to me—I do not have a lot of experience with this so could you tell me more about why you do it that way?
  3. I hope I didn’t sound cocky/stuffy/presumptuous/like a ‘know-it-all’ with my answer just now—most of what I know and depend on right now in my practice is based on the theory I learned in school. I know that the theory is part of it, but I don’t have the experience yet to ground that theory and make it ‘real’. Can you help me understand how the situation in this case differs from what I know theoretically?
- There is much to be learned in your new professional environment (who’s who, what are the institutional policies and regulations, what are your professional responsibilities, etc…).
- Remember that you are likely a typical ‘adult learner’ that does best when given a chance to apply what has been learned shortly after being introduced to the skill or theory – negotiate with the educator opportunities to move ‘in and out’ of a classroom and clinical setting during your orientation so that you can immediately apply what you learn, returning then to the classroom to learn more. And remember that you are on a steep LEARNING CURVE in this stage of your transition—it will take LONGER to process what you are doing so give yourself that time. Try not to get caught up in the speed of what you are doing, but focus on doing it RIGHT.

Getting Support:

1. How can you get more comfortable with your new roles and responsibilities?
2. How can you ‘learn’ and ‘perform’ (i.e. get time to repeatedly practice and gain a familiarity with what is expected of you)?
3. Do those around you know about your stage of transition? Do they know it will take you longer to do most tasks?
4. What 5 skills do you need to be able to do WELL where you work (that are performed often)?
5. How can you practice them until you become competent in them?
6. How do you learn best (observing, reading about then doing, practicing first in simulation)?
7. How can you apply this to your learning during transition?
8. What can you learn about the colleagues you work frequently with (including allied health and support staff)?
9. How can you negotiate a gradual and progressive introduction into your roles and responsibilities?

PERFORMING

• At this stage you will likely be most concerned with your ability to ‘perform’ the tasks and skills that are required of you.
• You may be aware that you are being ‘watched’ and may feel you are being ‘judged’ for how well you perform—acceptance of yourself is often dependent upon your colleagues and mentor’s acceptance of you.
• Your growing professional nursing self-concept depends on a healthy facilitation of your new roles and responsibilities. You will be expected to perform certain roles or skills as a professional nurse for which you may not have been prepared during your education, or for which you had not been given complete responsibility for when you were a student (it is virtually impossible to afford you opportunity to perform EVERY skill or give you EVERY responsibility of a professional nurse when you are a student).
• Graduates who are permitted and encouraged to ‘practice’ their skills and thinking under the watchful eye and ears of an experienced practitioner will do better overall.
• During this stage of your transition, it is very important to **ASK FOR FEEDBACK**: I recommend that you meet with your manager/educator and clinical support person at regular intervals and there are guidelines for the feedback process offered to you in the ‘Transition Orientation Template’ (see Appendices).

Getting Support:

1. What can your colleagues/mentors/preceptors do to facilitate your growing skill and confidence level?
2. How can you practice the skills you will need to do well in your workplace while you are still a student (i.e. can you perform the skills in a simulation setting before doing them in a clinical setting)?
3. How can you become competent at the 5 most frequently performed skills in the course of your work (i.e. if you are in acute-care could you organize to do ALL IV insertions on your unit for a 12 hour shift; if you are in the community, could you do NOTHING but immunizations for a month)?

4. How often can you turn a ‘statement’ (“I have never seen anyone give an injection like that!”) into a QUESTION (“I have not given injections that way but it looks like an interesting approach—could you tell me why you do it that way?”)?

5. Does your workplace facilitate feedback sessions? If not, how can you request this?

CONCEALING

- At this stage you will likely feel insecure about who you are as a nurse and what you know or are capable of doing.
- Depending on your age, your life experience and degree of self-confidence, you may be inclined to conceal feelings of inadequacy or concerns about your competence in different situations from the experienced people around you.
- Encouraging and understanding conversations will do much to ‘bring out’ your feelings and concerns.
- Try to connect with nurses who welcome your questions and are genuinely interested in your growth and who understand what it is like to be ‘new’. Talking with your colleagues and asking them a bit about themselves will likely reveal those who are interested in connecting with you and those who are not.

Getting Support:

1. What do you need to feel more comfortable around your senior colleagues/mentor?
2. How can your colleagues create a safe space where you can BE new but FEEL connected to the team?
3. What kind of support do you need to feel safe in your workplace? Who needs to know this?

ADJUSTING

- Remember that you are adjusting to many new roles, relationships and levels of responsibility.
- You may be adjusting equally to changes in your personal life as well as your professional life.
- Because there is a significant amount of energy being consumed by a variety of personal as well as professional adjustments in the initial 6 months of employment, you should really try NOT to accept overtime shifts, even though it is tempting to pay off all that debt!! Your ‘down’ time is critical during this rapid growth phase
Getting Support:

1. What are the personal changes you anticipate making after you graduate (i.e. are you changing relationships, managing your finances for the first time – buying your first home)?
2. What plans do you have to make time for yourself? Where are you going to get YOUR support from?
3. If you are a parent, how are you going to re-engage in your family's life gradually? How can you negotiate a re-integration strategy that meets their needs but allows you the space to experience this professional role transition?
4. How might this transition affect your ability to focus, commit, and engage with friends, family or a significant other?
5. What discrepancies do you see between what nursing IS where you are working and what you thought it would be? How can you discuss these with a mentor, your educator or manager, or another new graduate?
6. What might assist you to bridge the differences between what nursing IS and what you thought it would be?
7. How have your colleagues adjusted to these differences?
8. What do you need from your friends, family, significant other and colleagues to help you adjust to your new life?
9. What do your family and friends need from YOU? How can you help them understand what you are going through?

ACCOMODATING

• New graduates at this stage often find themselves caught between a rock and a hard place. They have never experienced many of things they are seeing and doing before. It is your development task at this stage to figure out what it is you need to 'accept' and what you can (and should) 'modify' according to your own way of doing things (perhaps a new theory that you were taught) or your own standard of practice.
• It is normal and healthy to seek counsel and modelling for how to ‘be’ in this new world. It is normal to need, and ask for rationale for why things are the way they are so that you are better equipped to decide if that is something you should ‘accommodate’ in your thinking or if it is something that runs contrary to your thinking, ethics or standards of practice. These are tough decisions, particularly when you want to be accepted by those individuals with whose practice you might take issue. Figuring out ‘who you are’ at a time when you also need to ‘belong’ is one of the greatest professional adjustments you will make.
Getting Support:

1. Are you concerned about the level of practice where you work?
2. Who can you speak with about your concerns?
3. What can you change about the way nursing is practiced in your workplace?
4. What can you do to develop your own way of practicing as a nurse without alienating or discounting valuable input from others?
New Graduate Entry To Practice Support Framework

**EDUCATION**

**PROFESSIONAL EMPLOYMENT**

1. DOING
   - Learning
   - Performing
   - Concealing
   - Adjusting
   - Accommodating

2. BEING
   - Searching
   - Examining
   - Doubting
   - Questioning
   - Revealing

3. KNOWING
   - Separating
   - Recovering
   - Exploring
   - Critiquing
   - Accepting

**PREPARATION**

**ORIENTATION**

- Introduction to workplace structure and function including orientation to professional roles and responsibilities within a work environment.

**TRANSITION**

- Facilitation of a transition from primary learner role to professional practitioner with responsibility and accountability within the context of a work environment.

**INTEGRATION**

- Development of increasingly advanced and enhanced workplace and professional skills including clinical reasoning and judgment, decision-making, communication, workload and crisis management, inter/intra-professional negotiation, conflict resolution and clinical collaboration.

**STABILIZATION**

- Maturation of professional identity, with a focus on career plans and trajectory, the honing of professional goals and ambitions for the purpose of building professional engagement and work commitment.

**Conceptual Model of Transition Support** © Judy Boychuk Duchscher
Senior Practicum/New Nurse Transition Schedule

The application of these senior practicum/new nurse transition suggestions will be most beneficial if you are a student intending to WORK on the unit where you are completing your final capstone course or final practicum/rotation OR if you are a new nurse approaching orientation. I am working on the assumption that this experience will last a MINIMUM of 12 weeks\(^1\) and will consist of your being integrated into a full-time line\(^2\) of varying 8/12 hour shifts beginning in the 5th week.

You will note that the Senior Practicum/New Nurse Transition Calendar at the end of this appendix infers a routine of Monday-Friday. I DO recommend that you STAY ON DAYS (this refers mostly to acute-care transitions or practica) until the end of your SUPERNUMERARY time. Supernumerary simply means that you are NOT included in the staffing quota for the clinical area.

Supernumerary status allows you to take on particular practice opportunities WHEN they arise. For example, as a new Outreach Nurse you could choose one day to spend time ‘in the park’ or ‘on the street’ talking with/seeking to understand the challenges of a homeless population; OR as a new (or wanting to find work in this role eventually) Cardiothoracic Rehabilitation Nurse, you might observe an open-heart surgery, follow the patient through to recovery and then visit with their family, gaining insight into the experience BEFORE this individual arrives to YOU as a nurse in cardiac rehab; OR, as a Med-Surg Direct-Care Nurse you might spend time with a dietician working with total bowel resection patients, or you might choose to observe the preparation of a Total Parenteral Nutrition bag by a pharmacist; OR you may ask to observe a radical head-neck resection in the operating room so that you can understand WHERE the drains are located when you are expected to change a dressing post-operatively. Supernumerary status allows you to take practice assignments like the ones described above because you are free to go to where the EXPERIENCES are.

The turnover required, particularly between day and night shifts can be exhausting and will deplete energy that will be needed for your intellectual, emotional and physical transition adjustments. It will obviously be important for you to experience the differences in rhythm between shifts IF you will be required to work them as a professional. Having said that, the more important adjustments you will need to make during your initial transition will be easier

\(^1\)Note that the suggestion of a 12 week transition program does not sanction nor recommend abbreviating existing or planned new nurse transition or residency programs of longer duration. Many established programs infuse similar components to what is suggested here, but over varying periods of time and in unique content combinations.

\(^2\)A line is the staffing roster/schedule followed by your preceptor/mentor, who is assumed to be an experienced nurse working as staff in that clinical practice area.
if some stability, consistency and familiarity can be interjected into your ‘routine’. Because the clear majority of students and new nurses are accustomed to a day-night circadian rhythm, disruption of these patterns AT THE SAME TIME as you are experiencing your transition can complicate things. While it is not recommended, if necessary, you can do several NON-day shifts during your supernumerary time as long as those shifts are done on the same line as YOUR PRIMARY PRECEPTOR/MENTOR (this is the individual with whom you are paired for the final 5 weeks of your transition program) (see schedule).

**NOTE:** Most centers refer to the initial introduction of new nurses into practice as a ‘**Transition**’ or ‘**Integration**’ Program but on occasion, it is referred to as ‘**Orientation**’. Please also note that the Senior Practicum/New Nurse Transition Calendar offered at the end of this appendix is modifiable—it is advisable to stay committed to the principles and the overall content, but the timelines and the order of the classroom content will need to be adjusted to meet the needs and requirements of the workplace. Take this information with you to your practicum, or use it as a basis to negotiate a transition program with your manager or educator.

