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Newly Graduated Registered Nurses and Medical-Surgical Nursing Units: A Literature Review

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Abstract

Newly graduated registered nurses (NGRNs) enter the 21st century workplace where they struggle with innumerable challenges and continue to be a marginalized and disenfranchised population. The purpose of this literature review is to understand how nurse educators can better prepare NGRNs for the 21st century health care environment. The comprehensive literature review will provide an understanding of the 21st century health care environment and the challenges it represents for NGRNs. Findings of the review were themed and include: increased acuity levels of patient care, demographic changes, patient care delivery changes, workload, technology, horizontal violence, ethical dilemmas and nursing retention. Evidence-based research is suggested to determine if identified strategies are required to improve nursing educational curriculum at Schools of Nursing nationally and internationally. Implications of the research could improve nursing practice, patient care, the workplace environment, and nursing retention.

Keywords: *New graduate nurses, Experiences, Perceptions, Medical surgical nursing*

1. Introduction

Nurses constitute the largest health care profession in the world, 19.3 million strong, with the majority of those nurses employed in hospital environments [1][2]. Most new nurses in the United States (U.S.) begin their professional careers in hospitals; however, compared to previous years, when a 30-year career in acute care was the norm, hospitals have had a dramatic decline in experienced nurses [3]. For every nurse leaving hospitals to work as a nurse in the community, an average of more than four dropped out of Ontario's nursing labour market altogether [4]. Approximately 60 percent of newly graduated registered nurses (NGRNs) in the U.S. leave their first job before the end of their first year [3], and the National Review of Nurse Education in Australia found that there was an extremely high attrition rate for nurses within five years of graduation. Since 2013, there has been a decline in the number of NGRNs obtaining a license to practice in Canada, with average annual growth of -3.2%, compared with 2.8% since 2007 [5]. The high turnover of new nursing staff is likely to continue, unless steps are taken to understand the historical, social, and political context that has propagated and continues to sustain a stressful, oppressive, and traumatic

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acute-care environment [1][4]. In fact, the transformation of the health care workplace over the past 20 years in response to economic and service pressures has had undesirable consequences for nurses' work in hospitals related to their use of time and skills [6]. For example, mergers that began 25 years ago to help reduce administrative redundancy and negotiate rates when purchasing supplies, equipment, and pharmaceutical products were often radical and guided by little empirical evidence [7]. Although the research was conducted in the U. S., Canada is referenced frequently and compared in relation to restructuring and mergers in health care delivery.

2. Literature search

A search of the literature began with keyword searches that included new graduate nurses AND (experiences or perceptions) AND medical surgical nursing. Limiters placed on the searches in CINAHL, ProQuest, and ERIC databases were: the timeframe of 10 years previous, English language, full text, references available, peer-reviewed, abstract available, and search modes to find all my search terms. Other keywords searched included new graduate nurses AND (experiences or perceptions). The findings of the literature review were themed with appropriate headings, which included increased acuity levels of patient care, demographic changes in the patient population, and changes to patient care delivery models, workload issues, and subsequent problems with nursing retention.

2.1. Workplace challenges

An increase in patient acuity has been well documented in the literature [8][6][9]. Acuity in health care can be described as both the number and degree of illnesses experienced by individual patients requiring acute care or the number of acutely ill patients a nurse is caring for during a shift. The number of acutely ill patients for whom a nurse is responsible during a routine shift is increasing, which is a major factor contributing to the challenges occurring in the health care workplace. Nurses are caring for patients with chronic illnesses who are frequently admitted with acute exacerbations of these conditions. In a comprehensive literature review of the lived experience of the transition of NGRNs in their first year of practice, Morrow [9] concluded that the exploration of the experience of new graduates in their first year of practice revealed ongoing challenges and historical inaction as nurses continue to be a marginalized and disenfranchised population. NGRNs are often overwhelmed not only by the numbers of patients they are expected to care for, but also by the acuity levels of patients who experience shorter lengths of stay despite complex challenges. Increased levels of patient acuity and ever-increasing costs associated with caring for sicker patients place substantial fiscal pressure on many acute institutions. Subsequently, nurses continually are pressured to "do more with less" [1]. Such requests render caring for patients an increasing challenge, and escalate the practice tensions that currently exist in an overburdened acute-care workplace. The expectations placed upon nurses in acute care medical-surgical nursing environments, due to the increased acuity levels of patients, are greater than they were a decade ago or even five years ago. Duffield, Gardner and Catling-Paull [10] reviewed literature from Australia and beyond, in their aim to explore some of the drivers for change and recommend a way to optimize nurses' work in the hospital environment. Duffield et al. reported hhospital work is now more challenging with patients who are more acutely ill. Never before has the role of qualified staff been more important to patient safety and well-being.

