UNDERSTANDING NEW GRADUATE REGISTERED NURSE'S PREPAREDNESS AND READINESS FOR LEADERSHIP

by

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Abstract

Background: The number of new graduate registered nurses (NGRN) is on the rise while the acuity and complexities of health care continues to climb. NGRNs are required to engage in informal and formal leadership in the clinical setting in a variety of ways, yet find this challenging.

Research Design: The purpose of this, qualitative descriptive, study was to understand NGRNs experiences of clinical leadership within the first 14 months of their practice. Semi-structured interviews were held with nine NGRNs at one tertiary hospital in a western Canadian province.

Findings: Four main categories were constructed. The first category, self-doubt in relation to leadership, describes participants' feelings of uncertainty about the nature, expectations, and supports related to the role. The second category, preparing for leadership, details participants' perceptions of their preparation for leadership prior to, and during, their undergraduate nursing education, and on the job. The third category, evolving leadership, describes the development of participants' leadership abilities over their first 14 months of practice. The final category, navigating the challenges, articulates strategies the participants used to overcome challenges they faced while acting and developing as leaders.

Discussion: Findings show that the majority of participants in this study did not feel ready for the complexities of being the RN leader. Participants were particularly challenged due to their self-doubt and lack of confidence at the beginning of their practice. Their self-doubt was reflected by a lack of preparation for leadership. Participants' confidence grew and developed over time allowing them to feel comfortable and included in their workplace. Support from formal and informal leaders was vital to their developing confidence in leadership.

Lay Summary

The number of new graduate registered nurses (NGRNs) is on the rise at the same time as patient levels of care increase. The purpose of this study was to understand whether NGRNs were prepared and ready for the leadership roles and responsibilities they were required to perform. Our findings indicate that NGRNs experienced growth over their first 14 months of practice but did not feel ready for many aspects of leadership. Participants benefitted from the support of informal and formal leaders to role model professional behavior and develop their confidence. This thesis suggests different ways that educators, organizations, and leaders can improve and continue to support NGRNs leadership abilities.

Preface

This thesis is the original, unpublished work by the author, Chloe Pedersen. This study was granted ethical approval by the University Of British Columbia Behavioral Research Ethics Board- Certificate Number: H18-00611.

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Acknowledgements

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Chapter 1. Introduction

1.1 Background

As the number of nurses preparing for retirement grows, the number of New Graduate Registered Nurses (NGRNs) in the workforce increases (Canadian Institute for Health Information [CIHI], 2019). In 2018, there were 38,041 Registered Nurses (RNs) registered in British Columbia (BC) (CIHI, 2019). The majority of RNs in Canada in 2018 were between the ages of 35-54 (46.9%), 29.5% were younger than 35 years and 23.7 % were over the age of 55 years (CIHI, 2019). The CIHI data further reported 2018 as having the highest number of graduating nurses, more than there had been in each of the previous five years with a total of 12,837 RN graduates (CIHI, 2019). This demonstrates the increasing prevalence of newer nurses entering the workforce in comparison to older, more experienced nurses preparing for retirement (Al-Dossary et al., 2014; CIHI, 2019).

These concerning trends suggest that new graduates may enter a demanding and challenging workplace without the availability of experienced mentorship and support. This may make the well documented stressful transition from student to graduate nurse even more difficult and overwhelming (Al-Dossary et al., 2014; Candela & Bowles, 2008; Hunter & Cook, 2018). Furthermore, staff nurses, managers, and NGRNs alike have agreed that a gap exists between NGRNs' undergraduate preparation and their actual ability to enact the realities of nursing practice (Romyn et al., 2009; Wolff et al., 2009).

The Stages of Transition Theory was developed to describe the stages NGRNs move through during their first year of practice (Boychuk Duschner, 2008). The first stage, *doing*, occurs during the first three to four months of work and describes how NGRNs focus on completing tasks on time, meeting expectations, and doing good work, all while experiencing

overwhelming stress. The following stage, *being*, which lasts four to five months is characterized by NGRNs continued stress and frustration but starting to question nursing practice and disengaging and then reengaging with nursing practice at the end of the stage. The final stage, *knowing*, describes NGRNs focusing on building their own professional identities, decreasing their stress and by twelve months feeling more confident and comfortable. In addition to *doing*, NGRNs are expected to act as leaders, anticipate and manage patient care crises, as well as, resolve interpersonal conflicts among other staff members (Candela & Bowles, 2008; Dyress & Sherman, 2011).

Although the literature has tended to focus on formal leaders, bedside nurses, including NGRNs, engage in leadership in less formalized ways (Chappell et al., 2014). Bedside RNs engage in informal leadership during daily patient care, performing clinical skills and working with the health care team, while formal leaders are responsible and accountable for administrative, managerial, and executive level workplace operations (Al-Dossary et al., 2016; Little et al., 2018). Informal leadership skills that NGRNs may be expected to perform include night and evening charge nursing (Sherman & Dyess, 2011; Ryan & Hodson, 1992), delegation (Wangensteen et al., 2008), patient advocacy, interprofessional collaboration (Al-Dossary et al., 2014; Ortiz et al., 2016), and identification of potential or current problems and their solutions (Sherman & Dyess, 2011). Informal leadership was used for purposes of this study.

The British Columbia College of Nurses and Midwives (BCCNM), (2018) the regulatory body for registered nurses (RNs) in BC, considers NGRNs to be nurses who have recently graduated from a recognized nursing program and are within their first year of practice (British Columbia College of Nursing Professionals [BCCNP], 2018). Nursing school educators believe NGRNs are prepared for entry level practice upon completion of their programs (Al-Dossary et

al., 2014; Dyess & Sherman, 2011; Mbewe & Jones, 2015). Conversely, it has been shown that neither employers nor NGRNs themselves believe NGRNs are necessarily prepared for the realities of practice, let alone for the embedded pressures of leadership (Candela & Bowles, 2008; Dyess & Sherman, 2011; Mbewe & Jones, 2015). BCCNM acknowledges that NGRNs are unable to provide the same level of care as more experienced nurses (BCCNP, 2018). The BCCNM believes that NGRNs require on the job training and support to encourage their growth and confidence (BCCNP, 2018). The BCCNM has created a document outlining the expected competencies NGRNs should be able to meet upon graduation (BCCNP, 2018). Although nurses and nursing managers understand that NGRNs are not necessarily ready to take on the same workload of their more experienced colleagues, the demands of the care environments often do not allow for modified assignments.

NGRNs are expected to transition from student to nurse and to effectively engage in multiple leadership skills, often within weeks of beginning their careers (BCCNP, 2018; Dyess & Sherman, 2009; Hunter & Cook, 2018). However, it has been well documented that NGRNs simultaneously lack confidence and practical experience to do this (Boychuk Duschner, 2008). Generally, until they have had at least six months of practice, NGRNs are not able to begin to participate in leadership activities (Al-Dossary et al., 2014). This is consistent with the Stages of Transition Theory that posits that until NGRNs have four to five months of practice, they have difficulty critically thinking, challenging their pre-graduate ideas and beliefs, and questioning the system (Boychuk Duschner, 2008). The expectation that NGRNs *hit the ground running* (Hunter & Cook, 2018; Wolff et al., 2010), especially in assuming leadership responsibilities, may be unrealistic during the first few months of transition. Expectations of NGRNs are enormous and

are likely unrealistic considering the high acuity of patients in hospitals today (Wolff et al., 2010; Romyn et al., 2009).

Preparation of nurses, as well as transition programs to support new graduates, are important topics among educators and administrators alike (Dyess & Sherman, 2009; Rush, et al., 2013). Rush et al.'s, (2013) integrative literature review examined studies related to transition to practice programs for RNs between the years 2000-2011 to determine best practices. These authors report that transition to practice programs improve NGRN competency and retention. They also describe that NGRNs prefer hands on education and that NGRN experiences with mentors decrease stress. In addition, mentors provide support for NGRNs which was found to be needed beyond the initial orientation period. Rush et al. (2013) found that there was no evidence from their review that new graduate transition programs prepared students for their leadership roles. Although transition programs vary, their purpose is to assist and support NGRNs while providing NGRNs with the skills and resources they will require as they move from student to independent entry level practice RN (Al-Dossary et al., 2014; Al-Dossary et al., 2016; Rush, et al., 2013)

However, despite knowledge regarding the benefits of transition to practice programs for NGRNs, little is known regarding NGRNs' perceptions of their preparation for leadership roles (Carlin & Duffy, 2013; Chappell & Richards, 2014). In addition, the majority of the literature uses the terms *preparation* and *readiness* synonymously when they arguably are different. Preparedness is defined as "the quality or state of being prepared" (Merriam-Webster, 2018) while readiness is defined as "the quality or state of being ready" (Merriam-Webster, 2018). Both definitions provide little explanation in the meaning of the word without understanding the root word. Prepared is defined as "subjected to a special process or treatment" (Merriam-

Webster, 2018). Therefore, preparedness focuses on the activities and experiences NGRNs have been exposed to to equip them for engagement in a particular activity. Ready is defined as "prepared mentally or physically for some experience or action" (Merriam-Webster, 2018). It can be concluded that a person's readiness is related to their personal qualities and attributes which will facilitate readiness for leadership. Nursing schools and transition to practice programs may prepare NGRNs in similar ways, yet readiness for the realities of life as a registered nurse (RN) may differ for each individual nurse. The high acuity of patients admitted to hospital and the nursing shortage, have combined to create a dire need for NGRNs be prepared and ready to effectively engage in both clinical leadership skills and formal leadership skills. Therefore, it is critical that NGRNs feel prepared for practice, well supported, and find leadership roles desirable for them to be effective nursing leaders.

1.2 Research Aim and Question

The purpose of this study was to answer: "Do NGRNs' perceive that they are prepared and ready for a leadership role in the practice setting?"

There were three main objectives of this study

1. To understand NGRNs' views of their role in nursing leadership, including how they engage in informal and formal leadership practices.
2. To understand NGRNs' views/perspectives of their preparation and readiness for the realities of leadership.
3. To learn about NGRNs' experiences of engaging in leadership.

In preparation for the implementation of the current study, existing literature relating to new nurses' experience with and preparedness for leadership was reviewed and now will be outlined.

Chapter 2. Literature Review

2.1 Overview

This chapter will provide an overview of the literature, including the steps taken to perform the literature review and results. Findings from this literature have been broken down into five main categories: preparedness and readiness for practice, uncertainty about what defines leadership, ambivalence about formal and informal leadership, and barriers and facilitators to leadership.

2.2 Methods and Literature Review Results

This literature review was conducted using a two-step process during 2016-2019. The first literature review obtained literature regarding NGRNs and their experiences with leadership. The second literature review was focused on NGRNs and their preparation and readiness for leadership and nursing practice. Two separate literature reviews were conducted because the first search did not produce evidence regarding NGRNs preparation and readiness for practice, or leadership. Article selection was completed by the graduate student. Following is a more detailed discussion of the two literature searches.

An initial literature search was conducted using the databases CINAHL and MedLine. The purpose of this literature search was to gain insight into NGRNs experience of leadership as RNs. Free vocabulary instead of controlled vocabulary was used in both databases for the term 'new graduate nurse' as it yielded more results. Free vocabulary was also used for the term 'leadership' because search results decreased in number when the controlled vocabulary term was used. Searches were not limited by date in either database due to the limited literature available. Inclusion criteria included English language, research papers from academic journals with full text, and abstract availability. Ninety-eight articles were uploaded to the graduate student's Refworks account. Subsequently, fourteen duplicates were identified and removed,

leaving eighty-four articles for review by title and abstract. Sixty-three articles were excluded based on their abstract and title leaving twenty-one articles for review. A further nine articles were excluded that did not meet one or more of the following criteria: participants were not NGRNs, NGRNs worked in specialty nursing areas (for example, pediatrics), focused on recruitment and retention generically and were not related to leadership, or emphasized leadership effects on NGRNs. Twelve articles were included in the literature review.

A second literature search was conducted using CINAHL and MedLine. The purpose of this search was to gain an understanding of NGRN preparation and readiness for practice. Free vocabulary was used, rather than controlled vocabulary, for the terms 'new graduate nurse', 'preparedness', and 'readiness' as these terms yielded more results. Again, searches were not limited by date due to the limited literature however, only full text, English academic journals, with abstracts available were included. Twenty-one articles were uploaded to the graduate student's Refworks account, and all were reviewed (title and abstract) as no duplicates were identified. Eleven articles were excluded based on title and abstract. Ten articles were read in full with five excluded that did not meet one or more of the following criteria: focused solely on a specific technique of preparing nurses for a particular issue (for example, simulation, specific programs, or recognizing patient deterioration), focused on the viewpoint of undergraduate students who had not yet practiced as RNs, or if focus was understanding why NGRNs had left or were planning to leave nursing. Five articles were included from this search. Results from this search were not limited to NGRN participants only.

