

THE EXPERIENCES OF NEW NURSE GRADUATES WORKING IN A NURSING
RESOURCE TEAM

by

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DEDICATION

This thesis is dedicated to my beautiful and cherished family. To Wawa (Jean-François) my husband who “gently” pushed me into pursuing my graduate degree, knowing me better than I know myself, that this was something I yearned for. You are my partner in music, in parenting, and for life. To my children Stephen, Taylor, Krys, Sarah and Sam, I thank you for your patience as I first completed my undergraduate degree and then moved onto to this next step in my academic and professional journey. You have walked this path with me and although you may not have always understood why I was doing this, you never faltered in loving me and seeing me as first and foremost, your mom.

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ABSTRACT

Float nursing is generally not recommended for new nurse graduates yet they are and have been hired into float pools and resource teams. A qualitative descriptive study guided by transition theory was conducted to obtain the perspective of eight new nurse graduate participant experiences of working in a nursing resource team. Using content analysis, the data yielded three themes: New Nurse Graduate Transition, Being a New Nurse Graduate on a Nursing Resource Team, and Supportive Work Environments: Essential to Success. Transitioning is a reality for all new nurse graduates regardless of where they are employed. The participants identified several rewards and challenges to working in a nursing resource team and described their overall experience as positive. There is not enough evidence to either support or refute hiring new nurse graduates into float nursing. However the findings from this study provide implications for practice, education, organizational policy, and future research.

LIST OF ABBREVIATIONS USED

AN	Agency Nurse
CNE	Clinical Nurse Educator
HHR	Health Human Resources
NG	New Nurse Graduate
NRP	Nurse Residency Program
NRT	Nursing Resource Team
QD	Qualitative Descriptive
RN	Registered Nurse

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Chapter One

Introduction

Nurses are the largest group of health care providers to have direct patient contact (Canadian Health Services Research Foundation [CHSRF], 2005; World Health Organization [WHO], 2009). However, their presence at the patient bedside is compromised by the nursing shortage, pending retirements, decreased full-time positions for new nurse graduates, and an aging population. With a global shortage projected to reach 2.8 million nurses by 2015 (WHO, p. 8) and a national shortage estimated to reach 60,000 nurses by 2022 (Canadian Nurses Association [CNA], 2009) health human resources planners are strategizing to develop comprehensive methods to ensure provision of safe and quality patient care. There is a wealth of research citing the need for a multifaceted approach to health human resources planning yet despite this focus and evidence, there remains a need to address the nursing shortages, staffing practices, and the reliance on historical methods of service provision that threaten patient care (Advisory Committee on Health Human Resources [ACHHR], 2000; Advisory Committee on Health Delivery and Human Resources [ACHDHR], 2007; Baumann et al., 2001; CHSRF, 2005; 2006; Canadian Nursing Advisory of Canada [CNAC], 2002; Canadian Policy Research Networks [CPRN], 2004; Tomblin Murphy & MacKenzie, 2013). Nurses, both experienced and novice, are working in environments that are far more acute and challenging due to many factors including: the nursing shortage, challenging workloads, an aging population, shorter hospital stays, increased acuity, a shift from hospital care to the community, and new and re-emerging infectious diseases (ACHHR; Canadian Federation of Nurses Unions [CFNU], 2008; 2012; Department of

Health, New Brunswick, 2009; Oulton, 2006; Simoens, Villeneuve & Hurst, 2005; Tomblin Murphy, MacKenzie et al., 2009). Researchers have identified a need for stable, consistent, and supportive environments for new nurse graduates (NGs) as they transition to their new roles and assume assignments that include high numbers of patients with increasingly complex conditions and high acuity (Benner, 1984; Boychuk Duchscher, 2001; 2009; Chernomas, Care, Lapointe McKenzie, Guse, & Currie, 2010; Johnstone, Kanitsaki, & Currie, 2008; Kramer, 1974).

One staffing strategy considered by employers to be cost-effective is the practice of float nursing (Baumann et al., 2005; Dziuba-Ellis, 2006). Dating to 1961 and used to augment existing staff during periods of increased patient census and/or acuity and during staffing shortages, float pools and resource teams have been associated with reduced overtime costs and reduced reliance on the use of agency nurses (Baumann et al.; Dziuba-Ellis; Stenkse, Biordi, Gillies & Holm, 1988). The terms float pool and resource team are often used interchangeably in the literature and both involve deploying nursing staff to areas of short-term need. However, float pools and resource teams differ in structure and practice. Float pools are viewed as the older, traditional approach and resource teams considered the more modern, responsive staffing approach (Baumann et al.; Dziuba-Ellis). The research generally does not recommend float nursing for NGs citing the need for stable, consistent environments for the new graduate (Boychuk Duchscher, 2001; Dziuba-Ellis; Kutash & Nelson, 1993; Stenske et al.). Nevertheless, NGs have been hired into float pools and resource teams in both Canada and the United States (Baumann et al.; Crimlisk, McNulty, & Francione, 2002). Float pool nursing has been described as delaying the NG transition to practice (Boychuk Duchscher, 2007) whereas resource team

nursing has been described as the ideal starting point for NG practice (Baumann et al., 2005). There is little research on float pool and resource team nursing from the NG perspective. To understand the impact of this staffing practice on the needs of NGs and NG job satisfaction, this area warrants further study. The intent of this research was to learn what the experiences are of NGs working in resource teams with the intent to inform practice, education, organizational policy, and research to better support the needs of the NG.

Background

New Nurse Graduates

New nurse graduates are now entering work environments that are far more complex than that of their predecessors thus impacting the successful navigation of transitioning to both the workplace and their new roles (Boychuk Duchscher, 2001; Morrow, 2009). In light of the nursing shortage, a collective gaze is rendered upon the NG as one means of ensuring provider supply. However, research indicates that NGs face a variety of challenges that can result in attrition and intentions to leave (Bowles & Candela, 2005; Goode & Williams, 2004; Hillman & Foster, 2011; O'Brien-Pallas, Alksnis, Wang, Tomblin Murphy, & Meyer, 2003; Spence Laschinger, Grau, Finegan, & Wilk, 2012). The reasons cited for NG attrition and intention to leave include stressful working environments, high patient acuity, unacceptable nurse-patient ratios, lack of support from administration and few opportunities for advancement, inflexible schedules, and an imbalance between effort and reward (Bowles & Candela; Lavoie-Tremblay, O'Brien-Pallas, G elinas, Desforges, & Marchionni, 2008). The transition into practice is well recognized in the literature as a stressful event for NGs (Anderson, Hair, & Todero,

2012; Benner, 1984; Boychuk Duchscher, 2001; 2007; 2008; 2009; Goode & Williams, 2004; Kramer, 1974; Rhéaume, Clément, & LeBel, 2011; Romyn et al., 2009; Spence Laschinger et al., 2012). Research on the NG transition experience has yielded several theories revealing that NGs pass through phases or steps as they leave the comfort of academe to enter the work force (Benner, 1984; Boychuk Duchscher, 2008; 2009; Kramer). Such research emphasizes strong, consistent mentorship and support to guide the transition in conjunction with structured orientation programs that extend beyond general hospital orientation (Bowles & Candela, 2005; Boychuk Duchscher, 2001).

Before undertaking an exploration into the experiences of NGs working in a resource team, it is necessary to understand the issues that give rise to this chosen topic of research inquiry. The nursing shortage is a large piece of the backdrop to this research. More than just an imbalance between supply and demand, the nursing shortage is a complex, multifaceted issue (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Birch, O'Brien-Pallas, Alksnis, Tomblin Murphy, & Thomson, 2003; Birch et al., 2007; CNA, 2009; Oulton, 2006; Tomblin Murphy, Birch, & MacKenzie, 2007; Tomblin Murphy, Kephart, Lethbridge, O'Brien-Pallas, & Birch, 2009; Tomblin Murphy et al., 2011). Accordingly, a brief overview of the nursing shortage, health human resource planning, and float pools and resource teams is warranted.

Nursing Shortage

The nursing shortage is the result of a gap between nurse requirements and nurse supply (Birch et al., 2003; Birch et al., 2007; Tomblin Murphy et al., 2007; Tomblin Murphy, Kephart et al., 2009; Tomblin Murphy, MacKenzie et al., 2009; Tomblin Murphy et al., 2011). Shorter hospital stays, increased acuity, a shift from hospital care to

the community, new and re-emerging infectious diseases, an aging population, and globalization all contribute to increased requirements for care (ACHHR, 2000; Birch et al., 2007; Department of Health, New Brunswick, 2009; Oulton, 2006; Simoens, Villeneuve & Hurst, 2005; Tomblin Murphy, MacKenzie et al., 2009). At the same time, supply has decreased due to an aging workforce, competing career choices for youth, unfavorable work environments, high absenteeism, and low morale (Department of Health New Brunswick; O'Brien-Pallas et al., 2003; Oulton; Simoens et al.). Responding to soaring healthcare costs, Canadian hospitals underwent major restructuring during the 1990s that negatively impacted nurses and their work environments (Blythe, Baumann, & Giovannetti, 2001; Bourbonnais, Brisson, Malefant, & Vézina, 2004; Burke, 2003; Davidson et al., 2007; Lynam et al., 2003). The supply of nurses was decimated through early retirements, layoffs, cuts to nursing education seats, replacement of registered nurses with less-educated personnel, and substituting full-time positions with casual and part-time positions (ACHHR, 2000; Baumann et al., 2001; Blythe et al.; CNAC, 2002; CHSRF, 2005; Decter, 1997; Grinspun, 2003; Shannon & French, 2005). In 2000, the ACHHR called for an increase in enrolments in nursing education, a recommendation that was widely implemented across Canada resulting in an increase in both enrolments and graduates (Canadian Association of Schools of Nursing [CASN] and Canadian Nurses Association [CNA], 2012). In 2011, the number of admissions to education programs, and the number of graduates from said programs had increased to 15,370 and 10,827 respectively (CASN and CNA, p. 5-6). Despite the increase in numbers, experts believe this is not sufficient to overcome the pending substantial loss of nurses through retirement (CNAC, 2002; CFNU, 2008; CHSRF, 2006). Furthermore, increasing

enrolment is but one strategy to address the gap between nurse requirement and nurse supply, that alone, is not powerful enough to have an impact on the gap (Tomblin Murphy et al., 2011).

The restructuring of the Canadian healthcare system inevitably bore negative consequences for nursing work environments with nurses describing the environment as chaotic, stressful, and overwhelming with excessive workloads becoming a reality of contemporary nursing (Baumann et al., 2001; Blythe et al., 2001; CNAC, 2002; CFNU, 2012; CPRN, 2007; Daiki, 2004; Lynam et al., 2003). Clerical duties and other non-nursing tasks were added to the already increased workload of the registered nurse as support staff and other non-nursing personnel fell victim to cutbacks of the 1990s (ACHHR, 2000; Daiki). Expected to manage the same workload burden but with fewer staff, work environments became increasingly stressful. Overtime and absenteeism increased, the number of graduates entering the profession decreased, and job satisfaction deteriorated (ACHHR, Aiken et al., 2001; Baumann et al.; Burke, 2003; CNAC; O'Brien-Pallas et al., 2003; Spence Laschinger & Leiter, 2006). Decades later, work environment continues to be a source of angst for nurses. In 2012, work environment, workload and work life issues had supplanted salary to become the top concern for Canadian nurses (CFNU, 2012). Increased levels of burnout, fatigue, absenteeism, injury, inadequate management support, non-collegial relationships with physicians and peers, and decreased quality of care all exacerbate work environments that are already challenged by the nursing shortage (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; CFNU; CHSRF, 2006; CPRN, 2007; Hayhurst, Saylor, & Stuenkel, 2005; Hill, 2011; International Council of Nurses [ICN], 2006; O'Brien-Pallas, Tomblin Murphy, Shamian, Xiaoqiang,

& Hayes, 2010; Poghosyan, Clarke, Finlayson, & Aiken, 2010; Spence Laschinger & Leiter, 2006; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010).

Of no small consequence is the impact of nurse staffing levels on patient safety. Given that nurses are the largest group of healthcare providers to provide individual patient care, there is a wealth of evidence establishing a relationship between nurse staffing levels and patient safety. Overtime and fatigue have been identified as contributors to inconsistent assessments and monitoring, increased nurse errors, impaired decision making and problem solving, and increased risk of falls and injury (CHSRF, 2006; Canadian Nurses Association [CNA] & Registered Nurses' Association of Ontario [RNAO], 2010; O'Brien-Pallas et al., 2010; Simoens et al., 2005). Moreover, research has found a relationship between decreased nurse staffing and increased adverse nursing sensitive patient outcomes such as: failure to rescue, mortality rates, hospital acquired pneumonia, urinary tract infections, sepsis, nosocomial infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, and increased lengths of stay in hospital (Aiken et al., 2002; Blegen, Goode, Spetz, Vaughn, Park, 2011; CHSRF; Needleman et al., 2002; Needleman et al., 2011). Nurses have reported that staffing shortages prevent timely response to patient call bells, prolong wait times for tests and procedures, and negatively impact early detection of complications and patient discharges (Buerhaus et al., 2005).

Consequently, the nursing shortage incited the call for health human resources (HHR) planning methods that would address insufficient staffing levels and would meet the increased demand for healthcare services. Traditional methods of planning fail to account for changes in service provision, epidemiology, the health needs of the

population, and the productivity of the workforce. Instead, traditional methods rely upon demographics of the population and the workforce and current usage of healthcare services to determine future provider requirements (ACHHR, 2000; Birch, O'Brien-Pallas, Alksnis, Tomblin Murphy, & Thomson, 2003; Tomblin Murphy, Kephart et al., 2009; Tomblin Murphy, MacKenzie et al., 2009; Tomblin Murphy et al., 2011).

Health Human Resources Planning

Health human resources planning has been well recognized as a priority in Canada involving the provision of sufficient human resources to meet projected demand (ACHHR, 2000; Baumann et al., 2001; Birch et al., 2003; Birch et al., 2007; CNA, 2012; CNAC, 2002; CFNU, 2012; CHSRF, 2005, 2006; CPRN, 2004; Tomblin Murphy et al., 2007; Tomblin Murphy, Kephart et al., 2009; Tomblin Murphy, MacKenzie et al., 2009; Tomblin Murphy et al., 2011). According to Tomblin Murphy, MacKenzie et al. and Tomblin Murphy et al., HHR plans must incorporate the interactions between and among the components of the healthcare system that according to Wranik (2008) include information, providers, services, and policy. One framework developed by Birch et al. (2007) enables users to test different policy scenarios using the data specific to their jurisdictions. This framework, known as Needs-based Planning, simultaneously estimates the requirements for and supply of providers by incorporating population health needs, encompassing determinants of supply and requirements, and recognizing that HHR planning occurs within a broad context of social, political, geographical, technological, and economic factors. This framework, when used in simulation to test policies specific to the nursing profession, determined that combining policies rather than focusing on individual policies, could eliminate the projected Canadian shortage of 60,000 RNs

within five years (Tomblin Murphy et al., 2011). In practice, however, HHR planning continues to be challenging due to insufficient funding, lack of systematic, standardized national data collection, and political agendas (Birch et al., 2007; O'Brien-Pallas & Hayes, 2008; Tomblin Murphy et al.; Wranik, 2008).

In the meantime, employers, policy makers and decision makers continue to face challenges in strategizing to find staffing solutions that will work within the confines of existing staffing levels, policies, and traditional methods of planning. Strategies such as mandated nurse-to-patient ratios and The Synergy Model (discussed below) have been discussed as models of patient care (CFNU, 2012). Nurse-to-patient ratios have been legislated in the state of California and in the Australian states of New South Wales and Victoria (CFNU; Cook, Gaynor, Stephens Jr., & Taylor, 2012; Donaldson & Shapiro, 2010; Gerdtz & Nelson, 2007; Tellez, 2012). With ratios ranging from 1:2 to 1:6 in California depending upon nurse specialty, and ratios of 5:20 in Australia, detractors fear that levels of nursing experience and knowledge as well as nurse turnover may be overlooked (CFNU; McGillis Hall et al., 2006; Serratt, Harrington, Spetz, & Blegen, 2011). Additional concerns include inability to adjust for changes in patient acuity, potential increased risk to patient safety, reliance on lower skill mix models, and reliance on overtime and temporary nurses to meet mandated staffing (CFNU; McGillis Hall et al.). Supporters, however, believe the benefits outweigh the concerns, specifically greater job satisfaction (Aiken, 2010; Donaldson & Shapiro; Tellez), decreased nurse turnover, increased re-entry of nurses into the workforce (Simoens et al., 2005), and a significant increase in the percentage of care and the productive hours of direct patient care provided by registered nurses (Donaldson & Shapiro).

The goal of The Synergy Model, developed by the American Association of Critical Care Nurses, is to create a synergistic relationship between the nurse and patient by matching skill level with patient acuity (CFNU, 2012; Kaplow & Reed, 2008; MacPhee, Wardrop, Campbell, & Wejr, 2011). This model embraces a shared-governance component in which the front-line nurse works collaboratively with the unit manager to determine the appropriate provision of patient care. Benefits of this model include responsiveness to fluctuations in patient acuity and available nurse competencies, shared decision making, and nurse autonomy (CFNU; Kaplow & Reed; MacPhee et al.). Conversely, this model has been criticized for being time-consuming and difficult to use (CFNU).

One staffing strategy used by employers since the 1970s (Baumann et al., 2005; Dziuba-Ellis, 2006) is the use of float pools and resource teams. New nurse graduates are finding first time employment in float pools and resource teams (Baumann et al.; Crimlisk et al., 2002; International Centre for Human Resources in Nursing [ICHRN], 2012), and while floating is not recommended by the literature as the optimal starting point (Boychuk Duchscher, 2001; CNAC, 2002), it may be that financial constraints and the reality of the work environment leave no alternative for the NG.

Float Pools and Resource Teams

The restructuring of Canada's healthcare system spurred by the need for fiscal restraint has had a myriad of negative consequences. Fiscal restraints were cited by Dziuba-Ellis (2006) as the major reason for the use of float pools and resource teams in both Canada and the United States. Float pools have long been a tool tapped by employers as a staffing strategy when coping with staff shortages or changes in patient

census and/or acuity (Baumann et al., 2005; Dziuba-Ellis, 2006; Stenkse et al., 1988) and have been identified by the CNAC (2002) as a solution to staffing shortages. By definition, float pools are “typically comprised of permanent staff and casual or relief staff who work on an ‘as needed’ basis to fill short-staffed shifts” (ICHRN, 2012, p. 4). Resource teams are often discussed in the literature as synonymous with float pools however; resource teams are considered to be a more responsive approach to staffing needs (Baumann et al.; Dziuba-Ellis) and in which nurse expertise is considered. Float pools on the other hand regard nurses as generalists, deploying nursing to staff to any area within the hospital regardless of nursing expertise and experience (Baumann et al.; Dziuba-Ellis).

Interpretation of the literature on the topic of float nursing must be undertaken with caution. There appears to be two forms of float nursing discussed in the literature: mandated floating or re-assignment, and float pool/resource team nursing. Although both involve the deployment of a nurse to areas in need throughout an organization, they are two very different practices. The main difference between the two is that mandated floating forces a nurse to float from his/her home floor regardless of the nurse’s wishes, and research reveals it to be an anxiety-provoking, stressful topic for nurses (Dziuba-Ellis, 2006; Good & Bishop, 2011; Kane-Urrabazo, 2006; Nicholls, Duplaga & Meyer, 1996; Pronger, 1995; Rudner Lugo & Peck, 2008; Rudy & Sions, 2003). Float pools and resource teams on the other hand, hire nurses with the expectation to be deployed throughout the hospital and the nurses hired have agreed to do so (Baumann et al., 2005; Dziuba-Ellis). The nurse perspective of mandated floating is evident in the research. However, little appears in the research on the nurse perspective of float pool and resource

team nursing, let alone the new nurse graduate perspective. Given the state of knowledge pertaining to the nursing shortage, increasingly complex and stressful work environments, and NG practice, float pool and resource team nursing presents an option for NG employment.

Purpose of the Research

Research does not generally recommend float nursing as the initial entry point for new nurse graduate practice, however, Baumann et al. (2005) described their resource team as the optimal entry point for new nurse graduates. The purpose of this research is to gain a rich description of the experiences of new nurse graduates hired into and working within resource teams. The nursing profession is in the midst of a chronic global and national nursing shortage. Challenged to ensure sufficient numbers of health human resources for provision of patient care, employers are hiring new nurse graduates in float pools and resource teams in Canada (Baumann et al.). There is little research-based evidence that either supports or refutes the practice of hiring new nurse graduates in float pools and resource teams. The research reported in this thesis endeavors to discover what new nurse graduates are experiencing in resource teams with the intent to inform practice, education, organizational policy, and research.

Reflexivity

The qualitative researcher engages in a process of being “conscious of the biases, values, and experiences that he or she brings to a qualitative research study”, a process known as reflexivity (Creswell, 2013, para. 2). It is the “degree of influence the researcher exerts, either intentionally or unintentionally, on the findings” (Jootun, McGhee, & Marland, 2009, p. 42). To this end, I must acknowledge my personal values

and beliefs and the resultant potential for unintended influence on the findings. My reflexive process continued throughout all phases of my work to enhance trustworthiness and transparency.

As I reflected on the inspiration for my research topic, I recognized it stemmed from my positive experiences as a float nurse. Upon graduation from my baccalaureate of nursing program I was hired for the float pool but immediately placed on a cardiac unit to fill a maternity leave vacancy. Although I enjoyed the cardiac nursing experience I felt the need to expand my nursing knowledge and skills and subsequently requested to float full-time. This proved to be an invaluable experience as I gained confidence and skills by nursing with a variety of patient populations. I had the opportunity to work with a variety of peers and enjoyed collegial relationships with my coworkers establishing a good work rapport. I was fascinated with the process of float nursing and began to reflect on how float nurses are perceived, why float nurses choose to float and what experiences were shared among float nurses. Furthermore, given that literature reveals the adjustment from the role of student to that of practitioner to be an intense, anxiety-provoking and exhausting period of transition, I began to question if float nursing would be advantageous to the practice of new nurse graduates. When a number of new nurse graduates were hired into the float pool in 2012, my interest in this topic was further piqued. Although I am no longer practicing within the same environment, nor am I a new graduate, my previous experience as a float nurse provides me with an appreciation of this experience. My experiential knowing informed my research approach and although subjectivity is central to qualitative inquiry, I chronicled my biases through reflexive practice during all stages of the research process.