2.2. Demographic changes

Canada's population is aging. Demographic predictions illustrate that the number of Canadians 65 years of age or older is expected to double in the next 25 years to reach 10.4 million seniors by 2036. By 2051, about one in four Canadians is expected to be 65 or over [11]. In 2015, estimates demonstrated for the first time, there were more persons aged 65 years and older in Canada than children aged 0 to 14 years. Nearly one in six Canadians (16.1%) was at least 65 years old, compared with 5,749,400 children aged 0 to 14 years or 16.0% [11]. By 2020, more than half the population of Australia will be over 50 years of age. The health workforce in Australia and most of the western world has been educated in an acute care model addressing the client's immediate and urgent health concerns [12].

One of the greatest challenges facing health care systems throughout the world is chronic disease. Chronic diseases increase with age and already 55% of Canadians suffer from one or more chronic disease conditions [13]. Chronic conditions are responsible for 60% of the global disease burden, and are expected to rise to 80% by 2020 [12]. More patients will be requiring nursing care for chronic diseases and acute illnesses associated with age and chronic disease co-morbidities. In addition, the impact of changes made to the delivery of health care in Canada, where larger numbers of health care workers with various levels of education make up the practice environment, and shorter lengths of hospital stays increase the workload and responsibilities for the registered nurse (RN). Recent changes in the health care environment with the present and expected increase in the number and complexity of patients who require nursing care will only augment the challenges cited by the authors. For these reasons, the context of the 21st century acute care medical-surgical nursing, with relation to NGRNs in that environment, requires attention from nursing researchers.

2.3. Health care delivery

The financial constraints on the Canadian health care system continue to increase. In 2016, health care spending in Canada was projected to reach 228 billion dollars. The underlying health care cost drivers include demographics (population growth and aging), price inflation, technology and utilization [14]. The preparation of graduate nurses in four-year university degree programs places major emphasis on providing nursing care for patients in a reformed health care system which has been the goal of Federal and Provincial governments for decades. Unfortunately, this reformed system remains a vision for both levels of government.

The complex and chaotic environment of health care in Canada has undergone many changes in the past decade. Jennings [7] suggested that restructuring did not achieve its intended purpose and reported on three studies that examined cost. The results reflected increased costs at both the unit level and the hospital level. The turmoil that accompanied restructuring and mergers related to lower job satisfaction among nurses and burnout, which in turn contributed to poor patient care. Jennings attempted to shift the focus toward the welfare of patients and staff and away from the fiscal agenda behind restructuring and mergers. Health and more specifically hospital administration have turned to industrial and business models to find solutions. Ironically, clinicians are expected to justify their decisions with evidence, but the administrators themselves remain immune.

A Health Council of Canada Report [15] identified health care workplaces to have difficulty engaging in long-term human resource planning and the development of their workforce, given government budget cycles and budget pressures. Despite a recognized need

for collaboration in planning, there is no clear mechanism for timely information gathering to support current planning efforts linked to population health needs. Changes to the way healthcare professionals are educated, trained, employed, funded, and regulated are needed to support the commitments on national health care renewal.

The Model of Care, a provincial change to health care delivery, emphasized that all providers would work to their full scope of practice, unlicensed providers would be integrated more fully into the care environment and the nursing care roles would be redesigned. Nursing care roles changed as increased numbers of non-graduate nurses with various levels of education entered the health care environment [13]. The changes to the delivery of health care caused increased responsibility, stress, and workload for the all nursing and non-nursing staff. The RN role expanded with an increase in delegation and leadership responsibilities.

The gaps identified in health human resource planning include limited information on professions that are self-regulatory and on unregulated workers. A lack of common understanding about the complexities of multidisciplinary teams makes it difficult to discern whether this shift in delivery models will, or will not, mitigate some of the health human resource problems predicted for the future. Unfortunately, pervasive and sometimes radical changes in policy are often implemented before informed evidence-based collaborative discussions happen.

