THE LIVED EXPERIENCE OF TRANSITION TO PRACTICE FOR THE NEW GRADUATE LICENSED PRACTICAL NURSE WORKING IN LONG TERM CARE

by

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ABSTRACT

For the past decade, the role of licensed practical nurse (LPN) has been a topic of discussion among the National League for Nursing (NLN) and the National Council for State Boards of Nursing (NCSBN). The NLN recently called for nurse educators to examine the LPN role in the current healthcare system. Transition to practice issues experienced by the new graduate licensed practical nurse (NGLPN) are important issues that reflect nursing education. This study explores the lived experience of transition to practice for the NGLPN working in the long-term care (LTC) setting. The study will open the conversation about NGLPN transition to practice among practical nursing educators and nursing administrators of LTC facilities. Van Manen’s and Benner’s use of interpretive phenomenology informed the study design. The researcher interviewed three new graduate LPNs, graduating from one school in a state community college practical nursing program. The graduates were interviewed three times for no more than 60 minutes each in an effort to learn about experiences of transition to practice in long-term care. Themes that emerged from the negative experiences include intimidating, disrupting behaviors, death and dying. Subthemes that emerged from the intimidating and disruptive behaviors include integrity, human dignity, and self-determination. The subtheme unprepared emerged from the death and dying theme. Themes that emerged from the positive experiences are relationships and feeling supported. Caring emerged as a subtheme of relationships. Personal growth and human flourishing (HF) emerged as a theme of the positive and negative experience.
DEDICATION

My dissertation is dedicated to my loving family, Derek, Taylor, Haleigh, Kyle, and Kaden. This dissertation could not have been accomplished without your love and contributions to the household. Working hard in life to accomplish goals is something that I learned from my family growing up. My mother worked and went to school from the time that I was in first grade until I was in my early adulthood in order to reach her goal of obtaining a Bachelor of Science in Nursing degree. My hope is that my children will also continue to work diligently to accomplish goals.

My dear Mother, Judy Powell Savage, died an early death at age 64. I share her story with my nursing students. She was a wonderful role model. We miss her dearly, but her legacy lives on. I promised her the night before she left this world that I would complete this goal. I worked diligently to stay true to that promise.

My grandmother, Evelyn Powell, was a pioneer of neonatal nursing in Tuscaloosa, AL. She worked 37 years in the hospital nursery, retiring in 1982. She was such a great role model and I loved her dearly. I know that she would be proud of my work. She started a legacy of registered nurses in the family that now includes 2 grandsons, a granddaughter, and 3 daughters. My brother, John, obtained a Master’s Degree in Business Administration in addition to his nursing degree and works as a Director of Surgical Services. My cousin, Clint, worked for 13 years in ICU and is now working towards obtaining his degree to become a Certified Registered Nurse Anesthetist. “Gigi” inspired us all.

My Grandmother was a legend in Tuscaloosa, AL for her strength and dedication as
professional nurse. She walked across the train trestle in the snow over the Black Warrior River years ago from her home in Northport, AL while pregnant with twins to get to work in the nursery. She was an amazing person and an outstanding registered nurse!

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CHAPTER I
INTRODUCTION TO THE STUDY

The National League of Nursing (NLN, 2014) is calling for nurse educators to examine the role of Licensed Practical Nurse (LPN) in the current healthcare system. Major policy changes have affected healthcare organizations over the past few years. Additionally, the Baby Boomers have entered late adulthood and this has increased use of Medicare funds. Initiation of the Affordable Care Act is resulting in major changes for those that provide healthcare to Medicare recipients. Medicare has implemented cost containment measures and hospitals are sending patients home sicker. Patients frequently discharge to long-term care (LTC) facilities for rehabilitation stays before going home.

Nurse educators teaching in practical nursing programs need to understand how changes influencing LTC facilities since implementation of the Affordable Care Act have affected new graduate LPNs’ (NGLPNs) transition to practice. New graduate LPNs working in LTC settings care for frail elderly clients with multiple comorbidities. Clients have the potential to decline rapidly and LPNs with only three semesters of education provide their nursing care. The aim of this study is to understand the lived experience of transition to practice for the NGLPN working in LTC. This will start the dialogue among practical nurse educators and nursing administrators about transition to practice experiences for NGLPNs working in LTC settings. This also reflects the NGLPNs’ satisfaction with preparation for the role. No studies have approached the issue phenomenologically from the specific perspective of NGLPNs transitioning to work in the LTC
setting. This perspective is important in order to understand the subjective meaning of those experiences.

In response to calls for changes in the educational preparation of health professionals by the Institute of Medicine (IOM, 2010) and the NLN (2010), the NLN developed the Education Competency Model (ECM) (p. viii). In developing the ECM, the NLN (2010) addressed the specific calls by these groups including the need to be more specific about the roles for each scope of nursing practice in order to prepare nurses that are able to meet the workforce needs.

Although the LPN role is included in the NLN’s ECM, most of the recent nursing research and education has focused on the registered nurse (RN) and advanced practice nurse (APN). The NLN (2014) recently asserted that the lack of focus on the LPN role could result in a deficit in providers to meet needs of the aging population.

The LPN is an important part of the nursing continuum, particularly in providing nursing care to the nation’s elderly population in the LTC setting (NLN, 2011). The ECM includes broad outcomes for each level of nurse from LPN to APN in diverse practice settings. Human flourishing (HF), one of the outcomes of the ECM, is defined as “an effort to achieve self-actualization and fulfillment within the context of a larger community of individuals, each with the right to pursue his or her own efforts” (NLN, 2010, p. viii). This outcome is seen by the researcher as a process that supports a successful transition to practice experience for the NGLPN.

The concept of HF encompasses “the uniqueness, dignity, diversity, freedom, happiness, and holistic well-being of the individual within the larger family, community, and population” (p. 33). For the practical/vocational nurse, the graduate competencies are to promote human dignity, integrity, self-determination, and personal growth of patients, oneself, and members of
the healthcare team (NLN, 2010, p. 33). This study examined the lived experience of transition to practice for the NGLPN. Figure 1 represents the relationship of the concepts that are involved in promotion of HF for the NGLPN.

*Figure 1. Concepts involved in the promotion of human flourishing (NLN, 2010).*

There are a number of areas that could negatively influence transition to practice. Any issue that affects human dignity, integrity, self-determination, or personal growth of the graduate, residents, or team members could have a negative impact on transition to practice for the NGLPN. The NGLPN may express methods or needs for skills to navigate complex healthcare systems and group processes already in place. Scope of practice variances from state to state could complicate understanding of the role, not only for the NGLPN, but also for those supervising NGLPNs. The NGLPNs could feel pressure to practice outside of scope of practice, if the supervising RNs delegate activities outside of the LPN scope.
The NLN (2010) ECM outcome of HF is congruent with outcomes of new graduate satisfaction in Accrediting Commission for Education of Nurses (ACEN, 2013) standards. The ACEN requires programs that they accredit to obtain data related to new graduate satisfaction, specifically the new graduates’ satisfaction with educational preparation for the role. The ACEN encourages subjective data related to new graduate satisfaction, during the 6-12 months after graduation. The ACEN suggested that qualitative data provides useful information on this criterion.

Defining the Problem

National Issues Concerning LPNs and the LTC Setting

There is a continued demand for LPNs. The United States Department of Labor Bureau of Labor Statistics [(BLS) 2013] reported occupational data on LPN jobs in the US. In 2010, the BLS (2013) indicated that there were 752,300 licensed practical/vocational nurses employed in the US. Job growth for this group of nurses was above average, and projected to rise 22% between 2010 and 2020 (BLS, 2013).

According to the NLN (2014), LTC settings need LPNs. With the aging Baby Boomer population, the demand for LTC has increased significantly (Zhang, Unruh, & Wun, 2013). At this time, LPNs provide 70% of nursing care provided to LTC residents (Corazzini et al., 2011). Several issues could complicate NGLPN practice readiness for LTC settings, including supervisory and delegation responsibilities in a LTC setting providing care for medically complex clients. Functioning in the LTC setting in the US, the LPN potentially has responsibility for supervision and delegation of care of residents for up to 16 hours a day without a RN present. Three semesters of educational preparation for the role is minimal.
New graduate LPNs care for elderly clients with multiple comorbidities. These frail elderly clients have potential to decline rapidly and LPNs with only 3 semesters of education provide the majority of direct nursing care. Compounding the issue, the Baby Boomers entered late adulthood, increasing the number of Medicare recipients actively receiving benefits. This increased use of LTC facilities and necessity for LPNs to provide care. Additionally, the Affordable Care Act resulted in Medicare implementing cost containment measures and hospitals discharging clients quicker.

There are problems with care of medically complex clients. Currently, Centers for Medicare and Medicaid Services [(CMS), 2014] note problems with Medicare recipients rebounding back to the acute care setting within 30 days of hospital discharge. In the LTC setting, LPNs are in a role requiring them to care for chronically ill, elderly clients with multiple comorbid health conditions. Most LTC settings provide rehabilitation services, which reimburse at higher rates for care of clients admitted from acute care settings. Therefore, NGLPNs working in the LTC setting are in a position of providing care to residents with higher acuity levels. The potential for rebound back into the hospital is higher, particularly if an RN is not present to help manage care.

Licensed practical nurses provide the majority of bedside care for elderly clients in LTC facilities. Most LTC facilities have rooms designated for rehabilitation, for which Medicare pays for 21-day post-hospitalization care for acute issues. Communication with residents and families by the nursing staff is pivotal to interventions aimed at reducing burdensome transitions for residents from LTC settings to and from acute care settings (Wittenberg-Lyles, Goldsmith, Richardson, Hallett, & Clark, 2013). Older adults are the largest group of healthcare users across all settings, requiring close nursing assessment and management related to one or more chronic
illnesses (Hartford Institute for Geriatric Nursing, 2011). Management of the complex interplay of factors that influence quality care and quality of life is critical, as older adults represent a nurse’s most complex clients (Tagliareni, Cline, Mengel, McLaughlin, & King, 2012).

Minimum nursing home staffing levels in the US are regulated by the Omnibus Budget Reconciliation Act of 1987 (Zhang, Unruh, & Wun, 2013). Federal law mandates LTC facilities to provide sufficient staff to care for residents (CMS, 2014). However, there is no current federal standard for the best nursing home staffing levels (CMS, 2014). Historically, the 1997 Balanced Budget Act resulted in decreased nursing home reimbursements, possibly motivating administrators of LTC settings to reduce RN and LPN staffing hours and other services (Grabrowski, Angelelli, & Mor, 2004; Konetzka, Yi, Norton, & Kilpatrick, 2004; Unruh, Zhang, & Wan, 2006). The American Health Care Association (2016) reported the average hours per resident day (HPRD) for LPNs is approximately one-half that of RNs.

National Issues for LPN Practice Regulation

The NLN (2014) recently cited a problem regarding the LPN role in that LPN scope of practice varies from state to state, as individual state boards of nursing regulate nursing scope of practice. This issue could have a negative impact on transition to practice for the NGLPN. According to the American Nurses Association [(ANA), 2010], nursing scope of practice is defined by “who, what, where, when, why, and how of nursing practice” (p. 11). The International Council of Nurses [(ICN), 2013] has the following definition of scope of practice:

The scope of nursing practice is not limited to specific tasks, functions or responsibilities, but is a combination of knowledge, judgement, and skill that allows a nurse to perform direct care giving and evaluate its impact, advocate for patients and for health, supervise and delegate to others, lead, manage, teach, undertake research and develop health policy for healthcare systems. (para 2)
Each state’s nurse practice act defines nursing scope of practice for all levels of practicing nurses, including LPN (called licensed vocational nurse [LVN] in California and Texas), RN, and APN. State boards of nursing govern nursing practice for the purpose of public safety.

Nursing regulations guide the scope of nursing practice. Silence or vagueness in nursing regulations on issues relating to scope of practice potentially affect patient safety and quality of care, particularly in LTC facilities (Corazzini et al., 2011). The variance state to state in scope of practice among state nurse practice acts complicates the problem further (Corazzini et al., 2013b). This issue impacts nursing education, since nursing scope of practice provides the foundation for nursing education.

New graduate LPNs could function beyond the established scope of practice for the state if they do not have a good understanding of the nurse practice act’s rules for LPN scope of practice. Licensed practical nurses work under the supervision of RNs or physicians. In LTC settings, LPNs work under the supervision of the RN. These two levels of nurses, RN and LPN, legally function under different scopes of practice. Current LTC standards require that RNs assess care needs of residents and plan appropriate care (CMS, 2014). The RN and LPN (CMS, 2014) implement the care plan, treatment of problems, and evaluation of residents’ outcomes. However, LTC settings are only required to have an RN on duty 8 consecutive hours a day, 7 days a week (CMS, 2014). Regulations require either an RN or LPN to be on duty 24 hours per day (CMS, 2014). Therefore, because it is a lower financial budget strain, LPNs provides care during as many as 16 hours per day.

National Issues Influencing the LPN Curriculum

The NLN (2011) identified a problem with the practical nursing curriculum, noting that the current curriculum does not adequately prepare NGLPNs for the role they will fill in practice.
The NLN (2011) specifically called for nurse educators to refocus the practical/vocational nursing curriculum. The directive proposed an LPN curriculum concentrating on gerontology, supervisory concepts in skilled-care and community-based settings (independent, assisted, and skilled care), and enhanced assessment skills, particularly related to commonly occurring hospital readmission rates from skilled care and home care (NLN, 2011).

Curriculum development and ongoing program evaluation is a necessity in any nursing program. Depending on the accrediting body that certifies the nursing education program, certain outcomes are required for success in addition to the National Council Licensure Examination (NCLEX) results. New graduate and employee satisfaction are two key outcome measures for programs accredited by the ACEN (2013), the only accrediting body that currently accredits LPN programs.

Curricular revision could be problematic if nurse educators solely focus on preparing students for the National Council Licensure Examination Practical/Vocational Nurses (NCLEX-PN), a mandatory regulatory requirement for practice. Students must pass the NCLEX-PN to obtain licensure, and nursing programs must have an NCLEX pass rate of at least 80% in order to comply with the state board of nursing requirements. As a result, the NCLEX-PN plays a major role in nursing program curriculum development for pre-licensure programs.

The National Council for State Boards of Nursing (NCSBN) conducts studies on new graduate nurses’ practice every 3 years. These practice analyses studies are quantitative and serve the purpose of providing data to support NCLEX revisions. According to the latest study, new graduate LPNs provide care for older adults at a higher rate than for younger adults. This breakdown includes older adult clients aged 65 to 85 at 57.9%, and oldest older adult clients aged 85 and beyond at 39.8% (NCSBN, 2013). The NCSBN (2013) data also show LPN practice
moving from hospitals to the community, including LTC facilities (54.2%), at rates higher than the previous study 3 years ago. This is a high percentage in comparison to the RNs (13.1%), who work in LTC settings (NCSBN, 2013).

A context-relevant curriculum is “responsive to learners, current and projected societal, health, and community situations, and imperatives of the nursing profession” (Iwasiw, Goldenberg, & Andrusyszyn, 2009, p. 102). The practice setting for LPNs has moved more from acute care facilities to LTC and community settings (NCSBN, 2013). Considering this issue and the increase in demand for LTC care for the aging Baby Boomers, the context could have a negative impact on transition experiences for NGLPNS.

The NLN (2014) recently published another document related to LPNs in the Vision Series, A Vision for Recognition of the Role of the Licensed Practical/Vocational Nurses in Advancing the Nation’s Health. This document outlined the need to address the role of LPN in the transformed healthcare system of the 21st century. The NLN (2014) called for nurse educators to implement changes in the LPN curriculum, specifically calling for nursing faculty to align nursing curriculum with current workforce trends (p. 5). In essence, they called for a context-relevant curriculum.

The NLN (2014) also saw the LPN workforce as a way to have a more racially diverse nursing labor force more reflective of the population. They saw the diversity as a way to provide more culturally sensitive nursing care. Licensed practical nurses represent the most diverse nursing workforce with approximately one-quarter (23.6%) of the LPN workforce being African American as compared to 9.9% of the RN workforce (HRSA, 2013). In 2012, 40% of LPNs in the US were from minority groups (HRSA, 2013).
In the new vision, the NLN (2014) called for education and practice experts to address the changing landscape of healthcare to support LPN curriculum changes that reflect the context of the practice environments today in order to “support LPN role transition to professional practice” (p. 4). The NLN (2014) has specifically called for the nursing education community to facilitate discussions among faculty, students, practice partners, and other stakeholders about the essential role of the LPN workforce to meet emerging healthcare needs in a reformed healthcare system.

The role of the LPN has not yet been addressed in the new healthcare arena (NLN, 2014). The NLN has called nursing faculty to develop program outcomes and course/unit objectives that are congruent with outcomes of the NLN (2010) ECM and reflect the uniqueness of school and local healthcare trends.

Using a model to guide curriculum development enables the faculty to focus on values and beliefs, embedding them in the curriculum, and making them a focus for the systematic plan of evaluation, which provides a framework for evaluation of the outcomes. As early as 1938, Dewey identified a problem with curriculum, asserting that without suitable reflection on underlying values and beliefs about teaching and learning, students experience every educational trend that comes along.

State and Local LPN Curriculum Issues

The Alabama State Community College System associate degree and practical nursing programs operate under a state-mandated curriculum, developed in 2008. The healthcare landscape has dramatically changed since that time. The goal of nursing program curricula is to prepare graduates for entry-level practice, ensuring practice-readiness. Practice-readiness is
“moving seamlessly into practice” (Wolff, Pesut, & Regan, 2010, p. 187). Wolff, Regan, Pesut, and Black (2010) further defined practice-readiness as follows:

New graduates attain entry-level competencies that prepare them for a global world as well as some job-specific capabilities to meet immediate workforce needs. Graduates are competent to provide safe client care in the context of today’s realities as well as adapting to new and changing circumstances in healthcare, nursing, and the provision of client care. They possess a balance of doing, knowing, and thinking to ensure safe care. (p. 9)

The purpose of all nursing education programs is to produce competent graduates, equipped to meet the demands of practice once licensed (Iwasiw, Goldenberg, & Andrusyszyn, 2009). The NLN (2005) Transforming Nursing Education position statement calls for curricula validated by evidence. The ACEN’s outcomes standards require LPN programs to demonstrate evidence of achievement in meeting program outcomes, including graduate satisfaction (6-12 months after graduation), using subjective data as an expected part of that evaluation process (2013).

The researcher’s personal experience in one nursing education program in Alabama prompted this study. In one program, which followed the Alabama state mandated curriculum, the practical nursing students’ first clinical opportunity occurred in LTC settings. This is similar to the Associate Degree Nursing (ADN) student’s first semester, as both programs focus on foundational/fundamental basic theory and skills for nursing care. In the LPN students’ first semester in the LTC setting, learning activities focused on supportive care for residents’ activities of daily living needs, which RNs and LPNs delegate to non-licensed staff. Students in the LPN program had the opportunity to practice assessment skills, but did not administer medication or practice supervision or delegation. Students in the LPN program did not return to LTC facilities as a clinical practice setting during the program of study.
The experiences after the first semester occurred in a hospital setting. These hospital settings did not employ LPNs, following a nationwide trend to use a practice model of RNs and unlicensed patient care technicians. In the clinical practicum hospital setting, the staff ratio was one RN per five to seven patients. In the LTC clinical setting, LPN employees provide skilled nursing care to 20 to 30 residents. Licensed practical nurses in a LTC setting may function as a charge nurse, a role involving supervision and delegation responsibilities, which is never the case in the hospital setting. The lack of supervisory or delegatory practice experiences prior to employment in LTC settings and the lack of preparation for the practice environment could negatively affect the transition experiences of NGLPNs working in LTC settings.

The aim of this study was to understand the lived experience of transition to practice for the NGLPN working in the LTC setting in order to start dialogue among practical nurse educators and nursing administrators of LTC settings. This study also contributes to the conversation on transition to practice specifically for LPNs transitioning to the LTC setting.