To understand the topic I chose to research, a review of the literature was conducted specific to both float pool and resource team nursing and the experiences of NGs as they transition to the work environment, including research specific to NGs working in float pools and resource teams.

Chapter Two

Literature Review

The research topic of new nurse graduate experiences working in a resource team requires an understanding of the existing body of knowledge pertaining to both float pools and resource teams and new nurse graduates (NGs). Dating to the 1970s (Baumann et al., 2005; Dziuba-Ellis, 2006), the use of float pools or resource teams is not a new staffing strategy and neither is the practice of hiring NGs into float pools and resource teams. References to NGs working in float pools and resource teams have appeared in works by Baumann et al., Boychuk Duchscher (2001), CPRN (2004), Crimlisk et al. (2002), and Libby and Bolduc (1994), yet with the exception of Boychuk Duchscher's 2007 dissertation on new nurse graduate transition, the NG perspective is absent. Given the present climate of nursing shortages, looming retirements, financial constraints, and difficulties experienced by NGs in securing full-time employment, NGs may have no alternative other than working in float pools and resource teams. Furthermore, given the alarmingly high rates of NGs' intent to leave the job within the first year of practice (Bowles & Candela, 2005; Goode & Williams, 2004; Hillman & Foster, 2011; Spence Laschinger et al., 2012), it is necessary to understand what is occurring beneath the surface. Specifically, what factors are driving the high rates of turnover intent, what is the NG experience as he/she transitions to the workplace within the first year of practice, the efficacy of transition programs such as nurse residency programs in facilitating the NG transition, and an exploration of the sparse literature on float nursing from the NG perspective. Finally, it is necessary to review the theory chosen to inform the proposed

research, Boychuk Duchscher's (2009) transition theory. This theory highlights the unique needs of this cohort regardless of where he or she chooses to practice.

Utilizing the databases of PubMed, Medline, Cumulative Index of Nursing Allied Health, PsychInfo, and the Dalhousie University library website, a total of 60 relevant works were chosen for both float pools, resource teams and new nurse graduates. A literature search pertaining to float pools and resource teams was conducted using the following search terms: "float pools", "float pools and nursing", "float pools and resource teams", "resource teams", "resource teams and nursing", "casual nurses", "float pools and new nurse graduates", "resource teams and new nurse graduates", "float pools and nurse graduates", "resource teams and nurse graduates." This search, conducted using the filters of peer-reviewed, English language, and the time period of 2002-2012, yielded relatively few articles, therefore it was necessary to remove the time period filter in order to capture all relevant articles. A total of 28 relevant articles were identified, nine of which were identified as research studies.

A literature search pertaining to NGs was conducted using the same filters but with the following search terms: "new nurse graduates", "nurse graduates", "nurse graduate turnover", "nurse residency programs", "float pools and nurse graduates", "resource teams and nurse graduates." A total of 28 relevant articles were identified; although outside the search parameters, the seminal works of Kramer (1974), Benner (1984), and Boychuk Duchscher (2001) were included.

The ensuing literature review will begin with the discussion of float pools and resource teams. The structures of each, highlighting the similarities and differences between the two will be reviewed, followed by a discussion of the benefits of float

pools/resource teams for both nurses and employers as a staffing strategy. The literature review will segue into a discussion of the literature surrounding the NG experience, briefly addressing the idea of practice readiness, the transition experience as he/she transitions to the workplace environment including a brief summary of Benner's (1984) novice to expert model. NG turnover and a discussion of nurse residency programs and their impact on reducing NG turnover are provided followed by a review of NGs working in a float pool. The literature review will conclude with a summary of key points and implications for the proposed research.

Float Nursing

The present climate of nursing shortages, looming retirements, and an aging population challenges employers to find creative staffing strategies. Flexible work practices such as those identified by the ICHRN (2012) enable employers to match staffing levels to fluctuations in patient needs while allowing more control over practice for nurses. One such practice identified by the ICHRN is the use of employer or in-house float pools. Often used interchangeably in the literature with the term "resource teams", float pools are considered to be a cost-effective staffing strategy in countering staffing shortages (Baumann et al., 2005; Dziuba-Ellis, 2006). By definition, float pools and resource teams are "groupings of casual, relief, or permanent staff employed by the organization to work on an 'as-needed basis' to fill vacant positions or cover absences" (Baumann et al., p. 9). There are similarities and differences between float pools and resource teams with resource teams appearing to be the preferred format. The following section presents a comparison of the two approaches, the benefits of using float pools or resource teams, and the characteristics of float nurses.

Float Pools vs. Resource Teams

Although regarded in the literature as one and the same, Dziuba-Ellis (2006) and Baumann et al. (2005) reveal there are more differences than similarities between float pools and resource teams. Float pools and resource teams are both staffed with nurses who choose to float (Baumann et al.; Dziuba-Ellis), are both managed centrally, (Baumann et al.), and offer incentives to nursing staff (Baumann et al.; Dziuba-Ellis). However, float pools are viewed as the older traditional model while resource teams are considered the more modern approach to flexible staffing (Baumann et al.; Dziuba-Ellis). With the intent to derive the structure of both float pools and resource teams, Dziuba-Ellis reviewed 56 articles, 12 of which were research studies with the remainder comprised of anecdotal reports. The literature review revealed that float pools are used to recruit and retain staff yet staff may not necessarily be hired directly into the float pool. Float pool staff are often hired on a part-time or casual basis and are expected to float from one unit to another regardless of their area of clinical specialty. Some float nurses function as a staff complement to assist with patient care, transfers, or treatments during high acuity or high census while some are assigned as replacement staff.

Resource teams are considered to be more responsive to staffing needs (Baumann et al., 2005; Dziuba-Ellis, 2006). According to Baumann et al. and Dziuba-Ellis, unlike float pools, nurses are hired directly into the resource team and assume full patient assignments. Resource teams are organized by clinical expertise and specialized care, with more management involvement and supervision. Additionally, in contrast to the traditional float pool, resource teams provide incentives, such as flexible work schedules, shift differentials, higher pay, and professional development. The main differentiating

characteristic of resource teams is the recognition of nursing expertise. Float pool nurses, viewed as generalists are deployed to any unit in the hospital requiring staff regardless of the nurse's skill set (Baumann et al., 2005) whereas resource team nurses are deployed to areas or clusters of units matching their skill sets and clinical expertise. Clustering involves grouping units together according to "similar patient populations or clinical specialty" (Baumann et al., p. 9) and floating nurses to clusters is the practice of deploying a nurse to the group of units that matches his or her skills set and clinical specialty. In comparison with float pools, resource teams appear to be the more desired form of an in-house pool of nurses trained to provide care within a variety of patient populations.

Benefits of Float Pools/Resource Teams

The main benefit cited by employers for using in-house float pools or resource teams is the cost-effectiveness (Dziuba-Ellis, 2006) of this approach. Healthcare organizations have relied upon contracting nursing services from external nursing agencies, a practice that is costly in terms of money, impact on permanent unit staff, and impact on patient care (Gale & Roark, 1985; Kutash & Nelson, 1993; Larson, Sendelbach, Missal, Fliss, & Gaillard, 2012). Agency nurses (ANs) typically receive higher pay and may not feel a sense of commitment to the organization thereby resulting in decreased vested interest in the work. Agency nurses may not be familiar with the patient population, the floor, or even the policies and procedures of the organization thus impacting quality and continuity of patient care (Gale & Roark; Kutash & Nelson; Linzer, Tilley, & Williamson, 2011; Page, 2008). Conversely, in-house float pool and resource team nurses are often familiar with the organizational culture and policies. They

receive the same orientation as staff hired to permanent units and although the nurse may not be familiar with unit specifics, he or she is familiar with the work place (Page. 2008). Additionally, Strzalka and Havens (1996) found that float pool nurses demonstrated more consistent documentation of patient care than did ANs and unit staff nurses. Using a descriptive comparative design, Strzalka and Havens compared documentation of specific patient care indicators between ANs, float pool nurses, and unit nurses. Nine clinical care indicators were listed on a patient care sheet and researchers analyzed the indicators that were checked off on 150 records by each of the three groups of nurses over an eight-month period. The findings revealed that float pool nurses documented more consistently than ANs and unit staff, with unit staff documenting the least consistently. However, these results must be interpreted with caution as they are reporting documentation of care, not actual care practices and the study involved only one unit.

Baumann et al. (2005) found the resource team approach to be beneficial to both nurse and employer. A large Canadian healthcare organization implemented a nursing resource team (NRT) in 2002 to counter the increased reliance on agency nurses and overtime during periods of fluctuations in staff, patient census, and patient acuity. Managed centrally, nurses were hired, orientated, and trained by the NRT. Utilizing the concept of clustered nursing, NRT nurses were deployed to units matching their areas of clinical expertise. By 2005, agency nursing services were no longer required, overtime was reduced, and nurses reported greater opportunities for professional growth. Nurse managers reported satisfaction with the NRT in that it proved a valuable recruitment tool. During periods in which nurse managers were fiscally unable to hire more nurses, the NRT allowed nurse managers to avail themselves of trained qualified staff. Additionally,

when funding permitted, nurse managers could hire trained staff directly from the NRT. The NRT proved a valuable retention tool in that during the two-year time period studied, 167 nurses were hired with an 83% retention rate.

Nurses employed within float pools/resource teams experience both benefits and challenges to this type of nursing. According to the literature review of Dziuba-Ellis (2006), some float pools/resource teams offer incentives as recruitment strategies. Shift differentials, flexible work schedules, and professional development have been identified as some of the benefits. Improved work-life balance, self-scheduling, and avoidance of floor politics have been reported as benefits by float nurses (Fitzgerald, McMillan, & Maguire, 2007; Thomas, 1972). In addition it has been found that float staff gain marketability and increased skill sets with greater opportunities for professional development (Baumann et al., 2005; Dziuba-Ellis; Gosztyla & Fowler, 1998; Hemann & Davidson, 2012; Thomas).

The literature also identifies challenges associated with float nursing. Fitzgerald et al. (2007) conducted focus group interviews with 61 Australian nurses working in the casual pool as part of a qualitative study. Seeking to determine the challenges and the rewards of working in a casual pool, three main themes emerged from the focus group discussions: social politics, nursing work, and professional performance. Participants expressed feeling socially excluded from extra-curricular activities and did not feel like part of a team. Furthermore, they reported being assigned to areas beyond their clinical capacity, receiving heavier patient assignments, and losing valuable patient care time when searching for information and equipment to care for their patients. The casual pool nurses also expressed lack of opportunities to engage in professional development

opportunities and lack of feedback regarding professional performance. Contradictorily, the participants expressed a preference to avoid extensive interactions with floor staff so as to avoid social politics. Additionally, Fitzgerald et al. (2007) found that the participants did not appear to accept responsibility for their own professional development.

Larson et al. (2012) employed a comparative study approach to examine the patient care assignments of staff nurses versus float nurses. Examining the assignment sheets of units who regularly use float nurses for five randomly selected shifts over a two-month period, researchers employed a data collection tool they devised to ensure consistent measurement of patient acuity across units and across shifts. A total of 217 shift assignments were analyzed during the data collection period involving 142 float pool registered nurses (RN). Although the findings of the study were statistically insignificant, Larson et al. found there was a tendency for float pool RNs to receive more difficult patient assignments, to handle more admissions, discharges, and transfers, and to be assigned more patients than staff nurses. Despite the statistical insignificance of the findings, this tendency supports anecdotal reports of Australian nurses in the study of Fitzgerald et al. (2007) in which study participants identified receiving heavier patient assignments.

Characteristics of Float Pool Nurses

The benefits and the challenges of float pool and resource team nursing give rise to the question “can anyone practice as a float or resource team nurse?” Linzer et al. (2011) suggest that float nurses possess characteristics that are unique and different than those of unit nurses. Unlike unit nurses, float pool/resource team nurses do not have a

home unit yet these nurses have chosen to be part of a float pool/resource team. In a study comparing personality traits of 31 unit-based RNs and 26 float pool RNs within a Magnet hospital, results revealed that unit-based RNs preferred to work on a specific unit with predictable routines whereas float pool RNs were less conforming. Float pool RNs were more open-minded and more receptive to new ideas whereas the unit-based RNs preferred traditional and proven methods. Float pool RNs were more open to change, questioned authority, were socially bold, and more autonomous. Furthermore, float pool RNs did not fear social situations thus they were at ease when being assigned to different units and meeting and working with new people. Although float pool RNs do not have a home base per se, these findings indicate this may not be a significant concern of the float nurse. Furthermore, these findings suggest it may be beneficial to both employer and float nurse to hire float pool nurses not only according to skill and competency but also according to the characteristics identified within Larson et al.'s (2012) study.

The characteristics of NGs entering professional practice contrast with the characteristics of successful float pool nurses identified above by Linzer et al. (2011). NGs generally are described in the literature as anxious, task-oriented, rigid in decision making, and accepting without question the judgments and decisions of senior or more experienced staff during the initial months of practice (Boychuk Duchscher, 2001; 2003; 2007; 2008; 2009; Casey, Fink, Krugman, & Propst, 2004; Ellerton & Gregor, 2003). Furthermore, Boychuk Duchscher (2001; 2007) advises against the practice of hiring NGs into float pools citing the need for stable, consistent environments for at least the first 12 months of practice.

Before exploring the efficacy or suitability of NGs practicing within a float pool/resource team environment it is necessary to understand the NG experience as he/she enters professional practice. Therefore, a review of the NG transition experience and the skill acquisition process for registered nurses will be presented, followed by a discussion of NG turnover and the factors impacting the NG decision to leave his/her position of employment during the first 12 months of practice. A program purported to be efficacious in the successful retention of the NG and the facilitation of the NG transition process will be discussed followed by a review of literature pertaining to NGs working in float pools/resource teams. This review highlights the gaps in knowledge that this research study begins to address. Finally, a précis of transition theory (Boychuk Duchscher, 2008) is provided to identify why this theory was chosen to guide the current study. Concluding the literature review of float pools and NGs is a summation of key points.

New Nurse Graduates: Practice Readiness

Dating to the seminal work of Dr. Marlene Kramer (1974), NGs have reported difficulties in transitioning from the school environment to that of the workplace. According to Kramer, NGs experienced “reality shock” which she defined as:

the phenomenon and the specific shocklike [*sic*] reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared, and then suddenly find that they are not. (p. vii).

The source of shock was identified by Kramer as the disparity between values learned as a student (professional values) and the values of the employer (bureaucratic), termed

Professional-Bureaucratic Conflict. Consequently, the NGs experienced a sense of role deprivation – the inability to enact the role as the NGs had expected (p. 53). More than 40 years later, NGs continue to have difficulties applying the values, ideals, and concepts learned in school to the complex work environment in which NGs are caring for more acutely ill patients (Boychuk Duchscher, 2001; Casey et al., 2004; Feng & Tsai, 2012; Goode & Williams, 2004; Pellico et al., 2009; Romyn et al., 2009). This particular difficulty has given rise to the question regarding the practice readiness of NGs. Nurse Educators and employers appear to have differing perceptions of NG practice readiness with 89.9% of nursing school leaders and 10.4% of hospital nurse executives believing NGs are adequately prepared (Nursing Executive Centre, Advisory Board Company, 2008).

Romyn et al. (2009) conducted a qualitative descriptive study involving 14 new nurse graduates and 133 employers, nurse educators and staff nurses in Alberta, Canada. Romyn et al. found that participants viewed the gap between NG knowledge and skills and employer expectations as “significant and problematic” (p. 6). Participants believed the term “practice readiness” had assumed myth-like proportions stating it was impossible for new nurse graduates to function effectively in all practice settings. Employers and staff nurses recommended stronger foundations in pathophysiology and anatomy courses as well as increasing hands-on experience in acute care settings. Furthermore, employers and staff nurses perceived nursing curricula to be theory-laden while educators maintained clinical practice hours are determined by national and provincial guidelines.

Berkow et al. (2008) conducted an online survey of 3,265 clinical nurse specialists, nurse directors, nurse educators, and staff nurses with greater than two years nursing experience to determine employer perception of NG practice readiness. Rating overall satisfaction of NG performance on 36 competencies in clinical and non-clinical skills, participants rated greater than 50% satisfaction with NG performance on only two of the 36 competencies: utilization of technology and rapport with patients and families. When grouping the 36 competencies into broad categories, all competencies pertaining to Management of Responsibilities (tracking multiple responsibilities, conflict resolution, prioritizing, anticipating risk, completing tasks within expected time frames, and others) were lowest ranked with task delegation ranked lowest of all.

The findings of both Berkow et al. (2008) and Romyn et al. (2009) align with new nurse graduate reports in the research of Casey et al. (2004) and Clark and Springer (2012). In a descriptive comparative study of 270 new nurse graduates (Casey et al.), only 4% of new graduates were comfortable performing all skills and procedures. In 2012, Clark and Springer reported the results of a qualitative descriptive study of 37 new nurse graduates regarding their transition experience during the first 12 months of practice. All 37 graduates had participated in a new nurse residency program and valued the clinical experience, however; they identified the need for further education in organization, prioritizing, communication, professionalism, and teamwork.

New Nurse Graduate Transition

Research has demonstrated that NGs have unique needs as they transition to the workplace (Boychuk Duchscher, 2001; 2007; 2008; 2009; Clark & Springer, 2012; Ellerton & Gregor, 2003; Newton & McKenna, 2007; Romyn et al., 2009). The transition

of NGs to practice has been well researched and documented by several authors, most notably Kramer (1974), Benner (1984), and Boychuk Duchscher (2001, 2003, 2007, 2008, 2009). This body of research demonstrates that the transition process occurs in various stages over the first few years of practice. Such research also identifies the need for supportive learning environments for the NG as (s)he transitions and socializes to his/her new role in the workplace. By definition, the term transition means “movement, passage, or change from one position, state, stage, subject, concept etc. to another” (Dictionary.com, 2013). In the nursing profession, the NG experiences this movement from the state of being a student to the state of being a practicing professional.

New nurse graduates undergo a series of stressors culminating in an experience that is traumatic and overwhelming as they transition. The initial months of practice are intense and exhausting for the NG (Boychuk Duchscher, 2001) as they expend a great deal of energy trying to fit in, working to conceal their anxieties for fear of appearing incompetent. New nurse graduates are task-oriented as they strive to learn the routines of the floor, are dependent upon their seasoned colleagues for guidance, are uncomfortable with delegating tasks, and fear interactions with physicians (Boychuk Duchscher; Casey et al., 2004; Clark & Springer, 2012; Ellerton & Gregor, 2003; Feng & Tsai, 2012). They accept without question decisions made by their senior colleagues not trusting in their own decision-making abilities (Boychuk Duchscher; Ellerton & Gregor). Rather than accept their lack of experience and knowledge as an expected part of their professional growth, NGs perceive it as a weakness (Boychuk Duchscher; Feng & Tsai). New nurse graduates have described the transition experience using metaphors such as “barely keeping my head above water” (Boychuk Duchscher), “barely treading water”, “in over

my head”, “almost sinking” (Romyn et al., 2009), an “overwhelming plunge” and feeling like “being dropped in the deep-end” (Feng & Tsai, 2012), likening the experience to drowning. Emerging from an environment in which feedback, support and expectations are readily available, graduates are suddenly immersed in an environment in which these supports are no longer easily tapped (Boychuk Duchscher, 2001) leaving some graduates feeling alone and “professionally isolated” (Dyess & Sherman, 2009, p. 407).

New graduates enter the workforce with limited practical experience as well as limited experience in work organization (Berkow et al., 2008; Casey et al., 2004; Romyn et al., 2009). Furthermore, NGs are unable to practice at the level desired by employers and colleagues who expect NGs to “hit the ground running” (Ellerton & Gregor, 2003, p. 104). Experience and competence increase over a period of time with the NG entering professional practice as a novice practitioner. Drawing upon the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980; Dreyfus, 1981 as cited by Benner, 1984, p. 13), Benner demonstrated this same model could be applied to the nursing profession. Learners pass through five stages of learning: novice, beginner, competent, proficient, and expert. The five stages can be summarized as follows: the novice nurse is the new graduate and does not have “situational experience” (Benner, p. 21). They follow rules and are unable to see the whole picture but as the new graduate is exposed to more situations, he or she builds a repertoire of experiential knowledge to draw upon to become the Advanced Beginner. After approximately one to two years, the nurse becomes Competent; he or she is now able to prioritize and plan more effectively to better cope with the demands of the job. When the nurse has achieved the ability to view the situation as a whole, and has a “deeper” understanding of the situation (p. 29) he or

she has reached the Proficient stage representing two to four years of experience. Finally, after an accumulation of experience and skill (greater than four years), the nurse no longer relies so much on rules as he or she does on just knowing and understanding the situation. The nurse cannot explain why she knows things; (s)he has reached the stage of Expert (Benner, 1984).

New Nurse Graduate Turnover

Despite the research on both NG transition and the utility of Benner's (1984) novice to expert model, NGs are choosing to either leave their areas of employment within their first year of practice, or in some cases, choosing to leave the nursing profession altogether. At a time when the profession is confronted with a chronic nursing shortage that will be exacerbated by mass retirements, retention of the NG is crucial. However, reported rates of turnover and turnover intent of new nurse graduates are cause for concern (Beecroft, Dorey, & Wenten, 2008; Bowles & Candela, 2005; Brewer, Kovner, Greene, Tukov-Shuser, & Djukic, 2011; Hillman & Foster, 2011; Kovner et al., 2007; Lavoie-Tremblay et al., 2008; Rhéaume et al., 2011; Spence Laschinger, 2012; Ulrich, Krozek, Hipps Ashlock, Marquez Africa, & Carman, 2010). Turnover rates within the first year of practice range from 7.1% (Ulrich et al.) to 13% (Kovner et al.) to 30% (Bowles & Candela). Rates for turnover intent range from 34% (Beecroft et al.) to 45.5% (Rhéaume et al.) to 61.5% (Lavoie-Tremblay et al.). Reasons for leaving the job or the profession altogether include high patient acuity, workload, lack of social support and guidance, an imbalance between effort and reward, high psychological demands, difficult working conditions, unstable employment, inefficient coping mechanisms, staffing inadequacy, insufficient resources, inability to practice according to a nursing model,

injuries, lack of full-time employment, and low self-confidence in skills and perceptions of competency (Beecroft et al., 2008; Bowles & Candela, 2005; Brewer et al., 2011; Lavoie-Tremblay et al., 2008; Rhéaume et al., 2011).