**Program Template (See Schedule Below)**

1) **Shadow**³ your PRIMARY⁴ preceptor/mentor for 2 days—pay attention to WHAT the preceptor does, HOW this individual manages their workload, the SKILLS they do consistently and repeatedly, and the DECISIONS/JUDGMENTS they make.
   a. **Identify a clinical situation** that you witnessed to use as the **debrief exemplar case**. Make extensive notes for yourself about it.
   b. **Consider at least ONE decision/judgment** the preceptor/mentor made that you would like more insight into—make note of the circumstances.
   c. Observe the process your preceptor/mentor uses in collaborating and delegating.
   d. **Makes notes** that outline the routines you witness in the practice of your preceptor/mentor so that you can design a similar schedule for yourself—over time you will modify it to meet your own unique style but it is a place to start.
   e. **Note the primary 5 clinical presentations** (population health concerns) of clients/patients that are in that practice area (i.e. children with chronic lung disease/adult cardiothoracic surgery/older adults with chronic heart disease/young adults with fetal alcohol syndrome) and develop a ONE PAGE synopsis on each of them that

³To *shadow* your preceptor/mentor literally means SHADOW them. You do NOT do anything ‘for’ or ‘with’ them. Your role is to *watch INTENTLY* what they do, *when* they do it, *why* they do it (that can come during the debrief but make a note to ask) and *what result* they get from doing what they did. As long as you are DOING, you are not OBSERVING.

⁴You will likely require several preceptors/mentors (one of these individuals COULD be the educator in your practice setting) in order to accommodate the recommendation of supernumerary status and a strict day routine for the initial weeks. During your transition/practicum it is advised that you CHECK IN regularly with your PRIMARY preceptor/mentor for the purposes of consistency and follow-through.
Appendix VI

includes pathophysiology, signs and symptoms, treatment, medications as well as health education and planning suggestions. Keep that information (along with other information you are gathering) in a small pocket binder, notebook, or mobile computing device such as a Blackberry®, iPhone®, iPad®, Android™ or some form of smartphone. Be sure you safeguard the confidentiality of any patient/client information stored on these devices!

f. **Debrief with your preceptor/mentor at the end of each of the 2 days**, and ask your preceptor/mentor the following questions:
   i. How did your day go?
   ii. Was this a busy day for you?
   iii. Was this a ‘typical’ day in this practice area?
      
      **NOTE:** this will give you insight into what a ‘normal’ or ‘busy’ day looks like for a nurse in your role in this practice area.
   iv. Tell me about this case (present the exemplar case)? What went WELL in this situation and what DISAPPOINTED you about your care in this situation? What might you have changed and why?
      
      **NOTE:** You are trying to understand what ‘well’ means to this practitioner. You want to get a response from them around what they were disappointed in because EVERY situation can be made better and you need to understand the nuances of what COULD have been better in that situation. The more subtle the disappointment the better—there is more learning for you there as you could likely pick out the GLARING issues that needed resolution. As you discuss the case, note whether or not YOUR impressions of what went well are the same as your preceptor/mentor’s. If they are NOT the same, explore this with them.

g. **Review your preceptor/mentor’s exemplar decision/judgment.** What brought them to that decision/judgment? What was their thought process behind the decision/judgment? What other options did they consider? What ultimately made them lean in this direction?

      **NOTE:** You are trying to get a sense of the nuances of decision-making in particular clinical situations. Compare your OWN thought processes to your preceptor’s to determine what is DIFFERENT in the way you are thinking. When you note discrepancies, ask your preceptor, “Before we talked, I was thinking in this situation that I would have done _____. What would you think about that and would you choose your response over mine and if so, why?”

2) **Shadow the Unit Clerk/Clinic Receptionist for a day** (review schedule). By lunch/dinner time, YOU should be admitting a patient, processing requests, answering phones or otherwise enacting the role of the UC/Receptionist.

      **NOTE:** If you haven’t already figured this out, the POWER POSITION in any workplace is in the administrative/clerical role. These individuals are the gatekeepers of information and can make your life exceedingly difficult or a haven of joy. Spending
time with the clerical employees where you work demonstrates respect for their position and provides you with insight into what they DO and DO NOT DO. In order to anticipate the appropriate time and task to delegate to them, so that you do not need to DO something that is really someone else's responsibility, you need to KNOW what they do. This is going to save you a lot of time and energy.

DEBRIEF AT END OF DAY WITH PRECEPTOR/MENTOR

3) **Shadow the LPN/RPN/Enrolled Nurse/RN for a day** (depending on your role you would shadow your ‘partner’ role).

   **NOTE:** If your workplace utilizes a ‘collaborative model’ of practice, you will be working in partnership with someone from another practice scope within the nursing profession (an LPN/RPN/Enrolled Nurse will work with an RN). This will involve a significant amount of consultation and teamwork, which itself demands a comprehensive understanding of the ‘other’ role. Spending time with your partner in a shadowing capacity allows them to demonstrate to YOU what their role is. **ASK QUESTIONS!!!!** As well, there are often policies or job/role descriptions that outline the details of specific roles on the healthcare team. These would be available either from the manager or human resources upon request. **READ THAT JOB/ROLE DESCRIPTION, and get access to any information from their professional regulatory body that speaks to their ‘scope of practice’ so that you understand what you CAN and CANNOT request or expect of your nursing partner. SHADOW this individual—watch how they engage and interact with the individual currently assuming YOUR role (remember, shadowing is about observation). Make notes for yourself about YOUR role and THEIR’s.

DEBRIEF AT END OF DAY WITH PRECEPTOR/MENTOR

4) **Shadow the Care Aide/Certified Nursing Assistant/Nursing Aide for a day** (this is a NON-licensed, but perhaps ‘certified’ individual working in a personal care role).

   **NOTE:** Many workplaces utilize non-licensed (but often certified) personnel to deliver personal care to clients/patients (particularly long-term care, rehabilitation and acute-care). The crucial point here is that these individuals have a job description as opposed to a ‘scope of practice’. Anything that is asked of them that lies outside of their job description is considered a ‘delegated’ task, the responsibility for which lies with the DELEGATOR!!! **BE AWARE** of this so that you maintain safe practice standards in making requests of these caregivers.
Appendix VII

Finding the Right Job

Congratulations! You made it through your nursing education program!

Now it is time to find a job!

But how do you get a job?
Which job is right for you?
What are your employment options?

GETTING A JOB

The Job Market

• This is a challenging time to be looking for work in any profession, primarily because of recent changes to the stability of our economy.

“It seemed surreal that in a profession with an acknowledged shortage of human resources, that a ‘hiring freeze’ could occur. When I ‘entered’ nursing, the economy was sound, and we were told of the endless possibilities for career options. While I still believe there are endless possibilities, it hurt very much to graduate and only see doors being closed. I thought that I needed A JOB. That I ONLY needed A JOB. To the point where after I graduated I up and left to move thousands of miles away because, like many new grads I felt the pressure to begin paying off student debt. Even though I moved to a full-time position with a health authority that had a ‘New Graduate Transition Program’ in place, I lost familiarity, predictability, reliability and consistency in my physical environment, the culture of the community and province, immediacy of family and friends and regional nursing culture. It was SUCH a drastic change, which at the time I believed to be in the best interest of my identity and career in nursing. But in uprooting so much of what I identified with in the bigger context of my life, I experienced an EXTREME sense of disconnect and loss of self. In other words, when my nursing identity was rocked by transition shock, I didn’t have any other part of my life (my prior ‘self’) to identify with. I literally did not know who I was or what I was doing….It was a hard process and difficult to dig my way out of; but with support from family, friends, Nursing The Future, time, and therapy I did make it through and came back to nursing ‘on my own terms’. I have reconciled with nursing and made it to a place where I can continue my professional development. From this experience, I now share with new nurses and senior students that time with family & friends, and pursuing your interests outside of nursing are SO important. These activities build your identity beyond nursing, so that you can still recognize yourself when your nursing identity is challenged as you are moving through the stages of transition. If you do decide it is necessary for you to move for work, think VERY CAREFULLY about your pillars of support and
I have personally lived through some LEAN professional years, but nursing employment is cyclical—the availability of work ALWAYS (and I mean ALWAYS) comes around... sometimes you just have to wait it out.

If that frustrates you, LET IT OUT (punch a bag...not a person...) and then MOVE ON—ANGER EATS YOU UP!!! Sustaining a level of frustration about something you can not control is just a waste of time, energy AND opportunity. It is quite possible that you won't see something DIRECTLY in front of you because your vision is either clouded by disappointment and anger, or you see ONLY what you are looking for and miss everything else.

For the newly graduated nurse, this ‘interesting’ job market means several things:

✓ The availability of work may depend more on regional economics;
✓ You may NOT get a placement in the practice area you desire immediately upon completing your program (for instance community or public health) and you may have to take employment where the jobs are available (for instance acute-care or private home-care);
✓ You may have to get CREATIVE;
✓ You may have to work SEVERAL casual/relief positions or for a nursing agency;
✓ It may be necessary to consider working (or volunteering) OUTSIDE of nursing TEMPORARILY. IF you do this, remember that REGARDLESS of what you do or where you do it, there is way to develop your nursing capacity or capability through that experience:
  o Work as a waiter/waitress or in retail (make contacts; practice speaking to strangers with the intent to get them to reveal something about themselves; practice your Socratic method...BUSTED...somebody needs to read Chapter 5 again!!!);
  o Volunteer at a shelter, hospital or clinic (or at public events like sports or entertainment—I volunteered for chili cook-offs (totally fun!), long distance running races, trade shows, exhibition/Shrine Circus (I made so many contacts, and even a few who wanted to 'introduce you to my son' ☺);
✓ Ask your previous instructors/faculty if they need anyone to assist them with teaching, act as a ‘patient’ during the student's practical examination time or offer to TUTOR struggling nursing students;
✓ Consider enrolling in a continuing education course (Critical Care Nursing), completing an advanced certification program (ACLS/Ortho Technician/Wound Management Specialist), or starting a graduate degree (MN);
✓ Work in a long-term care center as an aide, clerical assistant, or porter;
✓ Attend job fairs and keep connected with the Human Resource Departments of your local healthcare institutions;
Appendix VII

✓ Don’t forget that healthcare organizations are not the ONLY workplaces that hire nurses!! Approach local industries such as power, electric or water companies, construction sites, schools, churches, or your own nursing professional organizations and unions—you never know who might be looking but just hasn’t put their ‘sign in the window’ yet;

✓ Pharmaceutical and health supply companies are often looking for Clinical Specialists (nurses) and Sales Associates with healthcare background so get online and start ‘trolling’!!

✓ If you know where you want to work, connect personally with someone who works there and make an appointment with the Nursing Manager or Administrator to ask for advice and MAKE CONTACT (‘dropping in’ to nursing practice areas is generally discouraged because Managers are often unavailable without an appointment and it is more respectful to provide them with some advanced notice—having said that I have done this and it HAS worked…demonstrates initiative and interest);

✓ Consider being a Research Assistant (talk to you nursing program instructors/faculty) or contact a local researcher in ANY discipline and ask if they need any assistance with their work (they may be able to pay you but if they can’t, VOLUNTEER a few hours a week! and you will have a GUARANTEED reference 😊);

✓ Reconnect with connections made during school (this is where the level of engagement you had with EVERY experience, interaction and placement you had is going to PAY OFF;

✓ Prepare a KICK-BUTT Resume (the web has all kinds of free sites that can assist you).

✓ NETWORK, NETWORK, NETWORK (get OUT THERE and meet people in the practice area that interests you);
  o Think about leaving your state, province, territory or township for work in another region;
  o Consider writing the National Qualifying Examination for a country outside of your residence or origin (just keeping your options open!);

✓ OR…..go plant some trees in the Rockies, spend the summer working at Starbucks™ or take a vacation and TRAVEL!! (remember what I said about debt being enduring….)

• Ensure that you have a professional portfolio (some schools now support their students to create e-portfolios that they can send to potential employers) which contains your resume and any other certificates/credentialing (i.e. Basic Life Support, Child Safe Environments, Manual Handling, etc.). When you initially enter the workforce, you can include particular projects or papers that demonstrate excellence in various ways but MORE is not always BETTER. Be selective (target what you send to the job you are applying for) or an employer might just find your presentation redundant and frustrating! Start a current, well developed but succinct portfolio during school and update it periodically throughout your work experience. It makes for an impressive document to take (or send prior) to interviews!
• While there has been ‘some’ flux in the availability of jobs, it appears that there has been a recent leveling out of employment opportunities. While the current fiscal recovery mode has slowed the job market in some places, the exit of the early baby boomer generation (currently >60 years of age) will result in a steady need for human resources over the next 10 years.

