ACORN AUSTRALIAN COLLEGE OF PERIOPERATIVE NURSES | JOURNAL OF PERIOPERATIVE NURSING

Volume 31 | Issue 1 Article 5

3-1-2018

Is your graduate nurse suffering from transition shock?

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Abstract

The term 'transition shock' is a relatively new concept used to describe the experience of moving from the comfortable and familiar role of the pre-registration nursing student to the professional registered nurse (RN)[1]. The initial and most dramatic stage in this theory of role adaption occurs over the first four months of professional practice[1].

Transition shock has foundational basis in Kramer's theory of 'reality shock,' which describes the phenomenon of studying for many years to practice a particular role, and then finding the professional reality is different than expected[2]. Reality shock has four phases – the honeymoon phase, the shock phase, recovery and resolution. Dr Judy Duchscher's theory of transition shock penetrates beyond the professional aspects of shock[1].

Duchscher, whose research into this issue in nursing spans over ten years, states that 'nurses often identify their initial professional adjustment in terms of the feelings of anxiety, insecurity, inadequacy and instability it produces[1].' Few would argue that the first few months of a graduate RN's career are the most stressful[3] – consolidating the theory outlined by Kramer.

This paper seeks to define transition shock and outline signs and symptoms which may be exhibited by the graduate nurse. Potential solutions to mitigate the effects of the shock phase on the perioperative graduate will be extrapolated. It is hoped that perioperative nurses will have an improved ability to recognise the issue and, with greater awareness and understanding, potentially be able to improve support for perioperative graduates to ensure a smooth path to successful transition and, in the long term, increase retention of graduates in the profession.

In offering solutions, the logistical issues affecting education and support in the operating theatre are highlighted and issues for potential research are recognised.

Key words: transition shock, graduate nurse, preceptor, stress

What is transition shock?

Over ten years of research, Duchscher proved that transition to professional practice has a significant emotional toll on the graduate nurse. She cites statements such as 'drowning' 'terrified' and 'scared to death' alongside feelings of exhaustion in trying to 'stabilise the emotional roller coaster' the new graduates find themselves on in those first months[1]. Her research showed that graduates nurses fear being 'exposed' as incompetent, fear providing unsafe care and causing harm inadvertently, and fear not being able to cope with their responsibilities. Ultimately they fear rejection by new colleagues[1]. These feelings relate directly to the new graduate's level of confidence and self-image as a professional[1].

Duchscher's theory elucidates how the graduate's role, responsibility, relationship and knowledge foundations impact on the intensity and extent of this transition period[1]. Jewel[3] further states that during this time feelings of self-doubt, inadequacy and exhaustion lead

to a high rate of burnout[3], job dissatisfaction and turnover[4].

According to Kramer, graduates commence in the 'honeymoon' phase. This is observable by traits such as being idealistic about their professional role, and optimistic[5]. Graduates are generally excited about having secured paid employment[6] and commencing in their chosen career[7]. Orientation and supernumary time occur during this phase. Not surprisingly, as the 'reality' of nursing work sets in, graduates find themselves with a disparity between what they have been taught and expect to do, and the reality of actual nursing practice in the workplace. The honeymoon phase ends, and transition shock[3] sets in.

At the commencement of the shock phase, Duchscher states that the graduate will display 'a deliberate withdrawal from the intensity of the shock period'[1]. 'Emotions such as withdrawal, rejection, hostility toward others, fatigue and illness are displayed'[5]. It is successful transition through this phase that this paper seeks to assure for the perioperative graduate.

Sparacino[6] states that 'new graduates equipped with the tools to successfully navigate through the shock phase progress to the recovery' phase. This is evidenced by decreased anxiety[6] and improved coping mechanisms. Kramer's final phase of resolution can be either positive or negative, as the graduate will either transition confidently and go on to become, as per Benner[7], a competent practitioner, or they may exhibit symptoms of burnout and potentially leave the profession altogether[6].