A national study of new nurse graduates is currently underway in the United States known as the RN Work Project led by Kovner and Brewer (2011). Encompassing a 10-year data collection process, the project began in 2006 to study the career changes of new nurse graduates. Referring to data collected on nurse graduates from 2004 and 2005, Kovner and Brewer found that 18.1% of new graduates left their first employment positions within the first year of practice and 26.2% left their first positions within two years of practice. However, for both groups, 91.8% remained in the nursing profession. Kovner and Brewer state that although NGs are leaving their jobs, they are not leaving the profession. Although this is a positive finding, employers, decision makers and policy makers continue to bear the significant financial and non-financial burden of turnover when a NG leaves the position (Anderson et al., 2012; Kovner, Brewer, Greene, & Fairchild, 2009; O'Brien Pallas et al., 2008). Furthermore, the reasons cited by NGs for leaving their first positions of employment indicate that their unique needs are not being met.

Facilitating the Transition and Retention of New Nurse Graduates

Researchers exploring the transition experience of new nurse graduates have uniformly called for strategies to mitigate the stresses of transition to ensure the successful transition and retention of graduates (Boychuk Duchscher, 2001, 2007, 2008, 2009; Casey et al., 2004; Dyess & Sherman, 2009; Feng & Tsai, 2012; Pellico et al., 2009; Romyn et al., 2009). Recommendations have called for strategies that address

nursing curricula review (Feng & Tsai, 2012; Romyn et al., 2009), development of internships or residency programs (Casey et al., 2004; Romyn et al.), creating supernumerary positions (Romyn et al.), trained preceptors and mentors (Feng & Tsai; Romyn et al.), and extended orientation programs (Boychuk Duchscher, 2001). In a systematic review of 16 studies focusing on retention strategies, Salt, Cummings, and Profetto-McGrath (2008) determined that the most common strategy used was the preceptor program model with an NG focus. This retention strategy provides each graduate with a preceptor for a one-to-one guided orientation to practice. Orientation program lengths associated with the greatest retention rates were programs of three to six months duration. Salt et al. noted several limitations to the studies they reviewed, notably weakness of individual study designs, lack of theoretical frameworks guiding studies and only three of the 16 studies were classed as quasi-experimental using control groups. Regardless, Salt et al. recommended the implementation of a preceptor program with an NG focus.

Another retention strategy reported in the literature is the implementation of Nurse Residency Programs (NRPs). Dating to the 1970s (Kramer et al., 2013), a variety of NRPs are described in the literature, all reporting success in decreased turnover and increased retention (Clark & Springer, 2012; Crimlisk et al., 2002; Dyess & Sherman, 2009; Goode & Williams, 2004; Hillman & Foster, 2011). Employers and nurse leaders participating in Berkow et al.'s (2008) study identified that NGs require further experience and training in areas pertaining to management of responsibilities while NG participants in Casey et al.'s (2004) study identified low confidence in skill performance. Nurse Residency Programs appear to address these concerns as NRPs are purported to

have the benefit of increased confidence in skills, organization and prioritization, communication, increased control over nursing practice, sense of belonging, critical thinking, and organizational commitment (Anderson et al., 2012; Bérubé et al., 2012; Bratt & Felzer, 2011; Clark & Springer, 2012; Goode, Lynn, Krsek, & Bednash, 2009; Hillman & Foster, 2011). Reported content of NRPs include precepted clinical experiences, core course modules (Goode & Williams, 2004), standardized hiring processes, mandatory trained preceptors, classroom content (Hillman & Foster), mentoring, professional development sessions, and simulation experiences (Bratt & Felzer). Program lengths range from 16 weeks (Hillman & Foster) to 12 months (Bérubé et al.; Bratt & Felzer; Goode & Williams), however, congruent with Boychuk Duchscher's (2008) findings that NGs reach a peak of crisis at approximately five to seven months, Goode and Williams and Bratt and Felzer found that NRP participants reported decreased job satisfaction at six months that increased again by 12 months post-hire. Based on this finding, Bratt and Felzer assert the need for transition programs to be at least 12 months in length.

New Nurse Graduates Working in Float Pools/Resource Teams

It has been recommended that NGs should not float within the first year of practice, as they require relatively stable and consistent work environments (Boychuk Duchscher, 2001; CNAC, 2002). Although the ICHRN (2012) recognizes that NGs are hired into float pools it is recommended that special considerations be put in place to properly support and orientate NGs. Baumann et al. (2005) described their in-house resource team as an opportunity to provide “an optimal entry point and learning environment for newly graduated nurses” (p. 17), offering full-time employment, a more

extensive orientation than unit nurses, with greater opportunities for education and skill development. However, Baumann et al. do not report data from the NG perspective nor do they provide data to substantiate the success of NG practice within the resource team. Of all studies and literature reviewed, only Boychuk Duchscher (2007) reported an NG perspective on the practice of floating. In a qualitative study of 14 NGs in a Canadian hospital, Boychuk Duchscher (2007) reported that 50% of the participants were hired into a float position that was either part-time, full-time or casual employment in which they were required to work within two to five units. These participants received general hospital orientation, and buddied orientations on the units; however, the NGs reported having minimal practice experience on each unit. These participants reported the experience delayed or extended their transitional journey, stating it felt like starting a new job every time. What is not clear however from Boychuk Duchscher's study is whether or not the NGs were hired into a float pool/resource team. Although Boychuk Duchscher does not recommend floating of the new nurse graduates until after the first year of practice, Crimlisk et al. (2002) demonstrated that new nurse graduates can be successfully hired into and retained in a float pool when providing an orientation program designed specifically for NGs.

Crimlisk et al. (2002) report on an orientation program designed for NGs hired into the in-house float pool. New nurse graduates possessing strong clinical skills, diverse backgrounds, previous healthcare experience, and customer service experience were accepted into the in-house float pool and provided a four month orientation designed specifically for NGs in float pools. Delivered in four phases, the program was comprised of four classroom days with competency-based orientation to the units to which they

would be floating. Graduate evaluations occurred weekly between the preceptor and graduate with bi-weekly evaluations between the graduate and nurse educator. At program completion, participants completed program evaluations in which all participants reported they found classroom days beneficial, preceptorship was consistent, and all participants were confident they could provide safe and competent care, were confident in their assessment skills, technology and communication skills, medication administration, and critical thinking. Crimlisk et al. (2002) reported that since 1999, of the 39 NGs hired into the float pool and participating in the program, 82% remained employed in the hospital with 69% remaining in the float pool.

Summary and Implications for Research

Driven by an aging population, aging workforce, and impending retirements, the global, national, and provincial nursing shortage continues to challenge health human resources planners. Although a collective gaze is rendered upon the NG as a replacement for the outflow of nursing human resources, NGs are reporting difficulties in securing full-time employment (Baumann et al., 2013). The practice of float pool or resource team nursing has long been utilized as a cost-effective means of compensating for staffing shortages and fluctuations in patient census and acuity (Baumann et al., 2005; Dziuba-Ellis, 2006). The literature reviewed has revealed that although considered to be one and the same, there are differences between float pools and resource teams, with resource teams being the preferred, modern format of an in-house pool of nurses. It has been demonstrated that float pools and resource teams that are structured to meet the needs of both the nurse and the hospital are mutually beneficial. Research has suggested that float pool nurses possess specific personality characteristics that lend them the ability and

confidence to float (Linzer et al., 2011). However, further research is required to substantiate these findings, as it was the only such research study on this particular topic. Isolated studies have also indicated superior charting of care practices (Strzalka & Havens, 1996) and have reported tendencies of float pool nurses to receive heavier patient assignments (Fitzgerald et al., 2007; Larson et al., 2012).

Some authors do not recommend hiring NGs into float pools (Boychuk Duchscher, 2001; CNAC, 2002); however, references to this practice can be found in the literature (Baumann et al., 2005; Boychuk Duchscher, 2001, 2007; Crimlisk et al., 2002). Interestingly, this same literature does not reference the practice of hiring NGs into resource teams therefore it is unknown whether this practice is recommended or discouraged. Baumann et al. describe the practice as the ideal starting point for NGs, and Crimlisk et al. reported successful retention of NGs in float pools. Conversely, this same literature is conspicuous in the absence of the NG perspective of practicing within float pools and resource teams. Boychuk Duchscher's (2007) dissertation of the NG transition to practice was the only study found that referred to the NG perspective, however, as highlighted previously, the context of the floating experiences, structure of the float pools, orientation within the float pool, and specific experiences within the float pool was not reported.

The present health human resources climate may necessitate a reliance on in-house float pools or resource teams as the entry point for NG professional practice. As stated by Crimlisk et al. (2002), NGs provide employers with the opportunity "to employ a motivated, ready-to-learn, educationally prepared and intellectually stimulated nurse who happens to have limited clinical experience" (p. 211). Baumann et al. (2005) believe

resource teams are the optimal starting point for NG practice. To ensure the successful transition of the new nurse graduate to the workplace, the practice and experiences of NGs working in float pools or resource teams must be explored, as there is insufficient evidence to either support or not support this practice. Research exploring the experiences of NGs working in float pools or resource teams can provide insight into professional, organizational and patient outcomes. Given the current gap in our understanding of this issue, the primary focus of this proposed research is to learn what the experiences are of new nurse graduates hired directly into a resource team with the intent to inform practice, education, organizational policy, and research.

Chapter 3

Methodology

The purpose of this chapter is to present for the reader the research method chosen for the topic of inquiry. The research question: “What are the experiences of new nurse graduates working in a nursing resource team” required a qualitative approach. Creswell (2013) describes qualitative research as an approach that “begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem” (para. 3). When choosing a research method it is necessary to ensure a fit between the question and the chosen method (Lincoln & Guba, 1985). Qualitative researchers bring a set of beliefs, values, and assumptions to their work, which shape or help determine how they approach their research (Creswell). Accordingly, the chosen research method for this study – qualitative descriptive - will be reviewed, discussing the paradigmatic approach that informs qualitative descriptive research. A review of the theory chosen to inform sample selection and data collection will be provided followed by a discussion of ethical considerations, data analysis methods, and establishment of rigor.

Qualitative Description

Qualitative research answers the questions of “why”, “how, and “what” about a phenomenon (Neergaard, Olesen, Andersen, & Sondergaard, 2007, p. 2) and there are a number of well-known approaches to qualitative research, notably phenomenology, ethnography, grounded theory, narrative, and case studies (Creswell, 2013; Neergaard et al.; Sandelowski, 2000). However, another method described by Sandelowski is qualitative description (QD). The QD approach does not seek to build upon pre-existing

theories, does not seek to develop theories, nor does it seek thick descriptions; rather QD is employed when the researcher is seeking a “straight description of a phenomenon” (Sandelowski, 2000, p. 339). Of all qualitative methods, QD is the least interpretative and “largely unadorned” (Sandelowski, p. 337) but it is “one of the most frequently employed methodologic approaches in the practice disciplines” (p. 335). This does not, however, imply that QD studies are free of interpretation. Descriptions of an event or experience are influenced by the perceptions of both the participant and the researcher and by choosing to describe certain aspects of certain experiences the transformation of the data has begun (Sandelowski). Furthermore, Sandelowski (2010) states that “data never speak for themselves” (p. 78) and that all qualitative studies including QD “must do something with the data” (p. 78). In the reporting of findings, the researcher stays close to the data, presenting it as near as possible to the participants’ description of their experiences in their language (Neergaard et al., 2007; Sandelowski). As stated by Sandelowski, QD research offers “a comprehensive summary of an event in the everyday terms of those events” (p. 336).

Qualitative descriptive studies are informed by or draw from the naturalistic paradigm (Sandelowski, 2000). Described by Lincoln and Guba (1985), there are five axioms to this paradigm paraphrased as follows: 1) realities are multiple, constructed, and holistic; 2) knower and known are interactive and inseparable; 3) only time and context-bound working hypothesis are possible; 4) cause and effect are indistinguishable as all entities are in a state of mutual simultaneous shaping; 5) inquiry is value-laden. According to Polit and Beck (2006) the naturalistic inquirer accepts there are multiple realities constructed through interaction and there are multiple interpretations of reality.

Furthermore, Polit and Beck state that the naturalistic paradigm is also referred to as the “constructivist paradigm” (p. 15). When reviewing Creswell’s (2013) definition of the interpretive framework of social constructivism, the naturalistic paradigm is reflective of the social constructivism camp. According to Creswell, within social constructivism meanings are multiple and subjective and are constructed from interaction with others.

The design of QD studies reflects naturalistic inquiry. Such inquiries require that studies occur in the natural setting (Lincoln & Guba, 1985; Neergaard et al., 2007; Sandelowski, 2000), which is defined as one “that is natural to those being studied” (Polit & Beck, 2006, p. 504). Furthermore, the researcher and participant comprise the instrument of research, which possesses the capacity to encompass and adapt to multiple realities (Lincoln & Guba). Sampling is purposive and analysis is inductive (Lincoln & Guba; Sandelowski). Data collection employs semi-structured open-ended interviews either individually or through focus groups, data analysis is achieved through qualitative content analysis, and the outcome is straight description of the phenomena under study (Neergaard et al.; Sandelowski).

I chose qualitative description for my topic of inquiry, as it is the method most appropriate for my research. Little is known of the experiences of NGs working in float nursing and QD enables the experiences to be illuminated in the voices and words of the NGs. Although not mandatory, a substantive theory can be utilized to guide data collection within this paradigmatic approach (Lincoln & Guba, 1985). Based upon my literature review of the new nurse graduate transition to experienced practitioner, I chose Boychuk-Duchscher’s transition theory (2008) to justify my sample population and to guide my data collection, specifically the creation of my interview guide.

Theoretical Guidance

The transition experience of NGs as detailed in the literature, emphasizes that although experiences are individual, transition to practice is a predictable series of stages through which NGs progress during the initial 12 months as a practising nurse. The transition experience has been described as an exhausting and stressful journey that impacts the NG spiritually, physically, emotionally, intellectually, and socio-culturally (Boychuk Duchscher, 2008). This phenomenon is not entirely new, however, as the seminal work of Dr. Marlene Kramer (1974) recognized and documented the shock that NGs experienced when entering the workplace environment. Building upon the work of Kramer, Boychuk Duchscher embarked upon a ten-year programme of research on the NG experience from which she derived her transition theory and transition shock. The research programme, comprised of four research studies, revealed the transition process is non-linear and that NGs may regress at times in response to new situations and events. Boychuk Duchscher described the transition experience as “a process of becoming” (p. 444) that encompassed three stages: 1) Doing; 2) Being; and 3) Knowing. Within each stage is a series of events that mark the growth of the NG; the Doing stage, a three to four month process, encompasses learning, performing, concealing, adjusting, and accommodating. Furthermore, the Doing stage is marked by a level of intensity that Boychuk Duchscher referred to as transition shock (2009) as the graduate moved from the safety and comfort of the school environment to the less predictable and relatively unknown world of the work environment. The stage of “Being” encompasses a process of searching, examining, doubting, questioning, and revealing during which time the NG undergoes a period of rapid learning and skill development. The shock begins to fade yet

the NG experiences a peak of stress at approximately five to seven months when he or she questions career choice. The final three to four months represent the stage of “Knowing” and encompass the events of separating, recovering, exploring, critiquing, and accepting. The NG becomes focused on identifying his or her professional self and the separation from the student role is finalized. The NG continues to experience moderate stress and by 12 months the NG has gained increased comfort in his or her new role.

Transition theory was chosen to guide my research as it illuminates the professional development experience of vital members of the nursing profession – new nurse graduates. Transition theory presents the transitional journey from NG to experienced practitioner as a set of predictable stages that depict the extreme vulnerability of the NG. Float pool nursing and resource team nursing has become the initial employment experience of some NGs. Boychuk Duchscher (2007) believes float pool nursing delays the transition of the NG yet there is no mention of the impact of resource team nursing on the transition of the NG. During data analysis, the findings of this study were compared and contrasted with Boychuk Duchscher’s transition theory to determine: a) the impact of resource team nursing on the transitional journey of the NG, and b) to determine if the experiences of NGs working in resource teams align with the experiences of NGs working on single units. Boychuk Duchscher’s theory aided in elucidating the individual and systemic implications of the findings, specifically, the unique needs of this group of NGs and the role of the institution in supporting and facilitating NG transition when working in resource teams.

Setting, Sample, and Recruitment

Setting

The setting for this research was the nursing resource team of the largest teaching and adult care hospital in Atlantic Canada (Capital Health website, n.d.). The NRT was implemented in November 2012 (S. MacLean, personal communication, October 1, 2014) and provides replacement needs created by absenteeism, vacation and holidays, and short-term vacancies. The NRT is comprised of registered nurses and licensed practical nurses hired on a permanent full-time basis although part-time and casual work is available as well. The NRT is not considered a float pool, rather, nursing staff are supported by a clinical nurse educator and a Health Services Manager, and are hired into one of five clusters (areas of specialty): Medicine, Surgery, Long Term Care, Rehab, and Dartmouth General (S. MacLean, personal communication, October 1, 2014). Nurses employed within the NRT are provided education and training, are supported in developing career goals and are provided opportunities to achieve identified goals (Capital Health website, n.d.).

Sample

Sample population. The sample population for this research was NGs hired into the nursing resource team between November 2012 and June 2014. Although Boychuk Duchscher describes the transition process as encompassing the first 12 months of practice, Spence Laschinger (2012) suggests the transition period may extend beyond the initial 12 months of practice. Furthermore, NG turnover literature indicates higher rates of NGs leave their initial places of employment during their second year of professional practice (Bowles & Candela, 2005; Brewer et al., 2011; Cho, Lee, Mark, & Yun, 2012). The nursing resource team was implemented in November 2012 and included NGs in the

hiring. Since implementation, a total of 67 nurses have been hired into the NRT, 42 of which were NGs (S. MacLean, personal communication, October 7, 2014). The total pool of candidates from which to draw study participants was 42 new graduates.

Recruitment for this study began in May 2015 and ended in October 2015. The desired sample size was eight to twelve participants; once all recruitment was completed, a total of eight participants were enrolled in the study. No one requested to be withdrawn from the study and all eight participants were eligible for participation.

Sampling method. Qualitative description research employs purposive sampling with the goal to obtain information-rich data that enables the researcher to learn about the issues central to the research (Sandelowski, 1995; 2000). To define, purposive sampling is “a nonprobability sampling method in which the researcher selects participants based on personal judgment about who will be most representative or informative; also called judgmental sampling” (Polit & Beck, 2006, p. 507).

Sample size. There is no exact guide to determine a priori minimum sample sizes for qualitative studies (Morse, 2000; Patton, 1990; Sandelowski, 1995). Rather, certain factors must be considered such as: scope of the study, nature of the topic, sampling method, type of research method, and who or what will provide a comprehensive range of information (Lincoln & Guba, 1985; Morse; Patton; Sandelowski). According to Sandelowski, an adequate sample is one that provides rich understanding of the phenomenon under study but yet is not too small to support the claim of having reached redundancy, nor is too large for detailed analysis. Taking into consideration my chosen research method, my sampling method, literature pertaining to sample sizes, the number

of potential candidates to draw from, and consultation with my thesis advisor, the projected sample size for my study was eight to twelve participants.

The inclusion criteria for participation in the study was nurses who were 19 years of age and older; had graduated from a baccalaureate nursing degree program; were hired into and had worked in the nursing resource team between November 2012 and June 2014; and were able to converse and write in English. The exclusion criteria specified nurses with greater than two years nursing experience; and nurses who have not worked in the nursing resource team.

Recruitment Strategy

Permission to conduct my research was received from the Director of Professional Practice, Learning and Development and Chief Nursing Office and the manager of the nursing resource team. The recruitment strategy required the engagement of both the manager and the clinical nurse educator of the nursing resource team and the clinical nurse educator agreed to act as my study liaison. I assembled twelve sealed study packages, each containing a Letter of Invitation (Appendix B), a consent form (Appendix D), and a pre-stamped, pre-addressed envelope. The 12 sealed study packages and a Letter of Advertisement (Appendix A) were mailed to the clinical nurse educator of NRT. Upon receipt of the study packages and the Letter of Advertisement, the clinical nurse educator posted the Letter of Advertisement in areas frequented by NRT staff. The Letter of Advertisement identified the study, study purpose and directed interested candidates to contact the clinical nurse educator to obtain both my contact information and a sealed study package. Interested candidates obtained the sealed study package from the clinical nurse educator and contacted me via email indicating his or her interest in participating in

the study. Upon initial contact with interested candidates, I screened each candidate for eligibility using the study screening form (Appendix C). Eligible participants were invited to participate in the study and I then reviewed the consent form with each candidate, inviting the candidates to ask questions. Candidates interested in participating in the study were directed to sign the consent form and to return the signed form to me using one of two methods: fax the consent form to my facsimile number, or return the consent form in the pre-stamped, pre-addressed envelope provided in the study package. Upon receipt of the signed consent form, I signed the consent form and contacted each candidate to arrange a date and time for the telephone interview. A copy of the signed consent form was mailed to each participant.