• What may change more significantly than the ‘net’ job availability is WHERE the jobs are located (geography and practice setting). It may come down to making a decision that favors either LOCATION (some of you may have families or working partners and may not be in a position to move) OR making a decision that favors a ROLE/POSITION/PRACTICE AREA or desired hours or work (a preference for full time work). In both instances, your current stage of life (school-age children or a working partner who is unable to relocate) may impact your decision.

• Many parts of Australia recruit their own students to Transition to Professional Practice Programs (TPPP), which are 12-month government assisted, hospital-based ‘temporary’ jobs that provide an established program of transition support. This occurs through a centralized e-recruitment process and successful applicants receive a 0.84 or 1.0 full-time equivalent position. At the end of the year, they are able to reapply for any available positions.

**FINDING THE RIGHT JOB FOR YOU**

**Evaluating Your Potential Workplace**

• Consider the overall environment in which you are considering working. You will want to choose a job that fits for you—try to match the ‘culture’ and ‘pace’ of the unit with your interests, your energy level, your home life and your family responsibilities (i.e. community health, public health, or homecare may be a better choice if you did not enjoy hospital nursing while in school, or if you are unable to work flexible and varying shifts due to child-care issues or personal intolerance of night shifts).

• Try to check out potential workplaces by asking to go on a tour. Some institutions/regions offer regular information sessions about their employments opportunities so keep your eyes and ears open during your final study term).

• If you are not familiar with the practice setting, ask for an opportunity to shadow your partner nursing role (LPN/RPN/RN/Enrolled Nurse/Registered Psychiatric Nurse), unit aide, and unit clerk (see prior Appendix for details)—this will allow you to become familiar with their roles and to better appreciate the distinctions in the roles of various nursing scopes of practice relative to other caregivers. This knowledge will be valuable to you when it comes to initially understanding, and then ultimately delegating responsibilities to members of your practice team.

• When you are IN a potential workplace, observe the nurses in action. Spend time in the coffee room and chat informally with the nurses while they are working or on break, or
book a meeting with the clinical educator/manager/or supervisor to get a feel for how the unit is run. **Don't ever be afraid to ask questions.**

- Some considerations when looking for the right workplace ‘fit’ are:
  
  ✓ **Staffing levels** (nurse to patient/client ratios and work organization in the practice setting) are often structured in accordance with client/patient acuity levels or nursing workload measurement, staff experience and staff mix. It would be fair to say that the nurse patient care ratios vary between states, provinces and territories, but WITHIN those regions remain relatively consistent (so ‘theoretically’ if you had experience in San Diego, California, USA, you could predict that the staffing ratios would be relatively similar in San Francisco, California but you could NOT transfer that assumption to Calgary, Alberta, Canada).

  ✓ **Staffing schedules/lines** may be organized in advance by the manager, based on a set rotation (each nurse ‘rotates’ through a set schedule that consists of a 4-8-12 week schedule that keeps repeating itself), or flex-scheduling that is done by the staff themselves. Flex scheduling provides more room to modify and adjust your schedule on a rotational basis, but there are rules and regulations with this process—HAVE YOUR PRECEPTOR/MENTOR REVIEW THE FLEX-SCHEDULING PROCESS WITH YOU.

  ✓ If you are taking a position in **community or public health**, the hours are generally prescribed; 8 hour day shifts are the norm with start times varying according to the particular clinic/center you are working in and the role you are assuming (i.e. a needle exchange out-reach clinic will have different hours than a well-baby clinic, a geriatric rehab program or a interval home for offenders transitioning into the community).

  ✓ **Homecare positions** can be day or evening rotations and will depend on the caseload you assume. Generally, homecare nurses are required to provide their own transportation but are given a stipend for ‘wear’ on their car and reimbursement for fuel used. HOW this is provided will depend on the employer (flat compensation, gas receipts or mileage).

  ✓ **Long term care and acute-care** are generally scheduled (that might mean flex scheduling) positions. If you are unable to get a full-time position (Full-Time Equivalent [FTE]), you can always consider part-time, casual, per diem, relief (these positions are dependent on geographical/country location) or agency positions where you have varying benefits but you get experience and perhaps even exposure to a particular practice area that you might consider down the road.

- How you are ‘received’ (embraced or welcomed) into your new workplace will depend on a HOST of issues, but the most important in my experience AND in my research is the
Working on a Team

• As nurses working in health care settings, we are only one part of a large team of health care professionals working together to care for every aspect of our clients’ lives. Understanding the roles and responsibilities of each member of the team facilitates a collaborative approach to resource utilization and ensure that the expertise of all team members is available for the patients/clients/communities we serve.

• Knowing which member of YOUR team is the most appropriate person to deliver a particular aspect of care can help you to better understand your OWN role, and can help you draw upon the rest of your team members to optimize the care of the patient/client and their family or community.

• Below are job descriptions and responsibilities of many of the professionals you will encounter in your practice. It is difficult to include ALL varying job descriptions and diverse titling that comes with allied and support healthcare providers (this book is targeted at new nurses from Canada, the United States, Australia and the United Kingdom). Consider this when you arrive in your workplace; clarify, validate and verify the particularities of roles and responsibilities as they apply to YOUR practice context.

• While the positions identified below were generated primarily from the framework of an acute-care setting (the majority of new graduates begin their practice in acute-care), similar positions with varying titles will exist in rural, public and community healthcare centers. Further to this, it is important to note that not all areas will have each of these professionals, and the duties of each position may be divided differently based on the needs of the country, region, institution or healthcare facility, and client population you are serving.

Nurse Manager/Head Nurse

✓ Follows, promotes and upholds the unit/hospital’s mission statement and the practice setting’s standards and policies
✓ Prepares, monitors, controls and evaluates the annual operating budget
✓ Selects, hires, develops and evaluates all employees working within the practice setting for which they are responsible
✓ Monitors staff attendance/absenteeism/sick time
✓ Initiates employee disciplinary action and terminates if necessary
✓ Participates in nursing, medical, administrative and allied healthcare committees to facilitate the operation of the nursing department
✓ Monitors the quality of nursing care clients receive through audits and other means
Nurse Practitioner/Nurse Clinician/Clinical Nurse Specialist

- Has advanced clinical preparation, most commonly at a Master’s or advanced clinical practice level
- Takes primary responsibility for the coordination of healthcare interventions and nursing care
- Depending on the practice setting may write orders (nurse practitioner)
- May perform advanced interventional procedures (i.e. chest tube insertions, central line insertions)
- Coordinates clinical care follow-up during hospitalization or upon discharge if working within the community or in general practice
- Writes discharge recommendations
- Are usually practice based—functioning within a clinical specialty
- Generally spend significant time within the clinical practice setting and are quite accessible—often lead the ‘Rapid Response Teams’\(^1\) within acute care settings

Clinical Coordinator

- Takes responsibility for the clinical aspects of the nursing unit operation - this is frequently an advanced practice nurse (Master of Nursing preparation) or an practitioner with extensive experience in that nursing practice setting or in that nursing specialty
- Assesses staffing levels based on patient needs, ensuring staff are assigned and/or adjusted according to practice setting workload
- Assesses and acts on clinical needs of clients
- Monitors and ensures the quality, coordination, and continuity of nursing care
- Serves as a clinical resource person (particularly to new nurses) and/or supervises clinical care on the unit
- Provides input into nursing staff performance evaluations
- Advises nursing office of adjustments required in staffing – may actually find staff if required
- In the absence of the clinical coordinator, a charge nurse may be assigned to take temporary responsibility for the coordination of patient care

\(^1\)A Rapid Response Team (RRT), sometimes called a Medical Emergency Team is a multidisciplinary team organized and coordinated to respond to ANY situation where clinical instability is noted. RRTs are usually activated by nursing staff but can be called upon by ANY member of the hospital staff.
Charge Nurse/Assistant Head Nurse

✓ Not all nursing units have initiated the role of clinical coordinator—they may, instead, designate one or several individuals as charge or assistant head nurses
✓ Collaborates with, and offers assistance to staff as needed
✓ Recommends modification to nursing care when the patient/client’s condition or treatment dictates
✓ Takes client workload responsibilities as needed
✓ May serve as primary liaison between direct-care/bedside nurse and physician/medical staff
✓ Coordinates staff workload commitments and care of clients during an emergency
✓ Ensures there is proper staffing mix for each shift and replaces if there is an illness
✓ MAY assist with diagnostic, lab, and consultative service requests, particularly on shifts when there is NOT a unit clerk or clerical support staff available

Clinical Nurse Educator/Professional Development Nurse/Nurse Education Facilitator

✓ Takes responsibility for nursing orientation and continuing education in the practice area
✓ Serves as an educational and clinical resource person for nursing staff
✓ Assesses learning needs of nursing staff
✓ Plans, implements and evaluates staff orientation/transition facilitation
✓ Plans, implements and evaluates ongoing nursing education programs
✓ Identifies and evaluates individual staff capabilities and readiness for practice
✓ Instructs staff on new nursing policies, procedures, equipment and practice

Practical or Enrolled Nurse (LPN/RPN)

✓ A Licensed/Registered or Enrolled Nurse has a provincial/state/territory issued license to practice
✓ Serves in a complementary role to Registered Nurses and other health disciplines
✓ Shares responsibilities and functions with that of an RN, but is individually responsible for own nursing practice (i.e. if giving medications, Practical (LPN/RPN) or Enrolled Nurse is responsible to ensure appropriateness of medication delivery ‘rights’ and will be held accountable for the assessment, implementation, outcome and evaluation of medications given)
✓ Basic educational programs are designed to meet an established set of competencies for practice primarily in acute-care and long-term care facilities
✓ Scope of practice can be expanded by acquiring additionally approved competencies or certifications (institution and practice area specific) through a post-basic education program
Held to legal and professional consequences commensurate with scope of practice

Are required to provide annual proof of continuing education and acquisition of competencies in order to maintain their license to practice

Registered/Graduate Nurse (RN/GN)

A Registered Nurse is a practicing nurse with licensure from a province/state/territory—a Graduate Nurse is a recent graduate who has not yet become licensed and practices under a ‘restricted’ license (FIND OUT WHAT LIMITATIONS there are to your practice PRIOR to licensure)

Serves in a complementary role to LPN/RPN/Enrolled Nurses and other health disciplines

Shares responsibilities and functions with their nurse partners, but is individually responsible for own nursing practice

Basic educational programs (Diploma, Associate Degree or Baccalaureate Degree) are designed to meet an established set of competencies for practice in a variety of settings including, but not limited to acute-care, specialty practice settings, community and public health, forensics and psychiatric mental health (particular to the Registered Psychiatric Nurse preparation)

Scope of practice can be expanded by acquiring additionally approved competencies or certifications (institution and practice area specific) through a post-basic education program or post-secondary advanced degrees (Master/PhD)

Held to legal and professional consequences commensurate with scope of practice

Are required (in some jurisdictions) to provide annual proof of continuing education and acquisition of competencies in order to maintain their license to practice

Work collaboratively with LPN/RPN/Enrolled Nurses to determine what level of complexity is appropriate for the educational background, experience and permitted scope of practice

Housekeeping or Cleaning Staff

Answers telephones and refers calls and messages appropriately

These employees are VALUABLE extensions of the nurse’s eyes and ears! Remember that the hospital is the a temporary HOME to patients and their families

