2005

Transition From Advanced Beginner to Competent Nurse in the Labor and Delivery Unit

Janice McMillin

The University of San Francisco

TRANSITION FROM ADVANCED BEGINNER TO COMPETENT NURSE IN THE LABOR AND DELIVERY UNIT

A Dissertation

Presented to

The Faculty of the School of Education

Learning and Instruction Department

In Partial Fulfillment

of the Requirement for the Degree

Doctor of Education

by

Janice McMillin

San Francisco

May 2005

This dissertation, written under the direction of the candidate's dissertation committee and approved by members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

Janie A. McMillen — 4-28-05

Candidate — Date

Dissertation Committee

Susan Evans — 4.28.05

Chairperson

[signature] — 4/28/05

Mary Peter Traviss, OP — 4/28/05

ACKNOWLEDGMENTS

I feel relieved and thrilled to have finally completed my dissertation. Although it has been a long, tough journey, I would not change a moment of the experience. I am indebted to many people that helped and supported me along the way. First, I want to thank my family. My wonderful husband, Mike, has been exceptionally patient, when I have been stressed; caring, when I have needed a hug, and supportive to me when I had technology challenges. My parents, John and LaVerne Mahony, their love, pride and support have been the fountain of my confidence and strength to achieve.

I am most grateful to Dr. Susan Evans, my advisor and my mentor, whose wisdom and strength affects me in a deep and profound way. Her advice and humor got me through the times when I was confused and in doubt of myself. Her diligence in editing my papers has improved my writing tremendously. I want to express my gratitude to Dr. Mathew Mitchell, for inspiring me to enhance my presentations, and add a little something extra. His conscientiousness and devotion set a standard that I strive to achieve. I want to say big thank you to Sr. Mary Peter Traviss, who agreed to serve on my committee in spite of her impossibly busy schedule and made me feel my dissertation was special and important to her. I would like to thank Dr. Mollyn Bohnen and Dr. Louise Timmer, who recommended the L&I program to me and acted as my mentors. They have given me so much warmth, support and encouragement over many years that I am in debt to them forever. I would like to thank my coworkers at Methodist Hospital, thanks for all the encouragement; I will remember all of your kindness. Lastly, thank you to the participants in the study for sharing your experiences so willingly.

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CHAPTER 1

INTRODUCTION TO THE STUDY

Statement of the Problem

The 21st century nursing profession faces an unprecedented shortage of practicing nurses, an increasing demand for additional nurses, an aging nursing workforce to meet the nation's healthcare needs, and fewer nursing faculty available to prepare the next generation of nurses (Buerhaus & Staiger, 1999). Throughout the nation, healthcare facilities report difficulties in attracting qualified, experienced nurses for specialty units (Keating & Sechrist, 2001) and have begun actively competing to hire the few available new graduate registered nurses. Additionally, managing the turnover rate for new graduate nurses represents an ongoing challenge. In this study, a new graduate nurse is an individual who has recently completed her nursing program, regardless of whether the program led to a baccalaureate (BSN) or associate degree in nursing (ADN), and has passed the registered nurse (RN) licensing examination. Furthermore, in this study, the terms new graduate, neophyte, and novice are synonymous and refer to the same group of nurses.

New graduate nurses are leaving their first nursing position at a disturbing pace. McNeese-Smith (2000) reported that over half left their first professional nursing assignment in less than 1 year. It has been projected that approximately 6% of new graduate nurses become so discouraged during the first year of practice that they choose to leave the nursing profession completely (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002).

Retention of new graduate nurses is a vital part in ameliorating the critical nursing shortage. The loss of new graduate nurses has a ripple effect throughout the entire healthcare system. First, turnover has a large financial impact on healthcare institutions. Buerhaus, Staiger, and Auerbach (2000) estimated the cost of recruiting, hiring, and training a replacement nurse ranges between $42,000 – $64,000 per nurse, or approximately 100% of the nurse's annual salary. Second, the failure of neophyte nurses is disconcerting to the nurses themselves (Thomka, 2001). Student nurses spend a considerable amount of time, money, and effort preparing for a nursing career which they may soon abandon. The loss of each neophyte nurse deepens the already severe nursing shortage.

Kramer (1974) formulated the concept of reality shock, a description of the difficulties new nurses encounter during the transition from nursing student to professional nurse. In this study, transition refers to the process of developing specific skills and responsibilities in a gradual way, concluding with a neophyte nurse becoming a competent nurse. During transition, the disconnection between the ideals of nursing taught in nursing school and the pressures of the hospital environment may lead to reality shock and result in neophyte nurses leaving the profession (Kramer).

Research (Boyle, Popkess-Vawter, & Taunton, 1996; Boychuk-Duchscher, 2001; Ellerton, 2003; Hinds & Harley, 2001) describing the experience of transition for new graduate nurses has focused on adult medical-surgical acute care units and critical care units from the perspective of nurse managers and educators. There are, however, no studies examining the process of transition in the first year of professional practice from

the perspective of the nurse experiencing the transition. Specifically, this study examined the transition of reflective advanced beginner nurses in the labor and delivery unit from advanced beginner to competent.

The lack of research examining the transition of labor and delivery nurses from advanced beginner to competent lends itself to a phenomenological qualitative design. Phenomenology seeks to describe an experience as it is lived by the individual (Van Manen, 1990) The current study used semi-structured interviews to examine the lived experience of a reflective advanced beginner nurse in the labor and delivery unit.

Purpose of the Study

There is tremendous attrition from the nursing profession during the first year (McNeese-Smith, 2000). The first year of practice is the transition period from advanced beginner to competent nurse (Benner, 1984) and appears to be the most critical stage influencing new graduate nurse turnover (Boychuck-Duchscher, 2001). The transition process during the first year of nursing practice in labor and delivery has been understudied. While the five stages of skill acquisition from novice to expert have been described by Benner (1984), there are no descriptions of the early transition process in labor and delivery from the perspective of the labor and delivery nurse. The purpose of this study was to examine this transition using a phenomenological methodology.

Background and Need

According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the current nursing shortage poses a threat to the lives of patients (2001). Primary factors influencing the nursing workforce include job dissatisfaction, the large

number of nurses approaching retirement in the next 10 years, lack of adequate educational programs to prepare additional nurses, and overwork and stress caused by the overwhelming numbers of patients for whom a nurse must provide care.

California, like the rest of the nation, faces a nursing shortage unlike any shortage experienced in the past (Buerhaus & Staiger, 1999). California has the highest projected population growth in the nation which has increased the demand for additional registered nurses. According to a report by the State of California, Employment Development Department (1998), by 2010, there will be a deficit of more than 109,600 registered nurses (RNs) statewide. In addition to the projected deficit of registered nurses, California ranks 49th in the nation for the number of RNs per capita. California has 585 RNs per 100,000 population, compared to a national average of 798 RNs per 100,000 population. The shortage is even more critical in the central valley of California where there are only 452 RNs per 100,000 (Keating & Sechrist, 2001). This shortage is exacerbated by the aging of nurses already in the profession. According to the California Healthcare Association (2004), in 2003, the average age of a registered nurse in California was 47 years of age. In another report, over 30% of registered nurses practicing in California were over the age of 50 (Buerhaus & Staiger, 1999).

In a nationwide report by the American Association of Colleges of Nursing (2003), enrollments in nursing programs have increased over the past 3 years, reversing a six-year trend of decreasing enrollments in professional nursing education. Nationwide, the Fall, 2003 enrollment in entry-level baccalaureate nursing programs increased by 17% (AACN, 2003). This increase has been attributed to an increased public awareness

of nursing as a career and media coverage of the nationwide nursing shortage. Despite the increased interest in nursing programs, projections indicate that there still will not be enough graduates to fill future nursing demands. While increasing the number of graduates from nursing programs has been proposed as a possible solution to California's nursing shortage, currently, all nursing programs in California public colleges and universities are fully enrolled. As a result, a significant number of qualified students wishing to enter nursing programs in California have been turned away, or placed on waiting lists, due to the lack of nursing faculty and budget constraints (AACN, 2003).

The shortage of available nursing faculty affects many institutions' ability to increase enrollments (Keating & Sechrist, 2001). Among the factors affecting the supply of nursing faculty are an aging nursing professorate, fewer doctorally prepared nurses choosing careers in undergraduate nursing education, and low faculty salaries (AACN, 2003). The most significant factors, with regard to nursing faculty, are faculty age and retirement projections. In 2002, the average age of doctorally prepared nursing faculty was 53.3 years of age (AACN). Projections indicate that 200-300 doctorally prepared nursing faculty will reach retirement age, each year, between 2004 through 2012 (AACN). Of the 457 doctoral candidates in nursing who graduated in 2001-2002, 29% chose employment in institutions other than schools of nursing (AACN). Salary level was determined to be a significant factor in the employment decisions of doctorally prepared nurses (AACN). Nursing schools have difficulty recruiting faculty since university and college faculty positions do not offer salaries comparable to clinical nursing positions (AACN).

Healthcare facilities throughout California report difficulties in attracting qualified, experienced nurses for specialty units. The California Healthcare Association, which represents approximately 500 hospital and health system members, reports current annual hospital nursing vacancies at 15-20% (CHA, 2004). As a result, healthcare agencies have begun actively competing to hire the few available new graduate registered nurses. Managing the turnover rate of new graduate nurses, however, represents an ongoing challenge.

New graduate nurses leave their first nursing position at an alarming rate. McNeese-Smith (2000), in a study examining the turnover rate of new graduate nurses, reported that over half of new graduate nurses left their first professional nursing assignment in less than 1 year. Some neophyte nurses chose to leave the nursing profession due to role overload, job dissatisfaction, stress, low self-efficacy, and physician-staff relationships (Charnley, 1999; McNeese-Smith, 2000; Oermann & Moffitt-Wolf, 1997).

Kramer (1974) formulated the concept of reality shock, a description of the difficulties facing new nurses during the transition from nursing student to professional nurse. New graduate nurses must reconcile the professional ideals and values learned in nursing school with the realities and limitations of the work environment. Reality shock happens, according to Kramer, when new graduate nurses realize, after spending years preparing for a work situation, that they are unprepared for the actual job. In nursing school, students are taught to aspire to the goal of becoming an ideal nurse by providing everything for the patient's needs, from physical assessment to comfort in a professional

manner. In the work environment, efficiency, time management, and task completion have greater value than holistic patient care.

The disconnection between the ideals of nursing taught in nursing school, and the pressures of the hospital environment, can lead to reality shock and result in neophyte nurses leaving the profession (Kramer, 1974). According to Kramer, neophyte nurses have the greatest likelihood of experiencing reality shock. This process mirrors the novice to expert continuum proposed by Benner (1984).

Benner (1984) described five stages of nursing skill acquisition from novice to expert. Each stage is characterized by the abilities the nurse demonstrates in clinical practice. The first stage, novice, is characteristic of nursing students. After graduation, during the first year of practice, nurses are advanced beginners, the second stage. After at least 1 year of practice, nurses progress to the third level, competent. The fourth level, proficient is achieved after 3 to 5 years of nursing practice. The fifth stage, expert, is not reached by all nurses and requires a minimum of 5 years of nursing practice. This study focused on the transition from stage two, advanced beginner to stage three, competent. Insight into the transition from advanced beginner to competent, from the perspective of the nurse, can lead to the development of interventions designed to decrease turnover.

Retention of neophyte nurses is an important part of decreasing the critical nursing shortage. The loss of nurses results in a decrease in the hospital productivity and efficiency as a result of training replacement nurses. The most alarming outcome of nursing turnover, however, is the effect on patients. According to the JCAHO (2001), organizations with nursing turnover rates greater than 22% per year have increased rates

of patient mortality compared with organizations reporting less than 12% nursing turnover per year. Retaining nurses has a positive effect on patient outcomes.

To meet the challenges of recruiting and retaining nurses in an era of severe shortages, a number of national nursing organizations have developed a collective vision for the future of nursing. The strategic plan, *Nursing's Agenda for the Future* (2002), focuses on a number of factors contributing to the current nursing shortage. The plan addresses the work environment and education of nurses, including greater support for new graduates. Consequences of inadequate support for new graduates include decreased quality of patient care, medication errors, and possibly, the decision to seek a different job or leave the nursing profession entirely (Tradewell, 1996).

The shortage of nursing staff, and lack of support during the transition period, has the potential to increase stress and pressure for neophyte nurses (Thomka, 2001). The orientation period is a limited amount of time replete with new experiences, procedures, and policies, placing additional pressure to perform on neophyte nurses. After the orientation period, neophyte nurses are expected to take the same patient assignment as an experienced, competent nurse, leading to potential overload and ultimately, frustration with nursing as a career (Charnley, 1999).

This study examined the transition experience of first year labor and delivery nurses. Research describing the experience of transition for neophyte nurses has focused on the perspective of nurse managers, and educators. There are, however, no studies examining the process of transition from advanced beginner to competent nurse from the perspective of the reflective advanced beginner labor and delivery nurse experiencing the

transition. In a previous study of neophyte nurses employed in acute care, Oermann and Moffitt-Wolf (1997) found lack of nursing experience, interactions with physicians, lack of organizational skills, unfamiliar patient situations, and uncommon nursing procedures to be the most common stressors during the transition from school to work. Thomka (2001) examined new graduate's perceptions of transition and found that after completion of the six-week orientation period, experienced nurses expected new nurses to be proficient. The transition to becoming a proficient nurse is qualitative with the time required to develop competency in nursing as variable (Meretoja, Eriksson, & Leino-Kilpi, 2002). In a recent study, Ellington and Gregor (2003) found neophyte nurses in acute care medical-surgical nursing units, focused on learning a set of skills, routines, and practices which they readily adopted without question. The neophyte nurses in this study felt overwhelmed and frustrated when challenged with clinical circumstances for which they felt unprepared.

While personal opinions and anecdotal evidence about new graduates working in specialty units abound, published research about the transition experiences of new graduates to specialty units is scarce. Research about the transition experiences of neophyte nurses choosing specialty units has concentrated on adult critical-care units. In a previous study, Boyle, Popkess-Vawter and Taunton (1996) compared new graduate nurses and experienced nurses hired into critical care units to examine the factors which affected the socialization of nurses in critical care. The researchers found few differences between the new graduate nurses and the experienced nurses, except in two variables, self-confidence and mutual influence, both of which were higher in the experienced

nurses. The researchers concluded that the small sample size may have contributed to the lack of significant differences between the new graduates and the experienced nurses. In another study of new graduate nurses in critical care, Porte-Gendron, Simpson, Carlson, and Vande Kamp (1997) surveyed critical care managers and nurse educators to identify the minimum clinical competencies required of new graduate nurses entering critical care nursing. This study did not include the perspective of the new graduate nurse in evaluating clinical competencies. There are no published studies about the experience of acquiring skills at the competent level of Benner's model (1984) in labor and delivery.

There are distinct differences between the priorities and skills of labor and delivery nurses and nurses from adult critical-care units. Critical care nurses' main concern is the detection, treatment, and management of disease and end-of-life care with an emphasis on technical equipment. As a contrast, nurses in labor and delivery provide support to the mother and her significant other during the process of labor. Labor and delivery nurses use less equipment, and a more personal touch, culminating with the life-changing event of childbirth. Unique to labor and delivery nurses is the responsibility for not one, but two patients, the mother and her unborn fetus.

Labor and delivery nurses are accountable for the maternal-fetal unit, comprised of two interconnected individuals, the mother who can be seen and evaluated, and the fetus, which remains unseen and must be evaluated indirectly. The labor and delivery nurse cannot use tactile, auditory or visual senses when assessing the health of the fetus. The nurse must assess the fetal well-being through fetal heart rate monitor tracings and amniotic fluid appearance. Fetal heart rate tracing must be evaluated promptly and

interpreted correctly to plan appropriate interventions. Advanced beginners are responsible for accurate evaluation of fetal well-being based on the fetal heart rate monitor. In the case of fetal defect at birth, the fetal heart rate tracing and the nurse's interpretation of the fetal heart rate tracing, becomes the centerpiece of the litigation. According to Phillips (1999), perinatal nurses are at higher risk for involvement in a malpractice suit than their colleagues in other medical specialties, placing additional stress on the new graduate working in labor and delivery. A stressful work environment was reported as one of the most frequently cited reasons neophyte nurses gave for leaving the profession (Oermann & Garvin, 2002).

Understanding the transition from advanced beginner to competent, from the perspective of the reflective advanced beginner labor and delivery nurse, is important for several reasons. First, hospital nursing educators need to understand the transition from advanced beginner to competent to plan appropriate orientation, support, and continuing education experiences. Second, nursing managers can use the information to develop guidelines for evaluating the progress and providing feedback to nurses during the first year of labor and delivery. Third, the nurses themselves can reflect on their experiences from advanced beginner to competent nurse to provide possible strategies for reducing turnover and enhancing support during the transition. Fourth, the assignment of patients should be based upon the skill level of the nurse. Benner's model (1984) provides a detailed analysis of the competencies expected at each level of practice. Understanding the progress from advanced beginner (level 2) to competent (level 3) may assist in developing guidelines for appropriate patient assignments to nurses at the advanced

beginner and competent levels.

Theoretical Rationale

The theoretical framework chosen for this study was a model addressing the skill development of a nurse from novice to expert. Dreyfus and Dreyfus (1980) developed the theory of skill attainment by studying airline pilots' performance in emergency situations. Benner (1984) generalized the Dreyfus Model of Skill Acquisition to nursing. She proposed that the acquisition and development of clinical nursing skills is based upon knowledge and experience. Benner's model described five levels of increasing nursing skill: novice, advanced beginner, competent, proficient, and expert. According to Benner, the transition from novice to expert performance is attributable to concrete knowledge acquired through experience. The transition from novice to expert does not occur in a predictable, linear manner. It is an individual process, influenced by exposure to similar clinical situations over a variable amount of time.

According to Benner's model, (see Table 1) nursing students are at the first or lowest level of skill, the novice. As such, they are primarily concerned with written rules of practice and the correct performance of tasks. Novice nurses may be confused about their new role, speculating what tasks to perform, what is acceptable performance, and how to function properly on the nursing unit. Their actions, which are guided by policy and procedure, require the constant supervision of a nursing faculty member. Since novice nurses have limited practice in actual patient situations, in order to function, they must depend on formal rules they have learned in their undergraduate nursing education.

Benner (1984) described new graduate nurses as advanced beginners. Advanced beginners are curious about new experiences and enthusiastic to learn. They often experience reality shock because of the disparity between the structured educational environment and the reality of chaotic clinical practice (Kramer, 1974). While advanced beginners are able to recognize recurrent patient care situations in a predictable environment, they lack the flexibility to adapt prior knowledge to rapidly changing patient care situations.

Specialty units are unpredictable, rapidly changing environments. According to Benner (1984), the new graduate nurse, functioning at the advanced beginner level, would not have adequate clinical experience to adapt to a rapidly changing environment, such as a labor and delivery unit. Nurses functioning at the advanced beginner level express feelings of trepidation, apprehension, concern, ambiguity, and self-doubt (McNeese-Smith, 2000; Oermann & Moffitt-Wolf, 1997).

Neophyte nurses who choose to enter practice in a specialty unit need support in developing skills for prioritizing nursing care. They also need emotional support when they feel overwhelmed and fearful. Failure to understand and support the neophyte nurse during transition from advanced beginner to competent nurse can lead to disillusionment with nursing as a career and ultimately the loss of a valuable resource, the neophyte nurse (McNeese-Smith, 2000). To prevent turnover of neophyte nurses, it is important to provide adequate support to neophyte nurses entering practice in a specialty unit.

