



A Process of Becoming: The Stages of New Nursing Graduate Professional Role Transition

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abstract

Newly graduated nurses are entering the work force and finding that they have neither the practice expertise nor the confidence to navigate what has become a highly dynamic and intense clinical environment burdened by escalating levels of patient acuity and nursing workload. This research used qualitative methods to build on and mature aspects of the new nurse's transition experience into acute care. The theory of transition presented in this article incorporates a journey of becoming where new nursing graduates progressed through the stages of doing, being, and knowing. The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring, and engaging. Although this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. The intense and dynamic transition experience for these newly graduated nurses should inspire educational and service institutions to provide preparatory education on transition as well as extended, sequential, and structured orientation and mentoring programs that bridge senior students' expectations of professional work life with the reality of employment.

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The current global shortage of nurses is unprecedented, with demands for full-time nursing professionals growing faster than the rate at which new nurses are graduating (Barney, 2002; Purnell, Horner, Gonzalez, & Westman, 2001; Shields, 2004). The challenge of re-

placing nurses who have left the workplace and a desire for knowledge about the resources required to support those just entering it are motivating health care institutions and nursing leaders to explore exactly what constitutes a quality work environment (Buerhaus et al., 2007; Coomber & Barriball, 2006; Lin & Liang, 2007; May, Bazzoll, & Gerland, 2006). Growing rates of seasoned nurse attrition are resulting in the replacement of highly competent and experienced practitioners with newly graduated nurses who have neither the practice expertise nor the confidence to navigate a clinical environment burdened by escalating levels of patient acuity and increasing workload (Roberts & Farrell, 2003; Taylor, 2002). Compounding this human resource management crisis is evidence of a disorienting, discouraging, and exhausting initial work experience for young nurses that is resulting in high levels of burnout among them within the first 18 months of professional practice (Cho, Laschinger, & Wong, 2006; Laschinger & Leiter, 2006).

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This article presents the results of a 10-year evolving program of research on the new graduate transition experience, the most recent study having been conducted as part of the author's doctoral work. This latest body of work was undertaken with the intent to evolve a substantive theory of role transition to professional nursing practice for newly graduated nurses. What emerged was a staged experience of transition that occurs during the initial 12 months of the graduate's introduction to professional practice (Figure). Inherent within this transition are processes that move these novice practitioners through increasing levels of knowledge and broadening scopes of practice, and contribute to the ongoing development of their personal and professional selves. This theory of transition stages is intended to be used as a guide by clinical educators, unit managers, and hospital administrators who are recruiting, orienting, mentoring, and seeking to successfully integrate new nurses into their workplace.

BACKGROUND

The newly graduated nurse's experience of transition when entering professional practice, although not completely separate from the constructs of socialization and professionalization, is differentiated here as the process of making a significant adjustment to changing personal and professional roles at the start of one's nursing career. Understood in the context of this research, transition for newly graduated nurses consists of a nonlinear experience that moves them through personal and professional, intellectual and emotive, and skill and role relationship changes and contains within it experiences, meanings, and expectations. Although it is reasonable to presume an individualized transition experience for the newly graduated nurse, the first 12 months of work experience encompasses a complex but relatively predictable array of emotional, intellectual, physical, sociocultural, and developmental issues that in turn feed a progressive and sequential pattern of personal and professional evolution.

The basis for this theory of transition arises out of four qualitative studies spanning 10 years (Cowin & Hengstberger-Sims, 2006; Duchscher, 2001, 2003b, 2007) and the author's extensive study of new graduate transition and her work in establishing a national non-profit organization of support resources for newly graduated nurses (www.nursingthefuture.ca). The final study, which culminated in the conceptualization of the transition stages theory presented here, employed a generic qualitative approach of interpretive inquiry, using foundational knowledge on the newly graduated nurse's introduction to the workplace to frame an exploration

of the process of transition that occurs during the first 12 months of practice. Fourteen female graduates from the same 4-year baccalaureate undergraduate nursing program were selected from two major cities in Canada. Research strategies included a demographic survey at the start of the research; six face-to-face interviews at 1, 3, 6, 9, 12, and 18 months followed, in the initial two instances, by focus groups with participants from the second major city; pre-interview questionnaires requesting the completion of a process-revealing exercise (i.e., letter writing, collage construction, or picture drawing); monthly journals; and ongoing e-mail communication with all participants during the 18 months.