Duties involve regular cleaning of rooms and ward/units, changing of linen and the maintenance of hygiene within the clinical environment

Are frequently ‘present’ within the clinical environment and often ‘chat’ with patient/clients and their families. Because of their ‘neutral’ role in the practice setting, some patient/clients and their families disclose to these individuals information that they perhaps feel reticent to share with their primary healthcare providers

Called when discharges from acute-care are identified so that a cleaning of the room in preparation for the next admission can be completed expeditiously
Will do isolation or biohazard cleanup in certain situations

Ward/Unit Clerk or Clerical Administrator

- Answers telephones and refer calls and messages appropriately
- Directs personnel and visitors to the appropriate areas in the practice area
- Maintains accurate and current patient/client charts
- Files reports and memos
- Contacts departments for patient/client admissions, equipment or general practice area required services
- Orders supplies
- MAY chart demographic and statistical data (practice area specific)
- Transcribes physician orders (practice area specific)
- Prepares charts for client admissions and disassembles on client discharge

Ward/Unit Aide/Certified Nursing Assistant/Nursing Aide

- Assists patient/clients with bathing and toileting
- Changes and makes beds
- Assists with lifting, turning and positioning patient/clients
- Feeds patient/clients and/or assists with meals as needed
- Assists with ambulating and transferring of patient/clients within the unit and/or to other institutional departments if porter not available or not employed
- Assists in care of a body after death
- Sets up special rooms and carts (i.e. isolation carts)
- Cleans hospital equipment
- Disposes of soiled linen and waste
- Restocks supplies including linen in designated areas
- Runs errands, specimens, requisitions or transfers equipment to and from departments

Hospital Porter/Patient Services Assistant

- Transports patients/clients for diagnostics
- Transfers patient/clients between practice areas (including morgue)
- Operates, cleans and repairs equipment
- Cleans and sanitizing rooms
- Assists patients/clients with meals
- Transfers laundry
- Moves furniture and equipment
- Cleans up elimination or biohazard waste
- Delivers mail, files and clinical samples
- Picks up blood for transfusion
NOTE: For the following allied health and interdisciplinary roles, nurse practitioner or physician orders for consultation MAY be necessary. Please check your workplace or institutional policies.

Social Worker

- Coordinates complex discharge planning
- Counsels and supports client and family
- Assists client and family to make adjustments in living context after illness and before discharge
- Links client and family with community resources
- Assists client and family with transportation, accommodation or living needs at home

Discharge Coordinator/Planner (this role will go by a variety of titles even within ONE city or country)

- Coordinates the implementation of home-based services for clients on discharge from their current acute-care setting
  - Nursing care
  - Physiotherapy
  - Nutrition counseling
  - Home respite
  - Meal programs
  - Social work visits at home
  - Occupational therapy
  - Home intravenous and antibiotic program
  - Out of district/region patient/client transfers
  - Eligibility assessments for long term care placement

Dietician/Nutritionist

- Provides consultation, assessments and/or treatments for patient/clients who require:
  - Nutritional support such as enteral/parenteral feeding or oral supplements
  - Diet instructions/counseling for diagnosed conditions (i.e. Coronary Artery Disease)
  - Additional nutritional monitoring and guidance (i.e. malnourished or nutritionally deficient)
Spiritual Care Worker/Pastor

✓ Provides sacraments, religious rituals or celebrations
✓ Informs client and family of spiritual reading and video resources
✓ Links client and family with community spiritual resources
✓ Organizes follow-up visitation, counseling, and/or prayer

Physical Therapy

✓ Provides consultation, assessment and/or treatment for patient/clients who:
  o Require pre-operative education and post-operative preventative chest treatments (may need consultation to provide incentive spirometry)
  o Have physical deficits that affect safe, independent mobility
  o Require education and/or treatment for breathing difficulties/ clearing of respiratory secretions
  o Have or are at risk of developing musculoskeletal dysfunction
  o Have mobility needs for discharge

Occupational Therapy

✓ Provides consultation, assessment and/or treatment for patient/clients who require:
  o Retraining for activities of daily living
  o Ordering of appropriate equipment (i.e. wheelchairs, cushions, splints)
  o Pre-discharge assessment of home access and mobility

Respiratory Therapy

✓ Starts or changes treatment related to oxygen or ventilation
✓ Performs diagnostic tests such as arterial blood gases and lung function tests
✓ Supplies equipment for continuous monitoring of O₂ saturations or CO₂ levels, artificially ventilating, or instituting positive airway pressure intervention
✓ Controls settings for, and monitors hourly functioning of artificial ventilation
✓ Manages O₂ transport tanks in practice settings

Speech Therapy/Language Pathology

✓ Provides consultation, assessment and/or treatment for patient/clients who have:
  o Difficulty understanding and/or communicating in written or verbal language
  o Cognitive deficits which affect their ability to communicate
  o Slurred speech or difficulty with articulation of speech
  o Changes in voice pattern, cadence, pitch, tone or volume
  o Difficulty swallowing or at risk for aspiration
Palliative Care

✓ Assesses, supports and educates patient/clients and families regarding a life threatening illness
✓ Assists with symptom management including pain management (nurse practitioner/physician order may be required)
✓ Assesses and screens patient/clients for possible admission to the Palliative Care Unit (nurse practitioner/physician order required)
✓ Provides family counseling on ‘do not resuscitate’ orders
✓ Organizes supplies and/or oxygen for home therapy (nurse practitioner/physician order required)
✓ Counsels patient/clients and family in dealing with death/dying and end of life issues
✓ Provides bereavement follow-up
Appendix IX

Adjusting To Shiftwork

This section will offer suggestions for minimizing the effects of shift work on your body AND your spirit, and provide you with tips to effectively manage the inevitable disturbances that arise as a result of shift work.

• You may have never connected with the true meaning of ‘working shift’ until your very first string of nights! Never fear—life will normalize somewhat after a few months of getting used to SHIFTING.

• We live in a society where shift work is not well accommodated. Our days turn into nights and our nights into days, while businesses and the ‘social scene’ seem to roll along apparently oblivious to our scheduling chaos….go figure! You have chosen a profession where shift work is common, but remember that not all nurses work shift and you may decide that it is not for you (though I worked shift work for YEARS, and likely will again, it was never in line with my ‘circadian rhythms’). I remember one night shift I was particularly tired and before I got to work, I recalled that someone had once given me a bag of chocolate covered coffee beans (at this point I really didn’t care how old they were…). What better time to try them! So I took one (ok, well maybe I took a couple….they were chocolate after all ☺) and YEOWZA!!!! I definitely got through THAT night shift—in fact, I was awake for a WEEK!!!! Just sayin’…..

• There is little doubt that shift work will be a part of the first few years of your work (even if just part-time), so take it in stride.

• Shift work has been linked to a variety of health concerns. The most common health effects have to do with gastrointestinal and digestive disruptions, mood changes, and sleep/rest pattern alterations.

• Other hazards of shift work include: stress; chronic fatigue; a general decrease in alertness and energy; disruption of family and social life; feelings of isolation; a greater risk of compromising safety on the job resulting in a potential increase in errors, miscalculations, reduced critical thinking and poor judgment; and a greater affinity for physical accidents while at work.

• Despite the rigors of working shift, the odd hours and lack of structure have distinct advantages!! You may find you are able to get more done on your days off because your friends, partners or family are working. As well, you will likely find shopping and errands easier because the commercial ‘traffic’ is less than during normal working hours and weekends.

• The most difficult time at work on the night shift is between 0300-0600. Try to have the more important/demanding tasks completed before this time and note
that you need to be more diligent and take more care when completely your responsibilities at this time—plan for this drowsy time and keep busy!

- Take your breaks so you can relax and get some rest. This translates into more efficient nursing. If the staffing allows, you might try to sleep on your breaks—these power naps WORK. While you may feel initially tired upon waking, you will find after about 30 minutes that you have increased energy and clarity of thought and this will enhance your effectiveness for the remainder of the shift.
- Some people find that exercising on their breaks is beneficial. It helps them relax on day shift, and alternately keeps them awake during nights. You can go to a gym if your workplace provides one, or just walk/run the halls. If you want, keep a resistance band or hand weights at work for strength training. Find a buddy and exercise together. It’ll make exercising more fun and will also help keep you motivated.
- Adjust your workload to prevent boredom. If your nursing work is done, find something else that needs to be done. You could reorganize the lounge communication board, devise a strategy for communicating about practice issues amongst nursing staff, or draft a new policy or form for dealing with an issue related to practice in your work setting.
- Be careful when driving home after a 12-hour night shift as you are prone to fatigue—you may not even remember how you GOT home. Be sure to focus on the road!!!

**NOTE:** I have actually slapped my OWN face to ‘jolt’ myself out of a night stupor—upon reflection, I could have approached a co-worker and given them this pleasure….

### Managing Different Shifts

- Shift work is very hard on the body. It is often difficult to get adequate hours of sleep between shifts because of difficulty sleeping during daylight hours, managing life beyond work, and the challenge of continually switching from days to nights. Your body often does not have enough time to establish a set routine. Let your friends and family know your work schedule. They will more than likely accommodate you for events, and you won’t have so many phone calls, or people ringing your doorbell while you sleep. Here are some strategies that might help you to get your rest:

#### Night Shift\(^1\)

- Have a pre-shift nap 20-90 minutes before your shift. It can help you feel refreshed

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\(^1\)Evening shifts (3-11pm) are not generally a major issue from a sleep perspective but they can strain your social/personal life. It is possible to join events that continue to midnight, but otherwise you will have to forego social activities during working days. If you have children, you may not be at home when they arrive from school and you may not be available to feed them at dinner/ supper, bathe or put them to sleep. If you are a single parent, this might be a challenge that you need to consider. If, however you have a partner who works primarily a day routine, this might work well once you coordinate who will care for them between the end of school and your partner’s arrival home.
Appendix XI

Workload Distribution/Collaboration/Delegation

- Your workload as a new nurse (WHAT it is you are required to do and HOW you are going to manage it) will largely depend on: 1) your scope of practice (LPN/RPN/Enrolled Nurse/RN), 2) the setting in which you are practicing, and 3) the process of orientation, integration and transition into your work role and practice context.
- There are numerous documents available to you on ‘collaborative’ models of nursing practice and, while beyond the scope of this book, are important for you to review IF these documents are applicable within your practice setting. Please consult with your Nursing Manager or Educator for more information on appropriate documents that you should review prior to engaging in your professional practice role.
- Nurses most often work in ‘teams’, interacting with *intradisciplinary* (within the realm of nursing as a discipline) and *interdisciplinary* (between nurses and ‘other’ practitioners who reside outside the realm of nursing, and in some cases outside of healthcare [i.e. law enforcement]). As a new nurse, you will be in a position to ‘collaborate’, ‘share a workload’ and/or ‘delegate’ or ‘assign’ care to other professionals. The following serve as general definitions:

**Collaboration**

- There are distinctions between a **Collaborative Practice Model**¹ and a **Collaborative Model of Nursing Practice**. A collaborative practice model is an overarching model of care that approaches the health of individuals, families and communities from a multidisciplinary, wholistic perspective. It is usually a community-based healthcare practice setting that utilizes a team of nurses, physicians, social workers, pharmacists, psychologists and other allied practitioners to manage the health of a population (usually geographic).
- A **collaborative model of nursing practice**²³ is defined through the principles that overlay it as an approach to care. Collaborative practice requires that patients/clients, employers, LPN/RPNs, Enrolled Nurses, Registered Psychiatric Nurses and RNs (or an appropriate collaborative team as determined per geographical location) determine together how to best meet the needs of individuals and families requiring nursing services. Not uncommonly there are state/provincial/territorial or national practice acts that determine scope of practice, collaborative and delegation responsibility. Scopes of practice will vary