2.2.1 Preparedness and Readiness for Practice

Findings from these literature reviews highlighted the tendency for researchers to use the terms prepared and ready synonymously. Researchers examining practice readiness refer to

NGRNs as having the ability to "hit-the-floor-running" (p. 26); however, they also referred to this as NGRNs being "prepared for practice" (p. 24) (Watt & Pascoe, 2013). There was arguably a difference between NGRNs' preparation for practice and their readiness for practice. Regardless of their pre-registration educational program, NGRNs generally received further preparation to practice and engage in leadership roles and responsibilities by way of formal education and orientation as new graduates. However, each NGRN differed significantly as to their emotional readiness to assume the realities and responsibilities of everyday work life. This may be attributed to the individual characteristics of each NGRN. The majority of the research included in this literature review did not include the sole perspective of NGRNs. Rather they included perspectives from NGRNs, staff nurses, educators, and managers who voiced their opinions of NGRN preparation and readiness for practice.

Findings will be presented according to three main categories: uncertainty about what defines leadership, ambivalence about formal and informal leadership, and barriers and facilitators to leadership.

2.2.2 Uncertainty About What Defines Leadership

Uncertainty regarding what comprises leadership and what the leadership role for a new registered nurse looks like was evident throughout this literature review. In one qualitative study, which aimed to understand how NGRNs experienced leadership, NGRNs expressed difficulty differentiating between the term *manager* and *leader* (Carlin & Duffy, 2013). The researchers also found NGRNs to be unsure about their opinions of leadership. When probed, participants were able to list duties in which managers engaged but were unable to come up with a definition of leadership (Carlin & Duffy, 2013). Dyess and Sherman (2011) similarly found NGRNs had difficulty in defining leadership though they held leaders in high esteem. Holding such high

expectations of leaders likely increased stress and uncertainty for NGRNs' who may have doubted their personal ability to engage in leadership roles.

This literature review revealed mixed results regarding NGRN beliefs about their preparation for leadership positions (Candela & Bowles, 2008; Mbewe & Jones, 2015). Uncertainty regarding a NGRN role in leadership was evident in one study which examined recent graduates' perceptions of how well their educational institution had prepared them for practice (Candela & Bowles, 2008). This study found that 67% of survey participants thought they were prepared for leadership skills and 62% of participants thought they were prepared for a position in management (Candela & Bowles, 2008). Although the majority of participants felt they were nearly equally prepared to be leaders and managers, this finding revealed NGRNs uncertainty about the difference between roles and responsibilities of managers and being a bedside leader (Carlin & Duffy, 2013). Some of the challenges NGRN's have differentiating between manager and leader roles and responsibilities reflected their differences in understanding the context/level of leadership.

Al-Dossary et al. (2014), argued that NGRNs should have a strong understanding of 'clinical decision making'. The term 'clinical decision making' encompassed skills front-line nurses use on a daily basis and reflected their leadership capacities of NGRNs (Al-Dossary et al., 2014). Although not specific to leadership, other studies pointed to unrealistic expectations of NGRNs from the viewpoint of both experienced nurses as well as NGRNs themselves (Pfaff et al., 2014). Wolff et al. (2009) interviewed 150 nurses from a variety of practice areas with the majority of participants working in acute-care. Participants expressed a need for an increase in clinical practice hours near the end of the nursing program to assist with NGRN transition to practice. Romyn et al. (2009) interviewed a total of 147 nurses, 14 of whom were NGRNs, and

found that participants questioned whether or not expectations of NGRNs were realistic and if it was even possible for NGRNs to be prepared to practice in a variety of settings. NGRNs were required to engage in some informal leadership by way of delegating and prioritizing tasks but even these skills were found to be difficult for NGRNs (Hezaveh et al., 2014). However, if colleagues and supervisors expressed concerns regarding basic practice readiness of NGRNs, expectations may be unrealistic that they be competent to engage in formal or informal leadership roles and responsibilities at the beginning of their career.

2.2.3 Ambivalence About Formal and Informal Leadership

The ambivalence about formal and informal leadership category reflected leadership as a responsibility that was not necessarily desirable to NGRNs. One mixed methods study reported that a majority (84%) of participants felt uncomfortable with their leadership skills (Mbewe & Jones, 2015). This same study found that participants lacked confidence regarding their preparation for leadership or management roles. However, Mbewe and Jones' (2015) study targeted registered nurses from an associate degree program rather than baccalaureate prepared nurses.

Delegation and prioritization, two important leadership skills, were found to be difficult for NGRNs and led to NGRNs feeling as if they were no longer in control (Ekstom & Idvall, 2015; Hezaveh et al., 2014; Wangensteen et al., 2008). During the transition from student to nurse, NGRNs found the expectations and responsibilities of caring for a team of patients and potentially other nurses to be overwhelming (Hunter & Cook, 2018; Wangensteen et al., 2008). Generally, in the team nursing model the RN was the team leader, which required the RN to be skilled at delegation and prioritization. Ekstrom and Idvall (2015) found that NGRNs felt the need to have total control over their nursing team and would do so despite not meeting their own

basic needs, such as, missed meal breaks. NGRNs felt pressure to become skilled at all RN tasks while leading a team. This was reported to be difficult when NGRNs felt unable to rely on other team members to effectively complete tasks (Ekstom & Idvall, 2015). NGRNs also felt pressured to give a reason or justify the need to delegate a task rather than completing the tasks themselves (Ekstom & Idvall, 2015). According to Chappell and Richards (2015), NGRNs were not ready for content regarding leadership responsibilities early in a new graduate transition program, but were much more interested further along in the program. The high level of stress that NGRNs experience may leave new nurses unsure about what is expected of them in terms of leadership.

Generally speaking, *Nexters* or *Millennial's* (individuals born between the years 1982-2000) are increasing in the nursing workforce and have been shown to be attracted to immediate authority and want their voices to be heard regarding change (Jennings, 2000; St. Denis, 2016). Additionally, millennial NGRNs have been shown to be more interested in having a healthy work-life balance and are less committed to the organization (St. Denis, 2016; Wolff et al., 2009). Although it is important for NGRNs' mental wellbeing to have a work-life balance, having less organizational commitment may explain why NGRNs find the idea of formal leadership roles to be less than desirable.

Research has shown that NGRNs did not view the role of the charge nurse as desirable, rather they perceived it as stressful (Carlin & Duffy, 2013). The charge nurse role was the most formal leadership role, which NGRNs encountered during transition to acute care, and yet they felt unsure about engaging in this role (Carlin & Duffy, 2013). Carlin and Duffy's (2013) interpretive phenomenological analysis found that new graduate participants saw administrative duties as a barrier to the charge nurse's ability to engage in teamwork and decreased the charge nurse's visibility in the clinical areas, where NGRNs most frequently spend their time.

Conversely, other NGRNs felt empowered by the challenge of being in charge on night and evening shifts (Wangensteen et al., 2008). Wangensteen et al. (2008) conducted a qualitative study in Norway with twelve new graduate hospital nurses to understand how they experienced their first year as a practicing nurse. Participants felt that, although challenging, being in charge helped them grow as nurses and helped them to feel proud of the work they had completed in their first year of graduate practice. This is similar to findings from Ortiz's (2016) qualitative study which aimed to understand NGRNs professional confidence and how it developed over their first year of practice. All twelve of the participants discussed how independently making decisions improved their confidence regardless if they knew exactly what to do in the situation they were in. These disparate findings in these qualitative studies may reflect different timeframes for studying newly graduated nurses. Wangensteen et al. (2008) interviewed their participants one year after graduation, whereas Carlin and Duffy (2013) recruited participants who had been in nursing for less than one year. It has been shown that NGRNs require up to six months to build confidence related to leadership and that by twelve months NGRN have completed the popular Stages of Transition Model (Al-Dossary et al., 2014; Boychuk Duschner, 2008). Therefore, by one-year post-graduation, NGRNs may generally have a higher level of confidence, making it easier for them to engage in leadership roles.

2.2.4 Barriers to Leadership

Lack of readiness for practice generally was a barrier to readiness for NGRN leadership. There was an expectation that NGRNs would *hit the ground running* and be able to provide safe care similar to that of more experienced nurses (Romyn et al., 2009; Strickland & Welch, 2019; Wolff et al., 2010). In looking at preceptors' views of NGRN readiness for practice, Hickey (2009) found that NGRNs became easily flustered with the amount of work a RN is expected to

complete. Over 50% of survey respondents, who were RNs who had acted as a preceptor within the previous year, found that NGRNs were weak in areas of communication, teamwork, critical thinking, time management, assessment and psychomotor skills, all of which are arguably basic nursing competencies and critical to one's ability to be a successful leader. Conversely, Missen et al. (2016) found that Australian NGRNs were rated highly by staff nurses, in the areas of physical assessment and clinical skills (regularly performed), communication, emergency procedures, and preparedness for practice on a five point Likert scale. This study examined the opinions of 'qualified nurses' in relation to NGRNs' abilities to perform various skills and whether or not there were differences in the respondents' opinions based on their demographic information, clinical setting and geographical location. Compared to younger, less experienced respondents, those who were older and had been working for longer periods of time gave NGRNs lower scores on their survey responses, indicating a less than satisfactory performance. Although it is important to understand the views of NGRNs, in terms of preparedness, from staff nurse, educators, and managers, only NGRNs themselves are truly able to speak to their readiness for the realities of leadership practice. NGRNs also can provide important insights and ideas on how they can be better prepared for transition to practice.

2.2.5 Facilitators to Leadership

Several factors were identified as facilitating NGRNs' engagement in leadership. Wangensteen et al. (2008) found in their study of recently graduated nurses, that being able to effectively delegate was seen to be a facilitator to leadership. Despite the stress of being a NGRN, NGRNs were eager to rise to the challenge of taking on a leadership role. Understanding organizational policies and procedures was also seen to aid in NGRNs ability to engage in leadership by providing NGRNs with a sense of comfort and a feeling of belonging, all which

increased their confidence (Watt & Pascoe, 2013; Wolff et al., 2009). Developing confidence and feeling like part of the team has been shown to facilitate engagement in leadership (Al-Dossary et al., 2014; Ekstrom & Idvall, 2015; Luger & Ford, 2019; Mbewe & Jones, 2015; Wangensteen et al., 2008). NGRNs must be able to effectively think critically which requires them to have both strong theoretical knowledge as well as practice skills (Wolff et al., 2010). NGRNs acknowledged that their leadership skills and abilities would develop over time and that this development was a continuous process of personal and professional growth (Ekstrom & Idvall, 2015). Ortiz (2016) found the length of employment was insignificant to her participants' level of confidence; rather, their confidence fluctuated throughout the year and depended on the scenario they were in. Ortiz (2016) found that poor experiences with communication between coworkers negatively impacted their confidence.

Multiple studies described NGRN programs, or transition to practice programs, which facilitated leadership among NGRNs. Candela & Bowles (2013) found that simulation assisted NGRNs with their decision-making skills. Mentors and other nurses who NGRNs could turn to for help made NGRNs feel more comfortable and gave them a point-person to contact in times of need (Romyn et al., 2009; St. Denis, 2016). Romyn et al. (2009) found that NGRNs who had a mentor made fewer errors than those without a mentor and settled into the healthcare environment more easily. St. Denis (2016) interviewed a panel of four NGRNs who all expressed mentorship as a way to improve their feelings of inclusion. Mentorship from this small panel of NGRNs included mentors at work as well as involvement in professional groups and governing bodies. New graduate residency programs were also found to be effective in promoting nursing skills, confidence, and clinical competence (Al-Dossary et al., 2014). Interestingly, Chappell and Richards (2015), found that if NGRNs, with less than 24 months of practice experience, believed

the residency program was of high quality, and clinical leadership skill outcomes were positive. Regardless of the length of the program, NGRNs needed six months to transition from student to practice (Al-Dossary et al., 2014). It has been shown that NGRNs are not ready to engage in clinical leadership prior to six months (Al-Dossary et al., 2014). However, Chappell and Richards (2015) found that regardless of whether or not NGRNs participated in a transition to practice program, their clinical leadership skills did improve over their first year of practice.

Exposing students and NGRNs to various leadership roles, by using preceptors, may be an effective way to increase their knowledge regarding leadership, however, most of these preceptorships were organized with people in formal leadership positions (Vatan & Temel, 2016). Although formal leadership preceptorships may be effective in teaching NGRNs the skills and responsibilities of leaders, these may not be the types of leadership skills which NGRNs are expected to demonstrate upon graduation. It may be more important for NGRNs to understand the importance of 'clinical leadership' by working with experienced nurses who have strong relationships with other members of the healthcare team and are effective patient advocates as well as skilled nurses. Enabling and supporting NGRNs to develop relationships with other nurses on the unit has also been shown to improve retention of NGRNs (Moore et al., 2013). Exposing students and NGRNs, during preceptorships and transition programs, to informal nursing leadership roles is necessary to ensure that newly qualified registered nurses are fit to practice and feel comfortable and confident to act as leaders during difficult or high-stakes situations (Goode et al., 2013).

As NGRN numbers increase in the workforce, NGRNs may be required to take on leadership roles and responsibilities earlier than they feel prepared or ready. Understanding how NGRNs perceive their readiness for leadership may have a direct effect on policy regarding how

NGRNs are prepared and transition into practice. Therefore, the current study was designed with the intention of gaining a better understanding of NGRNs experience with leadership within their first 14 months of practice.

Chapter 3. Methods

3.1 Overview

The purpose of this study was to understand NGRN's experiences of their preparation and readiness for informal and formal leadership activities. This study also aimed to understand NGRNs view of their role in nursing leadership including how they engaged in informal and formal leadership practices. This chapter will outline the methodology used in this study, detailing the study design, sample, and setting. Further, the details of data collection and analysis will be outlined. First, the position of the researcher will be discussed.