Research Question

The broad research question was what is the lived experience of transition to practice for the NGLPN practicing in a LTC setting? The narrow research questions were, (a) What negative experiences did the NGLPN have during the transition to practice in the LTC setting? and (b) What positive experiences did the NGLPN have during the transition to practice in the LTC setting?

Significance for Nursing Education

The ANA (2012) Standards of Practice and Professional Performance guide nursing curriculum development. States have used the standards to guide the development of their own nursing practice acts and regulations (ANA, 2012). Curriculum development also relies on
contextual factors within and across the internal and external contexts of the program in order to
develop nursing programs (Iwasiw, Goldenberg, & Andrusyszyn, 2009). External contextual
factors are forces, situations, and circumstances that originate outside of the school and
educational institution that can influence the curriculum, including characteristics of learners,
learning expectations and environments, professional practice expectations and environments,
clients of nursing care, major health problems and risks, healthcare, and societal characteristics
and needs (Iwasiw et al., 2009).

Significance for Nursing Research

There is sparse research on the subjective practice experiences of the LPN in the LTC
setting. There are no interpretive phenomenological studies focusing specifically on the
subjective experiences of the NGLPN working in the LTC facility setting. Marginalization of
practice-based knowledge in nursing is an issue, as practicing nurses may not be aware of the
theories used to guide practice and these theories may develop in the context of practice (Reed &
Lawrence, 2008). It is important to discover and share the NGLPN perspective of issues
encountered in the LTC practice environment. This research adds to the body of data on practice-
based knowledge.

Significance for Nursing Practice

Practicing within one’s scope of practice is a legal and ethical issue for nurses. Scope of
practice issues could negatively affect transition to practice for the NGLPN. The ANA is an
organization of RN membership that seeks to promote excellence in nursing. A social contract
exists between nursing and society, as the profession is accountable to the public (ANA, 2010).
The newly revised ANA (2015a) Code of Ethics for Nurses with Interpretive Statements
addressed the nurses’ role concerning scope of practice. According to ANA’s Provision 4 in this
document, “the nurse has authority, accountability, and responsibility for nursing practice; makes
decisions and takes actions consistent with the obligation to promote health and provide optimal
care” (2015a, p. 31). In Provision 4.1, there are directions related to the nursing scope of
practice: “Nurses must always comply with and adhere to state nurse practice acts, regulations,
standards of care, and ANA’s Code of Ethics (COE)” (ANA, 2015a, p. 31). Ethical issues
encountered in practice could negatively affect transition to practice for the NGLPN.

The newly revised ANA Scope and Standards of Professional Nursing Practice (2015b)
contain 16 competencies comprising professional nursing practice. These standards should
inform nursing curriculum and development, as well as nursing practice acts, regulations, and
organizational policies and procedures. The standards start with the nursing process, which is the
framework for nursing guiding how nurses practice.

In 2007, the National Association for Practical Nurse Education and Service (NAPNES)
published the Standards of Practice and Educational Competencies of Graduates of
Practical/Vocational Nursing Programs, which also supported the need for LPNs to practice
within their own scope of practice. The standards were updated in 2007. With the changing
landscape of healthcare today, this study highlights issues and supports the need for further
investigation related to the current NAPNES standards.

Philosophical Perspective

The study was qualitative in nature. By conducting qualitative research, certain
assumptions were inherent in the work. The assumptions that support the study were as follows.
The ontological assumption was that researchers believe in the idea of multiple realities in that
different realities are espoused by researchers, study participants, and those reading studies. The
epistemological assumption was knowledge reflects the subjective experiences of those involved
in a particular context. The axiological assumption was that values shape qualitative research, which could result in biases. The methodological assumption was that the context was important and shaped the design of the research (Creswell, 2013).

Social constructivism was the worldview for the study. According to Creswell (2008), “social constructivists hold assumptions that individuals seek understanding of the world in which they live and work” (Kindle Location 451). Based on this view, subjective meanings of experiences helped identify the complexities of various views. The practice setting for LPNs has shifted to primarily community settings. The LPNs moved away from acute care in hospitals (NCSBN, 2013). The phenomenological approach provided understanding of the current transition to practice experiences through subjective data to gain insight into the subjective meaning of the experiences from the perspective of the NGLPNs.

Summary

The aim of the study was to understand the lived experience of transition to practice for graduates of one practical nursing program, practicing in one LTC setting in the state of Alabama. The researcher believed that transition to practice experiences for the NGLPN working in the LTC setting is important to understand. This will help start a conversation among practical nurse educators and LTC nursing administrators about transition to practice issues. Issues with scope of practice have the potential to negatively affect resident quality of care and cause frustration for the NGLPN, if educational preparation does not match workplace demands. This could potentially lead to NGLPNs leaving this work environment.
CHAPTER II
LITERATURE REVIEW

The aim of the study was to understand the lived experience of transition to practice for the NGLPN practicing in the LTC setting. The purpose of this literature review is to explore the available literature on the issues related to transition to practice particularly pertaining to the experience of NGLPNs working in the LTC facility setting. The study applied a qualitative method where the literature review preceded the study. The EBSCO databases were searched using the terms transition to practice, dignity, self-determination, integrity, personal growth, practice, nursing scope of practice, licensed practical nurse, new graduate, experience, education, regulation, LTC, and curriculum using the parameters of having been published between 2005 to 2015. The chapter begins with the theoretical context for the study and the background of the calls for change in the nursing and, more specifically, the LPN curriculum. A review of the literature on transition to practice and scope and regulation of practice for LPNs practicing in LTC facilities provides information on LPN experiences and new graduate LPN experiences.

Theoretical Context

National League for Nursing (NLN) Educational Competency Model (ECM)

The NLN (2014) called for practical nurse educators to design curricula, teaching and learning strategies, clinical practice opportunities, and evaluation methods that align with the NLN ECM (2010) program outcomes and current workforce trends. Given the fact that nurse
educators are preparing practical nursing students for practice in an evolving healthcare system, impacted by the Affordable Care Act (AFA), it is important to determine what transition to practice experiences are currently like for the NGLPN. This is important particularly in Alabama where the LPN program is under the umbrella of the state-mandated nursing curriculum in the community college setting.

The NLN (2010) developed the ECM because of national calls by the IOM (2010), the NLN (2010, 2011, 2014), and the Carnegie Foundation (Benner, Sutphen, Leonard, & Day, 2010) to change the way that nurses are educated. The NLN (2010) ECM is both a “contemporary” and “futuristic” model (p. 8). According to the NLN (2010), the ECM “engages the nursing student and nurse educator in a transformative, proactive, and collaborative encounter that represents an evolving and real-world experience in nursing education and practice” (p. 8). The model consists of seven foundational core values, including “caring, diversity, ethics, excellence, holism, integrity, and patient-centeredness” (p. 8). The NLN ECM competencies must be grounded in each of the core values for each type of nursing program, while the integrating concepts emerge from the core values of “context and environment; knowledge and science; personal and professional development; quality and safety; relationship-centered care; and teamwork” (p. 8). The program outcomes are as follows:

Nurses must use their skills and knowledge to enhance transition to practice for their patients, their communities, and themselves; they should show sound nursing judgment, and should continually develop their professional identity; and nurses must approach all issues and problems in a spirit of inquiry. (NLN, 2010, p. 9)

The four outcomes of the model allow nurses to enter into practice. The model is not bound to one program type.

The current study focused on transition to practice for the practical/vocational nurse. The ECM outcome of human flourishing is broadly defined as “nurses use of their skills and
knowledge to enhance human flourishing for their patients, their communities, and themselves” (NLN, 2010, p. 9). The concept of HF, according to the NLN ECM (2010) “encompasses the uniqueness, dignity, diversity, freedom, happiness, and holistic well-being of the individual within the larger family, community, and population” (p. 33). For the practical/vocational nurse, the graduate competencies are to promote human dignity, integrity, self-determination, and personal growth of patients, oneself, and members of the healthcare team (NLN, 2010).

Human flourishing is seen by the researcher as a process of successful transition to practice. Flourishing is defined as “developing rapidly and successfully thriving” (Oxford English Dictionary, 2016). Flourishing is not only a concept applied to human beings, but to all living things. According to Kleinig and Evans (2013):

The metaphor of flourishing gets us to focus on humans as developing, natural objects.

Moreover, flourishing bespeaks normatively laden development and change – a qualitative assessment of the developmental passage and accomplishment of a living thing. The plant/animal/human that does not progress over its life cycle or that changes for the worse does not flourish but stagnates, withers, suffers, or weakens. (p. 539)

Kleinig and Evans (2013) see flourishing as being focused on the developmental course of attaining skills or knowledge. For nursing students, this begins in their nursing program. As the literature suggests, there is a period of transition from new graduate to competent nurse, where the process continues. The developmental process does not end at graduation from the program. There is a process of development that continues upon starting a new vocation in a new setting.

One of the primary issues noted in the literature review concerning LPN scope of practice in the LTC facility setting ultimately had to do with organizational culture and communication
issues, which relate to the concept of HF. The literature review supported the fact that there are issues related to communication skills for both RNs and LPNs engaging in supervision and delegation in nursing practice, particularly problematic in LTC facilities, as the scope of practice issues impact quality of care. This could result in poor outcomes for the patients. In the NLN (2010) ECM, two of the apprenticeships focus on communication with the healthcare team members, the Apprenticeship for Relationship-Centered Care and the Apprenticeship for Teamwork.

The NLN (2010) ECM Apprenticeship of Relationship-Centered Care focuses on relationships with patients, families, communities, and healthcare team members and “integrates and reflects respect for the dignity and uniqueness of others, valuing diversity, integrity, humility, mutual trust, self-determination, empathy, civility, the capacity for grace and empowerment” (p. 27).

The Apprenticeship for Teamwork, according to the ECM, is “crucial to each of the other five concepts and, ultimately to patient outcomes” (p. 28). Teamwork, according to the ECM, “means to function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality patient care” (p. 30). This particular apprenticeship asserts that nursing practice should confirm that graduates are familiar with concepts and literature in a number of different teamwork principles, including scope of practice and roles and responsibilities of healthcare team members. Both of these apprenticeships support the NLN (2010) ECM outcome competencies related to HF.

Van Manen

Van Manen’s (1990) conceptualization of phenomenology is the method that supports the framework for the study. According to Van Manen (1990), the purpose of phenomenology is to
“grasp of the very nature of the thing” (p. 177). Van Manen viewed the phenomenon of study as the object of human experience (p. 163). He stated that the context influences the methodological procedures. Van Manen asserted, “it is methodologically important to keep one’s fundamental research question foremost in mind” (p. 166).

Van Manen viewed phenomenology and pedagogy as related concepts. According to Van Manaen (1990) “pedagogy requires a hermeneutic ability to make interpretive sense of the phenomena of the lifeworld in order to see the pedagogic significance of situations and relations” (p. 2). In this sense, Van Manen viewed phenomenology as a way to generate knowledge to serve the aims of teaching.

Interpretive phenomenology as the method for the study allowed the researcher to explore the lived experiences of transition to practice for the NGLPN working in the LTC setting. As a philosophy, the use of phenomenology as the approach to research is based on the premise “persons or beings that have consciousness and that act purposefully in and on the world by creating objects of meaning that are expressions of how human beings exist in the world” (Van Manen, 1990, p. 4). Description, interpretation, and self-reflection are the ideal methods for this human science, as Van Manen proclaimed, the goal of this science is to illuminate the meaning of human phenomena and comprehend the lived structures of meanings to gain understanding.

Lived experience was the epistemological basis for the proposed study. The intent of a phenomenological study is to retrospectively “explore directly the pre-reflective dimensions of human existence: life as we live it” (Van Manen, 2014, Kindle location 1048). According to Van Manen (2014), many life experiences remain “pre-reflectively lived” due to the fact that “we do not bring back to reflective awareness” (Kindle location 934). Having someone retell their experiences brings the experiences to reflective awareness (Van Manen, 2014). Van Manen
(2014) went on to explain that phenomenological experiences “arise from the flow of everyday existence” (Kindle location 949); stating that these experiences are “recognizable in the sense that we can recall them, name and describe them, reflect on them” (Kindle location 958).

The study drew meaning from the lifeworld of the NGLPN working in an LTC setting in order to illuminate their lived experiences of transition to practice. Phenomenological research encompasses the study of lived experience in order to gain an understanding of the nature or meaning of everyday experiences (Van Manen, 1990, p. 9). Phenomenological research reveals phenomena that come to one’s consciousness (Van Manen, 1990). According to Van Manen (1990), phenomenology involves a retrospective, reflective process to get to the essence of the experiences through a “systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience” (pp. 9-10).

According to Van Manen (1990), the way that an individual asks questions has a part in the research methodology with which they identify. Phenomenology, the study of lived experience, is well suited for obtaining subjective experience in context. To understand the meaning of experiences for the NGLPN, it is necessary to look at the meaning of the experiences from their vantage point.

Hermeneutic phenomenology provided an understanding of the essence of the experiences, revealing them through the stories of those experiencing them. Van Manen’s stance on phenomenology was that research always begins in the lifeworld, “the original, pre-reflective, pre-theoretical attitude” (1990, p. 7). Van Manen noted that hermeneutic phenomenology is descriptive and interpretive with the facts existing naturally in the life world, whereby the researcher converts the lived experience into a “textual expression of its essence” (p. 36).
Van Manen (1990) asserted that human science, such as phenomenology, also serves the aims of pedagogy, or teaching, asserting that “the fundamental model to the approach is textual reflection on the lived experiences and practical actions of everyday life with the intent to increase one’s thoughtfulness and practical resourcefulness or tact” (p. 4). Studying NGLPN transition to practice experiences through the lens of phenomenology allowed the researcher to uncover and describe, through verbal dialogue, the internal meaning structures embedded in those experiences. Phenomenology, according to Van Manen (2014), “continues to make us mindful to be critically and philosophically aware of how our lives (and our cognitive, emotional, embodied, and tacit understandings) are socially, culturally, politically, and existentially fashioned” (Kindle Location 481).

Benner

Benner (1994), who also drew from Van Manen’s work, noted that “by engaging in the interpretive process, the researcher seeks to understand the world of concerns, habits, and skills presented by participants’ narratives and situated actions” (p. xiv). Benner stated that seeking understanding in human science has more power than explaining and predicting due to the fact that understanding in interpretive phenomenology considers “historical change, transformations, gains, losses, temporality, and context” (p. xv). Benner has been instrumental in leading a “worldwide movement that questioned decontextualization” in nursing research, using phenomenological research to effectively demonstrate the value of the study of “individuals embedded in their family, social, cultural, ethnic, and work environments” (Chan et al., 2010, Kindle location 256-265).

Benner (1984) made an important distinction between practical and theoretical knowledge that is relevant to the proposed study. She explained how “knowing that,” or
theoretical knowledge, and “knowing how,” or practical knowledge, are two different kinds of knowledge (Benner, 1984, p. 2). Drawing from the works of Kuhn (1970) and Polanyi (1958), Benner demonstrated that many skills are learned without “knowing that” or theoretical knowledge and that “knowing how” or practical knowledge as developed in applied disciplines such as nursing may arise before and later extend theory development.

Benner (1984) drew from the work of Heidegger’s (1962) phenomenology to explain how knowledge embeds in experience. Benner worked under the assumption that “preconceived notions are challenged, refined, or disconfirmed by the actual situation” (p. 3). Benner also built on the work of Gadamer (2004), who opposed the idea of using an objective method to guide human science research.

Benner and Chan (2010) acknowledged that the work, *Interpretive Phenomenology in Healthcare Research*, demonstrates individuals “engaged in skillful activity, relationships, practices, and habits all within a particular social lifeworld, making it more accessible and visible” and asserted that this is what is needed in nursing practice to keep those practices from becoming marginalized (Kindle Locations 364-365). The work of interpretive phenomenology, according to Benner and Chan (2010) makes visible the knowledge embedded in human science that is in stark contrast to the Cartesian Medicine model of the study of disease that focuses on the cellular, tissue, organ, genomic, and biochemical levels. Benner and Chan (2010) proclaimed that interpretive phenomenology attempts to zone in on the social aspects of human science that are common, accessible, and intelligible by way of people’s lifeworld through the study of people involved in context.

Benner (2000) addressed the roles of embodiment, emotion, and lifeworld for rationality and agency about nursing practice and illness. Descartes influenced Kant, in advocating for the
fact that the mind is separate from the will and emotions. Benner (2000) explained how Kant’s ideas of the moral agent and separating the will from the emotions do not work in nursing practice or in the health/illness continuum.

According to Benner (2000), “our embodiment is a unity that we live, therefore we do not perceive the world in pieces or meaningless sensations, but as a whole pregiven, prereflective world” (p. 6). She based this fact on the work of Nightingale (1969) and on Merleau-Ponty (1962). Nightingale believed that in caring for the embodied person, the nurse must ensure that the person has holistic care to promote health and healing with access to light, fresh air, exercise, a clean environment, and adequate nutrition in order to help them thrive. Merleau-Ponty saw the embodied person as one existing in relationships connecting them to the world. Benner asserted that scientific knowledge that disregards the embodied experience in connection to the world fails to capture the “human experience” (p. 6).

Background

The Institute of Medicine (IOM, 2010) in the Future of Nursing: Leading Change, Advancing Health report made eight recommendations for changes that need to be made in nursing to enable nurses to assume an expanded role in the redesigned healthcare system. The IOM (2010) asserted that nursing education must be involved in the expansion of the nursing role.

The IOM (2010) report indicated the need to remove scope of practice barriers. The primary rationale related to the fact that states vary so widely concerning nursing scope of practice. The report charged state legislators to reform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules. The primary focus of this recommendation was on advanced
practice nurses. The report declared that improved nursing education is a necessity for the goals of the report to become reality.

The IOM (2010) also called for implementation of nursing residency programs to facilitate transition to practice. This is not a new problem, as transition to practice has been an ongoing issue since the 1970s.

In 2003, the NCSBN convened a focus group to discuss the findings of the 2003 LPN Practice Analysis, the study used to support the National Council for Licensure Examination development, and to write a white paper on the topic of LPN scope of practice (Smith & Crawford, 2005). In light of the expanding role of the LPN at that time, the NCSBN (2003) had concerns that the regulatory boards needed to reevaluate the LPN scope of practice and determine if LPNs received adequate educational preparation. The NCSBN (2003) convened the Practice, Regulation, and Education (PRE) committee to study the problem of LPN scope of practice, resulting in the development of the Desired Evolution of Practice model.

The NCSBN issued the Practical Nurse Scope of Practice White Paper, based on NCSBN studies, including PN focus group and boards of nursing survey findings on LPN scope of practice, as well as, findings from external research projects on LPN scope of practice (Smith & Crawford, 2005). These studies demonstrated variation in LPN scope of practice among states. Based on this research, the NCSBN suggested that dialogue between nursing practice, regulation, and education needed to occur. They also called for these discussions to address issues including standardized curriculum, nurse practice acts, articulation programs, and variance of scope of practice. Based on their study of the issues, they developed The Desired Evolution of Regulation Model. The model represented how the NCSBN perceived the relationship at the time, showing
differences among nursing practice, regulation, and education. The recommendation by the NCSBN was to overlap these three areas.

Since that time, new graduate transition to practice has been a topic of discussion among regulators, practitioners, and educators. In 2009, the NCSBN convened a transition to practice committee in order “to design an evidenced-based practice model to transition new graduates to practice” (para 1). At the same time, the NCSBN (2012a; 2012b) published the new Model Rules and Model Act. Both of these documents started a comprehensive framework for boards of nursing to utilize to facilitate a common understanding.