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from region to region, which is addressed by licensures (some reciprocity between states/provinces/territories usually exists). The collaborative model of nursing practice approach is about optimizing the appropriate utilization of nursing practitioners. Collaborative models of nursing care are enacted within a framework that respects the following principles:

- **Care is practiced safely and effectively with the intent to maximize the health and well being of the patient/client/family/community/region;**
- **Nursing practitioners act in a manner consistent with their scope of practice, ethical standards and legal guidelines as directed by their regulatory body; and**
- **Decisions related to workload sharing and care distribution are grounded in a shared decision-making model that optimizes the skills, abilities and knowledge of all nurses.**

- **The process of nursing collaboration in YOUR practice setting will, in part be up to YOU.** Collaboration is fundamentally about transparency, mutuality, respect, negotiation and a willingness to put care at the center of the decision making process. Basic principles to be followed when collaborating on a shared workload are:
  - **WHO is the most appropriate individual, taking into consideration the complexity of the workload and the knowledge/education/experience of the nurses, to take on WHICH of the practice roles and responsibilities?**
  - **HOW can you communicate consistently, frequently and accurately over the course of your day?**
  - **WHAT can each partner do to ensure a respectful, collaborative, effective and efficient utilization of the available nursing and support resources?**

**Workload Sharing/Distribution**

- **The outcome of a strong collaborative model of nursing practice is the appropriate sharing/distribution of the biophysical, cognitive, emotional, spiritual and psychosocial needs of patient/clients/communities/regions as these needs are ‘translated’ into the daily work requirements of a nursing team. Utilizing the knowledge, experience, skill capacity and competence of nurses from varying scopes of practice, collaborative decisions and judgments are made about how to OPTIMALLY ‘share’ and appropriately ‘distribute’ the work.**
- **This is NOT about a struggle for power between nursing credentials, but an authentic intent to provide the BEST nursing care.**
- **As a new nurse it is CRITICAL that you keep this intent uppermost in your mind as you integrate into a system that, like anything or anyone, can lose its way on occasion. I cannot tell you HOW the process of collaboration will work in your new practice setting but I can suggest that YOU be the one to begin the process.**
Appendix XI

Delegation

- It is important to understand the distinctions between ‘assigning’ and ‘delegating’. Assigning care implies that you are collaborating with another healthcare professional who is licensed and works within a scope of practice for which they can be held accountable. IF you are ‘assigning’ care, it is assumed that you are transferring responsibility and accountability for care to the individual to whom you are assigning the task. Conversely, delegation encompasses requests for the performance of a task for which the individual to whom the skill or task is being delegated is NOT licensed and therefore is NOT able to be held ultimately responsible for the performance of that skill within their professional scope. In this case, YOU (the delegator) retain responsibility and accountability for the performance of that skill or task.

- As a new nurse, you may be working quite independently and autonomously, as is often the case in home healthcare, community or public health. In those practice settings, you are assigned a ‘caseload’ of clients for whom you take ongoing responsibility. In the broadest reference, you may be involved in program development, implementation and evaluation (community or public health) or responsible for a ‘group’ of individual clients and families (home healthcare) whom you visit daily, weekly or monthly. Your care responsibilities exist on a continuum, depending on the needs of the clients, your scope of practice and comfort level in your role (for instance you may be caring for a high-level quadriplegic, responsible to administer medication, perform wound care or intermittent catheterization; or you may be visiting new mothers to assess their situational coping skills and to do a basic assessment on their newborn).

- In some cases, you may be practicing in relative isolation, as in a rural or remote nursing context. In this case, your work with other practitioners may be by distance (telemedia/videoconferencing) or by monthly face-to-face interactions with another practitioner (i.e. a medical physician or nurse practitioner may fly in to your nursing station periodically). While the clear majority of new nurses transition within an acute-care practice setting, there is a wide variety of practice/workplace scenarios in which you may be involved, and contexts of practice that you might be transitioning into as a new nurse. This increases the likelihood that you will need to delegate or assign care early in your tenure.

What is delegation and how is it different than collaboration?

- While LPN/RPN/Enrolled Nurses and RNs are often required to collaborate with each other, the process of delegating involves a Licensed/Registered Professional requesting an unlicensed/non-registered care provider (such as a nursing aide, certified nursing assistant, porter, ward/unit clerk or other clerical staff) to perform a task or procedure NOT within that care provider’s job description.

- The delegator retains RESPONSIBILITY for the care quality of the patient/clients AND accepts ACCOUNTABILITY for the delegated act.
Why is delegation important?

- Managing a patient/client workload within practice setting constraints is an increasing challenge for nurses in all settings.
- Delegation ensures that those for whom you are ‘caring’ receive the best possible attention, while also using nursing time, skills and education appropriately and efficiently.

How and when do I delegate?

- Delegating can be difficult for a new nursing graduate—you may not know the people to whom you are allowed to delegate and they may not be receptive to you because they don’t know or trust you yet.
- There will be a tendency to ‘do it yourself’ rather than ask someone else for assistance with your practice. That can be absolutely exhausting and others may conclude that you are not a ‘team player’.
- Sometimes it is difficult to delegate to someone who is older than you, who has been there longer than you, or with whom you sense a power struggle brewing. Rather than thinking of it as ‘ordering someone else to do something’, think of it as facilitating a team approach—you are working together to get the job done.
- Remember, if you are delegating the right task to the right person, THEY are responsible for the quality of their practice. Having said that, YOU will be held accountable for the outcome of that task if the individual to whom you are delegating is NOT licensed, educated, trained or otherwise prepared to perform the task. Essentially you are being held accountable for your decision to delegate THAT task to THAT person.
- Being respectful when either delegating OR collaborating (remember that the difference between these is a matter of responsibility and scope of practice/licensure) is a sure way to succeed—phrases such as:
  - “I know that you are an established caregiver here, so please forgive me if I don’t know exactly what you are responsible for. I am new, so I might ask you to do something you don’t normally do, or I might forget to ask you to do something you normally do. If that happens, let me know”;
  - “Jane, you’ve been around here longer than I have—who normally does vital signs on the post-operative patients?” OR “I understand you normally take vital signs on the clients. Would you mind taking Mr. Smith’s vital signs for me?”;
  - “I am unable to give Mr. Smith his pain meds. Could you do that for me?”;
  - “When you do the assessment on Mr. Smith, could you please report any unusual findings to me right away?”
- Be sure to sit down with your work partners immediately after report to sort out who is going to do what.
- When you are starting out as a new nurse and do not know the routines of the workplace, this organizational strategy can prevent slips and misses over the course of the day.
Pages 218 to 223 not available in this preview.
Don’t forget to think about what you did WELL—things can get a bit unbalanced if all we do is remind ourselves of what we did NOT do well.

Being organized means knowing your patient/clients, knowing what you have to do for them, and knowing what remains for them at the end of your shift (so you can report this to your colleagues).

As you become more comfortable with your own organizational patterns you will soon be able to integrate what happened BEFORE with what you want to do NOW, and you will be able to PROJECT further into the future of your patient/client’s condition. For example, if you are working a few days in a row, let the patient/client know that their hair wash can be done the 2nd day (try to limit what you do the 1st day because that is usually the day when you are least organized). Honesty is always your best policy—patient/clients and their families are more likely to understand your busy schedule if you keep them updated and informed as your day unfolds.

Organization takes time and practice and with a little of both, you will soon be an effective and efficient nurse. Be proud of what you have done each day. We never give ourselves enough credit!

**Prioritization**

During your shift, you will need to be constantly reorganizing and reevaluating your practice and collaborating with your nursing partners. The plan you start with will likely change because ‘stuff happens’ that will force you to modify your priorities and your actions—it is NORMAL to feel a little scattered as you adjust to the highly dynamic context of nursing practice.

The following issues MUST take priority when they arise—STOP WHATEVER YOU ARE DOING and address them:

1) **Airway and Breathing**
   - Is your patient/client in respiratory distress?
   - Are they breathing abnormally fast or slow?
   - Do they have an unusual pattern of breathing (i.e. irregular)?
   - Is their color blue or gray?
   - Is their oxygen saturation low (below 90%)?

2) **Circulation**
   - Is the patient’s heart rate or blood pressure too high or too low (relative to their normal)?
   - Are they symptomatic with these readings (are they dizzy, having palpitations, chest pain, shortness of breath, is their color poor, or is their urine output low)?
3) **Level of Consciousness**

- Is your patient/client unresponsive or difficult to rouse?
- Has there been a major change in the patient’s level of consciousness since you last saw them or are they presenting differently than you were led to expect in report?
- Are they able to converse or is their conversation illogical/inappropriate or their speech abnormal?
- Do they appear unusually sleepy?

4) **Bleeding**

- Is there a wound from which they are bleeding?
- Is the blood fresh?
- Are they on anticoagulants?

5) **Pain**

- Where is their pain?
- How does it feel (sharp, dull, squeezing, crushing)?
- When did it start and what were they doing at the time?
- On a scale of 0-10, at what level would their rate their pain?
- Is the pain worse now than it was 5 minutes ago?
- Have they ever had this pain before? When? What caused it?
- What relieves this pain?
- Do they have any other symptoms (nausea, sweating, shortness of breath)?
- Get a client’s pain under control as soon as possible—it will only get worse!

The following issues are NOT LIFE THREATENING but require PROMPT ATTENTION:

- **Lab value changes** most commonly include CBC, electrolytes, coagulation studies and blood glucose (including chemstrips). Be sure that you respond by calling the nurse practitioner/physician as needed. Sometimes there are standing orders to deal with lab values (i.e. heparin and insulin nomograms). Remember to think ahead to what might be the cause of the change relative to the patient’s condition (i.e. patient/client is receiving 40mg Lasix IV BID, their potassium level is 2.8 mmol, and they do not currently have a K+ supplement ordered).

- **Nausea and vomiting** may indicate a deeper problem and are very uncomfortable at best. The patient/client should be cleaned up and antiemetics given ASAP when appropriate.
NOTE: **Assessment of volume status in the elderly** is ESSENTIAL, but often forgotten! Assess all of your elderly patients for diuresis, diarrhea or vomiting and TREAT THEM FOR DEHYDRATION if you are AT ALL suspicious. Symptoms of volume depletion in the elderly are often not as accurate but be on the watch for lassitude, fatigue, muscle cramps, and dizziness. The most significant sign of volume depletion in the elderly is acute weight loss, muscle weakness and sunkenness of the eyes. Skin turgor, though a traditional method of assessing hydration, lacks precision particularly in the elderly—if you use this approach, test the inner aspect of the thigh or the sternum. Finally, vital signs can be a key assessment in their volume status so assess for postural hypotension and tachycardia.

- **Incontinence** can contaminate wounds, cause significant skin breakdown, be embarrassing to the patient/client or unnecessarily upset family members.
- **Patients going for surgery** or other procedures need to be prepped and ready to go on time. Vitals signs, operating room checklists and pre-operative teaching need to be completed and bowel prep or contrast medium need to be administered so other department schedules can be respected.
- **Patients returning from surgery** and invasive procedures need to be assessed and their vitals taken as soon as they are received back. Frequent vital signs following interventions or diagnostic tests need to be completed to maintain protocol and quality care. There will be a protocol in your practice setting, but if you are unsure, take the V/S every 30 minutes if the patient is stable until you find out what the protocol requires.
- **Medications**, especially antibiotics, need to be given on time (you generally have a 30 minute window either way—early or late).
- **Discharges** need to be completed in good time so that the bed can be cleaned and you can accept a new patient/client when needed.

The remainder of your nursing practice can be completed in between these events.

It is important to constantly be thinking about your nursing priorities as you complete your work. You need to be flexible and you will need to readjust your plan several times throughout the shift. Prioritizing based on client conditions will contribute greatly to the delivery of safe, quality nursing care. It is an essential skill for any nurse.