CONCEPTUAL FRAMEWORK OF TRANSITION STAGES

Transitions have been defined as passages or movements from one state, condition, or place to another "which can produce profound alterations in the lives of individuals and their significant others and have important implications for well-being and health" (Schumacher & Meleis, 1994, p. 119). The process of transition to professional practice among nursing graduates has been reported most notably by Kramer (1974). This process evolves in a fairly predictable manner from the honeymoon phase, where graduates are excited and exhilarated; through a shocking assault on their professional values that leaves them disoriented and disillusioned; and to the recovery and resolution phases, marked by a return of a sense of balance (Kramer & Schmalenberg, 1978).

Dearmun (2000), Duchscher (2001), Ellerton and Gregor (2003), and Kelly (1998) provide the next level of formalized analysis of newly graduated nurses' transition stages that informed this author's research. Remarkably similar thematic conclusions were presented that reflected the prior work of Bridges (1991), Kramer (1974), and Benner (1984). Dearmun and Duchscher both claimed that the initial 3 months of newly graduated nurses' transition is consumed by an adjustment to new roles and responsibilities, an acceptance of the differences between the theoretical orientation of their education and the practical focus of their professional work, and their integration into an environment that emphasizes teamwork as opposed to individually based care provision. A significant change in the graduates' perception of their experience is noted at approximately 5 to 7 months, propelling them to yet another stage of greater consolidation and meaning making (Duchscher). In all the research reviewed, varying degrees of attention were paid to the emotional impact of the transition on newly graduated nurses and its significance to