3.2 Researcher Position

I entered Graduate Studies immediately following graduation from a Bachelor of Science in Nursing degree. At the same time I also began working as a NGRN. As a novice nurse, I observed that the nursing staff complement was often comprised of colleagues with minimal experience like myself. I, and many of my novice colleagues, found transitioning from undergraduate practicums to working as an independently practicing RN to be challenging. I found myself taking on informal leadership roles while working on a busy surgical floor which exacerbated the pressure I felt from the amount, pace and complexity of the work. Considering the anticipated shift the nursing profession will experience in the next few years, with the retirement of senior nurses and the influx of NGRNs, I wanted to focus my studies on understanding how NGRNs feel about the pressures of everyday practice. Focusing on the expectations of informal and formal leadership roles, I was enthusiastic to learn about the position and expectations of novice nurses because of my own experiences as a novice nurse. I was keen to understand how other novice nurses perceive and handle current practice issues.

The reality in current nursing practice is that NGRNs must be prepared to take on informal leadership roles as soon as they begin their practice. This was my experience as a novice nurse and the reason for my interest in the research subject. I was hopeful that this contribution to understanding the position of NGRNs would lead to identifying ways their experience as novice nurses can be improved which may lead directly to improved new graduate retention and, indirectly, improved patient outcomes.

3.3 Qualitative Research

Quantitative studies, specifically, random control trials are known as the gold standard of research. Quantitative studies aim to produce facts and truths in response to questions of *when* and how *much* (Neergaard et al., 2009). However, questions that ask *what*, *how*, and *why* to gain an understanding of peoples' experiences of a phenomenon require a qualitative research approach (Neergaard et al., 2009). A key element of qualitative research is the understanding that there are multiple realities and each person can experience a phenomenon in a different way (Guba, 1981). Because this study aims to understand NGRNs perception and experience with clinical leadership, a qualitative method is the most appropriate fit.

3.4 Study Design

This study used a qualitative descriptive design. Qualitative description aims to provide a thorough summary of a specific experience. This study design is useful for healthcare research as it allows the researcher to gain a comprehensive understanding of how a person has experienced an event or series of events (Lambert & Lambert, 2012; Neergaard et al., 2009; Sandelowski, 2000; Sandelowski, 2010). Qualitative description was the most appropriate qualitative method to answer the research question posed by this study as it allows the development of a clear picture regarding the NGRNs perception of their preparation and readiness for leadership roles

and responsibilities with all the possible complexities included. Qualitative description was chosen for the research design because it is particularly well suited for situations where the goal is to understand a person's experience with a phenomenon inductively but does not fit well with some of the more traditional qualitative designs such as phenomenology or grounded theory (Neergaard et al., 2009; Sandelowski, 2010). Naturalism was the underlying theoretical foundation for this study, allowing for an understanding of the phenomenon in as natural a state as possible to avoid predetermined beliefs regarding the participants (Sandelowski, 2000). Qualitative description does not require a researcher to use a specific theoretical framework, encouraging links between the study being conducted and previous work and the expertise of those conducting the study (Neergaard et al., 2009).

Qualitative description does not require the researcher to move far away from the data, rather, the researcher stays close to the data in analysis and interpretation (Sandelowski, 2000). This allows the researcher to come to direct conclusions about information gathered from participants (Neergaard et al., 2009, Sandelowski, 2000; Sandelowski, 2010). A key feature of qualitative description is that study findings are presented in plain language that is easy to understand and accessible to stakeholder groups (Lambert & Lambert, 2012; Sandelowski, 2000). It is well known that NGRNs often find reading research to be challenging, especially quantitative results that can often seem inaccessible (Forsman et al., 2012). Therefore, it is important to this researcher that the participants, as well as other NGRNs, other nurses, and managers can easily understand the results of this study.

3.5 Sample and Setting

Following harmonized University of British Columbia Okanagan and Interior Health ethics approval (H18-00611), recruitment commenced. Data were collected from as many

participants as were required to reach saturation, where no new data were being collected during interviews (Fusch & Ness, 2015). Recruitment included new graduates from one tertiary hospital in Kelowna, British Columbia, Canada. Convenience sampling was used with a goal of obtaining maximum variation within the sample.

Recruitment for study participants occurred in three ways. First, e-mail invitations to participate were sent to all NGRNs through the NG Transition Program Lead. Second, an information poster was posted on bulletin boards throughout the hospital (in staff rooms, staff bathrooms, and nursing education boards). Third, the Graduate Student visited medical and surgical units at the hospital to talk with Managers and Patient Care Coordinators and have them encourage eligible NGRNs to participate in the study. Inclusion criteria included currently practicing NGRNs working on medical or surgical floors in Kelowna General Hospital with more than 4 months but not more than 14 months work experience as a RN. NGRNs who had not obtained full RN status due to failing the National Council Licensure Examination (NCLEX) or those who had not yet written the licensing exam were eligible to participate in the study as these nurses were still legally able to work under a provisional license in British Columbia. Whether or not a NGRN had his or her practicing license, their day-to-day work was the same as those with a provisional license.

The graduate student's phone number and email address were provided on the information sheet and through email communication. Prospective participants were encouraged to contact the graduate student if they had any questions, wanted more information, or were interested in participating. The graduate student communicated with prospective participants through email or telephone depending on their preference. Once questions were answered and the NGRN agreed to participate, an interview was set up. The consent form was emailed to

participants once an interview time was arranged. Forms were sent at least 24 hours prior to the interview time to give participants time to review the consent and give time for any questions to be answered. Any outstanding questions the participant had were answered at the time of the interview.

3.6 Data Collection

Consent was obtained prior to data collection. Data collection occurred over three months. Data collection occurred in two ways. Firstly, demographic data were collected via questionnaire at the beginning of the interview. Demographic data included information about participants' age, sex, whether they have had previous nursing or leadership experience, their current position, the area of nursing in which they worked (medical or surgical), what nursing care model they followed (team nursing or primary nursing model), and whether they had participated in a NGRN transition program (Appendix B).

Secondly, qualitative data were collected during one-on-one interviews with participants. Interviews were approximately 30 to 90 minutes in length and were audio-recorded. Interviews were held at the hospital library in a private room. If participants were unable to attend a face-to-face interview, a telephone interview was completed. All interviews were conducted by the graduate student using a semi-structured interview guide (Appendix C). The interview guide was developed in collaboration with the thesis committee to encourage consistency in interview content and format. Interview questions were developed to gain an understanding about NGRNs views of their first year of practice, their understanding of their role as NGRNs in formal and informal leadership, and their understanding and interpretation of preparedness and readiness for leadership. Each participant was asked all of the main questions and 'probing questions' were used to gain a deeper understanding of their experiences, allowed for expansion of their

accounts, or provided another way of framing the question if the participant needed help in understanding the main question. Because the interviews were semi-structured, questions were not always asked in the same order to allow participants to feel comfortable and at ease to speak freely. In addition to recording the interviews, the graduate student took field notes during the interview. Field notes allow researchers to document contextual information during qualitative interviews (Phillippi & Lauderdale, 2018). The graduate student documented any thoughts, feelings, or questions she had immediately following the interview. Following the interview, the graduate student reviewed her notes and attached them to the participant's interview.

3.7 Data Analysis

The graduate student entered quantitative data from demographic questionnaires into Excel and generated descriptive statistics. Mean and standard deviation, frequency, and range were obtained for each variable depending on whether it was continuous or categorical. Interview data were transcribed verbatim, coded, and analyzed by the Graduate Student to identify major categories. The student worked with her supervisor and committee and remained close to the data by analyzing it throughout the data collection process. This allowed the members of the thesis committee to return to the data to assess if anything required re-evaluation to gain meaningful data from participants. Interviews were conducted until saturation was met where no new categories were observed in the data (Bradshaw et al., 2017).

Qualitative data were analyzed using inductive content analysis. Content analysis is a commonly used analysis strategy in qualitative descriptive studies. (Elo & Kyngas, 2008; Kim et al., 2016). Content analysis allows the researcher to condense data into categories where the information shares similar meaning (Elo & Kyngas, 2008). Inductive content analysis is used when the aim of the study is to create a general understanding from specific information (Elo &

Kyngas, 2008). This data analysis technique works well for studies where there is little research known about the subject (Elo & Kyngas, 2008). There are three phases to the analysis process: preparation, organization, and reporting (Elo & Kyngas, 2008).

During the preparation of data, whole interviews were analyzed along with the Graduate Student's field notes. This gave the student the opportunity to become immersed in the data to gain a deeper understanding of what was going on. Data were then organized by open-coding, categorization, and abstraction. Open-coding involved line by line reading of transcriptions and writing notes in the margins that reflected ideas and thoughts about what participants were saying (Elo & Kyngas, 2008). The student, supervisor, and one committee member coded the first two interviews independently. They met to discuss the coding and developed a coding schema that grouped similar codes into higher order headings or categories. The Graduate Student used the coding schema to code the data, adding new codes and categories when data did not fit into the existing coding schema. This was done until all the data had been accounted for. Finally, during the abstraction phase, data were organized and named based on the content characteristic of each category. The data in these categories moved inductively, such that smaller units or sub-categories gave rise to broader categories that served to organize ideas in a way that described what the participants were reporting.

3.8 Methodological Rigour

Qualitative and quantitative studies differ in many ways however they both aim to provide a better understanding of a phenomenon through quality research. While quantitative research refers to this *quality research* as its methodological rigour, qualitative studies refer to this as trustworthiness. Trustworthiness in qualitative studies allows the researcher to confidently report that their findings are an accurate representation of the phenomenon (El Hussein et al.,

2015). Trustworthiness provides the researcher, or outsiders evaluating the study, with a set of criteria to evaluate the study's worth (Morse, 2015). Four criteria were used to assess trustworthiness: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Morse, 2015).

3.8.1 Credibility

The credibility of a study can be defined as "how well the research represents the actual phenomenon" (Morse, 2015, p. 1213). Morse (2015) encourages researchers to ask whether a person who experienced the phenomenon would be able to recognize the findings. Credibility can be achieved by testing the findings against multiple people's perceptions, also known as member checking (Guba, 1981). Member checking involves the researcher sharing progress and study findings with participants during the process of analysis to ensure it accurately reflects participants' experiences. To encourage NGRNs to participate in research and leadership, and to validate the findings, the graduate student asked two participants to review the findings and provide feedback. The two participants had no suggestions for feedback and believed the description to accurately reflect their experiences. After confirmation was received the findings were finalized.

3.8.2 Transferability

Transferability, or the ability of findings to be applied to a different setting, can be achieved by obtaining thick descriptions (Guba, 1981; Morse, 2015). Qualitative researchers understand that findings will not always be applicable to different, yet similar, contexts. Transferability of findings is dependent on whether the context of the study fits with the context in which the findings are being applied (Guba, 1981; Morse, 2015). Therefore, obtaining a large enough sample size with participants who provided rich, thick description was important to

enable others to assess whether the findings were transferable to another, similar context (Guba, 1981; Morse, 2015). Nine NGRNs participated in the study and provided rich accounts of their experiences. While a larger sample was desired, the diversity of participants enhanced transferability of findings to other settings.

3.8.3 Dependability

Qualitative researchers respect and honor multiple realities and acknowledge that not every person's perceptions will be the same. Despite varying realities, researchers want their studies to be dependable. Dependability can be defined as "the ability to obtain the same results if the study were repeated" (Morse, 2015 p. 1213). Triangulation is recommended to ensure dependability (Guba, 1981; Morse, 2015). Triangulation is the process of using multiple sources of data, multiple investigators, multiple theories, and/or different methods to answer the study question (Guba, 1981; Morse, 2015). Consistent with Guba's (1981), recommendation that at least two different sources of data are needed for triangulation, multiple sources of data were collected: questionnaire, semi-structured interviews, and field notes. An element of qualitative description is that researchers understand that their perceptions and beliefs may influence the final description (Sandelowski, 2000). Therefore, having a thesis committee made up of nurses with different experiences, backgrounds, and education allowed for different perspectives to be reflected. Despite differences in experience, beliefs, and perspectives, all members of the thesis committee agreed that final categories created were accurate descriptions of the data.

3.8.4 Confirmability

Although research is guided by the researcher's interests, identifying bias prior to initiation of data collection is necessary to assist with objectivity of study results (Morse, 2015). In qualitative research this is called confirmability (Guba, 1981). Biases appear in multiple ways

including researcher bias, bias in the research design, and sampling bias (Morse, 2015). The process of triangulation is used to strengthen a study's confirmability. Therefore, having a thesis committee comprised of nurses of varying ages, nursing backgrounds, level of education, and professional experience assisted in limiting researcher bias. Members of the thesis committee discussed potential bias prior to data analysis and continued to re-examine their bias throughout the analysis process. As the subject being studied is part of the Graduate Student's own direct experience, she maintained vigilant awareness of the possible ways that her own experience affected the interviews with participants and analysis of data. Additionally, the graduate student noted any feelings and thoughts that arose during interviews which affected her bias in her field notes.