### Maintaining Professional Standards

When you begin your work, there will be times when you just want to get through your shift ‘without killing anyone.’ While this is a reasonable objective, in time you will be able to lift your gaze from what you are doing at any moment to see what is happening around you—we call it the BIGGER PICTURE.

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✓ Know what the expected standards are in your practice setting and review your entry-to-practice competencies. If you feel the standards practiced there are not adequate, practice to the highest level possible and identify your concerns to the Manager.

✓ REMEMBER—UNSAFE PRACTICE ENVIRONMENTS VIOLATE YOUR CODE OF ETHICS AND ARE THEREFORE UNACCEPTABLE. You are OBLIGATED to complete a work situation report form (what this is called differs between geographical locations) and these should be readily available in your practice area.

✓ NEAR MISSES, or adverse events where ‘nothing bad happened’ after all was said and done (but the risk was THERE), are equally dangerous to patient/client safety. If something ‘nearly’ happens due to an unsafe practice environment, TAKE THE TIME TO REPORT THIS. You cannot be penalized, harassed or disciplined for submitting a work situation report (well I suppose you CAN be but you SHOULDN’T be as this your legal and ethical responsibility)!

✓ Further to this, you are obligated to report wrongdoing (practice performance or ethical conduct) of colleagues in the same fashion—this includes nursing, support staff and physician colleagues. This is what professional self-regulation means.

✓ Excellence and quality care exist on a continuum—there will be times when, despite your BEST EFFORTS you will be unable to provide optimum care to your patients. THIS IS ACCEPTABLE ON A TEMPORARY BASIS ONLY and care must ALWAYS be SAFE!

✓ Being unsure is different than being unsafe—you may be put in situations where you have not performed a particular skill in awhile and you need additional time to perform it—THAT IS OK!!! You might need some encouragement from a senior staff member and that is also OK! We are all in that position at various points in our careers but there may be times when you are given an assignment that is beyond your education, experience or comfort level—while everyone is NERVOUS when taking care of patients they have not had before, or caring for individuals whose diagnoses/clinical situations we have not seen before, YOU WILL KNOW (deep in your gut) WHEN THE SITUATION IS UNSAFE.

✓ A NOTE about professional appearance….remember that the practice environment is not about YOU—it is about the individuals you are caring for. While YOU may feel that the way you are presenting yourself is appropriate, you need to ‘check that out’. You can start by looking around you—how are the more experienced nurses or ‘leaders’ (the most respected individuals) in your workplace presenting themselves. Taking generational variations into consideration and appreciating that people have preferences according to their personality, there IS a way to dress professionally in a clinical practice area. Dress according to the demographic you are caring for—that may be different if you are practicing in a forensics unit, a youth safe-house, a large urban med/surg unit, a client’s home, an out-reach needle exchange van, or a geriatric rehabilitation unit.
THINK about the care population and how YOU would want a nurse to present themselves if YOU were receiving care. And remember that you can always look to your preceptor/mentor for guidance.

Practice Ethics

- **Remember that you are responsible for the following ethical practice standards:**
  - Safe Competent and Ethical Care
  - Health and Well-being
  - Choice
  - Dignity
  - Confidentiality
  - Justice
  - Accountability
  - Quality practice environments

- If there is an action or inaction that you believe **violates your code of ethics or scope of practice**, STOP... and explore things further. For further information on what YOUR scope of practice is, call or check the website of your local regulatory body or professional organization, or contact them directly. Remember, unethical practice (which includes an unsafe practice environment) threatens patient/client safety.

- If you witness or experience an unethical practice situation, you are obligated to speak to an experienced nurse or your nursing mentor—**if they seem unconcerned while you remain uncomfortable, this does not mean the situation is OK**. Use your critical thinking skills—approach another experienced nurse on the unit, activate the Rapid Response Team or page the Nursing Administrator on call.

- When you are able (likely AFTER things have settled), explore the situation more extensively with your Manager or mentor to discuss how they believe you should respond in the future. This advice also needs to be considered critically as you are responsible to the public through your professional association and union where applicable.

- If you are concerned about the standard of practice or with the state of professional relationships on your unit, and attempts to discuss the issues are not received in kind, contact your professional organization or your union.

**Potentially Unsafe Situations for a New Nurse**

- The following situations **MAY be considered unsafe** for a newly graduated nurse:
  - **Floating** to an observation/high dependency unit or critical care unit;
  - Working in an **observation/high dependency unit** or covering for breaks in these areas without experienced nursing access (**REMEMBER:** While there are LESS patients to take care of in an observation unit, they are much sicker and require a high level of practice expertise);
Caring for patients beyond the scope of your practice (i.e. asked to remove a central line catheter on a general ward/unit) without prior certification;

Taking the lead in a CODE, administering IV cardiac emergency drugs, or defibrillating (depending on the practice area, you may be certified in Advanced or Intermediate Life Support in which case you ARE permitted to defibrillate in appropriate circumstances);

Performing skills that require special certification but for which you have NOT been certified—if you haven’t done a procedure before, ASK a senior nurse if you are required to be certified to perform that procedure or look it up in the nursing care procedural care manual on your unit. If the procedure is not in there, or if it identifies itself as a ‘special’ procedure, you should be questioning it;

It may be difficult for you to admit that you ‘cannot handle’ a situation—this is totally understandable and we have all experienced that. But SAFETY of the patient, family, and the staff on the unit is PARAMOUNT. If you are EVER in an UNSAFE PRACTICE ENVIRONMENT or FEEL like you are in an unsafe practice situation, you must: 1) consult an experienced colleague, 2) ask for a change in your assignment, or 3) speak with your nursing unit manager, charge nurse, clinical coordinator, or nursing educator;

If you are on nights, and feel unsafe, contact the patient/client care supervisor or nursing administrator on call (through switchboard) or if this is a physical safety issue, page security STAT through switchboard;

As a newly graduated nurse, you should always have immediate access to experienced nursing staff for consultation—if this support is unavailable, you must bring this to the attention of the nursing unit manager or patient/client care supervisor and an ‘unsafe workplace form’ (may be termed variably depending on the institution) should be completed.
Appendix XIII

Thinking on Your Feet

• During the first few months as a new grad you will find yourself so busy in your new workplace that you will have little time to think about what you are doing and why. You will be satisfied with just surviving the shift, and getting all the essential tasks completed. But critically thinking about your nursing actions is very important for quality care and patient/client safety. It is your responsibility to ensure that your practice is as optimal as it can be and to question any decision or action that you feel is inaccurate, insufficient, unethical, illegal or otherwise inappropriate. While at times physicians or experienced nurses may give you the impression you ‘should not have bothered them’, you are ALWAYS doing the right thing when you choose to address an issue you find concerning or confusing.

• To be able to think on your feet, try these tips:

✓ Several times throughout the day, find a quiet place, out of the hallway and away from the central work area to review your to-do lists, your worksheets, care plans, clinical or situational assessments.

✓ Think about each client’s or communities overall status—does what you are seeing, thinking, hearing (or smelling☺) make sense? Is there anything you feel uncomfortable about or have a funny feeling about? If there is, DON’T IGNORE IT. Talk to a more experienced nurse or a physician about your concerns. Pursue the issue until you feel better about it, but above all TRUST YOUR INSTINCTS! They are rarely wrong!!

✓ When you sit down to document about your practice, try to go to a quiet corner or another room away from distractions. The time you take to document your assessments, interventions, evaluations and overall findings from your practice is a good time to think about what you have done that day and how effective it has been for the challenges facing those under your care.

✓ Constantly reflect on your practice AS you are practicing—ask yourself repeatedly, ‘is there anything I could be missing or may have overlooked?’ Once again, if you have any questions or concerns, tell someone. Everyone will be safer if you address an issue that, in the end is nothing serious. But ignoring a problem that turns out to be something serious can put the situation, and those you are caring for at risk. As you practice more, your judgment of what is significant will improve.

✓ If your day is crazy busy and you
find yourself overwhelmed—TAKE A TIME OUT. If necessary, forward your phone to another area, tell the nurse you are working with that you need a minute to gather your thoughts, or ask someone if they can cover your phone and, if in acute-care your patient/client call bells for about 10 minutes. Go to a quiet place to collect your thoughts and calm yourself down. Unless it is an emergency, whatever is needed can wait the 10 minutes you need to collect your thoughts—you will refocus and be MUCH MORE EFFECTIVE.

✓ Remember that your years of school have prepared you to think critically—while this takes getting used to, your capacity for critical reflection WHILE you work will consistently improve if you ‘exercise’ that thinking. It is your capacity to think deeply and broadly about each nursing action, interaction and clinical patient/client situation, and to act on that thinking in a way that optimizes the care you give that sets you apart from other disciplines and caregivers.

✓ Use the SBAR format (see Appendix XII) for identifying, describing and then addressing issues and challenges you have in the workplace—at the end of this Appendix, I have added a decision-making tool that I created for my students doing their senior nursing practicum. See if it helps YOU!

### Reaching Out

- As a new grad, you need to be able to ask for help when you need it, and admit when you are overwhelmed or over your head. It is not only a safety issue for your patients, it is a SANITY issue for YOU! There are several ways to reach out:

  ✓ Collaborate with your nursing partner (RN/LPN/RPN/Enrolled Nurse) immediately after your workday starts. Decide who should do what with whom and start working. Meet several times each working shift/day as a ‘unit’ or ‘team’ (if there are other allied healthcare practitioners working with you) to regroup; determine how each person’s workload is evolving, what has changed and reconfigure the workload/roles/responsibilities as needed.

  ✓Delegate tasks to other health care personnel (ward aides, nursing aides or assistants, clerical staff, housekeeping) and remember that we are ALL here to work TOGETHER—no nurse is an island.

  ✓ Inform your charge nurse or clinical coordinator that you are very busy and need extra help. If you need help IN A HURRY, yell, or pull the call bell cord out of the wall (most patient/client response systems are organized this way to prevent damage to the communications system if the cord is attached to the bed). Pulling the call bell cord out of the wall will set off an alarm and you WILL get help!

  ✓ Inform your Manager if your workload is overwhelming you and ask for assistance. But BE SPECIFIC (‘I need someone to demonstrate how to hold this child’ OR ‘I need someone from the Head Office [of the industry plant where I am the occupational health
nurse] to come to [city] and spend a week with me’ OR ‘I need someone to discharge this patient’ OR ‘Can I have someone to do my 1000 vitals?’). Remember that this is not a one-way street and someday you will be in the position to help your fellow colleagues who are also busy—what goes around comes around.

✓ Contact us at Nursing The Future (go online to www.nursingthefuture.ca) or write us at newgraduates@nursingthefuture.ca and we will organize to teleconference, speak with your colleagues and students, or give a presentation in your province/state/territory about professional role transition.

✓ If you have questions or need assistance with a clinical issue or procedure, speak to your preceptor/mentor, charge nurse, clinical nurse educator or another experienced staff member.

✓ BE PERSISTENT—sometimes you may feel as though your requests are not received as openly as you would like. This likely has more to do with the situation than it has to do with YOU.
CRITICALLY REFLECTIVE APPROACH TO PRACTICE

DATA

Has it changed? Is this normal for person/family/community?

LOOK AT/TOUCH/CONNECT WITH THE PATIENT/FAMILY/COMMUNITY BEFORE YOU DO ANYTHING ELSE

Trust your judgement!!
Don't do anything that doesn't feel right!
Pursue an answer that satisfies you!

