Transition Shock – Hitting the Ground Running
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Abstract

Since the early 1990’s newly graduated Registered Nurses in Australia have struggled with the transition from the protected ‘thinking orientated’ environment of academia to the clinical ‘practice orientated’ environment in the real world of nursing. The current educational system no longer fosters the traditional and informal passing down of knowledge and clinical expertise that was evident in hospital based training. Due to increased student nurse enrolments hospitals have trouble placing the increased number of students – therefore less clinical placements are available and students are completing degrees with minimal clinical exposure. The theory-practice divide that exists has created disparity between the expectation of the workplace and how well graduates are prepared for it. The need for graduates to ‘hit the ground running’ has manifested into a phenomenon coined ‘Transition Shock’ where the fear of making a mistake and feeling unsafe can be crippling to a new graduates confidence and self-image. Professional socialisation, the students ability to assimilate to the workforce environment, is identified as a potential buffer to Transition Shock, as are Graduate Nurse Programs, both of which are explored in this informative essay.

The transition between the protected ‘thinking orientated’ environment of academia to the clinical ‘practice orientated’ environment has proved difficult for graduate Registered Nurses (RNs) for many years (Levett-Jones & Fitzgerald, 2006; Nicol & Young, 2007). This essay will discuss the phenomenon of ‘Transition Shock’ and the contemporary issue of whether graduate RNs are prepared for the reality of the healthcare workforce and the expectation that graduates will ‘hit the ground running’. Firstly a brief history of nursing education will be detailed and socio-political influences will be identified. An analysis of the impact Transition Shock can have on personal nursing practice will be explored. Finally future consequences and attrition and retention rates of graduates will be discussed.

The watershed 1984 decision to move nursing education from the hospitals into the tertiary sector, has seen all Registered Nurses (RN’s) in Australia since 1994 educated to the undergraduate bachelor degree level (Fetherstonhaugh, Nay & Heather, 2008; Gaynor, Gallasch, Yorkston,
Stewart & Turner, 2006; Levett-Jones & Fitzgerald, 2006; Nicol & Young, 2007). This educational move created disparity between the expectation of the nursing workplace and how well graduates are prepared for it. (Cowan & Hengstberger-Sims, 2006; Stacey & Hardy, 2011). From this a phenomenon labeled ‘Transition Shock’ or ‘Reality Shock’ emerged as a common theme (Collins & Zournazis, 2005; Cowan & Hengstberger-Sims, 2006; Duchscher, 2008; Fetherstonhaugh et al., 2008; Gaynor et al., 2006; Halfer & Graf, 2006; Levett-Jones & Fitzgerald, 2006). Reality shock was first reported in 1974 when Kramer (1974) defined it as ‘the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not’.

To understand the socio-political influences it is necessary to examine the history of nursing education. Prior to 1994 nursing education in Australia was undertaken in hospital Schools of Nursing, in an apprenticeship model were students were employed as part of the hospital workforce (Fetherstonhaugh et al., 2008). This model produced RN’s that were well trained and familiar in the practical aspects of nursing (Fetherstonhaugh et al., 2008). During the 1970’s and 80’s concerns began to grow amongst nursing peak bodies that nursing graduates were showing limitations in the theoretical aspects of nursing and that these nurses would develop a narrow understanding of clinical nursing practices (Fetherstonhaugh et al., 2008). It was argued that for nursing to gain ‘professional’ status, nursing education would need to take place in the tertiary sector where educators would be better able to facilitate student’s development of knowledge and safe practice by effective use of theory and research (Fetherstonhaugh et al., 2008). As with other professions evidence-based practice would be taught and measureable against research (Fetherstonhaugh et al., 2008). In order to address the narrowing understanding of nursing practice and in contrast to hospital based training, it was decided that tertiary nursing students would be
placed in a variety of clinical settings over short periods of time throughout their education (Fetherstonhaugh et al., 2008).