A frequently acknowledged potential weakness of qualitative descriptive studies is that data analysis can be subjective due to perceptions and beliefs held by researchers (Sandelowski, 2000). The aim was to present a description of facts from the viewpoint of NGRNs in such a way that both participants and members of the thesis committee can agree that the representation of a NGRNs' perspective is accurately reflected (Neergaard et al., 2009; Sandelowski, 2000).

The study sample was from one tertiary hospital in Kelowna, British Columbia which may have introduced sampling bias. A majority of NGRNs working at this hospital have graduated from the same University and have attended clinical practica at the hospital. This may have had a direct impact on their practice compared to a NGRN with no previous experience in this hospital. However, the Graduate Student purposely recruited participants from a variety of medical or surgical floors within the hospital to allow diversity. Doing so was intended to reflect the variability in staffing composition of inpatient units, with some units having many more senior nurses to assist NGRNs in their transition to practice and other units with fewer senior

nurses. The presence of senior nurses on units may limit NGRN engagement in informal or formal leadership tasks/opportunities compared to units with fewer senior nurses. Those who choose to participate in the study may do so because they have an interest in leadership for their career trajectory or may have an issue they hope will be resolved.

3.9 Ethical Considerations

Harmonized ethics approval was obtained from the University of British Columbia Okanagan as well as Interior Health Authority. The graduate student worked as a staff nurse at the hospital being used to recruit NGRNs, however was on maternity leave during the time of recruitment. Since she was not part of the unit, had no knowledge of the NGRNs on the unit, or was not in a position of coercion, new graduates working on her unit were included in the study. To ensure anonymity, each participant was given a number and this was used as an identifier for both the interview and demographic data. Participants of the study were given a copy of the study information and consent that addressed issues of confidentiality. They were informed that participation was voluntary, that they could withdraw from the study at any point without consequence, and that participation in this study would neither negatively nor positively affect their position at the hospital. (Appendix A). During interviews, an agreed upon and approved list of definitions was supplied for each participant. The definition list was developed by the thesis committee (Appendix D).

The numbers assigned to participants were kept separate and password protected from study data. Survey data were uploaded onto a password protected database. Because the graduate student also worked at the hospital, if participants had concerns sharing information with her as a colleague, an alternate interview process was offered, where the participant could be interviewed by one of the other members of the thesis committee. The qualitative design of the study allowed

for full and complete discussion by the NGRNs, giving them the opportunity to openly share their experiences with leadership and the stories they told have been detailed in the findings.

Chapter 4. Findings

4.1 Overview

In this chapter, the findings from the interviews with nine NGRN will be presented. Four categories were constructed: *self-doubt in relation to leadership, preparing for leadership, evolving leadership, navigating the challenges*. These categories will be discussed along with a description of the nine participants in the sample.

4.2 Description of Sample

The average age of the study participants was 26 years (SD= 3.96) with a range of 22-33 years. The majority of participants were female (n= 7) and two participants were male. Eight of the participants had nine to 14 months' work experience while one participant had between six to nine months experience as an RN. Four of the participants worked on medical units, one worked on a surgical unit, two worked in other areas (cardiac and the operating room), and one worked on medical/surgical, and another in home health. Three of the participants worked on units where they did primary nursing and six participants worked on units where they practiced team nursing model. The majority of participants were in full-time positions (n= 7) while two participants worked casually. Only one of the participants who worked casually, reported their average weekly hours (n= 37.5). All nine of the participants had passed the NCLEX. The average length of orientation was 10.3 days (SD= 2.57) with the range being six to12 days. Six participants (n= six) took part in the hospitals NGRN program where they received 12 shifts of orientation. However, one of the participants who took part in the NGRN program only got eight shifts of orientation. The other three participants were not part of the NGRN program and received seven, eight, and 12 shifts of orientation. Three participants reported no previous post-secondary education prior to entering their nursing program. Three participants completed University

Degrees, while two had previous University courses, and one completed a trade. Three participants received their nursing degree from a University outside of the study hospital's geographic area while six participants completed their training at a University within the hosptial's geographic area.

Three participants reported having previous leadership training. They described training such as coaching football, working with people with brain injuries, and training as a manager/ shift leader at a restaurant. One of the three participants described her leadership training as the charge nurse workshop and leadership training in nursing school. Six participants reported no previous leadership training. Similarly, three participants reported having previous leadership experience while six reported no previous experience. Two of the three participants were the same participants who reported having previous leadership training and reported their training and experience were the same. One participant who reported no previous leadership training reported having leadership experience while acting as a 'co-manager' and 'working' as their experience.

4.3 Self-Doubt in Relation to Leadership

All except on**e** male participant identified self-doubt about their role as RNs especially in relation to leadership. They described instances of not knowing where to go, what to do, or what was even expected of them. Participants expressed times where they felt unable to live up-to their coworkers' or their own personal expectations. Much of the self-doubt was related to being a new nurse in general, and often facing unfamiliar situations they did not know how to handle or act upon. One participant described this experience as "Everything is too overwhelming to me" (Participant 7). "I was just trying to survive basically, and I had no idea who to ask and I wanted to ask everyone like what to do" (Participant 1). Participant 3 described feeling nervous and

identified her lack of confidence when making difficult decisions. It was common for participants working in team nursing model to describe their role as the leader of their nursing team and their felt need to make the final decision about patient care independently without consultation with their co-workers. At the same time as they held these self-expectations, participants doubted their ability to make decisions about their team of patients. It was evident that participants felt the pressure of their role as the RN; “the fact that you are dealing with people’s lives is huge and kind of any mistake you make could put somebody's life on the line uh so I think that extra pressure is really hard in nursing” (Participant 1). These critical decision-making times were often during code situations or when patient status was rapidly changing.

In contrast to the other NGRNs, one male participant did not express self-doubt. Rather, he explained that knowing others had previously completed the same program and successfully worked as RNs before him allowed him to know that everything was going to be fine and that he could do it just like all the nurses before him.

4.4 Preparing for Leadership

Participants described an overall lack of preparation for leadership. Although participants felt under-prepared for leadership, many reflected on experiences from their pre-undergraduate employment, their undergraduate program and on-the-job experiences that had provided some level of preparation.

4.4.1 Pre-Nursing Preparation for Leadership

Participants’ maturity and past experiences in life, education, and/or work helped them not only to adjust to working as RNs but specific skills were beneficial in assuming their informal leadership role. Participant 2, who had a child and was on maternity leave at the time of interview, reflected on her growth and change in mind set after becoming a parent and expressed

how becoming a mom had enhanced her ability to empathize with patients, families, and her co-workers. While not related to being a parent, some of the older study participants discussed how their age and life experience benefitted them by giving them some confidence and maturity to deal with challenging situations. Participant 3, who had worked as a hairdresser prior to taking her degree, found that her ability to talk to strangers was advantageous and took away one hurdle for her. Participant 7, who, prior to nursing, worked as a supervisor in a restaurant, described her ability to talk to people, manage time, multitask, and cope with the day-to-day busyness as skills she had learned from previous work life experience that she was able to use in her new role. She described this by saying

> What's easy is like, being like, not dealing with patients, but like interacting with patients like that's very easy for me. So, I find that it's easy to like, not fake it, but like kind of just get through my day because I worked in the restaurant industry for like 10 years so it's kind of like same idea. Totally different, but for the most part I like getting to know my patients, talking to my patients, and you can kind of figure the rest out.

Participants also identified areas in their lives that helped them to assume the role of the RN and aided in acting as a leader. Participant 8 had worked as a care aide prior to upgrading to becoming an RN. For him, he was confident and comfortable in a healthcare setting. Providing basic patient care was not a new task which arguably decreased the amount of stress he faced as he entered into a new role. Although one of the younger male participants had held leadership roles in sports in the past, he did not verbally state that this helped him in his nursing career.

On the other hand, some of the younger participants acknowledged their lack of life experience and felt that it negatively impacted their ability to be taken seriously by coworkers.

For example, Participant 1 described how he came into nursing with a lack of maturity and life experience:

> You're entering a different world and you're entering a different role and you're a leader and you are dealing with peoples lives and its tough and then you have LPNs that are like "you suck" sort of thing or like "you're just a kid" and then you have to make all these decisions and stuff it makes you grow up fast.

4.4.2 Undergraduate Leadership Preparation

NGRN participants described varying preparation and experiences for leadership within their undergraduate programs. Some expressed shortcomings in their undergraduate leadership preparation while others described opportunities during their undergraduate education that had promoted leadership development.

4.4.2.1 Shortcomings

For some, lack of preparation related to changes in undergraduate curriculum that reduced the amount of hospital practicum experiences. Participant 5 described the impact of curricular change in her undergraduate program,

> School I didn't find really prepared me for the acute care world, except for my practicum but as far as the schooling goes, it didn't really, we didn't really do a whole lot of hospital-based learning in our program. . . We only had two hospital practicums; that was it. We were part of the new curriculum where your hours were cut in half.

Participant 2, similarly described a lack of program focus on acute care but maximized the two acute care practicums she had,

> I think the only thing that prepared me for my actual work were my two practicums and I just had to soak up as much as I could um you know; study on the side and just go from there.

Participants who had done preceptorships on the units on which they were now working as new graduates had familiarity with the unit that helped ease some of the difficulties during the transition phase of moving from student to practicing RN.

Participants identified the emphasis in their undergraduate programs on the theoretical aspects of leadership that did not translate into real world leadership experience and application. Participant 2 captured this theory-practice gap in her program,

> I mean you can, for example study as much of something as you want but if you know you've never done it or you've never been in a situation where you've had to be a leader, I don't think that anyone would really maybe feel ready and I think that's part of the problem. I mean we would go over leadership and roles in school and everything, but we were never actually put in a situation in school where we had to be a leader you know. So, I think it was all theoretical and no practice.

Participant 6 echoed the lack of practical preparation for leadership, "there are only so many sim labs and stuff you can do that prepare you for leadership situation, but maybe just more practice." In contrast, other participants identified that more time in the Simulation Lab would be beneficial to helping them experience and practice leadership during their undergraduate work.

NGRN participants described comparing themselves to other NGRNs who came from different provinces and undergraduate programs and felt they lacked similar preparation. Participant 5 described students from a large university in another province, who she perceived had considerably more preparation to do before they could go on the unit.

> My friends who went to U of X, just the training that they have to do before they can even be on the floor is a lot more extensive. Like they have all these modules they have to do. Everything they do has to be signed off by their unit educator. They go around and do all these skills to make sure they're prepared. . . They did a lot of work and a lot of signing off and the educators would go with them for shifts, and make sure they were competent and ready.

Whether participants considered they were adequately prepared or not, overall, they did not feel ready. They described this lack of readiness as not having had experiences in situations in the past to draw from to handle similar situations they faced in the present. Participant 3 described this polarity of being prepared, but not ready by saying

> I've gone through a million mock codes over and over again and you prepare yourself, like I know what to do but then in that situation, you're like oh my god I don't know what to do. You're not ready.

Participant 3 talked about only feeling ready when they had dealt with the same situation multiple times which allowed them to build their knowledge and confidence so that in the event something goes wrong you feel able to handle the situation. Most of the participants identified time as a factor in making them feel ready and expressed confidence that their ability to deal with leadership situations would improve with more experience and exposure to situations in which they were required to take on a leadership role.

4.4.2.2 Opportunities

Several NGRN participants described opportunities from their undergraduate programs that had prepared them for leadership as new nurses. Participants described undergraduate group work to complete projects and papers as one way they were prepared for leadership. Participant 7

described how group work prepared her to work through challenging situations with multiple people who each had their own opinion. Participant 4 explained how she noticed that people would fall into leadership roles organically when participating in group work. She stated,

> even in a small group of like four people, people that want to lead will lead and stand out so you can kind of see qualities and traits in people that are going to make a good, or not so good, leader.

Writing papers together and working through case studies in class were areas participants identified as places where they could act or see others act as leaders. Some participants expressed their desire to fall back in the group and had no interest in leading, while others described wanting to take charge to ensure the task was done properly.

The majority of participants also described a mandatory leadership course as part of their degree. This course was described as a class that you can just "cruise through to get a good mark" (Participant 7), but was also found to be beneficial when working as a nurse because it allowed them to practice eloquently speaking to a group of people, listening and validating people's opinions and treating their peers with respect. Participants shared few details about what they had learned in the leadership course other than identifying different styles of leadership. A course that was more hands on and practical was suggested as more helpful for learning nursing leadership.

Practicums in which they worked with community partners to make change were opportunities for leadership during their undergraduate degree. This allowed them the opportunity to practice effective communication and represent their school in a professional setting. These group community projects were also unstructured which allowed participants to engage in problem solving. Group community practicums pushed participants out of their

comfort zones and helped build confidence and resourcefulness as leaders. Participant 1 described this by saying

> being able to kind of go out of your way to find people and like talk to them. Like "hey you have this resource and like can you help me with it" sort of thing. And that's what a lot of the community and leadership stuff was, was being really resourceful.