One state found a way to influence curriculum change. In Minnesota, state legislation mandated that nursing programs in the state be nationally accredited or in candidacy status by January 1, 2016 (Field et al., 2014). Only 3 of the state’s 23 LPN programs had achieved national accreditation at the time of the mandate and the majority of those needed major curricular revisions to meet the accreditation standards. To start the process, they developed a statewide PN Curriculum Collaborative Project with a team consisting of a project manager, 42 faculty members, and 8 industry partners (Field et al., 2014). Recommendation number 6 of the IOM (2010) report guided the first step of the process of curriculum revision: “Faculty should partner with healthcare organizations to develop and prioritize competencies so curricula can be updated regularly to ensure graduates at all levels are prepared to meet the current and future healthcare needs of the population” (p. 13). According to Fields et al. (2014), the following documents were standards used to guide the work of the group: Minnesota PN Scope of Practice; National Accreditation for Practical Nurse Education and Service, Incorporated [(NAPNES, 2007]]; the NLN ECM (2010); and the Statewide Workforce Healthcare Assessment. One of the lessons learned was that the process gave the participants a voice, because the analysis phase
included a survey of nursing program directors, faculty, students, and industry partners to acquire feedback on the relevance of concepts and student learning outcomes for the curriculum project.

Transition to Practice

Spector et al. (2015a) determined essential elements to the transition process are communication and teamwork, patient-centered care, evidenced-based practice, quality improvement, and informatics. They developed the Transition to Practice Model (TTPM) with online modules for implementation. However, the results of the study were not favorable to the TTPM; when comparing those using the TTPM with a control group. Those in the control group were indisputably better. The study found that the new graduate nurses transitioning into a hospital-based program with a previously established program had “fewer errors, fewer negative safety practices, and higher overall competence ratings” (Spector et al, 2015a, para 5). Other factors were better for the control group as well, including decreased stress related to jobs, increased satisfaction, and lower job turnover. The new graduates in the TTPM group had similar favorable outcomes. However, the best outcomes were in locations with pre-established programs. The study found that the new graduates in hospitals with limited transition programs were “more likely to report errors, report negative safety practice, report that they felt less competent, report higher job stress, and decreased job satisfaction and were twice as likely to leave their nursing position, during the first year of practice” (para 8).

Nursing Theory Practice Gap

In a Carnegie study, Benner et al. (2010) addressed the ongoing problem of the nursing theory practice gap in nursing education. Asserting that the problem is in the classroom, “the classroom experience is at odds with the strong ethos that results in deep commitment to professional values and, as many students noted, deep personal transformation” (Kindle location
Benner et al. asserted that in order to help nursing students develop formation into the role of nurse, nurse educators need to teach to three apprenticeships, including intellectual or cognitive apprenticeship, a skill-based apprenticeship related to clinical judgment and practice, and an apprenticeship to the ethical comportment or behavior of the profession.

Benner et al. defined formation as:

The method by which a person is prepared for a particular task or is made capable of functioning in a particular role, developing the moral imagination or the ability to imagine the moral content inherent in the practice of nursing. (p. 87)

Benner (2015), in reporting on the findings from the Carnegie Foundation study on the preparation for practice professions of medicine, clergy, engineering, law, and nursing, stated that these professions must address three professional apprenticeships, including the cognitive apprenticeship, the practice apprenticeship, and the formation and ethical comportment apprenticeship (p. 1). According to Benner, the term apprenticeship was a metaphor to “describe embodied knowhow that must be integrated and usually modeled or demonstrated by a practitioner-teacher” (p. 1). A previous study found that the US nursing programs are indeed strong in the pedagogies of situated coaching and experiential learning, but only in the clinical and simulation settings (Benner et al., 2010). They asserted that faculty integrates apprenticeships into all teaching and learning settings, including the classroom (p. 1) in order to address the practice-education gap in nursing education and significantly shift nursing education in the realm of teaching and curricula. According to Benner et al. (2010),

Classroom teachers must step out from behind the screen full of slides and engage students in clinic-like learning experiences that ask them to learn to use knowledge and practice thinking in changing situations, always for the good of the patient. (p. 14)

She used paradigm cases, developed with an interpretive phenomenology study to demonstrate current practice examples of this exemplary practice in nursing education.
Benner (1984), in her work, *Novice to Expert*, enlarged the views of how nurses in a practice profession progress toward professional. According to Benner, nurses have failed to document their practices, and as she stated, this is an essential aspect of theory development. Benner (1984) used paradigm cases to demonstrate the different levels of the continuum through which nurses’ progress from novice, to advanced beginner, to competent, to proficient, to expert. The new graduate nurse is not a competent nurse, based on Benner’s model, since he or she needs to acquire practice-based experiences to progress to this level.

New Graduate Nurse Practice Experiences

Most of the new graduates’ experiences noted in the literature focused on the RN. In the current healthcare environment, transition stress for new graduate nurses is a reality. New graduate nurses report that they feel inadequately prepared (Qiao, Li, & Hu, 2011). Benner (1984) agreed and demonstrated that the new graduate needs practice experiences in order to achieve the level of competent nurse.

Transition issues experienced by new graduate nurses are problematic. Perceived stressors of new graduate nurses involve low confidence in their ability to transition to the role, lack of control over practice and workload, incivility by peers, and feelings of isolation and burnout (Feng, Chen, Wu, & Wu, 2011, p. 98). Other stressors include problems related to equipment operation and use (Wu, Fox, Stokes, & Adam, 2012). Further adding to the stress of being a new graduate includes the potential for errors in practice that occur more frequently among novice nurses than experienced nurses (Saintsing, Gibson, & Pennington, 2011).

Lack of support during the transition period is a problem that new graduate nurses face (Higgins, Spencer, & Kane, 2010). Specific strategies need to be in place to combat the problem of incivility and disempowerment in the workplace (Smith, Andrusyszyn, & Laschinger, 2010).
Effective coping strategies can aid adjustment to new graduate nurses’ role (Qiao, Li, & Hu, 2011). Coping strategies implemented by new graduate nurses include:

Applying various stress-releasing methods; trying to make personal changes rather than trying to change others; being more cautious when undertaking unfamiliar tasks, and focusing attentions on direct patient care, which offered a higher probability of reward through patient-given encouragement and gratitude that enhanced subjects’ sense of accomplishment. (Ming-Chu, Yao-Mei, Lin-Kun, & Ling-Chu, 2011, p. 98)

New graduate nurses suggest the first year of employment as a nurse is difficult with “introduction into the hospital culture, struggling to maintain a balance, being a nurse, assuming a professional role, and strategic choices” (Rheaume, Clement, LeBel, & Robichaud, 2011, p. 80). Previously employed new graduate nurses transitioned easier than those not previously employed (Phillips, Estherman, Smith, & Kenny, 2013).

Transition struggles for new graduate nurses related to the socialization process of “fitting into the bureaucratic system, of maintaining interpersonal relationships with colleagues and familiarizing themselves with the unit rules and culture” (Feng & Tsai, 2012, p. 2064). Assistance from nurses offset difficulty experienced by nurses during the period of transition (Tastan, Unver, & Hatipoglu, 2013). Support in dealing with complex patients, orientation to new milieu, and respect from coworkers were predictors for successful transition (Phillips, Estherman, Smith, & Kenny, 2013). New graduate RNs have reported issues with inconsistent preceptor assignments resulting in both satisfactory and unsatisfactory encounters and evolving levels of growth and confidence in time management and communication abilities (Spiva et al, 2013).

Modifiable workplace factors also play a significant role in influencing new graduates’ job and career satisfaction and turnover intentions (Laschinger, 2012). Counseling programs could improve new graduate nurses’ coping (Ming-Chu et al., 2011). Helpful relationships with
colleagues positively influence recruitment and retention of new graduate nurses (Martin & Wilson, 2011; Thrysoe, Hounsgaard, Dohn, & Wagner, 2012). New graduate nurses desire to fit in with the unit staff and feel that they are a part of the unit’s social group (Malouf & West, 2011). A phenomenon found to be associated with new graduate nurses in Taiwan was “struggling to be an insider,” which included “being new as being weak, masking myself, internalizing the unreasonable, and transforming myself to get a position” (Lee, Hsu, Li, & Sloan, 2013, p. 789).

Culture and Nursing Practice

Culture influences recruitment and retention of new graduate nurses (Kelly & Ahern, 2009). New graduates indicated that there is “tension between the ability of individuals to act and the physical, social, managerial, and cultural environments which care takes place” (Hosburgh & Ross, 2013, p. 1124). Psychological capital and perceived person-job fit are significant variables in new graduate nurses’ work life, contributing to decreased burnout and increased physical and mental well-being (Laschinger & Grau, 2012).

Work environment variables that contribute to a positive work environment are needed to promote retention of new graduate nurses (Kramer, Brewer, & Maguire, 2013; Laschinger, Finegan, & Wilk, 2009). Concerted and inventive efforts are required to support new graduate nurses’ transition to practice in order to combat their disenfranchisement and marginalization (Horsburgh & Ross, 2013; Kelly & Ahern, 2009; Morrow, 2009). Evidence-based tactics to enable nurses and entrench methodical approaches, enabling impartial and contextually relevant stewardship of new graduate nurses into the future are immediately needed (Parker, Giles, Lantry, & McMillan, 2014).
To facilitate retention, competency development needs to be fortified (Ming-Chu et al., 2011). New baccalaureate nursing graduates perceived the following competencies to be important for new nursing graduates: “interpersonal communication, self-management, personal and professional development, basic clinical knowledge for self-learning, nursing assessment and care delivery, professional and ethical nursing practice, and implementation of the nursing workload” (Matsutani et al., 2012, p. 9). In-service programs that allow new graduate nurses to practice clinical reasoning in situations dealing with a patient with a deteriorating condition also need to be implemented (Purling & King, 2012).

Empowerment is an important variable in promoting work engagement and effectiveness of new graduate nurses (Spense, Laschinger, Wilk, Cho, & Greco, 2009). Leaders and colleagues should demonstrate trust, provide time for competency development, and support the newly educated nurses’ initiative to increase his or her competence in order to promote recruitment and retention of new nurses (Sneltvedt & Sorlie, 2012). Another very important aspect of the transition of new graduate RN is the new nurse-preceptor relationship to help support new nurses’ transition to practice (Kramer, Maguire, Halfer, Brewer, & Schmalenberg, 2013; Moore & Cagle, 2012).

Authentic leadership facilitates supportive work environments for new graduate nurses (Spense, Laschinger, Wong, & Grau, 2012). Administrators that gain better understanding of the experiences of new graduates will ultimately improve in-service programs, and retain future nurses (Lee, Hsu, Li, & Sloan, 2013). Nurses in clinical practice settings need to be conscious of the substantial part that experienced RN and nurse unit managers undertake in the socialization of new graduate nurses (Kelly & Ahern, 2009).
LTC Nursing Practice

Quality of care in LTC facilities is an issue of great importance. A number of factors, including staffing levels, staff mix, and structural issues in nursing, including the size, ownership, resident case-mix, and payer mix (Grabowski et al., 2004), impacts quality of care in LTC facilities.

Staffing ratios in LTC facilities affect quality-of-care issues present in the LTC facility setting (Morr et al., 2009). An appropriate staff mix has a significant impact on clinical outcomes and is important in achieving high-quality care (Castle & Engberg, 2007). For LTC facilities with a higher RN to LPN ratio, clients have been noted to receive better quality of care (Horn, Buerhaus, Bergstrom, & Smont, 2005). In a LTC facility with higher LPN to RN ratios, quality of care is reduced (Zheng et al., 2006). Despite increased RN to LPN ratios support better quality of care, LTC facilities commonly have a greater proportion of LPNs than RNs on duty (Harrington et al., 2012).

A major barrier to quality of LTC facility care is the high rate of nurse and nurse aide turnover (Barry, Kemper, & Brannon, 2008; Castle, 2012). This turnover often results in the use of agency staff or low nurse-patient ratios, which negatively influences quality of care and resident quality of life (Castle & Engberg, 2007).

Federal regulations have had an impact on quality of care for LTC facility residents in the US. The Omnibus Budget Reconciliation Act of 1987 mandated requirements for staffing patterns in certified LTC facilities that provides Medicare and Medicaid Services. These guidelines required that LTC facilities have one RN on duty for 8 consecutive hours, 7 days a week, including a Director of Nursing (full time), one RN, and one licensed nurse (RN or LPN)
for the remaining 16 hours a day (Harrington et al., 2012). Improved staffing levels in LTC facilities occurred since this LTC facility reform act was enacted (Zhang & Grabrowski, 2004).

The most recent regulatory changes with the 2010 Patient Protection and Affordable Care Act are certain to have a huge impact on quality of care, pertaining particularly to CMS payments. Penalties to hospitals for hospital readmission, value-based and pay-for-performance plans, and other payment reforms emphasize quality and penalize systems that deliver poor care (Tilden, Thompson, Gajewski, & Bott, 2012). The rising cost of Medicare and Medicaid programs have necessitated change for continuation of these government-funded programs (CMS, 2011).

National Quality Initiatives are in place to help improve care transitions from the acute care setting in order to prevent rehospitalization of those discharged (Callahan et al., 2012). There is a great deal of focus on transitions of care from the standpoint of acute care and clients covered by Medicare. Medicare is the government-sponsored insurance for those 65 and older or those who are disabled. Medicare has recently stopped paying for acute care hospital stays for patients readmitted to the acute care setting for the same problems within thirty days of hospitalization. Individuals covered by Medicare are eligible for LTC facility rehabilitation stays in LTC facilities rehabilitation settings for up to 21 days.

Nursing Scope of Practice in LTC

A factor contributing to decreased quality of care in LTC facilities is the fact that scopes of practice of the RNs and the LPNs are not clearly delineated, particularly in regard to delegation (Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013c; Mueller, Anderson, McConnell, & Corazzini, 2012). Discounting scopes of practice results in diminished quality of
care in the LTC facility setting (Castle & Anderson, 2011; Castle & Engberg, 2007; McConnell et al., 2010; McGilton, Boscort, Brown, & Bowers, 2014).

Nursing practice is more than a series of tasks, carried out by doctor’s orders. Nursing practice is the range of activities and processes used by nurses for “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in care of individuals, families, communities, and populations” (ANA, 2010, p. 10). Practice models facilitate organization of nursing practice.

According to Mueller and Slavik (2010), “nursing practice models provide the framework for the design and delivery of nursing care to residents in LTC facilities and characterize the manner in which nursing staff assemble to accomplish clinical goals” (p. 270). An example of a NPM is team nursing. In team nursing, for example, care could be set up with an RN, LPN, and a nursing assistant work together to care for a group of patients. Scope of practice delineates nursing care through nursing practice models.

Scope of Practice Regulation in LTC

According to Corazzini et al. (2011), the regulation of LPN practice by nurse practice acts influences quality of care. Corazzini et al. studied LPN supervision and delegation in NPAs for all 50 states and the District of Columbia, comparing results to the CMS data for US LTC facilities. They found that the states where the NPAs did not allow LPNs to supervise and delegate had better quality outcomes. The study noted a relationship between the NPA restrictiveness and the kind of LTC facilities that occupy the state. They found that states with more corporate-owned chain LTC facilities had greater the restrictiveness in the LPN practice.
Finally, they determined that silence in the regulations negatively affects patient safety and quality in LTC facilities.

Corazinni, Anderson, Mueller, Thorpe et al. (2013c) also studied the NPAs of all 50 states and the District of Columbia in order to describe the regulatory differences in how LPNs contribute to nursing assessment, care planning, delegation, and supervision; the key components of nursing process and professional nursing care (ANA, 2010). Using a mixed-method design, they also compared how the differences related to quality of care. The study results showed that states vary considerably as they guide LPN and RN practice. Corazinni, Anderson, Mueller, Thorpe et al. (2013c) found that the nursing care was better in the states which offered clear NPA guidelines for LPN scope of practice and better RN availability. The NPA for Alabama was silent concerning assessment and care planning in LPN practice. The NPA for Alabama permits some aspects of supervision and delegation in LPN practice.

Through qualitative case study research, Corazzini, Anderson, McConnell et al. (2013a) compared how RNs and LPNs enacted their scope of practice through the primary functions of nursing scope of practice in two states, Minnesota and North Carolina. Through telephone interviews data, the researcher collected from the RN Director of Nursing of each LTC facility and at least two other licensed nurses, RNs and LPNs. They asked them to describe their approaches to assessment, care planning, supervision, and delegation. The study found that three factors separated the cases in key components of professional nursing care. These factors included quality of connections, degree of interchangeability, and the RN-to-LPN staffing ratios. The quality of connections noted in the study was as follows, “the degrees to which formal and informal connections were used in assessing, care planning, supervising, and delegating” (Corazzini, Anderson, McConnell et al., 2013, p. 15). They noted formal connections to be
scheduled activities, including meetings and quality improvement actions. The informal happenings according to Corazzini, Anderson, McConnell et al. (2013) were discussions that took place when the nurses happened to meet on the unit. The degree of interchangeability was “the degree to which LPNs were considered equivalent to RNs in assessing, care planning, delegating, and supervising” (Corazzini, Anderson, McConnell et al., 2013a, p. 15). The staffing ratios were the “degree to which LTC facilities have adequate numbers of RNs for RN-level clinical expertise and management of LPN contributions to assessing, care planning, delegating, and supervising” (Corazzini, Anderson, McConnell et al., 2013a, p. 16). The findings indicated that in order to enact their scope of practice in the LTC facility setting, RNs and LPNs must collaborate (Corazzini, Anderson, McConnell et al., 2013a). Corazzini, Anderson, McConnell et al. (2013) asserted that if there is no focus on how nurses enact their scope of practice, the focus will be on tasks. As a result, according to Corazzini Anderson, McConnell et al. (2013a), the complexities associated with the provision of comprehensive team-oriented nursing care will not receive appropriate attention.

Delegation in LTC

Corazzini et al. (2011) carried out a qualitative, descriptive study to determine how RNs in leadership roles in LTC facilities delegated care. There were two approaches that RNs used to follow the job description and consider scope of practice. The majority of nurses surveyed in this study were Directors of Nursing (DON) from skilled nursing facilities. They interviewed DONs at a national conference of an organization of RNs that hold leadership positions in LTC facilities. The “follow the job description” approach to delegation was more task oriented, rather than outcome oriented. Whereas, the “scope of practice” approach appeared to be more outcome oriented. Benefits of delegation in the LTC facility setting, according to Corazzini et al. (2011),
included getting the work done and empowering staff in their duties. Delegation benefited work processes, ensured that the facilities operated well, and residents observed more frequently. The study also noted that delegation helped ensure they had time to monitor outcomes of care provided. Barriers of effective delegation included poor partnerships across licensed and unlicensed nursing staff, attitudinal barriers, and paucity of RN-level clinical leadership. This particular study found it problematic that practical nurses lacked delegation skills, when LPNs delegate to nursing assistants (unlicensed assistive personnel) in the LTC facility setting. Corazzini et al. (2011) also identified LPN skills as a barrier to effective delegation resulting in difficulty recruiting LPNs trained to delegate.

Hall et al. (2005) in Ontario, Canada, focused on the relationships involved in the delegation process with focus groups of all staff and nurse managers from six different LTC facilities. The aim of the study was to improve management practices in LTC residential facilities and enhance the quality of the supervisory relationships between the nurses in supervisory roles and those carrying out basic nursing care. Two sets of supportive data were obtained and further categorized as managerial “communication” behaviors and “role-modeling practical” behaviors (Hall et al., 2005, p. 183). The study found that communication behaviors included (a) considerate listening; (b) praise, recognition, and positive reinforcement; and (c) respect and trust. The study data on role-modeling practical behaviors entailed open behaviors of helping, teaching, and advocating. The study data supported the need for a transformational leadership style to improve supervision and delegation practices.

According to a study by Rubin, Balaji, and Barcikowski (2009), education was the key to helping ameliorate the issues regarding delegation and supervision of nursing aides. According to the data from their study, nurse supervisors, both RN and LPN, were key to educational
reform and must be taught collegial methods when delegating authority. According to Rubin et al. (2009),

We believe newer models of communication need to be addressed early on in formal nursing curricula and continued through in-service education at the bedside, emphasizing the benefits of inspirational role modelling, but nursing supervisory excellence does not occur in a vacuum. An enlightened administration, plagued by remuneration issues, must also ensure (and understand) that teamwork must permeate all levels of the LTC facility hierarchy, and condescension must be replaced by a mission emphasizing mutual dialogue and empowerment (p. 830).