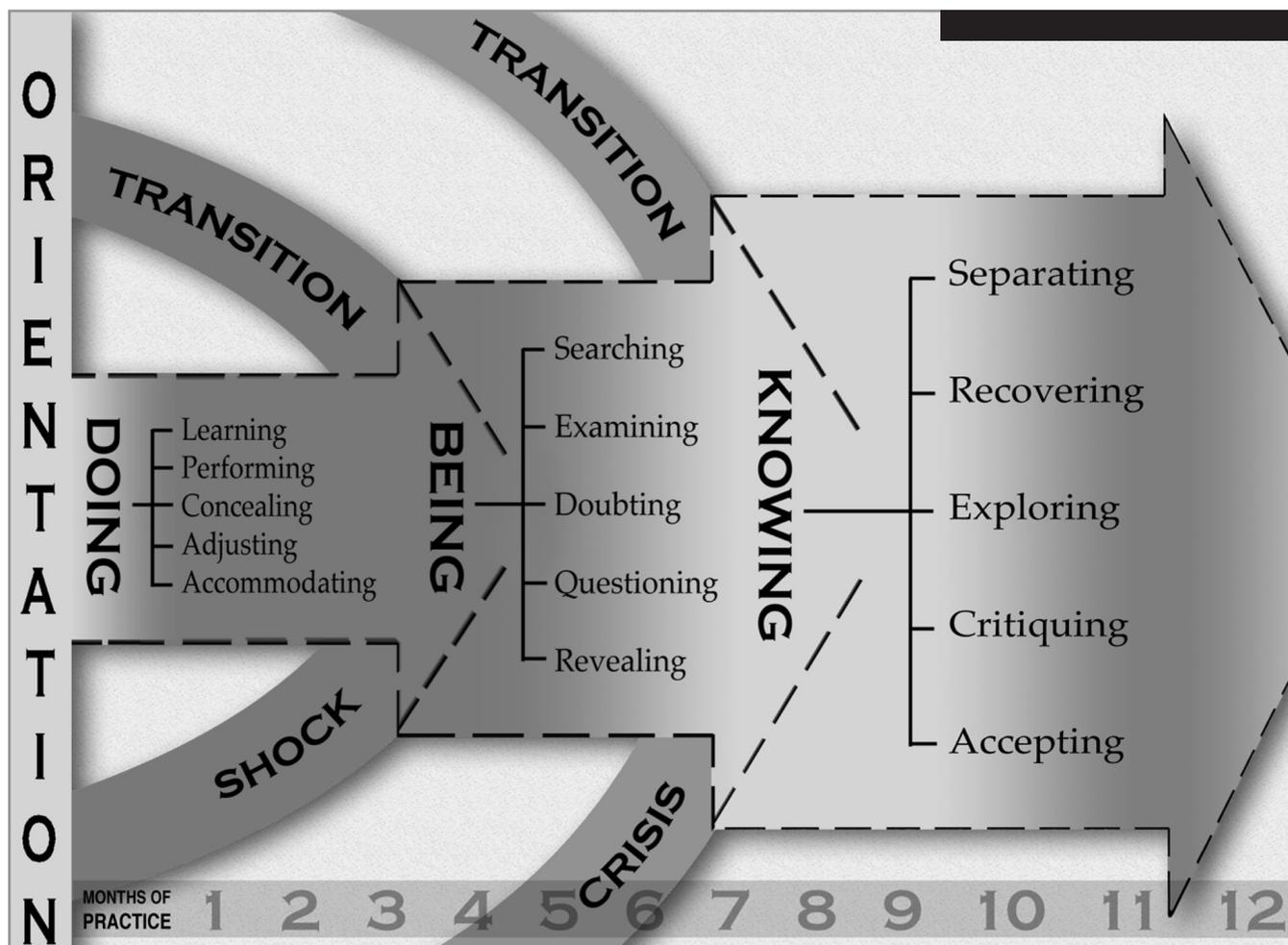


Figure. The Stages of Transition Theory.

newly graduated nurses' ability to advance through the stages. With the exception of some of Kramer's work in the 1960s, no studies mentioned formally acknowledged the significance of either developmental or sociocultural origins to or physical expressions of role transition stress for newly graduated nurses. Finally, few studies since Kramer's have distilled out the nuances of the transition experience at various stages or have sought to clarify the relationship of the stages of growth and change in the newly graduated nurse to the passage of time.

Several authors have more peripherally enhanced the understanding of the phases and stages of transition for the newly graduated nurse (Brown, 1999; Casey, Fink, Krugman, & Propst, 2004; Chang & Hancock, 2003; Goh & Watt, 2003; Ross & Clifford, 2002; Schoessler & Waldo, 2006; Tiffany, 1992). Issues commonly cited as troublesome for newly graduated nurses at various points in time throughout the initial

12 months relate to a lack of clinical knowledge and confidence in skill performance, relationships with colleagues, workload demands, organization and prioritization as they relate to decision making and direct care judgments, and communicating with physicians. Although many of these studies measured or identified particular concerns at points in time (e.g., scheduled testing by instrument, interview, or focus group), few gave insight into what aspects precipitated their occurrence or supported their presence, precisely when the issues originated, or what factors may have impeded or mediated the resolution of those issues. The intent of this final study in the author's grounded theory research program was to examine further, build on, and mature aspects of the newly graduated nurse's transition experience into acute care such that an accurate overall representation of this experience and the processes encompassed within could be confidently introduced into the scholarly community.

STAGES OF TRANSITION

The initial 12 months of transition to professional acute care practice for the graduates in this research was a process of becoming. Both a personal and a professional journey, participants evolved through the stages of doing, being, and knowing. The whole of this journey encompassed ordered processes that included anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring, and engaging. Although this journey was by no means linear or prescriptive nor always strictly progressive, it was evolutionary and ultimately transformative for all participants. Further, data manifested ongoing, but transient, regressions precipitated by the introduction of new events, relational circumstances, and unfamiliar or complex practice situations or contexts into the graduates' assumed location on the transition continuum that is represented by the stages theory presented here.