4.4.3 On-The-Job Preparation

The majority of participants described a continuing lack of preparation for leadership once they were on-the-job. During their first year of practice, six participants had been put in positions of leadership, such as night charge nurse, while one participant had worked in a formal leadership position at a Long-Term Care home. Three participants had not assumed the charge role in the first year. Common among participants was assuming these leadership positions without training, and they described the experience as being highly stressful. This lack of preparation was apparent for one participant (Participant 4), who described her experience of being the In-Charge nurse. She stated,

> Probably because I hadn't had any like education or training on how to do it. Like I'm really, I'm the type of person who I really like I want to learn something before I do it. It would be nice to understand like how to sit at the computer and be an acting PCC for a day, but they don't tell you that, they are just like 'oh it's you today' and its very stressful.

Part of the challenge of being in charge was feeling as if they had little to no support and feeling pressure from the shift coordinator to take inappropriate patient assignments. One participant recalled an experience where she advocated for her team to not take a patient and ultimately felt forced to take the assignment.

Overall, participants had difficulty recalling leadership preparation during their NG orientation and education days. All nine participants completed an orientation on the unit they were hired, with orientations varying in length from four to twelve shifts. Three of the participants were not eligible for the NG Transition Program offered by the health authority. These three participants were not eligible because they were hired in the Fall/Winter when the program was not offered; despite not qualifying for the NG Transition Program, one of these participants was provided with 12 orientation shifts by the manager. The NG program allows NGRNs to have 12 full orientation shifts, a program lead who checks in with them as they progress through the first year in practice, and three paid eight-hour education days. Despite the support this NG Transition Program offers, only one participant (Participant 4) identified a time in which leadership was discussed. She explained that during one of the education sessions they discussed conflict resolution between co-workers, patients, or family.

Even though there was a Charge Nurse Workshop offered by the health authority, it was not regularly available and participants often described having to ask and press to access these leadership preparation opportunities. Participants assumed they would not be put in charge during their first year and so had not really pursued attending the workshop. One participant had attended the Charge Nurse Workshop offered by the Hospital but did not describe it as being overly helpful. She described limited learning related to informal leadership tasks such as delegating, communicating, or problem solving.

4.5 Evolving Leadership

In reflecting on their past year in practice, NGRNs described their evolving leadership. The majority of participants talked about being impressed with how far they had come since graduation and how they had already started to feel more comfortable in situations that were

previously found to be stressful or scary. They recounted initially being expected to participate in leadership, simply because of their new-found role as an RN. Participants felt there were expectations, from both their co-workers and themselves, they had to live up to. Acting as the RN leader involved taking up the activities of the team lead. Beyond conferral, NGRNs aspired to qualities they valued in leaders.

4.5.1 Stepping Into Conferred Leadership

NGRN participants viewed leadership as inherent to being an RN and stepping into the RN role meant stepping into leadership. They described this conferred leadership differently depending on whether NGRNs transitioned into team nursing model or primary nursing model. Seven of the participants worked in areas where they engaged in team nursing model in which they shared the workload with a partner (another RN or LPN). The other two participants worked on a cardiac unit which employed primary nursing in which they worked alone and were solely responsible for leading their group of patients. Participant 5, who was on a team nursing model unit, described this conferred leadership, "I think when you become an RN, you kind of automatically agree to becoming a leader, especially with the teams we work with, with an RN/LPN line, you kind of step in with students too." Participant 1 elaborated on this team leadership:

> Because we [RNs] have a bigger scope we are a bit of a team leader. So definitely having oversight of knowing your full team and what is going on and also like your team members too, like what they are doing and are able to do.

In contrast, NGRNs who worked in areas of primary nursing, did not experience the same challenges with leading a team of co-workers. Participant 8, said "I haven't had a lot of formal

leadership positions where I am delegating to LPNs to do certain tasks and stuff, so I can't really speak to that so much."

Often this conferred leadership created initial challenges for NGRNs in a team-based context. Even though as the RN they were the designated team lead, NGRNs were often racked by self-doubt and considerable uncertainty about their ability to lead teams and simply tried to stay afloat during the first few months of practice. While they found it beneficial to have a partner to rely on and with whom to brainstorm ideas, they struggled with feelings of perceived inadequacy (not feeling good enough) in not being able to meet their partner's expectations of them. Contributing to NGRNs self-doubt, was their own comparison between their inexperience and the experience of others on the teams they led, creating a sense of leadership as a grey area. One participant described working with experienced LPNs by saying:

> Generally times when I have been with an LPN they usually have been more experienced than me, because I am obviously a new grad, or was a new grad. . . so normally they kind of tell me what to do or what I should do as an RN and then in turn tell me what they couldn't do as an LPN. (Participant 8)

Participant 6 described this pressure by saying

> I noticed that the RN/ LPN teams on the floor, especially when you're working with an LPN who has worked for 15 years and suddenly you are like making the decisions and you have to somehow have the critical thinking experience that they probably have and they know what to do but you're the one who has the make the final call.

Although NGRNs assumed responsibility for team leadership, they often felt like imposters, as the inexperienced decision-makers surrounded by experienced LPNs who could

make the decision. Participant 1 described leadership as a grey area where he felt like the leader in name only:

> In my mind it's a grey area for me as a leader because there are so many other people who are more experienced than me and might have a different perspective and they are able to jump around above me. . . you are just kind of out there and everyone else is calling the shots and you're like ok, let's do it.

Not only was there the feeling of being inadequate to the task but also the tension of the hierarchical structure that at times subordinated their LPN partners. For example, one male participant expressed distress in situations in which only RNs could perform a duty leaving less desirable tasks for his LPN partner that compelled him to justify the need for his partner to complete his patient care tasks. He was much more comfortable with a team shifting and sharing leadership, an arrangement in which, "everyone jumps around and stuff, like the LPN will go talk to the doc instead of the RN sort of thing, depending on experience and what not." (Participant 1). For this participant he relied and appreciated the expertise of those he was working with and was able to benefit and learn from those he worked with. For him, those he worked with modeled leadership behaviour.

In contrast to the pressure of conferred leadership of NGRNs who transitioned into team nursing model, there were fewer leadership challenges for those NGRNs who transitioned into a primary nursing model. NGRNs in primary nursing worked alone with a smaller team of patients that they managed on their own. Participant 8 described this by saying "I feel like I lead amongst my patients but not necessarily amongst the staff too much"

4.5.2 Enacting the Nurse Leadership Role

During their first year of practice, NGRN participants described experiences in which they enacted as the leadership role. Acting as the leader described NGRN's experiences of performing the highly specific tasks/activities/roles of an RN leader. Many of these tasks related to team leading – leading team rounds, making team assignments, and giving shift report. One participant, in particular, shared extensively her experience enacting the nurse leadership role. She described her daily RN leadership behaviors:

> Making assignments, appropriate assignments, being in contact with the doctors if needed to come in, or kind of taking control of which patients we are getting. I know sometimes that's an issue for us because we get off service patients. (Participant 7)

RN leadership extended to communicating and collaborating with the larger allied health team, with a large part of this role relating to the physician. Participant 1 discussed the importance of collaboration with different members of the healthcare team and consulting them appropriately as part of the RN's leadership responsibilities.

> Collaborating with the healthcare team I think that's leadership as well. Like grabbing the doc when you need them, or grabbing the physio, or grabbing the transition nurse, or your PCC. I think that's part of leadership as well. Another component is teaching, teaching patients as well, patients and families like how to give insulin or take a medication properly.

Study participants reported both challenges and positive experiences communicating with different members of the healthcare team. Participants who had previous careers or were more mature in age, found this communication less intimidating while younger participants with less life and professional experience found this communication very intimidating.

> I did hairdressing before this for a long time so I have years of experience of like talking to people and building relationships so that was a bit easier and then being a bit older, like I'm not that old, but I was with a lot of kids that were like 20 years old when they were going through their nursing so, I don't know, I just had a little bit more life experience kind of I guess I would say, like I was a bit more mature than them. (Participant 3)

4.5.3 Aspiring to Valued Leader Qualities

Beyond being conferred to leadership by virtue of their RN role and acting as the RN leader, NGRNs aspired to certain qualities they valued in a leader. These qualities included seeing the big picture, gaining confidence, and mentoring and being approachable for others.

4.5.3.1 Seeing the big picture

NGRN participants thought it was important for leaders to see the big picture and aspired to be this kind of leader. Seeing the big picture was understanding in more detail the movement and flow of patients at a unit level and within the healthcare system. It involved knowing who to contact, where to find information, when to contact the correct person to help expedite patient flow, and strategizing about available resources. A mature female participant captured this big picture leading: "just being aware of what is going on the unit and who is super sick and who is ready to go and anticipate problems that may come up" (Participant 7). Participants thought that nurses who could understand the flow of the unit, the acuity of multiple patients and how to react in situations where their patient's status declined were strong informal or formal leaders.

Despite its importance to NGRNs many participants found having this broader perspective challenging especially in the early days of becoming a NGRN. NGRN participants described initially only being able to concentrate on their assigned patients let alone help their

co-workers or know what was going on with the rest of the floor. Participant 7 described it as tunnel vision:

> I just need to focus on my tasks and do my assessments, and do my meds, and fill out my paperwork properly and forget everything else. Um, and it was literally tunnel vision.

Participant 4 elaborated this further, "in the moment it can be a challenge. To figure out how to best utilize the resources that you have. Especially if things are going crazy."

Other participants described having developed this quality of seeing the big picture as a result of their experiences as NGRNs. Participant 8, who was in a float position, described having the big picture as a result of moving from floor to floor, "I think I have a better idea of the big picture like of how people flow through the hospital out to the community and get home." Participant 1, similarly described seeing the bigger perspective in, and responding to, changing and stressful situations,

> You have to know when to have fun and you have to know when to hunker down and be like okay, we need to get stuff done right now. Like this person is sick, um we have other patients that are sick too, like you go do this, I'll go do this.

Participants found seeing the big picture to be initially challenging but over time this improved. Participant 5 described this uncertainty by saying,

> I don't think you can ever know what nursing is until you're in it. I think you have no idea what nurses do and their scope of practice. I didn't think there would be as much of a leadership role as there is.

Another participant found that with time she started to pick up on cues during team rounds about what to expect or look for during a patient's stay for a specific illness or surgical procedure.

Participants used lists or having afternoon meetings with their partner helped to make sure they were staying on top of the day-to-day tasks.

4.5.3.2 Gaining Confidence

New graduate participants valued confidence in a nurse leader and aspired to being confident leaders themselves. Their confidence in being a leader had evolved from their undergraduate days when they had observed in their student peers those who were natural and strong leaders. Now, in practice, they described particular milestones, situations and acquired skills that had facilitated their growing confidence over time. Participant 3 described her growth in confidence, "watching yourself grow in that first year and it's been really cool like actually, being like so scared at first and eventually feeling more and more confident as the year goes by was like a really cool thing."

A major milestone in confidence building was passing the NCLEX. One participant explained that studying and passing the NCLEX had given her more confidence in her own knowledge and skills. For her, the NCLEX validated her nursing knowledge. "I felt more confident in my own knowledge and skills, even studying for the NCLEX finishing that and I even learnt more from that and I just felt a little more comfortable" (Participant 2).

Being put in leadership roles pushed new graduates out of their comfort zones. The majority of participants acknowledged that being pushed into the unknown allowed them to work through uncomfortable moments that grew them as leaders. Participant 5 simply put this as "Sometimes you just have to step up and step in and help someone else. Then people can get the best care." NGRNs described gaining confidence as a result of both stressful, emergent situations and non-emergent situations. Participant 3, who worked on a busy surgical unit described how

being involved in stressful situations had given her confidence to know what to do next time. She discussed a code blue situation:

> I remember my first code was really difficult, it was good cause we brought him back, but, like having no idea what to do like when you have to do your first skill I guess or something that you have to do for the first time, or when you have to think on your feet and, like, I remember just being like I don't know where anything is and like, throwing stuff off the cart, like, that was really difficult but that's also where I learned the most, like after, yah.

Participant 2 who had assumed formal leadership position at a Long Term Care home during her first year in practice discussed gaining confidence from a stressful, less emergent situation,

> having to run the care conferences. You are the one running it, I kind of felt like this little brand-new RN who has never met these residents, and I have to run the care conference which has all the multi-disciplinary staff there. So, PT, OT, Psych, doctor, family physician, you know. Their whole care team and then you're having to run it. So, and, and speak as if you know them when I really didn't. So, I think I did the best I could, and I don't think I would want to put a new grad in that situation you know. So, I don't think I enjoyed the experience but at the same time I learnt from it because when I went to [another unit] and I had to do them I felt fine and didn't feel nervous and felt like I knew what I was doing. So, in a way being thrown in was good but at the time not so good.

Participant 8, who worked as a care-aide before going into nursing, similarly described his confidence in his day-to-day role of managing both emergent and non-emergent situations,

> I think actually kind of having the patient load wasn't too bad like assessing your patients and that sort of thing is like if you just have a surgical patient that is [on a] pathway and

> is pretty straight forward, then that was actually surprisingly easy. I don't know, its not hard to manage that type of patient, its when they have a problem then having to figure out that problem and trying to figure it out quite quickly, if they are that sick, then that's where it gets stressful.

Unlike some of the participants, he did feel ready despite having similar nursing experiences to the other participants. This participant described himself as being confident in the knowledge he had and found it reassuring to know that other nurses before him had started out and been successful in their careers.