Table 1

Benner's Novice to Expert Continuum (Benner, 1984)

Level	Characteristics
Novice	Student nurses Lacks experience, relies on rules Concerned with task performance
Advanced Beginner	New Graduates Enthusiastic to learn, curious Lack flexibility to adapt to rapid changes in patient care
Competent	1-3 years in same specialty Appears organized and efficient Begins to feel a sense of mastery
Proficient	3-5 years in same specialty Evaluates clinical situations as a whole Can rapidly assess a complex clinical situation, uses inductive decision making
Expert	Not all nurses will attain this level Has intuitive grasp Has many practical experiences Can prioritize salient components

The third level of the nursing skill continuum is competent (Benner, 1984). Becoming a competent nurse generally takes 1 to 3 years of experience in a particular clinical area. The competent nurse appears organized and efficient and begins to feel a sense of mastery. Attainment of competency is the basis of routine, safe nursing practice (Benner). In this study, a nurse enters the labor and delivery unit as an advanced beginner and, after a minimum of 1 year of practice experience, makes the transition to competent nurse.

The next level of clinical nursing is the proficient nurse. The proficient nurse is

able to evaluate clinical situations as a whole, rather than as concrete components. This holistic understanding contributes to inductive clinical decision-making. A proficient nurse can rapidly assess a complex clinical situation as a whole by anticipating changes in the patient's condition, even before the patient exhibits overt changes in vital signs and worsening symptoms (Benner, 1984).

Developing the next level of skill, expert, is not simply a function of increased time as a clinician. Benner described the expert nurse as someone who has many practical experiences, which lead to the development of an intuitive grasp on varying clinical situations. The expert nurse has the ability to assess the salient components of a clinical situation without being distracted by extraneous information. Not every practicing nurse will develop the intuitive nature of an expert nurse. The role of the nurse who reaches the expert level is development and evaluation of nursing research (Benner).

The neophyte nurse enters practice as an advanced beginner requiring orientation and support from a nurse who has attained at least the third level of skill, a competent nurse. Benner speculates that the most suitable preceptor for a neophyte nurse at the advanced beginner level is a nurse at the competent level. Competent nurses are closer to the level of advanced beginner and may be more aware of the need of advanced beginners for concrete learning (Benner). Proficient and expert nurses use intuitive methods rather than rule-governed behavior for patient assessment and become frustrated with advanced beginners who need rules and policies to guide their performance (Benner).

During the transition period, an advanced beginner needs a supportive preceptor

who understands the needs of the advanced beginner nurse and has a patient assignment that allows enough time to support the learning needs of the advanced beginner. Because of the worsening nursing shortage, preceptors may be assigned who are not adequately prepared, or who are not in an appropriate patient assignment which allows them the time to dedicate to the learning needs of an advanced beginner. In addition, the amount of time an advanced beginner requires to learn a particular skill varies.

There are a number of complex skills needed to function in labor and delivery, such as fetal monitoring, vaginal examinations, and performing an intravenous puncture. Developing these skills takes varying amounts of time, depending on the number of available patient experiences. There are no studies examining the transition of labor and delivery nurses to understand the skill acquisition of advanced beginner labor and delivery nurses.

Learning from the practice of more expert nurses is widely used in clinical practice and nursing education (Benner, 1984). New labor and delivery nurses learn clinical skills by relying on the knowledge of more experienced nurses. Benner's novice to expert theory incorporates the concept of learning from the expertise of others. Benner states it is important for nurses to share clinical situations and practices through narratives to enhance the understanding of nursing practice. Nursing is a practice-oriented profession and the knowledge acquired in daily practice is crucial to the progress from novice to expert skill levels (Benner). Exploration of the transition of advanced beginner labor and delivery nurses from the narrative perspective of the nurses provides additional insight into skill attainment in this specialty nursing practice.

Significance of the Study

This study has implications for advancing nursing education and practice by adding to the knowledge base about the transition experiences of advanced beginner labor and delivery nurses. This study is important for at least three reasons. First, the study provided a better understanding of the process of transition from the advanced beginner stage to the competent stage in labor and delivery nurses. A greater understanding of the transition experience can lead to the development of improved orientation, training, and support programs for advanced beginner nurses. Nursing educators and administrators can use the information obtained in this study to assist in development of orientation programs designed specifically to meet the needs of advanced beginner labor and delivery nurses.

Second, the study provided information to assist nurse managers in evaluating advanced beginner labor and delivery nurses during the first year of practice. Describing the process of advanced beginner to competent can lead to development of competencies expected at the advanced beginner and competent levels in labor and delivery nurses. These competencies may be used to evaluate work performance based upon skill level.

Finally, the study provided the opportunity for labor and delivery nurses to share their experience from advanced beginner to competent. Sharing the experience allows for self-reflection on the transition experience. Hargreaves (2004) stated that engaging in self-reflection encourages nurses to evaluate their practice, promotes self-awareness, and may help reduce the theory-practice gap.

Research Questions

This study addressed five research questions:

1. What were the expectations about the first year of nursing practice of reflective advanced beginner labor and delivery nurses?
2. What factors hindered and/or facilitated the transition experience for reflective advanced beginners in labor and delivery?
3. What areas of labor and delivery did the reflective advanced beginner nurses' feel competent to perform?
4. What was the perception of reflective advanced beginners about their educational preparation for labor and delivery practice?
5. What were the influences that led reflective advanced beginner nurses to choose labor and delivery?

Definition of Terms

Advanced beginner In this study, an advanced beginner is a registered nurse who has graduated from a nursing program, passed the NCLEX examination for registered nurses and has less than 1 year of experience.

Competent nurse In this study, a competent nurse is a registered nurse with a minimum of a year of full time labor and delivery experience. The competent nurse possesses the knowledge and skills sufficient to comply with nursing unit standards. The nursing unit standards are defined in the annual employee evaluation. A competent nurse meets the minimal expectations on the annual employee evaluation.

Neophyte Nurse A registered nurse with less than 1 year of experience. In this

study, this term is used interchangeably with new graduate and novice.

Reflective advanced beginner In this study, a reflective advanced beginner is a registered nurse with a minimum of 1 year, but less than 2 years of experience in labor and delivery.

Transition In this study, transition is the process of developing specific skills and responsibilities in a gradual way concluding with a neophyte nurse becoming a competent labor and delivery nurse.

CHAPTER 2

REVIEW OF THE LITERATURE

The nation is facing a critical shortage of nurses, which is expected to worsen over the next decade. Nursing turnover amplifies the already critical shortage of nurses. In the first year of practice, over half of nurses leave their initial professional nursing position (McNeese-Smith 2000) and six percent leave the nursing profession entirely (Aiken et al., 2002). According to the novice to expert model proposed by Benner (1984), attainment of the competent skill level requires at least a year of nursing practice in a particular specialty. This study examined the transition from advanced beginner to competent in reflective advanced beginner labor and delivery nurses during the pivotal first year of practice. This chapter reviews previous research regarding the transition experiences of novice nurses in the first year of practice. The pertinent literature affecting new graduate transition is organized into three broad areas: first, the theory-practice disparity, and reality shock; second, organizational factors affecting transition and retention, and finally, transition into specialty units.

The Theory-Practice Disparity and Reality Shock

According to Benner (1984), a sound educational foundation prepares the neophyte nurse for beginning nursing practice. Nursing, however, is an occupation with no minimal educational requirements for entry into practice. In the United States, there are three different educational routes to becoming a registered nurse (RN). The first route is to enter a three-year hospital diploma program. In this type of program, nursing students work while they take classes in the hospital where they will be employed upon

graduation. The two other nursing routes are college programs. Community colleges offer an associate degree in nursing (ADN), while four year universities offer a bachelor of science in nursing (BSN). All three types of nursing preparation qualify students to take the registered nurse board examination leading to licensing as a registered nurse. Although there is no consensus about the minimum educational preparation required for a career in nursing, the education of nurses has primarily moved from hospital-based diploma programs to university settings.

Likewise, the focus of training has changed from the hospital-based clinical practice of nursing skills to the academic acquisition of nursing theory. The result of this shift in educational focus has been a decrease in the number of hours spent in clinical practice and an increase in the classroom lecture component of nursing school. Because the university, rather than the hospital, employs the clinical nursing educator, the nursing educator has became further removed from daily clinical nursing practice. One result of changing nursing education from the hospital to the university setting is the theory-practice gap (Landers, 2001). The theory-practice gap is the perceived difference between the principles of an ideal nurse taught in the university setting and the realities reflected in clinical practice (Landers). The theory-practice gap can cause problems for the new graduate nurse during the transitional first year of practice (Kramer, 1974). The ideal values of nursing practice, instilled during nursing school, may not be congruent with the actual nursing practice experienced in the workplace.

Kramer (1974) has described the outcome of the differences between nursing school ideals and actual hospital practice as reality shock. Reality shock has been defined

as the reactions of new graduate registered nurses after they have spent a number of years preparing for a nursing career only to realize that they are not prepared for the reality of daily nursing practice (Kramer). While new graduate nurses are at the highest risk for reality shock, experienced nurses also may suffer reality shock when making the transition to a different area of nursing practice. Kramer delineated four phases of reality shock and their implications for new nurses. These phases are skill and routine mastery, social integration, moral outrage, and conflict resolution.

In the first stage, skill and routine mastery, new nurses focus on the acquisition of required nursing skills while learning specific unit routines. Nurses in this stage are enthralled and excited by new experiences (Kramer 1974). In this stage, the individual separates from student status and becomes a registered nurse. The known world of academia is replaced by the unknown world of clinical practice (Evans, 2001).

The second stage, social integration, reflects relationships with the nursing and medical staff. In this stage, new nurses attempt to make social connections with their working peers in order to fit into the group. According to a study of new graduates, the ideals of nursing practice learned in school are secondary to acceptance in the nursing unit (Hinds & Harley, 2001).

The third stage, moral outrage, occurs when the new graduate realizes the ideal, holistic nursing care taught in school is compromised in the working hospital environment. The new nurse feels a sense of outrage at the difference between what she has been taught with respect to patient care and the reality of the pressures of nursing shortages, patient demands, and budgetary constraints (Kramer, 1974). This is a period of

danger for new nurses when they are more likely to become discouraged with nursing and may choose to leave nursing as a profession (Kramer, 1985). If the new nurse chooses to remain in the profession, she will experience the final stage of resolution.

Resolution occurs when the new nurse reconciles the difference between the values learned in school and the reality of nursing practice in a rapidly changing healthcare environment. In this stage, nurses generally begin to discover ways to cope positively with conflicts in values (Kramer, 1974). Although reality shock was first described over 30 years ago, there have been a number of recent studies confirming the experience of reality shock in new graduate nurses (DeBellis, Longson, Glover & Hutton, 2001; Evans, 2001; Hinds & Harley, 2001; Jasper, 1996).

Evans (2001) studied a group of recent graduates from two United Kingdom university nursing programs. Participants were a convenience sample comprised of nine child health nurses working in London. The purpose of this qualitative study was to examine the concerns and expectations of new registered nurses at the beginning of their career. The researcher conducted a focus group to allow participants to discuss their feelings about their concerns as registered nurses.

The transcript from the focus group was content analyzed using the steps identified by Colaizzi (1978). Results suggest that new nurses experienced reality shock during the beginning of their career. Instead of the four stages of reality shock identified by Kramer (1974), Evans (2001) identified three stages: separation, transition, and integration. Separation was the stage of moving from the student role into the role of registered nurse. In transition, the participants entered the unknown, and uncomfortable

arena, of clinical practice. Participants attributed their discomfort to entering the nursing profession. In integration, the participants recognized the importance of role models, helpful colleagues, and belonging to the work group.

The participants reported that the hospital environment did not always support new nurses or assist them in coping with issues related to reality shock that arose early in their career. The researcher concluded that reality shock will continue to be a concern for new graduates until employers establish realistic and consistent expectations of new graduates in a supportive environment.

Evans' (2001) study using a single focus group of new graduates may not be generalizable to the larger population of neophyte nurses. Participants were recent graduates employed as child health nurses in the United Kingdom (U.K.). Nursing practice, in England, while similar in technical skills, is different in organizational structure from nursing practice in the United States (U.S.). Further, the labor and delivery environment in the U.S. may be different from child health nursing. The current study of labor and delivery nurses in the United States may yield results different from those obtained in the British study.

The U.K. recently implemented Project 2000, a new, more academically focused university nursing education program. Previously, registered nurses in the U.K. were trained in three-year, hospital-based diploma programs. Nursing education leaders in the U.K. recommended that nursing preparation should be more academically focused, rather than service based in order to enhance the theoretical base for nursing practice. Jasper (1996) examined the experiences of the first cohort of graduates from Project 2000

during their initial year of practice.

A focus group, comprised of eight novice nurses, was conducted using semi-structured interview questions as a topic guide. Five themes emerged during data analysis: coming out of school, living in the real world, the effect of the label, learning to cope, and us and them. Participants felt unprepared for their new role as a registered nurse and recognized the difference between the ideal world of the nursing student and the real world of the practicing nurse. They expressed their disappointment and disillusion at not being able to provide nursing care to their own standard. The results of this study confirmed the existence of reality shock as identified by Kramer (1974), as well as the theory-practice gap (Landers, 2001).

The researcher concluded that the Project 2000 graduates retained their humanistic values about nursing. This conclusion, however, may be a result of the focus group process. Participants may have communicated ideal nursing, rather than actual nursing practice. The researcher stated participants experienced reality shock and the dichotomy between school and work values, but had coping skills to deal with the difficulties encountered during the first year transition from student to practicing nurse.

The study was designed to evaluate Project 2000, an educational nursing reform in the U.K. The results of the study were specific to a group graduating from a newly designed academic nursing program in England may be different from experiences of new graduates in established educational programs in the U.S..

DeBellis et al. (2001) examined the transition of Australian undergraduate nursing students to employment as registered nurses. Twenty-one nursing graduates of the 1995

cohort at the Flinders University of South Australia agreed to participate in interviews and focus groups. Individual semi-structured interviews were conducted between six and twelve months after graduation. A focus group was conducted 15 months after graduation. The researchers identified nine themes addressing issues and difficulties experienced by new graduate nurses: doing without thinking, pretending to be a registered nurse, orientation, preceptorship, stupid questions, doubting abilities, unresolved conflicts, unsafe practices, and stress.

Participants experienced the reality of daily practice, heavy workloads and the inability to prioritize their nursing care. They also experienced a variety of responses from nurses working on the unit ranging from a welcoming, friendly environment to rudeness and belittling comments were perceived to demonstrate a lack of understanding from some senior nurses about the level of practice expected from a new graduate nurse. Stressors experienced by all participants included shift work, lack of sleep, exhaustion, inability to think, and frustration when they were not able to cope with the heavy patient assignments.

The researchers concluded that new graduates experienced reality shock, the pressures of the nursing shortage, and the increasing acuity of patient conditions. It was concluded that new graduates were beginning practitioners who needed individual support to develop into competent registered nurses and that both the environment and the unit culture have a strong influence on the transition experiences of new graduates.

DeBellis et al. (2001) did not specify the areas of nursing specialty represented by the participants. Transition experiences of nurses in general hospital units may be

different from specialty units. Labor and delivery is a distinct practice area with unique challenges for the new nurse. Examining new graduates from different specialties can provide insights to the problems specific to each specialty.

Hinds and Harley (2001) examined the experiences of four new graduate registered nurses in Australia. This study focused on the reasons why new graduates discarded the ideal nursing values learned in school in favor of becoming socialized into the existing nursing culture. The researchers used an ethnographic methodology in which three new graduates participated in interviews conducted four and eight months after entering practice in an acute care setting. A fourth new graduate kept a journal of her experiences. Content analysis of the interview transcripts and the journal were conducted yielding three themes: understandings of power, ideal nurse, and good nurse, bad nurse.

Participants experienced the exertion of power by more senior nurses on the unit. These nurses attempted to influence the conduct of the new graduates in an effort to socialize the new graduate nurse into the unit culture. Participants also experienced a dichotomy between what they learned during nursing school and how they actually functioned on the nursing unit, a confirmation of the experience of reality shock described by Kramer (1974).

Researchers concluded that being accepted was more important to the participants than maintaining the values learned in nursing school. Non-acceptance by more senior staff can result in job dissatisfaction and the loss of new graduate nurses. Hinds and Harley (2001) used a small sample of only four nurses in one region of Australia which may not be reflective of experiences of new graduate nurses in the U.S.

These studies all describe similar transition experiences for new graduate nurses and identify a theory-practice gap. It appears that a significant gap exists between the structured clinical experiences of the student and the real-life work experiences of the practicing nurse. The new graduates in these studies had unrealistic expectations of the hospital work environment. It is rare for students to experience a realistic patient care assignment during nursing school (DeBellis et al., 2001) which can lead to the reality shock when they become responsible for a full workload of patients. Even under ideal circumstances, it often takes more than three months for new nursing graduates to become oriented and comfortable with the required skills and work routines of the nursing unit (Ellerton & Gregor, 2003). The new graduates in these studies reported a difference between the theory learned in nursing school and actual nursing practice. Their feelings were consistent with the characteristics of an advanced beginner in Benner's model. The advanced beginner has theoretical knowledge, but lacks the practical experience to guide her behavior (Benner, 1984).

Organizational factors affecting new graduate transition and retention

Organizational factors can affect how nursing staff perceive the quality of their work. Previous research has focused on organizational factors which either facilitate or hinder a successful transition for new graduate nurses such as socialization into unit culture, job satisfaction, unit staffing, and orientation. The support and guidance of more experienced staff can affect the success or failure of new graduate nurses' transition (Boychuck-Duchscher, 2001; Ellerton & Gregor, 2003; McKenna, Smith, Poole & Coverdale, 2003; Oermann & Garvin, 2002; Oermann & Moffitt-Wolf, 1997; Thomka,

2001).

Thomka (2001) retrospectively examined the transition experience as beginning nurses by surveying a convenience sample of 16 registered nurses, 13 women and 3 men working in a mental health facility in the Midwest. Participants completed a researcher-developed questionnaire designed to elicit perceptions about initial relationship building with experienced staff during the transition from nursing student to professional nurse. The participants in this study had 15 years or less of nursing practice and were asked to reflect upon their initial nursing position at the time of graduation.

Participants identified a variety of interactions, both positive and negative, with more experienced registered nurses working in the nursing unit. The majority of participants reported incidents indicative of supportive interactions with colleagues. A smaller number reported situations that were not helpful to their professional development and four participants reported negative experiences that led to thoughts of leaving the nursing profession. The retrospective design of this study, however, missed the nurses who left the profession before the study was conducted.

The researcher concluded there was a lack of consistency in the treatment of new graduate nurses by more experienced staff members and negative interactions could lead to nurses leaving the profession. This retrospective study required participants to recall initial nursing experiences 15 years after entering the profession. The passage of time may have affected participants' perceptions of their experiences. None of the participants in this study were new graduates during the first year of employment and none were employed in labor and delivery.

Ellerton and Gregor (2003) interviewed a convenience sample of 11 baccalaureate prepared new graduate nurses employed in adult medical-surgical units in hospitals in Canada. The study examined the transition of new graduate nurses upon completion of a three month orientation period. A semi-structured interview focused on specific work activities and priority setting during the participants' average work shift, as well as their confidence in performing those tasks.

Researchers identified a single, overall theme for the nurses' description of work three months after graduation, learning the job. Participants reported that they experienced work as a set of skills, routines, and practices adopted without question since starting work on the unit. They described patient care as a list of individual tasks that needed to be completed. This finding is in agreement with Benner's (1984) model of skill acquisition for the advanced beginner in which the nurse focuses on skills and tasks required but does not differentiate which task is most important.

The participants described themselves as overwhelmed and frustrated with clinical situations and felt unprepared which reinforces the findings of reality shock in new graduate nurses (Kramer, 1974). Socialization into the nursing unit had more influence on their practice than their academic preparation. This finding is similar to results observed by Hinds and Harley (2001) who found that new graduates abandon values learned in nursing school in favor of becoming socialized into the nursing unit.

The participants in this study reported characteristics consistent with advanced beginner nurses (Benner, 1984). Upon completion of a three-month orientation, participants needed additional experiences, directed by more senior staff members, to

become competent nurses. All the participants in this study were employed in adult medical-surgical units in Canada. The required skills and patient care experiences of new graduates in a general medical-surgical unit are different from nurses making the transition to labor and delivery nursing in the U.S.