Doing

The initial period of professional role transition for these acute care nurses encompassed approximately the first 3 to 4 months of the study. All participants underwent a period of orientation prior to study commencement and were working more than 50% maximum hours on varying acute adult and pediatric medical surgical units in different hospitals. One worked in a neonatal intensive care unit. The majority had been hired into temporary part-time or casual positions, but were working full-time hours. Thirty percent of the participants were shared (e.g., float position) between two and five different units on an ongoing basis. None had yet written their registered nurse qualifying examination; thus, all were working under the probationary title of graduate nurse. The initial transition from a structured, relatively predictable life into a new set of expectations and responsibilities posed numerous challenges to both their personal and professional selves. Although initially excited to manage the transition from student to professionally practicing nurse, the participants quickly realized that they were unprepared for the responsibility and the functional workload of their new roles:

It's strange. I don't really feel like I am finished school. Like I walked to work one morning and as I was walking, I was thinking, 'I'm getting paid to do this,' because it's like I was still in school. And then, within my orientation week I was told that the staff had just run off this nurse who wasn't doing very well. They told me that they had made it so miserable for her that she would leave . . . and I think they were proud of it—that they had gotten rid of her. I think it's maybe to maintain quality control, but it's definitely one of my fears that I won't be accepted. That if I am failing, they won't come alongside me, but will show me the door.

The majority of these newly graduated nurses entered their professional transition with expectations and anticipations that were more idealistic than realistic. They often blamed the disparities between what they had anticipated regarding their roles as nurses and what they were being expected to do in the "real" world on lack of educational preparation. When asked, none of the participants at this stage considered the culpability of their workplaces in failing to prepare them for or gradually introduce them to the roles and responsibilities of a fully practicing nurse. They were surprised at the intense and heavy workload of ward nurses, struggled with the non-nursing duties they were expected to assume, and ultimately expressed disappointment at the low value placed on their contribution to assigned units and nursing's contribution to institutional operations in general.

This first stage of entry into professional practice was marked by a tremendous intensity, range, and fluctuation of emotions as graduates worked through the processes of discovering, learning, performing, concealing, adjusting, and accommodating. Within several weeks of being hired, these novices were afforded full patient loads equal to those of their senior nursing counterparts, but without reasonable access to expert counsel or practice support. None of the participants in this study was formally mentored, and the majority went from "buddy" experiences to full responsibility without graduated progression.

Their discovery that all was not as they had expected it to be sent these newly graduated nurses into a flurry of learning and subsequent performing. Understanding what was expected of them, doing it well, and completing their tasks on time were their primary concerns. This focus became clearer upon hearing their stories of being chastised by senior coworkers on the unit or called at home after their shift because they had forgotten to do something. Uncertain who they could trust and driven by a need to belong, these graduates went to great lengths to disguise their emotions from colleagues and worked to conceal any feelings of inadequacy.

Because so much of what the newly graduated nurses were experiencing was new to them, the functional learning curve that dominated this stage of transition was steep. As a result, the solid professional identity developed by many by the end of their undergraduate years fractured under the weight of performance anxiety and self-doubt. These graduates felt stressed "about absolutely everything." The new practitioners' adequate and sometimes advanced entry-level skill and knowledge were constantly challenged by their wavering confidence, their limited experience with the application of that skill

and knowledge, and a lack of predictability of and familiarity with the many variations in clinical contexts. The relentless requests to assist with or perform procedures for which they had little or no reference caused significant levels of anxiety. These situations posed a high level of risk to graduates of being exposed as incompetent and subsequently reducing their credibility in the eyes of their colleagues.

During this initial stage of their transition, the new nurses felt able to reasonably manage a workload consisting of a nurse to patient ratio of less than 1 to 8 but were often left caring for anywhere between 8 and 16 adult patients without consistent support from another licensed practical nurse or registered nurse. High levels of stress were associated with caring for patients who were clinically unstable; being expected to multitask (i.e., answering phones, speaking with physicians, processing orders, and dealing with multiple patient and family issues concurrently) while providing direct care to patients (i.e., starting intravenous therapy, dispensing medications, and performing dressing changes); caring for patients who were critically ill or dying; or dealing with families who had numerous questions or demands. Many examples were given of graduates whose intense focus on every job detail prevented them from hearing or seeing what was happening around them. As a result, graduates universally expressed anxieties around “missing something” or inadvertently and unintentionally bringing harm to someone under their care because of their ignorance or inexperience.