Data Collection

Data collection methods for QD studies are typically conducted using individual interviews and/or focus groups. Individual interviews in QD studies usually entail a semi-structured or minimally structured approach (Neergaard et al., 2007; Sandelowski, 2000). Approaching the interview without preconceived ideas enabled the principal investigator to approach the interaction with some objectivity and enabled data to emerge naturally and inductively, known as emergent design (Lincoln & Guba, 1985). The data collection tool of choice in QD studies is one that is capable of adjusting to multiple realities. This tool is known as the “human-as-instrument” (Lincoln & Guba, p. 39) with both the participant and researcher acting as instruments. For purposes of my research, I conducted individual, semi-structured interviews comprised of open-ended questions. Individual interviews provided a safe environment for building a connection between myself as the researcher, and the participant, thus fostering rapport and trust.

Interview structure

Falling within social constructivism, establishing “rapport and trust from the outset” (Ryan, Coughlan, & Cronin, 2009, p. 311) is vital to the success of obtaining rich information. The choice of individual interviews required active listening on my part, staying attuned to the unspoken message. To free myself from the constraint of pen and paper, I audiotaped the interview sessions. Acting upon the recommendations of Ryan et al., I opened with an introduction to my study and the purpose of the study. To facilitate placing the participant at ease I began each interview with “non-threatening, factual questions” (p. 311). Ryan et al. recommend placing more sensitive questions later in the interview. I used Boychuk Duchscher’s transition theory (2008) to inform and guide my research, thus, some questions were reflective of Boychuk Duchscher’s transition theory. To view the questions composed for the interviews, please refer to Appendix E.

Data Analysis

Although described as the least interpretative of qualitative methods, Sandelowski (2010) states “data never speak for themselves” (p. 79) and QD research does not remove the researcher’s obligation to analyze or interpret the data. Furthermore, the findings are not a reproduction of participant response; rather, QD researchers are required to “make something of their data” (Sandelowski, p. 78). The data analysis of choice for QD studies is qualitative content analysis (Sandelowski, 2000), which Hsieh and Shannon (2005) define as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding an identifying themes or patterns” (p. 1278). A literature review of qualitative content analysis by Hsieh and Shannon identified three distinct approaches: 1) summative content analysis; 2) directed content

analysis, and 3) conventional content analysis. Of the three methods presented by Hsieh and Shannon (2005) conventional content analysis was deemed most appropriate for the proposed research. The summative approach employs “manifest” and “latent” content analysis (p. 1283) to identify and quantify certain words to “explore usage” (p. 1283) and search for underlying meanings. The directed approach is used when there is limited knowledge pertaining to an existing theory. Employing a deductive methodology (top-down), directed content analysis seeks to validate an existing theoretical framework and will begin with pre-determined codes. Conventional content analysis on the other hand, is used when the researcher seeks to describe a phenomenon.

The conventional content analysis approach was determined to be best suited to this QD study. As earlier described, QD studies seek to describe a phenomenon thus making a fit with the conventional method. Furthermore, the conventional method is applied when knowledge on the topic is limited. The conventional content analysis method employs an inductive approach, an analysis approach identified as a characteristic of naturalistic inquiry (Lincoln & Guba, 1985). By definition, inductive analysis “moves from the specific to the general, so that particular instances are observed and then combined into a larger whole or general statement” (Chinn & Kramer, 1999, as cited by Elo & Kyngäs, 2007, p. 109) allowing categories to emerge from the data rather than applying preconceived variables. According to Hsieh and Shannon (2005) conventional content analysis requires the researcher to begin by reading all data repeatedly to achieve a sense of the data in its entirety. The next step is to read the data word by word, highlighting key words that appear to capture key concepts as the initial step of deriving codes (recurring themes, Polit & Beck, 2006). The coding process involves taking note of

first impressions, thoughts and initial interpretations until the themes begin to emerge, creating the beginning-coding scheme. The codes are then sorted into categories, developing definitions for categories and subcategories using participant quotes. Discussion of the findings identifies how the data contributes to practice, teaching, and future research.

The data analysis approach of QD data can share similarities with grounded theory and or phenomenology. However, with QD data analysis, the researcher is not seeking to develop theories like grounded theorists, nor are they seeking a “nuanced understanding of the lived experience” like phenomenologists (Hsieh & Shannon, 2005, p. 1281). The advantage of using the conventional approach in QD research is the ability to obtain rich information directly from the participant that is unencumbered by preconceived categories, but the QD researcher must ensure a complete understanding of the data in order to render an accurate presentation of the findings (Hsieh & Shannon). Although I utilized transition theory to guide my study, I did not use the theory to predetermine codes; rather transition theory sensitized me to specific concepts related to NGs working in NRTs.

Rigour or Trustworthiness

Researchers both quantitative and qualitative, desire to obtain, present, and ensure quality data (Polit & Beck, 2006). To achieve this goal, researchers strive to establish rigour in the research; however there has been much debate over how to do so in qualitative research (Creswell, 2013; Polit & Beck; Tobin & Begley, 2004). Lincoln and Guba (1985) outlined four criteria for establishing rigour or trustworthiness in qualitative

research informed by the naturalistic paradigm: 1) credibility; 2) dependability; 3) confirmability; and 4) transferability.

Credibility

According to Tobin and Begley (2004), credibility is the qualitative version of internal validity and measures the congruence between participant response and the researcher's representation of response. This is achieved through a variety of strategies such as: member checking which involves presenting initial findings to participants; peer debriefing in which objective peers review the study; prolonged engagement and persistent observation in which the researcher invests sufficient time in the setting to build trust and rapport; and triangulation of data which involves using multiple methods of collecting data to ensure an accurate representation of the phenomenon. Lincoln and Guba (1985) view member checking as an important component of credibility and describe it as a method used to test interpretations and conclusions with the members of the study sample. The process occurs continuously and can be both formal and informal. Formal member checking involves meeting formally to present the participant with initial interpretations of the data and to allow the participant to critique. Informal member checking occurs simultaneously throughout the data collection phase, simply by summarizing content to the participant to verify information and to gain feedback. This allows the participant opportunities to immediately correct misinterpretations. For the purposes of this study, I used one telephone interview to gather the study data. Working within this limitation, I engaged in continual informal member checking throughout the interview process, seeking confirmation of my understanding of the participants' descriptions of their experiences.

Dependability

According to Tobin and Begley (2004), dependability is the qualitative version of reliability and is established through creating an audit trail. The researcher must ensure the process is transparent, logical, traceable, and documented (Schwandt, 2001, as cited by Tobin & Begley, 2004, p. 392). To ensure dependability within my study, I maintained a field journal in which I documented research activities, methods decisions, and maintained records of all supporting documents. In addition, I maintained an audit trail of process and decisions regarding my interpretation of the findings and reporting of the results, ensuring congruence with the methodology and alignment with the participant's descriptions.

Confirmability

Confirmability is the qualitative version of objectivity or neutrality (Tobin & Begley, 2004) in which two or more people can agree on the "data's accuracy, relevance, or meaning" (Polit & Beck, 2006, p. 336). Similar to ensuring dependability, confirmability can be achieved through use of a journal of activities and creating an audit trail that is clearly traceable. Polit and Beck list six classes of records required for audit trails: "1) raw data such as field notes and interview transcripts; 2) data reduction and analysis products; 3) process notes; 4) materials relating to intentions and dispositions such as personal notes on intentions; 5) instrument development information such as pilot topic guides; and 6) data reconstruction products such as drafts of the final report" (p. 336). For the purposes of my study, confirmability was achieved through journaling, and creating an audit trail of the analytic process, inclusive of decisions regarding coding and themes. Confirmability was also achieved by virtue of having a thesis committee whereby

my thesis supervisor and co-supervisor reviewed my work for accuracy, relevance, and meaning.

Transferability

Transferability is the qualitative version of external validity (Tobin & Begley, 2004). In QD research, transferability is considered on a case-to-case basis (Lincoln & Guba, 1985) and is difficult as there is “no single correct or ‘true’ interpretation” (Tobin & Begley, p. 392). Research informed by naturalistic inquiry can only provide a rich description and only those who review the findings can determine if the information can be transferred to other contexts (Lincoln & Guba). The results of my study are specific to NG experiences in a nursing resource team, however the results may contribute to or validate the existing research base pertaining to overall NG experiences in transitioning to the work environment. The results of this study are specific to the study setting. However, the results have implications to nurse work environments outside the study setting. The experiences described by the participants in my study provide a framework for understanding the experiences and unique needs of NGs working within a float pool format within my home facility.

Ethical Considerations

Ethically, I was cognizant of the rights of participants during all phases of my research. As such, I adhered to the principles within the “Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans” (TCPS-2, 2010). It was my duty to ensure participants were fully informed of their rights as research participants, their rights to autonomous decisions, and their right to engage in free, informed and ongoing consent. The voluntary nature of free, non-coerced consent was made explicit in conjunction with

the right to withdraw consent at any time without consequence. My area of inquiry was the experiences of NGs working in an NRT and as such my target sample population was vulnerable. New graduates may have been reluctant to participate for fear of antagonizing the employer, or fear of impact on employment, furthermore, I was required to be aware of the potential power imbalances between the participant and myself.

My actions throughout the research process demonstrated concern for participant welfare, which encompassed not only physical, mental, and spiritual health but also all other aspects of participants' lives. I ensured provision of confidentiality as evidenced by maintaining all pertinent, identifying documentation and information in a secure, locked environment. All electronic files were password protected. To further ensure confidentiality, participants were identified through use of a pseudonym and data that may identify the participant was not included in quoted responses of the participants. .

I ensured the participants were fully aware of the risks and benefits inherent within my research. As such, the risks inherent within my study, although not exhaustive, potentially included: increased anxiety or other mental or emotional distress if the participant's experience was negative; and anxiety pertaining to fear of repercussions from employer. In the event participants did experience any of the identified risks, they would have been encouraged to contact the Employee Assistance Program. Potential benefits, although not exhaustive, nor guaranteed, potentially included: catharsis from the opportunity to voice negative experiences that may have occurred; the opportunity to contribute to research, the opportunity to make suggestions for NGs working in nursing resource teams, and the opportunity to inform practice, education, organizational policy, and research.

When recruiting participants I ensured justice within my inclusion and exclusion criteria. As a researcher, I was required to be aware of vulnerabilities in my sample population. Justice does not equate to treating everyone equally (TCPS-2, 2010) but rather justice recognizes those factors that render persons vulnerable. In short, I had to abide by the three core principles of the TCPS-2: Respect for Persons, Concern for Welfare, and Justice. To address issues of concern for the study participants I provided the contact information for the Patient Representative for the study setting within the consent form.

Summary

Qualitative description research was the method chosen for the proposed research regarding the experiences of NGs working in a nursing resource team. Little is known on this topic thus seeking a rich, straight description of these experiences is congruent with the QD method. According to Neergaard et al. (2007), QD is useful for healthcare research as “it can help to focus on the experiences of patients, relatives and professionals and their views of the patient-professional interaction and the organisation of the healthcare system” (p. 4).

Qualitative description as a research method fits within my ontological, epistemological, axiological, and methodological assumptions. I accept multiple realities, I seek subjective reports of participant experiences according to his or her perceptions, I recognize that the data will be value-laden and I employed an inductive approach. My worldview falls within social constructivism, which is congruent with QD and the naturalistic paradigm. I remained “data-near” (Sandelowski, 2010, p. 78) providing a rich description of participants’ responses ensuring rigour throughout the conduct of my

research. Ensuring both ethical conduct of my proposed research and trustworthiness of my data was crucial to providing findings that will inform practice, education, organizational policy, and research.

Chapter Four: Findings

The experiences of new nurse graduates during their first 12 to 24 months of practice have been well researched and documented. What is not well known or understood is the experiences of new nurse graduates working in nursing resource teams. A qualitative descriptive study targeting new nurse graduates hired into a nursing resource team (NRT) was conducted to answer the question “What are the experiences of new nurse graduates working in a nursing resource team.”

As each participant shared his or her experiences, it became evident there were layers to these experiences that held meaning for the NGs and required focused discussion. Three main themes arose from the participant interviews: New Nurse Graduate Transition; Being a New Nurse Graduate on a Nursing Resource Team; and Supportive Work Environments: Essential for Success. The first theme, New Nurse Graduate Transition, presents the experiences of being a new nurse graduate in the workforce as described by the study participants. The second theme, Being a New Nurse Graduate on a Nursing Resource Team, presents the experiences of what it was like to work in the NRT as an NG including the advantages and the challenges. The third and final theme, Supportive Work Environments: Essential for Success, describes the unit, management, peer and social supports provided to the study participants. Finally, this chapter will conclude with a summary of the findings overall.

New Nurse Graduate Transition

When interviewing the participants about their experiences as new nurse graduates working in a nursing resource team, it became evident that central to these discussions was the experience of being a new nurse graduate entering the workforce. As

the discussions evolved, the participants described feeling incompetent, nervous, stressed and overwhelmed as they adjusted to their new roles. Some participants described feeling unprepared for the real world of nursing and others shared feeling as though colleagues did not trust in their abilities as new nurse graduates. Finally, the participants reflected on their initial months of practice demonstrating growth and insight.

Adjusting to both the reality of the nursing work environment and the incumbent expectations of their new roles were described as difficult for the participants. Some participants voiced feeling unprepared and not measuring up to expectations when they entered the work environment. Alicia spoke of feeling “at a loss” because many skills were “just brushed over” in school and “things on the mannequin are not what they look like in real life.” Like Alicia, Laura described not having the opportunity to practice many of her skills as a student. Laura began her nursing career in a nursing home before securing employment in the hospital and had never inserted a catheter or a nasogastric tube. She described her foray into the acute environment as follows:

When I first started one of the managers of the units kind of thought I should know how to do all of that stuff...and I didn't need more orientation and that I should have learned all of it in school and I should be comfortable doing it and I should be writing to the school to say that they should give us more clinical training so that we are ready to work when we come out of school.

The realization they were now accountable for the patients within their care was stressful for the participants. Alex captured this realization when he described:

It is a lot of stress. And I don't think it's fully realized. I mean when you're a student you don't have to worry about and ah and the patient is not actually yours, and you can obviously be just like, oh, that person is sick and it's somebody else's worry, but once you're out there it's kind of like you!

Not only were they responsible for the patients in their care but as one participant shared, patient care was dependent upon their decisions and time management skills. Assuming responsibility for an increased patient load compounded the experience for the participants. Keeping pace with the floor and not missing anything was Alicia's biggest concern. She described having had only one patient as a student and now she no longer had "that extra person to check for me." Laura described the stress of managing on her own:

And trying to get everything done on time or if there was something that went wrong with one patient, if they became unstable, and knowing that I have three other patients that I still have to get to and another patient is sick or whatever.

Faced with increased patient load and responsibilities, the participants described striving to find a balance between functioning on their own and knowing when to ask for help. This presented a challenge to one participant in particular. Although Laura found the majority of people willing to help and answer questions, she encountered some who were not:

If you had something kind of go wrong with a patient, say when they became unstable and you weren't really sure who to go to to ask or sometimes there were nurses on who weren't as supportive. And you didn't want to go ask or they may think that you should know this. I did a lot of googling, instead of wanting to ask someone.

Alicia wrestled with the perceived expectation that twelve months post-graduation was the cut-off point for "having it all together." As she elaborated:

If somebody goes very ill-they ill on you very quickly, because I'm now a year out and people expect me to have that basic knowledge base behind me and I should be able to roll with that situation to its conclusion, whatever that conclusion may be. Whereas six months ago or three months ago even, people would be like well, you're still really new, they seem to think that a year is the cut-off for a new grad at this point.

As the participants transitioned to their new roles, some struggled with trusting in their own abilities and knowledge. Olivia described it as second-guessing herself and “getting your bearings and putting on a brave face.” The participants described striving to gain the experience to know what is normal and what is not and knowing when to escalate a situation. As Erin explained:

I think as a new grad that’s a lot of you know, putting all the pieces together that you learn in school. That takes a long time and it takes a lot of conversations with more experienced nurses to know.

Although Kim described being a new nurse graduate as “scary”, she was not afraid to ask questions and did not care if she “looked stupid.” Peggy talked of how everything worried her, little things that when looking back would not be “such a big deal” but because she was dealing with people’s lives it was very stressful. The participants recognized that the new graduate transition was occurring at the same time as adjusting to the NRT as evidenced in Erin’s quote:

Now I’m not sure if my experience as a new grad was more difficult because I was an NRT, or if it’s sort of the same difficulties that all new grads have, but feeling competent in all of my abilities and you know, wondering what the hell I got myself into. What made me think I wanted to do this?

As the participants progressed in their learning and development they described how their confidence grew. However, they also discussed instances where colleagues continued to question their abilities. Laura described that despite feeling as though she was starting to “get the hang of things” some colleagues seemed to question her ability.

In the following quote she describes how she addressed this:

[My colleague stated] “I’ll let you do the vitals and I’ll do the rest of the assessments” and I kind of had to speak up and say, “No I’m comfortable with this, I just kind of need someone there to show me around.”

The participants shared how transitioning also involved finding their voice. Alicia described having to find a balance between being assertive yet diplomatic:

Initially, being overly firm and asserting myself toward people was not my personality at the beginning of this career. But you really have to stand up for yourself and you have to stand up for your patients, so it becomes more and more easy each time you have to do it, even though you don't really want to. Because they are your coworkers at the end of the day so you don't want to make it a hostile work environment for yourself either. But you can't let someone bowl you over either so you have to find a diplomatic way to solve the problem.

Although the participants in this study encountered challenges as they transitioned to their new role and to the work environment, they also described how they persevered and overcame these challenges. During the interviews, the participants reflected on their first months of practice, sharing insights and articulating their perspectives on how they had evolved in their chosen career. They had progressed from being overwhelmed and stressed to a state of increased confidence within themselves. Despite the books she read and the "horror stories" she heard regarding how new nurse graduates may be treated, Alicia described she had a "pretty good experience" overall. She stated:

It's really all about maximizing the use of your resources and the use of your knowledge, and if you're not sure, find somebody that does know and then learn from them. Even though you can still ask questions as you have more experience, people are much more open to answering your questions and showing you and helping you learn, as a new grad because they know that you're new and you may not have encountered certain things. But so far, I've found that the year has gone by ridiculously quickly.

Some participants believed they had a smoother passage into practice and speculated on the possible reasons. Erin described having a "pretty easy segue" that she attributed to having worked in a chronic care environment during her initial months of practice. Erin explained:

At the [nursing unit name] I was really grateful that I was there and I didn't feel like my intervention was important to keep them alive. You know what I mean?

Erin believed she would have experienced “more of a shock” had she initiated her practice in an acute care environment with an increased level of acuity. Olivia described life experience as facilitating her transition in terms of “communicating with others, and all that kind of stuff which nursing includes, and being able to think on my feet.” Kim described:

I don't know if it's because I'm an older, or not older, but not straight out of high school. I've had other jobs so I'm used to customer service.

The participants recognized they were not alone in their experiences as NGs transitioning to the work environment, noting that all NGs, to some degree, share similar experiences. Alicia had advice for future NGs:

Have the patience with yourself to know that you're still learning, encourage people to have patience with you as well because you are still learning. I learned more the first year on the job than I did in school. So just don't panic, it will come.

Erin summed her transitioning experience as:

Now that I'm more comfortable as an RN I can look back and say you know that it wasn't me as an individual being challenged, it was being a new RN I was challenged and I had a hard time and it wasn't great at first. But now that I have more experience and I've done it for awhile now, I know that sort of everyone goes through that no matter what kind of work they're doing as a nurse, whether you're an NRT or regular staff on the floor.

The theme “New Nurse Graduate Transition” presented the participants' experiences as they transitioned to their new roles and to the work environment. Although some participants spoke of being aware of this transition period this awareness did not prevent the participants from feeling stressed, nervous, and overwhelmed.

However, as the interviews progressed, the participants reflected and described their professional growth, identifying factors they believed contributed to an easier transition. The following theme “Being a New Nurse Graduate on a Nursing Resource Team” will present the participants’ experiences of working in the nursing resource team as new nurse graduates.

Being a New Nurse Graduate on a Nursing Resource Team

All participants were hired into the nursing resource team (NRT) as new nurse graduates (NGs). The participants described what it was like to work in the NRT as NGs and their experiences will be presented in the following sub-themes: The Process and Structure of the Nursing Resource Team; The Advantages of Working on a Nursing Resource Team as a New Nurse Graduate; The Challenges of Working on a Nursing Resource Team as a New Nurse Graduate; and finally, Personal Attributes: Facilitators to Success. The first sub-theme describes how the participants became aware of the NRT and what influenced their decision to work in the NRT. It also describes the NRT and the orientation process for the NRT. The second sub-theme presents the advantages of working in the NRT as NGs. The third sub-theme describes the challenges the participants encountered while working in the NRT and includes the participants’ recommendations for mitigating these challenges. The fourth and final sub-theme presents the personal attributes the participants identified as facilitators to their success on the NRT.

The process and structure of the nursing resource team. In sharing their experiences of working in the NRT, the participants’ descriptive accounts centered heavily on the process and structure of the nursing resource team. Implemented in

November 2012, the NRT provides staffing relief to the various nursing units among six facilities, although of the eight participants, only two made brief reference to working in another facility. The NRT is comprised of clusters, which are defined as a grouping of similar nursing units according to specialty. According to the participants each cluster typically consists of approximately four to five units although some participants described working on five to six. The participants received an extensive orientation that included a general hospital orientation followed by an orientation to his or her cluster. The participants described a typical NRT orientation as follows: the participants received 10-12 shifts of orientation on the first unit in the cluster followed by a period of time working on that same unit. The participants then orientated to the second unit in the cluster for eight to ten shifts followed by a period of time working on that same unit. This was followed by an orientation to the third unit in the cluster for six to eight shifts and an orientation to the fourth unit in the cluster for four to six shifts. Throughout their NRT orientation, the participants were paired with either a nurse from the unit or with a fellow NRT nurse. For those who joined the NRT in its inception, they were paired with a nurse from the nursing unit but as the NRT grew, NGs would at times be paired with a fellow NRT nurse. The length of orientation to the NRT varied due to the built-in flexibility that provided NGs the option of additional time on a particular unit if needed.