Boychuck-Duchscher (2001) used a phenomenological qualitative research design to explore factors in the work environment which affect the transition of new graduate nurses to professional nursing. Participants included five females, ages 23-25, who graduated from a baccalaureate nursing program. All participants were employed in acute care medical-surgical units in a Canadian hospital. Each subject was interviewed twice, two months after graduation, and again six months after the first interview. Using content analyses of the data, three themes were identified: doing nursing, the meaning of nursing, and being a nurse.

The participants in this study described their primary goal as task orientation, including learning skills and routines of the nursing unit typical of the advanced beginner stage (Benner, 1984). Participants wanted to deliver quality patient care, but were exhausted both emotionally and physically. This finding is consistent with other studies of new graduate nurses (Ellerton & Gregor, 2003; Hinds & Harley, 2001). Participants also experienced reality shock when making the transition from nursing school to work as defined by Kramer (1974). The participants articulated the fear of physicians, an area not found in the previous studies of organizational factors. All the participants experienced verbally abusive behavior from staff physicians and some participants related incidents of verbally abusive behavior from other registered nurses.

The researcher concluded that all participants had experienced a traumatic transition from student to professional nurse. The researcher found that all participants had extreme emotional highs and lows during the duration of the study which may have affected their perceptions about their initial experiences. Data were collected at isolated points in time, which may have coincided with a particularly difficult period for the participant. The transition from nursing student to professional nurse may better be studied after the peak of the emotions has passed. Reflection on the transition process may lead to more valid interpretations of the transition experience for new graduate nurses.

Boychuck-Duchscher (2001) examined transition experiences of acute care nurses in general medical-surgical units. The current study examines the transition process of the advanced beginner to competent nurse in labor and delivery, at least 1 year after graduation when the peak of the emotional experience has passed.

McKenna et al. (2003) used a mixed methodology survey research design to investigate the interpersonal conflict experienced by new graduate nurses during their transition to professional nursing practice. The researchers mailed surveys to all nurses in New Zealand who had graduated during the previous year (N=1,169). The return rate of completed surveys was reported at 47%, yielding 551 usable questionnaires. The majority of respondents were female, less than 30 years of age, of European descent, and employed in acute care, general medical-surgical hospital units. The researchers used the Impact of Event Scale, a measure used to determine the level of distress experienced during the 7 days preceding the administration of the instrument. Internal consistencies

were reported using Cronbach's alpha for the intrusion (α=.86) and avoidance (α=.82) sub-scales of the Impact of Event Scale. The two subscales had reported test-retest reliabilities of r=.87 for intrusion and r=.79 for avoidance, with one week between measurements. Content validity was reported as the correlation between the subscales of the IES (r=.63). The survey also included an open-ended question designed to allow the respondents to describe the most distressing incident, the consequences of the incident, and outline any steps taken to leave nursing because of the incident.

Covert interpersonal conflict was common among the respondents, over half of the participants reported being undervalued (treated like a nursing student) by other nurses. Over one third had learning opportunities blocked, felt neglected, been distressed by the conflict, or thought they were not given adequate support from other nurses. Over one third experienced rude, abusive, or humiliating verbal statements from other nurses. Verbal sexual harassment was reported by 25 (5%) of the study participants.

The researchers found no statistical relationship between conflict and type of nursing unit, or any statistical differences in incidents of conflict between nursing units. There were no statistical differences in relation to gender or ethnicity, however, age had an influence on some types of conflict. Nurses under the age of 30 were more likely to experience feeling undervalued ($X^2 = 17.1$, $p \leq .001$), more likely to feel they were not given adequate support from other nurses ($X^2 = 6.3$, $p \leq .01$), and more likely to experience verbal humiliation ($X^2 = 10.3$, $p \leq .006$).

The open ended question describing the respondents' most distressing incident was completed by 170 (31%) respondents. The most common descriptions involved rude, abusive, or humiliating comments. The level of distress was rated by 112 (66%) respondents as moderate or severe. In most cases, the incident involved the individual's supervisor. Forty-one respondents reported the consequences of the event affected their feelings of confidence. Psychological consequences were mentioned by 33 respondents including expressions of fear, anxiety, sadness, depression, and frustration. Twelve respondents experienced physical symptoms including weight loss, headaches, fatigue, and hypertension. Sixteen respondents (14%) required days off from work because of the event. An even higher percentage of respondents (34%, n=58) reported that they considered leaving nursing as a result of the incident. Of the respondents who considered leaving nursing, 14 stated that they intended leaving the profession and 11 other respondents reluctantly stayed in nursing with the issue unresolved.

The researchers concluded that many new graduates experience horizontal violence, operationally defined as interpersonal conflict between nurses. The researchers stated that some new graduates might perceive constructive criticism as conflict. The number of respondents indicating they considered leaving nursing because of the conflict, however, was indicative of the perceived impact of conflict in new graduate nurses. Younger respondents appeared to be more affected by conflict than older respondents. The only statistically significant findings for this study were in respondents under the age of 30.

While the researchers did not draw conclusions about the relationship between age and conflict, there may be some characteristic in nurses under age 30 which may lead to greater conflict with other nurses, or younger nurses may have a different perception about conflict. The first year of practice is critical to the development of the new graduate nurses' confidence. Experiences of conflict with other nurses may affect the development of confidence in new graduate nurses.

Oermann and Moffitt-Wolf (1997) used a descriptive-exploratory survey of 35 new graduate nurses to examine the relationship of social support to the stresses and challenges experienced during the first month of clinical practice. The majority of participants were female, employed in adult acute and critical care nursing units in the Midwest region of the U.S. The researchers used the modified Pagana Clinical Stress Questionnaire and a social support measure designed by the researchers.

The researchers found a moderate amount of stress was experienced by participants during the first month of employment ($m=3.12$) using a 0 (none) to 4 (a great deal) Likert scale. Participants identified predominant stressors as lack of experience as a nurse, interactions with physicians, lack of organizational skills and new situations and procedures. In this small sample, the researchers did not find a statistically significant relationship between social support and stress. They reported a weak positive correlation between social support and confidence ($r=.39$, $p\leq.029$) and a moderate correlation between social support and stimulation in clinical practice ($r=.57$, $p\leq.001$). Stress was found to be positively correlated with fear ($r=.59$, $p\leq.0001$). The small sample size is a significant factor in interpreting and applying the results of this study.

In a related study, Oermann and Garvin (2002) utilized a quantitative survey research design of 46 new graduate nurses to examine the stresses and challenges facing new graduates after completion of a three-month hospital orientation. The majority of participants were female, working on medical-surgical or critical-care nursing units, with a mean age of 39 years. The researchers used the same modified Pagana Clinical Stress questionnaire (r=.89). The researchers found a moderate amount of stress was experienced by participants during the three months of employment (m=2.3) using a 0 (none) to 4 (a great deal) Likert scale. The participants in this study rated their stress almost one point lower on the stress scale than participants in the previous study (2.3 compared to 3.12). The researchers, however, still interpreted stress as moderate in both studies. There were no statistically significant differences between the amount of stress experienced by the participants and the type of unit in which the new graduates were currently working.

Oermann and Garvin (2002) identified the major stressors for participants as not feeling confident and competent, making mistakes, and encountering unfamiliar situations. The researchers found no relationships between stress and age, prior work experience, or months of current experience. It was concluded that stress is a part of the experience of making the transition from student to professional nurse, regardless of age or experience. In this study, as in the prior study, the small sample size may affect the statistical results.

Shader, Broome, Broome, West, and Nash (2001) investigated the relationship among nurses' perceptions of work satisfaction, job stress, group cohesion, and

anticipated turnover. Two hundred and forty one staff nurses and five nurse managers from 12 general medical-surgical nursing units and intensive-care units participated in the study. While new graduates comprised only 8.7% of the sample, 63.8% of the overall sample have been in their current position for less than 3 years.

Researchers measured work satisfaction using the Index of Work Satisfaction (r=.85). Job stress was measured using a modified version of the Job Stress Scale (r=.86). Group cohesion was measured using the Bryne Group Cohesion Scale (r=.87), and anticipated turnover was measured using was the Anticipated Turnover Scale(r=.86), as well as, by the actual turnover rate.

Findings suggest that job stress and anticipated turnover decrease as levels of job satisfaction and group cohesion increase, even among inexperienced nurses. The researchers found a negative relationship between job stress scores and group cohesion ($r=-.41$, $p\leq.001$) and work satisfaction had a negative correlation with anticipated turnover scores($r=-.47$, $p\leq.001$). Higher work satisfaction scores correlated with greater group cohesion($r=.42$, $p\leq.001$), and lower anticipated turnover($r=-.47$, $p\leq.001$). Finally, higher work satisfaction was positively correlated with a predicable work schedule($r=.44$, $p\leq.001$), lower work stress($r=-.205$, $p\leq.001$), lower anticipated turnover ($r=-.29$, $p\leq.001$) and higher group cohesion($r=.43$, $p\leq.001$).

The researchers also identified differences among age groups in this study. For all age groups, there was a negative correlation between work satisfaction and anticipated turnover ($r=-.35$, $p\leq.001$). A stepwise regression revealed which factors predict turnover. For participants in the 20 to 30 year old group job stress was the most significant factor in

predicting anticipated turnover (R^2=16, p≤.001). For participants between ages 31-40, work satisfaction was the most significant factor predictive of anticipated turnover (R^2=.31, p≤.001), for participants over age 40, group cohesion was predictive of anticipated turnover (R^2=.28, p≤.001).

Shader et al. (2001) concluded that nursing turnover could be decreased by addressing work problems on an individual level. It was suggested that nurse managers work to match individual nurse's needs with organizational issues, such as work scheduling. This solution may be too simplistic to address the multiple factors influencing nursing turnover.

New graduate nurse's transition into specialty units

There have been a number of studies addressing advanced beginners who enter into different specialty units. Murray (1998) studied advanced beginner nurses making the transition from hospital to home health care. The entry of advanced beginner nurses into critical care nursing has been the subject of several studies (Boyle, Popkess-Vawter, & Taunton, 1996; Oermann, 1995, Porte-Gendron et al., 1997). Finally, Hom (2003), proposed a program for the transition of advanced beginner new graduate nurses into perinatal nursing. None of these studies, however, have examined the transition of advanced beginners to competent in labor and delivery from the perspective of the reflective advanced beginner.

Murray (1998) distributed a survey to 109 home health nurses to explore the transition of hospital nurses to home health nursing. Seventy-five nurses returned the Role Orientation scale and demographic questionnaire. The majority of participants in the

study were female, between 20 and 50 years of age, and all participants had less than 2 years of experience as a home health nurse at the time of the survey. The Role Orientation scale is a five item Likert scale ranging from strongly disagree (1) to strongly agree (5) measuring adjustment to the role requirements of a situation. The highest possible score on the Role Orientation scale was 25, with higher scores indicating greater capability of the individual to perform in the situation being studied. Researchers reported the mean score as 16 SD ± 3.5 suggesting participants had a moderate degree of adjustment to the new role of home health nurse.

The researchers found no statistically significant relationships between demographics and role orientation. Role orientation and duration of time in home healthcare approached statistical significance ($p \leq .051$) and concluded that role orientation is significantly influenced by length of time in home healthcare.

Oermann (1995) used a descriptive research design with a quantitative survey to examine the relationship between job satisfaction of critical care nurses and completion of an undergraduate critical-care nursing course. There were two groups of participants: 42 participants, working in critical care, who completed the undergraduate critical care nursing course and a control group of 59 participants, working in critical care, who did not take the course.

The researcher used the Index of Work Satisfaction ($r=.89$) to measure participants' job satisfaction. While the researcher found no statistical differences in total job satisfaction between the control group and those who graduated from the course, the researcher concluded participation in the critical care course enabled new graduates to

enter critical care. As with previous studies by the same researcher, the small sample size may contribute to the statistical analysis of the measures chosen for the study.

Porte-Gendron et al. (1997) used a comparative survey design with mailed questionnaires to verify the minimum clinical skills required for new graduates entering critical care nursing. Researchers mailed a questionnaire containing 105 clinical competencies to 42 randomly selected baccalaureate nursing educators and 45 randomly selected critical care nurse managers across the U.S. The useable surveys yielded a total sample size of 82.

Participants rated the competencies as essential, desired, or not required. A point value was assigned to each rating and the assigned points were summed across all respondents. The researchers reported a high degree of agreement about essential competencies among the participants. The researchers found that 81 of the 125 competencies, rated as essential or desired competencies by the participants, were defined as necessary competencies for the new graduate.

Boyle et al. (1996) used a descriptive, comparative design to examine the factors that affect socialization of new graduates in critical care nursing. There were two groups of participants: 50 new graduate nurses and 89 experienced registered nurses from six hospitals in the American Midwest. The researchers used a battery of standardized instruments to measure precepting, support systems, assignment congruence, role conception, self-confidence, affective responses, organizational commitment and conflict resolution. The instruments were administered to the new graduate participants at three different points; at one to two weeks, three months and six months from the beginning of

employment. The experienced nurse participants in the study completed the socialization instruments once.

At one-to two weeks of employment, the researchers found new graduate participants scored significantly higher ($p \leq .05$) than experienced participants on professional boundaries, authority, and commitment to profession and significantly lower ($p \leq .05$) on self-confidence. The researchers found no difference in the two groups on state anxiety. The differences between groups at the six-month point found only two variables, self-confidence and mutual influence, differentiated the two groups, with experienced participants scoring significantly higher on both measures ($p \leq .05$). A negative correlation was reported for the number of preceptors and job satisfaction ($r = -.038$, $p \leq .05$), intent to stay and self-confidence($r = .51$, $p \leq .05$). A positive correlation was reported for group cohesion and self-confidence($r = .47$, $p \leq .05$), commitment to profession ($r = .44$, $p \leq .05$), job satisfaction ($r = .55$, $p \leq .05$) and intent to stay ($r = .39$, $p \leq .05$). A negative correlation was found for length of orientation and job satisfaction($r = -.36$, $p \leq .05$). The researchers explained the unexpected finding by stating new graduate participants who spent more time in orientation experienced difficulty with the skills of complex patient care and the transition to critical care.

The researchers found few differences between the groups, perhaps due to the small sample size and sampling methods used for experienced participants. There was a small sample size in the new graduate participant group (N=40) at six-months. Four failed the registered nurse board examination and two left the critical care unit. Further, the researchers defined experienced participants as those who began their career in

critical care and had at least 1 year of experience. The differences may have been greater, especially on the anxiety measures, if the experienced participants had been working in critical care for a longer than 1 year. According to the novice to expert model (Benner, 1984), the experienced participants in the Boyle et al. (1996) study may not have made the transition from the advanced beginner stage to competent nurse by 1 year of experience. In the current study, participants were all reflective advanced beginners with a minimum of 1 year of labor and delivery experience.

Hom (2003) developed an orientation program for new graduates entering perinatal nursing. Using Benner's (1984) novice to expert model as a framework, Hom created an orientation checklist to document the new graduate's skill performance. She also provided examples of orientation tools for perinatal nurses including a weekly feedback guide to track progress of skills and identify further learning needs. Because the education of the new graduate in perinatal nursing is challenging, the result of poor orientation may be dissatisfaction of the new graduate as well as high turnover. This article contained descriptions of one hospital's orientation program.

Previous studies, many conducted in countries outside the U.S., have examined the transition experiences of new graduate nurses from nursing school to different specialties, including acute care (DeBellis et al., 2001; Evans, 2001; Hinds & Harley, 2001; Jasper, 1996) and critical care (Boyle et al., 1996; Oermann, 1995; Porte-Gendron et al., 1997). There are no studies, however, addressing the transition experience of labor and delivery nurses. Labor and delivery nursing is a specialty with a set of technical skills separate from other nursing specialties. Nurses in labor and delivery are confronted with

situations not commonly in other nursing specialties. The current study of labor and delivery nurses from advanced beginner to competent fills the gap in knowledge about the transition experience of nurses in this specialty.

CHAPTER 3

METHODOLOGY

The current study used a phenomenological qualitative design. Phenomenology has been described as a philosophy, an approach, and a method which seeks to describe an experience as it is lived by the individual (Van Manen, 1990). Because the focus of the current study was the transition from advanced beginner to competent nurse in the labor unit, with the purpose of understanding the experience from the perspective of the individual nurse, phenomenology was selected as the methodology. According to Streubert and Carpenter (1999), phenomenological investigation is a useful method for examining nursing education and student experiences. Phenomenology centers on the meaning of an experience from the viewpoint of the individual, therefore the focus on the human phenomena is inherent to the humanistic, holistic ideals of the nursing discipline.

This chapter presents a synopsis of phenomenology as a philosophical perspective and as the methodology for the current study. This chapter discusses the origin of phenomenology, characteristics of the research design, the researcher's role, recruitment and protection of human subjects, data collection procedures, data recording, data analysis procedures, and time line. This chapter includes the research questions and a description of the research methodology. The latter includes the sampling procedure and population, instrumentation, and procedures for data collection and analysis.

Phenomenology as a Research Methodology

Phenomenology is the study of the lived experience, concentrating on the person's perception of the phenomena being studied. There are two distinct approaches to

phenomenological research, descriptive and interpretive. Descriptive phenomenology, based on the work of Husserl, strives to present an objective, vivid explanation of the chosen phenomena (Koch, 1996). Interpretive phenomenology, influenced by Heidegger, goes beyond the detached description of the phenomenon and seeks to understand the individual's experience of being in-the-world (Koch, 1996).

In descriptive phenomenology, influenced by Husserl (1965), a researcher goes through the process of phenomenological reduction. This method begins with the researcher clearly stating her prior experiences with the phenomenon being studied. The researcher must then suspend or bracket, prior beliefs, theories, understandings, thinking and judgment about the phenomenon. This bracketing allows the researcher to concentrate on the phenomenon as it unfolds (Koch, 1996). In contrast, interpretive phenomenology, influenced by Heidegger (1982), is contextual; experiences happen in the context of the world and humans cannot bracket their relationship to the world.

An interpretive, Heideggerian phenomenological approach was chosen for the current study because the study focuses on examining the perceptions of an individual within the context of a group of individuals sharing a common experience as a way to better understand reality. Benner (1984) used this approach to study skill acquisition in nurses, culminating in the novice to expert continuum.

Phenomenology as a Philosophy

Phenomenology is a philosophy as well as a research method. Edmund Husserl is considered the founder of phenomenology as a philosophy (Cohen, 1987; Koch, 1996). Although Husserl's original work was in mathematics, his interest changed to the field of

philosophy. According to Husserl (1965), phenomenology is a rigorous method of describing human experiences. Husserl searched for an approach to describe things as they really are, without prejudice or supposition on the part of the observer. Husserl, however, realized that humans are inseparably connected to the world and proposed the concept of intentionality, defined as an individual's conscious connection to the world. In other words, the researcher's prior knowledge will influence the perception of future experiences. The influence of researcher's previous experience can be revealed through the process of phenomenological reduction. In this process, the researcher strives to list his/her prior knowledge and beliefs about the phenomena in order to focus the research on the experiences of the participants, rather than the researcher's prior experience and knowledge about the phenomenon (Koch, 1996). When designing a study, the researcher's previous experiences with the phenomenon being explored are exposed, to allow the reader of the research to understand the perspective of the researcher. A task of the reader of the research is to determine what role, if any, the researcher's previous experience may have had in influencing the results of the study (Koch).

Husserl (1965) proposed that the best method for understanding a phenomenon is through the person's own words describing an event. This description of everyday events, a person's lived experience, was first described in the works of Husserl and has been used extensively in the nursing literature (DeBellis et al., 2001; Ellerton & Gregor, 2003; Evans, 2001; Hinds & Harley, 2001).