Not uncommonly, participants’ descriptions of clinical situations exposed a prescriptive approach to their thinking. One participant suggested that this early practical application of knowledge was akin to “being in a private little bubble and things are going on all around me and I cannot hear them, I cannot see them.” The limits to their problem solving and clinical judgment were not surprising because they had never experienced many of the scenarios to which they were being exposed. Strategies to manage complex clinical scenarios seemed unavailable to their minds, which were consumed with completing tasks and routines within the rigid time frames imposed by the structure of the units where they worked. It was understood that failure to adjust to or comply with existing routines could garner exclusive attention, an outcome that conflicted with the developmental task of “fitting in” to their dominant professional culture.

Contributing to their stress was the expectation that they would delegate appropriate tasks and responsibilities to other licensed and non-licensed personnel, many of whom were older and advanced in clinical experience

and practice seniority. Participants also found themselves frustrated by what they perceived as archaic ways of thinking about nursing by some senior colleagues, and expressed disappointment regarding the rigid and distracting allocation of non-nursing tasks. Although these graduates felt the immediate need to accommodate what was being practiced without asking why, they later identified these issues as primary factors contributing to their lack of professional fulfillment in an acute care 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.

During this stage of transition, the graduates’ overall energy was divided between the demanding professional adjustments cited above and the sociocultural and developmental changes occurring in their broader lives. These women experienced changes such as new living arrangements, terminated or advanced intimate relationships, and the acquisition of unprecedented debt through the purchase of cars and homes, all serving as both exciting distractions and unexpected burdens. Concurrently, these normally high-spirited young nurses were adjusting to intimidating levels of clinical responsibility, navigating new professional associations while struggling to let go of long-standing personal relationships, seeking acceptance into a tradition-bound and hierarchical nursing culture, and adjusting to the physical demands of intensive, alternating, and sometimes unpredictable or inflexible day or night shift schedules. It was in the context of undergoing this tremendous inventory of developmental change that these nurses made advanced clinical judgments and practice decisions for which they felt minimally qualified and completely responsible. They were exceptionally hard on themselves when they felt they had failed to identify or appropriately intervene in a changing clinical situation regardless of competing demands. Despite the fact that many of the situations in which they were placed were beyond their intellectual or practical capability, their behavior was consistently self-deprecating.

Being

The next 4 to 5 months of the newly graduated nurses’ postorientation transition experience was marked by a consistent and rapid advancement in their thinking, knowledge level, and skill competency. Concurrently, this stage sparked disconcerting doubt in the participants

regarding their professional identity by challenging pregraduate notions of nursing and exposing the inconsistencies and inadequacies in the health care system. One participant articulated this as follows:

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.

The high degree of frustration and subsequent energy consumption that characterized the prior stage of their transition continued at a slower, but relentless pace. To cope with the drain on their resources, many of the newly graduated nurses sought refuge in their personal lives, separating themselves from their work environment (e.g., refusing overtime) and putting distance between themselves and their colleagues (e.g., choosing to forego staff functions). Fundamental to this stage was an increased awareness of themselves professionally, an exploration of the role of the nurse relative to other health care professionals, and a fundamental search for balance between their personal and professional lives. During the initial half of this stage, the participants became increasingly comfortable with their roles and responsibilities as nurses. This comfort permitted them to begin a concerted examination of the underlying rationale for nursing and medical interventions and the appropriateness and effectiveness of the health care system. Scrutinizing the practice context and its relationship to the graduates' professional role aspirations took on more importance during the final stage of their transition. During the course of this second stage, the newly graduated nurses would disengage, question, search, reveal, recover, accept, and ultimately reengage in their chosen career; the difference was this time it was on their terms.

As one participant suggested, the initial segment of this second stage found these nurses "caught up in a turn." There was awareness that something was different, but they would spend several months struggling with the changes brought about by their commitment to become a "real" nurse. Many questioned why they had left the comforts of their established school routine only to expose themselves to a daily onslaught of daunting responsibility that left them feeling perpetually incompetent, inadequate, exhausted, disappointed, devalued, frustrated, and powerless. This downward spiral motivated a protective withdrawal from their surroundings as they attempted to recover a sense of control over their lives. They expressed a strong de-

sire for clinical placements that offered stable patient situations, and several of the newly graduated nurses changed to casual employment status so they could choose the work hours required. Most had tired of the constant "newness" and were looking to escape the barrage of learning, growing, and changing; they wanted to be surrounded by familiarity, consistency, and predictability.