The study data support the development of a model of communication between nurses, RNs and LPNs, and nursing aides, or unlicensed assistive personnel, including “active listening, compassion, respect, trust, empathic curiosity (knowing peoples’ stories), intuition, need to be understood, cultural sensitivity, and nonjudgmental attitudes” (p. 830).

Culture Transformation and the LTC Setting

There has been a call for a culture transformation in the LTC settings to ensure residents’ choice, dignity, respect, self-determination, and purposeful living (Pioneer Network, 2010). Integrated findings across studies of culture transformation models demonstrate potential psychosocial benefits to LTC residents, as well as the fact that nurses in the LTC settings have an important role in the success of culture change initiatives and the health outcomes of residents (Hill, Kolanowski, Milone-Nuzzo, & Yevchak, 2011). Those who advocate culture change in the LTC setting base this on the belief that creating a more resident-centered, home-like environment will promote better outcomes and improve quality of life (Hill et al., 2011).

Summary

The literature review supported the need for a study that evaluates the NGLPN’s attainment of the Apprenticeships for Teamwork and Relationship-centered care, ultimately obtaining the NLN ECM (2010) competencies related to HF. There have been a number of
proposed mechanisms to improve quality of care for LTC residents. However, none of these focused on having a workforce of LPNs prepared to meet the demands of practice. Providing a workforce that feels prepared to meet the demands of practice could have a positive impact on the resident’s outcomes. Gaining an understanding of the lived experience of transition to practice for the NGLPN in this setting will provide feedback on the new graduates’ positive and negative transition to practice experiences, ultimately demonstrating whether the NGLPN felt prepared to meet those demands.
CHAPTER III
RESEARCH DESIGN AND METHODOLOGY

The aim of the study was to understand the lived experience of transition to practice for the NGLPN practicing in the LTC setting. Interpretive phenomenology is the philosophy and method used for the qualitative research study. The purpose of phenomenology is to describe the meaning of a concept that several individuals share. The definition of phenomenology is “the study of lived experiences and the ways that we understand those experiences to develop a worldview” (Marshall & Rossman, 2009, Kindle location 1890-1894). The work of Van Manen and Benner provided framework for this study.

Van Manen (1990) worked under the assumption that there is a broadened understanding of rationality in that human science research that requires understanding. According to Van Manen,

In contrast to the more positivistic and behavioral empirical sciences, human science does not see theory as something that stands before practice in order to “inform” it. Rather theory enlightens practice. Practice (or life) always comes first and theory comes later because of reflection. (p. 15)

According to Benner and Chan (2010), “To understand practitioners and caring practices, one has to be able to study the person in a social context and also engaged in carrying out a caring practice” (Kindle Location, 417). Interpretive phenomenology is a research method that provides subjective understanding of practice experiences. The aim is to gain the participants’ subjective understanding of practice through interpretation of their prereflective understanding of those experiences. Human science research involving the practice experiences of individuals is not
predictable as is theory. We must enter the participants’ lifeworld. Interpretive phenomenology makes this possible. This is accessible through prereflective understanding, which can be accessed by interviews. Through interviewing, we can gain understanding of the practitioners’ lifeworld, as they reflect on practice experiences. This provides insight into their subjective understanding of the practice experiences.

According to Van Manen (1997), phenomenology involves serious reflection on the lived experience of human activities. He goes on to say that this reflection must be “thoughtful and free from theoretical, prejudicial and suppositional intoxications” (p. 12). Van Manen (1990) provided a methodological structure for hermeneutic phenomenology that includes the following six activities:

- Turning to the phenomenon which seriously interests us and commits us to the world
- Investigating experience as we live it rather than as we conceptualize it
- Reflecting on the essential themes which characterize the phenomenon
- Describing the phenomenon through the art of writing and rewriting
- Maintaining a strong and oriented pedagogical relation to the phenomenon
- Balancing the research context by considering parts and whole

(p. 30-31)

Through turning to the phenomenon that seriously interests us and commits us to the world, as in the case of this research study, the researcher is involved in the examination of the NGLPNs’ experiences of transition to practice through the lens of phenomenology. As a researcher, and former practical nurse educator in a community college setting, this topic is of personal importance. Personal experience revealed that LPNs who returned to an ADN program of study discussed experiencing supervisory and leadership roles as NGLPNs in LTC settings.
They also spoke of negative experiences related to working in the environment. The subjective experiences of NGLPNs can provide important data on positive and negative experiences for the NGLPN related to transition to practice in the LTC setting.

According to Van Manen (1990), experiences are noteworthy as we gather them, remember them, and assign memory to them. He compared the phenomenological human science process to an artistic endeavor. The phenomenon of life is apprehended and presented through an etymological description with the aim to determine the nature of the experience and give it meaning. Understanding of the experiences of transition to practice for the NGLPN in an LTC facility environment requires dialogue with those who have had these experiences. Through interviewing the new graduate LPNs about their experiences, the researcher worked through the art of questioning to derive meaning from their stories.

Van Manen (1990) emphasized that the construction of the semantics supports the essence. This process provides interpretation, based on the essence of the semantics. The researcher derived the semantics by exploring the subjective understanding of the participants’ experiences. The researcher used the interpretive process to describe, analyze, and reflect on the experiences of the NGLPN, practicing in the LTC setting. The essence of the participants’ words, phrases, or sentences provided the interpretation of the meaning.

Van Manen (1990) affirmed that phenomenology has dual concerns in the “preoccupation with both the concreteness (the ontic) as well as the essential nature (the ontological) of a lived experience” (p. 39-40). The details of practice in this setting provided the concrete aspect of the experiences. Interviewing illuminated the phenomena of transition to practice.

Van Manen (1990) believed pedagogical standards support the process. He saw the method of research and writing as overlapping. The researcher questions the way that one
experiences the world through an act of “intentionality, or becoming more fully a part of the world” (Van Manen, 1990, p. 5). Van Manen asserted that this form of research always begins in the lifeworld and asked a modest question of what it is like to have a certain experience. New graduate LPNs were asked to share these experiences as they happened, exposing their subjective understanding of the experiences. Using Seidman’s (2013) method as a guide for the structure for the interviews, the researcher explored participant experiences of transition to practice in the context of their own life histories, drawing meaning from the experiences. The three interview structure helped provide a beginning, middle, and end to the participant experiences.

Sampling Plan

Three NGLPNs participated in the study. The director of nursing at the study site granted permission to the researcher to post the study announcement and conduct the study with the NGLPNs in the facility. Participation was voluntary and the director of nursing was not involved in the recruitment process. Initially, the researcher placed a poster in the facility to recruit participants (Appendix A). The first participant volunteered to participate and helped recruit the other two participants.

The researcher spoke with the potential participants on the phone and met with them in a private location to explain the study details. The participants were screened during the first meeting to ensure that they met the study eligibility criteria. The eligibility criteria for participating in the study included the following: NGLPNs practicing in their first job, graduating from the same community college practical nursing program, employed in the study site, practicing no more than 15 months, and practicing no less than 6 months. Three participants agreed to participate in the study by giving verbal consent and signing the consent form. They each graduated from the same community college in the same cohort in December 2014. The
participants mentioned two other members of their practical nursing class that started the job in the same setting around the time that they did and quit shortly afterward. Based on the participant comments, these three participants were the only NGLPNs that were close to the inclusion criteria of 6 to 15 months. The community college is located in the south central US and functions under the state community college mandated practical nursing curriculum. The ACEN (2013) criteria for obtaining subjective data from program graduates suggests between 6 and 12 months of practice. There was no rationale for the range. The three NGLPN participants were close to the range. Participants were in their first LPN practice position since graduating from the community college practical nursing program. One of the participants previously worked a second job in a clinic in addition to working in the LTC facility.

Protection of Participants

The researcher applied for and received Institutional Review Board approval from The University of Alabama Institutional Review Board prior to beginning the study (Appendix B). The researcher took steps to disguise the participants' identity by assigning a pseudonym to each person with their assistance. Study documents other than the informed consent did not contain the participant's actual name, only the pseudonym. The researcher scanned and saved all study-related documents in a file on the researcher’s password protected computer.

Participants were all LPNs. The researcher verified their practical nursing license via the Alabama Board of Nursing’s online licensure verification system. The primary researcher obtained the license number during the screening process, and verified online to ensure that the nurse was licensed with the ABON. The researcher obtained written informed consent from each participant.
Data Collection

According to Seidman (2013), “a phenomenological approach to interviewing focuses on the experiences of participants and the meaning that they make of that experience” (Kindle location 518). Seidman’s (2013) structure for interviewing, along with the methodological structure developed by Van Manen (1990) aided the researcher in designing the semi-structured interview schedule. Seidman (2013) developed four themes that provided the rationale for use of his interview technique, including (a) The temporal and transitory nature of human experience; (b) Whose understanding is it? Subjective understanding; (c) Lived experience as the foundation of “phenomena”; and (d) The emphasis on meaning and meaning in context (Kindle locations 518-594).

Seidman’s (2013) three-interview series format guided the researcher in developing the interview schedule for face-to-face, semi-structured interviews with the participants. According to Seidman (2013), “stories are a way of knowing” and “telling stories is essentially a meaning-making process. When people tell stories, they select details of their experience from their stream of consciousness” (Kindle location 342). Researchers have access to investigate an educational organization, institution, or process by interviewing those individuals who make up the organization (Seidman, 2013). He stated that the three-interview technique allows both the interviewer and the participant to explore the experience, the context of the experience, and reflect on the meaning, which takes sufficient time to accomplish. Seidman (2013) stated that attempting to accomplish this goal with one interview would place the researcher on “contextual ice” (Kindle location 611). He went on to say that interviewing as a method of analysis is most consistent with the fact that people have the ability to make meaning through language and we do not want to rush this process. An important part of this process of interviewing as a research
method was to help the participant understand their experiences by encouraging them to make their pre-reflective thoughts visible. The interviewer helped the participants make sense of their experiences by providing them with a beginning, middle, and an end to their story.

Each interview in the series was no longer than 60 minutes in length. This approach, according to Seidman, “allows both the interviewer and the participant to explore the participant’s experience, place it in context, and reflect on its meaning” (2013, Kindle location 611). Van Manen (2009) stated that the researcher can mobilize the participants to engage in reflection on their experiences. The three-step interview process as outlined above facilitated this process. A semi-structured interview schedule guided the interview process. The interview schedule is included in Appendix C. The researcher interviewed participants three separate times with 2 days to 2 weeks between the interviews.

In the first interview following this approach, the interviewer asked the participants to explain their background related to the phenomenon of transition to practice up until present time. The researcher asked participants to reconstruct earlier experiences with peers, friends, family, classmates, and teachers, including experiences with LTC facilities prior to entering school and during their practical nursing program. The researcher also asked participants how they came to the decision to become a LPN and chose to work in the LTC setting.

The second interview concentrated on the concrete details of the participants’ lived experience of transition to practice as a NGLPN practicing in the LTC setting. The researcher asked about details of their work, specifically asking them to reconstruct the details of positive and negative practice experiences during their transition to practice. The researcher asked participants to talk about their relationships with coworkers, residents, or other interdisciplinary team members.
The third interview involved asking participants to reflect on the meaning of their experiences in an attempt to address the “intellectual and emotional connections between the participants’ work and life” (Seidman, 2013, Kindle location 645). Participants shared how they understood their practice experiences in their life, based upon the information that they shared about their lives before becoming an LPN, and about their work as an NGLPN. The researcher asked the participants to share where they saw themselves going in the future, based on these experiences.

The interviews took place in the location of the participants’ choice. Seidman (2013) suggested that it is important to record and transcribe interviews. Recording is beneficial to both the researcher and the participant, as there is a record of the interviews, which adds a layer of accountability for the researcher to the participants (Seidman, 2013). The researcher recorded all interviews. The researcher transcribed the recorded interviews verbatim and stored the transcripts in the researcher’s password-protected computer.

The researcher made reflective notes, which helps the researcher develop thoughts by getting them in writing as they occur, as this process frees the mind for new thoughts and perspectives (Glesne, 2011). The researcher made notes immediately after each interview. The notes were used to guide further questioning in the following interviews.

Data Analysis

Interpretation of the data started as the first interview concluded. Data were reduced with an open attitude by reading and highlighting interesting passages and including material if there was any doubt, a process that helped shape data into a usable form. Following the data analysis processes used by Seidman (2013), the researcher developed thematic vignettes by reading the interview transcripts, marking passages of interest, and coding the passages. The researcher
labeled passages with words describing the emerging categories and the location in the original transcript. The researcher copied, pasted, and placed the highlighted passages into documents labeled based on categories and their location in the original transcript. The researcher used vignettes and statements from the data after taking a more critical look and further reducing profiles in order to keep only the most compelling aspects of the data (Seidman, 2013). Following Seidman’s processes, the researcher removed characteristics of speech not written, such as “uhm,” “ah,” and “you know.” The researcher maintained interview transcripts in their original format, along with the recorded interviews and files of extracted data in order to keep an audit trail. All files were stored in the researcher’s password protected computer.

The literature review facilitated the development of the final themes and subthemes. The researcher did not start the coding process with categories in mind. Initial categories emerged from the data. The literature was reviewed, based on the initial categories of data. The researcher looked for common themes related to the emergent data categories. The researcher also looked to the data to determine what was present and what was missing. The researcher reflected on the process of interviewing, studying transcripts, developing profiles, and labeling categories of data in order to discern any connecting threads in the data, understand the connections, and determine what the researcher learned in the process.

Trustworthiness

Creswell and Miller (2000) described eight validation strategies to follow to ensure trustworthiness of research. They recommend that researchers follow at least two of the eight processes. This study used the following two procedures to meet the standards of trustworthiness: writing a detailed and thick description and member checking. Detailed, thick descriptions offer the reader the ability to compare their own thoughts to those of the researcher.
The researcher also followed the procedure of member checking. According to Marshall and Rossman (2011), “through member checks, the participants can correct the researcher’s representations of their worlds” (Kindle location 659).

The researcher interviewed each participant at least three times, which involved prolonged engagement in the field. Each interview was at least 2 days apart, which allowed the researcher and the participant to reflect on the interview. At each subsequent interview, the researcher shared thoughts on the data and emerging interpretations with the participants. The researcher invited participants to correct any interpretations that they felt were inaccurate. The researcher’s interest was in the participants’ views of the researcher’s analysis as well as what was missing.

As a doctoral student, the researcher shared this dissertation research work with a committee that served as an outlet for external reflection and debriefing on the research. The researcher addressed bias through understanding the researcher’s subjective thoughts. The researcher did this after interviews and throughout the research process writing reflective notes, addressing subjective thoughts on the information learned.

Ethical Considerations

Ethical principles, based on the Belmont Report, supported the study. These ethical principles were beneficence, respect for human dignity, and justice (Polit & Beck, 2008).

Beneficence as a principle of research requires that the researcher minimize harm and maximize benefits. The research did not expose the participants to any unnecessary risks for harm or discomfort. During the interview process, the participants could experience emotional stress in reflecting on experiences that they had in their first job. The researcher explained to
participants during the informed consent process that they were free to withdraw from the study at any time.

The researcher protected participants from exploitation and afforded them the right to privacy by using pseudonyms in the transcripts and successive reports generated. The researcher was also cognizant of the participants’ time. The researcher informed the participants at the onset of the interviews of the timeframes for the interviews, and the researcher did not go over the scheduled 60 minutes for each of the three interviews.

The principle of respect for human dignity ensures that participants have a right to self-determination and full disclosure. Participants had the right to volunteer to participate in the study. To reciprocate for the time involved in participating in the study, the participants received a $30 Starbucks gift card at the completion of the three interviews. Participants in the research study received full disclosure as to “the nature of the study, the right to refuse participation, the researcher’s responsibilities, the likely risks and benefits” (Polit & Beck, 2008, p. 172).

Researcher Positionality

As a former nurse educator of LPNs in the Alabama Community College System, I heard stories of practice experiences in the LTC setting. Those stories were the impetus for this study development. Potential exists for bias in regard to my personal experience as a practical nursing educator.

Summary

Interpretive phenomenology is the method for the current study. Semi-structured interviews guided by Seidman’s (2013) method supported development of the interview schedule. New graduate LPNs graduating from the same cohort of the same community college participated in the study. The participants transitioned to practice in the same facility. Interviews
were recorded verbatim and transcribed by the researcher. Data analysis was conducted starting with the first interview. Categories emerged and the literature was reviewed to assist with theme development. Approval from the Institutional Review Board was obtained from the University of Alabama. Pseudonyms were used in all documentation to protect participant identity. Member checks and writing detailed, thick descriptions ensured trustworthiness of the study. Participant consent was obtained voluntarily. Participants received reciprocation for participation with $30 Start Bucks gift certificates. Principals of ethics were incorporated to ensure beneficence, respect for human dignity, and justice. Participants time was honored. Interview times did not exceed the timeframes agreed upon.
CHAPTER IV
ANALYSIS

This chapter provides an overview of the themes that emerged in the analysis of data collected. The purpose of this study was to understand the lived experiences of transition to practice for the NGLPN working in the LTC setting. For the purposes of this study, participants were NGLPNs practicing in the LTC setting between 6 and 15 months. The researcher used a broad research question as a guide for the development of the semi-structured interview schedule. Seidman’s (2013) method guided the development of the interview schedules (Appendix C). Three separate semi-structured interviews with each participant done in an effort to provide understanding of the context of the participant’s background growing up, going through nursing school, and entering practice as a NGLPN. Thorough data analysis provided emerging themes from the interviews.

The broad research question was what is the lived experience of transition to practice for the NGLPN working in a LTC setting? The narrow research questions were (a) What negative experiences did the NGLPN have during the transition to practice in the LTC setting? and (b) What positive experiences did the NGLPN have during the transition to practice in the LTC setting?

This chapter begins with an explanation of experiences through a presentation of themes and subthemes inferred from the data. Participant experiences exemplify themes. Finally, the researcher addressed the research questions.
Participant Backgrounds

Kathleen, a Caucasian female, grew up in the community where she went to school. Her position as an LPN in the LTC facility was her first job. However, she had volunteered at the local hospital every summer since she was 14 years old. Kathleen grew up in the home with both of her parents and her sister. Both sets of grandparents played a significant role in her life. Her mother worked in the radiology department of the local hospital and her father worked in a local industry. Her sister was finishing medical school this semester. She shared that since she was 14 years old; she desired to become a nurse. Kathleen also explained that as she grew up she had a seizure disorder and visited her neurologist’s office frequently, and she really loved the visits there because of the kindness of the nurses and doctor.

Elizabeth, an African American female, moved from a neighboring state to attend school. She said that she was in a program in her high school that provided opportunities to explore medical professions. She started this program in the 10th grade. Elizabeth had worked other jobs prior to becoming an LPN practicing in the LTC setting. She started working in a chain restaurant while in high school, and she continued to work for the same company when she moved to the town where she presently works as an LPN. She shared that she actually continued to work in that job while working as an LPN, only recently resigning. She stated that she just could not let it go because she really loved working there. Elizabeth lived with both parents growing up. Her mom worked as a supervisor at a local manufacturing plant and her father was a truck driver for a local company. She spoke of having two siblings, neither working in health care professions. She did have an aunt that worked as a Certified Nursing Assistant (CNA) in an LTC facility.
Lisa, an Asian American female, moved to the US from the Philippines. She was a single mother of a little girl, age 7 years old at the time of the interview. Lisa said that she did not set out on a path to become a nurse. She actually went to school in her home country to become an industrial engineer and finished the program. However, when she was at the end of her program, her mother became terminally ill. Lisa was her primary care giver until her mother’s death. Lisa went on to work as an engineer, but felt as though something was missing in her life. Her mother had kidney disease and did not tolerate dialysis. Lisa spoke of the poor care that she felt her mother received in her country. She also spoke about the fact that she did not understand things that went on with her mother’s health and medical treatment. Lisa’s two siblings and a stepfather were not very involved in her mother’s care. After immigrating to the US, Lisa started working as a CNA in an LTC facility and loved the work there. She decided to go to nursing school and said that she saw nursing as a way to deal with her mother’s death.