Heidegger further refined the philosophical concepts originated by Husserl (1965). Heidegger (1982) viewed phenomenology as ontology, a way of discovering how

phenomena present themselves in the lived experiences of human beings. Heidegger was interested in the meaning of being and the search to understand a person's experience of being in the world. Heidegger considered Husserl's phenomenological reduction to be impossible, because humans can not reject their own assumptions of the world. He asserted, however, that through genuine reflection, people can become cognizant of many of their assumptions. According to Heidegger, the basis of studying people and the most important characteristic is the relationship of the individual to the world. The question of being precedes the investigation of knowing because humans are self-interpreting. The earth existed before humans, but the world is composed of people and their experiences. As a human being, one's interpretations of phenomena are influenced by a combination of being born human, family and cultural background, collective life experiences, and the world in which one lives (Koch, 1996). The self-interpreting character of humans, the quest for understanding of the human experience of being in the world are the bases of interpretive or Heideggerian phenomenology.

Lived experience is subjective, with each individual experiencing a different reality. Heidegger (1982) described the concept of intersubjectivity, the perspective of a group of individuals undergoing shared events. Each individual relates to, is influenced by, and influences the experiences of other individuals sharing a similar experience. Heideggerian phenomenology can be defined as a way to understand shared meanings and practices embedded in specific situations. In this study, phenomenology provides a basis for exploring the individual nurse's own experience of transition within the context of other nurses in similar circumstances. Phenomenology may offer means to a better

understanding of the transition experience of the labor and delivery nurses who are the subjects of the current study.

In this study, phenomenology was manifested as a qualitative research method using semi-structured interviews to examine the reflective advanced beginner nurse's lived experience of transition. Phenomenology was used in this study to give meaning and understanding to the experience of transition from advanced beginner to competent nurse from the perspective of the reflective advanced beginner nurse. Phenomenology was chosen because it centers on the meaning of an experience from the viewpoint of the individual, and the focus on human phenomena is consistent with the humanistic, holistic ideals of the nursing discipline. The subjects in the study became participants during the interpretation of the meaning of the lived experience of transition.

The Researcher's Role

Heideggerian phenomenological approach is qualitative, interpretive research. As such, the researcher must address the influences of prior experience, knowledge, and values in the context of the phenomena being studied (Creswell, 1994). The process of revealing the researcher's background and interest is an essential component of the interpretive phenomenological research process (Van Manen, 1990).

The researcher for the current study is currently employed as a clinical coordinator and charge nurse in a labor and delivery unit in a metropolitan area of Northern California. In addition, the researcher is a part-time faculty member in a baccalaureate nursing program, teaching clinical obstetrics to nursing students and acting as preceptor to beginning labor and delivery nurses. The researcher has been employed in

three different labor and delivery units in the same geographical area where the study was conducted. Upon graduation from a baccalaureate nursing program, the researcher made the transition from new graduate to labor and delivery nurse, the phenomena under investigation.

The researcher became interested in the transition of labor and delivery nurses from advanced beginner to competent while employed in the role of nurse manager in a labor and delivery unit. During the 3 years the researcher was employed as a nurse manager, five labor and delivery nurses, out of a staff of 52 nurses, left their jobs during the first year of labor and delivery experience. Even though five nurses out of 52 appears to be an acceptable rate of turnover, the cost to the institution for recruitment, training and orientation exceeded $300,000. There were additional costs for overtime and temporary nurses to replace the nurses who resigned, making the total expenditure close to $500,000. The reasons for the neophyte nurses leaving their positions were not clear. The current study explores the experiences of neophyte labor nurses during the first year of practice to examine which issues may lead to nurse turnover.

The Researcher's Assumptions

The researcher had the following assumptions about advanced beginner nurses entering labor and delivery:

1. Advanced beginner nurses graduated from a nursing program that prepared them in basic nursing skills, ethics, nursing process and careful medication administration.
2. Advanced beginner nurses had minimal clinical experience in labor and delivery during nursing school.

3. Advanced beginner nurses may have unrealistic expectations about the stress and responsibility in labor and delivery
4. Nurse educators and managers are interested in the successful transition of advanced beginner nurses in labor and delivery by providing individual training and evaluation.
5. Orientation and training provided adequate experiences to develop the skills needed to practice as a labor nurse.
6. Labor and delivery is a rapidly changing, unpredictable environment. Advanced beginner nurses may have difficulty adjusting to the unpredictability of nursing practice in labor and delivery.
7. Becoming a competent labor nurse requires at least a year of full time experience.
8. Communicating with other members of the healthcare team can be a source of conflict and stress.
9. Advanced beginner nurses are not confident in their nursing assessment about the condition of the patient.

Recruitment of sample and protection of human subjects

After approval from University of San Francisco IRBPHS was granted, the researcher made a presentation to the OB/Nursery (Perinatal) Nurse Managers Group Meeting. This group meets quarterly to discuss perinatal issues and practices in the Northern California Region. Managers from the 414 maternity hospitals in 23 counties from Northern California were represented. A brief presentation and outline of the proposal was given to each manager, who was asked to identify the potential participants from the labor and delivery unit.

The inclusion criteria for a reflective advanced beginner nurse in the current study was a minimum of 1 year, but less than 2 years of full time experience as a registered nurse in a labor and delivery unit. The transition from nursing student to professional nurse is fraught with emotions, therefore, studying the transition process after the peak of the emotions has passed may lead to more valid interpretations of the transition experience for new graduate nurses (Boychuk-Duchscher, 2001). The inclusion criteria were developed to encourage the participants to reflect on the transition experience. The reflective advanced beginner nurse participant must have entered into the labor and delivery specialty directly after graduation from nursing school. Exclusion criteria were previous experience as a registered nurse, other than in labor and delivery, and previous experience as a licensed vocational nurse.

One week after the group presentation, the nurse managers were contacted by telephone and asked to provide contact information for potential participants who meet the inclusion criteria. A letter of introduction was provided to potential participants identified by the nurse managers (Appendix C). Potential participants were contacted by telephone to solicit their interest in participating. If the participant agreed to the interview, a mutually agreed upon date and time was scheduled. Prior to the interview, a letter was sent (Appendix D) to remind participants of the interview date and time. In addition, the letter introduced basic study concepts, allowing the participant to have adequate time to reflect on the phenomenon of interest (Van Manen, 1990).

Data collection procedures

Participants were a purposeful sample of reflective advanced beginner labor and

delivery nurses, with a minimum of 1 year and a maximum of 2 years of full time labor and delivery experience as a new graduate nurse. The researcher provided a letter of introduction to potential participants who were identified by the managers. The researcher recruited potential participants until 15 participants who met inclusion criteria were identified. Fifteen participants provided an adequate sample to allow for subject withdrawal and to achieve redundancy. Redundancy, or saturation, is defined as the number of participants who need to be interviewed before no new data emerge, indicating the phenomenon under investigation has been fully described. In similar studies in nursing, saturation required between 4 and 10 participants (DeBellis et al., 2001; Hinds & Harley, 2001; Thomka, 2001).

The individual interviews were semi-structured using a researcher-developed interview guide (Appendix A). In semi-structured interviews, the researcher conducting the interview becomes the data collection instrument, instead of using a questionnaire, test, or inventory to measure the variables (Creswell, 1994). The contents of the interview guide were reviewed with two clinical nurse specialists responsible for the education and orientation of beginning labor and delivery nurses to ensure the clarity of questions and elicit suggestions for improvement. Next, the interview guide was piloted using a neophyte nurse who fit the inclusion criteria in order to assist in establishing credibility criteria, test the function and quality of recording equipment, and practice conducting the interview. Credibility criteria for qualitative research entail confirming that the data analysis and identification of themes are believable from the perspective of the participant. Using a pilot participant who met inclusion criteria helps to establish

credibility of the questions on the interview guide.

The interview guide was developed to direct the conversation with the reflective advanced beginner. In this study, semi-structured interviews were conducted with an open framework to allow for focused, conversational, two-way communication. Each semi-structured interview began by trying to minimize the hierarchical situation so that the participant felt comfortable talking with the researcher. The opening question was of a general nature to facilitate the conversation. An interview script was used, consisting of a set of questions as a starting point to guide the interaction. Interviews were used to give and receive information about the phenomenon being studied.

Unlike a questionnaire with detailed questions formulated ahead of time, a semi-structured interview begins with more general questions or topics (Creswell, 1994). In semi-structured interviews, the interview guide is used to give structure to the discussion; however, not all questions are designed and phrased before the interview. Many questions are created during the interview, allowing both the interviewer and the person being interviewed the flexibility to probe for details or discuss issues which arise during the dialogue (Creswell). Each interview is unique and develops during the conversation, therefore, not all the questions in Appendix A may be used in every interview, and additional questions, not in the interview guide, may occur during the interview.

After the pilot study was completed, participant interviews were scheduled. A meeting time and place was mutually determined between the researcher and the participant. The participants were given informed consent prior to the interview and any questions about the study were answered (Appendix E). Following completion of the

interview, each participant was reimbursed $10.00 for mileage and parking fees. The participants were entered into a drawing for the registration fee for a two-day continuing education program intended for perinatal nurses, presented in Sacramento in March, 2005 (value $150.00).

Upon completion of transcription, the participant received a follow-up letter (Appendix F) with instructions to review the interview transcripts. In addition, each participant was provided with a copy of the audio interview on a CD to compare to the transcript and refresh the memory of the interview. Each participant was contacted by phone to elicit any discrepancies or additions and solicit the participant's insight into the interpretation of the meaning of their responses. Asking the participant to ascribe meaning to their words assisted the researcher in interpreting the themes that emerged during the data analysis procedure (Van Manen, 1990). The participant also had a crucial role in establishing credibility in qualitative studies because credibility of the study is the reliability of the data from the perspective of the participant (Van Manen, 1990).

In qualitative research, the researcher brings a unique perspective to the study. Confirmability in qualitative studies is the extent to which the results could be confirmed or corroborated by other researchers. There are a number of strategies for enhancing confirmability (Creswell, 1994). In the current study, the researcher completed a research journal documenting decisions and procedures for analyzing data as part of an audit trail. The purpose of an audit trail was to provide a clear reproducible connection between the raw data and the reported findings. This included the transcripts of the interviews, content analysis decisions and participant comments. The audit trail provided other researchers

with adequate details of the research to reproduce the study in another setting.

Data recording

All interviews were digitally recorded and transcribed. The compact discs were stored in a locked cabinet in the researcher's office and destroyed upon completion of the data analysis. All identifiable proper names were removed from the transcripts, coded with initials, and assigned a code number corresponding to the participant. This step was taken to ensure confidentiality and provide a method to return the correct protocol to the participant for validation.

Data analysis procedures

Content analysis of the transcripts was performed using an approach commonly used in nursing phenomenological investigations (Kociszewski, 2003; Rubarth, 2003; Wilkin, 2004). Colaizzi's (1978) seven steps are:

1. Read all of the subject's descriptions, termed protocols, to achieve understanding.
2. Review protocols to extract significant statements that directly pertain to the specific phenomenon and identify any repetitions.
3. Formulate meanings from significant statements using creative insight to move from participants said to what they meant, illuminating hidden meanings without changing the original data and allowing the data to speak for themselves.
4. Identified meanings are grouped into clusters of themes, allowing for emergence of themes common to all subject's protocols. Validation is

achieved through referral back to original protocols to identify anything that is not accounted for in the clusters of themes and whether the themes propose anything which isn't implied in the original protocols. Discrepancies and contradictions are noted without dismissing data that does not fit into clusters of themes.

5. A comprehensive description of findings are extracted from the results.
6. An exhaustive statement of study findings is formulated.
7. Internal validity is addressed by returning the protocols to the participants to review the findings. This step allows the participants to identify any discrepancies, add any missing or incomplete information and remove sensitive information. Any relevant new data that emerges from this step must be integrated into the findings.

Timeline

The timeline for completion of the current study is found in Appendix B. The flexible timeline allowed for unexpected delays and unanticipated problems during data collection and analysis.

CHAPTER 4

FINDINGS

This study examined the transition from advanced beginner to competent nurse in the labor and delivery unit. This phenomenological qualitative study used a purposeful sample of 12 labor and delivery nurses currently employed in six private hospitals in Northern California. All participants in the study had at least 1 year, but less than 2 years, of experience in labor and delivery nursing. Fifteen potential participants who met inclusion criteria were recruited, 12 interviews were conducted and three individuals voluntarily withdrew from the study prior to scheduling the interview.

The current study used audio-recorded, semi-structured interviews to examine the transition from novice to competent in labor and delivery nurses. Participants chose the place and time of the interview. Each recorded interview lasted between 50 and 90 minutes. Upon completion of the interview, participants were provided with a copy of their digital audio interview on a compact disc. Within two weeks after the interview, participants were mailed a copy of the interview transcript with a letter asking them to review the transcript for discrepancies or additions. Participants were contacted by phone to discuss the interview and validate the experiences captured during the interview. The feedback given established that all participants thought the transcripts accurately characterized what was said during the interview, that the content realistically reflected their experiences during the first year of practice and none of the participants had additions or corrections to submit.

Content analysis was performed on the transcribed interviews using Colaizzi's (1978) seven-step method. In order to gain a greater understanding of the experiences of advanced beginner nurses, the researcher listened to each of the audio recordings three times; each transcript was read four times. The researcher's thoughts and feelings generated during the review process were recorded in the researcher's diary to assist with bracketing, the self-reflection done by the investigator to examine her personal beliefs about the transition experience of advanced beginner nurses in the labor and delivery unit. This step of self-reflection was performed to enhance the investigator's awareness of any potential presuppositions and biases that could alter the interpretation of the results. Significant statements and phrases that captured the essence of the experience were extracted from each transcript and pasted into a separate document.

In total, 354 significant statements were examined and preliminary themes began to emerge from the data. The significant statements were formulated into general restatements which allowed for the development of 48 theme clusters. The transcripts were studied again, the audio recordings were reviewed and further links were found between the 48 categories. The categories were consolidated to result in 16 emergent themes common to participants' descriptions of the transition from advanced beginner to competent nurse in the labor and delivery unit. To confirm the themes and sub-themes, participants were contacted and given the opportunity to examine and comment on the emergent themes (Lincoln and Guba, 1985; Patton, 1990). To enhance the trustworthiness and reliability of the data, feedback and insight from the participants was included in the development of the final 16 themes.

This chapter is organized according to the five research questions and the themes that emerged.

Research Question 1

What were the expectations about the first year of nursing practice of reflective advanced beginner labor and delivery nurses?

The overarching theme that emerged for this question was that the participants did not anticipate the intensity of the stress related to being a labor and delivery nurse. The three subthemes reflected components of the overarching theme that were associated with expectations for the first year of practice. These themes were the intensity of the job, the responsibility for an unseen fetus, and the steep learning curve encountered by participants training to care for a woman in labor and delivery. The first theme, which was common to all 12 participants, was surprise at the intensity of the job. This feeling was shared by one participant:

> To me the stress level is more than I expected, because you expect it to be all fun and games. You get to sit there and watch the baby come out, it all works easy, and you don't realize how much there is to it. It doesn't happen easily for everybody, so it's a lot more stressful than you would imagine.

Many participants reported they expected their first year of practice as a nurse to be challenging, but they found the job to be more intense and demanding than they had anticipated.

> It [the first year of practice] is much more stressful than I thought it was going to be, much more. I think nursing in general is a stressful thing, but I think labor and delivery is particularly stressful. When you are learning to work in labor, you really have to think about everything, it is overwhelming and intense. You feel like a burden to other nurses. You're basically alone, it's just you and the patient, and it is really hard.

One-third of the participants reported that they were stressed by the intensity of the emotional experiences associated with events such as a maternal death or a fetal demise. Participants stated they had anticipated the job of a labor nurse to be rewarding and gratifying, not the grim experience of dealing with the death of a fetus and the emotions associated with the unexpected death of a mother in labor. Participants stated they expected their job would be to care for healthy women, assist them during birth, and participate in the creation of new families. The participants were not prepared for events which were not so joyful, such as a maternal death or a fetal demise.

> Death on OB seems the most unnatural and shattering event. You have to be prepared to deal not only with the families experiencing these losses and their pain, but you have to confront your own feelings regarding newborn/fetal death and how you will cope with a particularly tough shift. And also, although rare, mothers do die of obstetric complications. Nothing is worse than seeing a young, apparently healthy woman develop complications and die this way. I wasn't prepared to deal with a firestorm of emotions from the family and friends of the patient and those from within me. I cried and cried, nothing can prepare you for the sad feelings.

Several participants were surprised by the intensity of dealing with time management issues. Participants stated they were surprised by the number of tasks they needed to manage at the same time. Participants anticipated that they would be able to manage their work routine in an efficient manner, but found the pace to be overwhelming.

> I think it [labor and delivery] is more intense than I thought it would be. I have to manage more things and at a quicker pace than I thought I might have to. It is all very hard, sometimes I feel like I'm drowning and I'll never catch up. It's all coming at me at the same time, it is too much.

Participants expected the transition from advanced beginner to competent would be stressful, however, they did not anticipate the intensity of the stress, the emotions and the difficulty prioritizing the simultaneous tasks required to care for a labor and delivery

patient.

The second theme, shared by all 12 of the participants, was the responsibility for an unseen fetus. Participants expected that, upon graduation, they would be a licensed, registered nurse, responsible for safe patient care. Participants had not anticipated the added responsibility unique to labor and delivery for the fetus a patient who is concealed. The nurse in labor and delivery is responsible for interpreting the health of the fetus through reading the fetal monitor strip. This was reflected by one participant:

> There are just a lot of things you really have to be responsible for. One of the biggest things that you have to be responsible for is the fetal heart monitor strip. To me, it's a very, very big responsibility. If they [the fetuses] have late decelerations, and they [the decelerations] are very subtle, you have to make sure that you can recognize that. If their long term variability becomes decreased, you have to make sure you can recognize that. It's a lot of things to remember. And when you're in there and sometimes in the heat of things you are trying to do everything, but sometimes, it's just a really big responsibility.

Participants who worked during the night shift had additional concerns about the responsibility for interpreting fetal well-being when the physician was not readily available for consultation and intervention. Nine participants worked the night shift and all expressed their apprehension about the responsibility for the safety of a concealed patient, the fetus:

> I expected it [labor and delivery] to be intense, scary at times, especially on night shift, because it falls on the nurse to be monitoring the patient. And that's a lot to be responsible for. It is two lives that you're responsible for. I expected there to be a lot of internal pressure on myself to say, 'Am I catching everything?' 'Am I watching everything?' 'Am I seeing if there's a problem, am I watching everything?'

The responsibility for the well-being of an unseen fetus using only a fetal monitor was more stressful than participants had expected. The added responsibility of working on the

night shift and having fewer resources available and no physician readily available to intervene caused more stress than participants had imagined.

The final theme that emerged related to the first research question was the steep learning curve encountered by participants training to care for a woman in labor and delivery. Many participants were stressed when they realized how much they had to learn. Participants expected to be able to learn everything needed to care for a woman in labor during the 6-8 week orientation period after graduation from nursing school. Orientation consisted of a paid 6-8 week training period, approximately 250 hours, which included didactic and hands-on clinical practice. Advanced beginner nurses were assigned to an experienced labor and delivery Registered Nurse (RN) and followed his/her schedule throughout the orientation period. The role of the experienced RN was to provide individualized instruction, supervision and mentoring during the clinical training portion of the orientation. Didactic portions were taught by the clinical nurse specialists and educators from the area hospitals and were standardized for all advanced beginner nurses in Northern California labor and delivery units used in this study. Participants found that there were many aspects of caring for a labor and delivery patient that were not mastered by the end of the orientation period. One participant stated:

> Being a new L&D nurse can be so overwhelming. I am just feeling like it is so much to learn. I've only been working on L&D for about 13 months and I still feel extremely overwhelmed at times. It is frustrating to know that there is so much to learn and feeling like I want to know it all right now. I know it's not realistic, but I still want it [to know everything now].

Another participant described her frustration about being a novice nurse under duress caused by the amount of learning still needed. During a delivery situation, she compared

herself to other nurses with more experience:

> I feel the expectation there. Being in the room with a nurse I know has more experience, watching her with the doctor and feeling wow, how am I ever going to get there? She anticipates that doctor's need, she just knows. I want to know the things she knows and I just don't.