Nurses' work. Over the last decade, health care restructuring, budget cuts and the shortage of health professionals have prompted health care organizations to attempt to use their human resources more effectively. One strategy, as described earlier with the Model of Care has been to change the mix of RNs and licensed/registered practical nurses (LPNs) working in a facility or agency and to introduce unregulated health care workers into the health care setting [6]. The strategy must ensure patient safety and nursing staffing levels are examined with a focus on looking at the root causes of errors rather than on the blaming of individuals. The Canadian Nurses Association [6] survey of Canadian RNs' perceptions of patient safety in hospitals reported that nurses overwhelmingly state their work environment is increasing risk to their patients. Because of an overlap in the scope of practice of RNs and LPNs, there is difficulty in making affordable staff mix decisions that will benefit patients. If staffing decisions are made solely on the legislated scope of practice, then several key factors could be overlooked, and patient safety affected. Several studies, identified by the Canadian Nurses Association, have indicated that the higher the proportion of regulated nursing staff in the staff mix and the higher the number of hours of care provided by RNs, the better the patient outcomes. California, USA and Victoria, Australia, have legislated minimum ratios of RNs to patients. Whether this approach is effective and appropriate has not been determined. More research is required to address issues of nursing staff mix and patient safety [6].

Duffield, Gardner, and Catling-Paull [10] who explored change in patient acuity levels and ways to optimize nurses' work in the hospital environment, also reported on changes to health care delivery. Changes to skill mix had an impact on nurses' work and the time available for patient care; hospitals in most developed countries have restructured or downsized by removing positions not directly related to the organization's core business of patient care. Often this work is "picked up" by nurses. A low patient-nurse ratio and a greater proportion of registered nurses are central to effective surveillance for both the detection of errors and the prevention of adverse effects.

Because of the fiscal health care demands incurred over the past decade, governmental budget cuts with health care restructuring and changes to health care delivery models were designed to use human resources more effectively. It is not enough for the strategies to be

implemented with good intentions: They must ensure patient safety as well as nursing staffing levels that are sufficient to meet patient needs.

Technology. A Health Grades report by Stein and Deese [13] estimated that in the previous three years, medical errors in US hospitals contributed to 600,000 preventable patient deaths. In April 2004, the White House issued an executive order calling for the nationwide adoption of interoperable electronic medical records within a decade. Ironically, less than three months later, a newly appointed Canadian Coordinator released a strategic plan to make the idea a reality in Canada [13]. Four years later, in 2008, the plan was introduced in all hospitals in Canada. The Electronic Health Record (EHR) and specifically Clinical Information System (CIS) were incrementally implemented in health care facilities from 2008 until 2013 when the system "went live." The importance of ensuring patient safety was the focus of the discussions surrounding EHRs. The alarming statistics emphasized the need for hospitals to adopt clinical information technology (IT) such as EHRs, decision-support tools, barcode scanners, and online clinical documentation. A Joint Commission on Accreditation of Health Care Organizations [13] reported that organizations adopting these technologies had a reduced risk of health care errors, as well as an increase in productivity and nursing satisfaction. Increases in the amount and type of documentation and reporting required of nurses now comprise a large component of nurses' work [6]. Nurse leaders from three highly regarded institutions were asked to identify challenge areas and how the IT industry might evolve to better support nursing. Work environment and delivery of care, nursing education, and recruitment and retention of nurses were the key challenge areas identified. The value of a preceptorship program for NGRNs with emphasis on fostering partnerships with schools of nursing was also identified in the study.

Horizontal violence. Defined as overt and covert nonphysical hostility, such as criticism, sabotaging, undermining, infighting, and bickering [16], horizontal violence refers to the harsh reality experienced by some nurses beginning their careers in nursing. Roberts described it, in a classic quote, as "eating our young." Acts of horizontal violence can range from intimidating body language to sarcastic comments, abusive language, and all acts of unkindness, discourtesy, divisiveness, and lack of cohesiveness. King-Jones [16] reported on several earlier studies conducted on NGRNs. Two additional studies explored the intentions of NGRNs: the first reported 62% of 3,266 nurses studied reported experiencing verbal abuse and 24% reported that they would resign their positions by their second year of work, the second study of 544 NGRNs found that 31% reported being bullied and concluded that bullying is a significant determinant in predicting intent to leave the organization [16].