Honeymoon phase idealism excitement optimism		
Shock phase emotional withdrawal rejection, possible hostility fatigue, illness		
Recovery phase reduced anxiety increased coping ability		
Resolution phase		
successful transition to confident and competent practitioner	OR	burnout and possible decision to leave the profession

Solutions

Duchscher describes that maladaptive transitions occur due to lack of practical and emotional support, lack of confidence, uncertainty in relating to new colleagues, and unrealistic performance expectations[1]. Several solutions can be tentatively proposed.

In the perioperative environment, graduates need, first and foremost, a supportive and positive nurse unit manager (NUM). The NUM must provide, through leadership, a positive work environment[8] and culture of collaboration, while also fostering personal and professional growth[9]. A caring preceptorship team helps create positive working relationships with the graduates[8] enabling them to not only feel part of the team but also feel emotionally supported[2]. A committed educator is required to support the graduates through facilitation of theoretical, technical and non-technical knowledge, and provision of emotional support.

Graduate perioperative nurses need regular and timely access to educators who have a clear understanding of the learning needs of novices[8] and are able to provide targeted fulfilment of knowledge deficits[2]. This supportive role also needs to provide feedback and guide critical reflection in addition to that provided in situ by the preceptors. It is important to note that the feeling of isolation that many graduates feel is due to the sudden withdrawal of previous academic supports[10]. The preceptors and clinical educator can fulfil this role in the professional environment.

The important and often unrecognised role of the preceptorship team must be highlighted. Preceptors offer invaluable support in nurturing the graduate; in particular, the skill they provide in regards to 'challenge vs support' model of educational leadership with novice nurses must be recognised and celebrated. Sadly, preceptor burnout is an issue in the perioperative environment. Indeed, it is a concern across all fields of nursing, and necessitates further reflection and research into the cause and potential preventative strategies.

There may be multiple factors contributing to preceptor burnout – constant hypervigilance towards the novice's actions, time stressors from the surgical team whose demands often compete directly with the safe provision of a learning environment, emotional overload, lack of support and, perhaps, the inability of a department to match the skills of the graduate to the appropriate surgical specialty. Compassion fatigue (a cumulative condition where a nurse is 'desensitised' and their ability to care is reduced)[4] is well researched in the acute care sector but, again, little is known about this in the perioperative arena and how it may

stem from the preceptor–graduate relationship.

A generous preceptorship team – given many perioperative nurses are part-time workers – may reduce the burden, as perhaps may regular education about the principles of adult education, how to provide constructive negative feedback, Bloom's Taxonomy etc. These education sessions would have an added benefit of allowing the preceptor group time to debrief, reflect and consolidate individualised education plans.

Perioperative graduates need clear role expectations and a support network of peers with whom they can normalise their unique situation. They need to commence with solid anatomical and physiological knowledge, role and medico-legal perioperative knowledge, and also be inducted into the intricacies of the operating suite – the culture, the non-technical and communication skills they will be expected to display, and so on. This 'professional socialisation' is vital in the initial transition period, as graduates are, at this time, focussed on their own skill acquisition and the realities of their work[11].

The high level of physical exertion sustained by the graduates in Duchscher's study was essentially spent on fulfilling the tasks associated with their role and hiding the difficulties of this physical, emotional and intellectual exhaustion from colleagues[1]. This was often coupled with life changes such as altered living arrangements, new debt and the work–life challenges of shift work[1]. Participants detailed worrying about work before and after shifts, and also dreaming about work, so there was little respite[1].

For the graduate nurse in the perioperative arena, the cost of physical exhaustion can be potentially lessened again by a strong preceptor group who can discuss pre-emptively the physical symptoms of a long day of perioperative nursing and offer supportive measures as required.

The leadership team should encourage graduates to rest on their day off. Responsibility must lie with the network to disallow graduates to 'pick up' extra shifts during this time.

In order to assist a perioperative support team to prevent graduates from worrying about work at home, ideas such as debriefing regularly with an educator or preceptor may lessen this stress. Reflective tools, such as mandated reflective journalling during the transition process, and providing the time, support and space to share experiences with other graduate peers is invaluable[2].

Duchscher's research found that intellectually, graduates were initially excited, inspired and enthusiastic but once orientation was complete and they were no longer supernumerary, 'overwhelming fear, doubt and all-consuming stress' set in[1]. This was worsened by a lack of feedback, and a lack of awareness of the graduate role and responsibilities[1].