Finally, one of the participants explained her frustration with the slow pace of learning and the steep learning curve associated with becoming a competent labor nurse: "It's very hard to be in a fast paced, high risk area like L&D... anything and everything can go wrong. I am so eager to learn and frustrated by what I don't know."

In summary, participants' expectations of the job of a labor nurse did not correspond to the reality of how intense their emotions and experiences would be in practice. Participants had the expectation that the first year of practice as a registered nurse would be stressful, but these reflective advanced beginner nurses were unprepared for the intense emotional responses related to the unexpected fetal or maternal death. The participants were also apprehensive about the responsibility associated with evaluating the well-being of a fetus that can not be seen, but must be assessed using a fetal monitor. In addition, the participants were frustrated by the steep learning curve experienced during the transition from advanced beginner to competent labor and delivery nurse.

Research Question 2

What factors hindered and/or facilitated the transition experience for reflective advanced beginners in labor and delivery?

Four themes emerged that participants identified as factors that hindered the transition experience. These factors included negative interactions with others, inadequate length of orientation, the need to learn technical skills, and how to adequately

document the nursing care for a woman in labor and delivery. The theme that participants identified as facilitating the transition experience was positive relationships with other nurses.

The first theme, which hindered the transition process for all 12 participants, was negative interactions with others, including physicians, preceptors, and other nurses. The participants were particularly affected by negative interactions involving an individual in authority, especially when the incident occurred in the presence of others. A particularly harsh exchange was shared by one participant:

> I've gotten barked at in front of, yelled at in front of the patient, I mean, I have got yelled at in front of other people, I have been disregarded, I have been brushed aside, I get yelled at in the operating room. The other day, I got barked at [by the physician] in the operating room in front of the anesthesiologist, the scrub technician, the patient, another nurse, you name it. That really hurt my feelings, yes it really hurt my feelings because she didn't just say it to staff, she said it in front of patients.

Negative interactions with nurse preceptors were another obstacle for the participants. Nurse preceptors are experienced nurses responsible for training advanced beginner nurses during the orientation period. Feedback and instruction offered by the nurse preceptor was often presented in a negative manner. One participant thought about resigning her position because of her negative relationship with her preceptor. The participant described this negative relationship by saying:

> I had a preceptor who used to yell at me in front of patients and doctors that was pretty rough. It was rough. My preceptor slapped my hand and commented on just about everything I did in a negative vein. Yes, that was not a good, happy thing. Yeah, she used to like yell at me and criticize me in front of people, in front of patients. I really hated coming to work.

Negative relationships with other nurses also hindered the transition of advanced

beginner nurses. All 12 participants described conflicts and unpleasant interactions with other nurses as a cause of constant stress. One participant described a distressing interaction that affected her feelings about her job:

> She told me, right in the nurse's station, right in front of everybody 'this is the second medication error you've made in three months' or however long it was. And I thought, how unprofessional. After that, I couldn't stand the woman. That was my last straw with her. And really, she was one of the reasons I hated my job so much in the beginning.

Participants were hindered by negative interactions with others, especially when the interaction involved a person in authority. Situations described by participants caused them to examine their feelings about their job and the individuals involved in the interactions. Negative interactions lead 6 of 12 participants to dislike their job and 4 of those 6 participants who disliked their job to seriously consider resigning their position.

The second factor that emerged, causing a hindrance for the participants, was the length of the orientation period. Ten of the 12 participants felt that the orientation period was too brief for an adequate understanding of the nursing care for a patient in labor and delivery. One nurse explained the hindrance related to the brief orientation period by saying:

> I'm not going to get this [labor and delivery nursing] in a year. I'm not even going to get this [labor and delivery nursing] soon. I am a year now out of the [labor and delivery] classes, even during the classes I thought this is a lot, wow this is a lot. They tried to cheat me out of my orientation because they thought I was doing so well and they [the manager] tried to put me on my own after 5 weeks when the normal orientation is 6-8 weeks.

The participants felt the orientation period for advanced beginner nurses learning labor and delivery should be longer than the average six weeks given to most participants. The participants referenced the substantial amount of information that must be absorbed to

safely provide nursing care for a woman in labor and delivery. The participants also discussed the number of specific technical skills that take significantly longer than the six weeks of orientation to learn. These specific skills were reflected in the subsequent theme.

The third theme that emerged, which hindered the process of transition, was mastering the specific technical skills needed to manage a patient in labor. All 12 participants identified three skills unique to labor and delivery nursing as difficult to master during the first year of practice. These skills were vaginal examinations, fetal monitoring interpretation, and judging the time of birth. The first of these skills, vaginal examinations were described by all 12 participants as the most important, yet difficult, skill for an advanced beginner nurse to master. One participant discussed this essential skill:

> My vaginal exams are so hard to get right. I can do a vaginal examination and know whether the cervix is open or closed and where the cervix is, but, if the water is still intact, and they are between about 3 cm and 6 cm, I can't do it. I still feel the need to get reinforcement from another nurse, because I do not want to tell the doctor the patient is 100% dilated, completely effaced, go ahead and come on in for delivery... when they are really at four centimeters.

The second skill all 12 participants mentioned as difficult to master during the first year of practice was fetal monitoring interpretation. Properly interpreting a fetal monitor strip, and recognizing when a fetus is in distress, is a critical skill for labor and delivery nurses. This skill was mentioned by all 12 participants as particularly significant because of the implications of not recognizing ominous fetal heart rate patterns. One participant stated:

> Fetal monitoring can be so difficult, hard to know if the baby is really doing okay, I guess it's just because I am new and I want to be sure that I don't miss late decels and fetal distress. I think it is the most scary for me when it is busy and you

> don't have anyone to ask for their opinion. Are those late decelerations and the baby needs to get out or is the baby okay? Sometimes I'm don't know if I should call the doctor or just wait, I hate to look stupid, but I don't want to get a bad baby either. Fetal monitoring is really critical, really important for making sure the baby is okay.

The third difficult skill, mentioned by all 12 participants as a hindrance to successful transition during the first year of experience, was judging the time of birth. Knowing when to call the physician to come to the hospital for delivery was identified by 8 of 12 participants as a difficult skill to master. One participant described an experience that incorporated two hindrances, judging the time of birth and negative interactions with others, this way:

> Trying to time when to call the physician for delivery, especially on multips [women who have given birth before] at 2am is so hard. How fast will they deliver? Will they deliver right after they rupture their membranes at 5cm? You don't want the doctor there too early, they get mad at you and if you call too late, they get mad at you. It is a no-win situation.

The third theme, mastering three difficult technical skills, vaginal examinations, fetal monitoring and timing when to call the physician for delivery, were cited by the participants as hindrances to the transition from advanced beginner to competent nurse. All 12 participants felt these skills are critical for an advanced beginner to practice and refine.

The final theme that emerged which resulted in a hindrance for 11 of 12 participants was documenting the care for a woman in labor and delivery. Participants cited several factors that contributed to the ambiguity regarding proper documentation. These factors were the excessive number of different forms, the uncertainty about where to record information on each form as well as the proper method of documenting the care

of a patient in labor. Concern about appropriate documentation was expressed by one participant:

> Triple and quadruple charting is very frustrating. I am worried that I don't chart well enough. If your preceptor is a good charter, then you learn to do it [charting] better. If your preceptor is a poor charter, well then, you don't learn so well, mine wasn't a good charter. I don't want to end up in court in a couple of years and I can't defend myself with my charting. I worry about it [documentation] a lot.

While the participants recognized the importance of documentation as a lasting record of the care given to each patient, the participants did not feel secure that the quality and quantity of their documentation was adequate to recall their patient care a later time, if needed.

The one theme that was identified by all 12 participants as facilitating their transition was supportive relationships with other nurses. All participants identified at least one nurse who had a positive effect on their transition experience. The characteristics associated with these supportive nurses were assisting the advanced beginner nurses in learning their job, helping new nurses prioritize their work, giving positive feedback and encouragement, and making new nurses feel more confident. One nurse participant described this positive relationship:

> One gal on nights has been very nice to me, helpful and always available to help. She said the first 2 years are brutal and then it's going to get better. So you just have to stick it out, and I think she was right. She reassured me that I was doing a good job and some things are out of your control, and you just have to accept that. I feel more secure when she's working; I know I can count on her.

In summary, participants readily identified a number of hindrances to the transition from advanced beginner to competent nurse. Specific hindrances included negative interactions with others, especially those in authority, but also with peers.

Participants seemed especially distressed when the negative interaction occurred in the presence of others, including patients and peers. Participants felt the length of orientation was too brief to fully grasp the skills and knowledge needed to safely care for a woman in labor and they identified three skills specific to labor and delivery that hindered the transition from advanced beginner to competent nurse. These three skills were vaginal exams, fetal monitoring, and timing the delivery. Because none of these skills were taught in nursing school, the participants had to acquire these skills during training on the labor and delivery unit. Participants also expressed concern about the quality and quantity of their documentation for a woman in labor and delivery. They were worried that their documentation did not adequately reflect the care given to the patient. Finally, only one theme emerged that participants identified as facilitating the transition experience. This theme was positive relationships with other nurses. The participants uniformly expressed the importance of a positive mentor relationship with at least one nurse that facilitated their transition from advanced beginner to competent nurse.

Research Question 3

What areas of labor and delivery did the reflective advanced beginner nurses feel competent to perform?

One theme emerged that was associated with the feelings of competency. This theme, described by 11 of 12 participants, was competence to assist with low-risk patients in labor and delivery. Low-risk patients were described by participants as those who have no medical complications and a normal, spontaneous vaginal delivery. Eleven participants described this feeling of competency as the highlight of their first year as a

labor and delivery nurse. Participants described the feeling of elation associated with the first time the participant was able to perform all functions of a labor and delivery nurse without having to get assistance from a more senior nurse. One participant described being able to manage low-risk patients:

> Well, when I first got out of orientation, I was scared to death. I did not want to go to work, I hated my job. And I wanted to get a new job. But now, a year later, I feel competent with normal patients. For example, I had a patient come in the other night, I knew she was in labor and that was so exciting. I knew it. I got her vaginal exam right, she was 5 centimeters dilated. When I am right on the vaginal exam, that makes me feel competent and then I did the delivery without having someone hold my hand. That was a total boost. It makes me feel like I can handle the job.

Participants felt that it took between 6 and 12 months of consistent experience in labor and delivery to feel competent in performing the specific skills that were incorporated in managing a low risk patient. These skills included admission assessment, determining if a patient was in labor by assessing the cervical changes and contraction pattern, starting an intravenous infusion, implementing pain relief measures, pushing during second stage of labor, preparing the patient for delivery and managing postpartum bleeding. One participant summed up these competencies by stating:

> I feel like I am able to do the job, like I am competent enough to do the job. I actually do have the brain, the skill, to pull through with it. I can see a patient through from when she comes in, I know she's in labor, changing her cervix, dilating and effacing. I can start the IV, help her breath through the contractions, give pain meds or an epidural, help with the pushing, although it still makes me nervous, because I'm afraid I'll have to deliver and I'm not ready for that, I've managed to avoid a nurse delivery so far. I know how to help the doc with the delivery, I'm starting to know what they want, but I'm far from anticipating the needs of the doctor. I've had a couple of heavy bleeds after delivery and I want help from the other nurses for that, I know what to do, but I don't want to be alone. But it's a rush to be able to do a normal labor patient, it makes me feel great.

While participants felt competent with low-risk deliveries, the skills and experience

needed to manage high-risk patients were beyond what advanced beginner nurses with 1 year of experience felt competent to perform. High-risk patients were described by the participants as patients with underlying medical conditions, including hypertension, heart disease, blood incompatibility and preterm labor managed with multiple drugs. Participants felt they did not have enough experience with high-risk patients during the first year to feel competent in caring for high-risk patients.

> I'm still pretty new to L&D and instead of feeling like I have it nailed, I have experienced various levels of feeling incompetent and inadequate. I do feel better now then I did a month ago but I don't think I'll ever be completely comfortable with the high-risk patients. I know there is so much to learn. I won't lie, I am not comfortable really when a woman with high blood pressure comes in. It takes time to really see all labor and delivery has to throw at you.

Reflective advanced beginner nurses with 1-2 years of experience felt more confident than those nurses with less than 1 year of experience, in caring for high-risk patients. Even with 1-2 years of experience, participants did not describe themselves as competent in caring for high-risk patients. One participant with approximately 18 months of experience stated:

> I don't know, I still don't know, am I a labor nurse? Well, I have a job and it's in labor. You feel competent when you feel like you can handle the high risk issues, or when you can contribute something. It's been really, really hard because I'm not competent, I don't feel competent. I feel more confident in my skills but as always there are those times where I just need encouragement or verification that yes, this is what you're suppose to do.

In summary, participants felt competent in caring for low-risk patients and performing the skills associated with low-risk labor and delivery with 6 to 12 months of experience. After a year of experience, participants had worked in a variety of low-risk and high-risk patient situations. With at least a year of experience, participants described

themselves as competent in caring for low-risk patients and confident, but not competent, in caring for high-risk patients. While all 12 of the participants felt competent in caring for low-risk patients, after a minimum of 6 months to 1 year of experience, none of the 12 participants felt competent in caring for high-risk patients even after 2 years of experience in labor and delivery.

Research Question 4

What was the perception of reflective advanced beginners about their educational preparation for labor and delivery practice?

Two themes emerged that were associated with the perception of advanced beginners about their educational preparation. The first theme, basic nursing theory, was described by all 12 participants. The second theme, preceptorship, was described by 4 of 12 participants. All 12 participants described their nursing training as emphasizing basic nursing theory with little specific preparation for labor and delivery. Participants spoke favorably about the quality of their nursing programs, but were disappointed in the small number of clinical hours spent in labor and delivery. One participant described her basic nursing educational preparation:

> It's a great school, it's a good nursing school, but we spent three days in labor. I spent three days a labor unit, where we literally stood back, we had no involvement whatsoever, so that was kind of difficult. Nursing school teaches you basic skills, most of them not labor [and delivery] related, and gives you a theoretical foundation, but that's about it.

Participants recognized that the purpose of all basic nursing programs is to prepare graduate nurses to pass the registered nurse licensing examination and start work in a general medical-surgical unit. One participant stated:

> I thought my education prepared me as a novice nurse well enough, but the skill portion did emphasize med/surg, which didn't prepare me at all [for labor and delivery]. I went directly into labor and delivery upon graduation and never used any of the skills they focused on in nursing school. I had to learn completely different skills such as vaginal checks, fetal heart rate monitoring and scalp electrode placement. Nursing school prepares you to begin safely. Those labor and delivery skills come with practice on the floor and in my case, the skills they teach in nursing school you may never use.

While nursing school did not focus on labor and delivery or other nursing specialties, participants recognized the importance of nursing staff and faculty as role models for nursing practice. One participant stated:

> So, it wasn't even a full semester of OB [clinical experience], [it was] only half of a semester. And I think if I remember correctly, we did three days in the nursery, three days in postpartum, and three days in labor, with actual laboring patients. And I can tell you my experience in a labor room, consisted of spiking an IV bag, and I think I helped hold a leg, but what nursing school did was provide me with some wonderful role models I try to emulate in my practice.

Participants represented eight different nursing programs, five were baccalaureate programs and three were associate degree programs. All 12 participants were satisfied with the quality of their nursing education, which provided the theoretical background required to pass the licensing examination, and training for safe, basic nursing practice. All 12 participants stated that their nursing programs focused mainly on medical-surgical nursing and provided minimal preparation for students interested in specialties such as labor and delivery.

The second theme, preceptorship was described by four participants from one baccalaureate program. These four participants had additional experience through a preceptorship program which consisted of two semesters of focused experience in one area of nursing. The participants spent 125 hours in labor and delivery paired with a

practicing labor nurse, learning to care for women in the labor and delivery unit. One participant had two preceptors with opposite experiences:

> One of my preceptors was excellent, and I think that she did a great job of preparing me. My 5th semester preceptor was overly available for teaching, and she was just great. She gave me so many opportunities to practice my skills. My first preceptor wasn't very good, she was more concerned about her own license, I think, and therefore I didn't get to do as many things as I should have. The things that I did do, I was cut down for. She told me she didn't have patience to be a preceptor and she told me that I shouldn't make her look bad because it's her name on the paper. I wanted to cry so hard, but I fought back the tears and remained positive.

Another participant was surprised at the quality of the preceptor experience, she stated:

> I was surprised to find out that she was more supportive than I would have imagined. She always told me I could do it. I felt very supported. It made me think I had what it takes to work in labor and delivery.

The other eight participants who attended programs without preceptor experiences thought the experience would have been valuable. One participant stated:

> I wish my nursing program had a preceptorship. I did a semester of leadership, a total waste of time since I probably won't be a manager for a really long time. It would have been really great to get more time in labor and delivery before I got hired there, I would have had a chance to see the unit, practice some skills and decided if labor was where I wanted to be before I wasted too much time. I think every nursing program should offer the preceptorship or an internship, something besides more med-surg. We had enough of that [medical-surgical].

In summary, the participants thought nursing school provided theoretical background and basic skill preparation for practice as a medical-surgical nurse. None of the participants felt that nursing school prepared them for practice as a labor and delivery nurse. Even the four participants who experienced extra clinical time in labor and delivery with a preceptor did not feel well prepared for practice as a labor and delivery nurse, although the participants who worked with a preceptor felt they had a better

understanding about the reality of practice as a labor and delivery nurse.

Research Question 5

What were the influences that led reflective advanced beginner nurses to choose labor and delivery?

Two themes emerged that were associated with the influences that led advanced beginners to chose labor and delivery nursing as a career. The first theme was the influence of personal experience. Five of the participants decided to become labor and delivery nurses after giving birth to their own children and interacting with the nurses. One participant described her own labor and delivery experience and her decision to become a labor nurse:

> It's been my dream to become a nurse since the birth of my first child, as I had wonderful nurses. I felt that my experiences in childbirth were something that I could bring into my own practice as a labor and delivery nurse.

Another participant had different experiences while giving birth to her own children which influenced her decision to return to school and train to become a labor and delivery nurse:

> I had completely different experiences each and every time I had a child. The great labor experience made me feel exuberant and excited, like I wanted to experience that everyday I went to work. The bad one, well, it was after the good labor and that experience taught me what I don't want to be like as a labor nurse and made me really want to be a labor nurse so I could be sure that none of the patients I took care of got treated the way I did. I wanted to make a difference, a good difference.

The experience of giving birth profoundly influenced four of the participants to pursue a career as a labor and delivery nurse. Both positive and negative experiences during the births of their own children contributed to their aspiration to become a labor

nurse and influenced their practice as an advanced beginner nurse.

The second theme described by seven participants who had not given birth, and one participant who had given birth, was the result of a childhood dream. Participants described the realization of a goal set when the participant was in high school or earlier. These participants knew they wanted to be a nurse early in their lives. Specifically, these seven participants had a desire to be a nurse working with children or babies, rather than sick adults. One participant described her high school dream: "In high school, I wanted to be a nurse. I knew I didn't want to do just a regular nursing floor. I wanted to do labor and delivery. That's all I wanted to do."

Another participant described her goal of becoming a nurse working with children:

> I have known all my life I wanted to do pediatrics or infants, that's all I ever wanted to do, I could have cared less about the medical surgical part of nursing school. I just endured it [medical-surgical] because I had to, but I knew I loved working with the babies from the time I was young and dreaming of what I wanted to be when I grew up.

Only one participant was influenced to become a labor and delivery nurse by a clinical instructor during nursing school. Although she knew she wanted to be a nurse early in her life, the decision to pursue labor and delivery nursing came with this experience:

> Well, it was my instructor, my clinical instructor for labor and delivery in nursing school; she said you should look into labor and delivery nursing. She saw something in me that I didn't see, she made me feel very good and I decided then I would be a labor nurse.

In summary, participants who had not given birth were guided by a childhood aspiration to work as a nurse with children or babies. One participant was influenced by the suggestion of a clinical instructor during nursing school. Participants who had given birth to their own children were so deeply influenced by their own birth experiences that

they decided to become labor and delivery nurses. One participant was influenced during nursing school by a clinical instructor in labor and delivery.