Two of the participants, Kathleen and Elizabeth, started their educational journeys in a university, setting out to attend Bachelor of Science in Nursing programs. However, the programs were very competitive. Kathleen said that the university nursing advisor encouraged her to pursue a community college nursing program, because she did not have the grades to be competitive in the university program setting. Elizabeth had a similar scenario. However, she said that she made the decision, after speaking to another student, whose sister had wanted to attend the university’s nursing program, but did not get in because her grades were not high enough. Elizabeth and Kathleen applied to the associate degree nursing (ADN) program. Kathleen got into the program, but was not successful in her pharmacology course and was given the opportunity to enter the practical nursing program, rather than sitting out an entire year to re-enter the ADN program. Elizabeth applied to both programs and was accepted into the LPN
program. Lisa entered the LPN program after obtaining a degree from a university in the Philippines in Industrial Engineering. All three of the participants finished in the same cohort of the same practical nursing program.

Themes

Through analysis of the data, themes emerged to reflect the positive and negative experiences of the participants. The researcher determined that the themes were negative or positive, based on the following questions that were asked during the interviews, a) What negative issues have come up, during your time practicing in the LTC setting? b) What positive issues have come up, during your time practicing in the LTC setting?

The overarching theme that emerged from the negative practice experiences included intimidating and disruptive behaviors, death and dying. Human dignity, integrity, and self-determination were subthemes that interacted with intimidating and disruptive behaviors theme. Unprepared was the subtheme for death and dying. The overarching theme that emerged from positive experiences included relationships and feeling supported. Caring emerged as a subtheme of relationships and feeling supported. The theme of personal growth emerged as a theme from positive and negative experiences.

In the following sections, the researcher discusses the themes and subthemes that emerged from the data. Practice experiences are also shared with researcher interpretation and impact, emotions, and perspectives of participants.

Participant Representation of Theme: Intimidating and Disruptive Behavior

The theme that emerged from the participants’ negative practice experiences was intimidating and disrupting behaviors, death and dying. The subtheme for death and dying was
unprepared. The following subthemes of integrity, human dignity, and self-determination emerged from intimidating and disruptive behaviors.

Theme: Intimidating and Disruptive Behaviors

The NGLPNs transitioning to practice experienced intimidating and disruptive behaviors. The Joint Commission (2008) issued an alert regarding intimidating and disruptive behaviors in healthcare settings, stating they can lead to patient safety issues. The intimidating and disruptive behaviors mentioned in the alert included verbal outbursts, threats, passive activities, and uncooperative attitudes.

Each participant shared experiences of intimidating and disruptive behaviors during the practical nursing clinical experiences and transition to practice in the LTC setting. These experiences were not only a problem that was directed toward the NGLPNs. The NGLPNs spoke about instances directed toward residents. There were also experiences of intimidating and disruptive behaviors directed by resident’s family members toward the NGLPNs.

Subthemes emerged from the intimidating and disruptive behaviors. These subthemes were integrity, human dignity, and self-determination. Integrity is defined by the NLN (2010) ECM as “recognizing with humility, the human dignity of each individual patient, fellow nurse, and others, whom we encounter in the course of our work” (p. 12-13). Human dignity is addressed in the American Nurses Association’s (ANA, 2015a) Code of Ethics in Provision 1: “The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1). The ANA (2015a) referred to human dignity as an inherent right, stating. “All persons should be treated with respect simply because they are persons” (ANA American Nurses Association, 2015a, p. 45). Self-determination was addressed in the Model of Professional Nursing Practice Regulation (MPNPR), which demonstrated how
standards inform the discussions on regulation in nursing practice (Styles, Schuman, Bickford, & White, 2008). The MPNPR is a triangular hierarchy, including Nursing Professional Scope of Practice, Standards of Practice, Code of Ethics, and Specialty Certification at the base of the triangle. Nurse practice acts, rules, and regulations are at the next level up. Institutional policies and procedures at the next level up. At the top point of the triangle is self-determination, where the nurse must consider all of the layers below to inform their practice (Styles et al., 2008).

LTC clinical rotations in nursing school. Participant experience. Kathleen spoke of issues of intimidating and disruptive behaviors that she encountered in the LTC setting during her first semester of the program; “the facility that we went to, the nurses were not friendly.” Kathleen explained that during her first semester when she was taking the fundamental nursing course, her practical nursing clinical experience involved going to the LTC facility and shadowing the CNAs. She was not directly shadowing the LPNs in the facility during this semester. She was shadowing the certified nursing assistants as the semester curricular focus centered on the basic activities of daily living, such as hygiene care, changing linens, and assisting with toileting and ambulation. Kathleen stated that she did have to communicate with the LPNs to get information about her assigned resident. She felt that they did not value her input from the communication and devalued her in general when she wanted to inquire further about her assigned residents for the purposes of her clinical experience goals. Kathleen shared that when she and her peers approached the nurses, LPNs and RNs, for information about the residents “they would ignore us or they wouldn’t, they would be angry that we even asked them something.” She described their behavior as unfriendly, stating, “just their attitudes, their facial expressions, just their whole demeanor they put off towards us as students were not very friendly,”
This is an example of intimidating and disruptive behaviors that the practical nursing student encountered in the LTC setting clinical rotation. This situation occurred in the student’s first semester of the practical nursing program. The student spoke to her clinical instructor about the behaviors. The student nurse did not remember any in-depth conversations with the clinical instructor and the other students in the group, only conversations at lunch among the students. The behaviors described are passive activities directed by the LPN staff. The behaviors negatively impacted the student nurse’s experiences in the LTC setting. This could deter some student nurses from considering the LTC setting for future employment.

Impact, emotions, and perspective. Kathleen spoke of the negative, intimidating, and disruptive behaviors that she experienced as a student nurse. She essentially experienced uncooperative attitudes by the LPNs on the unit. She alluded to the nurses’ facial expressions as a cue that they were angry about her asking questions. She attributed the treatment to the fact that she was a student. Kathleen spoke of her interaction with her clinical instructor about these experiences and the stated that clinical instructor did not engage in dialogue with her or her classmates about these experiences, stating,

We did tell them [instructors], when we went to go get charts and we came back. We were like, “oh gosh, they were not very friendly.” They (the instructors) just kind of laughed or something like that. Then, after that, when we all went to lunch, we all vented to each other and our whole group felt the same way. We felt like we were such a bother to them and in the way they made us feel like that.

The students had to debrief on their experiences of intimidating and disruptive behaviors alone. This would have been a great topic for the formal post-conference at the end of the clinical day. The clinical instructor could speak to the behaviors, how to handle the behaviors, and how the behaviors impact resident quality of care. This supports the concept of an apprenticeship to
the ethical comportment in nursing practice, where the student learns the behavior of the occupation (Benner et al., 2010).

*Subtheme: Self-determination.* This experience did not deter Kathleen from wanting to work in the LTC setting. She stated that she told her family that she wanted to work in the LTC setting. Kathleen shared the following experience, which puts this decision into perspective:

Even then, everybody came out [of school] and [said] I’m never working in a nursing home. We had somebody drop out of the program, after leaving our first clinical day in the nursing home, because it was so bad; but me and another friend of mine, it drove us to say, “we want to work here.” This is what we want to do because it is a place that is looked over and there are people there who need to care more. So, I took it on myself and I went home and told my parents, “I think that I want to work in a nursing home.” My dad was like, “it’s so dirty and it’s so stinky” and I said, “I know, Daddy. It’s so bad, somebody’s got to fix it.” I said, “Not saying that I can fix it, but maybe I can help the problem some.” So, that’s how I ended up applying for all nursing homes, when I graduated.

Kathleen’s comments reflect her self-determination. She knew that there were negative issues that were associated with working in the LTC setting, but she wanted to work there to and try to “fix it.” She told her father, “It’s so bad, somebody’s got to fix it”. Kathleen considered the standards of care that she had learned in the practical nursing program and ethics inherent in the fact that she felt that the LTC environment needed to be “fixed”. She said that the “people there that need to care more” and that place is “looked over.” The intimidating and disruptive behaviors that she experienced in the LTC setting as a practical nursing student did not deter her from wanting to work in this setting.

*Subthemes: Integrity and human dignity.* Kathleen’s comments also reflected her willingness to promote the dignity of the residents by trying to improve their environment. She said, “That place is looked over and there are people there that need to care more.” Her comments reflected that she “recognized with humility, the human dignity of each individual patient” (NLN, 2010, p. 13).
Kathleen’s comments also reflected that she did not feel respected because she was a student. She felt that she was not valued for that reason. She went on to say that now, based on her practice experiences as a NGLPN, she understands how students can slow you down, but she remembers that she was a student and treats the students the way that she would have wanted to be treated. This reflects her own integrity in her interactions with and in promoting the human dignity of the students assigned to work with her. She also spoke about working with NGLPNs and encouraging them during the transition to practice. She said that she tells them to “hang in there,” ensuring them that the experiences would get better with time.

*Participant experience.* Lisa also spoke of witnessing intimidating and disruptive behaviors in the LTC setting, when she was in nursing school:

The first thing that I’ve noticed as an LPN, when we were in clinicals [during the practical nursing program]. You are seeing those behaviors of the CNA that you have to watch for. You have to watch out for and you gotta be, you gotta to have the leadership skills and strengths to handle. Not only how to pass the medications, but making sure that coworker that works with you are doing what they are supposed to do. . . . Third semester, I saw how the LPNs would you know they would say things, like, “Oh my gosh the CNA didn’t do it again, something like that.” So, I was like, this is what I need to watch out for, when I become an LPN. I saw how the CNAs would, she would tell the CNAs this, and the CNAs would have an attitude. [They] would talk back at you.

Lisa spoke about these negative experiences during her practical nursing program clinical rotations. The passive activities of the CNA not carrying out their assigned duties were disruptive for the LPN preceptor in this situation. Lisa saw this situation and realized that she may have to deal with issues like this practicing in the LTC setting as an LPN. Opportunities like this one are perfect for nursing instructors’ debriefing with nursing students. The NGLPNS had at most 8 clinical days in the LTC setting during their entire practical nursing program. Having more days in the setting with the clinical instructor present would help facilitate teaching about how to handle situations like this one. During the last semester, the practical nursing students had
the opportunity to shadow the LPN in the LTC setting for 4 days. Although the instructor was available if needed, the instructor was not present in the LTC setting.

*Impact, emotions, and perspective.* Lisa spoke about behaviors that she noticed that she would have to watch for when becoming a professional, including the CNAs “talking back” and “having an attitude” or refusing to assist a coworker. The CNA behaviors could also indicate that there is an issue with their workload. Lisa’s comments also reflected her understanding of this fact and her respect for different views.

This issue was also included in the NLN (2010) ECM Apprenticeship for Relationship-Centered Care. Lisa recognized “threats to the integrity of relationships, and the potential for conflict and abuse” (NLN, 2010, p. 27). She explained that she could understand the CNAs’ perspective due to her previous experiences working as a CNA in the LTC setting. Since she had experience as a CNA and an LPN, she was now able to understand the situation from both standpoints. She said, “You understand where they are coming from, because if you can pretty much watch them or you can sense the reason that they cannot do what you want them to do is maybe they are not yet caught up with the job.” She reflected on the fact that there were days as a CNA that were overwhelming due to her having such a heavy load of residents to care for in that setting. She also said that she had an advantage from that experience in that she could also identify when the CNA should be able to handle the load.

*Subtheme: Self-determination.* Lisa considered the scope of practice that she would have as an LPN in the LTC setting. In reflecting on the fact that she would be supervising CNAs, she saw the situation from two perspectives. Working as a CNA previously herself, she recognized that there were days that CNAs were extremely busy. She realized that she would need to address such issues when the work did not get done. She heard the LPN say, “The CNA did not
do it again.” This reflected the fact that this was not a onetime occurrence. Lisa saw how the CNA reacted when the LPN questioned the CNA about not doing some task that she was responsible for that day. Lisa noted that the communication did not go well, ending with the CNA “talking back” and “having an attitude.”

*Subthemes: Integrity and human dignity.* Lisa reflected on her circumstances from multiple perspectives. She had been a CNA, an LPN, and she had been a team leader in a manufacturing facility as an industrial engineer. She said that witnessing these interactions helped her understand the kind of integrity as a leader that she wanted to have, when she practiced as an LPN. Lisa’s comments reflected the fact that she had the integrity to understand, value, and respect the perspectives of the CNA team members. These comments also reflected her respect for the CNAs human dignity as team members, when addressing such issues.

*Practice experience.* Elizabeth also reflected on the intimidating and disruptive behaviors that she witnessed in the LTC setting, when she did a clinical rotation there as a practical nursing student:

I was all about learning, when I was in school and I still am, but the only negative thing is that I have seen is with CNAs, the way they talk to the residents or the way they handle them. I would do it a different way or I would train my CNAs to do it a different way or I would suggest a different way, but with me being a student, I didn’t want to step in and be like, you shouldn’t do it that way. . . . The only thing that really stood out is the way the CNAs would handle the residents. I don’t know. Language, language was really shocking, when I did my clinicals, when I was shadowing the LPN at the nursing home. The language, it is just the way that they would talk to them [residents]. I don’t know, no, it’s not right. I mean, I guess dealing with the same people every day. Maybe they need to change a floor or rotate or something, maybe.

Elizabeth recognized problems that occurred in the LTC setting as a student. The intimidating and disruptive behaviors included verbal outbursts directed at the residents. This is a situation where the student nurse could have benefited from debriefing at the end of the clinical day. This would be another opportunity for exploring this situation with the clinical group and discussing
how to handle the situation. This is an issue that would facilitate the apprenticeship for ethical comportment, where the student learns the behavior of the occupation (Benner et al., 2010).

Impact, emotions, and perspective. Elizabeth spoke about the language being shocking when she was in the clinical setting as a student nurse. She did not like the way that the CNA spoke to the patient. She did not feel prepared to handle the situation that she observed. This spoke to her lack of experience in supervision. Elizabeth shared about experiences encountered in the LTC setting as a practical nursing student. Lisa spoke about her concern for the way that the CNAs and other staff communicated with the residents. She did not think that they should have spoken to the residents the way that they did. She suggested that they needed to rotate to another floor. She recognized the problems inherent in the treatment of the residents.

Subtheme: Integrity and human dignity. Elizabeth’s concern reflected her integrity. She had concerns for the residents’ dignity. Integrity in nursing practice is “recognizing with humility the human dignity of each individual patient” (NLN, 2010, p. 12-13). She said, “I think a lot of CNAs are burnt out. LPNs too that I work with.” She stated that she felt that the LPNs and the CNAs “don’t care” and were “burnt out.” Elizabeth said that the behaviors that she witnessed as a student nurse were “not right.” She stated that she felt that it was “not right” to talk to residents the way that she saw the staff talking to them. She described a lack of integrity by the staff concerning the residents’ human dignity. Her comments also reflected her knowledge related to the NLN (2010) ECM’s Apprenticeship for Relationship-Centered Care. She recognized threats to the integrity of relationships, and the potential for conflict and abuse.

Participant experience. Lisa shared an experience that she had with a LPN at the nursing home that was her mentor for her rotations during her last semester of her LPN program. Lisa said,
The negative experience is pretty much some of the employees not happy with their jobs. You can tell, by the time they get into work (clapped), just their vibes. You can sense it and the way that they interact with residents. It shows very much. It is visible and right there, when I become an LPN. That’s how it made me think when I become an LPN, that kind of attitude, I don’t want to put into myself. You look at how it affects your residents, how it affects your bosses, your supervisors, and how it affects your other coworkers. Of course you might have problems like at home that you cannot get rid of them when you go to work, but you need to go to work to pay your bills. That is completely like understandable, but if you come in every time with this mentor would come in and have the attitude. Then, you pretty much give the impression that she is not real-happy with her job.

The intimidating and disruptive behaviors mentioned by Lisa reflect passive activities. This situation reflected that student nurses need to have mentors and preceptors in the clinical setting that want to be in this role. This is difficult to find, especially when the preceptors are not getting additional pay for the role. The students were sent into the setting to shadow a nurse at the end of the program. The student recognized that the preceptor was not happy about mentoring her. This was not the best situation for learning for the students, particularly when the students only had 8 days in the LTC setting throughout their entire practical nursing program. The last 4 days were optional and involved shadowing an LPN in the setting without a clinical instructor present.

*Impact, emotion, and perspective.* Lisa shared how her nursing mentor had an attitude “that she is not real-happy with her job.” The mentor’s actions were disruptive. She shadowed this mentor for about 4 days, during her last semester in the nursing program. She said that she could sense it in the way that she interacted with the residents. She indicated that the mentor’s negative attitude could relate to issues that the nurse had at home. Lisa noticed that her mentor’s attitude affected everyone that she worked with in the LTC setting.

*Subthemes: Integrity and human dignity.* Lisa reflected on the fact that she was glad to have observed the nurse’s behavior and she had the integrity to realize that she did not ever want to have that kind of attitude. She said that she could see how it affected everyone that she worked
with in the LTC setting. Her comments aligned with the NLN’s statements about integrity in that integrity means “recognizing that certain actions would compromise our own dignity as human beings and nursing professionals”. She recognized “threats to the integrity of relationships, and the potential for conflict” (NLN, 2010, p. 27). This is a competency of the NLN Apprenticeship for Relationship-Centered Care.

LPNs and NGLPNs. Participant experience. Elizabeth shared a situation experienced during her orientation to her job in the LTC setting:

It was only one person, I mean, I understand everybody doesn’t like to orient, but she was just mean. Like, just mean and had an attitude and it was awful, but as the shift went on, she started to warm up a little bit. It worked out, but she just, I guess she just didn’t like to orient people. No, and I understand, because I don’t like to orient people all of the time, but I am not going to be mean to them, no way. So, that one lady she wasn’t, she wasn’t nice, but it’s just one in one day, but she eventually warmed up to me. . . . That was when I was orienting in the nursing home, but then when I got to the rehab the first day, it was the ladies that weren’t orienting me, but they were just mean looking, just mean. People just do not do well with new people.

Lisa explained that she understood that her mentor during orientation that day was not “nice”. She said that the experience was “awful.” Lisa described this as a negative experience during her orientation. She also spoke about the other nurses being “mean looking.” These intimidating and disruptive behaviors were passive activities that negatively impacted the NGLPN’s transition experience. New graduate nurses need to be supported and mentored by nursing staff. This should be considered when placing NGLPNs with mentors.

Impact, emotions, and perspective. Elizabeth shared about the LPN orienting her being “mean” and the other nurses on the unit being “mean looking.” She said that she could understand now, because she has to orient nurses and she does not always want to do it. However, she said that she would never “be mean to them.” She described “mean” as “having an attitude” concerning the nurse that was orienting her. She described the behavior of her mentor,
“being mean” and “having an attitude,” which reflects passive activities that intimidated Elizabeth. She also said that it was “awful.” Elizabeth surmised, “People just do not do well with new people.” Elizabeth described other nurses intimidating, passive behaviors on the unit of being “mean looking.” She did say that the nurse warmed up as time continued.

**Subthemes: Integrity and human dignity.** Elizabeth’s comments reflected the fact that she recognized that certain actions would compromise her dignity as a human being and a nurse (NLN, 2010). She reflected on the fact that she would never be mean to other nurses, even if she did not want to orient them. This reflects her integrity in that she had respect for the “dignity” of the nurses that she oriented (NLN, 2007, p. 13).

**Subtheme: Self-determination.** Elizabeth recognized that these intimidating behaviors reflected that the nurses did not “do well with new people.” Lisa determined the ethics of the situation, stating that she would never be mean to new nurses, even if she does not like to orient them. She recognized that new nurses deserved respect as humans and that is how she would treat them.