> I'm pretty confident in what I know I feel like. Definitely it's stressful being a new grad being a new nurse, but I kinda just like, let's do this. I don't know, I just felt like I could do the job and so far, I have been doing it. (Participant 8)

NGRN participants gained greater confidence over time in challenging ideas or ways of doing things, advocating for changes in staffing or patient care, and in standing up for themselves. A female participant, (Participant 7) who worked full time on a cardiac unit described her growth in confidence:

> I could probably do more. Like if I had ideas like, when you're new I feel like it's kinda hard to like, speak out against things, like you don't want to stir the pot, or ruffle feathers and all that but now that I know all my coworkers and like, I could be more inclined to say something. If I thought something needed to be changed or if I had some ideas or stuff like that.

Participants thought that a person's confidence allowed them to take constructive feedback easier and learn from a situation rather than focusing solely on the negative. Participant 7 described her confidence in asking for help,

> It kinda, that makes things easier. Like you might not know how to do something but I have no problem to go and ask someone to go and show me how to do it so I can watch or whatever, if I haven't done it or something like that.

4.5.3.3 Mentoring and Being Approachable to Others

NGRNs valued the mentorship of experienced and knowledgeable RNs and aspired to be leaders like them. They described this leadership quality developing as they precepted and mentored new graduates. Participant 2, found it interesting, she was already mentoring other nurses even though she felt she was still "learning and finding [her] own way in nursing." Two NGRNs had been preceptors for undergraduate nursing students. Participant 5 described that she "like[d] hav[ing] leadership opportunities. Because even as a new grad, there's students that are kind of under our wings already. People have asked me to kind of look after preceptorship students for shifts." Participant 9, who had been a preceptor to a fourth-year student, aspired to being approachable in the same way she valued this quality when she sought help,

> being approachable too because if your preceptee is too scared of you to go to you for advice or help then I don't think you're going to be very successful like I know some people who I would go to for help and then some people I know not to go to, like don't even bother because its not going to be as positive of an experience as I want it to be.

Being seen as leaders, by themselves or their co-workers, gave NGRNs a new purpose and gave them motivation to push themselves.

> I think it's been positive so far. I kind of enjoy having leadership roles, it pushes me to have to be on top of everything and keeping up with things and looking into things I maybe should already know, filling in any blanks. (Participant 5)

4.6 Navigating the Challenges

Participants identified many challenges in relation to being a leader and a new RN but were able to navigate them through receiving support and actively strategizing or reaching out.

4.6.1 Informal leadership support

As they transitioned into their new roles and leadership in particular, NGRN participants spoke repeatedly about their need for support. Participant 8 talked about having different expectations of formal leaders and relied less on formal leaders for day-to-day patient care challenges. He described this difference by saying

> a formal leader you're kind of just yes or no should I give it yes, okay like I'll do it, and maybe come back and ask you about it if I have time where as an informal leader its not that you don't trust them but you are going to them because you want some more information for me.

Formal leaders, such as nurse educators, held a less visible role on the floor, "she's (nurse educator) easy to get a hold of and she only works though like Monday and Tuesdays for us. . . so its not like there is always an educator" (Participant 7). Participant 1 echoed the inavailability of their unit educator "she's like in and out just like that". Participant 1 went on to describe how asking closed ended questions made it intimidating to communicate any actual concerns to a formal leader.

Many of their supports were from informal leaders on their units, co-workers who were in the trenches with the NGRNs on a day-to-day basis doing the job they were learning to do and as such, played an irreplaceable role in shaping their practice. They described the valuable support they received from co-workers in a variety of ways. These included modelling how to work as a team, mentoring, and being an approachable resource. Participant 7 described the co-

worker support she received, “My unit though was very supportive, so I felt pretty safe being at work. I felt like my coworkers were there if I needed anything which is probably the only reason I survived.”. Participants respected and looked up to these co-workers who role modelled different ways to be a nurse and guided and supported their practice.

Informal leaders helped support them by teaching NGRNs to work as a team. For example, Participant 1 described working with an experienced LPN by saying “it helped having those, veteran LPNs because they would kind of carry the team while you were like frantically trying to figure out how to be a nurse.” With informal leadership, tasks were delegated among team members who worked together to provide safe and thorough nursing care in a high stress environment. Participants highly valued solving problems through teamwork. They all described at least one situation where the team came together to support one another during a difficult situation.

> It wasn’t the best code, they didn’t know the code status, had to do CPR on him until they found it out, I know that they were pretty down so we all tried to pitch in and help them, help them with an assessment and make sure they were doing okay, let them take a bit of a break and like answer all their bells for them and let them really cool down and then keep checking in with them throughout the night and make sure they’re actually doing okay (Participant 3)

The mentorship informal leaders offered was an invaluable source of support for NGRNs. Participants watched and used them as resources at all times but particularly during times when management, educators, and PCCs were unavailable. Participants often worked night and weekend shifts, when most of the support was lacking, and relied on informal leaders to answer questions and help them with unfamiliar or complex situations. NGRNs described them as taking

time out of their days to build up their confidence and debrief after challenging days, such as Participant 3, who described a colleague's support:

> I just remember one experience where I was just so upset, it was the worst day and afterwards I don't know [formal leader]. . . made me feel really good. She took me aside and talked to me and it was mostly just looking at how others, what others have done for you and its kind of like makes you want to make others feel like that too.

Participant 2 talked about her reliance on mentors "I have really been leaning on experienced RNs and asking lots of questions because you can only know what you know." Participant 6 who worked casually on a surgical unit described a situation where she relied on her mentor by saying:

> I had like a situation on nights where my patient was really apneic and there was nothing in the chart about previous sleep apnea, and so that's when I reached out to my mentor person and they were like call RT and microblog the doctor or call the hospitalist or whatever. It was so, that was helpful.

Participants described how approachable informal leaders supported them in a variety of ways. Nurses who were approachable were more likely to answer questions and engage in conversations so that NGRNs could learn rather than be told what to do without learning the rationale.

> being super approachable and having like a really good knowledge base and experience like we have a few nurses that have been on the floor for 13 years and its just like oh go ask her she will know this policy or this random thing that you never come across and ya. I think the floor just informally designates them as your lifesaver (Participant 6)

One participant viewed approachable informal leaders as more helpful than the *most* experienced nurse on the floor. Participants described relying on nurses with more experience than themselves to be available to answer their questions and guide them during situations where they did not know what to do. However, they did find that nurses with at least a few years of experience on the floor where they worked were the informal leaders they tended to look to for support.

4.6.2 Other support networks

Not all of the support was from more experienced co-workers on their unit. Participants found that going to their friends or family members who were nurses to be another way they used to deal with the challenges of nursing. These more personal relationships were seen to offer beneficial learning opportunities. Participant 6 talked about having a group of friends from nursing school where they got together to share their experiences and found that they were able to help each other by getting, gathering, and learning new bits of information from each other's experiences for future situations. Participant 1 echoed the importance of support from friends and family who were nurses and can relate to the experiences they were going through. "we can all be like 'oh ya, oh ya, I had a similar situation' so its like a good feeling knowing that people are in the same boat as you".

4.6.3 Proactive Strategizing

Participants actively strategized to address challenges in transitioning to their new RN role and building their leadership capacity. These included advocating for training, asking questions, and self-scheduling.

Assuming charge nurse responsibilities was an area of leadership for which new graduates required considerable support. They often reflected on their lack of training/orientation

for this role and actively strategized to address the gap. Participant 5 described advocating for night charge nurse role training to meet a current gap,

> I'm in charge sometimes on nights, even as a new grad and I didn't have any training so I've kind of taken steps. I asked a whole bunch of other people, how do you feel when you're in this position, like have taken training, and like most of them haven't so I wrote a chit and emailed my PCC and Educator to try and take some steps to see if there could be additional training for night charge because it's important.

Being proactive in asking questions was a common strategy NGRNs used in learning the proper way to perform a new skill or manage challenging patient situations. Participant 7 said "you might not know how to do something but I have no problem to go and ask someone to go and show me how to do it so I can watch or whatever, if I haven't done it." Through asking questions and dealing with difficult and different situations, the participants learned to pick up on cues about what might happen next with their patients and were able to become more forward thinking or engage in more long term planning rather than just dealing with one issue at a time.

> You pay more attention to like cues that you think might be part of the long-term plan and I would kind of more ask for that when I was getting report and stuff like do you know what we are doing with this guy and where they are going. (Participant 6)

However, participants were strategic in accessing online policies and procedures before asking questions. As Participant 2 shared, "I found that I was asking a lot of questions and making sure, [but] before I do something, I pull the policy up or the procedure manual up" (Participant 2)

Self-scheduling was used strategically to manage the challenges. One participant (Participant 6), who was casual, intentionally worked evening shifts as a way to avoid the chaos of the morning. This allowed her to still gain experience, while having a workload that was much

more manageable. Participant 1 managed the stress of working as a NGRN by starting casually and working infrequently so that he had the time to decompress and reflect after his shift. He described this as:

> I think even if you can financially do it, taking your time and doing one shift a week helped a lot because then you could go do a shift, stress out, and then kind of relax a bit after.

Overall, participants were able to utilize resources and personal coping skills to help them to get through the first year of practice.

4.7 Summary

In this chapter on findings, the sample of nine participants has been detailed. The categories that emerged in the study were outlined and discussed. These categories included *Self-doubt in Relation to Leadership, Preparation for Leadership, Evolving Leadership and Navigating Challenges.*

Concerning Self-doubt, all but one participant, a male, reported self-doubt about their role as leader. In terms of Preparation for Leadership, participants reported a lack of preparation for their roles as leaders but described their Evolving Leadership, for the most part, in positive ways. The majority felt they had grown in this area in their first year and the aspects of this growth have been outlined. Participants described the challenges they navigated in growing as leaders and identified the strategies that were helpful in their first year of practice. Participants described feeling very challenged by the expectations of their roles as NGRNs but most demonstrated the ability to overcome these and feel successful.

Chapter 5. Discussion

5.1 Overview

What undergirded NGRNs foray into clinical leadership was self-doubt and lack of confidence in the RN role. This self-doubt was reflected in lack of preparation during their undergraduate education, orientation and on-the-job preparation for clinical leadership. Over their first 14 months of practice, participants' confidence in their own abilities improved, allowing them to feel comfortable in their work place. Support, most importantly from informal leaders, was important in building confidence and role modelling professional behavior.

5.2 Self-Doubt in Relation to Leadership

Self-doubt about their ability to lead a team of nurses when it was an expectation in their new graduate transition was particularly prevalent among the NGRNs interviewed. The lack of new graduate nurse confidence (or self-doubt) has been well documented in the literature in relation to the new graduate nurse's transition to professional practice (Hunter & Cook, 2018; Makarem et al., 2019; Magnusson et al., 2017). Makarem et al. (2019) found that professional confidence was lowest during the first 10 years of a nurse's career. The BCCNM has identified specific competetencies that NGRNs are expected to be able to perform upon graduation however, acknowledges that NGRNs capabilities will grow and develop over time (BCCNP, 2018). Therefore, it is understandable that NGRNs find it challenging moving from life as a student to independent practice. Similar to other research (Makarem et al., 2019), NGRNs in the current study lacked confidence as new nurses but for them it translated into a lack of confidence in their informal leadership abilities.

NGRNs self-doubts about their leadership abilities appeared to be influenced by the nursing model of care into which they transitioned. Findings provided beginning evidence to

suggest that the model of nursing care has some influence on new graduate transition to leadership. Working in a team nursing model appeared to undermine confidence as it added a layer of leadership, responsibility and expectation to which NGRNS were largely unaccustomed. Pfaff et al. (2014) also found the need to live up to other nurses and health care professionals' expectations had an impact on NGRNs. As undergraduates, they would have developed/honed skills in leading care for a group of patients, consistent with a primary nursing model, but did not develop or hone skills for leading a team which contributed to a more challenging transition for those NGRNs in a team based context.

While they experienced benefits of having team members with whom to discuss situations, the hierarchical structure between RNs and LPNs created challenges in leading a team, similar to findings reported in another study (Hunter & Cook, 2018). New nurse graduates in the current study repeatedly described lacking knowledge and skills in decision-making related to the team, a finding also reported in a study (Hezaveh et al., 2014) of Iranian novice nurses who described challenges in coordinating the care team on various shifts, especially when they were forced into the role. Hunter and Cook (2018) found that NGRNs were challenged by trying to figure out how to work as a NGRN while navigating relationships and personalities with co-workers. Participants in the current study also found it challenging to work with different personalities on the units where they were employed. Those participants who worked on units that use a primary nursing model spoke less about overcoming interpersonal relationships and personalities compared to the participants who worked on a team nursing model unit. Due to the nature and scope of the LPN role, participants who worked on a team nursing model unit automatically took on the role of 'team-leader' for their group of patients and were responsible for the sickest and most complex patients on the team despite the fact they were often working

with a much more senior or experienced LPN partner. Not all of their experiences were negative but they described feeling more pressure to be the leader than those participants who worked in a primary nursing model.