Participants' sense of self-trust was tenuous during the initial phase of this stage. Many sought validation for their decision making and clinical judgments from senior coworkers whose level of practice they respected and admired. Unlike the first transition stage, where they required more prescriptive directives about what should be done in particular clinical situations, participants were now expressing a desire for clarification and confirmation of their own thoughts and actions. Knowing they could make decisions and implement nursing actions that were not only safe and appropriate but also astute was important for their confidence. During the initial several months of this second stage, graduates were placed in leadership positions (e.g., put in charge of units or students or made responsible for orienting new staff) that they consistently deemed as inappropriate and unsafe. A disturbing finding was the frequency with which they were placed in clinical situations beyond their clinical competence, cognitive, or experiential comfort level. More than 30% of participants with less than 5 months of experience were either requested to go to or assigned shifts in an observation unit. All of them expressed significant discomfort at these requests, although the majority either felt too new to make demands about their placements or interpreted the appeals for advanced responsibility as a statement of confidence in their abilities, making it difficult to refuse the requests.

The start of this stage was delicate for the newly graduated nurses as the desires to hold on and to let go were equally strong. The newly graduated nurses identified overly vigilant supervision of their practice as a display of doubt in their abilities, but feelings of abandonment when left without experienced nurses to reach out to in unfamiliar, unexpected, or unstable situations. The peak of this struggle occurred for most around 5 to 7 months when a crisis of confidence, mitigated by the intersection of insecurities regarding their practice competency and their fear of failing their patients, colleagues, and themselves, motivated a renewed commitment to maturing their practice that would carry them through the next several months. During the course of the remainder of the second stage, the newly graduated nurses found more middle ground, claiming less

often that “the good days are great and the bad days are horrible.” An increasingly moderate perspective on their professional experiences became evident. Having been previously frustrated by their perceived lack of progress, the graduates relaxed into a more comfortable space that permitted the mild angst that came with what they did not know to coexist with the growing confidence in what they did know.

An essential element to the newly graduated nurses’ recovery during the latter part of this stage was reacquainting themselves with personal aspirations that had been subverted for professional growth. Less cognitive, physical, and emotional energy was needed to manage the now familiar nursing procedures and clinical situations. Participants required less energy to debrief about work, affording them more time to adjust to and accept the changes to their personal and work life schedules and enjoy their new-found liberation. Within several months (approximately 6 to 8 months postorientation), a rejuvenated spirit reawakened and inspired them to seek out challenges to their thinking, put themselves in new and unfamiliar practice situations, and plan long-term career goals.

Knowing

The final stage of the newly graduated nurses’ initial 12 months of practice was focused on achieving a separateness that both distinguished them from the established practitioners around them and permitted them to reunite with their larger community as professionals. Dialogue revealed that the majority of graduates harbored apprehension about moving out of the learner role into one they perceived held greater expectations and a reduced margin of error. During this final stage of their professional role transition, newly graduated nurses continued the recovery they had started during their second stage. Some participants experienced a shift in primary supportive relationships from non-nursing pregraduate friends and family members to coworkers and nursing colleagues, whereas others were crystallizing intimate relationships through engagements and weddings. There was a sense, particularly during the initial months of this final stage, that the graduates just wanted to “get up and go to work and come home to my life . . . my eyes and ears are open, but my mouth is closed.” Especially toward the latter half of this stage, an increased amount of time was spent exploring and critiquing their new professional landscape. Also, graduates began taking notice of the more troubling aspects of their sociocultural and political environments.

Although participants identified themselves as only moderately stressed at both the 9- and 12-month study

time periods, the factors contributing to their stress level changed from their individual capacity to cope with their roles and responsibilities to frustrations in dealing with the system (i.e., the institution or health care) at large. An overwhelming majority of participants offered descriptions of nurses “being at the bottom” of the hierarchy of authority and power. A growing discontent with what they perceived as professional devaluing would culminate in yet another, although much less dramatic, reduction in their momentum. For many, this served as the point of origin in their search for professional fulfillment outside of their acute care bedside role.