Undergraduate nursing education today entails completion of a three year undergraduate degree and is designed to prepare students to be advanced beginning level practitioners (Johnstone, Kanitsaki & Currie, 2008; Newton & McKenna, 2009). Graduates are expected to have the ability to critically think and have the capability to make independent clinical decisions to ensure patient safety (Etheridge, 2007; Newton & McKenna, 2009). As nursing becomes increasingly technological and scientifically based, graduates require a greater educational focus on science and technology. (Johnstone et al., 2008). This is in contrast to previous nursing education where nursing experience was viewed as more important to patient outcomes than educational knowledge (Cowin & Hengstberger-Sims, 2009). But it is well documented that the move from the protected environment of undergraduate student nurse to graduate RN has significant discrepancies between what is understood about nursing from tertiary education and the reality of healthcare service delivery (Cowan & Hengstberger-Sims, 2006; Duchscher, 2008; Fetherstonhaugh et al., 2008; Hodges, Keeley & Troyan, 2008; Levett-Jones, 2006; Madsen, McAllister, Godden, Greenhill & Reed, 2009; Nicol & Young, 2007; Stacey & Hardy, 2011). The educational system no longer fosters the traditional and informal passing down of knowledge and clinical expertise that was evident in hospital based training (Newton & McKenna, 2007). Due to increased student nurse enrolments in response to work-force shortages hospitals have trouble placing the increased number of students – therefore less clinical placements are available and students are completing degrees with minimal clinical exposure (Nicol & Young, 2007). Graduates report that experiences in the universities simulated laboratory environment do not accurately reflect the complexities, challenges, emotions and conflicts that are the reality of the clinical environment (Newton & McKenna, 2007). Rochester, Kilstoff and Scott (2005) suggest that social and personal emotional
intelligence gained from experience is not adequately addressed within undergraduate education. Further to this both new graduates and experienced RN’s have expressed concerns about the degree to which new graduates are able to function as RN’s upon graduation (Evans, Boxer & Sanber, 2007). These disparities between optimal professional nursing practice and the reality of nursing care have been aptly referred to as the theory-practice divide (Newton & McKenna, 2009). The gap between which is often fraught with feelings of anxiety, inadequacy and insecurity (Duchscher, 2008, Edgecombe & Bowden, 2009; Levett-Jones, 2006; Madsen et al., 2009; Stacey & Hardy, 2011).

The most significant impact to personal nursing practice is felt during the initial three to four month period of the graduate year when the fear of making a mistake and feeling unsafe can be crippling to a new graduates confidence and self-image (Duchscher, 2008; Levett-Jones, 2006; Newton & McKenna, 2007). Levett-Jones (2006) further adds that the first three to six months is the most critical period for ultimately creating a commitment to a career in nursing. During this vital period students report that they were unaware of the complexity of thinking and problem solving that occurs in the clinical setting, and that they are often unable to think on their feet and change a planned way of doing something in response to what is happening with a specific patient (Etheridge, 2007; Evans, Boxer & Sanber, 2007). Experiences of stress related to the acuity of patients, concerns over quality of patient care and time management issues are common (Gaynor et al., 2006; Halfer & Graf, 2006; Newton & McKenna, 2007). Particularly difficult for students is the responsibility of caring for a five or six patient case load and the assumption that graduates are professionally socialised and confident to be able to communicate with physicians and other members of the multidisciplinary team (Newton & McKenna, 2007).

Stacey and Hardy (2011) describe professional socialization as the molding of newcomers to conform to the systems in place and learning the rules, written and unwritten, in order to act in
accordance with the expectations of the profession. Cowan and Hengstberger-Sims (2006) simply state professional socialisation is the ability of the student to assimilate to the healthcare culture. Newton and McKenna (2009) report that socialising into the graduate nursing role is a process that begins with an initial period of self absorption. Graduates focus on themselves and their clinical skills and coping with the realities of practice for the first six months of the transition (Newton & McKenna, 2009). After the first six months the focus shifts to the bigger picture of patient care and relationships. Critical thinking and professional development become easier as graduates begin to work independently (Newton & McKenna, 2009).