**Participant experience.** Elizabeth also shared some issues that she encountered with a nurse on the unit:

At first, I had issues with a nurse. I don’t know. I don’t know why she felt, I don’t know, just how you get the vibe, where somebody doesn’t like you? I had that issue, but it just eventually went away. When I first got there, I guess, I don’t know, maybe I would make some mistakes and she would come behind me and have to fix it or whatever, but it would be something just so simple. . . . She made me a better nurse though. She did, because if somebody is constantly on you (snapping), on you, on you, on you (snapping each time), you have to make sure I am not making this mistake again. I’m not going to do this again, or let me make sure I got this right.

This is an example of an unsupportive environment for the NGLPN transitioning to practice in the LTC setting. The intimidating and disruptive behaviors included passive activities on behalf of the more experienced nurse that followed this NGLPN. These behaviors impacted the
NGLPN’s transition experience negatively. New graduate LPNs need supportive environments to learn and grow.

*Impact, emotions, and perspective.* Elizabeth reflected on the fact that the nurse would report her, instead of talking to her directly. Elizabeth reflected on a situation where the night nurse that followed her was constantly reporting her to her supervisor for not doing tasks. She described the nurse was “hateful” and “not a likeable person.” She said that it was “very challenging.” She said, “It made me a better nurse.” She said that she worked diligently not to make the same mistake again. She said that the nurse finally left the unit, stating, “I don’t have to cross paths with her anymore.” Elizabeth said that her CNAs told her, “She treats every new nurse that comes on like that.” She said, “Everything is good now.” She also reflected on how she handles situations when nurses forget to do tasks. She said, “I don’t try to get her in trouble.” She said that she will just call the nurse “if something looks fishy,” and she will handle it herself. Elizabeth did not want the newer nurse to have the same negative experience that she had with the nurse that followed her.

*Subtheme: Self-determination.* Elizabeth shared the following about the situation:

Like the girl I had to count with, she was just negative, but I got over that. She didn’t make me cry (laughed). I know a lot of CNAs would tell me, every nurse that came through, she would make them cry. I’m like no (laugh), but that’s the only negative thing. These comments reflected Elizabeth’s self-determination. Despite the way that she was treated, she was able to work through the situation. She even laughed about the situation. She reflected on the fact that she was proud that she did not cry. Elizabeth also said the following regarding the situation:

It just at first it was like, “oh I do not want to go to work” or at first it was like, “oh she is off today, everything should be fine.” I hate for anybody to feel like that, but it is like, if I see something that somebody else didn’t do, I don’t make it a big deal, if I can fix it. I don’t make it a big deal.
Elizabeth stated that she had feelings of not wanting to go to work, but if the nurse were off, the day would go fine. The intimidating treatment by the nurse was a stressor that she had to deal with on a daily basis. Reflecting on how she coped, she said, “You do have to be strong, you do! She was (pause) not nice!” She was able to work through the situation and continued to go to work in the same area of the LTC setting. When asked if she ever thought about quitting her job because of this negative issue, she stated adamantly, “No.” Elizabeth had self-determination that facilitated her transition to the setting.

Subthemes: Integrity and human dignity. Elizabeth said that she would not want anyone to feel the way that the nurse made her feel. Her comments reflected the fact that she “recognized with humility the human dignity of fellow nurses” reflecting the NLN (2010) ECM’s definition of integrity. She recognized that nurses deserve respect, even when they are learning.

Participant experience. Elizabeth shared other negative experiences in the LTC setting:

Nothing negative other than women gossiping and talking about other women. Stuff like that, that’s the only, but I guess you can’t dodge that (laughed). There is no way you can dodge that, but I just kind of separate myself. I’ll get up and kind of walk away, because you can’t tell them. Some of them you can’t tell, because you will start a whole other thing. So I just kind of separate myself, if I hear something that I don’t want to hear.

This is an example of intimidating and disruptive experiences that Elizabeth encountered during her transition to practice. These passive activities negatively impacted the NGLPN’s transition to practice in the LTC setting. Elizabeth distanced herself from these behaviors.

Impact, emotions, and perspective. Elizabeth shared that gossiping was a negative issue that she encountered as an NGLPN in the LTC setting. She said that she handled the situation by separating herself from the individuals who were engaging in gossip. She said that if she were to address the issue, it would start other issues. She recognized that the gossiping was not a behavior that she wanted to be involved with in the LTC setting.
Subtheme: Self-determination. Elizabeth recognized that the gossiping was a disruptive, passive behavior and she removed herself from the situation. She navigated this conflict skillfully, one of the practice competencies of the NLN (2010) ECM Apprenticeship for Teamwork. She noted that if she addressed the gossiping, she would start more conflict. Elizabeth’s comments were very insightful, demonstrating that she understood how to navigate potential conflict.

Subthemes: Integrity and human dignity. Elizabeth acted with integrity in this situation. Integrity as defined by the NLN (2010) is “striving to do the right thing at the right time for the right reasons” (p. 12). She also demonstrated that she “recognized with humility the human dignity” of those that the gossip was referenced toward, as she removed herself from the situation (NLN, 2007, p. 12-13). She reflected on this being a negative aspect of the transition to work in the LTC setting.

Resident family members and the NGLPN. Participant experience. Kathleen shared the following:

She [resident’s daughter] told me that she was going to call state and have them take my license. I was not providing good enough care and her mother should be getting better care than this. She just, oh, she just cussed at me and everything and it was no fun. She had been sick. She actually had cancer and she’s now passed, the sponsor [resident’s daughter] has. She was telling me all that and just telling me that I was an awful person in other words. It wasn’t that she was mad at me. She was just mad and I know upset about her mother, because her mother was declining and then passed soon right after that.

Kathleen shared intimidating and disruptive behaviors that she experienced from her resident’s family member. The behaviors included verbal outbursts and threats. These experiences negatively impacted Kathleen’s transition to practice.

Kathleen’s actions were in line with the NAPNES (2007) competencies for the LPN, “assist the client and significant support person(s) to cope with and adapt to stressful events and
changes in health status” (p. 7). Kathleen’s experience also highlighted what often happens in the LTC setting. Clients are at the end of life and often decline at some point. Death and dying is a normal experience in this setting. Dealing with the emotions that residents and their family members have at the end of life is a part of the job. Practical nursing students need training on how to deal with these challenging conversations. The RN should have been called in to help with this situation. The family member really needed to meet with the care planning team to discuss her concerns about the client’s declining situation. More time in clinic in the LTC setting and more mentoring during the transition to practice would allow the student nurse to learn how to handle similar situations.

Impact, emotions, and perspective. Kathleen shared that she cried all the way home, after the experience. She said that she called her mother and cried with her. She saw it as one of the worst days that she had as an NGLPN. She said that it happened right after she got off her 2-week orientation for her job. Kathleen spoke of the communication with the resident’s daughter as being “hard” with her cussing, calling names, and threatening to call “the state.” The phrase “calling the state” is a way to complain to the department that oversees licensure of nursing homes, and most states have an ombudsman that acts as a liaison between the resident and the department.

Subthemes: Human dignity and integrity. Integrity is defined by the NLN (2010) ECM as “striving consistently to do the right thing at the right time, for the right reasons” (p. 12). Integrity encompasses the term human dignity, in that in nursing practice, integrity involves “recognizing with humility, the human dignity, of each individual patient, fellow nurse, and others, whom we encounter in the course of our work” (p. 13). Kathleen shared the following regarding her emotions and how she was able to handle the situation:
She was telling me all that and just telling me that I was an awful person in other words. It wasn’t that she was mad at me. She was just mad and I know upset about her mother, because her mother was declining and then passed soon right after that. All I needed to do was, I started crying. I didn’t know what to do, so I said, “Ms. So & So, I don’t know how to answer. I don’t know how to help. But, can I pray with you. That’s the only thing I know to do”. So, I prayed with her out loud and (pause) that really helped our relationship. She apologized. I still had to stay on my p’s and q’s and on my tiptoes, when she was around (laughed), but that did fix it, because we did connect on a spiritual level (pause). She was a woman of faith and so that did help. It helped the situation some and she apologized later on, but still, it was what she said and how she said it. Oh, it just hurt my heart.

Kathleen was able to work through the situation and identify what was troubling the family member. She shared that the resident’s daughter had health issues and she was dealing with the stress of seeing her mother’s health decline. Kathleen’s integrity and respect for the human dignity of her residents and their family member enabled her to see past the insults toward her nursing skills and the cursing directed at her, to identify the fact that the daughter was projecting her anger about her mother’s decline on Kathleen. Kathleen was able to turn the situation around and help the resident’s daughter cope with her mother’s condition.

Subtheme: Self-determination. Kathleen shared more about her emotions related to this experience. She also reflected on her early experiences in the transition to the role:

My parents didn’t know it until a couple of months ago. I cried every morning on the way to work, every morning of orientation, and the first probably month or so, afterwards. I cried every morning on the way to work and just praying, praying for strength and praying for guidance and just praying so hard to have a good day. . . . That was beforehand, but then after that incident, I definitely found it harder and harder to get up in the morning and go to work and just on the way, just so much anxiety that I would have driving to work. Because it is a good twenty-minute drive from my house to the facility and just those twenty minutes, I would be no radio, no noise. I would just be praying so hard and trying not to cry to where my mascara would run, but just (laughed), if that makes any sense.

This reflects Kathleen’s self-determination. She talked about the emotions that she had because of her experiences and how she coped. She said that she found it hard to get up and go to work in the morning. She spoke of having a lot of anxiety about her experiences. She drew on her coping
mechanism of prayer to help her get through the challenges of her experiences with the incivility that she encountered. This experience and others interfered with Kathleen’s transition to the LTC setting. She spoke a great deal about coping by praying and talking issues over with her parents.

CNAs and the NGLPN. Participant experience. Kathleen shared about how stressful her early experiences in the LTC setting were:

I remember telling my parents “I was so stressed,” after I started working. I was like, I just needed somebody put on the bedpan and they were like heavy, and I couldn’t put them on there by myself. I had to ask for help and nobody would come to help. I had to learn how to ask. I’m not one to say, “Go put somebody on the bedpan,” [I say], “Will you help me put so and so on the bedpan? Will you help me do this or can you help me get so and so on the bedside commode?” Slowly, they started gaining my trust and realizing that I am nice (laughing). So it worked out good. It worked out fine and so now, we are friends. I love all my CNAs and they all love me and we have bonded together. The first little while it was really hard. They didn’t know my name and I didn’t know their names. They weren’t too sure about me, but now we are good. That was definitely really hard.

This is an example of intimidating and disruptive behaviors. The passive activities of not helping the NGLPN negatively impacted the NGLPN’s transition to practice. Having only 8 clinical days in the setting, during the entire program does not leave enough time to help the NGLPN with practicing supervision and delegating skills. Practical nursing students need more time in the setting and more support during the transition to practice these skills.

Emotions, impact, and perspective. Kathleen experienced stress related to the intimidating and disruptive behavior by the CNAs that she supervised. She spoke of being “so stressed” and not being able to do the job of helping her resident on the bedpan. She spoke of not being able to get the CNAs to help her, stating that she asked for help and “nobody would come help.” This reflects passive activities that were disruptive. Kathleen also stated that the CNAs told her “we do what we want to do.” This intimidating behavior caused a great deal of stress for Kathleen.
Subtheme: Self-determination. Kathleen said that she had to learn how to ask for help. She reflected on her relationship with the CNAs that she supervises now as compared to then, stating that they have “bonded,” but reiterating that it was “hard.” This reflects the process of Kathleen’s self-determination.

She also reflected on some of the issues that she felt related to their resistance to help her in the beginning, stating they did not know each other’s name and that she “gained their trust”.

Kathleen also shared that she had to change the way she communicated with the CNAs:

They [CNAs] are, a lot of them are very sarcastic. I learned to be sarcastic back to them, get kind of get a good thing flowing, and a good, a good rapport, and everything went fine from there. Just trying to find that happy medium and to find that happy medium that took just a little bit.

Kathleen shared about how she learned to work more effectively with the CNAs. She struggled with communicating effectively in the beginning of her transition to the LTC setting. She said that it took her a while and that she had to approach them with a similar “sarcastic” attitude in order to “find a happy medium” in order to work more effectively with the CNAs. She used effective communication and team building skills, both competencies of the NLN (2010) ECM Relationship-Centered Care.

Subthemes: Integrity and human dignity. Kathleen also said the following regarding how she went about gaining the trust of the CNAs:

I’m not one to say, “Go put somebody on the bedpan”. [I say] “Will you help me put so and so on the bedpan? Will you help me do this or can you help me get so and so on the bedside commode?” Slowly, they started gaining my trust and realizing that I am nice (laughing) and so, it worked out good. It worked out fine and so now, we are friends. I love all my CNAs and they all love me and we have bonded together. The first little while it was really hard. They didn’t know my name and I didn’t know their names. They weren’t too sure about me and . . . but, now we are good. So, that was definitely really hard.
Kathleen’s comments reflected her integrity in that she “recognized with humility the human dignity” of the CNAs (NLN, 2010, p. 12-13). She found a way to work with the CNAs and gained their trust and stated, “they all love me and we have bonded.”

*Participant experience.* Lisa also spoke of the very stressful situations that she encountered in her supervisory role as an LPN practicing in the LTC setting:

Supervising the CNAs, I got yelled and cussed, and asked to get out of the room at one point . . . As an LPN, I want this to get done, but I cannot do your job. I won’t be able to do my job within the shift. I mean, it is just not fair if you are here to be working on the nursing station, and I got some medicines to pass. You don’t want to answer the call light and then I am going to tell you to answer the call light, and you don’t want to answer the call light. Then, that’s not right. You got to do it. We are on a team here.

This was an example of intimidating and disruptive behaviors directed from the CNAs towards the NGLPN. The behaviors included verbal outbursts, where the CNAs yelled at her and cursed her. This also reflected passive activities of not carrying out the duties of the job of CNA.

*Impact, emotions, and perspective.* These intimidating and disruptive behaviors negatively impacted Lisa’s transition to the environment. Her nonverbal body language was evident during her discussion of this event. She was clapping her hands at the end of sentences as though to make a point. She spoke of CNAs that she supervised having verbal outbursts, yelling and cursing at her. She also spoke of behaviors that she had to address as the supervisor:

That’s something you cannot let go. Just don’t bother to fight all of the battles, because it is not worth it. You are always going to have other employees who don’t have the attitude that you have. There are always going to have employees who don’t have the passion that you have and sometimes, they might really be doing their best today. They are not doing their best tomorrow. There is something going on in their life and they get easily, kind of influenced by it or basically, you are gonna have to understand things. There are some points, boundaries, where you are going to have to say no, I am not gonna let this go. So, that is when you talk to the RN supervisor, pretty much chain of command.
Lisa spoke about how it was important to follow the chain of command, when dealing with such issues, but asserted that if the nurse was not able to get help, to keep going up the chain of command. She was able to handle the situation, despite the obvious stress that it caused her.

*Subtheme: Self-determination.* Lisa had the self-determination to work to handle this negative experience. She addressed the situation by going to her supervisor. She also stated that if that did not work, she took the situation up the chain of authority until she got a resolution. She followed her chain of command to address the situation.

*Participant experience.* Lisa also shared another issue of disruptive and intimidating behavior that she encountered in the LTC setting:

I lately had somebody approach me, when I was in the kitchen. This was an issue at work too. I play at work. I like make jokes and all. Like, make it a sense of humor at work and we do that. I was thinking that these people that approached me were just making jokes with me. I am ok with that too, but the way they approached me was like “where are you from?” [and I replied] “I am from the Philippines.” [They stated], “why do you use knife and fork in eating ham? I saw you before using knife and fork eating fried chicken. Was the fried chicken with a bone or was it boneless?” Then they were like, “Well you should be using chop sticks, because that’s what Chinese and Koreans do.” Whoa, wait a minute, “Are you playing with me?” and this they keep on, “Well why are you not eating your greens?” I am like, “OK, that’s enough. It’s offensive already.”

This is an example of intimidating and disruptive behaviors encountered by one of the NGLPNs. Lisa is from the Philippines. No other NGLPNs described intimidating and disruptive behaviors that were directed at the NGLPN based on their ethnic background. This situation was unique. However, the experience had a negative impact on the NGLPN’s transition to practice.

*Impact, emotions, and perspective.* Lisa explained that she had traveled abroad frequently and she had never experienced treatment like she did in this situation. Lisa explained that she felt supported in this situation, which helped her cope. She said that this was very important to her and she described the comments that the staff members made as “offensive.” She was shocked that she experienced this treatment currently in this town, a college town with a lot of diversity.
Lisa did speak of feeling supported by her supervisor, which helped her cope with the situation:

I reported that to the assistant director of nursing and they kind of, it made me feel better, because they kind of did something about it. It was quick. They suspended one of them, two of them, and talked to them about it. The administrator got involved and came up to me and told me this is something that we don’t tolerate at work. The director of nursing came up to me and give me a hug, and the director of nursing told me that this is something that we don’t tolerate. They made sure that there is action that is being done.

Lisa felt satisfied with the actions of the administrators in this situation. She reflected on the fact that the support of her administrators facilitated her dealing with this negative transition experience.

*Subtheme: Integrity and human dignity.* Lisa shared the following regarding this situation:

The administration stood up for me. So, I want to be working in this kind of environment. That is how I knew I want to stay in this company forever, because I want to work in this kind of company that respects me as I am, despite of my cultural background. Even though people will not understand me, at least there is another support . . . I want to be treated as how I treat my residents too.

According to the NLN (2010), “nursing takes place in a rich cultural climate, one that embodies the belief that nursing is for all, and that each person’s worth and dignity is to be respected and valued” (p. 12). Lisa’s comments reflected that fact that she wanted her worth and dignity to be respected. Lisa reported the situation to her supervisor. She was very upset about the situation. This was evident in her body language and facial expressions. Her comments reflected that she wanted to be respected as she respects her residents. Her comments reflected the fact that she felt supported and that her supervisor’s actions demonstrated that they do respect her worth and dignity. She felt that her administrators had integrity to support her in this situation, which made her want to work in this LTC facility forever.
Participant experience. Lisa also spoke about the fact that she had difficulty communicating with some of the physicians that rounded on the patients in the LTC facility.

Doctors, they would have like kind of a different attitude if you are an LPN and you tell them something. My experience and you tell them stuff [and] you know in your heart that you know this, because you are exactly working with this resident on a day-to-day basis. They would look at you like, “I have like three seconds to listen to this.”

This reflects intimidating and disruptive behavior by the physician toward the NGLPN. This is unique, as most of the NGLPNs spoke of the good working relationship that they had with the certified registered nurse practitioners that made rounds at the facility. Lisa also spoke about her good working relationship with the certified registered nurse practitioners. This particular experience was really opposite from the experiences with the certified registered nurse practitioners. This experience reflected how the physician’s lack of time to speak to the LPN could negatively impact the transition to practice for the NGLPN. This could impact resident safety had the NGLPN not been motivated to go up her chain of command to get her resident help. The intimidating behavior by the doctor could prevent some nurses from contacting the MD, when they really need to contact them.

Impact, emotions, and perspective. Lisa spoke about the situation with some doctors not wanting to communicate with her regarding residents’ problems. She also spoke about how this affected her work in the LTC setting. She explained that with some doctors, it felt as if they did not value what LPNs said about the resident condition. She shared that this made it difficult for her to accomplish her job. She also mentioned that not every doctor was like this, that some were very personable.

Subtheme: Self-determination. Lisa said that the RNs have their duties and they are busy and she felt like she knows her residents better, because she works with them on a daily basis. Her self-determination to get the help that she realized her resident needed was very apparent in
this situation. Lisa handled the situation by letting her RN supervisor know that the doctor did not give her orders for the issue that she had with the client, and she let the RN handle it from there. Her comments reflected the NLN (2010) ECM Apprenticeship for Teamwork. In response, Lisa “acted with integrity, consistency, and respect for differing views” (p. 30).