Established research pertaining to new nurse graduates discourages float nursing during the first 12 months of practice, yet, the participants in this study joined the NRT as new nurse graduates. As part of the discussions surrounding the structure and processes associated with the NRT, the participants shared how they became aware of the NRT and the factors that influenced their decision to join the NRT. When seeking employment

opportunities, some participants described going through a general application process to the health care facility. As per the participants this process required the applicants to identify approximately three areas in which he or she wished to work. Some participants described becoming aware of the NRT during the interview process in which either the NRT manager was part of the interview or the human resources department introduced the NRT option to the applicants. One participant became aware of the NRT through a friend who was recently hired into the NRT and another participant described being contacted by the NRT via an email recruitment process. Still another participant described reaching out to the human resources department of the health care facility to seek employment opportunities and was informed at that time of the NRT option.

As to why they chose to join the NRT as NGs, the participants' reasons were varied. The majority of the participants spoke of the opportunities the NRT provided; the opportunity to work on many different nursing units, the opportunity for learning, and the opportunity to find a niche. Olivia described her decision to join the NRT as:

I think the job was built for me...I don't like to get stagnant, bored. I like to move around a lot and I'm very social in terms of friends and trying new things and that sort of thing and the learning aspect was really important to me. So I was really excited for that.

Mandy shared the basis for her decision:

I could go on many different floors, be properly trained and get all that experience in a shorter period of time versus just going to one floor for a year.

For Erin, it was the opportunity for education and support that "none of the other jobs that I looked at stressed that as much as the NRT did." Prior work experience through a contracting company as a Patient Service Worker (PSW) cast the NRT in an appealing light for Alicia who was accustomed to working on several different nursing units. Alicia

described having established basic working relationships with many of the core nursing staff and stated:

Going to different floors was not new to me and I actually really enjoyed it because I got to see a whole lot more and experience a whole lot more.

Other participants described their decision to join the NRT as being influenced by not knowing what they wanted to do in terms of nursing specialty and this employment option provided the opportunity to find their niche. Kim described not being offered a position on the nursing unit she wanted, but when the NRT manager offered her a permanent full-time position she accepted because the “cluster had the floor I wanted.” Laura described wanting to work in the city that was the home of the NRT but could not find a job. She had finally received an email from the NRT recruiting new nurse graduates and applied because the email described the NRT as “good for new grads, so I applied and got an interview.”

Regardless of why the participants chose the NRT, when the opportunity arose to work in the NRT, the participants appear to have joined with little trepidation. Choosing to work in the NRT as an NG added a layer of complexity to the participants’ NG experience yet the participants were able to identify several advantages to working in the NRT as NGs.

Advantages of working on a nursing resource team as a new nurse graduate.

As NGs working in the NRT, the participants identified several positive aspects to the experience. The participants described feeling prepared to be on their own, identifying sufficient orientation to the NRT as cause for their success. Olivia stated “I do think they

gave us enough orientation where I didn't feel kind of stranded and drowning." Erin described her readiness to practice as:

I think I had gotten to the point where I couldn't have learned any more, or been more prepared by somebody else. It was the point where I needed to go out and try things on my own in order to learn what worked for me and to apply things, the things that I had learned.

Having the wide-spread exposure to other nursing units and skills naturally led the participants to compare their experience in the NRT to what they perceived it would have been like had they been hired to one unit. The participants believed the NRT experience "helped" their transition to practice. Laura believed she received more orientation than she would have had she been on one floor and because the different floors required different skills, Olivia described the NRT as providing her with a "broader tool belt" rather than a "specific one." When comparing herself to peers she graduated with, Alicia described the NRT as providing her with "a lot more experience and a lot more knowledge than some of the other new grads that I went to school with." Kim believed that in some ways she "has it better" in the NRT. As she explained:

It's probably made my scope a lot wider and I feel like a lot of the floor nurses get really like tunnel-visioned [sic] into just what they do there... I just feel like everyone always says how calm the Nursing Resource Team is and just that we probably seem to know, maybe not what we're doing, but like we just seem to get a lot of praise so I feel like when you see more, you know more and do better I guess.

Overall, the participants appeared to view the NRT experience as helpful to their transition to practice and viewed the NRT as beneficial to their knowledge and skill development. As Olivia described:

I really do feel like we grew faster as nurses from being part of this team. Like we became good nurses fast and I honestly think like other nurses on the floor would say that too.

The exposure to multiple units within their chosen cluster provided participants with insight to a variety of practices. Kim described it as “it opens up your eyes to other floors...I’m exposed to more than one norm.” Although belonging to the same health care service, each floor had different nursing staff and a different way of doing things. This enabled the participants to add to their repertoire of skills. As Olivia explained:

I feel you learn what’s important because you see the different things on each floor where the positives and negatives and you can kind of pull it all together, and kind of put that into your own practice. How things work on different floors and what doesn’t and not just like systematically but what works with patients what works in this situation and what doesn’t.

Erin described the exposure to multiple units as:

I think that’s what helped me to transition from the role of a student, the role of a professional practitioner is you know gaining the insight that everybody has to develop their own practice and you can only do that by practicing. So I think being in the NRT helped me learn that experience quicker because I was exposed to more stuff and more often.

Conversely, Olivia also identified that this broad exposure prevents NRT members from becoming specialized in any one area of nursing. However, some participants identified that their skills developed from the exposure to multiple floors and the multiple nurses they trained with. Furthermore, the opportunity to work in higher acuity areas combined with repeated exposure increased the participants’ confidence levels to cope with challenging situations. Alicia elaborated:

So when I have somebody that’s going sick and even though we don’t want that to happen, the more times it happens, the more confident you get and you have the skills behind you in order to deal with it so just having that knowledge base and that skill and the confidence that keeps coming from that because on some of my units you wouldn’t see if very often. So being able to be in different places and recognize different things and seeing different things is a really positive thing and beneficial to any new grad.

As the participants built upon their repertoire of skills, they soon found themselves in situations in which not only were they learning new skills but they were transferring these skills to other areas. Alicia described a situation in which a nursing unit often deferred to her for a particular skill because they knew she was certified. As Alicia explained:

So we learn different skills and we get certified a lot which makes it really more valuable to be floating around to different places because then you're able to transfer those skills around and help certify other people as well.

The ability to transfer skills to other areas was not only perceived as an advantage to the NRT nurses; floor staff welcomed these skills as well. When working on a cardiac unit Mandy removed a PICC (peripherally inserted central catheter) line from a patient to the amazement of the floor nurses who did not have that skill, and at that point she recognized that:

...and so there's these different skills that you never really realized that you kind of picked up that other floors wouldn't have or other staff wouldn't have.

Working in the NRT provided the participants the opportunity to reciprocate in the teacher-learner relationship. Like Alicia, Peggy described the core nursing staff often deferred to her for help with skills they were unfamiliar with. Olivia attributed this to “because they know I have a great educator a lot of the nurses would approach me and be like, have you done this before?”

Increased marketability was another identified advantage of working on the NRT because of the accumulation of diverse experience and skills. Kim described her experience as: “I'm essentially doing four jobs as opposed to just one” and believed her

experience in the NRT would enable her to secure a position in any of the four areas within her cluster. Laura described her experience as: “it will look good on my resume.”

Flexibility in both scheduling and in the number of nursing units within each cluster was important to some participants and the NRT met that need. When floated to a floor outside Mandy’s cluster she was granted the option to have it included in the number of floors within her cluster. Olivia appreciated this flexibility as it provided change when the floors within the cluster were no longer challenging enough. Another aspect of flexibility pertained to the participants’ schedules. Mandy explained:

So you get your schedule and if something really doesn’t work, before they book a floor into it then they can change it. Because it’s not based on floor needs.

Requesting time off was not a concern for the participants even for those with less seniority than core staff on the nursing units. Peggy expounded on this:

I don’t have a lot of seniority, but I do get everything I need or I want for vacation, because I’m on the resource team and because I’m not booked to any floor months in advance. I could say I want like a week in August off, and I’ll get it off because I have no ties to a floor.

The scheduling flexibility extended to situations when the participants would be scheduled for a shift and but there would not be a floor to work on. The participants had the option of taking the shift as a vacation day or an education day; again, because the NRT members were not committed to a floor, facility staffing was not impacted. Having flexibility gave the participants control to some degree over their work environment.

Working on several floors exposed the NGs to a variety of interpersonal dynamics among their colleagues. However, as Kim described, she was only on the floors long enough to establish acquaintances but not long enough to “get pulled into the politics,” a

sentiment which Olivia agreed with. Avoiding floor politics was an advantage the participants valued; Peggy described how working in the NRT was helpful in avoiding floor politics:

You're still a visitor when you go, no matter what. Even though they'll include you in stuff, you're still not a full staff. You don't deal with all the troubles they go through.

Apart from avoiding floor politics, working on multiple nursing units was advantageous because it provided a change of scenery or an escape when the participants experienced particularly difficult shifts. Unlike core nursing staff who must return to the same unit shift after shift and work with the same challenging dynamics or patients, NRT nurses had the advantage of going to a different floor with different patients. As Laura explained:

It's also nice to, say you're having kind of a rough few shifts and then you know you're going to a different unit the next day, you're kind of relieved that you'll have a whole different day. You know that you're not going to have the same patients and you know you're not going to be in the same environment, kind of something new and you're kind of refreshed.

For Kim, the NRT enabled her to “get a break from floors” whereas if she worked on one floor, she could have the same assignment that she disliked for several shifts. Olivia described this advantage as the “pro of the Nursing Resource Team:”

You might have a crazy day on an acute floor and then you're almost happy that you're going to go to the stroke floor, and kind of have a different way to nurse.

However necessary the change of scenery may have been for the participants, the core nursing staff appeared to value the NRT presence on their respective units.

According to the participants, the core nursing staff considered the NRT as an advantage over utilizing nurses from an outside agency for staffing relief. Utilized by the facility to

counter staffing challenges, nursing units appeared to view the “agency nurses” as having insufficient experience with, and knowledge, of the nursing units. Mandy provided a comparison between agency nurses and NRT nurses:

They have no support and they don't have an educator and all these things so there's a lot of people who come to these floors and they have no education, they have no orientation, like their orientation is two days on a floor and you can be floated throughout the entire hospital. Whereas Nursing Resource Team staff come and stay for a long period of time, get the proper training and then when they're there they actually are confident.

As a result, the nursing units were described as being grateful and happy to have the NRT nurses work in their areas.

The participants in this study joined the NRT as NGs and choosing the NRT as an entry-to-practice point was described as having several advantages for the participants. Once orientation to the NRT was complete, the participants described feeling prepared to work on their own. The repeated exposure provided by working on multiple nursing units, with multiple patient populations and with multiple core staff was described as providing a broader perspective, increased confidence levels, an increased knowledge base and an increased skill set. For some participants these particular advantages were described as facilitating a faster transition to practice. The exposure to the variety of units and learning from multiple core staff was described as providing insight into what the participants would like to incorporate into their own practice. Furthermore, as the participants developed their knowledge base they described having the ability to transfer their skills to other areas and having the advantage of increased marketability. The participants valued the flexibility in their schedules, which they considered an important

advantage. Moving from floor to floor enabled the participants to avoid floor politics and offered a change of scenery.

Although the participants identified several advantages to working as NGs in the NRT, they did encounter challenges as well. These challenges are presented in the following sub-theme The Challenges of Working on a Nursing Resource Team as a New Nurse Graduate.

Challenges of working on a nursing resource team as a new nurse graduate.

The participants described several advantages to working on a nursing resource team, but in addition to being a new graduate, the NRT experience posed unique challenges.

Working in the NRT provided the opportunity of learning the routines and required skills of multiple floors, but for some this was described as an information overload. Mandy described it as:

A lot of information all at once. So it can be overwhelming, and I think it's overwhelming in general as a new grad...it's a lot of information, a lot of different services, a lot of new faces.

Alicia struggled with the onslaught of information describing it as having to “switch from one mindset to another.” Gaining enough of the base knowledge for each floor to enable Alicia the skill to cope with moving between floors within the cluster and to become acquainted with the differing populations and staff was initially challenging for her.

When Kim initially joined the NRT, she described feeling like a new nurse graduate over and over. She explained:

[I] Felt like I started from square one every time; getting to know new floors, new staff, new doctors, new orders, where they keep stuff. So you're a new grad every time you go to a new floor. Granted, I felt a bit better each time because you're still gaining that experience and knowledge; it's a bit harder for us than maybe for someone on one floor.

Another described challenge was a lack of sense of belonging to any one unit. Some participants described feeling as though they did not have a home base, as Laura explained:

I find I love going around to all the different units but you never feel like you have a home. That's probably the hardest thing.

Erin described that not being part of a floor was challenging for her because of “seeing situations that are less than ideal and maybe you want to do something to change it. In addition, she also described feeling as “somewhat of an outsider” and did not believe she was in a position to speak out. The participants described that not having a home base created a feeling of loneliness and separation from the core staff. This was challenging for some participants as they observed core staff of each unit develop camaraderie from working together consistently. Mandy described camaraderie as a big part of nursing but she explained that NRT members are not viewed as part of the core staff. For Laura, the loneliness aspect was challenging because as she described:

You see all of the other nurses are really close with each other, friends, they go out together and I guess they, maybe I'm not there long enough for them to I guess become good friends.

Erin, however, provided a different perspective of feeling apart from the core staff, positing that by avoiding floor politics perhaps the exclusion may be self-imposed:

I think a lot of it is my own personal keeping outside of the things. When it comes to cultural and politics of the floor I try to stay out of that as much as possible. So keeping out of gossip is also kind of keeping out of the cliques. And so in some ways you can feel excluded.

Coinciding with the challenge of not having a home base was the challenge of navigating interpersonal dynamics with core staff. Alex described the process as “building relationships with people.” According to Alex, school prepared him for

everything else but not how to work with other nurses. Erin described the fine art of negotiating these relationships:

It's sort of up to me to feel when would it be appropriate to, or when do I feel comfortable opening up more to these people and when do I think that it's better for me to keep out of it. When is it inappropriate and when is it going to be beneficial for you? So I have to make this decision a lot because I work with so many different people...

Alicia identified the challenge of trying to avoid becoming involved with conflict occurring among core staff as some core staff may expect the NRT member to become part of the conflict. Laura described this as:

Probably my biggest ones were any kind of conflict between like other nurses, other nurses talking about some of them who aren't there and kind of wanting you to join in and you don't really want to join in.

Lack of consistency was a common thread among the participants; each nursing unit had different routines, there was a lack of patient continuity, and inconsistent deployment to the floors within their clusters. Although the units within the clusters were part of the same health service, the units were individual in terms of routines, skill requirements, provision of that service, and storage of supplies and equipment. This was considered a challenge for the participants as they strived to acquire the information specific to each unit. For example, Mandy revealed that some floors conducted patient rounds differently and the charting is different on every floor. Others identified the challenge of having to search for supplies and equipment and the loss of valuable time as a result. Erin described it as:

Things are in a different place so all those little things that keep you efficient, knowing exactly where to go to look for something, suddenly you're in a new environment and you have to know where to look for things all over again. ...that can be really difficult especially when

you're a new grad and you're just learning how to navigate your way through a day. A single shift is challenging, managing your time appropriately is very difficult.

Lack of patient continuity was described as a challenge when working in the NRT. As members of the NRT, the participants could provide nursing care on different floors with different patient populations everyday. This aspect of the NRT complicated the participants' ability to understand and respond to the patients' and families' dynamics. It was difficult for the participants to enter a patient's room and not fully comprehend the situation they were entering into.

Some of the participants described the challenge of not being deployed or assigned consistently or equally to all floors within their clusters. This presented difficulties in staying current with floor changes such as staff turnover, new routines or protocols specific to the floors, and feeling competent with the skills specific to the unit(s). Erin found it difficult to work on one unit for a single shift and to not return to that same area for a lengthy period of time. Referring to this experience as "you're back to square one," Peggy further explained:

That is especially hard as a new grad because you don't have that intuition and that base knowledge.

Olivia described the experience as "relearning everything," more so for the specialized areas within her cluster in which the knowledge gap could be significant. One final impact of inconsistent deployment to floors within the clusters was the trust factor. Alicia described it best as:

Because you're not there all the time, some people don't really trust your knowledge base. They'll question your judgment on some things, even if it's something that they would do. They'll either double check or they'll go behind your back and go and do something or talk to somebody.

The participants identified that more consistent and equal deployment within their clusters would help mitigate this challenge.

Perhaps the most significant challenge for the participants was the facility float policy and its impact on the NGs working in the NRT. The policy, which is separate from NRT nursing, guides the decision to float junior staff from one floor to another that is experiencing a staffing shortage. Some participants stated they would usually volunteer to float if the floor was within their cluster because as Erin stated “I don’t think it’s right that as an NRT they would send a regular staff to one of the floors in my cluster when I [am available]; just makes sense to me.” The challenge with the float policy was encountered when nursing unit staff defaulted to floating the NRT nurse. Some units – not all – held firm in the belief that NRT nurses should automatically be floated rather than core staff because as Laura described “we don’t really belong there.” However, the NRT manager mandated that NRT nurses could not be automatically floated and this created conflict in some areas. Laura described what it was like on one particular unit:

So the last few shifts I’ve had to go to a certain unit, they’ve kind of given me the cold shoulder. One of their nurses had to float and our manager had told the floor that we’re not to be floated...I’ve had a couple of shifts where nobody seems to really want to talk to you or they just seem kind of cold to you.

As a result, when Laura knew she was scheduled for that particular unit, she was anxious, wondering who would be floated. If a core staff member was not floated the staff were “usually pretty good”, but if someone was floated “some of them can make us feel guilty.” Scenarios such as this created an additional element of uncertainty for the participants.

Some participants recalled being floated to floors outside their clusters during their first months of practice when the need arose. Mandy was floated after being in the workforce for approximately four months. She described it as “scary” because she was assigned to a floor with “five to ten services at any given time and they were still short with me coming on and I ended up with eight patients.” Kim described being floated outside her cluster after approximately six months of practice:

I have only floated three times in a year, two of which were with the same floor. It was well outside my cluster. The two times I went to one floor, it’s a medicine hematology/oncology and I’d never done medicine anything so that was like I don’t know what I’m doing and then the other one was surgical but again they were still short even with me going there and it was horrendous. No one had time to show me anything. It was not fun. I didn’t like it.

When asked how she would feel about floating now that she has been in the workforce for one year, she replied she would feel more comfortable now that she has the experience of working on different units versus one floor. As a result of the facility float policy and the impact it had on the NGs in the NRT, the participants prepared themselves for the possibility of floating when reporting for shift. As Alex described:

You kind of come on and get settled and then the first thing is who is being floated, should it be me, you know, who is getting floated? That’s usually the best thing to settle so you know exactly how many people are there, are you short, are you not short.

The participants in this study accepted the necessity to float provided they were indeed the most junior nurse on the unit, however, because some nursing units automatically defaulted to floating the NRT member, some participants found themselves in situations of conflict. To mitigate this challenge, the participants spoke of their desire for facility-wide increased awareness of the NRT role and increased awareness of the distinction between the NRT and the float policy.

The participants in this study shared the unique challenges they experienced as members of the NRT. Working on multiple units required the participants to learn multiple routines, multiple skill sets, and to navigate interpersonal relationships with multiple staff on the units within their clusters. This was described by some as information overload that was compounded by the inconsistent or unequal assignment to the units within their clusters. The challenge of not being assigned to a unit within their cluster for an extended period was described by some participants as having to relearn everything. The most significant challenge described by the participants, however, was the application of the facility float policy that requires the most junior nurse to float off one unit to another that is experiencing staffing challenges. While the participants described being willing to float provided they were the most junior nurses or if the unit was within their clusters, some described nursing units that automatically floated the NRT member, regardless of policy. To mitigate these identified challenges, the participants recommended more equal assignment to the units within their clusters and an increased awareness of the float policy and increased awareness of the distinction between the float policy and the NRT.

Despite the challenges identified by the participants in this study, the NGs persevered. To a degree, the NGs attributed this perseverance to a set of personal attributes that enabled them to function in an NRT environment. These personal attributes are presented in the following sub-theme “Personal Attributes: Facilitators to Success on the Nursing Resource Team.”

Personal attributes: facilitators to success on the nursing resource team. The participants in this study chose to work in the NRT as NGs. They identified within

themselves, personal attributes or predisposing factors they believed gave them an advantage for working in the NRT environment. Alicia worked as a patient service worker in the hospital setting while attending school. When functioning in this role Alicia worked on a variety of nursing units and therefore knew where supplies were kept and had a basic working relationship with some of the nursing staff. Alicia attributed this past nursing unit experience to helping develop her time management skills. Customer service experience and joining the nursing profession as a mature adult, was beneficial to Kim when she joined the NRT. Kim described how her past employment experience, especially in customer service, was helpful to her in adjusting to the NRT:

I think having all that kind of customer service has helped me enormously and I'm so used to dealing with people from all walks of life. You just got to grin and bear it, the customer is always right, so I'm very used to just biting my tongue and you know, this is the worst case scenario. I'm not saying every patient is, you know if someone says something or you're not getting along with someone then I'm just kind of used to that, you just smile and then get on with it. I think those things probably helped me the most.

Mandy believed that being self-directed and accountable gave her an advantage for working on the NRT and believed that it requires a certain type of person to work on the NRT:

I think you really need to be a certain personality to be on the Nursing Resource Team. Certain people just shouldn't be on it. And the reason why we work well is because the people that are on it, actually do this well.

Mandy was not alone in the belief that personal attributes played a key role in having success on the NRT. All eight participants identified several attributes including: confidence, being open-minded or open to change, being calm, laid-back, easy-going, adaptable, and flexible. Peggy described herself as someone who “gets bored easily on

one floor” and described the NRT as “maybe it’s for a person who kind of likes to do different things.” Olivia described some key personal attributes as:

You definitely need to be open-minded. And you definitely need to be positive. And you definitely need to enjoy change and you need to enjoy being ready for new situations and just working it, you know somewhat spontaneously, sort of, I guess. You just need to be ready to learn and you’ve got to adapt. It’s a big thing.

Going hand in hand with being open to change was flexibility and adaptability.