Madsen et al. (2009) highlight the need to adequately socialise nursing students into the professional environment is the responsibility of the tertiary education providers. Unfortunately, short clinical placements which were seen as desirable in avoiding the narrowing focus of the hospital trained nurse can result in graduates who are unfamiliar with the day to day operations of healthcare environments and spend a significant amount of time learning their place in the social structure (Hodges et al., 2008; Newton & McKenna, 2007). For this reason the scheduling of clinical placement less than 4 weeks at any time of the degree may not be best practice (Levett-Jones, Lathleen, Higgins & McMillan, 2008; Rydon, Rolleston & Mackie, 2008). Despite this universities claim constraints around exposing students to longer clinical placements include escalating costs of providing clinical supervision staff and the concurrent shortage of qualified nurses to support students in practice (Levett-Jones et al., 2008). More recently Australian universities are including a period of extended clinical placement in the final semester of the degree, but Levett-Jones et al. (2008) argue that waiting until that late stage may not maximize the potential for purposeful clinical learning. Although it is argued that it is not the clinical placement hours that matter, but the quality of the experience (Levett-Jones et al., 2008).
Halfer and Graf (2006) report that the most difficult and stressful aspect of professional socialisation reported by American graduate nurses was a lack of experience interacting with physicians. This can become a patient safety issue as graduates may avoid contacting physicians until a situation is serious due to their own insecurities and lack of confidence to contact them earlier (Dyess & Sherman, 2009). This is echoed in Australian research by Kelly and Ahern (2008) and Cowan and Hengstberger-Sims (2005). Further studies have identified another major component graduates felt they were unprepared for in the initial transition period as being decision making and the responsibility of the RN role (Cowin & Hengstberger-Sims, 2006; Dyess & Sherman, 2009; Kelly & Ahern, 2008). As students, the graduates had not been required to make clinical decisions and spent all of their time on clinical placement buddied with experienced RN’s and clinical facilitators who were decision makers (Kelly & Ahern, 2008). Graduates have reported feeling overwhelmed and professionally isolated when not knowing what to do in a situation and feeling that there is no one to guide them (Dyess & Sherman, 2009). This is particularly evident in complex units where graduates are faced with high care patients requiring a number of critical clinical judgments on a regular basis (Dyess & Sherman, 2009). Due to cost containment issues and staff shortages the pressure is on hospitals and health service providers to limit orientation periods for new employees therefore graduates are entering clinical settings where they assume responsibilities that are potentially beyond their capabilities (Dyess & Sherman, 2009).

Traditionally graduates would not have been employed in specialized areas requiring high-level decision making skills until later in their careers (Cowin & Hengstberger-Sims, 2006). But in today’s nursing environment of nursing shortages and extensive workloads neophyte nurses may be required to take on leadership roles early in their careers (Cowin & Hengstberger-Sims, 2006).

One mechanism designed to support new graduates in their transition from university to the workforce and to bridge the aforementioned theory-practice divide are graduate transition programs
In Australia transition programs offered by state health departments and other healthcare service providers have become accepted as the most appropriate way for graduate RN’s to enter the workforce as they are designed to facilitate professional adjustment, develop confident and competent RNs which in turn develops a commitment to the career of nursing (Levett-Jones, 2006). Johnstone et al. (2008) add the graduate nurse transitions programs should provide a platform to successfully transfer theoretical knowledge into practice in a supportive and non-threatening environment. Further highlighted is that data strongly suggests integration of new nurses into the organizations systems and processes is best provided within the first four weeks of the graduate program (Johnstone et al., 2008).