Assess your patient/family/community
Look at all prior documents – history and progress notes
Look in the Medication Administration Record
Read the care plan/community plans
Access emergency plans
Read your reference texts/doc/literature
Ask a colleague their opinion
Talk with the NP/MD/Nurse Leader/MD House Officer/ER Response Team

UNSTABLE

RED
- Life threatening for patient/family
- Community is at IMMEDIATE RISK (i.e. fire, shooter)
- Alert senior colleague – CALL OUT, pt cord out of wall
- Press CODE BUTTON, DIAL 911
- Page/Call the NP/Physician/Administrator on Call

STABLE

YELLOW
- Concerned but situation stable
- Consider Critical/ER/Rapid Response Team
- Think—Connect—Collaborate—Act
- Connect with your nursing practice partner

What is causing this?
- Is it part of a current situation/diagnosis?
  - Is this to be expected?
- Is it part of a past history/previous event?
  - Has this happened before?
  - When? Why?
- Is it something we are doing/have done?
  - Medications? Intervention?
  - Treatments? A complication of?
  - Procedure?
- Is it something we are NOT doing?
  - Are we missing something?
  - Do we need a consultation?

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Pages 234 to 241 not available in this preview.
## Am I Being Bullied At Work?

<table>
<thead>
<tr>
<th>Is there someone I work with who repeatedly:</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yells at me, especially in front of others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Ignores me, either by not speaking to me in the workplace or not including me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>in workplace socializing; and/or not returning my phone calls or emails</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Dismisses what I’m saying or put me down either alone or in the presence of</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>others</td>
<td></td>
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<tr>
<td>4. Sabatages me or makes me look foolish by withholding information and trying to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>make me look incompetent</td>
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<td></td>
<td></td>
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<tr>
<td>5. Gossips or spreads rumors about me</td>
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<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Frequently treats me like I’m incompetent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Blames and criticizes me to embarrass or humiliate me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Tries to intimidate me by interrupting, contradiction, or undermining me or</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>my work</td>
<td></td>
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</tr>
<tr>
<td>9. Gives me the silent treatment but makes rude gestures (e.g. eye rolling,</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>‘tsking’, or communicating non-verbally to others)</td>
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<tr>
<td>10. Teases, ridicules, insults, or plays tricks on me to embarrass me in front of</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>others</td>
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<tr>
<td>11. Always insist on getting their own way, never considers my point of view and</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>never apologizes</td>
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<tr>
<td>12. Takes credit or fails to give credit for ideas or work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Add up the numbers for a possible total score of 48.

**14 or below:** you might want to consider how to address incidents of workplace incivility. If you are experiencing discomfort because of a work situation involving another person, conflict resolution or assertiveness training may help you.

**15 to 26:** there are indications of a repeated and persistent pattern of behavior. Talk to someone you trust to consider what action may be required.

**26 or above:** consider the health affects that you may be experiencing (physical, emotional, behavioral) from this bullying situation and talk to someone who can help you decide on appropriate action.

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Health Affects of Bullying

Check off those symptoms that you feel you may be experiencing as a result of a workplace bullying situation. If you find yourself checking off ‘sometimes’ to ‘often’, it is suggested that you discuss your findings with your family practitioner, Employee Assistance Program, or other trusted individual who can help you make some decisions about what you can do.

<table>
<thead>
<tr>
<th>Psychological &amp; Emotional impact</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-blame</td>
<td></td>
<td></td>
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<tr>
<td>2. Rumination, loss of sleep and nightmares</td>
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<tr>
<td>3. Loss of sense of humor</td>
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<tr>
<td>4. Loss of confidence and self-esteem</td>
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<tr>
<td>5. Severe anxiety</td>
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<tr>
<td>6. Fear</td>
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<td></td>
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<tr>
<td>7. Panic attacks</td>
<td></td>
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<tr>
<td>8. Despair</td>
<td></td>
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<tr>
<td>9. Feelings of isolation</td>
<td></td>
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<tr>
<td>10. Becoming over-emotional, or easily losing control over my emotions</td>
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<tr>
<td>11. Feelings of powerlessness</td>
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<tr>
<td>12. Feelings of confusion</td>
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<tr>
<td>13. Forgetfulness</td>
<td></td>
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<tr>
<td>14. Hypersensitivity</td>
<td></td>
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<tr>
<td>15. Loss of concentration</td>
<td></td>
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<tr>
<td>Behavioral changes/experience</td>
<td>NEVER</td>
<td>RARELY</td>
<td>SOMETIMES</td>
<td>OFTEN</td>
</tr>
<tr>
<td>1. Crying</td>
<td></td>
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<tr>
<td>2. Irritability</td>
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<tr>
<td>3. Feeling vengeful</td>
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<tr>
<td>4. Nervousness</td>
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<tr>
<td>5. Shortened attention span</td>
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<td>6. Ill health</td>
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<td>7. Changes in sleeping, eating and work patterns</td>
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<td>8. Loss of libido</td>
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<tr>
<td>9. Becoming obsessive</td>
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<tr>
<td>10. Memory lapses</td>
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<tr>
<td>11. Clumsiness</td>
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<tr>
<td>12. Withdrawal</td>
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<tr>
<td>13. Excessive focus on work or co-workers</td>
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<tr>
<td>14. Exhaustion</td>
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</tbody>
</table>

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15. More prone to making mistakes, feeling less reliable at work

16. Drinking more alcohol/increasing medication use

17. Happier on days off but becoming edgy the night before going back to work

<table>
<thead>
<tr>
<th>Physical symptoms as a result of bullying</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
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</thead>
<tbody>
<tr>
<td>1. Lowered resilience, taking longer to bounce back</td>
<td></td>
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<tr>
<td>2. Panic attacks on approaching the workplace or bully/s</td>
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<tr>
<td>3. Depression</td>
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<tr>
<td>4. Post Traumatic Stress Disorder (PTSD)</td>
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<td>5. Betrayal Trauma Stress Disorder (BTSD)</td>
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<td>6. Headaches and migraines</td>
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<tr>
<td>7. Sweating or shaking</td>
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<tr>
<td>8. Stomach and bowel problems</td>
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<tr>
<td>9. Raised blood pressure</td>
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<tr>
<td>10. Muscle spasm</td>
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<tr>
<td>11. Back pain and other chronic pain</td>
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<tr>
<td>12. Lack of energy</td>
<td></td>
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<td></td>
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<tr>
<td>13. Loss of appetite</td>
<td></td>
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<td></td>
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<tr>
<td>14. Nausea and vomiting</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>15. Skin rashes</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>16. Hyper-arousal</td>
<td></td>
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<tr>
<td>17. Hypersensitivity to external environments</td>
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<tr>
<td>18. Suicidal ideation</td>
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<tr>
<td>19. Suicide attempt</td>
<td></td>
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</tbody>
</table>
Communicating With Physicians

- Let’s clear the air—most physicians are great to work with. And you know what….THEY ARE HUMAN TOO!!!! They appreciate and value the role of the nurse, and perceive the relationship between nurse and physician as highly complimentary and collaborative.
- While you may not have had a lot of ‘practice’ speaking with physicians while you were a student, you do this all the time as a new graduate and IT WILL GET EASIER EACH TIME.
- A Jursi, Intern or even a Resident seems to be received somewhat differently than an Attending Physician, House Officer, Staff Physician, or even a Fellow\(^1\). Perhaps this is because the former are still considered ‘students’, and therefore on a more equal footing to the new nursing graduate with respect to their knowledge and experience in the ‘real’ world.
- You may be initially nervous at the thought of having to communicate with physicians—this is normal. But with the trend toward interdisciplinary education we hope to change that!
- Here are some strategies for you to consider when planning to communication with your medical colleagues (AGAIN, use the SBAR Framework recommended in Appendix XII):

  ✓ Do you have all the information you need to present the issue over the phone?
  ✓ Have you consulted an experienced nurse to discuss the situation you are calling about? Particularly on nights, you will be extra nervous about contacting a physician, as you will likely wake this individual up! Be sure to connect with an experienced nurse before you call, just to help you prepare and boost your confidence.
  ✓ Do you know what it is you want from this physician? Do you have a sense of the orders you are expecting? This will save you a follow-up call—using the SBAR, write down what you want before you call!
  ✓ A change in the condition of your patient/client that threatens their health is an absolute indicator for physician communication—it is better to err on the side of caution!!!!

We do NOT Tolerate Disrespectful Behavior!

- On occasion, the new graduate will experience communication with a colleague (physician, nurse colleague, allied health practitioner or support staff) that is condescending, disrespectful or rude. In the rare situation (often a highly emotionally charged situation), one can understand a person being ‘upset’ or ‘short’. But the use of profanity or professional slander is ABSOLUTELY UNACCEPTABLE!
- While we all have ‘bad days’, it is expected that we will treat each other with professional respect and ethical consideration. Behavior of an inappropriate nature (i.e. throwing instruments in the Operating Room, or swearing at a nurse) must be reported to the

\(^1\)Fellows are practicing physicians who have chosen to advance their level of specialty training. They are considered in the same realm, or at the same level as Attending or Practicing Physicians.
Manager, Clinical Educator and the professional association or union—all of the individuals representing these professional and regulatory organizations are available to you depending on the situation and your comfort level. Communications about relational ethics should be held in strict confidence.

**Responding to Unprofessional Behavior**

The following suggestions might help you as you consider your response to unprofessional behavior from a colleague:

- ✓ “Your tone suggests that you are angry—is there something I have said to upset you?”
- ✓ “I have contacted you to report a clinical concern I have for your patient—I appreciate your professional consideration.”
- ✓ “I will make a note of your concerns for my Nursing Manager.”
- ✓ “Your ‘name the behaviour’ (i.e. swearing/yelling/sarcasm) is uncalled for and unprofessional—while I understand that you may be upset, I cannot accept that behaviour.”
- ✓ If the situation is not urgent, you can say “Please call me back when you have calmed down and wish to discuss this professionally.” Contact the Nursing Manager, Charge Nurse, or Nursing Administrator-on-call to deal with the situation.
CODES and Rapid Response Teams

- Let’s be honest—there is no such a thing as an EASY CODE. The problem with codes is that they are always different, always stressful and always unpredictable. Expect that you will be scared, shaky, unsure and that you will forget something or do something out of sequence—MOST NURSES FEEL THIS WAY unless they deal with codes on a day-to-day basis.

- Advanced Cardiac Life Support (ACLS) or Intermediate Life Support training will assist you to know what to do in the event of a code situation—they they run you through ‘megacodes’ that simulate the ‘real life’ situation. Ask your manager to support you to take either of these courses; they are likely offered through your institution or through the local community colleges.

- If you are unable to access these courses, ask that the clinical educator or manager organize a ‘mock code’ for you, and for the other nurses on the ward—make sure that you get a chance to ‘come upon’ the situation and practice what you would do.

Approaching the Situation

- If you think something does not LOOK, SMELL, FEEL or SOUND right
  
  **GO DIRECTLY TO THE PATIENT**

- DO NOT PRESS THE CODE BUTTON YET
- ASSESS the patient
- Open their airway by pulling their jaw forward and tipping their head back—are they breathing? Put your ear near their mouth and watch their chest.
- Feel for their carotid pulse—Do they have a pulse (FEEL FOR 5 SECONDS!!!!)

**IF THE PATIENT**

**DOES NOT HAVE A PULSE**

**or**

**THEY ARE NOT BREATHING**
Appendix XVII

PUSH THE CODE BUTTON ON THE WALL
OR
PULL THE PATIENT CALL BUTTON/CORD OUT OF THE WALL

✓ Holler out for help—your colleagues will come running!
✓ When the code cart arrives OR if you have a crash cart ON YOUR UNIT

GRAB THE BOARD FROM BEHIND THE CRASH CART
PLACE IT UNDER THE CHEST OF THE PATIENT

✓ If you are uncomfortable knowing what to do in a code, BE THE RECORDING NURSE or DO CPR.
✓ If you are taking on the role of recorder, remember to holler out a review of all that has been done every 5 minutes (i.e. meds given, tests and procedures done, etc.)