Additional Findings

Three additional themes emerged that were not related to the research questions posed by this study. These themes were somatic symptoms, adjusting to shift work, and medication errors. The first theme, somatic symptoms, was described by all 12 participants. Somatic symptoms occur commonly in reaction to stressful situations (Oermann & Garvin, 2002). Advanced beginner nurses described a variety of somatic symptoms frequently experienced during their first year of practice. Participants described headaches, stomach pain, intestinal problems, sleeping disturbances and heart racing. One nurse described her nervous response:

> Honestly when you're training for a new thing like labor, every day I came and I was nervous. Every morning when I came in, my stomach was upset. I don't know if everybody else is like that, but that's how was for me. I had nausea, stomach-ache, and diarrhea. Oh sure, I'm a stomach girl. I have always had stomach problems when I'm nervous.

Another advanced beginner nurse described her experience after an emergency c-section in the labor and delivery unit. The patient died after the c-section and the participant described the effect of the patient's death on her:

> I had a lot of trouble sleeping for a couple of days after that emergency c-section. I felt like I'm on the verge. On the verge of tears, the verge of crumbling, the verge of I'm never going to come back, the verge of I don't know what I was thinking. I felt like I'm not going to put myself through this [labor and delivery]; it wasn't worth it [the stress].

Participants consistently felt uncertain about their skills and worried about missing something that would cause harm to the patient or her fetus. Even after a year of

experience, this participant described her somatic symptoms:

> I feel like a nervous wreck all the time at work. I knew that I would be nervous going into it, but I still have a stomach ache in the pit of my stomach, like a knot, sometimes. I am so worried that I will miss something and the baby will be damaged. I hope that feeling will go away eventually.

One participant vividly described her first year as a labor and delivery nurse and the physical manifestations of the stresses of this demanding job:

> The demands of a grueling first year were so hard. I had a headache most nights from the stress, it was hard to come to work, I was so stressed out, I couldn't sleep well, too much going on in my mind. I didn't feel like eating, my stomach was churning. My heart would race and I felt like I couldn't catch my breath. What if I was on my own and I forgot to do something? I didn't want to hurt a little baby. I felt terrible most of the time, I just wanted to call in sick, but I knew I couldn't do that too often or I wouldn't have a job, the stress was overwhelming.

The stress of labor and delivery nursing expressed itself in somatic symptoms such as headaches, stomach pain, diarrhea and headaches for all 12 advanced beginner nurses practicing in the labor and delivery unit. Most participants recognized that the symptoms were related to the stresses encountered during the transition from advanced beginner to competent nurse and anticipated that the symptoms would subside when they felt more competent in their skills.

The second theme that emerged was adjusting to shift work. Nine of 12 participants worked the night shift, which were usually 12 hours in length. All nine participants described their difficult adjustment to working on the night shift, both on their physical well-being and their personal relationships. One participant described her dilemma working night shift:

> I thought I would be able to handle the night shift, but I am really struggling. I am very sad about this. I love this type of nursing [labor and delivery] and have learned so much in the short amount of time I have been there. It is my family life that is suffering. All I want to do is sleep or catch up on sleep. I sometimes am up

> for 48 hrs straight minus 4 hours of sleep. My disposition is horrid. I do not even like hearing myself speak to my husband and my patience level is minimal with my children.

Another participant expressed her distress at feeling trapped on the night shift:

> When I graduated and took the job, I really wanted to work in labor and delivery and I thought I could learn to handle nights. But after doing it for over a year, my body isn't adjusting to the night shift. I don't sleep well during the day, I have my kids to think about, I can't work all night and stay up with them all day, I don't know how much longer I can do nights. With a lack of sleep and the strenuous job of a labor nurse with lots of bending and lifting, I am afraid I'll get distracted and hurt myself. I don't know if I can wait for a day shift position to open up before I have to get off the night shift. It could be years before a day job is available. I won't be able to hang in there until then.

Participants were not prepared for the difficulties of working the night shift and the toll it took on their physical health and relationships. Two of the nine participants who worked night shift seriously considered leaving their positions because of the effect of working the overnight hours. The remaining seven participants who worked the night shift had experienced a difficult adaptation physically and mentally to working the night shift.

The final theme that emerged from the content analysis of the transcripts was medication errors. Ten of the 12 participants admitted to making a medication error of some type during their first year of practice. The severity of the medication errors ranged from a delay in the administration of an ordered medication to the administration of the wrong dosage. One participant had a possible explanation for her medication errors involving administration of incorrect pain medication to patients:

> I think the medication errors were a product of being inexperienced and not quite being able to juggle everything effectively or efficiently. I just didn't check everything enough; I didn't feel like I had the time, I was too busy.

One participant explained her medication error as a communication misunderstanding

with the physician and described the negative interaction with another physician that resulted:

> I thought she [the physician] wanted the antibiotics given every 8 hours. I wrote down what she told me and then when the physician covering for her called me on the phone, she [the physician covering] started yelling that she wanted it every 4 hours. I'm getting yelled at, I mean yelled at, yelling at me about each other [the physicians] and that is bunk. I was so mad, I had to hold the phone away from my ear, at the nurses station you could hear the yelling. I got written up for the mistake when I think it was the physicians who were at fault, not me.

Another participant described her experience with a potentially life-threatening medication error that she recognized as her fault and her subsequent somatic response:

> Just a couple of weeks ago, I had a close call with Mag [magnesium sulfate]. I started a 4 gram bolus from the bag, I forget to set the limit [on the infusion pump] and the patient got about twice as much as she should have gotten. The night nurse actually caught my error and the patient had a really high Mag [magnesium] level, I think it was about 12 as I remember. She [the patient] could have stopped breathing, she could have died, it really scared me bad, I felt like throwing up, my heart was racing and I felt like I couldn't breathe, I could have killed her if the night shift nurse hadn't caught it. Thank God she [night shift nurse] was there.

Participants described a variety of medication errors made during the first year of practice. During nursing school, all participants were repetitively taught and tested about the five rights of medication use: the right patient, right drug, right time, right dose, and right route. In spite of these safe guards to medication administration, the participants made errors that included the wrong drug, drugs given at the wrong time(s), and incorrect dosage of medications. There were no incidents that involved the wrong patient or the wrong route of administration for medication. The participants could recite the five rights of medication administration, but even with those safeguards, 10 of the 12 participants made at least one medication error during their first year of practice.

Summary

This study examined the transition from advanced beginner to competent nurse in the labor and delivery unit using semi-structured interviews. Content analysis was performed on the transcribed interviews using Colaizzi's (1978) seven-step method. From the content analysis, 16 themes emerged (See Figure 1). Participants did not have realistic expectations about the transition from advanced beginner to competent nurse. Advanced beginners recognized that the nursing profession was stressful, but they found labor and delivery to be more stressful than anticipated. Advanced beginners seemed to be surprised at the intensity of the job with the added responsibility of assuring the well-being of a fetus that can not be seen. The advanced beginners recognized the complex nature of caring for a woman in labor, but were distressed about the length of time required to learn the specific skills needed to care for a woman in labor.

Participants reported that several factors hindered the transition from advanced beginner to competent in labor and delivery nurses. The first factor was negative interactions with others, especially those in authority, particularly preceptors and physicians, but also other nurses as well. The negative interactions affected the advanced beginner's confidence and participants felt those negative interactions hindered their transition from advanced beginner to competent nurse. Advanced beginner nurses found that the length of time needed to master the variety of technical skills needed in labor and delivery also hindered their transition to competent nurse. The skills identified to be the most challenging were vaginal examinations, fetal monitoring, and timing when to call the physician for the delivery. Advanced beginner nurses appeared unclear about where

interventions should be documented on the numerous forms as well as how often documentation should be completed for a woman in labor and delivery. This uncertainty was a hindrance for advanced beginner nurses in their transition to competent nurse.

The only factor identified by the participants that facilitated the transition from advanced beginner to competent nurse was positive relationships with other nurses, although negative relationships with other nurses hindered the transition from advanced beginner to competent nurse. The participants relied on these positive relationships with other nurses to assist the advanced beginner nurses to learn their job, better prioritize their work, give positive feedback and encouragement to the advanced beginner nurses, and make the advanced beginner nurses feel more confident.

Advanced beginner nurses felt competent in caring for low-risk labor patients a year of labor and delivery experience, however, they did not feel competent in caring for high-risk, complicated labor and delivery patients during the first year of practice. Advanced beginners felt the basic skills needed to care for a low-risk labor and delivery patient required from about six months to 1 year of consistent full-time experience. These skills were the nursing assessment of a patient to determine if she is in labor, interpreting the fetal monitoring strip, performing a vaginal examination, administering pain relief and assisting the physician with the delivery of the infant. Advanced beginners felt the high point of their first of practice was the feeling of competency associated with being able to manage a patient in labor without asking for assistance from a more senior nurse.

Figure 1 Emergent Themes

Themes	Percentage	Consistent with previous research	Contradicted	Unique to study
Job intensity	12/12 (100%)	Kramer (1974)	-----	Responsibility for fetus, liability for fetus
Responsibility for an unseen fetus	12/12 (100%)	-----	-----	-----
Steep learning curve	12/12 (100%)	DeBellis et al. (2001); Ellerton & Gregor, (2003); Meretoja et al., (2002)	Unpredictable, experiences can not be scheduled	-----
Negative interactions with others	12/12 (100%)	Boychuck-Duchscher, (2001); Boyle et al., (1996); DeBellis et al., (2001); McKenna et al., (2003)	-----	-----
Inadequate length of orientation	10/12 (83%)	------	-----	-----
Learning technical skills	12/12 (100%)	-----	-----	Skills: vaginal exams, fetal monitoring and timing delivery
Adequately document nursing care for labor	11/12 (92%)	------	-----	Documenting care, litigious nature of labor
Positive relationships with other nurses	12/12 (100%)	Boychuck-Duchscher, (2001); Ellerton & Gregor, (2003); McKenna et al., (2003); Oermann & Garvin, (2002); Oermann & Moffitt-Wolf, (1997); Thomka, (2001)	-----	-----
Competence with low-risk patients	11/12 (92%)	Benner, (1984); Casey, Fink, Krugman, & Propst, (2004)	-----	Competency low-risk patient
Basic nursing theory	12/12 (100%)	Ellerton & Gregor, (2003)	-----	-----
Preceptorship	4/12 (33%)	Boychuck-Duchscher, (2001)	-----	-----
Personal experience	4/12 (33%)	-----	-----	Personal experiences, childhood dreams influenced decision
Childhood dream	7/12 (67%)	------	-----	-----
Somatic symptoms	12/12 (100%)	Oermann & Garvin , (2002)	McKenna et al., (2003)	Somatic symptoms during transition period, gradually decrease, resolve
Adjusting to shift work	9/12 (75%)	DeBellis et al., (2001)	-----	-----
Medication errors	10/12 (83%)	Beyea, et al., (2004); Mayo & Duncan, (2004); Tradewell, (1996)	-----	Medication errors common

Advanced beginner nurses seemed satisfied with their general nursing educational program, but felt they had little preparation during nursing school for their career as a labor and delivery nurse. Participants whose nursing programs included a preceptor experience in labor and delivery had a better understanding of the functions of a labor nurse; however, the participants did not feel totally prepared to assume the role of a labor nurse after graduation. Those participants whose nursing school did not include a preceptor program expressed the desire for additional clinical hours in labor and delivery before accepting a position in the unit.

There were two main influences on participants' decision to choose a career as labor and delivery nurses. One influence was personal experience with a nurse during the delivery of their own child. Both positive and negative experiences with the delivery of their own children were potent influences on the decision to be a labor nurse and their practice as a labor nurse. The other influence was a childhood desire to be a nurse and work with children. The participants in this group were driven by the long time goal to work with children or infants rather than a direct experience in a labor and delivery unit. One participant was influenced to choose labor and delivery nursing by a clinical instructor during nursing school.

There were three additional findings that were not directly related to the research questions. First, these advanced beginner nurses frequently had somatic symptoms during the first year of practice. Common reported symptoms included headache, gastrointestinal upset, nervousness and inability to sleep. Participants stated that they commonly experienced these somatic responses in relationship to thinking about work. All

participants experienced at least one of the symptoms during their first year of practice.

Second, advanced beginner nurses had difficulty adjusting to shift work, especially night shift. Working night shift affected both sleep patterns and personal relationships. All the participants experienced sleep disturbances, difficulty thinking and staying awake during the night shift. Two of the participants have considered resigning their positions because of the problems encountered while working the night shift.

Finally, participants reported the common incidence of medication errors in labor and delivery. In spite of knowing the five rights of medication administration, the participants admitted to giving the wrong medication, either at the wrong time or the wrong dosage. None of the participants administered medication to the wrong patient or by the incorrect route. The severity of the mistakes ranged from those with no effect on the patient to one participant who described a potentially fatal medication error.

Participants felt the transition from advanced beginner to competent in labor and delivery was more stressful and took longer than anticipated. Participants expected to work with generally healthy women in a joyful environment, celebrating the miracle of birth and helping to form new families, teaching patients to care for themselves and their infants. The participants expected to be prepared to assume care for patients in labor at the completion of their six week orientation period. While the participants expected the transition from advanced beginner to competent nurse to be stressful, the participants did not anticipate the intensity of the stress and participants had not fully estimated the impact of the added responsibility for the well-being of the fetus that can not be seen and must be evaluated through a fetal monitor.

CHAPTER 5

SUMMARY AND DISCUSSION

This study examined the transition from advanced beginner to competent nurse in the labor and delivery unit. The purpose of this study was to examine this transition using a phenomenological methodology. This qualitative study used a purposeful sample of 12 labor and delivery nurses presently working in six private hospitals in Northern California. All participants in the study had at least 1 year, but less than 2 years, of experience in labor and delivery nursing. Semi-structured interviews lasting between 50-90 minutes were conducted with each participant. The audio-taped interviews were transcribed and content analysis was performed using the seven-step method suggested by Colaizzi (1978). The findings of this study are summarized in this chapter according to the research questions and their implications are discussed.

Discussion

The findings of this investigation add to a growing body of knowledge on the transition experiences of advanced beginner nurses. Additionally, this study offers a better understanding of the transition experience from advanced beginner to competent in the labor and delivery unit from the perspective of the advanced beginner nurse. Previous research focused on the advanced beginner nurses' transition experience in medical-surgical units and critical care units (DeBellis et al., 2001; Ellerton & Gregor, 2003; Meretoja et al., 2002). While there are no published studies focusing on the transition experience in the labor and delivery unit, the findings of this study are congruent with the novice to expert theory of skill acquisition proposed by Benner (1984).

Research Question 1

What were the expectations about the first year of nursing practice of reflective advanced beginner labor and delivery nurses?

The results of this study suggested that three aspects were particularly salient to the expectations about the first year of practice as a labor and delivery nurse. First, advanced beginners expected the first year of practice as a nurse to be stressful; however, they did not foresee the intensity of the stress unique to being a labor and delivery nurse. Advanced beginners in labor and delivery expected to work with healthy women giving birth; however, they encountered incidents during their first year as a labor and delivery nurse, such as maternal death or fetal demise, which resulted in unanticipated emotional distress. Next, advanced beginner nurses were stressed by the responsibility for an unseen fetus, the liability for interpreting the fetal monitor strip, and recognizing when the fetus was in distress. Advanced beginner nurses worried about the grave implications of making an error in fetal monitor interpretation. Lastly, advanced beginner nurses felt that training to be a labor and delivery nurse required more time and was more stressful than they had expected. Advanced beginner nurses experienced difficulty with prioritizing tasks and time management during the first year of practice. Although they had expected to be capable of caring for a patient in labor and delivery after the 6-8 week orientation period, they did not feel competent to care for a patient in labor and delivery after their brief orientation period.

This study suggests the orientation period for advanced beginner nurses learning labor and delivery should be longer than the average 6 weeks given to most advanced

beginner nurses. Learning to care for a woman in labor and delivery involves a substantial amount of complex information which takes longer than 6-8 weeks to attain. Because of the unpredictable nature of labor and delivery, advanced beginner nurses in this study were not able to obtain consistent learning opportunities needed to understand the full array of patient conditions encountered in the labor and delivery unit. This lack of consistent experiences resulted in the advanced beginners completing the orientation period without having been exposed to the breadth of patient conditions for which the advanced beginner is responsible. The results suggested that being competent to care for a low-risk patient required approximately 1 year of experience.

Participants in this study identified three pivotal technical skills required to become a competent labor nurse. These skills were not taught in the basic nursing program and required longer than the usual 6-8 week orientation period for the participants to master. These specific skills are vaginal examinations to determine cervical dilation, fetal monitoring, and judging the progress of labor and timing when to call the physician for delivery. Properly interpreting a fetal monitor strip, and recognizing when a fetus is in distress, is a critical skill for labor and delivery nurses. This skill is particularly significant because of the fetal morbidity and mortality associated with incorrect fetal monitor interpretation. This finding is consistent with prior research with new graduate nurses (Ellerton & Gregor, 2003; Meretoja et al., 2002) which described the variable amount of time needed to master the skills required of a new graduate nurse on a medical-surgical unit and the frustrations associated with the overwhelming task of learning the skills necessary to make the transition from an advanced beginner to a

competent nurse.

Advanced beginners in labor and delivery found their expectations about the job of a labor nurse did not correspond to the reality of how intense their emotions and experiences would be in practice. The participants described their surprise at the intensity of the job compared with what they had expected and felt unprepared for the daily challenges of being an advanced beginner in labor and delivery. These feelings of being unprepared, and the difference between what the advanced beginner nurses expected during the first year of practice and what they actually experienced, are indicators of the existence of reality shock. Reality shock, according to Kramer (1974), is the reaction of new graduate registered nurses after they have spent a number of years preparing for a nursing career only to realize that they are not ready for the reality of daily nursing practice. The current study indicated that reality shock for an advanced beginner nurse in labor and delivery was related to the responsibility for a fetus that could not be seen and the liability for interpreting the fetal heart rate tracing. This finding is unique to advanced beginners in labor and delivery and has not been described in previous studies on reality shock in advanced beginner nurses (DeBellis et al., 2001; Evans, 2001; Hinds & Harley, 2001; Jasper, 1996).

Participants also experienced difficulty setting priorities and managing multiple tasks at the same time. Labor is a rapidly changing, unpredictable environment. Nurses in labor and delivery cannot plan the activities for the day in advance. Each patient's condition has the potential to change quickly and result in the reexamination of previous priorities. An advanced beginner in nursing has not had enough experience to easily

reorganize and reevaluate priorities.

The reported difficulty in prioritizing tasks and managing multiple tasks was consistent with findings about new graduate nurses in another recent study (DeBellis et al., 2001). While advanced beginner nurses in labor and delivery experienced reality shock similar to neophyte nurses in medical-surgical nursing, the source of the reality shock was different. In medical-surgical nursing, the reality shock was related to the large patient assignment, priority setting for multiple patients, and delegating (DeBellis et al., 2001). In the current study, advanced beginners experienced reality shock as a result of the responsibility for the well-being of a fetus that could not be seen and must be evaluated using an electronic fetal monitor.

Participants faced a steep learning curve while training to care for a woman in labor and delivery. Participants reported they took from 6 to 18 months of practice as a labor and delivery nurse to become competent in caring for low-risk labor and delivery patients, and even longer to become competent in caring for higher risk patients. The time needed to develop competency varied for each individual nurse, depending on the number and type of delivery experiences. Since it is not possible to predict or control the availability of experiences required to develop competency in labor and delivery, the time needed to acquire a sufficient number of experiences was variable. This finding is in contrast to a recent study which examined advanced beginners in medical-surgical nursing (Meretoja et al., 2002). Advanced beginners in medical-surgical nursing have a more predicable environment and more consistent learning experiences. Procedures are usually scheduled in advance in medical-surgical nursing, thus advanced beginner nurses

can coordinate their learning experiences and practice needed skills.