Unrealistic expectations also contributed to the self-doubt. Participants' in a team nursing context expressed needing to make the final decision about patient care independent of consultation with their co-workers. This may reflect their need to prove themselves to the team and staff to legitimize their conferred role. This unrealistic expectation to lead independently has surfaced in other new graduate research. Ekstom and Idvall (2015) found that NGRNs felt the need to have total control over their nursing team at the expense of meeting their own basic needs (e.g., missed meal breaks). Further, NGRNs self-expectations reflect Magnusson et al.'s (2017) do-it-all new nurse delegation style. They found this to be the most common delegation style among newly qualified nurses, which they attributed to a lack of confidence. Participants in the current study felt the need to care for sick and complex patients despite being early in their transition and feeling in over their heads. NGRNs would work assignments they were given even if they felt unprepared to take care of their assigned patient load. This expectation to take on the same patient load as a more experienced or senior staff quickly into their graduate transition was reinforced in another study of NGRNs (Hunter & Cook, 2018).

5.3 Preparation for Leadership

5.3.1 Undergraduate

Overall, NGRNs perceived their undergraduate leadership preparation as lacking both in practical experience and in direct leadership skill development. This was true despite undergraduate education development directed by BCCNM's entry to practice guidelines (BCCNP, 2018). As undergraduates are unable to assume the full scope of an RN, new graduates

are understandably thrust into full scope with commensurate expectations for rapid transition to leadership. Evidence is mixed as to NGRN perceptions of their preparation for leadership positions (Candela & Bowles, 2008; Mbewe & Jones, 2015). In one study, 67% of BSN prepared new graduates thought they were prepared for leadership (Candela & Bowles, 2008). Ross et al. (2018), in their study of undergraduate preparation for leadership, found that most of their participants stated their educational experience beneficial to their understanding and development of leadership. More hands-on experience, participants from just one school, and multiple perspectives beyond just new graduates may, have cast a more positive impact on undergraduate preparation than the current study found. Ross et al. found that hands on practice was important to the NGRN, student, and stakeholder participants. Although participants of the current study found some benefit to their mandatory leadership class in skill development, such as working in a group, hands-on leadership skill opportunities were lacking. Furthermore, leadership courses were not based in a clinical areas, so as students, they had minimal opportunity to practice clinical leadership which is required of them upon graduation.

Participants described missing several leadership skills they were called on to perform as new graduates during their final preceptorships. It was common during their undergraduate clinical practica for their preceptors to collaborate with members of the allied health team or contact doctors for orders on their behalf. Much of the collaborative work was described as 'behind the scenes' by current study participants. As such, NGRNs had little experience with leading team rounds, calling doctors, or collaborating with other members of the interprofessional team. This is a similar finding to Pfaff et al. (2014); the majority of their participants felt unprepared for interprofessional collaboration during their undergraduate training.

While they overall felt underprepared, NGRN participants did identify undergraduate opportunities and experiences that had cultivated leadership skills. In particular, group work in community and capstone practicums had equipped them with communication and conflict management skills. They were able to transfer these leadership skills from some experiences in their undergraduate programs to their current practice. The findings of this study echo those of Ross et al. (2018) who found that group work was the main way that nurses learned and engaged in leadership during their undergraduate program. Foli et al. (2014) similarly found that students who worked in groups during a service learning project, part of a senior year leadership and management course, experienced an increase in leadership behaviors during the term. Fifty-two percent (n = 31) strongly agreed that their ability to delegate had improved as a result of the class. Irrespective of undergraduate preparation, as participants highlighted, some students may be more natural leaders and step into it more comfortably while others, may be more uncomfortable and retreat and choose not to lead. Whether they are more interested in leadership abilities or they inherently hold leadership qualities and traits, not all of the participants found it desirable to be a leader.

NGRNs described skills they acquired from paid employment prior to their nursing program that had prepared them for leadership. These were skills at interacting with others, time management, and coping with multiple demands. Phillips et al. (2014) similarly found that new nurse graduates who were employed in both health and non-health settings developed skills including leadership that were transferable to their new graduate transition. Phillips et al. (2014) also found that those who worked in healthcare either prior to, or during, their undergraduate education felt more comfortable due to being in a familiar environment. Further, Philips et al. (2014) found that life experience not related to formal work, such as parenting, aided in NGRNs

ability to work as RNs. While not related to being a parent, some of the older participants in this study discussed how their age and life experience benefitted them by giving them some confidence and maturity to deal with challenging situations. On the other hand, some of the younger participants acknowledged their lack of life experience and felt that it negatively impacted their ability to be taken seriously by coworkers.

5.3.2 On-the-job preparation

NGRNs repeatedly described being in the charge role during their first year in practice without the benefit of training. Although some of the participants described being interested in the one-day charge nurse workshop they were not able to attend due to the workshop being offered infrequently or due to scheduling conflicts. While others, who had attended, did not think they would need the knowledge within the first year of practice. This is a concern as it was common for the majority of participants to have been in charge during either the evening or night shift or on weekends, when there is less support and fewer resources available to NGRNs. Similar to current findings reflecting the stress of the charge nurse role and lack of support, Carlin and Duffy (2013) found new nurse participants identified the charge nurse role as stressful and were involved in situations such as admitting and assigning appropriate patients, which they felt unprepared for. Wangensteen et al. (2008) found that participants understood that being in charge required them to have an overview of all the patients on the ward as well as some understanding of the interpersonal relationships on the unit. Although not specific to the charge role, participants in the current study similarly felt this pressure on a smaller scale related to the team they were leading and/or the partner they were paired with. Despite lack of undergraduate and on-the-job preparation for leadership, new nurse graduates evolved and gained confidence in their informal leadership over their first year of practice.

5.4 Evolving Leadership-Building Confidence

NGRN's growing confidence was a product of time in their new scope of practice as an RN, but time during which they employed active strategies to advance their clinical leadership skills. Gaining knowledge, becoming familiar with surroundings and teams, being pushed out of their comfort zones, handling expectations related to emergent and non-emergent situations, challenging ideas or ways of doing things, advocating for changes in staffing or patient care, and standing up for themselves and accepting feedback were all ways they gained leadership confidence. These resonate with the confidence builders reported in other research related to new graduate transition, generically, but not specific to leadership (Ortiz, 2016; Zamanzadeh et al., 2014). Ortiz (2016) observed that gaining experience, practicing independently, building relationships and communication, making mistakes and receiving positive feedback were instrumental in the development of confidence during the NGRNs first year of practice. Although not specific to clinical leadership, Zamanzadeh et al. (2014) found Iranian NGRNs actively used strategies to gain self-confidence during their first two years of practice. This included strategies related to enhanced familiarity (curiosity), knowledge (questioning, querying sources, personal study), clinical skills learning (personal experience, experience of others) self-exploration (analyzing, personal reflection), validation (feedback from others, referencing non-human sources), and personal creativity to improve patient management.

Ortiz (2016) found that communication was an important aspect of confidence building. Like participants in the Pfaff et al. (2014) study, current study participants found communication to be a challenge. By participating and collaborating, either formally or informally, participants became more confident and felt as if they were better able to take part in decision making in relation to the care of their patients.

Growth over their first year in knowledge and abilities was self-evident to NGRNs. Specifically, participants experienced growth in their management of different situations and the process of passing on and sharing knowledge with other nurses or student nurses. As the confidence of current study participants grew, so did their interest in leadership aspects of the RN role. For example, being in charge was less intimidating, questioning a current practice became more comfortable, and preceptoring students more manageable. Ortiz (2016) found the same; through experience and building relationships with other nurses and the healthcare team, NGs built confidence and as such, tasks that were once daunting became easier. Pfaff et al. (2014) also found that supportive relationships with members of the healthcare team improved nurses' confidence in relation to interprofessional collaboration.

NGRNs value and aspire to be leaders able to see the big picture. Seeing the big picture for NGRNs in the current study means understanding the movement and flow of patients at a unit level and knowing the people and resources to expedite this. Visioning leadership at this higher system level contrasts with their more narrowed focus in their early days of transition but demonstrates how they had moved to seeing a bigger picture. Although not specific to NGRNs, Sorensen and Hall (2011) found that seeing the big picture for front-line level leaders involves creating an immediate impression of what the day would bring and being on top of things. Despite apparent similarities, seeing the big picture in the current study is viewed at a system level versus the more circumscribed patient assignment level in the Sorensen and Hall study.

Participants reflected back on their first few months of practice and related their experience to Judy Boychuck Duchscher's Transition Shock Model (2008). One participant recalled discussing the stages during one of the in class days in the NG program and described her experience as similar. Boychuk Duchscher's research found that NGRNs felt prepared but

not totally ready to jump into the everyday expectations of being a RN. Participants of this study reported similar feelings; they felt as if they had been prepared but still were not necessarily ready for the realities of work, let alone leadership responsibilities.

5.5 Support

In this study and others, support was found to be a key factor in NGRN developing confidence in leadership. Ross and colleagues (2018) found that if the unit and the team were unwelcoming, unfriendly, or unsupportive NGRNs felt less confident. Despite experiences with unkind or unsupportive co-workers that undermined self-image (feeling poorly about themselves) and confidence as a nurse (ability to work as a nurse), participants experienced support from informal leaders and mentors on the unit that fostered confidence in their nursing and leadership abilities. This is a similar finding to other studies that have highlighted the benefit of feeling welcomed and included in the team (Ross et al., 2018). Pfaff et al. (2014) found that supportive relationships and respect among the team improved confidence.

Team problem solving supported and promoted leadership confidence among NGRN participants. Many of the situations participants described were solved by coming together as a team to figure out solutions. Hunter and Cook (2018) also found that participants were able to learn professional behaviors and how to manage and attend to situations by working on the nursing unit. Being able to resolve a situation by brainstorming, supporting each other, and combining knowledge may teach nurses that they can fix situations. These findings echo Hunter and Cook's (2018) findings which indicated that NGRNs who were able to debrief and ask for advice felt more supported in their work areas. In a sense, being able to manage a challenging situation, built confidence for participants and acted as positive reinforcement that the NGRNs could handle difficulties. Similarly, informal get togethers with nursing friends also gave

opportunity to reflect on, and identify possible solutions in clinical situations. This informal problem solving further strengthened their confidence in being able to handle similar emergent situations in the future. Interestingly, as their confidence improved, so too did their interest in leadership.

5.6 Leadership

The participants in this study indicated that they received most of their support from informal leaders on the floor, who they described as respected mentors. Not only were informal leaders more readily available to them, but these working relationships allowed them to feel more comfortable turning to them for input and direction. NGRN participants found the greatest support from these informal mentors was when they would walk them through dealing with uncomfortable situations, when they felt stuck or unsure. This reflects the important role of informal leaders in the positive development of new nurses through guidance and feedback, or what has been previously described as “coaching moments” (Sherman, 2016). Other researchers found a more active coaching role of clinical mentors, showing that new graduate nurses found the best place to learn how to be an RN was on the floor with other RNs watching how they behave and handle situations (Hunter & Cook, 2018). Hunter and Cook (2018) also found that NGRNs in their study described the role of informal leaders in shaping their professional identity.

Mentoring others such as undergraduate students and new nurses was an indicator to NGRNs that they were being recognized as leaders by others. Through organized mentorships (preceptoring students or orientating nurses to the unit) participants became confident and validated that they were valued by their unit and capable nurses. More frequent mentoring opportunities were those between co-workers and other NGRNs that allowed them to contribute

and strengthen their sense of competence. Pfaff et al. (2014) found that providing NGRNs with formal and informal leadership opportunities improved their confidence.

5.7 Strengths and Limitations

Limitations to this study include the small sample size. The nine study participants reflect NGRN demographics in BC and Canada with relation to age and sex (CIHI, 2019). There were nine participants, however; there were a range of ages, sex, and life experience among the sample. The participants also came from a variety of educational institutions and had practiced for a range of time from 6-14 months. The sample came from one urban, tertiary hospital, therefore findings are less transferable to smaller rural sites due to the fact that the amount of resources, staff, and types of work being done may vary. Additionally, findings are less transferable to larger urban centres with more resources and supports available to NGRNs. Two of the participants came from specialty areas (cardiac nursing), where models of care are different than on medical-surgical units. A strength was the Graduate Student was a newer nurse herself, this allowed her to be relatable and not intimidating to participants and provided a safe space for participants to feel as if they were talking to a co-worker.

5.8 Implications/ Recommendations

Findings from this research have several implications for undergraduate education, hospital organizational changes, and research. Each will be discussed.

5.8.1 Education

Participants highlighted the lack of leadership experience they received during their undergraduate programs. Areas in which they engaged in leadership occurred during group work and community practica. Although this was beneficial and helpful for leadership it is not experience that can be readily applied when they are working on acute care units or in acute care

specialty areas and providing patient care. Programs and areas of education which allow students to handle situations such as delegating tasks, making patient assignments, communicating, attending and leading allied health rounds, and handling patient status changes would benefit the readiness of new nurses to engage in these necessary leadership tasks. Increasing opportunities for undergraduate students to engage in these types of skills would provide them the chance to gain hands on experience and improve confidence for when they are NGRNs. As more nursing units use a team based approach to provide care, it is important to ensure that NGRNs are given education regarding working with a partner that would be beneficial to helping them act as a team leader. By engaging in leadership tasks early in their education, students can start to develop relationships with nurses on the units which has been shown to improve overall confidence (Hunter & Cook, 2018).