REMEMBER

✓ ASSESS THE PATIENT
✓ ACTIVATE CODE STATUS
✓ START CPR
✓ CART ARRIVES—PUT THE BOARD UNDER PATIENT
✓ RECORD AND REVIEW
institutional policy. Deaths often occur at night when there is no attendant so you will have a unit policy on how to deal with this situation—ask a senior nurse if you are unsure.

Debriefing After a Death or CODE

- Experiencing the rapid decompensation, cardiac arrest or death of a patient/client is never easy—no matter HOW LONG you have been nursing or HOW MANY DEATHS you have witnessed.
- Ask to leave the unit to regroup if you need to—go somewhere private where you can cry (i.e. chapel) or seek out a colleague to talk to about your feelings.
- If you feel traumatized by the death (difficulty refocusing or controlling your emotions), request relief to go home and don’t be afraid to speak with your Manager about the situation. I remember having to do that after a young woman died in our critical care unit. I had nursed her for several days but she died of an overwhelming infection for which we were unable to determine a cause. She was 30 years of age and left behind 2 young children and a husband who was clearly struggling to comprehend what was happening. I recall him asking me to remove her wedding ring, which I did with some difficulty because she was so edematous (not uncommon in end-stage sepsis). As though it were a movie playing in slow motion through my mind, I see her husband walking toward me, looking as though he was ‘afraid’ to come too close. He gingerly held open his hand and I put a single gold wedding band in his palm. Like it was yesterday, I remember him looking at it with utter confusion and disbelief, then looking up at me, then looking back at the ring…. as though doing so might bring some insight into, or awaken him from, the nightmare that surrounded him. We never spoke. After a few moments he turned and walked away. I wept for a while in my now quiet corner of the unit. Then I went home early. Everyone understood because many of us have been there.
- It is important NOT to BLAME YOURSELF when a patient/client dies! Assuming that you have given all you can for as long as you can to whomever you care for, there are some things you simply can’t stop, change or prevent.
- IF you feel there was something that could have been done and wasn’t, that is a discussion you should have with your Manager, the Nurse Practitioner or the patients Primary Care Physician.
- If you feel you are NOT COPING with a clinical event with which you were directly or indirectly involved, I encourage you to let your supervisor or educator know or CONTACT YOUR Employee Assistance Program—they are there to assist you at any time and will do so CONFIDENTIALLY if that is your preference.
- For many years I worked as a critical care nurse, coordinated several heart and lung transplant programs and was responsible for the clinical management of hundreds of multiple-organ donors at centres throughout Canada and the United States. Then, one day, my ‘motor’ just up and stopped!! I could NOT get it started again…YUP, I had burned out BIG TIME. In retrospect, it is clear to me that I simply could not see all that I had seen, and do all that I had done for all those years without eventually experiencing
some ‘push back’. As I reflected on what had preceded this ‘set back’, I realized that in all my years as a critical care trauma, cardiac and transplant nurse, I was NEVER debriefed about the horrific tragedies I witnessed. Nor did I seek counseling for what was clearly expressing itself as Post-Traumatic Stress Disorder (PTSD) until I was well into my decline. As the saying goes, those were the ‘old’ days and I believe (and certainly HOPE) that it IS different now.

Dealing With Families in Crisis

• Distraught families really want to be heard—SO LISTEN!!! You DON’T have to necessarily SOLVE their problem (unless of course you can), because often times you CAN’T. Let them talk and respond with, “I appreciate/understand/can see that you are upset” OR “You have every right to feel the way you do.”

• Take the distraught individual/group to a quiet, preferably isolated room (multi-purpose room, quiet room, report room, lounge) where you can sit down with them. Get THEM to talk while YOU listen.

• Ask them: 1) how they are feeling, 2) what it is that is most upsetting them, and 3) what you can do to help.

• When possible, ask them if there is another family member you might call to support them—if one is available, encourage them to accompany you into the room. Remember that they will usually trust their family or friends over you—know the situation and the players so you will know WHEN, HOW and through WHOM you will be able to diffuse the volatility that often comes with trauma, grief, stress and sleeplessness (all contextual elements of families in crisis).

• If at all possible, don’t make ‘promises’ to family members. Using phrases such as “I will see what I can do” OR “I am going to follow-up on that/find out and get back to you” OR “I will contact_____to find out what options we have” are acceptable ways of offering hope and optimism without instilling false security.

• Remember that an experienced nurse, your Manager or Clinical Nurse Educator are good resources in situations you feel have gone beyond your experience of comfort level.

\[^{4}\text{See http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001923/}\]
Appendix XIX

Nursing In Rural and Remote Areas

The decision to take a nursing post in a rural or remote (RR) practice area as a new graduate is as critical as it is complex. The primary reasons most nurses choose this practice setting are:

1) The nurse or their partner were born and/or raised their and want to return ‘home’ to provide care for their community.
2) The nurse completed a practicum in a RR community and the setting appears to be consistent with their personal characteristics, attributes and lifestyle preferences.

The most common reasons nurses STAY in a RR practice setting are: 1) the need for professional services in northern communities, 2) the career opportunities that exist for both the nurse and their partner, 3) the resonance of a rural lifestyle with their personal lifestyle preferences, and 3) the potential for clinical practice growth within a community-based and collaborative multidisciplinary approach to care.

New graduates can be particularly challenged in RR practice settings due to their limited clinical experience (particularly as it applies to the broad range and scope of potential issues that can arise) as well as their limited independent decision-making and clinical judgment of complex individual, family and community situations. The unpredictable, inconsistent, potentially and unstable and highly complex scenarios that can present in these practice settings make this a demanding setting for a new nurse.

Some RR practice settings DO employ new graduates. If you choose this setting it will be CRITICAL for you to discuss the availability of an extended and comprehensive (mentored) transition program.

Consider the following points as you make your decision:

- There is a large scope of responsibility and, depending on the staff compliment (availability of nursing, support and allied health practitioners) and a new nurse may be required to take a Charge Nurse role immediately (this is particularly relevant to Associate Degree/Registered Psychiatric Nurse graduates).
- Highly developed collaboration and delegation skills are critical because of the relative independence of the nursing role and the need to assume leadership responsibilities within a short period of time.

1Particular acknowledgement goes to Anna-Marie Offiah, Kendra Ayers and Lorisa Earnshaw from the All Nations’ Healing Hospital inn Fort Qu’Appelle, Saskatchewan, Canada for their contribution to the insights revealed in this Appendix.
• RNs may be the only nurse in a rural facility during late evening and night shifts, while LPN/RPNs are most frequently paired with an RN during the day or evening.
• There are often minimal diagnostics, staff and equipment, requiring that the nurse have exceptional assessment, diagnostic, implementation and evaluation competencies.
• Responses to a diverse set of individual, family and community issues demand significant ingenuity and creative problem solving. There may not be access to advanced practitioners such as nurse practitioners or physicians (i.e. sometimes only by phone or videoconference, or during onsite visits weekly/monthly) and the availability of allied health professionals and emergency support (i.e. CODES) is often minimal.
• Because of the broad range of possible clinical situations that present in this setting, nurses need to know ‘a bit about everything’ or put another way, they need to ‘be an expert at things they rarely do’. The nurse may be expected to be proficient at a host of skills that may lie outside the immediate purview of a basic nursing education (i.e. phlebotomy, housekeeping, autoclaving, human resource planning and management, clerical duties, obstetrical emergencies/births).
• Relationships between nurses and RR communities are usually quite strong; it is not uncommon to be called at home for advice about personal issues that may or may not relate directly to ‘health’ (i.e. how to unplug a toilet, repair a leaking roof or assist in getting out of a snow drift).

If you HAVE chosen RR as a new nurse here are some TIPS FOR SUCCESS:

• **Choose a GOOD** mentor and do it QUICKLY—rely on them to ask questions, solve problems and debrief with you frequently. Model your practice after them.
• **Negotiate with your Manager to be certified in as many advanced practice skills as you can** (i.e. obstetrical emergencies, Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, intra-partum nursing, rural acute-care nursing certification, community and emergency mental health certification).
• **Ensure you have access to an experienced practitioner** at all times (hopefully your mentor!) that you can contact any time of the day or night when you are working alone in a leadership role (by phone if necessary). **Have their cell phone on YOUR speed dial** ☺
• **Plan ahead** as best as you can for what you will do IF someone calls in sick, is unable to GET to work (i.e. weather) or if you have an emergency (large and small scale). Know **WHO** you will contact, **HOW** to contact them and **WHAT** you will do when confronted with the most common situations. This is when having a ‘what to do when_______ happens’ manual that **you prepare yourself,** would be GREAT!
• **Build relationships** in the community and **LEARN FROM** all the professionals, support staff and administrative people you work with. They will be your support in times of need.
• **DEBRIEF** with your mentor or an experienced nurse **FREQUENTLY** (car pooling is particularly helpful, as the ride to and from work provides opportunity for in-depth and confidential discussion).
• The Manager or Charge Nurse in these RR locations are CRITICAL to your success: **STICK TO THEM LIKE GLUE** for the first year!!

• Ensure you spend time during your transition and integration program with staff from **ALL departments** (i.e. housekeeping, lab, x-ray)—you never know when you will need to DO THEIR JOB!

• If you are practicing in a rural setting **try to start by caring for the most stable, predictable and consistent patients on the floor**. GRADUALLY work your way into more urgent or emergent situations if possible, though in a small rural health center this is challenging to control. Many new nurses are simply put where they are needed.

• Most **remote practice settings **DO NOT HAVE inpatient beds** and therefore the practice is largely community-based public health and emergency care—situations requiring admission are usually transferred to the closest tertiary health center.

• **Work hard at valuing and promoting the people you work with**—these are ‘tight’ communities and you often ‘make it or they break you’. Remember, this is THEIR community (the residents) so it is YOU that will need to do the adjusting and accommodating initially—over time you will establish your credibility and influence, allowing you to make the changes you believe are necessary to enhance the health of the population.

• Access as much **continuing education** as you possibly can—with online courses and remote resource knowledge access (handheld computers and mobile devices) so easily available, your only ‘limitation’ might be wireless access in the more remote centers. In RR nursing, you need information to be **ACCURATE and AVAILABLE**—and yesterday isn’t soon enough!

• **Guard the safety of your practice**—it may be tempting for administrators or more experienced practitioners to launch you into roles you are not yet comfortable with or adequately prepared for.
Appendix XX

Working in High Acuity

The recent downturn in our economy has been reflected in nursing staff shortages and reduced practice support resources EVERYWHERE. Some of the hardest hit are high-acuity practice areas that see the most unstable, least predictable and sickest on our health continuum; emergency departments and critical care units. Quite simply it is difficult to recruit and retain nurses in these areas.

It is not surprising to me that the fast-paced, dynamic and largely independent practice context of these areas attracts the intellect, creativity and high energy of some of our new grads (hey…..that is what attracted ME to critical care!!!). But as a rule, there is a lack of predictability, stability, consistency and familiarity in these patient/client populations that does not match with the knowledge, practice or development needs of a new nurse.

In fact, until a few years ago, nurses hired into these practice areas required a minimum of 2-5 years of experience, advanced skills in clinical assessment, and experience with a variety of complex clinical situations. These protocols for hiring were based on the assumption (and I do not think this has changed) that practitioners in these areas manage multiple demands of often equally high priority and require ample confidence and a high degree of professional capability. When practicing in these areas, nurses are often expected to prioritize judgments (and be able to rationalize or justify those judgments) that are of high significance and for which there is minimal time for discernment. The CAPACITY to fulfill these expectations was thought to be beyond that of an inexperienced, or beginning practitioner.