Referring to friendliness, flexibility and being accommodating, Erin explained:

Those are all traits that make it easier to roll with all the changes that happens as an NRT. When things stop going your way you still have to maintain a pleasant demeanor, or else people aren’t going to want you around.

Kim, Alex, Laura, Alicia and Peggy described themselves as calm people and believed this contributed to success in the NRT. Alicia elaborated by stating:

I think if you’re high-strung this is not the job for you. Because I see some of my fellow classmates that were just on one floor and they were just losing it every day for months and months and just couldn’t get it together. And I said can you imagine what you would have been like if you’d have more than one floor thrown in?

Kim believed “you can’t be set in your ways, you have to be able to adapt to the floor and just everything” and Laura stated that when she encountered new situations she was “not too stressed about them.” Mandy succinctly summed it up as:

You have to be very adaptable. You have to be very honest. You have to be able to go with the flow. You have to be strong in terms of your skills and knowledge base and you have to be humble enough to actually ask the questions that you don’t know and you cannot be scared. Being timid of course of other staff or being timid of doctors is just not a good way to get your patient skills...those are kind of like the things that I can think of that make a good nurse for the Nursing Resource Team.

The participants’ experiences as NGs within the NRT were such that some stated they would recommend the NRT to future new nurse graduates provided the future NGs

were not anxious, timid or afraid of float nursing. Kim stated she would tell future NGs that it is a great experience and an opportune time to join the NRT at the beginning of a nursing career. Mandy described she would tell future NGs:

I would highly recommend it...you know Dalhousie students show up all the time for clinical, and a lot of the fourth years ask, how is the Nursing Resource Team? And I cannot say anything but positives about it. So they kind of ask me, what's it like, how does the scheduling go, is the manager nice, they really care about who the manager is. Do you have the resources and supports and the answer is yes.

The participants in this study identified several personal attributes they believed contributed to their success on the NRT. These attributes included self-confidence, being open-minded, flexible and adaptable, and being calm. Furthermore, the participants recommended the NRT to future new nurse graduates provided the NGs were not anxious, timid or afraid. Personal attributes however, were not the only identified factors to ensure success in the NRT for the participants. The most noteworthy contributor to their success on the NRT was attributed to the supports the participants received from their peers, the nursing staff of the units within their clusters, the manager of the NRT, and the most significant support of all, the clinical nurse educator of the NRT. These supports and the value the participants placed upon them are presented in the final theme, Supportive Work Environments: Essential for Success.

Supportive Work Environments: Essential for Success

New nurse graduates require supportive work environments as they transition to practice in the nursing work environment. For the participants in this study, the most salient aspect of working in a nursing resource team was the multiple supports they received that enabled them to succeed in the NRT as NGs. They described receiving support from core nursing staff and other members of the health care team on the units

they worked on. Some identified receiving support from the manager and administrative support of the NRT. However, the two greatest forms of support for the NGs were identified as the Clinical Nurse Educator of the NRT and peer support from within the NRT. The theme “Supportive Work Environments: Essential for Success” presents the participants’ experiences in the following sub-themes: Unit Supports, Manager and Administrative Supports, Clinical Nurse Educator Support, and Peer Support.

Unit support. In previous themes the participants described their interactions with core staff of the various nursing units the participants worked within. Although they shared interactions that were not always supportive of the NGs, they did identify that overall they received much needed support from the core staff and from some clinical nurse educators of the various nursing units. Laura and Alicia described core staff as willing to help and answer questions; Alicia described core staff as “generally open to helping and passing on their experience.” Mandy described having a “good working relationship” with the core staff, particularly from senior nurses who provided feedback to support her practice. Not only did they provide feedback such as tips to improve upon a task or providing different ways to think about a situation, they also provided Mandy with positive feedback on her performance. Mandy, Erin and Olivia also described some educators of the various nursing units as being supportive of the NRT staff. Mandy described one educator in particular, as “amazing and she always made sure that you were kept in the loop with the floor on education days and resources for the floor.” As Peggy described “the individual floors are great too. I can still call them. They know me and I know them pretty well.” Laura described feeling supported and welcomed by the core staff of one unit within her cluster:

I really enjoy working there because they make you feel like you're part of that floor. As soon as I get there they are all saying hi and we haven't seen you in a while, we're so happy you're here. And they'll ask you all about what's been going on in your life.

Finally, the participants identified the charge nurses of the various units as an “invaluable source of support.” The participants valued the support they received from core staff, clinical nurse educators and the charge nurses of the units they worked on. However, although the participants did not have a home unit per se, they did not feel abandoned or left to their own devices. Without exception, all participants described the immeasurable support they received from both the manager of the NRT and the clinical nurse educator (CNE) of the NRT, support they identified as key to their success on the NRT

Management support. All participants in this study described their management team as key for their success in the NRT environment as NGs. For purposes of this discussion, the management team consisted of the manager of the NRT and the clinical nurse educator. The participants described the manager and CNE as always available when needed, approachable, and knowledgeable. Laura described the manager and CNE as “great supports” and further elaborated:

You could email them, call them any time of the day and they would walk us through something or they would even come to the unit and kind of walk you through stuff.

Support from the NRT manager was invaluable to the participants when coping with the float policy; in particular when the manager intervened to clarify that NRT nurses will not be automatically floated. Situations such as just described developed trust between the management team and the study participants. Alicia described the NRT manager as “pretty good to talk to if we have any concerns, especially about the politics and stuff on some floors.” Mandy described the manager as:

Everybody at this hospital has a high respect for her. And a lot of the senior staff have probably already had her as a manager and they have nothing but good to say about her. And she's very approachable, and she is very knowledgeable and easy to kind of be around but not be intimidated or like scared.

The visibility of the CNE was vital to the participants. As described by the participants, the CNE role encompassed providing education to NRT staff, notifying NRT staff of community events and educational opportunities outside the facility, and notifying NRT staff of policy changes and updates. Erin stated:

I get so many emails from our nurse educator every day, it's almost too much information She emails us several times a day with new policies, new opportunities for learning, new grand rounds on geriatrics and whatever, you know. We do our own NRT education days and they obviously keep in touch with us about that.

Without exception all eight participants described the CNE as a crucial source of support using such adjectives as "informative", "amazing", "wonderful", "awesome", and a "huge, huge support." All participants described the many visits the CNE would make to each unit to meet with NRT staff, seeking to offer assistance if required and inquiring how each NRT member's day was progressing. Kim highly valued the visits from the CNE, as she described:

Our nurse educator...she makes the rounds. We don't have a home base so she has to individually come to every floor that everyone is working at and tracks down, so she is just amazing. She'll find us everywhere and make sure we're doing okay and check up on us.

Furthermore, Kim valued the CNE viewing her as more than "just an employee." The CNE was described as always available for the NRT staff, and for Erin the actions of the CNE spoke louder than her words. Stating, "it feels good knowing that she's there for you," Erin further described:

It's one thing to say you know, you can call me at any time than

it is for her to show up, uninvited, pretty well every day and be like, well here I am, if you have anything that you need to talk about, or help with.

This was a necessity for Erin who described herself as an NG as hesitant to ask for help; to know that someone would be there for her without her having to ask was invaluable. Olivia described the same feeling, that even though she personally would not call the CNE any time of the day or night, she had comfort and security in the knowledge that she could do so if she really needed to. As Mandy described, “the quality of the educator makes a huge difference” and for Alex, he described the manager and CNE support as “probably the reason why I stayed, NRT is great and the support you get...it’s amazing.”

One final form of support within the management team was the administrative support provided by the scheduler for the NRT. The scheduler is responsible for arranging the NRT staff schedules and although not part of the management team per se, she was described by Kim as someone who “will bend over backwards to do anything for you that she can.” Peggy expanded further:

We have a scheduling administrator who does everything she can to make our schedules livable and get the vacation we need and time off we need. It’s really great in that respect and a lot of people are jealous about that.

As vital as the manager and CNE supports were to the participants, they also discovered supports from within their NRT group that were just as critical for the NGs in the NRT: peer and social supports.

Peer and social supports. The participants previously described not having a home base and feeling lonely as challenges to working in the NRT. To counter these challenges, the participants described taking part in various social events organized specifically for the NRT members. The social events were organized by the NRT “Fun

Crew” a social committee of sorts initiated by the CNE but managed by the NRT members. The Fun Crew organized events such as bowling or dinners as a method to bring the NRT members together. Participating in social events outside the work environment enables the NRT members to connect and discuss common experiences or frustrations and to just be together as a unit. Describing these social events as a “type of bonding” Mandy explained:

They’re really helpful in the sense that it’s nice to get the whole team together and for the team to be able to discuss different frustrations and things that are going good. You know, what are some things that we could be doing as a team. So we actually have events and hang out as a nursing resource team outside of work; that’s important to try and get some team spirit and for the new staff to kind of get to know the old staff that have been here for awhile.

The nature of nursing work schedules made it difficult for everyone in the NRT to attend the various social outings, however, the participants described other means of building connectivity such as newsletters and a webpage to which they can post information if needed. Kim described this as an effective way of “keeping us connected even though I absolutely don’t see anyone outside of my cluster and I barely see the people that are in my cluster...I think the social media and email is huge to keep us connected.”

The participants also described receiving peer support from one another when working together on the same unit and having the opportunity to be preceptored or to act as preceptor for new employees hired into the NRT. Only two participants described what it was like to work with another NRT nurse on the same unit. This was a source of support for Peggy who described her experience of working with another NRT nurse as follows:

When there’s another resource team person on the shift with me, we

look at each other like oh okay, we're probably going to pair up today and do stuff together. We have each other's backs. It's just kind of intuition.

On further discussion Peggy explained that NRT nurses have the "same work ethic" and Laura described it having "something in common and something to share."

When hired into the NRT, the participants were preceptored or orientated by core staff of the nursing units. However, as the NRT grew and progressed, some participants had the opportunity to be preceptored by fellow NRT nurses. Alex appreciated the advice he received when preceptored by an NRT nurse as he received a perspective of NRT nursing that core staff could not provide. Other participants had the opportunity to act as preceptor and mentor to new NRT nurses, thus enhancing the support system within the NRT. Although the participants may not have the extensive knowledge of the various units within their clusters, preceptoring new NRT nurses had value. Mandy elaborated:

It was kind of nice to share more the, this is how to float well and this is how to kind of swing with the flow. In terms of the questions, like the deeper questions about the service, she got that more from the other core members but I was at least able to show her kind of all the basics and that.

As Erin described:

I think that there's something to be said about having NRT preceptors because we understand what makes each floor unique. People get sort of wrapped up in the culture of their own floor and they don't necessarily understand the things that are the same, you know, universally and the things that make them unique. So sometimes things get overlooked in an orientation that, you know a regular staff member may think, oh, well everybody does it this way as an NRT we help bring in the proper and the more up to date ways of doing things. And when we preceptor our own we have a chance to say okay...they do it this way on the floor, but that's not what the policy says.

Entering the workforce as new nurse graduates was challenging; entering the nursing resource team as new nurse graduates added a layer of complexity to the new

nurse graduate experience. However, the participants described their experience in the NRT as helping their transition to practice and they identified several benefits and challenges to working in the NRT. Key to the success of the NGs in the NRT was the orientation they received and perhaps more importantly, the supportive work environment they described.

Summary

The participants in this research study were eight new nurse graduates hired into and working within a Nursing Resource Team in an Atlantic Canadian tertiary care hospital. Comprised of clusters – groupings of similar nursing units according to specialty – the nursing resource team provides staffing relief for nursing units within six health care facilities. The participants engaged in semi-structured telephone interviews to share and describe their experiences of working in a nursing resource team as new nurse graduates. However, these experiences were foregrounded in the overall experience of being a new nurse graduate in the workforce which was presented in the first theme “The New Nurse Graduate Experience.” The participants described feeling overwhelmed, stressed and anxious as they transitioned to their new roles and the work environment and as they reflected on their initial months of practice, the participants recognized and articulated their professional growth. In a natural progression, the experiences as described by the participants encompassed what it was like to be a new nurse graduate on the nursing resource team and these experiences were presented in the second theme describing the advantages and the challenges of working in a nursing resource team as a new nurse graduate. Finally, the third and final theme, “A Supportive Work Environment is Vital to the Success of New Nurse Graduates on a Nursing Resource Team” presented

how crucial a supportive work environment was to these study participants, with the manager and clinical nurse educator described as the most significant supports.

A discussion of these findings as they relate to existing literature and research will ensue in the following chapter including recommendations for nurse managers, policy makers, and educational institutions and implications for new nurse graduate practice.

Chapter Five: Discussion

Health Human resource planners and employers are strategizing for solutions to address staffing shortages, increased nurse workload and increased overtime. Nurses have clearly articulated the need for policies and strategies to improve work-life balance and to provide support for their health and wellbeing (Price, 2015). Float nursing, whether in the form of float pools or nursing resource teams, is one staffing strategy that has been and is utilized by employers. However, recent research has generally discouraged the practice of hiring new nurse graduates (NGs) into float nursing citing the need for stable and relatively consistent work environments for the first 12 months of practice. Despite an absence of research on the impact and outcomes of new graduates being hired into float pools and resource teams, NGs have been and continue to be hired into float nursing. The main research question for my study was “What are the experiences of new nurse graduates hired into and working in a nursing resource team.” A total of eight NGs hired into an NRT in an Atlantic Canadian hospital were interviewed using semi-structured interview questions to gain their rich descriptions of what it was like to be an NG working in an NRT. The following discussion will center on the three main themes arising from the analysis of participant interviews: New Nurse Graduate Transition; Being a New Nurse Graduate on a Nursing Resource Team; and Supportive Work Environments: Essential for Success. The results of this study highlight three key topics for discussion: transition reality, the structure and processes of an NRT as they relate to the NG, and finally, float nursing and the new nurse graduate.

Transition Reality

Transition to practice from education is a challenging time for NGs and the transition experience was central to the experience of new graduates in this study. Participants revealed that transitioning from the role of student contains an element of shock that is recognized widely in the literature as a common experience for NGs as they enter professional practice (Boychuk Duchscher, 2009; Kramer, 1974; Valdez, 2008). As extant research and theory have documented, there are challenges inherent to the NG transition experience and this was reflected in the experiences described by the participants in my study. The participants described feeling anxious, stressed and overwhelmed as they coped with managing increased patient care loads, negotiating interpersonal dynamics, trying to internalize and retain newly acquired skills and education, and not feeling adequately prepared for the work environment. Dating to the work of Kramer, NGs have described similar experiences as they moved from their role of student to reality of the workplace. Since Kramer's seminal work, additional research on NG transition has revealed similar transition experiences and challenges experienced by new graduates (Benner, 1984; Boychuk Duchscher, 2001; 2007; 2008; 2009; Casey et al., 2004; Chernomas et al., 2010; Clark & Springer, 2012; Dyess & Sherman, 2009; Ellerton & Gregor, 2003; Feng & Tsai, 2012; Morrow, 2009; Romyn et al., 2009; Spence Laschinger et al., 2012).

The participants in my study described a progression in their professional development during their first months of practice, a finding that aligns with the stages of NG development as described by other researchers and theorists studying new graduate nurse transition (Benner, 1984; Boychuk Duchscher, 2008; Kramer, 1974). As the participants entered professional practice they were excited to be entering this new phase

in their nursing careers. However as they became immersed in the work environment and their new roles, they began to encounter the challenges of being a NG. Participants were initially focused on completing tasks and keeping pace with the floors, striving to differentiate between priorities, and gaining confidence in interactions with other health care professionals. As their confidence grew over time, they fluctuated between seeking independence but needing reassurance and support from senior colleagues. These described experiences are redolent of the honeymoon and shock phases described by Kramer and the novice and advanced beginner stages as described by Benner.

An analysis of the participants' descriptions of their experiences as a new graduate did not necessarily yield a new understanding of the transition process beyond what is currently known in the literature. However, working in the NRT as an NG did present an added layer of complexity for the transition of the NGs in my study. As with all NGs entering the work place, the participants were challenged to learn new routines, new protocols, new expectations, and were challenged to negotiate and develop interpersonal relationships. However, these challenges were compounded as a result of working on multiple nursing units. Initially, the participants in my study described feeling like a new nurse graduate each time they were deployed to a different nursing unit within their cluster, a finding similar to that in Boychuk Duchscher's (2007) study in which those who were hired into float nursing positions reported the same experience. Although the participants in my study were initially challenged with adjusting to multiple nursing units, the experiences of repeated exposure to multiple nursing units and clinical situations provided them with the experiential knowledge they required to progress beyond the novice stage. This was described by the participants as helping their transition

to practice, believing they gained experience and knowledge far quicker than had they been working on a single nursing unit.

Regardless of where NGs are hired, whether on a single nursing unit or in a nursing resource team, the experience of transition to practice is central to the NG narrative. Four decades after Kramer's (1974) seminal research on NGs experiencing reality shock as they wrestled with the disparity between what they perceived their role to be and what they encountered in the work place, NGs today continue to experience an adjustment process as they enter the nursing profession. However, the intensity of the experience can be influenced by the quality and length of the orientation program, supports within the work environment and to some degree, personal attributes of the NGs.

Nursing Resource Team Structure as it Relates to the NG

The participants in my study joined the NRT as NGs, viewing it as an opportunity for education and skill development. They shared their experiences of working in the NRT as NGs, much of which centered on the structure and processes of the NRT specifically the orientation they received in the NRT and the supports they received as members of the NRT.

Nursing Resource Team Orientation. The participants described the orientation they received in the NRT as appropriate for preparing them to practice independently. They described receiving precepted orientation to each unit within the cluster followed by a period of independent practice on each unit before moving to the next unit in the cluster. The length of orientation varied for the participants depending upon their readiness to move to the next nursing unit as well as the acuity of the nursing unit. However, the minimum length of orientation was reported to be approximately four

months. Having to learn and recall routines, protocols, and skills for multiple nursing units was initially overwhelming for the participants in my study. Yet, as the orientation through the clusters progressed, the participants noted that the orientation on one unit reinforced the orientation received on the previous unit, thus the experience became easier each time.

Several authors have identified orientation programs and nurse residency programs (NRPs) as strategies (Anderson et al., 2012; Salt et al., 2008) to facilitate the transition of NGs. Although the literature reports varying lengths, structures and content of such programs, it appears that precepted orientation programs greater than four weeks duration followed by a period of independent practice result in a successful transition to practice with improved communication skills, increased job satisfaction (Rush et al., 2013; 2015) and greater employee retention (Salt et al.).

Conversely, literature regarding orientation programs for float nursing is sparse ranging from utilizing unit-specific tip sheets for nurses forced to float from their home units (Leon & Pase, 2004; Roach et al., 2011) to a comprehensive float pool orientation program designed specifically for NGs (Crimlisk et al., 2002). Designed to serve as a guide to assist nurses floated to unfamiliar areas, tip sheets provide information pertinent to the nursing unit and patient population. Upon arrival to the nursing unit, the nurse mandated to float is provided a brief tour of the unit and a tip sheet (Leon & Pase; Roach et al.). While useful for guiding nurses unfamiliar with a nursing unit, tip sheets alone would not suffice for NGs hired specifically for float nursing. On the other end of the scale, the four-to-five month orientation program described by Crimlisk et al. appears to have recognized the need to support the NG transition to practice by providing a

combination of precepted orientation and classroom training. The orientation described by Crimlisk et al. differs significantly from the orientation provided to the NG participants in Boychuk Duchscher's (2007) study who were hired into float nursing. The NGs in Boychuk Duchscher's study did not report receiving an orientation designed to support them as float nurses, rather they were paired with a "buddy" and orientated between two to five nursing units, not returning to a floor for several weeks to months following initial orientation. Consequently, each time the NGs in Boychuk Duchscher's study were assigned to a floor, they felt they were starting a new job.

The participants within my study received precepted orientation. However, many reported being precepted by several different individuals including experienced NRT nurses and core unit staff, rather than a dedicated preceptor. One participant viewed having several preceptors as an advantage allowing her to draw from several resources to inform her own practice. This finding is similar to that of St. Martin, Harripaul, Antonacci, Laframboise and Purden (2015) in which NGs viewed having several preceptors as a positive experience. Some authors however, would argue against this inconsistency citing the need for dedicated and appropriately trained preceptors (Haggerty, Holloway & Wilson, 2012; 2013; Valdez, 2008) to properly prepare the NG for practice. Preceptors play a significant role in developing confidence in the NG (Kelly & McAllister, 2013) and in helping them to engage with the nursing team as a whole (Henderson, Ossenber, & Tyler, 2015), lending support for the call for preceptorship training. Some authors believe it is the quality rather than the quantity of preceptorship that is associated with improved NG transition (Rush et al., 2015; Valdez).

Although initially overwhelmed by the volume of information and the requirement to orientate to several units versus just one, the participants within my study reported feeling prepared to practice independently. They described having an increased knowledge base and skill set and enjoyed the ability to transfer the knowledge and skills to other nursing units. Having the exposure to different clinical situations was described as beneficial to them in helping to develop their individual practice. As NGs transition to practice, they are not only developing their clinical skills and professional practice, they are socializing to their new roles and to the work environment. The participants in this study described several forms of support they received as members of the NRT.

Supports within the nursing resource team. NG development is impacted by both the orientation experience and the presence of a supportive team (Parker, Giles, Lantry, & McMillan, 2014; St. Martin et al., 2015). NGs place great value on support for their professional practice (Spence Laschinger, Cummings, Leiter, Wong, MacPhee et al., 2016) and when NGs feel valued and supported their self-confidence and competence will subsequently increase with safer and improved patient care (Clark & Springer, 2012; Gardiner & Sheen, 2016). The participants in my study reported receiving support from several sources: core nursing unit nurses, nurse educators from the various nursing units, peers within the NRT, the manager of the NRT, and more significantly, the clinical nurse educator (CNE) for the NRT.