Creating opportunities to spend time with formal nursing leaders during practicums would allow students to have a better understanding of the big picture thinking necessary for formal and informal leaders. Preceptorships with nurse educators, PCCs, shift coordinators, practice leads, or managers would aid students in understanding different leadership positions as well as the role and skills related to each area of leadership. These preceptorships could be short-term and could be included in a theory-based leadership class all of the participants spoke about. Combining the theory with hands on practice would allow students to apply the knowledge they learned, see a variety of leadership styles and practices and better appreciate the importance of formal leadership.

It is well documented that nursing students feel pressured and have a narrow focus while on the units (Boychuk Duschner, 2008; Pfaff et al., 2014). Simulation units could be used to practice emergent situations or situations where students can practice acting as the leader.

Simulation has been found to be helpful in nurses decision making development (Candela & Bowles, 2013). Participants discussed that they did not feel ready for situations because they had never been in the situation before. Often the types of situations are common ward issues such as having a patient with abnormal lab values where the nurse is responsible for deciding when to call the doctor and what information they would need to have. These types of simple, yet intimidating, scenarios could easily be practiced in simulation labs.

5.8.2 Organizational Development

Organizational workplace changes could contribute to enhancing practice and leadership confidence in NGRNs. Participants discussed the value of formal nurse mentors to provide support as needed when they first started. It would be beneficial to have a trained and designated informal mentor on the unit who is relatable and in the trenches with NGRNs. Both formal and informal mentors (managers, educators, PCCs and preceptors) should ask NGRNs focused, open ended questions rather than saying things like "everything good?" Making time for NGRNs to have formal check-ins with mentors where they have time to talk and debrief could help to make NGRNs feel supported and validated.

Developing mentorship education/training would build capacity among mentoring nurses and the units (Al-Dossary et al., 2014; Romyn et al., 2009). These education sessions would create a space to clearly outline the expectation for the mentor in their role to support the NGRN while also provide education about how to be a mentor. Sessions would highlight how to support NGRNs and teach practical ways to build confidence for NGRNs which would improve their ability to engage in leadership. Just as the participants of this study discussed, the mentors would be able to work as a group to get through challenging situations they may be face and would give

them a safe space to discuss and work through issues rather than discussing them on the unit if it was not appropriate.

Creating a charge nurse workshop specifically for NGRNs that clearly articulates the role and expectations would be beneficial to increasing confidence and transparency for NGRNs when they are put in the in-charge role during the evenings and weekends. Further areas of development for the in-class days of the NGRN program would be to discuss leadership skills relatable to NGRNs working on medical-surgical nursing units. This could be done after or around the 5 month mark. Using Boychuk Duschner's Stage of Transition Theory (2008), NGRNs start to develop their own professional identity by around 4-5 months of practice but still heavily rely on trusted co-workers to give them advice and validate their decisions. Therefore, providing increased education during the second stage of transition, *being*, would likely be an appropriate time for NGRNs to better understand and be able to apply the knowledge. Discussing communication tips and tricks would be helpful to further prepare NGRNs for the challenges of nursing, of working and leading a team, and working with other professionals in the health-care field.

5.8.3 Research

The study sample consisted of nine participants who all worked in one urban-based tertiary level hospital. Overall, participants appeared to feel unprepared to be the team lead when working on units which provided care in a team-based structure and were largely trained to work as a clinician using a primary nursing model. Research that pilots and evaluates programs to prepare NGRNs for the team-lead role would be beneficial to support their transition. Ongoing nursing shortages and NGRN recruitment and retention are significant challenges heightening the need for NGRN leadership training. In rural sites this need is even greater where small

staffing compliments create significant requirements and opportunities for NGRNs to engage in leadership (Lea & Cruickshank, 2017). Research with NGRNs working at a variety of hospitals, from small or rural settings to larger more urban centres, to see how their view of leadership varies would broaden understanding. Understanding how NGRNs, at a variety of worksites, are prepared and ready for leadership will assist with building confidence and could have an impact on recruitment and retention in all settings. Two of the participants were male while seven were female. One of the male participants felt ready and prepared for the realities of work while the other younger male was more hesitant but openly discussed the desire to work as a leader and did not think he would work very long as a bedside nurse. It would be interesting to look at gender differences to explore the role of gender in leadership confidence and interest. Gender differences in terms of career advancement to formal leadership roles would be another area of interest. Understanding NGRNs working in specialty areas (maternity, pediatrics, intensive care, or emergency) and their experiences with transitioning to leadership would allow for a broader understanding of the subject and differences between nursing delivery models and leadership. Participants found it challenging to work with other nurses but relied heavily on their co-workers knowledge and skill to guide them during day-to-day work and difficult situations. Findings from this study saw some differences between those working in team nursing versus primary nursing model but was not a focus of this study. However the small sample size did not allow for definitive claims about the differential impact either of the two approaches.

5.9 Conclusion

The purpose of this qualitative descriptive study was to understand NGRNs preparedness and readiness for the realities of informal and formal leadership as a NGRN. Nine NGRNs from one Tertiary Hospital participated in semi-structured interviews and completed a demographic

survey. Data were analyzed and organized into four categories: *self-doubt in relation to leadership, preparing for leadership, evolving leadership, navigating the challenges*. Overall, NGRNs entered new graduate practice with self-doubt as leaders. They found their undergraduate preparation in clinical leadership lacking. Areas of improvement include providing undergraduate students with opportunities to engage in clinical leadership during their practicum and ensuring that preceptors understand the importance of allowing students to participate in leadership tasks such as delegating, leading team rounds, and communicating with families and members of the allied health team. Similar to other studies, participants found that previous life experience was beneficial to their ability to lead.

Confidence grew over time for participants and this was consistent with other studies. Multiple examples of building confidence were discussed which included gaining knowledge, developing supportive relationships, and being pushed out of their comfort zones.

Suggestions for how to improve leadership were identified. The importance of mentors for NGRNs was highlighted and should be an area of development within hospital settings. Health care organizations together with Universities should ensure that preceptors are prepared to train NGRNs how to engage in leadership. Creating a Charge Nurse workshop specific to the needs of NGRNS would be another way to prepare NGRNs for leadership requirements especially during hours where there is historically less support. This study was a small sample from one tertiary hospital, further research should be completed in other areas and with larger groups of NGRNs.

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Appendices

Appendix A

NGRN Leadership Transition

Consent

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Study Information/Purpose
The purpose of this MSN thesis study is to understand new graduate registered nurses perceptions of their preparedness and readiness for formal and informal leadership roles and responsibilities during their first year of practice. Gaining a better understanding of the experience of new graduates and their leadership preparedness and readiness has implications for improving future education and practice for new graduate nurses.

Who Can Participate?
Any registered nurse or registered provisional nurse who has been working at Kelowna General Hospital for more than 4 months but not more than 14 months is able to participate. 10 participants will be interviewed.

What Does the Study Involve?
The study involves one face-to-face interview with the MSN student, Chloe Pedersen, which will last approximately 60-90 minutes. The interview will be audio-recorded. You will also be asked to complete a demographic questionnaire. Findings will be shared with you and you will be asked to provide feedback to ensure that what you are saying is being accurately described.

What Information Will Be Collected?
You will be asked to complete a questionnaire that will ask you about your age, sex, current work situation, and about any previous leadership experience. In the interview you will be asked questions about how you were prepared for practice, whether you felt ready for practice, what your first year as an RN has been like, and what your experience and perspectives of leadership have been during your first year of practice. The interview will be recorded and later transcribed for analysis. The graduate student will also take notes during the interview.

Costs and Compensation
There may be costs associated with transportation to and from the interview. You will be compensated with a $10 Starbucks gift card for your participation.

Risks
There are no perceived risks to participating in this study. However, if you experience distress as a result of your participation in the interview, we can stop the interview until you feel ready to recommence. If additional supports are required, the graduate student will ensure that you are referred to counselling support through the employee and family assistance program at Interior Health. Interviews will be held in private areas where the discussion will not be overheard. There will be no impact on your employment positively or negatively if you choose to participate or not in this study. All information will be confidential and will not be shared with your employer.

Benefits
There may be no direct benefit for you from participating in this study. It will give you the opportunity to share your thoughts and experiences of being a new graduate registered nurse. Study findings are expected to have a positive impact for future new graduate nurses by providing new information and understanding regarding the experience new graduate registered nurses have of leadership preparation and readiness that can be used to provide greater support.

Confidentiality
The interview will be uploaded to a secure server at UBCO and all information will be kept on a password protected computer. Demographic information and consent forms will be kept in a locked cabinet in Chloe Pedersen's home office during the study and upon completion of the study will be transferred by the graduate student to a UBCO locked cabinet used by Dr. Rush for her research. Consent forms and data will be stored separately. Only research team members will have access to the data. Each participant will receive a code number that will be used as an identifier both for the interview and survey data as a way to protect your identity. Quotes will be used but no identifying information will be attached; made up names will be used. When the Graduate Student's thesis is accepted, findings from the study will be publicly available in journal publications and will be housed on a library online repository. Findings will be shared with participants of this study along with other NGRNs and those who work with and support NGs such as Interior Health managers using means such as presentations, briefs to managers, and any other way that the information could be utilized in a way that would improve the work experience of novice nurses.

Contact for Concerns about the Rights of Research Participants
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics toll free at 1-877-822-8598 or the UBC Okanagan Research Services Office at 250-807-8832. Please reference the study number (H18-00611) when contacting the Complaint Line so the staff can better assist you. It is also possible to contact the Research Complaint Line by email (RSIL@ors.ubc.ca) or Interior Health's Research Ethics Board (250-870-4602) or email (researchethics@interiorhealth.ca).

Withdrawal from the Study
Your participation in this study is entirely voluntary. You may refuse to participate or you may withdraw from the study at any time during the course of this study without penalty. At your request your contribution would be excluded if the process of analysis had not begun. However, once the process of analysis begins individual contributions will not be extracted.
You will be given a copy of this consent form to keep for your records. The researchers will keep a copy for their records.

Study Contact
If you are interested or have any further questions, please contact the graduate student, Chloe Pedersen, at 250-215-0108 or chloe.pedersen@alumni.ubc.ca.

Consent and Signature Page

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. You can refuse to answer any questions we ask, or you can change your answer at any time during the study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on you.

□ **Yes** □ **No** Your signature below indicates that you have received a copy of this consent form for your own records.
□ **Yes** □ **No** Your signature indicates that the researchers have answered your questions about the study to your satisfaction.
□ **Yes** □ **No** Your signature indicates that you are aware the interview will be recorded.
□ **Yes** □ **No Your signature indicates that you consent to your interview being transcribed**
□ **Yes** □ **No** Your signature indicates that you consent to participate in this study.

I hereby consent to participate in this study:

_____ _____
Participant Signature Date

_____ _____
Printed Name of Participant Date

If you choose to participate in this study, please indicate if you would like to receive a research summary and your contact information.

- ❑ I would like to receive a research summary at the address listed below:

_____
_____
_____
_____

Appendix B

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Interior Health

NGRN Leadership Transition

Demographics

QUESTION	ANSWERS		
AGE			
SEX	Male	Female	Other
AREA OF WORK	Medical	Surgical	Other
MONTHS OF WORK SINCE GRADUATION	4-6	6-9	9-14
EMPLOYMENT STATUS	Full-time	Part-time	Casual
IF CASUAL OR PART-TIME, HOW MANY HOURS DO YOU WORK IN A 2 WEEK PERIOD?			
DO YOU HAVE ANY PREVIOUS LEADERSHIP TRAINING?	Yes	No	
IF YES, BRIEFLY DESCRIBE			
DO YOU HAVE ANY PREVIOUS LEADERSHIP EXPERIENCE?	Yes	No	
IF YES, BRIEFLY DESCRIBE			
WHAT TYPE OF LEADERSHIP EXPERIENCE DO YOU HAVE?			

HOW LONG WERE YOU IN A POSITION OF LEADERSHIP?					
DID YOU PARTICIPATE IN A NEW GRADUATE ORIENTATION? HOW LONG WAS IT?	Yes	No			
PREVIOUS EDUCATION	No other education	University Degree	University Courses	Diploma Program	Certificate/ Trades Program
DOES YOUR MAIN FLOOR OF WORK USE PRIMARY CARE NURSING OR TEAM BASED NURSING	Primary care	Team based			
HAVE YOU PASSED YOUR NCLEX	Yes	No			

Appendix C

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Interior Health

Interview Guide

Main Question	Probing Questions
• What was your first year as an RN like?	• What are some of the positive things about your first year as an RN? • What has been difficult for you?
• What does leadership mean to you as an RN?	• What kinds of things do you do at work that you consider leadership roles and responsibilities? • What are your thoughts on formal as opposed to informal leadership roles for RNs? • Tell me about your thoughts regarding leadership and its relation to formal roles.
• How were you prepared for leadership?	• In Undergraduate? • In NG orientation? Unit orientation? • On-the-job?
• Describe a situation(s) in which you were a leader. What has your experience of being a leader been like for you?	• Tell me about feeling respected. • What was difficult? • What was easy?
• How ready did you feel to take on leadership responsibilities and a leadership role?	• What made you feel more ready for a leadership role? • What was difficult for you?
• What do you see as a difference between being prepared and ready?	• What could have been done to help you to be ready during undergraduate education or orientation? • In what ways would you say you were ready or not? • What kind of preparation did you have? • How prepared did you feel?