By the 12-month marker, all graduates had reached a relatively stable level of comfort and confidence with their roles, responsibilities, and routines. Many spent time “comparing” their practical skill level and cognitive prowess with that of the newest graduates entering their clinical environments, making mention of the differences they noticed between themselves and these new colleagues:

Perhaps I noticed such a difference because I reported off to a new grad. And the contrast between our reactions is what made me realize I have changed. I watched as her eyes became bigger and bigger as I gave report. She almost started panicking before I was even done and stated she felt really overwhelmed. I remember exactly how she felt, but I was surprised (and relieved) that I no longer felt this way about work.

Being able to answer questions rather than simply ask them and assist others with their workloads were both identified as notable signs of their progress. Several participants suggested that these changes were attributed to advancements in their organization and prioritization, whereas others claimed that “all of a sudden, you look back and it’s like how did I get from there to here, because it’s gradual and it happens without your realizing it.” Another participant stated, “You know, it could be exactly the same scenarios, but my ability to cope has changed,” illuminating the grounded perspective expressed by the whole of the study group at this final stage.

DISCUSSION AND RECOMMENDATIONS

Bridges (1991) claimed that prior to embarking on a transitional process, individuals must recognize in themselves a need for change. This “defining moment” for the newly graduated nurses of this final study was dually developmental, because many of them were experiencing total and independent responsibility for the first time, and situational as they explored the new dimensions of their professional roles separate from being students. These young professionals generally have limited prac-

tical nursing experience, lack social and developmental maturity, and struggle with basic clinical and work management skills (i.e., communicating with and delegating to others and balancing time with responsibilities and tasks).

The theory presented here suggests that the measures taken to address the issues inherent in the newly graduated nurse's initial period of introduction to professional practice are sensitive to time and the nurse's relative position on the continuum of individual transition experience. New graduates begin with a rather prescriptive and linear approach to both their thinking and their practice (Duchscher, 2003a). While they adjust to changing roles, routines, responsibilities, and relationships, newly graduated nurses require all their energy and focus for each specific task at hand (e.g., administering medications, speaking with physicians, or performing a dressing change). As Benner (1982) articulated, "the heart of the difficulty that the novice faces is the inability to use discretionary judgment" (p. 403), which mitigates against a successful linear application of theory to clinical practice. The limited capacity for multitasking and the inherent challenge in higher-order decision making that requires the melding of variant sources and levels of information complexity make functioning in the dynamic environment of acute care exceedingly difficult for newly graduated nurses (Ferguson & Day, 2004; Roberts & Farrell, 2003; Taylor, 2002). Allowances should be made for a reduced workload and the newly graduated nurse should be given dependable access to a consistent seasoned clinical colleague who is also afforded work relief, who is being compensated for and educated about the advanced leadership role, and with whom the newly graduated nurse has a trusting relationship. It is unreasonable to expect undergraduate educational institutions to prepare graduates to competently perform all of the skills required by a contemporary acute care workplace. Therefore, it is essential that newly graduated nurses be allowed to repeatedly practice the multitude of nursing and transfer of function skills required by their transitioning unit during their orientation period. Supernumerary staffing arrangements allow newly graduated nurses to take advantage of the varying needs by staff for the performance of skills in a range of clinical situations. The novice can then perform and further learn required skills under the watchful eyes and skillful preceptoring of many different clinical experts while serving to offset the unit workload. This inadvertently cultivates an environment of teamwork among the staff and satisfies newly graduated nurses' desire to belong.

Prolonged orientation periods (12 to 24 weeks) that are grounded in a balance of classroom theory and clin-

ical practice wean the graduate into the rigors of being a fully responsible and accountable professional practitioner (Cowin & Duchscher, 2007). Graduates require consistency, predictability, stability, and familiarity in their initial clinical practice situations for at least the first 4 months. Having newly graduated nurses float between more than two units, expecting them to orient students and other new staff, implementing rapid turnover shift schedules for them or requiring them to work excessive overtime, putting them in charge of units, or rotating them into high-acuity observation subunits are all practices that should be avoided during the initial stages of professional role transition because they may create an unsafe environment for patients and staff.