Core-nursing staff was described as being helpful to the NGs in my study. They were willing to answer questions and provide feedback to help develop the participants' practice. Nurse educators associated with various settings ensured the participants were informed of educational opportunities pertaining to their specific units. Socialization

within and to the NRT was facilitated through the development of the NRT Fun Crew, a social committee initiated by the CNE of the NRT but managed by the NRT members. The Fun Crew arranged social events that provided the opportunity for NRT members to meet as a group outside the work setting to discuss and share common experiences. The most valued form of support received by the participants, however, was that provided by the CNE of the NRT. The CNE consistently met with the participants when they were working, visiting each participant on the nursing units, ensuring the participants had the information they required, providing guidance when learning new skills or reviewing policies, and providing support simply by being present. This support is reported to continue to present day.

Having a supportive team has been described in the literature as key to NG development (Casey et al., 2004; Clark & Springer, 2012; Dyess & Sherman, 2009; Feng & Tsai, 2012; Gardiner & Sheen, 2016; Malouf & West, 2011; Phillips, Esterman, and Kenney, 2015; Romyn et al., 2009; Rush et al., 2013; 2015; St. Martin et al., 2015). A supportive work environment encompasses precepted experiences, guidance from senior, experienced nurses, feedback on performance, and education (Gardiner & Sheen; Johnstone et al., 2008) with the length determined on an individual basis (Johnstone et al.). The NGs in my study received precepted experiences; received guidance from fellow NRT nurses, and the CNE was instrumental in keeping the NRT nurses connected to educational opportunities.

The participants in my study enjoyed working on different nursing units within their clusters, but for some, it was difficult not having what they termed as a “home base.” They enjoyed positive relationships with the nursing staff but it was difficult to

observe close relationships developing among the nursing staff on the units. Avoiding floor politics was an advantage for the NGs in my study, yet the task of negotiating the balance between trying to be part of the team yet remaining separate from the undercurrents that threatened to pull them into the drama of “the politics” was very challenging for some.

The fulfillment of the need to belong is an important aspect of NG transition to practice (Malouf & West, 2011). To improve the socialization process for NGs, literature recommends training senior nurses on the existence of culture shock, providing opportunities for socialization into the professional role, and establishing clear expectations for both the NG and the preceptor (Valdez, 2008). For NGs employed in float nursing, the need for support is crucial as they are required to develop social bonds with several individuals on more than one nursing unit in conjunction with learning and developing their clinical practice. Current literature does not reference the impact of float nursing on the socialization of the NG into the work place and new roles. Given that the NGs in my study described feeling lonely and not being part of the team, this indicates there is a need for consistent social support for the NG in the NRT to feel connected with the employees of the nursing units. The CNE of the NRT recognized and provided support – educational, social, and informational - upon hire of the NGs and continues to do so to present day. However, to ensure that NRT nurses are considered part of the greater team, senior management, the management team of the NRT, and individual nursing units must share the responsibility of providing social, educational, informational, and organizational support.

Float Nursing and the New Nurse Graduate

The participants in my study were hired as NGs into the NRT, which is a form of float nursing. Traditionally, float nursing is discouraged as the entry to practice point for NGs (Boychuk Duchscher, 2001; Dziuba-Ellis; Kutash & Nelson, 1993; Stenske et al., 1988), however, they are being hired into this form of nursing employment. Existing literature pertaining to float nursing has identified several challenges such as social exclusion, losing valuable patient care time searching for supplies, fear of losing one's professional license, not being part of the team, and working with different patient populations and nursing staff (Boychuk Duchscher, 2007; Dziuba-Ellis, 2006; Fitzgerald et al., 2007). Yet, there are several rewards or benefits that have also been identified in the literature: avoiding floor politics, flexible schedules, and increased skill set (Baumann et al., 2005; Dziuba Ellis; Fitzgerald et al.; Thomas, 1972). The NGs in my study described similar rewards and challenges when working in the NRT and perceived their overall experience as positive, even recommending the NRT to future NGs. There remains however, two key points for discussion – the element of choice for the NGs in my study and the impact of the facility float policy on the NGs.

Professional Choice. The eight participants in my study chose to work in the NRT as NGs. The rationale for choosing the NRT included perceived learning opportunities, anticipated supports within the NRT, seeking any job in nursing, and one NG felt it would be a fit for her personality. Regardless of why the participants chose the NRT, the decision to do so was their choice. These participants fall within the millennial generation or generation Y which is defined as those individuals born between 1980 and 2000 (Weston, 2006). A review of the literature concerning recruiting the millennial generation into nursing describes the millennial generation as competitive, constantly

seeking new challenges and need to be stimulated, expect and need support, and can process new information quickly (Hutchinson, Brown, & Longworth, 2012). Considering these traits, NRT nursing may be an appropriate career choice for the NG as NRTs offer variety and to some degree, offer choice. The NGs in my study had choice of the cluster they wished to work in and viewed the NRT as an opportunity for training and developing expertise in a shorter time period than had they chosen to work on a single nursing unit. As a consequence, NRT nursing can potentially be viewed as a specialty of nursing offering the opportunity to develop a broad skill set, increased knowledge base and the variety and choice for this current generation of nurses.

Health human nursing resources in Canada are significantly challenged by retirements, fewer new nurse graduates, overtime, and absenteeism all of which form a vicious cycle. With a mandate to provide patient-centered care, nurses are frustrated with the inability to provide this care when coping with high patient care loads and staffing shortages (Price, 2015). Recruitment and retention is a priority and is a concern when faced with these challenges. NRTs provide permanent employment with the incentives of opportunities for development, education and learning across a wider variety of patient populations. The NRT in this study was described by the NGs as providing scheduling flexibility. This feature and the incentives identified above positions NRTs as a viable recruitment and retention option when seeking a work-life balance, a key need that has been identified for all nurses, regardless of generation.

Although the nurses in the NRT chose to work in this form of float nursing, the NGs in my study worked in a setting that utilized both mandated floating and NRT nursing. Unfortunately, the distinction between the role of the NRT and the facility float

policy was not clear for some nursing units and ultimately the NGs in my study were impacted. The following discussion presents the impact of the facility float policy on the NGs working in the NRT.

Facility Float Policy and the NRT. The existing literature base references two forms of float nursing: mandated floating which requires a nurse to float from his or her home unit to another experiencing a staffing shortage or increased patient census or acuity and the use of float pools or nursing resource teams. When mandated or forced to float, nurses are removed from their area of comfort to one that is unfamiliar. Historically viewed as an anxiety-provoking practice the anxiety associated with this practice stems from working in an unfamiliar area with unfamiliar patients, experiencing unfriendly reception of the floated nurse by the nursing unit, fear of error and patient harm, and fear of losing one's license (Dzuiba-Ellis, 2006; Kane-Urrabazo, 2006; Nicholls, Duplaga & Meyer, 1996; Rudner Lugo & Peck, 2008). Conversely, float pool nurses and NRT nurses are hired to float and while not without challenges, these nurses chose this form of employment over other options. Although two distinct staffing practices, mandated floating and nursing resource teams tend to be viewed as one and the same. Unfortunately, this misperception bears negative impact on unit nurses and resource team nurses alike.

The setting in which my study took place has a float policy that requires a nurse to float from his or her home base/unit when another unit is experiencing staffing challenges. The setting also has a specific nursing resource team that is staffed with nurses hired to float between four or five nursing units within a cluster or area of specialty. The float policy is a strategy utilized for short notice staffing challenges

whereas the NRT provides a dedicated staffing relief model to clusters of nursing specialties or services that are grouped together according to similar patient populations and/or nursing requirements. However, the differentiation between the float policy and the role of the NRT appears to be unclear for some nursing units within the facility. Although the float policy and the NRT are two distinct staffing strategies, some nurses within the facility appeared to view both practices as one and the same. This misperception had a negative impact on the NGs in my study. The participants shared experiences of nursing units defaulting to floating an NRT nurse from the unit rather than core nursing unit staff. Although the NGs emphasized they did not object to floating to units within their clusters, they recounted instances in which they were floated to an area outside their cluster and these experiences were invariably stressful and anxiety provoking. An attempt to prevent nursing units from defaulting to NRT nurses for mandated floating served to incite discord on certain nursing units. This discord created a non-welcoming atmosphere on the unit when a unit nurse was floated rather than the NRT nurse. Additionally, the participants reported negative discussions directed at the NRT on Facebook, a social media site

The view held by some nursing units that the NRT nurses were most appropriate staff members to float indicates a knowledge gap in understanding the role of the NRT and the experience levels and needs of the NGs. NRT nurses and unit nurses both experience anxiety when floating to unfamiliar areas yet the experiences described by the participants in my study demonstrate a disregard by unit staff of the impact floating had on NRT nurses- especially given that they were new graduates. Literature pertaining to floating does not recommend floating of NGs for at least the first 12 months of practice

due to the need for NGs to have a consistent work environment in which to develop their practice and competence (Boychuk Duchscher, 2001; CNAC, 2002). Mandated floating requires the nurse to adjust to and assimilate the routines, expectations and protocols of the units they are floated to, without necessarily having the prerequisite knowledge or experience. NGs have very little clinical experience and experiential knowledge to float safely throughout a healthcare facility. Not only are NGs new to their profession, they may be new to the facility itself. The NRT however, is unique in that the NGs are specifically trained to float between four to five specific nursing units within a particular cluster – not the facility as a whole. The NRT is well resourced in terms of having a dedicated CNE for the NRT and providing cluster-specific training and education. There is a distinct difference between floating throughout the facility and NRT nursing. They are supported within the NRT, yet if required to float throughout the facility, they are essentially on their own. This knowledge gap may also serve to further entrench the divide between the core nursing unit staff and the nurses of the NRT in which some NRT nurses felt they did not have a home base.

To my knowledge, this is the first study to report on the impact of co-existing floating practices in a healthcare facility from the perspective of NGs. This finding from my study highlights the marginalization experienced by employees of the NRT that can result from misperceptions and misunderstanding of the NRT role and the needs of NGs. The participants in my study did not embrace the facility float policy any more than the nursing staff of the nursing units did and the conflict they experienced led them to clearly advocate for improved facility-wide awareness of the role of the NRT and the role of the NRT nurses.

Summary

This study of eight new nurse graduates hired into a Nursing Resource Team sought to determine the experiences of being a new nurse graduate in this form of float nursing. This chapter discussed the key findings of this study as they relate to existing literature surrounding transition, orientation and supports, and float nursing and the new nurse graduate. My study and those of Baumann et al. (2005) and Crimlisk et al. (2002) indicates that float nursing may not be an inappropriate career choice as traditionally framed within the literature. The transition experiences of the participants in this study demonstrated that transitioning and reality shock is central to the NG experience, regardless of where the NG is employed. Although the NGs in my study identified several challenges of working in an NRT, they also identified rewards and supports that provided an overall positive experience. The participants in this study also chose to work in the NRT given the many opportunities they believed this employment option presented including education, support, and experience. These NG participants fall within the millennial generation, a generation that requires variety, support, and stimulation, which may position NRT nursing as preferred option for NGs. For employers, NRT nursing may be utilized as a recruitment and retention tool for this generation of nurses.

This study did not seek to evaluate the impact of the NRT in relation to new graduate, patient or system outcomes. However, the results of this study do have implications for practice, education, organizational policy and future research. These implications as well as the strengths and limitations of this study are discussed in the following chapter.

Chapter 6: Implications, Strengths and Limitations & Conclusion

The purpose of this study was to discover the experience of being an NG in an NRT. The eight participants in this qualitative descriptive study shared their experiences, providing rich descriptions of their transition to practice working in an NRT, the supports they received and the rewards and challenges they encountered. The findings that arose from this study hold implications for practice, education, organizational policy, and research.

Implications for Practice

The participants in my study entered their profession as NGs in an NRT. Designed to provide dedicated and trained staffing relief, the NRT is comprised of clusters, which are groupings of four to five nursing units with similar patient populations and skill requirements. The NGs were orientated to each nursing unit within their chosen clusters and were required to learn and adjust to the various routines, protocols, and social dynamics on each nursing unit. The transition experiences described by the NGs in my study were similar to those described in existing literature pertaining to NG transition. Yet, the findings from my study highlight several challenges that persist in supporting new graduates despite the significant knowledge base pertaining to NG transition. One practice implication arising from my research is the need for education on new graduate transition for experienced nursing staff.

NGs need to feel they are a valued part of the team, which requires senior nurses to accept and respect the contributions of the NG (Malouf & West, 2011; St. Martin et al., 2015). The NGs in my study described the difficulties they experienced when senior nurses questioned the NGs' skills and knowledge. One NG referred to the unspoken

expectation that 12 months is the cut-off point for having the required knowledge base to function as a registered nurse. The expectation for NGs to enter practice “ready to hit the ground running” (Ellerton & Gregor, 2003) is not a new phenomena; participants in Romyn et al.’s (2009) study discussed the discrepancy between what the employer and existing employees expected of NGs and what the NGs were in reality, capable of providing. Additionally, given the challenging work environments that nurses are now working in, support is necessary not only for the NG but also for the staff tasked with preceptoring and mentoring the NGs. Senior staff may actually be staff who have five years or less of experience, and coupled with staffing shortages and limited budgets for resources sufficient NG support may be difficult to provide (Wolff, Pesut, & Regan, 2010).

The process of integrating NGs into their new role and into the workplace is a responsibility that should be shared by employers, nurse managers, clinical nurse educators, and unit nurses alike. To facilitate the process it is recommended that measures be put into place such as: formal training programs for preceptors (Haggerty et al., 2012; 2013; Valdez, 2008), creating formal mentor programs in the workplace and supporting nurses who wish to mentor (Price, 2015); and educating informal teachers/support persons – other nurse colleagues within the workplace who assist the NG (Johnstone et al., 2008) on NG transition; and creating collaborative support structures that begin in the academic setting and continue forward into the workplace during the first year of practice with guaranteed employment at the end of the first year of practice (Price, 2015).

The setting of my research has many structures and supports in place to support both NGs and the individuals who preceptor, mentor and support them. Specifically, the

setting of the NRT in my study provides formal training for preceptors focusing on the topics of: the different types of learners, advocating for a positive experience between preceptor and preceptee, identifying skills to support the integration and socialization of the preceptee, and learning the various assessment tools to evaluate the preceptee's nursing practice. The setting also provides a two-day Enhancing Leadership Course that reviews generation theory, the phases of novice to expert, diversity, conflict resolution, setting goals and learning objectives, and finally, time management and prioritization (S. MacLean, personal communication, October 17, 2016). In addition to the initiatives mentioned above, other creative strategies could be implemented to educate existing staff on the need for NG support. Such strategies may include utilizing social media such as Facebook ® to create a support and/or information group, and creating an educational video like that implemented by the IWK in 2014 which educates new and existing staff on the unique needs of the NG and how staff can positively impact their transition to practice (IWK Health Centre website, n.d.).

Implications for Education

Nursing students within their educational programs are not trained in one field or specialty area of nursing rather they are provided clinical experiences on various nursing units throughout their education which prepares them as generalist practitioners. Upon graduation NGs possess a broad exposure to the various nursing specialties and as such, this broad exposure may make the NGs more adaptable to float nursing. The practice of float nursing for NGs, however, has been largely discouraged citing the need for stable and consistent practice environments yet the reality of present day staffing challenges presents the very real possibility for the NG to float.

The participants in my study intentionally chose the NRT as their work place for a variety of reasons. However, when they were students, they were not aware of this option of employment. Career counseling for nursing students throughout their academic program is one identified need of new graduates and this strategy could help prepare students to consider a variety of employment options including the options to join a float pool or NRT (Price, 2015). Considering the unique needs and aspirations of the millennial generation, which often include the quest for change and growth, NRT nursing could be presented as a nursing specialty, offering the appeal of variety and choice.

A final implication arising from these findings is the need to educate NGs about the NG transition experience. Some of the participants in my study indicated they were aware of the NG transition but did not seem to recognize their experiences as aligning with established new graduate theories (Benner, 1984; Boychuk Duchscher, 2008; Kramer, 1974). It is therefore proposed that formal education on the NG transition experience be incorporated throughout nursing education, again coinciding with information on coping skills and available support structures.

Implications for Organizational Policy

The NGs in my study had described several forms of support they received as NGs in the NRT, yet because they did not have a home base or unit some described feeling isolated and not quite part of the core teams on each of the units they worked. The CNE for the NRT was a significant source of support for the NGs however, the responsibility for providing support – social, informational and educational - should be shared among the employer, unit managers, and core nursing staff of the nursing units to build a sense of connection for the NRT nurses. NGs are challenged not only with

transitioning to a new role but they must also learn the rules, routines, and the behaviors of the organization (Feng & Tsai, 2012; Phillips, Esterman, and Kenny, 2015). NGs have a strong need to belong and to be viewed as a member of the team (Feng & Tsai; Malouf & West, 2011). This may be compounded for NRT nurses who must learn the rules, routines and behaviors for several nursing units, not just one. NRT nurses are required to work on four to five nursing units within a cluster, therefore it is suggested that a formalized process be implemented to include NRT nurses in staff meetings for the nursing units within the clusters and to consistently include the NRT nurses in any updates or information pertaining to any units within the cluster.

To cope with unexpected fluctuations in staffing, patient acuity and or patient census, health care facilities may enforce a floating policy. Such a policy typically requires a nurse to float from his or her home unit to one that is experiencing the fluctuations listed above. The setting for my study has a float policy and an NRT – two different forms of float nursing with the former mandating a nurse to float and the latter staffed by nurses who choose to float within a cluster. As indicated by the NGs in my study, the lack of differentiation between the two practices had a negative impact on some. Some nursing units within the study setting viewed NRT nurses as more appropriate to float than core nursing staff and conflict arose when core-nursing staff was floated over an NRT nurse. It is recommended that a formal communication plan be implemented for each nursing unit to clarify the difference between the float policy and the role of the NRT. Additionally, as supported by the literature pertaining to new nurse graduates, it is suggested that policies be implemented to protect NGs from being floated outside their cluster during the first 12 months to two years of practice. Furthermore, it is

recommended that policy be developed to limit the number of nursing units within clusters. The ideal number of nursing units within a cluster has not been determined by research, however, based upon the participant experiences in this study, four to five nursing units was manageable for these NGs.

Implications for Future Research

Little is known of the NG experience in float nursing and the literature that does exist has largely discouraged the practice. Findings from this qualitative study indicate that float nursing, particularly NRT nursing, was an overall positive experience for the NG participants in my study. Valuable insight resulted from the rich descriptions provided by the NG. However, there is a need for further investigation and inquiry in regard to NGs and NRT nursing.

Further research is warranted to explore the impact of NRT nursing on NG transition. Potential future research questions include: does NRT nursing delay or facilitate the NG transition and what are the contributing factors? Some participants in my study perceived their transition was easier, even hastened, compared to that of their classmates hired onto single nursing units. A study comparing the NG transition of NGs hired into an NRT and the NG transition of NGs hired to single nursing units over a period of time – on hire, at three months, six months, nine months and finally twelve months, can provide insight into the impact NRT nursing has on the NG transition.

The participants in my study described the conflict they experienced when core nursing unit nurses were floated off unit rather than an NRT nurse. They described feeling as though they did not have a home base. A second qualitative descriptive study can be employed to obtain the perceptions the charge nurses, nurse managers, clinical

nurse educators and core nursing unit staff have regarding the NRT, the NRT nurses and NGs working in an NRT. An institutional ethnography study of the NRT and study setting may also be employed to provide insight into the social processes involved.

Thirdly, what impact does the NRT and NRT nurses have on patient and system outcomes? Mendez de Leon and Stroot (2013) state that hospitals that utilize resource team nursing “typically save between 2% to 5% of total nursing labor costs” (p. 76). If utilized and managed appropriately, Mendez de Leon & Stroot believe NRTs can also improve outcomes for both staff and patients. Baumann et al. (2005) had identified the elimination of the costly use of agency nurses post-implementation of the NRT. Dziuba-Ellis (2006) identified reduced overtime costs as a benefit to float nursing. However, further research is required to quantify and justify the cost-savings of utilizing NRTs. There is a known relationship between insufficient staffing levels and poor patient outcomes - failure to rescue, mortality rates, hospital-acquired pneumonia and other negative outcomes have been identified in the literature (Aiken et al., 2002; Blegen, Goode, Spetz, Vaughn, Park, 2011; CHSRF; Needleman et al., 2002; Needleman et al., 2011). Additional research both qualitative and quantitative is required to determine the impact of NRT nursing on patient and system outcomes, and on nursing sensitive indicators. Specifically: 1) what impact do NRTs have on patient outcomes; 2) do NRT nurses possess the necessary skill and knowledge levels to provide safe patient care; 3) what specific cost savings do organizations realize when utilizing NRTs; 4) what is the ideal number of nursing units within a cluster; and 5) what impact do NRTs have on workload, burnout, fatigue, and absenteeism of core nursing staff.

This study did not address nor consider the impact of resource team nursing on casual nursing staff. Casual nurses do not have a permanent employment status, but rather work hours as needed according to unit needs and/or according to their personal schedules. Casual nurses typically work on a specific nursing unit of their choice. This study did not inquire into whether casual nursing staff is hired into the NRT. However this cohort of nursing staff bears consideration in research given that hiring nurses into casual positions, including new graduates, has been a hiring practice in the absence of full-time positions and may have implications for new graduate transition. Some future research questions may include: (a) What are the experiences of nurses working within casual positions? (b) What are the experiences of new nurse graduates hired as casual staff? (c) What is the impact of NRT nursing on casual nursing staff? And (d) What are the minimum number of hours required for casual staff to become and remain competent in NRT nursing?

This study also did not inquire into the experiences of nurses working in a float pool. Float pools and nursing resource teams are two different staffing approaches to float nursing. A study comparing the structures and the experiences of nurses working in a float pool to the structures and experiences of working in a resource team can provide further insight into the two floating approaches and may or may validate the claim that nursing resource teams are the better approach to float nursing.

A final area of interest that may warrant research is the consideration of gender. The participants within this study encompassed seven female and one male new nurse graduate however, the impact of gender on choosing NRT nursing and on the experience of NRT was not considered nor explored. Specific questions may include: Does gender

impact the decision to choose NRT nursing and what impact, if any, does gender have on the experience of NRT nursing?