Advanced beginners in labor and delivery demonstrated skill acquisition congruent with the theoretical framework chosen for this study, the skill development of a nurse from novice to expert (Benner, 1984). Benner proposed that the acquisition and development of clinical nursing skills is based upon knowledge and experience. According to Benner, the transition from novice to expert performance is attributable to concrete knowledge acquired through experience. The transition from novice to expert does not occur in a predictable, linear manner. It is an individual process, influenced by exposure to similar clinical situations over a variable amount of time. In this study, nurses who worked more hours per week in a hospital with a higher number of deliveries per month attained competency sooner than the nurses who worked fewer hours in a hospital with a smaller number of deliveries. The nurses working in a higher volume labor unit had more consistent exposure to low-risk labor patients which resulted in more rapid skill acquisition.

Research Question 2

What factors hindered and/or facilitated the transition experience for reflective advanced beginners in labor and delivery?

There were four factors that hindered the transition experience for the advanced beginner nurses in labor and delivery. The first factor was negative interactions with others, including physicians, preceptors, and other nurses, especially when the individual held a position of authority and the incident occurred in the presence of others. The second factor that caused a hindrance was the inadequate length of the orientation period,

which has been already been discussed. The third factor was mastering the specific technical skills needed to manage a patient in labor. Three skills unique to labor and delivery nursing were described as difficult to master during the first year of practice. These skills were vaginal examinations, fetal monitoring interpretation, and judging the time of birth. The skill acquisition factor was discussed in the previous research question. The final factor was documenting the care for a woman in labor and delivery.

Conversely, positive relationships with other nurses facilitated the transition experience. There were supportive nurses who assisted advanced beginner nurses to learn their job, prioritize their work, and gave positive feedback and encouragement to make the new nurses feel more confident.

The advanced beginner nurses in labor and delivery in this study were subject to multiple negative interactions, including incidents of verbal abuse from physicians and other nurses which damaged their self-confidence. Because the transition from advanced beginner to competent is a period of confidence building, negative interactions may hinder the transition. The negative interactions between advanced beginner nurses and others, including physicians, preceptors, and other nurses resulted in feelings of self-doubt and avoidance. These findings are consistent with a number of studies describing negative interactions that adversely affected advanced beginners entering nursing practice (Boychuck-Duchscher, 2001; Boyle et al., 1996; DeBellis et al., 2001; McKenna et al., 2003). Participants in this study were hesitant to report the negative interactions to anyone, possibly because of their subordinate position. This finding is consistent with advanced beginners in previous studies who did not report incidents of negative

interactions, including verbal abuse (DeBellis et al., 2001; McKenna et al., 2003). In addition, incidents of negative interactions are associated with an increased attrition rate among nurses (Rosenstein, 2002).

This study revealed a facet of the transition process for advanced beginner nurses in labor and delivery that has not been addressed in previous studies of neophyte nurses. The participants in this study were concerned about documenting the care for a woman in labor and delivery. Specifically, they were apprehensive about the quality of their documentation, recognized the litigious nature of labor and delivery, and wanted to insure that their documentation was clear, accurate, and sufficient to describe high risk situations to protect themselves from malpractice law suits. Although they were trained in proper documentation during the orientation period by a senior nurse, advanced beginner nurses reported that the quality of documentation was not consistent among senior nurses. Participants were uncertain about their documentation because no one from management formally evaluated their documentation either during or after the orientation period. None of the participants were formally evaluated during their first year of practice, leaving them hesitant and insecure about their progress toward competency.

Advanced beginner nurses in this study identified the importance of a positive relationship with a more experienced nurse in the transition from advanced beginner to competent nurse in the labor and delivery unit. The advanced beginner nurses reported that they appreciated the guidance and support provided by these nurse mentors. The positive relationships with mentors helped to ease the transition for the advanced beginners in the labor and delivery unit. This mentor relationship gave the participants an

opportunity to seek advice, guidance and reassurance during their period of confidence building. This finding is consistent with previous research that suggested the support and guidance of more experienced staff can affect the success or failure of new graduate nurses' transition (Boychuck-Duchscher, 2001; Ellerton & Gregor, 2003; McKenna et al., 2003; Oermann & Garvin, 2002; Oermann & Moffitt-Wolf, 1997; Thomka, 2001).

Research Question 3

What areas of labor and delivery did the reflective advanced beginner nurses' feel competent to perform?

The findings of this investigation suggests that advanced beginner nurses described feeling competent in caring for low-risk patients and performing the skills associated with low-risk labor and delivery after approximately 6 to 12 months of experience. Low-risk patients were described as those who have no medical complications and a normal, spontaneous vaginal delivery. Advanced beginner nurses described the feeling of being competent as a highlight of their first year as a labor and delivery nurse. Competency was described by participants in this study as the feeling of elation associated with the first time they were able to perform all functions of a labor and delivery nurse without having to get assistance from a more senior nurse.

After a year of experience, advanced beginner nurses had worked with a variety of low-risk and high-risk patient situations. After at least a year of experience, participants described themselves as competent in caring for low-risk patients and confident, but not yet competent, in caring for high-risk patients.

The advanced beginners in this study described feeling that they could prioritize

the nursing care of low risk of labor and delivery patients, and had some skill mastery after approximately 1 year of practice. In this study, participants entered the labor and delivery unit as advanced beginners and, after a minimum of 1 year of practice experience, made the transition to competent nurse. This finding is consistent with the work of Benner (1974) which found that competency required between 1 to 3 years of experience. Another recent study of new graduate nurses (Casey, Fink, Krugman, & Propst, 2004) also found that becoming a competent nurse generally takes 1 to 3 years of experience in a particular clinical area.

Research Question 4

What was the perception of reflective advanced beginners about their educational preparation for labor and delivery practice?

The advanced beginner nurses in this study described the quality of their nursing programs as good, but they were disappointed in the small number of clinical hours spent in labor and delivery. While nursing school did not focus on labor and delivery or other nursing specialties, the nursing staff and faculty were role models for nursing practice. Participants in this study reported a difference between the theory learned in nursing school and actual nursing practice. Although the participants described nursing school as providing a solid theoretical base, few clinical hours were dedicated to labor and delivery and the specific skills needed in labor and delivery were acquired after graduation. Because most new graduates obtain their first position in a medical-surgical nursing unit, the goal of a basic nursing program is to train individuals to become safe, entry level providers of care on a medical-surgical unit. Basic nursing programs provide minimal

preparation for a specialty other than medical-surgical nursing. This finding is consistent with prior studies which have suggested that new graduates are likely to experience a disparity between the theory taught in nursing school and real nursing practice new graduates experience in their hospital employment (Ellerton & Gregor, 2003).

Because of the nursing shortage, new graduate nurses are able to begin their career in specialty units directly after graduation from nursing school. The question remains; should new graduate nurses go directly into a specialty, such as labor and delivery, or should they spend a year in a general medical-surgical unit? The findings of this study suggest that nurses starting their career in labor and delivery face a number of obstacles during the transition from advanced beginner to competent nurse. While the transition from nursing school to practicing as a registered nurse is never simple, making the transition in a predicable environment such as medical-surgical, mother-baby, or postpartum unit may be easier than in a volatile, litigious environment such as labor and delivery. Specifically, the advanced beginner nurses in this study faced intense stress related to the responsibility for a fetus that could not been seen, a stress unique to being a labor and delivery nurse. In addition, advanced beginners reported that training to be a labor and delivery nurse required more time and was more stressful then they had anticipated. The skills needed to become a competent labor and delivery nurse, such as vaginal examinations, fetal monitoring, and timing when to call the physician for delivery are not taught or practiced during basic nursing school. The skills required to be a competent labor and delivery nurse are different than the skills needed on a general, medical-surgical unit, consequently, a new graduate nurse with the desire to become a

labor and delivery nurse should consider spending the first year of practice as a nurse on a postpartum or mother-baby unit. This would allow the new graduate to practice basic skills such as assessment, delegation, and prioritization in addition to specific skills, such as fetal monitoring and infant assessment, which are not available on a general, medical-surgical unit.

The findings of this investigation also suggest that preceptorship provided a bridge between the theory of nursing school and the real life practice of nursing. A preceptorship program consists of approximately 250 hours of focused experience, during the final year of a nursing program, working directly with an experienced nurse. Several participants in this study had completed a preceptor program. These nurses had more realistic expectations about the job of a labor and delivery nurse and they had additional clinical hours to practice the essential skills necessary for labor and delivery. Those who did not have the opportunity to participate in a preceptor program recognized the value of such a program and wished they had been offered the preceptor experience during nursing school. Previous research (Boychuck-Duchscher, 2001) has supported the benefits of a preceptorship to close the gap between nursing school and actual practice by utilizing a focused one-on-one experience with a practicing nurse to provide additional practice hours for the neophyte nurse prior to graduation.

Research Question 5

What were the influences that led reflective advanced beginner nurses to choose labor and delivery?

The majority of the advanced beginner nurses in this study had decided to become

labor and delivery nurses prior to starting nursing school. Some were influenced by a profound personal experience with the birth of their own child or as a result of a childhood dream to work as a nurse. None of the participants wanted to work in a general, medical-surgical unit after graduation. For these advanced beginner nurses, the desire to become a labor and delivery nurse was stronger than the advice of nursing instructors to seek a position in a general, medical-surgical unit prior to becoming a labor and delivery nurse.

There are no previous studies that identified influences that led advanced beginners to choose labor and delivery nursing as a career, which may provide an opportunity for future research. This study described the influences of personal experiences and childhood dreams on the decision to become a labor and delivery nurse and adds to the understanding of what factors influenced these advanced beginner nurses to choose labor and delivery nursing.

Additional Findings

This investigation identified three additional areas that were not related to the research questions posed by this study. These were somatic symptoms, adjusting to shift work, and medication errors. Advanced beginner nurses in this study experienced a number of distressing psychological symptoms and physical symptoms. While all participants described at least one symptom, each thought she was the only one experiencing these symptoms during the transition period. The findings of this study indicate that having some somatic symptoms is a normal part of the transition period and that the symptoms gradually decrease over time and eventually resolve. A previous study

of new graduate nurses reported that many considered leaving the nursing profession because of the stressful situations that resulted in psychological or physical discomfort (McKenna et al., 2003). While none of the participants in this study reported that they were considering leaving the nursing profession, several seriously considered finding a different job in nursing during the transition period because of the somatic symptoms they experienced.

Participants in this study described the difficulty adjusting to the night shift with resulting lack of sleep, difficulty thinking, fatigue, and the negative effect on personal relationships and coping. Advanced beginner nurses in labor and delivery did not work any night shift rotations during nursing school. As a result, they were not at all prepared for the profound physical and psychological changes that accompanied adjustment to the night shift. The difficult adjustment to night shift caused several nurses in this study to consider changing jobs and even switching nursing specialties in order to avoid working at night. For these participants, the night shift affected their quality of life and family relationships. Previous research (DeBellis et al., 2001) similarly concluded that neophyte nurses experienced stressors which included shift work, lack of sleep, exhaustion, inability to think, and frustration when they were not able to cope with the heavy patient assignments.

Most participants in this study admitted to making at least one medication error which involved antibiotics, magnesium sulfate or pitocin during their first year of practice. Although all participants were instructed during nursing school about the five safeguards for medication administration, participants made errors that included the

wrong drug, drugs given at the wrong time(s), and incorrect dosage of medications. The medication errors were not a result of a lack of knowledge, but rather some participants reported that the reason for these errors may have been fatigue or inexperience.

Previous research involving medication errors made by neophyte nurses similarly concluded that medication errors made by neophyte nurses on the medical-surgical unit may be the result of distracted, tired, and exhausted nurses (Beyea, Kobokovich, Becker, & Hicks, 2004; Mayo & Duncan, 2004; Tradewell, 1996). A recent study highlighted the frightening reality that nationwide, labor and delivery units had a 5% rate of harmful medication errors, which was more than twice the national average threshold (2.3%) of harmful errors for years 1998-2003 (Beyea et al., 2004).

This investigation focused on the transition experience from advanced beginner to competent nurse in a labor and delivery unit. Although there was some agreement between the findings of this study and previous research that examined the new graduate nurse working in a medical-surgical unit (Boychuck-Duchscher, 2001; DeBellis et al., 2001; Ellerton & Gregor, 2003; McKenna et al., 2003), some findings were unique to the labor and delivery unit. This investigation identified three facets of the transition experience unique to labor and delivery. First, participants described the fundamental skills required to become a competent labor nurse, including vaginal exams, fetal monitoring and timing when to call the physician for delivery. Secondly, advanced beginners in labor and delivery were concerned about adequately documenting the care of women during labor and delivery due to the litigious nature of obstetrics. Finally, this study identified the factors that influenced these advanced beginner nurses to choose

labor and delivery nursing as a career.

Previous studies have focused on the new graduate nurse working in a medical-surgical unit (DeBellis et al., 2001; McKenna et al., 2003; Boychuck-Duchscher, 2001; Ellerton & Gregor, 2003). This study is consistent with previous research in several findings. First, this study confirms previous research about the existence of reality shock in advanced beginner nurses. Although advanced beginners in both medical-surgical and labor and delivery units experienced reality shock, the source of the reality shock is different for advanced beginners in labor and delivery. Second, previous studies suggested that advanced beginners required a minimum 1 year of experience to become competent (Benner, 1984). Participants in this study required a minimum of 12 months to attain competency as a labor nurse. Third, advanced beginners in medical-surgical units and labor and delivery units experienced negative interactions with others that affected their self-confidence and hindered the transition from advanced beginner to competent. Fourth, advanced beginner nurses in medical-surgical and labor and delivery describe the theory-practice gap and the supportive role of a preceptor program in bridging the gap. Fifth, advanced beginner nurses working in medical-surgical and labor and delivery experienced psychological and physical manifestations of stress, and difficulty adjusting to night shift work. Lastly, the majority of advanced beginners in both medical-surgical and labor and delivery units made medication errors during their first year of practice.

Previous research has focused on the transition from advanced beginner to competent nurse in the medical-surgical and critical care units. In contrast, this study examined the transition process from advanced beginner to competent in the labor and

delivery unit from the perspective of the advanced beginner nurse. The findings of this study contribute to the understanding of the transition process from advanced beginner to competent nurse. In addition, the findings suggest aspects that are unique to the transition process for advanced beginners in the labor and delivery unit.

Conclusions

Six key findings emerged from this study. First, is the length of time needed to become a competent nurse in labor and delivery. Advanced beginner nurses in labor and delivery require a minimum of 1 year of experience to become competent in caring for low-risk labor patients and at least a year of experience for participants to describe themselves as confident, but not competent, in caring for high-risk patients. None of the participants described themselves as competent in caring for high-risk patients, even after 1-2 years of experience in labor and delivery.

Participants felt the typical 6-8 weeks of orientation provided for newly hired advanced beginner nurses was inadequate to master the skills necessary to care for a patient in labor and delivery. Participants identified three critical skills, vaginal examinations, fetal monitoring and timing of when to call the physician for delivery, which required longer to learn than the 6-8 week orientation period. Participants stated that they needed additional support after orientation to master those skills. For the advanced beginners in this study, support included formal feedback about their skills, documentation and performance during the transition from advanced beginner to competent nurse.

The second key finding to emerge from this study is that labor and delivery nurses

experienced reality shock, similar to symptoms experienced by neophyte nurses in medical-surgical nursing, but the source of the reality shock was different. The source of reality shock for the advanced beginner nurse originated from the burden of responsibility inherent in caring for a woman in labor and the liability for interpreting the well-being of the fetus through the fetal monitor. The reality shock occurred after completion of the orientation period when she was solely responsible for a patient. The intensity of the responsibility for the mother and her unseen fetus resulted in unanticipated stress for the advanced beginner nurse.

Third, all participants experienced negative interactions with staff, including other nurses, supervisors, managers, preceptors, and physicians. These negative interactions, characterized by McKenna et al. (2003) as horizontal violence, affected the self-confidence of the participants during the first year of practice, a time of confidence building. Participants did not feel prepared to handle the conflict nor did they feel comfortable reporting these interactions to others. Instead, they chose a strategy of avoidance in order to cope with negative interactions with others. By avoiding the situation, the advanced beginners never resolved the conflict so the situation stayed the same or it escalated.

Fourth, participants reported debilitating psychological and physical somatic symptoms during the transition period. There were several reasons for these responses. The responsibility and accountability for the unseen fetus and interpreting the fetal monitor heart tracing results causes advanced beginner nurses to experience symptoms such as headaches, nausea, diarrhea and difficulty sleeping. These symptoms appeared to

be normal physiological responses to the intensity of the job and subsided for all participants after the first year of practice. The advanced beginner nurses in this study did not expect to have these somatic symptoms related to the stress of the job and did not realize that other advanced beginner nurses in labor and delivery had experienced similar symptoms during the first year of practice.

Fifth, advanced beginner nurses experienced a theory-practice disparity after graduating from nursing school. While nursing school provided the theoretical background for safe practice in a medical-surgical unit as well as the knowledge required to pass the national registered nurse licensing exam, nursing training did not impart the knowledge or specific skills required to be a labor and delivery nurse. New graduate nurses with the desire to become a labor and delivery nurse may benefit from beginning nursing practice in a general women's unit, such as postpartum or antepartum. This experience may provide additional clinical practice in general nursing skills as well as the specific skills needed to become a competent labor and delivery nurse, such as fetal monitoring and vaginal examinations. Participants expressed a desire for programs which offered more clinical hours in the specialty units, including labor and delivery. Participants acquired the knowledge and skills to be a labor and delivery nurse during and after the orientation period.

Finally, medication errors were common during the transition period. Medication errors typically involved administering the wrong antibiotic, at the wrong time or administering an incorrect dosage. Other medication errors included administering magnesium sulfate at a too high a rate and incorrect calculation of pitocin administration.

While none of the medication errors reported in this study resulted in serious injury to a patient, all errors had the potential to cause harm. The advanced beginners in this study recognized the potential for patient injury related to medication errors and struggled to cope with the humiliation of having been involved in a medication error.

Limitations

There are several limitations to this study. First, this study used a small, convenience sample of advanced beginner nurses from six private hospitals in Northern California, limiting generalizability of the findings to other populations. A convenience sample was chosen because the participants were in close proximity to allow for face to face interviews, they met inclusion criteria, they were employed in a facility supportive of employee participation and they were willing to participate. The sample was only as representative as the subjects who chose to be interviewed. All participants were Caucasian females, except one Asian female, therefore, minorities, such as African-American, Hispanics, and men were not represented at all. Asians were under-represented in this study. Characteristics of potential participants who chose not to participate in the study is another limitation to this study. Another limitation was that the size and type of the hospitals and number of deliveries in each unit varied, which may have influenced the findings. Participants who were employed in a hospital with a higher number of deliveries may have been involved in more deliveries and with more high risk patients. The additional experience in a hospital with a higher number of deliveries may have influenced the time required to attain competency. All participants were employed in private, non-profit, hospitals. Teaching hospitals or Health Maintenance Organization

(HMO) hospitals may have different environments which could influence the time required to become competent as well as the negative interactions between advanced beginners and staff.

Recommendations

Future Research

The findings of this study have implications for future nursing research. This study used a phenomenological approach to better understand the transition from advanced beginner to competent nurse in the labor and delivery unit. Since there were no previous studies examining the transition experience in labor and delivery units, the findings of this study could be used as a foundation for further nursing research pertaining to advanced beginners in labor and delivery. The phenomenological approach could be used for several follow-up studies, including a study designed to explore the transition from advanced beginner to competent using a sample of nurses working in large teaching facilities or Health Maintenance Organization (HMO) owned hospitals. The differences may have implications for nurse leaders, nurse educators, and research.

More broadly, advanced beginner nurses in labor and delivery who represent diverse groups, including male nurses should be studied. A better understanding about the transition experience of male and diverse advanced beginner nurses in labor and delivery may have different implications for nursing leaders, educators, and researchers.