Ongoing issues in the nursing workplace, horizontal violence and team communication in particular, are reported by Eagar, Cowin, Gregory and Firtko [17] in a series of focus group interviews with nurses in the acute care setting. Predictably, the consequences of an unhappy workplace caused by horizontal violence had an impact on the individuals, their families, and their colleagues, and was a major source of stress. As well as the impact on the individual, the researchers warned of the economic considerations for managers if they failed to respond adequately to a "toxic" workplace environment. In addition to the loss of nurses from the health systems, there was a link between poor staff morale and poorer patient outcomes [17]. Other consequences included increased errors, decreased patient satisfaction, and increased sick leave leading to increased workload with increased levels of stress. Findings from the Eagar et al. study [17] revealed that undergraduate baccalaureate programmes must ensure that their curricula include clear direction about professional role delineation and scope of practice decisions. A recent national two-wave survey of new graduate nurses across Canada reported over half of new nurses in the first year of practice reported high levels of emotional

exhaustion and many witnessed or experienced incivility (24-42%) at work [18].The confusion that continues to abound has unfairly added to a workplace that is often short staffed, under resourced, and under skilled. The unhappy health care environment, caused by horizontal violence and described in the literature, is concerning for all members of the health care team, but it is most especially concerning for NGRNs.

Ethical dilemmas. Nurses may have little or no formal ethics education and those who have such experiences may have acquired it through continuing education programs or informal methods of instruction rather than via degree programs [19]. Moral distress and the frequency of morally distressing events were described by Zuzelo in data collected using a Moral Distress Scale and an open-ended questionnaire. Qualitative data analysis revealed the nurses sought support and information from nurse managers, chaplaincy services, and colleagues. The RNs requested further information on biomedical ethics, suggested ethics rounds, and asked for a non-punitive environment surrounding the initiation of ethics committee consultation.

Storch, et al. [20] outlined the outcomes of Leadership for Ethical Policy and Practice from a three-year participatory action research study involving nurses, managers, and other health care team members in organizations across British Columbia, Canada. The authors contended that the ethical dimensions of nurses' workplaces could be adapted in a variety of settings locally, nationally, and internationally where action is needed to develop guidelines to create positive ethical climates, promote ethical practice, and provide support from formal nurse leaders. From initiating projects where nurses and other health care providers met on a regular basis to discuss and address whatever ethical matters arose to helping nurses recognize ethical issues and address conflict and end-of-life issues, Storch et al. identified the hope that nurses' work environments could be changed. A significant finding from the research appeals for support of nurse managers and senior executives (chief nursing officers or their equivalents). This support is deemed to be critical if ethical climates are to be enhanced and moral communities developed. Such collaboration leads to greater attention to ethical practice and improves the quality of nursing care delivered to individuals, families, and communities. Moral and ethical distress may be contributing factors that influence nurses' decisions to leave the nursing labour market.

2.4. Support for nurses

High numbers of RNs have left the profession to seek different careers [4]. The declining numbers suggest a need for reflection on how well organizations support and retain nursing staff. One goal of nursing education is to imbue students with a realistic view of the role of the professional nurse. Debates continue on what has distanced nursing students from the realities of nursing. The lived experience of graduates has not been researched thoroughly, and thus orientation and graduate programs may not be reflective of the real needs of newly graduated or qualified nurses [21]. Findings reveal problems within the socialization process where periods of anxiety are experienced each time a graduate is rotated to a new area.

King-Jones [16] suggested that the benefits of rotating must be carefully weighed against the potential emotional distress that the rotations may cause. The nurturing of new graduates was seen as important. The belongingness, achieved through mechanisms such as effective mentoring or partnerships, enhances learning and can influence future career decisions. The socialization process for nurses is noted by King-Jones in her discussion of horizontal violence and new graduate nurses. Kelly and Ahern [22] concluded that new graduates were not prepared for the reality of working in the nursing profession. Socialization during the first

six months of employment has the potential to affect attrition and retention of new graduates. Health sectors must recognize the importance of the working culture if NGRNs are to be retained in the profession of nursing.

3. Conclusion

As the landscape of health care delivery in Canada and around the world continues to rapidly evolve, it is apparent that the RNs' work environment is becoming increasingly complex. When baccalaureate student nurses graduate, they are immersed in this environment with high expectations of working in a collaborative, collegial setting and having time to provide the excellent nursing care in the manner in which they were taught. The number of RNs leaving the profession within their first year is alarming and the factors that influence RNs' work, from the increase in older patients with chronic disease to the moral distress and horizontal violence, all contribute to the challenges confronting NGRNs. "No profession has greater responsibility with more vulnerable populations than do nurses" [23].

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