The construct of resilience has been researched[12] and is cited as one factor that facilitates a successful transition, job satisfaction and career longevity. Are nursing graduates being educated that resilience is an important skill they must have in order to transition successfully? How can it be taught and measured? More research is required in this field, particularly for the perioperative specialty.

Feelings of stress could potentially be decreased for new graduates with a comprehensive pre-reading package prior to introductory orientation. This would also require educator-facilitated reflection and discussion. Specific study days for the unique areas of perioperative nursing would also be of benefit.

Principles of asepsis and surgical specialty, specific academic tasks and documentation, and medico-legal requirements could be discussed, and a hands-on instrumentation session for the perioperative graduate provided. For the perianaesthetic graduate, further training in principles of anaesthesia, drugs and common complications with their management, pain management and airway practice could be provided. Key to this theoretical foundational knowledge would be active learning and simulation, both task–trainer and immersive in approach. Furthermore, vital to this foundation would be adequate supernumerary time.

Research[13] shows that consideration also needs to be given to the workload, which can be expanded as confidence and competence grows. This may be possible in the perioperative environment through careful allocation of lists, careful skill mix and similar methods but of course does pose practical challenges. In a perfect world, the graduate perioperative nurse would spend sufficient time in one specialty before moving to the next (following through with the 'mastery theory' of adult learning), be kept away from emergency cases initially, work only 'in hours', and commence with less instrumentation-intensive cases or, in the peri-anaesthetic arena, less complex patients.

The main socio-developmental issues in those first months pertained to the graduate nurses 'finding and trusting their professional selves, distinguishing those selves from others around them, being accepted by the larger professional nursing culture, balancing their personal

lives with their professional work and finding a way to meld what they had learned during their undergraduate education with what they were seeing and doing in the 'real' world[1]. Thus, it is not surprising that graduates were hypersensitive and self-critical[1].

In these initial first months, graduates were focussed primarily on 'getting the work done on time' rather than other higher order tasks such as patient advocacy. In this instance, it could be argued that the challenges associated with the graduate nurse in the ward environment differ significantly to those in the operating theatre. It could be presumed that graduate nurses moving into the acute sector would have previous experience in the ward environment, and thus a clearer idea of the role expectation, if not the reality.

Graduate nurses in the perioperative environment are often very self-critical; however, this may stem from an intrinsic need to succeed, please their support team and be accepted as a part of the team rather than a disparity between what they are currently experiencing and what they have learned at university or on a clinical placement. How many graduates who have a perioperative rotation as a preregistration student actually have the chance to work in the operating theatre as a graduate nurse? More research is required into this correlation but regardless of prior exposure it is vital to have the right preceptor matched to the graduate, clear expectations and clinical hurdles to achieve, and regular facilitated self-reflection.

Conclusion

Despite the potential solutions outlined in this paper for mitigating transition shock for graduates, the practical and logistical challenges of running an operating theatre remain. Lists need to be completed, emergencies dealt with, staff shortfalls coped with. Skill mix is often not ideal and in some cases it is impossible for a graduate to work alongside one of their preceptors. Time for education is limited, as is allowable time off the floor for debrief. In this current climate, time appears to still be granted generously for medical colleagues but is still largely absent for the nursing profession. In this fiscally challenged environment, who will lead the change to promote education as the solution to not only transition shock amongst graduates but also as a potential way to maximise staff retention in the long term?

Research has shown that all graduate nurses will go through transition shock to a degree, and this is replicated when they rotate to a new ward or environment[13]. It can be surmised that a graduate nurse commencing in the perioperative environment is particularly at risk. Duchscher suggests incorporating formal transition shock theory into orientation and transition programs[1]. It is hoped that by highlighting the phenomena of transition shock, awareness will be raised and some practical solutions implemented to make the transition process smoother for graduate perioperative nurses. Transition shock and its effects on the graduate perioperative nurse is an area that warrants further research.

Acknowledgements

The author would like to acknowledge Heather Edis, Associate Professor Cheryle Moss, Dr Marilyn Richardson-Tench and Dr Judy Duchscher for their support.

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