Subthemes: Integrity and human dignity. Lisa’s actions reflected one of the definitions for integrity, “accepting accountability for our actions while being fully committed to the betterment of patient care and while advocating for patients in a consistently professional and ethical manor” (NLN, 2010, p. 13). She reflected on the situation and stated:

These people are they are pretty much facing different things at work and I am facing different things at work. You cannot force them to think like you are. Just respect that boundary and if they don’t get it [and] if it doesn’t interfere much with how you care for the residents, just don’t, just ignore it. If it is something that is really important, you ask the RN, could you please, because sometimes the RNs are not there. They are busy, they have meetings and stuff. You really want to tell the doctor, “Hey there is something going on with my resident” and if they don’t bother to, just ignore it, because you are just an LPN. Some doctors will do that.

Lisa’s statements reflect her integrity in that she recognized “with humility the human dignity” of the doctors (NLN, 2010, p. 12-13). She said that she ignored the fact that the doctors disregarded her comments. She said that they were “facing different things at work” and she was as well. She found another way to help her residents. Her main goal was to make sure that her residents got the care that they needed.

Participant Representation of Theme: Death and Dying

Death and dying was a theme that emerged from the NGLPN’s negative experiences. The subtheme that emerged from this theme was unprepared. The NGLPN’s did not feel prepared for the experiences associated with their resident’s death and dying in the LTC setting.
Participant Experience

Kathleen shared her first experience in dealing with death and dying of her resident in the LTC setting:

They had hospice care. I don’t remember which hospice facility or whatever was coming in and seeing them, but it was actually the family that yelled at me [about the declining condition of their parent]. It was that family. That was a different experience! It was very interesting. It was not peaceful. That’s for sure. I think that was what upset me the most. It was not a peaceful going. Also, it was my first double I had ever worked. It was on Friday the 13th. So, it was just all combination of bad day to work. It was Friday the 13th and I think there was a full moon, too. It was about 30 minutes before my shift ended at 11. I was just exhausted, mentally, physically, just drained, and then that happened. The family had agreed to hospice care but in the moment they wanted something done and they did not let her pass peacefully, if that makes sense any. They were shaking her, shaking her, and yelling at her and that kind of thing and that was just hard to watch. I held it together, then, and I hollered for the RN supervisor and got him down there with me and then after that, I had to walk out and do all of this paperwork. I had to call all of these people and do all of this paperwork. Do all of this and act like everything was fine and I held it together until I got to my car and that was definitely, it was crazy.

This experience reflected the fact that NGLPNs need more experience with caring for a dying resident. Kathleen did not have any experience with caring for dying person. Her first experience, as she described in this situation was very stressful. In this particular situation, Kathleen noted that the resident’s death was not peaceful, primarily due to the family’s reaction. She said that she was able to “hold it together” until the resident died. Then, she had other responsibilities to handle. At that point, she called the RN supervisor. When she saw that the family members were not handling the situation well, she called for help. Kathleen really should have called the RN supervisor sooner to help handle the situation. The situation was complex and she needed the RN to help navigate this situation. She did not seem to recognize that this complicated situation indicated the need for RN intervention. This was beyond her scope of practice. Although she called the RN Supervisor at some point, it should have been sooner.
Impact, Emotions, and Perspective

Kathleen shared that this negative experience that was her first experience ever witnessing someone dying and the actual death. She shared how the experience was stressful, given the fact that the family was not handling it well with the yelling and shaking the resident. Kathleen also reflected on the issues surrounding this experience, her first death of a resident in the LTC setting. The family’s reaction made it difficult for her to contend with at the time.

She also explained how she had never encountered such an emotional response by family members and it was shocking to her. Kathleen also reflected on her feelings of going back to work, right after the emotional experience of dealing with the death of the resident:

Like I saw a quote or something this weekend, I screen shot it on my phone. It was from the TV show Scrubs. It was talking about, I don’t know if it was a doctor or a nurse has to walk in there and tell the family that that patient has passed and he has to walk out and spend the rest of the day at his job, but that family gets to spend the rest of the day to grieve. It was talking about medical professionals’ experience that and two seconds later go take care of somebody else. You really don’t really get to feel it right that moment, because at that moment, there is just so much paper work. You have to make so many notes, do so many things, call so many people, and then you start to feel it, and everything. It’s just, I don’t know, it’s very, it’s just weird. I don’t know how else to explain it. It is a very weird feeling.

In nursing practice, when a client is dying, the nurse cares for both the client and their family. Kathleen’s comments about her feelings, expressed another fact, which is that the nurses cannot attend to their own emotions about the fact that the client is dying until later on, after all of the work is complete. She had never experienced death and dying previously. This was totally a new experience for her and she really gained a great deal of insight from this experience. She acknowledged that it was easier to deal with after her first experience.

Subtheme: Unprepared

Kathleen stated that she did not feel prepared for this experience. She shared the following regarding her expectations:
I wasn’t anticipating the screaming, the hollering, the crying, the shouting, the shaking. I was not anticipating that at all. They had told me, when I took report that afternoon, you know, she doesn’t look good. She’s probably going to pass tonight. I was like “ok” and I was preparing myself, but seeing how the family reacted, that really, was just very difficult. I’ve learned now that people react differently, some people very differently.

Kathleen stated that she did not expect the emotions that the family had. She said that the death was not peaceful due to the family’s response. She also verbalized the kind of preparation that she would have liked to have in nursing school, stating,

I wish that our instructors would have given us more of their experiences. I don’t know if any of them ever worked in a nursing home or long term care facility, but, kind of hearing other peoples would have been good.

She also stated, “I only had 3 or 4 days in the nursing home in my third semester. It would have been nice to have had a longer time or spent a full week there would have been really nice.”

When asked about the kind of experiences that she would have liked to have to prepare her for her role, Kathleen said,

Just any experiences in general, when it comes to long-term care, or when it comes to your first resident who passes. I had one of my best friends in nursing school that was well she texted me the night that her first resident passed and she was just so upset. I had my first one pass with me, a couple weeks or a couple of days afterward. It was pretty soon afterward. I was able to call her and we comforted each other. I don’t think I was really prepared for that, mentally or anything like that. I wasn’t prepared to see someone pass. So, that would have been good, if we were kind of prepped on that more.

Kathleen was very specific about the fact that she did not feel “mentally” prepared to deal with the death and dying that she experienced in the LTC facility. She drew support from a peer that had similar feelings about her own experience. She acknowledged that she would have liked to have more exposure to stories about experiences and more clinical time in the LTC setting. She also said that she would have liked to have more preparation to deal with caring for a dying resident and their family.
Participant Experience

Lisa also spoke of her feelings of inadequacy in dealing with the death of a resident. She, like the other two participants felt unprepared for this part of their job. Lisa had dealt with her mother’s death and dying process, but this experience of being the nurse in the LTC setting was different for her. She brought up specific issues that concerned her and how she was able to cope with her feelings:

The first experience, the one that I had, she died; I was not on the shift. I just learned, when I went home, and already came back, oh she already passed away. So, it wasn’t that bad, but the second time, or maybe the third time, the third time that I had somebody pass away, during my shift, and I was the one who gave the Morphine Sulfate. It’s like a protocol there, like (for) comfort. For comfort, like just give them Morphine and I gave it. I told this to my RN Supervisor. I told her a few hours later and I told her, “I felt something in me. It’s not comfortable. I felt like I gave her, her Morphine to die.” I felt like I was an instrument for her to die faster. Something like that. I felt uncomfortable with it and that whole day, I was just not into anything. I felt just horrible.

Lisa’s comments about caring for a dying client reflected the fact that she did not feel prepared to care for the dying client. Death and dying is a common occurrence in the LTC setting.

Practical nursing students need preparation to care for people at the end of their life, particularly during the process of dying. Lisa did not understand symptom management at the end of life. She should have had more training regarding care of the dying resident. She also needed support during this situation.

Impact, Emotions, and Perspective

Like Kathleen, Lisa struggled with caring for residents who were dying. She felt concerned about being the last one to give medication to the dying resident, stating that she “felt like I was an instrument for her to die faster.” It was an uncomfortable situation for her, one that she had not experienced in her LPN program. Despite the fact that she is working in LTC, where residents are at the end of life, she had little preparation for this in her practical nursing program.
Most of the residents in the LTC facilities are over 65 years old. Many residents die in this setting. The NGLPN did not have a good understanding about pain management at the end of life.

Subtheme: Unprepared

The nurse needs knowledge on the death and dying process and the normal grieving processes that go along with providing nursing care for a dying client. Not only are nurses caring for the client, they are also caring for the family. The nurse also has the potential to encounter ethical dilemmas. In giving pain medication to a dying client, you may well be the last nurse to give the client pain medication before they die. Lisa struggled with this particular issue. She felt like she caused the death, when in essence the client was actively dying. Staff that deal with death and dying on a regular basis need to work through emotions that go along with their own grief. Lisa spoke of debriefing with her supervisor as she reflected on her experience and her conversation with her supervisor about her feelings regarding caring for this dying resident.

Participant Experience

Elizabeth, like the other two participants, spoke about how she did not feel prepared to deal with death and dying in the LTC facility. She shared one particular experience that was very stressful for her:

Now I have only had one person to actually die on my shift or that I took care of . . . He was only there for maybe that one day and I came back on my shift. I hadn’t even been in the room yet to check on everybody and they called the code. I had to go in there and do CPR. Now, I knew how to do CPR, of course, but I think it was the emotional part. Yeah, I guess you don’t know until you experience that for yourself, but it was a little difficult for me. It was hard, but the nurses around me, if it wasn’t for them, they helped a lot.

Elizabeth explained her feelings about her first resident’s death. Her comments reflected the fact that she did not feel prepared for the emotions associated with caring for the dying client. She
also explained that she did not know what to do when this occurred. Support from other nurses helped Elizabeth cope with the experience.

Impact, Emotions, and Perspective

The experience of caring for a dying resident affected Elizabeth. She expressed that she was definitely not prepared in school for dealing with death and dying. Her tone of voice changed throughout her telling the story, as though the remembrance and reflection affected her deeply. She spoke about the fact that the resident was a “sweet man” and he was “her resident,” and she felt that she needed to help him. She also spoke about how she felt supported by her CNAs in this particular situation. She used terms like frantic, emotional, and difficult to describe her emotions. She said that she knew that she needed to do CPR, described the situation as overwhelming, and stated that the other staff knew what to do, but she did not. She said that she does know what to do now, having had the experience.

Subtheme: Unprepared

Elizabeth stated, “Death, death, somebody dying, we didn’t get prepared for that in school.” When asked if she learned about death and dying in the practical nursing program, she said, “No, if so, it was very brief, like you clean them up afterwards.” Elizabeth said that the teamwork helped her deal with the situation. She said that her CNAs had been through these experiences before and they helped her. She also said that her RN supervisor informed the family and spoke to them after the death. She also said that she felt more prepared to handle her next experience.

Participant Representation of Theme: Relationships

Relationships emerged as a theme related to the NGLPNs positive experiences. All three of the NGLPNs spoke about positive experiences involving relationships with residents during
their transition from student to nurse. The NLN (2010) ECM spoke of Relationship-Centered Care as it “positions caring [and] therapeutic relationships with patients, families, and communities” (p. 27). Caring emerged as a subtheme of relationships. According to the NLN (2010), “Caring means promoting health, healing, and hope in response to the human condition” (p. 11). This definition was used to guide development of the ECM. Participant comments reflected this definition of caring.

Participant Experience

Kathleen shared her positive experiences in the LTC setting:

Every day something happens that just makes me smile and makes me happy. I don’t know, when a resident says, “You are my favorite nurse.” That’s really special or the first time I worked, I picked up a double and worked 3 to 11. On 3 to 11 [shift], you kind of tuck people into bed. “Night, love you” is what they say to you, “Oh love you too”. The first time a resident told me, they loved me, I was like, oh, I just feel so special. I would come in and [hear], “I am so glad you have me today.” That kind of stuff is always positive. I hear that every day, and it just makes me happy. Now I have a couple who live on my hallway, a married couple, who are my residents, and they just, [for example], I was recently out for surgery and they cried, while I was out. The wife cried because she missed me so much. Just coming back and seeing her, that was so much fun. It was just so rewarding.

Kathleen’s comments reflected that the relationships that developed with the residents in her care are important to her. The residents’ comments and reaction to her being out of work reflected their positive regard for her. She indicated that these relationships were “rewarding.”

Impact, Emotions, and Perspective

Kathleen shared the emotions that she felt when residents made comments to her regarding their feelings about her. She said that the remarks by the residents were special and made her realize that she was making a difference. She also spoke about how she tries to promote a better atmosphere for the residents.
Subtheme: Caring

Kathleen shared the following:

You think, “I’m not making a difference.” Just going through and trying to get stuff done and trying to keep a smile on your face and stay positive, which I try to do every single day. Be bubbly, be a bubbly person in kind of a gloomy atmosphere, because they don’t want to have to live there. They want to be home, and so when they say and they appreciate that and you see that you are trying to make a difference and you do! That’s really, really positive.

This reflected that the positive aspect of the experiences for Kathleen was the confirmation that she was making a difference through caring for the residents. Through her attempts to promote a better atmosphere for the residents, she was promoting health, healing, hope. She did this through striving to make the “gloomy” atmosphere better for the residents.

Participant Experience

Kathleen also shared how she worked to promote a better environment for the residents:

The other nurses and CNAs kind of get aggravated with me, they say I am showing them up, but for Christmas, I wrapped all of their doors with wrapping paper and made bows and put bows on the door. For Valentine’s Day, I covered all of their doors in white paper and hearts and everybody had a different valentines’ saying on their door. [For example], you’re a great catch and had a fish on it that I made. Just stuff like that. All 16 doors had different sayings and things. I gave them little goody bags and presents for Christmas, little presents for Valentine’s Day and Easter will be getting something. That kind of stuff is just fun and they love it. It is just like peppermint candy and a bracelet you spend a dollar on and they think it is like the best present ever. I gave all of the ladies’ bracelets for Christmas. They wear their bracelets every single day and so when I see their little bracelet that I spent a dollar on, it is just so much fun to see them (laughing). It is just cool that they really appreciate that and everything.

Kathleen shared how she worked to make holidays special for the residents on her unit. This experience reflected the activities that she carried out to improve the atmosphere for her residents. This activity was not a requirement of her job.
Impact, Emotions, and Perspective

Kathleen’s comments reflected her attempts to promote hope for her residents. She spoke previously about how she tried to make the “gloomy” atmosphere better for them. She shared how she worked to make the environment and atmosphere better for the residents. She said that she tried to make every holiday special for the residents under her care.

Subtheme: Caring

Kathleen had personal experiences of visiting her own grandparents in an LTC facility as a child. These memories reflect the positive and negative aspects of the setting. Kathleen shared her memories:

The only thing I remember about the nursing home growing up was like wherever my grandfather was . . . it may actually be the facility I am working at now, but I don’t remember that. It smelled horrible, like it smelled terrible and I was little and we only would go to celebrate his birthday and it was just stinky and it was like cold and I just remember not liking it. [I was] older when my great grandmother was in there. We would just go into the family room and it was a great nursing home she was in. She had some trouble with her memory and so they put leaves beside her door all the way to the dining room. So she could follow the leaves back and forth to her room and like to other rooms she went to and like she had different color, leaves and she knew which color of leaves to follow. So, I thought that was really sweet.

Kathleen’s memories on her experiences of visiting her grandparents reflected the negative and positive aspects of the LTC environment. Kathleen spoke about the impact that this experience had on her wanting to become a nurse:

I think later on it did, not then, but later on thinking back about it. Especially the way, like you know somebody took time to cut up leaves to show my grandmother how to get to the dining room. Thinking about that, like the little things. Thinking, ok, I can be that for somebody, I can be the person that cuts out leaves for somebody or whatever it may be.

Kathleen’s comments reflected her caring, as she stated that she wanted to be the person that promoted hope and health for the residents of the LTC facility. She realized that cutting leaves and doing other special things for the residents positively impacted their lives.
Participant Experience

Elizabeth shared about her motivation to go to work:

I don’t let a lot of things get to me. I just kind of brush some things off and continue to go through my day. When the patients, like I can be, like I can be on my way to work and not want to go. Once I get there, it is totally different, because you realize that you are taking care of these people and these people, for me make me want to work. I don’t know what it is, but I can be like aww, I don’t want to go to work today, but when I get there, I am fine.

Elizabeth’s comments reflected the fact that she had positive relationships with the residents on her unit. She spoke about the stressors that caused her to have feelings of not wanting to go to work. However, she said the residents were what made her want to go to work. She had developed relationships with the residents. She reflected on the relationships as positive aspects of her job. These relationships motivated her to work.

Impact, Emotions, and Perspective

Elizabeth reflected on her relationships with the residents. Although there were times when she lacked the desire to go to work, she felt motivated to work with the residents upon arriving. She attributed her motivation to the residents. She was speaking about the stresses that were associated with the job, but the fact that she cared about the residents helped her carry on in the role. When asked if the residents made the job positive for her, she stated, “they do, they really do.” She stated “you are taking care of these people” and she said that is what makes her want to work.

Subtheme: Caring

Elizabeth made a statement that sums up her perspective on nursing:

I think you have to be really special to be a nurse. I think you can be a really bad nurse, really easily, because, it’s, it’s just not for everybody. I don’t think that everybody has it in their heart to be a good nurse. I mean we can all be a nurse, we can give out pills, we can give out shots, but you got to have that special place in your heart to be a good nurse.
Elizabeth acknowledged that the skills do not necessarily make the nurse. She said that essentially anyone could do the skills, but that to be a good nurse, it involves having “a special place in your heart.” This reflected the caring attitude that helps one promote not only health and healing, but hope.

**Participant Experience**

Lisa shared about the positive aspects of her job:

A lot like loving more of my job, like the rewarding experience, when people doesn’t feel good and you like have to use all of you nursing skills (clapped) and your critical thinking skills and all the right tools and all the right communication skills that you can think of that you can use. You use this and you are pretty much kind of in charge of it, and then you make these people feel better afterwards and it’s a very, very positive experience. The family members appreciate you for that and the residents themselves appreciate you for that. Being appreciated for what you do to them is very rewarding. It is something that you cannot, you cannot say, “I am just here for nursing school for salary”. It makes you like, “I believe that I am here in nursing school because I love my job.”

Lisa’s comments reflected the fact that the positive experiences working in the LTC setting were related to the relationships that had developed through caring for her residents. Her comments reflected the fact that she was not just working there for money. She worked in the setting because she loved her job. She also mentioned that the experience was “rewarding.”

**Impact, Emotions, and Perspective**

Lisa shared her positive experiences in the LTC setting. She said that it she has the skills to use to make people feel better and stated that this is a “rewarding” experience. She said that being appreciated also makes the experience positive. Her statements reflected that fact that she used her nursing skills to promote health and healing for her residents.

**Subtheme: Caring**

Lisa shared her emotions about the experiences:

I love it, you know, so for me it’s like, I think it’s so corny to say “I am gonna make a difference in this world.” It is so corny, but this doing so, yea you are making a
difference, maybe not in the world, [but] someone’s life today and you are getting paid for it. You are getting paid for it. You are making a difference and you are getting paid for it. I mean why would I not love this job. It is very positive experience (laughing)! So, that’s what made me like every day, I want to go back to work.

Lisa’s comments reflected the NLN (2010) ECM core value of caring. Lisa said that she was motivated to go to work because she was making a difference for people. She said that she loved her job. She reflected on the fact that she was making a difference for people and she was getting paid to do it. This fact motivated her to want to go back to work and love her job.

Participant Representation of Theme: Feeling Supported

Feeling supported was also a theme that emerged from the NGLPNs positive and negative experiences. Each of the participants reflected on how feeling supported impacted their experiences as a NGLPN practicing in the LTC setting.