Further work could establish whether a longer orientation period would expedite the transition from advanced beginner to competent. A longitudinal study could be designed to compare orientation periods of different lengths. The length of orientation

required to learn the skills necessary to care for a low risk patient in labor could be determined.

Further research might utilize an observational approach to study samples of advanced beginners through the transition to competent nurses. The close observation involved in this type of study might reveal factors related to transition which were not reported during the interview process used in this study.

Finally, quantitative studies could be conducted to broadly measure one of the findings from this study. For example, a study could be designed to examine the overall number of medication errors committed by advanced beginner nurses compared to nurses with more experience. The specific types of medications involved in errors may reveal patterns of errors which were not reported in this small sample interview study. Another study could be designed to determine the time of medication errors to determine if time of day or night influences the rate of medication errors in the labor and delivery unit.

Professional Practice

This study provided a better understanding of the transition experience from advanced beginner to competent nurse in the labor and delivery unit. The findings of this study have a number of important implications for professional practice. Previous research suggested that the first year of practice is a vulnerable time for a new graduate nurse, with approximately 6% leaving the nursing profession during the first year (Aiken et al., 2002). Since most new graduate nurses begin their career in a hospital, it is beneficial for nursing leaders to have a better understanding of the transition from advanced beginner to competent nurse in labor and delivery from the perspective of the

advanced beginner nurse.

The participants identified both positive and negative aspects of the transition from advanced beginner to competent nurse in the labor and delivery unit. The negative elements reported by participants included the inadequate length of orientation, debilitating somatic symptoms related to stress, negative interactions with staff, and feedback concerning proper documentation. One positive aspect was a supportive relationship with a mentor, a more experienced nurse to provide guidance and advice during the transition period. A better understanding of the issues that challenge advanced beginners may lead to the development of programs designed to facilitate the transition experience and decrease the attrition of nurses during their first year of practice.

Based on the findings of this study, the following recommendations are intended for nursing leaders in hospitals. Nursing leaders can assist advanced beginner nurses in labor and delivery by choosing nursing preceptors who have the knowledge, skills and desire to work with advanced beginners. Staff nurses who have the interest in precepting advanced beginners should be provided with formal training including specific content related to the transition process.

Preceptors can play an important role in the transition experience. Participants in this study indicated that they found it helpful when a single preceptor nurse was assigned to their orientation. Having a single individual guide the advanced beginner through the orientation period was viewed as beneficial for consistency of learning. Participants reported three skills that were the most difficult to master during the transition process: vaginal examinations, fetal monitoring and timing when to call the physician for delivery.

By understanding the implications of this finding, preceptors could focus on teaching these skills during the orientation period and provide additional practice experience in fetal monitoring, vaginal examinations and when to call the physician for delivery.

Preceptors need to give constructive feedback to the advanced beginner nurses, in a compassionate manner, away from public scrutiny. The relationship between the preceptor and advanced beginner nurse is important to the transition process. The relationship should be mutually beneficial, or another preceptor should be chosen quickly and without any consequences to either nurse. Preceptors should be sensitive to the common somatic symptoms displayed by advanced beginner nurses, including headaches, stomach pain, diarrhea, nausea and fatigue and allow the advanced beginner nurse to discuss their anxiety and provide reassurance.

The optimal time for orientation is still unknown. Advanced beginner nurses who chose to enter a specialty directly after graduation may require additional orientation time than those who have experience on a general women's care unit, such as postpartum or antepartum. Participants in this study entered directly into labor and delivery after graduation. They felt that the length of the orientation period should be increased in order to learn the skills needed in labor and delivery nursing. The preceptor, manager, and advanced beginner could meet periodically during the orientation period to evaluate the advanced beginner's progress and determine if additional orientation time would be beneficial. While the crisis of the nursing shortage creates pressure to complete the orientation period in a specified period of time so that the advanced beginner will be available for patient care, each advanced beginner progresses at a different rate.

Providing an individualized plan as well as additional time for advanced beginner nurses may reduce feelings on anxiety and lower the attrition rate of novices.

The results of this study have implications for nursing education. A previous study similarly concluded that advanced beginner nurses experienced a theory-practice gap upon entering the work force (Landers, 2001). Nurse educators can gain an understanding of the transition experience from the perspective of the advanced beginner nurse. The advanced beginners in this study reported not having enough clinical hours during nursing school in labor and delivery. Since new graduate nurses are being hired into specialty units upon graduation, nursing educators should provide students with additional clinical experiences, in the students' area of interest, to prepare the students for the transition and to provide more realistic expectations about nursing practice. Several participants were in nursing preceptorship programs consisting of concentrated clinical experiences while paired with an experienced nurse. Preceptorship was reported to provide additional time to practice clinical skills, organize patient care, and develop a more realistic expectation of actual nursing practice. Additional findings of this study suggest that medication administration, fetal monitoring and conflict resolution are identified areas of need for these advanced beginners and as such, these are topics for nursing educators to focus on during nursing school and during the orientation period.

Finally, participants in this study were unprepared for the challenges associated with working the night shift. The participants did not have clinical experiences in nursing school working during the night shift. Since most of the graduates will first be employed in a night shift position, nursing educators need to discuss the problems associated with

working during the usual sleeping hours, such as sleep disturbances, difficulty concentrating, and the potential negative effects on family relationships.

This chapter discussed the findings of the study examining the transition experiences of advanced beginners to competent nurses in the labor and delivery unit. Suggestions for topics of future research were given and implications of the study for professional practice, including specific suggestions for nursing leaders and education were provided.

The study used a phenomenological qualitative method to examine the transition from advanced beginner to competent nurse in the labor and delivery unit from the perspective of the advanced beginner. Twelve reflective advanced beginners, who had at least 1 year, but less than 2 years of experience, were interviewed in order to investigate the individual's perspective of the transition from advanced beginner to competent nurse in the labor and delivery unit. This study yielded a deeper understanding of the transition experience from the perspective of the reflective advanced beginner nurses. The 16 themes that emerged are not distinct periods of time, nor are they concrete steps, but rather, these themes reflect a process of experience, recognizing patterns and skill acquisition that culminated in the advanced beginner nurse feeling competent in caring for low-risk labor patients. This transition from advanced beginner to competent nurse required the participants a minimum of 6-12 months to complete. The reflective advanced beginners in this study recognized the process of becoming competent to care for low-risk patients was the highlight of their first year of practice, however, the participants did not feel competent to care for a high-risk patient in labor and delivery during the first 2

years of practice in labor and delivery.

In conclusion, the transition from advanced beginner to competent nurse in the labor and delivery unit is an individual dynamic process, not a finite accomplishment. Nursing educators and nursing leaders need to collaborate on strategies that reduce the theory practice gap, reality shock and facilitate the transition from advanced beginner to competent nurse in the labor and delivery unit.

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APPENDIX A

Interview Guide

To address the research questions, participants were presented with the following prompts:

1. Tell me what it is like to be a labor and delivery nurse.
2. How does your practice as a labor nurse compare to what you thought it would be like?
3. How well do you think your nursing program prepared you for practice?
4. Why did you want to become a labor nurse?
5. Describe the high point or proudest moment of your first year as a labor nurse.
6. How did that experience affect you-what changes associated with that experiences did you observe?
7. What thoughts, emotions, etc., were generated by that experience?
8. How did that experience alter your relationship to others?
9. What else, significant to that experience, would you like to share?
10. Describe the low point or worst moment of your first year as a labor nurse.
11. How did that experience affect you-what changes associated with that experience did you observe?
12. What thoughts, emotions, etc., were generated by that experience?
13. How did that experience alter your relationship to others?

14. What else, significant to that experience, would you like to share?

15. Can you give me an example of when you first felt "competent" as a labor nurse?

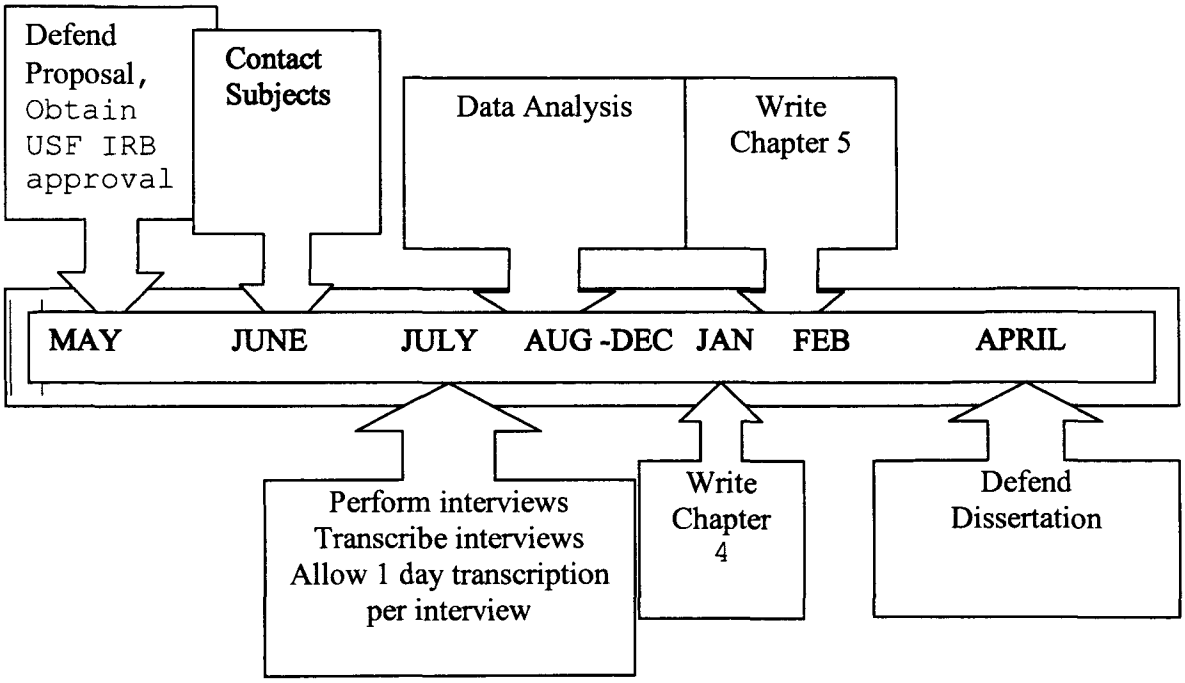
16. What could have been done to improve your first year of practice?

17. Are there any other important issues which have affected your first year of practice that we haven't discussed yet?

APPENDIX B

Timeline

McMillin Dissertation Timeline



APPENDIX C

Letter of Introduction for Potential Participants

Date, 2004
Dear Labor Nurse:

My name is Jan McMillin and I am a doctoral student in the School of Education at the University of San Francisco. I am conducting a study on the experiences of new labor nurses. I am interested in learning about your experiences during your first year of practice, how well your education prepared you for your role as a labor nurse, and your motivation for choosing labor as your nursing specialty. Your hospital management has given approval for me to contact you for this study.

You are being asked to participate because you are a labor nurse who entered into labor and delivery directly after graduation from nursing school. Your insights and experiences are extremely valuable to a better understanding of the transition to becoming a competent labor and delivery nurse. The results of this study will be used to develop better orientation and educational programs for nurses interested in labor and delivery. I asked your manager to give you this letter to introduce my study and ask for your participation. If you agree to be in this study, you will participate in an approximately one hour in person audio-taped interview with me about your experiences.

The interview will be conducted at your convenience at either the nursing building at CSU, Sacramento or your place of choice. You will be reimbursed for mileage and parking and refreshments will be provided. In addition, participants will be entered into a drawing for registration fees for the 2-day continuing education conference, Perinatal Hot Topics, to be held in Sacramento in February, 2005 ($150.00 value).

If you are interested in participating, please return the letter of interest in the enclosed self-addressed stamped envelope, fax to (916)686-0299; call me at 916-849-0793 or by email: profjanmc@comcast.net

Thank you for your consideration. I look forward to meeting with you.

Sincerely,
Jan McMillin, RNC, MSN
Doctoral Student
University of San Francisco

Letter of Interest

I am interested in participating in your study, Transition from Advanced Beginner to Competent Nurse in the Labor and Delivery Unit. Please contact me to arrange a place and time for an interview.

Name_____

Hospital:_____

_____

Shift you work_____

Best time to call_____

Primary phone number _____

Work phone_____

Email_____

What is the best way to reach you?_____

Thank you again for your interest.

Jan McMillin

(916)849-0793

Please return in enclosed envelope or fax to (916) 686-0299

APPENDIX D

Letter Sent to Participants Before Interview

Date

Participant Name and Address

Dear (Name of Participant),

I would like to thank you for your interest in participating in the research study, "Transition from Advanced Beginner to Competent Nurse in the Labor and Delivery Unit".

Your interview has been scheduled for (Day, Date) at (Location). A map has been provided for your convenience. The interview should last approximately 60 minutes. The interview will be audio-taped so that your experiences can be accurately captured. The audio tapes will be transcribed. During transcription, any information such as names or places that could identify you will be removed during the transcription so your information can remain as confidential as possible.

When the interview is completed, you will be reimbursed $10.00 for your transportation and parking fees. In addition, your name will be entered into a drawing for the registration fees for the 2-day continuing education Perinatal Hot Topics conference scheduled for February, 2005. Please take some time been now and our interview to reflect on the following questions:

1. How does your practice as a labor nurse compare to what you thought it would be like?
2. Describe the high point or proudest moment of your first year as a labor nurse.
3. Describe the most difficult point during your first year of nursing
4. What could have been done to improve your first year of experience?

Your commitment to this research study will provide valuable insight to understanding the experiences of first year labor and delivery nurses. Please free to contact me if you have any questions and I look forward to meeting with you.

Sincerely,

Jan McMillin, RNC, MSN
(916) 849-0793 or profjanmc@comcast.net

APPENDIX E

Informed Consent Form

UNIVERSITY OF SAN FRANCISCO

CONSENT TO BE A RESEARCH SUBJECT

Purpose and Background

Ms. Janice McMillin, a graduate student in the School of Education at the University of San Francisco is conducting a study on transition experiences of first-year labor and delivery nurses. The nursing shortage has resulted in new graduate nurses entering specialty units directly upon graduation. The researchers are interested in understanding the transition experiences of new graduate nurses in labor and delivery units.

I am being asked to participate because I am a labor and delivery nurse with at least 1 year of experience and I entered labor and delivery directly after graduation from nursing school.

Procedures

If I agree to be a participant in this study, the following will happen:

1. I will complete a short questionnaire giving basic information about myself, including age, gender, ethnicity, and job history.

2. I will participate in an interview with Ms. McMillin, during which I will be asked about my educational preparation and my experiences as a labor nurse.

I will complete the questionnaire and participate in the interview at the office of Jan McMillin in the School of Nursing at CSU, Sacramento.

Risks and/or Discomforts

1. It is possible that some of the questions may make me feel uncomfortable, but I am free to decline to answer any questions I do not wish to answer or to stop participation at any time.

2. Participation in research may mean a loss of confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times or computer files with security passwords. Only study personnel will have access to the files.

3. Because the time required for my participation may be up to 2 hours, I may become tired or bored.

Benefits

There will be no direct benefit to me from participating in this study. Sharing the experience, however, allows for self-reflection on the transition experience. Hargreaves (2004) stated that engaging in self-reflection encourages nurses to evaluate their practice, promotes self-awareness, and may help reduce the theory-practice gap. but this can not be guaranteed. The anticipated benefit of this study is a better understanding of the transition of new graduate nurses in labor and delivery units, but this can not be guaranteed.

Costs/Financial Considerations

There will be no financial costs to me as a result of taking part in this study.

Payment/Reimbursement

I will be reimbursed $10.00 for my participation in this study. I will be paid in cash immediately after I have completed the questionnaire and interview. I will also be eligible for a drawing for registration fees for February, 2005 Perinatal Hot Topics conference ($150.00 value). If I decide to withdraw from the study before I have completed participating or the researchers decide to terminate my study participation, I will still receive full reimbursement and be eligible for the drawing.

Questions

I have talked to Ms. McMillin about this study and have had my questions answered. If I have further questions about the study, I may call her at (916)849-0793 or Dr. Susan Evans at (415)422-5892.

If I have any questions or comments about participation in this study, I should first talk with the researchers. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with protection of volunteers in research projects. I may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by e-mailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Department of Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, CA 94117-1080.

Consent

I have been given a copy of the "Research Subject's Bill of Rights" and I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study, or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as a student or employee at USF.

My signature below indicates that I agree to participate in this study.

Subject's Signature Date of Signature

Signature of Person Obtaining Consent Date of Signature

APPENDIX F

RESEARCH SUBJECTS' BILL OF RIGHTS

The rights below are the rights of every person who is asked to be in a research study. As a research subject, I have the following rights:

(1)To be told what the study is trying to find out;

(2)To be told what will happen to me and whether any of the procedures, drugs, or devices are different from what would be used in standard practice;

(3)To be told about the frequent and/or important risks, side effects, or discomforts of the things that will happen to me for research purposes;

(4)To be told if I can expect any benefit from participating, and, if so, what the benefit might be;

(5)To be told of the other choices I have and how they may be better or worse than being in the study;

(6)To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study;

(7)To be told what sort of medical or psychological treatment is available if any complications arise;

(8)To refuse to participate at all or to change my mind about participation after the study is started; if I were to make such a decision, it will not affect my right to receive the care or privileges I would receive if I were not in the study;

(9)To receive a copy of the signed and dated consent form; and

(10)To be free of pressure when considering whether I wish to agree to be in

the study.

If I have other questions, I should ask the researcher. In addition, I may contact the Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. I may reach the IRBPHS by calling (415)422-6091, by electronic mail at IRBPHS@usfca.edu, or by writing to USF IRBPHS, Department of Counseling Psychology, Education Building, 2130 Fulton Street, San Francisco, CA 94117-1080.

IRBPHS 2001 MANUAL

APPENDIX F

Letter Sent to Participants After Interview

Date

Participant Name and Address

Dear (Name of Participant),

I would like to thank you for your participation in the research study, "Transition from Advanced Beginner to Competent Nurse in the Labor and Delivery Unit".

Your interview has been transcribed and any information such as names or places that could identify you has been removed during the transcription so your information can remain as confidential as possible. Please take some time to review your interview transcript. I will be calling you in approximately two weeks. At that time, you will have the opportunity to share any final thoughts or reflections about the interview and the meaning you attach to your words.

Your commitment to this research study has provided valuable insight to understanding the experiences of first year labor and delivery nurses. I wish you luck in your future and please feel free to contact me if you have any questions or would like a copy of the research findings.

Sincerely,

Jan McMillin, RNC, MSN
(916) 849-0793 or profjanmc@comcast.net

THE UNIVERSITY OF SAN FRANCISCO

Dissertation Abstract

Transition from Advanced Beginner to Competent Nurse

in the Labor and Delivery Unit

The purpose of this study was to examine the transition experience from advanced beginner to competent nurse in the labor and delivery unit. This phenomenological qualitative study used a purposeful sample of 12 labor and delivery nurses currently employed in six private hospitals in Northern California. All participants in the study had at least 1 year, but less than 2 years, of experience in labor and delivery nursing.

Participants were interviewed using a semi-structured interview protocol and the transcripts were analyzed using Colaizzi's seven-step method (1978). To enhance the trustworthiness and reliability of the data, feedback and insight from the participants was included in the development of the final 16 themes that described the transition from advanced beginner to competent nurse in the labor and delivery unit.

The findings of this study suggest that participants did not anticipate the intensity of the stress unique to being a labor and delivery nurse, specifically, the responsibility for the well-being of a fetus that could not been seen and must be evaluated using a fetal monitor. This study identified four factors that hindered the transition and one influence that facilitated the transition from advanced beginner to competent nurse in labor and delivery. This study also described the competencies of advanced beginner nurses caring for low-risk patients in labor, and examined the factors that influenced these advanced beginner nurses to choose labor and delivery nursing as a career. Implications for

professional practice are discussed and suggestions are given for future research.

Janice McMillin, Author

Dr. Susan Evans, Chairperson,
Dissertation Committee