As new graduates advance through the stages of transition, their needs change. During the second stage of transition, the newly graduated nurse has advanced through Benner's (1982) novice level of competence and into the stage of advanced beginner. In general, the newly graduated nurses' comfort with the routines of their unit and their familiarity with roles and responsibilities that have been established by the experiences gained during the initial months of their transition serve as a foundation from which they can draw to both predict and respond to presenting situations. Whereas new graduates will likely be comfortable with more common events consisting of stable client presentations and consistent relationships and expectations, placing them in complex and rapidly changing situations may illicit feelings of "terror in which they recognize that they are in over their heads and lose all capacity to plan or act" (Benner, p. 57). What is needed at this point in the transition experience is a process whereby graduates can be permitted to relax and enjoy their hard-earned comfort level while being challenged to slowly advance their thinking and practice within the safe confines of a mentored relationship.

After approximately 6 months of graduated and facilitated clinical learning, new graduates are ready to be introduced to more unstable patient populations (e.g., stepdown or observation units), assuming the close availability of seasoned staff (e.g., not scheduled as the sole nurse in high-acuity units or left alone during breaks without readily accessible clinical backup). At this point, newly graduated nurses should be assisted in taking responsibility for increasingly complex decisions and making judgments related to changing patient situations with the coaching of advanced clinicians. Advancing graduates beyond their capacity (e.g., advanced cardiac life support or charge nurse training) would be easy to do at this stage, but could prove counterproductive in the long run. These new professionals have been through a significant growth experience and need time, particu-

larly during the initial several months of the second stage of transition (4 to 6 months), to recover their sense of balance and restore their depleted energy reserves. Encouraging graduates to pursue personal enhancement activities and “settle” their lives outside of nursing will set the stage for a more long-term commitment by the graduates to their work environment.

During the final stage of transition (8 to 12 months), newly graduated nurses maintain a variable tension between a contented enjoyment of their work and the inherent tendency toward mobility and career advancement that is characteristic of this generation (Duchscher & Cowin, 2004). Mentors and managers working with newly graduated nurses would be well served to join with them in formulating a 2- and 5-year career trajectory that addresses their most immediate plans and supports, both educationally and organizationally, their projected professional aspirations. It is in this stage that newly graduated nurses seek to establish a separateness that both distinguishes them from and allows them to unite with the practitioners in their larger community and develop a sense of agency that permits them to see the potential for and process of making sustainable change within a bureaucratic system (Benner, Tanner, & Chesla, 1996; Pask, 2003). The awakening of this insight should be part of the evolving relationship between a mentor and a senior graduate and considered a healthy, essential step in the newly graduated nurse’s sociodevelopmental maturity.

New graduates will likely express some discontentment about the encroachment of work on their personal lives, a concern that may be exacerbated if they did not receive reasonable support early in their transition. Experiences of being restrained in the enactment of their professional role, growing frustration with the apparent complicity of their colleagues to the improprieties of the practice environment, and the feelings of powerlessness that these issues may engender in newly graduate nurses should be considered a natural part of their professional development. It is possible that the deleterious influence of these factors on newly graduated nurses’ sense of agency may be muted by opportunities to actualize some form of change in the unit or the institution during the latter half of this stage (10 to 12 months). Having an institutional or region-wide, rather than a unit-based, approach to advancing the career pathway of newly graduated nurses and being open to challenge and change at all levels of the organization are not only desirable attributes of the contemporary workplace, but may well determine the recruitment and retention capacity of all future health human resource institutions.

key points

Role Transition

Duchscher, J. B. (2008). **A Process of Becoming: The Stages of New Nursing Graduate Professional Role Transition.** *The Journal of Continuing Education in Nursing*, 39(10), 441-450.

- 1 The experience of transition for the new graduate entering professional practice is distinguished here as the process of making a significant adjustment to changing personal and professional roles at the start of one’s nursing career. Although not explicit, the period of time during which the initial transition to professional practice in nursing is generally thought to occur encompasses the first 12 months as a graduate and then registered nurse.
- 2 The initial 12 months of transition to professional acute care practice for graduates is a process of becoming. Both a personal and a professional journey, participants evolve through three stages identified here as doing, being, and knowing.
- 3 The Stages of Transition Theory suggests that allowing graduates time to adjust to what “is” within a context of support that allows them to develop their thinking and practice expertise will assist them to move through the stages of professional role transition.

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