Unfortunately Levett-Jones (2006) reports that current graduate transition programs across Australia are inconsistent and vary significantly between states and territories. Clinical rotations vary in length, number and type as do preceptorships, mentorships, supernumerary time and formal orientation programs (Levett-Jones, 2006). While students are aware that they need a high level of support to make the transition to competent RN some graduate transition programs are falling short in providing adequate support (Levett-Jones, 2006). Johnstone et al. (2008) reiterate that support during the graduate transition programs is crucial as it acts to improve job satisfaction, commitment, motivation and importantly develop confidence.

Another potential buffer to transition shock is the use of reflection and reflective practice (Mann, Gordon & MacLeod, 2009). Collins and Zournazis (2005) agree that nurses who prepare well for their new roles by debriefing and keeping a reflective journal are less likely to suffer from transitional stressors and more likely to enjoy long rewarding careers in nursing. It is reported that reflective practice acknowledges the need for students and graduates to think professionally and integrate theory and practice from the outset and throughout their learning (Mann et al., 2009). Due to the success of reflective practice in assisting the learning of nursing students, graduates and also
experienced nurses, reflective activities have been incorporated into the Australian Nursing and Midwifery (ANMC) National Competency Standards for Registered Nurses as well as undergraduate and postgraduate continuing education over recent years (ANMC, 2005; Mann et al., 2009). Stacey and Hardy (2008) propose a form of reflective practice involving the use of digital storytelling to enable graduate nurses to identify personal strategies from previous graduates’ experiences to better manage the transition period. This form of reflective practice offers newly graduated nurses the opportunity to reflect on and relate to experiences of other newly graduated nurses in the form of digitally recorded reflective diaries (Stacey & Hardy, 2011). The graduates are able to make connections between their personal and professional lives by sharing the similar experiences and feelings of others (Stacey & Hardy, 2011).

Graduate RNs are the future of nursing and with the predicted ‘baby boomer’ generation retirement in the next 10 to 15 years a significant proportion of the current nursing workforce will leave the profession (Gaynor et al., 2006). Retention of graduates to avoid exacerbating the current and future nursing workforce shortages is critical (Gaynor et al., 2006). Rouse and Rooda, (2010) suggest that an increase of 30% in the number of nurse graduates will be needed by 2016. The increasing complexity of the healthcare environment demands work readiness from its neophyte nurses and that nursing graduates will ‘hit the ground running’ which poses the constant risk that new nurses will leave the profession during these struggles (Cowan & Hengstberger-Sims, 2006; Hodges et al., 2008). Madsen et al. (2009) report that attrition rates of nursing graduates within the first year of practice in Australia are as high as 20%, and other research suggests figures are as high as 60% in the USA (Halfer & Graf, 2006; Hodges et al., 2008; Rouse & Rooda, 2010). The initial stage of a nurse’s career shapes their professional identity and the values that represent their philosophy of nursing (Stacey & Hardy, 2011). Negative transitional experiences and poor role models result in personal disillusionment and the development of cynical attitudes towards the role
(Stacey & Hardy, 2011). The consequences for nurses who remain in the profession can include developing negative person-centred values that can have detrimental effects on quality of compassionate care (Stacey & Hardy, 2011). Nursing is more stressful, intense and technological than ever before and graduates are expected to cope, even as some of their more senior colleagues struggle with contemporary healthcare (Cowin & Hengstberger-Sims, 2006; Levett-Jones, 2006). In order to prevent increased attrition rates and improve job satisfaction and stress levels for graduate RNs there needs be an effective partnership between nursing education and workplaces to take responsibility for the work-readiness that is demanded of graduates (Cowan & Hengstberger-Sims, 2006).

In conclusion it is evident that collaboration between academics and clinicians is essential for the smooth transition from graduate RN to competent and confident practitioner. Graduates can help themselves by employing reflective practice techniques and ultimately improving their chances at a long rewarding career in nursing. Something that is crucial in the upcoming environment of worldwide critical nursing shortages.

References