Strengths and Limitations of the Study

This qualitative descriptive study answered the research question “What are the experiences of new nurse graduates working in a nursing resource team?” This study provided an understanding of a topic that has not been previously explored within the literature. The experiences of the participants as they transitioned to practice validate those currently described in literature pertaining to the new graduate transition to practice. However, this study also extends the current knowledge by providing an understanding of the unique experiences of new nurse graduates working in a nursing resource team. This understanding provides insight into how we can best support NGs employed within a similar context – where they consistently practice on more than one unit. The rich descriptions of the new nurse graduate participants provided valuable insight into the advantages, challenges and considerations and aligned with new graduates’ experiences of working as part of a resource team/float pool.

According to Kornbluh (2015), the qualitative researcher seeks to understand a phenomenon by “examining the ways in which participants experience, perceive and make sense of their lives” (p. 397). However, assessing the quality of the research is challenging (Worthen, 2001 as cited by Kornbluh). Although the study was limited by having only one interview per participant, the semi-structured interview guide and the use of informal member checking throughout the interview process strengthened my ability to ensure trustworthiness. As I engaged with each participant during the interviews, I continually sought confirmation of my understanding of their experiences as they

described them to me. As a novice researcher, I engaged with my advisor throughout the data analysis process, ensuring my understanding and analysis was relevant and true to the participants' descriptions of their experiences. Although the findings of this study are specific to the study setting and the study participants, I recognize the transferability of the data to nurse work environments outside the study setting. As an administrator working within and with a float pool staffed by both experienced and novice nurses, I believe the findings of my study can be utilized as a framework to understand the needs of new graduate float nurses within my home facility.

However, there are limitations to this study that must be considered when interpreting the findings. It must be recognized that staffing challenges for nurses are not solely influenced by the nursing shortage, rather, health human resource challenges are influenced by the broader socio-political environment. The study results are limited to the particular setting of the study and to the participants in the study and therefore, cannot be generalized to other facilities utilizing NRT nursing. This study provides but one aspect of NGs working in NRT nursing and the results may not be representative of all NGs working in NRT nursing.

The study setting was located outside the home province of the researcher, therefore, by necessity data collection was obtained through telephone interviews. This may have placed some limitation on the fulsomeness of the data obtained. Not having the ability to conduct the interviews in person prevented the opportunity to observe non-verbal cues that may have added to the data. The interview guide selected for this study countered this limitation to some degree. The use of a semi-structured interview guide allowed for open questions and prompts by the researcher to encourage discussion.

The results of this study, although representative of just a small number of NGs, provide insight into the NG experience of float nursing that did not currently exist. The limitations of the study do not preclude the value of the data rather the limitations aid the reader in placing the findings in perspective and can be used to inform future practice, education, policy, and research initiatives.

Conclusion

This qualitative descriptive research study provided valuable insight into a previously unknown aspect of NG experiences – the experience of working in float nursing from the new nurse graduate perspective. The discussion revealed that regardless of where new nurse graduates are employed, the experience of transition adjustment is a reality for NGs. The structure and processes within the NRT were such that the NGs described their orientation as appropriate for preparing them to function independently and the support they received from the CNE of the NRT was invaluable.

Although float nursing has largely been discouraged as a practice area upon graduation, the participants in my study deliberately chose to begin their professional practice in an NRT. Varying reasons for this decision were described, however, the fact remained that NRT nursing was the choice of the NG participants. The participants in this study were also all representative of the millennial generation who has been characterized as seeking variety, stimulation, and support in their employment thus potentially positioning NRTs as a fit for this generation of nurses.

The results of this study hold several implications for practice, education, organizational policy and future research. Educating charge nurses and core nursing unit staff on the NG transition experience may provide a new understanding of what to expect

of the NG and what the NG is capable of. Exposing nursing students to NRT nursing during academic and clinical training may help acclimate nursing students to the option of float nursing. Career counseling for nursing students, identifying the various forms of nursing employment, such as NRT nursing, is also recommended to prepare nursing students for the realities of the work environment. To best support NGs in NRTs healthcare facilities that utilize both a float policy and NRT nursing must strive to create better understanding of the distinction between the float policy and the role of the NRT and NRT nurses. Healthcare facilities must also ensure there is a concerted and collaborative effort between management, nursing unit staff, and clinical nurse educators to provide for the support – social, educational, informational, and organizational – of nurses working in the NRT. Finally, this study highlighted several areas for future research: comparing the NG transition experience for NGs working in an NRT and NGs working on single units; exploring the impact of NRT nursing on patient outcomes; obtaining the perceptions of charge nurses, CNEs, nurse managers, and core nursing staff on the value of NRT nurses; and exploring the efficiency of utilizing NRTs.

To my knowledge, this is the first study to obtain the experiences of working in a nursing resource team from the perspective of the new nurse graduate. This study provides some insight for nurse leaders, educators, and employers into the unique experiences of NGs working in an NRT and can provide a platform for further research and decision making in regards to new graduate transition support and contingency staffing models such as float pools. The understanding derived from this study provides insight into how we can best support new graduates as they enter practice settings and

provides insight into employment situations designed to be responsive to the current healthcare environment and health human resource needs.

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Capital Health

DO YOU WORK IN THE NURSING RESOURCE TEAM?

or

HAVE YOU WORKED IN THE NURSING RESOURCE TEAM?

If the answer is “YES” and you have graduated from a B.N. program between May 2012 –May 2014 and have been hired into the NRT between November 2012 and June 2014, you are invited to participate in the following study:

THE EXPERIENCES OF NEW NURSE GRADUATES WORKING IN A NURSING RESOURCE TEAM

My name is Stephanie Goguen and I am a Masters of Nursing student of Dalhousie University. I live and practice in Saint John, New Brunswick and I am conducting my research at your institution. I am currently looking for individuals to participate in my research study: “The Experiences of New Nurse Graduates Working in a Nursing Resource Team.”

It is a well-researched and documented fact that many new nurse graduates experience a period of transition as they adjust to the role of professional practitioner. What is not well known is the experience of the new nurse graduate who is hired into and working within nursing resource teams. To better understand this experience and the impact on new nurse graduates, I am seeking individuals to take part in my research study.

If you are interested in participating, please contact the Clinical Nurse Educator of the Nursing Resource Team to receive a study information package and my contact information.

I thank you for your time!

Stephanie Goguen, BN/RN/MN Student

[Appendix B](#)



Capital Health

Date:

Stephanie Goguen, BN/RN/MN Student
139 Neck Road,
Summerville, NB E5S 1B1

LETTER OF INVITATION

Dear Sir or Madam:

My name is Stephanie Goguen and I am a Master of Nursing student of Dalhousie University and I am conducting a research study entitled “The Experiences of New Nurse Graduates Working in a Nursing Resource Team.” Although I live and practice in Saint John, New Brunswick, I am interested in conducting my study at your institution. I am conducting a study to better understand the work experiences of new nurse graduates who have been hired into and who have worked or are currently working in the nursing resource team. As a former float nurse I became fascinated with the process and have an appreciation for the rewards and challenges of this type of nursing.

It is a well-researched and documented fact that many new nurse graduates experience a period of transition as they adjust to their new role of professional practitioner. However, what is not as well-known is the experiences of new nurse graduates who work in nursing resource teams. To better understand this experience, the impact on the new nurse graduate, and the needs of the new nurse graduate, I am inviting you to participate in my study.

Participation in my study would require one telephone interview, at my cost, of approximately 60-90 minutes in length. Interviews will be audiotaped and later transcribed. You will be assigned a pseudonym of your choice for anonymity. This pseudonym will be used during the actual interview. Participation is voluntary and you may withdraw from the study at any time. Participation or refusal of participation will in no way affect your employment.

If you are interested in this study and would like to learn more, please contact me through email at st806470@dal.ca and we can arrange a date and time that I can contact you by telephone. If after our discussion you wish to participate, I will review the consent form with you and we will arrange a date and time convenient for you to begin the study.

Regards,



Capital Health

**THE EXPERIENCES OF NEW NURSE GRADUATES WORKING IN
A NURSING RESOURCE TEAM
PARTICIPANT SCREENING FORM**

Date of Screening: _____

QUESTION	YES	NO
1. Are you 19 years of age or older?		
2. Have you graduated from a Baccalaureate of Nursing Program between May 2012-May 2014?		
3. Were you hired directly into the nursing resource team?		
5. Are you still working in the nursing resource team?		
6. Can you read and write in English?		
7. Are you interested in discussing the study with the Principal Investigator?		
8. May the Principal Investigator contact you to review the study?		

Participant Contact Information:

Name _____

Email: _____

Telephone Number: _____

Mailing Address: _____

Study Package Received? YES NO

Appendix D

Informed Consent Form Non-Interventional Study

STUDY TITLE: The Experiences of New Nurse Graduates Working in a Nursing Resource Team

PRINCIPAL **Stephanie P. Goguen, BN/RN/MN student**

INVESTIGATOR **139 Neck Road, Summerville, NB, E5S 1B1**
st806470@dal.ca; (506) 648-6744

FUNDING AGENCY: **This study is funded by the Nursing Research & Development Fund Development Grant from Dalhousie University**

1. Introduction

You have been invited to take part in a research study. A research study is a way of gathering information on a treatment, procedure or medical device or to answer a question about something that is not well understood. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This informed consent form explains the study.

You may take as much time as you wish to decide whether or not to participate. Feel free to discuss it with your friends and family. The study staff will tell you if there are any study timelines for making your decision.

Please ask the study staff or the Principal Investigator to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this research study.

The researchers will:

- Discuss the study with you
- Answer your questions
- Keep confidential any information which could identify you personally
- Be available during the study to deal with problems and answer questions

You are being asked to consider participating in this study because you have graduated from a baccalaureate of nursing program between May 2012 and May 2014 and have worked or are currently working in a nursing resource team.

If you decide not to take part or if you leave the study early, your employment will not be impacted in any way.

If you wish to withdraw from this study, any and all study data collected up to the point of withdrawal will continue to be used by the research team. It will not be removed.

2. Why Is This Study Being Conducted?

The primary objective of this study is to better understand the experiences of new nurse graduates who have been hired into and have worked or are working in a nursing resource team. It is a well-researched and documented fact that many new nurse graduates experience a period of transition as they adjust to their new role of professional practitioner. However, what is not as well known are the experiences of new nurse graduates working in nursing resource teams. The purpose of this study is to better understand this experience; the needs of new nurse graduates working in nursing resource teams and the impact on the new nurse graduate.

3. How Long Will I Be In The Study?

Participation in this study will involve one telephone screening conversation and one telephone interview of approximately 60-90 minutes duration.

The length of this study for participants is a one-time telephone interview and the entire study is expected to take about 12 months (from data collection to reporting of results).

4. How Many People Will Take Part In This Study?

It is anticipated that about 8 to 12 local people will participate in this study at the Queen Elizabeth II.

5. How Is The Study Being Done?

This study is a Qualitative Descriptive study in which participants are asked to describe their experiences to the Principal Investigator in one-on-one telephone interviews guided by a semi-structured interview format.

6. What Will Happen If I Take Part In This Study?

The Principal Investigator has travelled to the Queen Elizabeth II health care facility to present the study “The Experiences of New Nurse Graduates Working in a Nursing Resource Team”, describing the study and the purpose of the study. A Letter of Advertisement was posted in the Nursing Resource Team inviting all NRT employees to contact the Clinical Nurse Educator of the NRT to obtain the contact information for the Principal Investigator and a sealed study package containing: a Letter of Invitation, this consent form, and a pre-stamped pre-addressed envelope.

Participation in this study will involve:

- A Screening process
- A Consenting process
- A Telephone Interview

Screening: Upon initial contact with the Principal Investigator, you will be asked the following questions:

- have you graduated from a baccalaureate of nursing program between May 2012 and May 2014;
- were you hired into the nursing resource team between November 2012 and June 2014;
- are you still working in the nursing resource team;
 - How long have you worked/did you work in the Nursing Resource Team
- can you read and write in English;
- are you interested in discussing this study with the Principal Investigator?

Consenting Process: If after the Principal Investigator has reviewed the study with you and you wish to participate, the Principal Investigator will review the consent form with you over the telephone. You will be asked to sign the last page of the consent form and to return the consent form with your signature to the Principal Investigator. You will have two options for returning the consent form: 1) you may fax the consent form to the Principal Investigator; or 2) you can forward the signed consent form to the Principal Investigator in the pre-stamped, pre-addressed envelope that was included in your study package.

Telephone Interviews: Study participation will involve one 60-90 minute telephone interview guided by a set of questions designed to have you describe your experiences of working in a nursing resource team. The Principal Investigator will telephone you and will bear the cost of the telephone charges involved.

The telephone interviews will be audiotaped to ensure accuracy of data collection. The data will be later transcribed verbatim with guaranteed anonymity. You will be assigned a pseudonym of your choice for anonymity.

The interview guide consists of demographic questions (age, marital status, previous work experience, educational institution, educational background, length of employment in resource team, employment status), your decision to work in a nursing resource team, supports provided to you while working in the nursing resource team, the type of orientation received, barriers to working in a nursing resource team, benefits of working in a nursing resource team, and your experiences as a new nurse graduate working in a nursing resource team.

As a participant in the study “The Experiences of New Nurse Graduates Working in a Nursing Resource Team”, you are free to choose not to participate in any further interviews at any time.

7. Are There Risks To The Study?

Breach of confidentiality: As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk. Protecting your privacy is an important part of this study and your confidentiality will be respected. Pseudonyms will be assigned to each participant in the audiotapes, transcripts, field notes of the Principal Investigator, and published findings. Direct quotes used by the Principal Investigator in the study results will not include information that could identify you. Your personal information and interview data will be maintained in a locked, secure area.

This study is a requirement of the Principal Investigator’s Graduate program. As such, the Principal Investigator and Co-investigators (thesis advisor and thesis co-advisor) will be reviewing this information.

Interviews: You may find the interviews upsetting or distressing. You may not like all of the questions that you will be asked. You do not have to answer those questions you find too distressing.

By signing this consent form you are in no way waiving your legal rights or releasing the Principal Investigator from her legal or professional responsibilities.

8. Are There Benefits Of Participating In This Study?

There is no guarantee that you will directly benefit from participating in this study, however, some may find it beneficial to share experiences in a safe, non-threatening environment. Although there may not be a direct personal benefit, future new nurse graduates may benefit from the results of this study.

9. What Happens at the End of the Study?

If you wish to receive a summary of the findings at study completion, please notify the Principal Investigator during the interview process.

It is anticipated that the results of this study will be published and or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.

10. What Are My Responsibilities?

As a study participant you will be expected to:

- Follow the directions of the Principal Investigator
- Report any problems that you experience that you think might be related to participating in the study
- Provide truthful and honest responses to study questions

11. Can My Participation in this Study End Early?

Yes. If you chose to participate and later change your mind, you can say no and stop the research at any time. If you wish to withdraw your consent please inform the Principal Investigator. Data collected up to that point will continue to be used by the research team and will be included in the study results. You will not be identified.

A decision to withdraw from the study will not affect any work performance evaluations you may have.

Also, the Capital Health Research Ethics Board or the Principal Investigator has the right to stop participant recruitment or cancel the study at any time.

Lastly, the Principal Investigator may decide to remove you from this study without your consent for any of the following reasons:

- In the opinion of the Principal Investigator you are experiencing side effects that are harmful to your health or well-being;
- There is new information that shows that being in this study is not in your best interests;

If you are withdrawn from this study, the Principal Investigator will discuss the reasons with you and plans will be made for your continued care outside of the study.

12. What About New Information?

If the study is changed in any way that could affect your willingness to stay in the study, you will be told about the changes and may be asked to sign a new informed consent.

14. Will It Cost Me Anything?

Compensation

Participation in this study will not involve any additional costs to you. The Principal Investigator will bear the telephone charges incurred during data collection.

Research Related Injury

If you become ill or injured as a direct result of participating in this study, necessary medical treatment will be available at no additional cost to you. Your signature on this form only indicates that you have understood to your satisfaction the information regarding your participation in the study and agree to participate as a subject. In no way does this waive your legal rights nor release the Principal Investigator, the research staff, or involved institutions from their legal and professional responsibilities.

15. What About My Privacy and Confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. No identifying information (such as your name) will be sent outside of this health care facility. If the results of this study are presented to the public, nobody will be able to tell that you were in the study.

However, complete privacy cannot be guaranteed. For example, the investigator may be required by law to allow access to research records. If you decide to participate in this study, the investigator(s) and study staff will look at your personal information and collect only the information they need for this study. "Personal health information" is health information about you that could identify you because it includes information such as your;

- Name,
- Address,
- Telephone number,
- Age or month/year of birth (MM/YY),
- Information from the study interviews and questionnaires;

When you sign this consent form you give us permission to:

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety while participating in this research.

Access to Records

Other people may need to look at your personal information to check that the information collected for the study is correct and to make sure the study followed the required laws and guidelines. This study is an educational requirement for the Principal Investigator

thus members of the research team will have access to the data collected to verify accuracy. These people include:

- Thesis Advisor
- Thesis Co-Advisor.
- The Capital Health Research Ethics Board (CHREB) and people working for or with the CHREB because they oversee the ethical conduct of research studies at Capital Health;

Use of Your Study Information

The research team will collect and use only the information they need to complete this research study. "Study data" is information about you that is collected for the study, but that does not directly identify you.

Any study data about you that is sent outside of Capital Health will have your pseudonym and will not contain your name or address, or any information that directly identifies you.

The investigator(s), study staff and the other people listed above will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

The research team will keep any personal information about you in a secure and confidential location for 7 years then destroy it according to Capital Health policy. Your personal information will not be shared with others without your permission.

When the results of this study are published, your identity will not be disclosed.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please notify the Principal Investigator Stephanie P. Goguen, Horizon Health Network, st806470@dal.ca or (506) 648-6744.

The Research Ethics Board and people working for or with the Research Ethics Board may also contact you personally for quality assurance purposes.

Your access to records

You may ask the Principal Investigator to see the information that has been collected about you. You may ask to make corrections to this information by talking with a member of the research team.

16. Declaration of Financial Interest

The Nursing Research & Development Operating Grant fund of Dalhousie University has provided funding for this study. The amount of payment is sufficient to cover the costs of conducting the study.

17. What About Questions or Problems?

For further information about the study call Stephanie Goguen. Stephanie Goguen is in charge of this study at this hospital (she is the “Principal Investigator”). Stephanie Goguen’s work telephone number is (506) 648-6744. If you can’t reach the Principal Investigator, please refer to the attached Research Team Contact Page for a full list of the people you can contact for further information about the study.

18. What Are My Rights?

You have the right to receive all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision. You also have the right to ask questions and to receive answers throughout this study.

After you have signed this consent form you will be given a copy.

If you have any questions about your rights as a research participant, contact the **Patient Representative** at **(902) 473-2133**.

In the next part you will be asked if you agree (consent) to join this study. If the answer is “yes”, you will need to sign the form.

19. Consent Form Signature Page

I have reviewed all of the information in this consent form related to the trial called:

The Experiences of New Nurse Graduates Working in a Nursing Resource Team

I have been given the opportunity to discuss this study. All of my questions have been answered to my satisfaction.

This signature on this consent form means that I agree to take part in this study. I understand that I am free to withdraw at any time without affecting my future employment.

I agree to audio recordings as described in this consent form.

I do not agree to audio recordings as described in this consent form

/ ____ / ____

Signature of Participant

Name (Printed)

Year Month Day*

/ ____ / ____

Signature of Investigator

Name (Printed)

Year Month Day*

/ ____ / ____

Signature of Person Conducting
Consent Discussion

Name (Printed)

**Note: Please fill in the dates personally*

I Will Be Given a Signed Copy of This Consent Form

[Appendix E](#)

SEMI-STRUCTURED INTERVIEW GUIDE

**The Experiences of New Nurse Graduates
Working in a Nursing Resource Team**

1. Review of consent form and clarify any issues/concerns regarding the research and participation in the research.

2. Demographic questions:

Age	
Marital status	
Educational institution participant graduated from	
Previous educational background	
Previous work experience (healthcare, sales, office work, etcetera)	
When were you hired into the nursing resource team?	
How long have you been working in the nursing resource team?	
Are you full-time, part-time, or casual	

3. What made you decide to join the nursing resource team? What influenced your decision?

4. What kind of orientation did you receive to the nursing resource team?

- a. What did your orientation include?
- b. How many floors were you orientated to and what floors were you orientated to?
- c. How long was your orientation to each floor?
- d. Who guided your orientation on each floor (i.e. assigned a preceptor)?

5. What was your first shift post-orientation like working as an NRT nurse? What were your thoughts, feelings?

6. What kinds of support do you or did you have when you first started working as a new grad in the nursing resource team? (i.e. personal, professional, mentorship program)
 - a. What were your relationships like with preceptors, mentors, superiors?
 - b. How prepared were you to work on your own?
 - c. What kind of support(s) do you have now?
7. How would you describe a typical shift? What is your routine?
 - a. How often do you go to areas to which you never received an orientation?
 - b. What are your relationships like with staff from the units you go to?
8. What was it like being a new graduate in the workforce? What was it like being a new graduate working in the nursing resource team?
 - a. How has working in a nursing resource team affected your transition from the role of nursing student to the role of professional practitioner?
 - b. What things, if any, do you need that you are not receiving?
 - c. How are you notified of any educational sessions (i.e. skills reviews, annual e-learning programs)?
 - d. How are you evaluated?
9. What is the most difficult thing or things about working in a nursing resource team? As a new grad?
 - a. What situations, if any, make you uncomfortable working as a new grad in a nursing resource team (i.e. going to areas without orientation, handling situations you've not experienced before)?
10. What are the barriers or challenges of working in the nursing resource team as a new grad?
 - a. what would you change, if anything?
 - b. What would you add?
11. What are the positive aspects or facilitators of working in the nursing resource team as a new grad?
 - a. What skills, knowledge, and attributes have helped you during this experience?
12. What do new grads need when working in the nursing resource team?
 - a. What would you tell future new grads about coming to the nursing resource team?
 - b. What would you like management to know about new grads working in a nursing resource team?

13. What would you like to ask me?