Participant Experiences

Kathleen shared the following regarding her RN supervisor at the LTC facility:

I look up to my RN supervisor so much. She’s on her feet all day running. I can ask her a question when there is any problem. She somehow always knows how to fix it. There are sometimes when she has to go above herself and ask the DON or someone else, whoever it relates to, but a lot of times, she can figure it out. She knows the medication. She knows how to fix it. Knows the tricks and trades and the secrets of the computer system that none of us know and just things like that. She knows, she’s so professional on the phone, and so well spoken and that’s something that I am not (laughing). So, I would love to have the interaction that she does with the nurse practitioners and our physicians and things like that. The CNAs, and the LPNs and the RNs, and just everybody knows that they can come to her and ask her anything. Also, she’s there for us, like not just an employee/coworker, she’s also a friend to all of us. So that’s just really nice. If I’m having a bad day, I can go to her. If she is having a bad day, she can come to me.

Kathleen’s comments reflected the fact that she felt supported by her supervisor. Her supervisor was supportive, and available when she was needed. This was a positive aspect of the practice experience for Kathleen.
Impact, Emotions, and Perspective

Kathleen spoke about the characteristics of her supervisor whom she admires. She said that her supervisor was someone she could count on to have the answers and help her problem solve regarding issues that arise on the unit. She described her supervisor as a leader that not only she, but other staff members, could come to for help. She went on to say,

I had a great, a great RN supervisor, and she was kind of a mentor to me and still is. She was like “ask me anything” and she taught me how to use my nursing judgment, how to be more confident in those decisions, believe in myself, and that I understand what I am doing, because I am the nurse (laughing).

She described her supervisor as a mentor and a friend. Her supervisor helped promote her dignity, motivated her to believe in herself, and led her to trust her knowledge as a licensed practical nurse. She was encouraged to ask her supervisor any questions. She also had a great deal of respect for her supervisor.

Impact, Emotions, and Perspective

Kathleen saw her supervisor as a role model. She aspired to be able to lead like her supervisor. She compared her supervisor to others with whom she has worked with in the facility:

I have worked with all the other supervisors, and a lot of them leave you out in the cold, and don’t help and that kind of thing. She has definitely been there to help me along and now that I do know. I am not saying that I know everything, but, a lot of things I do know, and now she can delegate more tasks to me. If she’s not here, people come to me to ask questions now, which is crazy to think about now, but they do.

Kathleen attributes her supervisor’s leadership to her successful transition. She said that she has worked with the other supervisors in the facility and that she does not get the same support from those supervisors. She said that people now come to her with questions and her supervisor can delegate more tasks to her.
Participant Experience

Elizabeth shared the support that she received from her RN supervisor:

I guess my supervisor. She made it a little bit easier for me. She would kind of comfort me if I had a question or maybe if that worker made me upset or something. She would kind of simmer, simmer the problem, I guess.

Elizabeth spoke of her supervisor when discussing positive experiences, during the transition to practice in the LTC setting. Lisa’s supervisor helped her deal with the negative aspects of transition.

Impact, Emotions, and Perspective

Elizabeth spoke about her supervisor helping her to resolve problems. She also commented regarding how she felt about her supervisor’s supportive comments, “My supervisor always tells me I caught on fast! I was glad to hear that.” She said that having her support made it “easier” to face the issues that she encountered during her transition to practice in the LTC setting.

Participant Experience

Lisa shared the support that she received from her supervisor and the impact that it had on her:

The first time I had that [trouble with a CNA not doing their job], I did not know the right way. I was scared that if I spoke out, this person gonna get in trouble. I don’t want them to get fired. That was the first in my mind. I don’t want anybody to get fired; but then the second time, I had to like well it’s gonna happen to me over and over again, if I don’t put my foot forward. So, the second time, yea, I did the right thing. It’s just tell the RN supervisor and I am glad I did, because I found that the people, my supervisors, were supportive of that. If they see that it is something that is not supposed to be done or something that you need to have it done correctly, then yes, they did it. Like they would support you. They have like help, pretty much help. They would pretty much make sure somebody is doing her job, her or his job. I was like, ok, and I was glad. That makes my job more easier and make me more happy also in my job.

Lisa felt supported by her supervisor during times that she needed help with the CNA not doing their job. Lisa mentioned this in regard to positive experiences in the LTC setting.
Impact, Emotions, and Perspective

Lisa was speaking about her issues with CNAs not wanting to do their job. She said that she did not report the CNA at first because she was concerned that the CNA would lose her job. However, after repeated issues, she decided to get her supervisor involved. She explained that she was supported by her supervisor and this made her job easier and made her happier in her job. She said that the supervisor helped her make sure that the CNAs were doing their job. She also said the following regarding her supervisor, “I love her!” She explained that her supervisor lets her have autonomy, but if she sees that she is behind or needs help with something, she helps her.

Lisa also said the following regarding her supervisor and leadership:

Leadership means that you have the initiative to deal with what is in there. Like, if you need vital signs, go speak up and ask somebody, where is the vital sign machine? Like be there. Be there [and] help out. That is pretty much the kind of leadership, the kind of supervisory role that I love with my supervisor. The kind of leadership that I love is the leadership in her. I know it because I have been trained in leadership, leadership skills, when I was in the plant work. It’s not like being bossy, like telling people what to do. It is pretty much showing and helping people how to do it, being there and that is the kind of leadership that I love. Not micromanaging, micromanaging, just letting you do stuff and like that.

Lisa shared her perspective on the leadership style that her supervisor had and why she liked it. Her supervisor was supportive and she was there when she was needed. Lisa worked as an industrial engineer in a manufacturing plant and she was trained in leadership skills. Lisa recognized that her supervisor had a particular style of leadership that help her succeed in doing her job. She said that the style involved “showing and helping.” It also meant that she was present when needed. This was a positive experience for Lisa that facilitated her transition.
Participant Representation of Theme: Personal Growth

The theme of personal growth emerged as a theme of the meaning of the experiences that the NGLPNS had in the LTC setting. Growth is defined as “the process of developing physically, mentally, or spiritually” (Oxford English Dictionary, 2016). The meaning that the participants drew from their reflection on the practice experiences was one of personal growth. All of the participants are preparing to enter into a mobility ADN program to become a RN in the summer. They will have worked for about 18 months prior to returning to continue their education. They all reflected on the fact that the experiences in the LTC setting made them want to further their education. They also reflected on the fact that they were glad that they had the opportunity to practice in the LTC setting as an LPN.

Participant Experience

Kathleen went on to explain how her LTC practice experiences facilitated her reconstructing her goals:

It’s definitely positive. I mean there are days that you get down on yourself and you think, “Oh gosh, I need to be a better nurse.” I need to do this or whatever it is, but it’s been such a positive experience. There is nothing that has been so overwhelming that has made me doubt my decision of going to the nursing home or going to a LTC facility or anything of that sort. . . . It definitely makes me want to get more, further my education. I love what I do right now, but then, I see my RN supervisor [and] I think, maybe I would like to do that or something. Have a little more, have more education, background, and experience to be able to, someone would come to me. I would know the answers to the questions. I could help somebody with their problems, with a new graduate or something like that. So, that’s really, that’s really neat to me, because I want to be the person that people come to, to ask the questions. I do kind of have that now, because I do orient new graduates and students that come through for their preceptorship.

During the last interview, Kathleen spoke of the meaning of her transition to practice experiences in the LTC setting. Despite the negative experiences, Kathleen said that she loved what she does. She also said that she now orients students and NGLPNs. She also spoke of her desire to get more education to be able to have more responsibilities and to be able to help others with
problems that they face in practice. She has been accepted to an associate degree nursing program to become an RN.

Impact, Emotions, and Perspective

Kathleen’s comments reflected her personal growth through her experiences as an NGLPN. Kathleen reflected on her overall experiences as a NGLPN and stated that it has been a “positive experience.” She also shared the following:

After I graduated and got my job, I learned a lot. I do know that . . . I’m more confident in my giving medications, more confident in my treatments, more confident in my nursing decisions, and nursing thought process and when the doctor needs called; when they don’t need to be called; when the supervisor needs to be involved; when they don’t.

Kathleen’s comments reflected the fact that she continued to learn, after graduating, which is in line with Benner’s (2008) novice to expert theory. According to Benner, new graduates are not considered fully competent. They need practice experiences to facilitate competency development.

Participant Experience

Elizabeth reflected on her experiences as an NGLPN:

I feel good about it. I mean I have had some good experiences. I think I made the right decision. I think it is for me. I have had a lot of good experiences and bad experiences, but I have learned from a lot of things within a year of working from now. From last year, I feel like I am a great nurse compared to where I was when I first started. You just learn how to do things. You learn your way of doing things. You just make sense of a lot of stuff throughout the time of working. This experience is definitely going to make me continue my education to get my RN and to get my BSN and MSN.

Elizabeth spoke about the learning experiences that she had during transition to NGLPN. She reflected on the positive and negative experiences and stated that she feels like a great nurse now, compared earlier in the transition to practice.
Impact, Emotions, and Perspective

Elizabeth shared that she is starting a mobility associate degree nursing program this summer. She stated that she felt that she will be more successful based on experience obtained as an LPN. Although she shared that she wants to go work in a hospital to gain more experience with nursing skills, she said that she would encourage other nursing students to go the same route that she went. Her comments reflected her personal growth. She reflected on positive and negative experiences and concluded that she was glad that she had gone the LPN route and that she planned to further her education to the MSN level.

Participant Experience

Lisa also shared how her experiences as an NGLPN influenced her plans for the future:

It made me want to go back to RN program, like that’s why I am going back to RN program this May. I know this is what I want to do. That positive experience I have from my job, from nursing job, it made me like maybe in the future, I am gonna go to BSN program.

Lisa also spoke of her experiences and stated that they were positive. Although she shared many negative experiences about her transition experiences, during the last interview, she surmised that she knew that this is what she wanted to do. She was also motivated to increase her education. This reflects her personal growth.

Impact, Emotions, and Perspective

Lisa, like the other participants, was starting a mobility ADN program this summer. She reflected on her experiences as an NGLPN, the positive and the negative, and surmised that her experiences have been positive overall. She relayed that the experiences as an NGLPN made her want to further her education. She said that she wants to continue to a bachelor’s degree in nursing program. Her comments reflected her personal growth.
Research Questions Answered

The themes and subthemes that emerged from the study are seen in Figure 2.

Intimidating and disruptive behaviors and death and dying are on the bottom layer of circles. Overlapping these circles are circles reflecting the positive themes of relationships and feeling supported. The subthemes link the positive and negative themes as follows: self-determination links intimidating and disruptive behaviors with feeling supported; human dignity and integrity link intimidating and disruptive behaviors to relationships; caring links relationships to death and dying; and unprepared links death and dying with the theme feeling supported. The center circle links the themes of positive and negative experiences to reflect the NGLPNs’ personal growth. The subthemes connect the themes related to the positive and negative experiences to the theme personal growth. Personal growth is the theme of the broad research question reflecting the lived experiences of transition to practice.

![Figure 2. Transition to Practice for NGLPNs Working in the LTC setting.](image-url)
The research questions are answered in the following section. The narrow research questions will be answered first. Then, the broad research question will be answered.

The first narrow research question was what negative experiences did the NGLPN have during transition to practice in the LTC setting? Themes that emerged from negative experiences were intimidating, disruptive behaviors, and death and dying.

The NGLPNs reflected on different types of intimidating and disruptive behaviors experienced when they were practical nursing students. Primarily, behaviors during their education were directed from LPNs. Although two NGLPNs spoke of witnessing intimidating and disruptive behaviors directed toward residents and between LPNs and CNAs. After graduating and entering practice, NGLPNs reflected on intimidating and disruptive behaviors received from CNAs, LPNs, resident family members, and physicians. Only one NGLPN spoke of experiencing the behaviors directed by physicians.

Intimidating and disruptive behaviors interacted with positive themes of relationships and feeling supported. For example, NGLPNs spoke of coping with intimidating and disruptive behaviors. Relationships that NGLPNs developed with residents of the LTC facility helped facilitate coping during transition to practice. Although NGLPNs experienced intimidating and disruptive behaviors from coworkers and resident’s family members, NGLPNs consistently spoke about relationships with residents as personal motivation to continue to want to work in the setting. The motivation resulted from the NGLPNs integrity and respect for human dignity of the residents.

One example of how themes and subthemes overlapped is when Kathleen spoke about a resident’s daughter who yelled, cursed, and threatened her. Kathleen spoke of the impact from this negative experience. She relayed this as the worst day. She spoke of crying all the way
home. She also said she did not tell her parents that she cried every day on the way to work for weeks. Other intimidating and disruptive behaviors contributed to her emotions. Although Kathleen experienced negative behaviors as a student nurse in the clinical in the LTC setting, she still wanted to work in LTC as an LPN to help residents. She told her parents that residents need a better environment. Her caring attitude motivated her to improve the environment for residents. Kathleen consistently engaged in activities that were not required such as decorating for holidays and purchasing inexpensive holiday gifts for 18 residents.

The subthemes of integrity and human dignity linked intimidating and disruptive behaviors to relationships. Integrity was defined by the NLN (2010) ECM as “recognizing with humility, the human dignity of each individual patient, fellow nurse, and others, whom we encounter in the course of our work” (pp. 12-13). Human dignity was addressed in the ANA (2015a) Code of Ethics in Provision 1, “The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1). Kathleen’s actions and comments reflected these values. Although CNAs directed intimidating and disruptive behaviors toward her early in her transition, she attempted to build rapport and eventually was able to do so. These same attributes assisted Kathleen to overlook the intimidating and disruptive behaviors from the resident’s daughter. This demonstrated Kathleen’s respect for the human dignity of the resident and her daughter. All of these actions reflected Kathleen’s integrity. Her goal was to support the resident, working towards supporting their dignity.

Feeling supported emerged as a theme related to positive transition experiences. All of the NGLPNs spoke about having supportive RN supervisors who helped facilitate transition to work. The NGLPNs communicated that supervisors were available to enable coping with the situations encountered. This theme also interacted with the theme of intimidating and disruptive
behaviors. The subtheme of self-determination linked intimidating and disruptive behaviors to feeling supported. Self-determination enabled the NGLPNs to seek help when needed. Supervisor’s helped NGLPNs address intimidating and disruptive behaviors that they did not feel prepared to handle.

Another theme that emerged from the negative experiences was death and dying. Unprepared was a subtheme, as the three NGLPNs reflected on the fact that they did not feel prepared to deal with death and dying of residents. The NGLPNs spoke of difficulties encountered in dealing with family member’s emotions and personal emotions involved with caring for their first dying resident. This theme linked to relationships and feeling supported. Despite feeling unprepared, NGLPNs coped with experiences of caring for their dying clients. Lisa and Elizabeth spoke of getting help from their supervisors, during their first experiences with a resident’s dying and death.

Kathleen was not working her normal shift, when she had her first experience caring for a dying resident. Although Kathleen did not receive the same support that she usually received from her supervisor, this was not her typical shift and she had only worked in the facility for a few weeks at the time. She was not familiar with the routine and she was the nurse, primarily responsible for the residents on the unit.

Kathleen’s first experience with death and dying in the LTC setting was one that was not peaceful. Although Kathleen developed a rapport with the family and she worked to support them through the process, the family did not cope well. Kathleen lacked knowledge and experience needed to handle the situation. Calling the evening RN supervisor sooner could have facilitated a more peaceful experience for both resident and family. Hospice was available for this resident as well. Hospice agencies have RNs, chaplains, and social workers on call to help
with such issues. However, Kathleen lacked the experience and understanding to facilitate the process. The RN supervisor was not aware of the issue, as the LPN has to make them aware of problems requiring RN intervention. This issue resulted in the LPN handling issues that are potentially outside of their scope of practice.

Lisa also experienced stress in her first experience with the death of a resident. She had uncomfortable feelings about being the last nurse to administer Morphine before a resident died. She spoke to her RN supervisor about those feelings after the experience. This situation demonstrated how death and dying and feeling supported interacted. Lisa’s understanding of the discussion with her supervisor was that she would get used to this process and this has to be done for a resident during the dying process to prevent suffering. The subtheme of unprepared was highlighted in this situation, as Lisa needed more understanding about the dying process and her role in caring for a dying resident. This demonstrated an unmet need for the NGLPN. Training and support were essential to provide quality care to dying residents. This training was needed both during the practical nursing program and while transitioning to practice.

The second narrow research question was what positive experiences did the NGLPN have during transition to practice in the LTC setting? Relationships and feeling supported emerged as themes of positive experiences for NGLPNs. The subtheme of relationships was caring. Each NGLPN spoke of how they promoted health, healing, and hope for their residents and how this caring process enabled them to cope with work related stress of dealing with dying residents. Relationships formed with residents dealing with aging bodies and chronic health conditions motivated NGLPNs to continue working in LTC despite negative experiences encountered.

The NGLPNs also reflected on feeling supported by supervisors who facilitated coping with death and dying. The supportive climate facilitated flourishing for NGLPNs despite
negative experiences encountered. Supervisors’ encouragement and “being there” empowered NGLPNs to overcome work-related stress such as intimidating and disruptive behaviors and feeling unprepared to handle death and dying.

The broad research question was what was the lived experience of transition to practice for NGLPNs working in the LTC setting? The NLN (2010) ECM outcome of HF for the LPN is “to promote the human dignity, integrity, self-determination, and personal growth of patients, oneself, and members of the healthcare team” (p. 33). Although the NGLPNs encountered negative and positive situations in the LTC setting that had an impact on their transition to practice, the NGLPNs comments reflected achievement of human flourishing. This process occurred over time, during the transition, and was facilitated by NGLPN’s caring, self-determination, human dignity, integrity.

Feeling supported and relationships also contributed to personal growth. Despite negative experiences NGLPNs faced through intimidating, disruptive behaviors, and feeling unprepared for death and dying, the NGLPNs’ mean drawn from the experiences reflected personal growth. During the last interview, each NGLPN reflected on transitioning to work in the LTC setting. Personal growth was embodied in the meaning of the transition to practice experiences. Each NGLPN had plans to start an associate degree nursing program to become an RN in the upcoming months. Although two of the NGLPNs started to school with plans to attend a baccalaureate in nursing program, they indicated that they were happy that they had the opportunity to work as an LPN in the LTC setting. They also spoke of learning during the process and adapting to challenging situations with the support of supervisors.
Summary

In this chapter, the researcher introduced the findings from the thematic breakdown of the data obtained, while exploring the NGLPNs’ lived experiences of transition to practice working in the LTC setting. The research questions and designated themes guided the researcher to make sense and answer the questions.

The themes of intimidating and disruptive behavior, and death and dying emerged from the negative experiences. The subthemes of self-determination, integrity, and human dignity emerged from intimidating and disruptive behaviors. Relationships and feeling supported emerged during analysis of the positive experiences. Personal growth emerged as a theme related to both the positive and negative experiences. The subthemes were found to be consistent with development of the NLN (2010) ECM graduate competencies related to the outcome of HF (human dignity, integrity, self-determination, and personal growth of patients, oneself, and members of the healthcare team), as reflected in the dialogue about the participant comments. The participants’ subjective understanding of the experiences helped the researcher understand issues reflecting on the NGLPNs’ transition to practice. Chapter V includes a discussion, implications, limitations, and recommendations for future research.
CHAPTER V
DISCUSSION, LIMITATIONS, AND RECOMMENDATIONS

Discussion

This study applied interpretive phenomenology in order to understand lived experiences of transition to practice for NGLPNs working in the LTC setting. This study opens the dialogue among practical nurse educators and nursing administrators of LTC facilities about the subjective meaning of the transition experiences for NGLPNs working in the LTC setting. The data analysis and the research questions were carefully considered in order to interpret the meaning of NGLPNs’ experiences in the LTC setting. The literature was reviewed in regard to the themes.

Negative Aspects of the Transition to LTC

Feng, Chen, Wu, and Wu (2011) found that new graduate RNs experienced uncivil behavior from peers during the transition to practice. A significant finding associated with the NGLPNs’ negative transition experiences was that NGLPNs encountered intimidating and disruptive behaviors in the LTC setting. The intimidating and disruptive behaviors were directed from family members of the residents, CNAs, LPNs, and physicians. The NGLPNs in the study witnessed intimidating and disruptive behavior in the LTC setting. They spoke of these issues when questioned about negative experiences encountered in transition to the LTC environment as a student and as a nurse. Multiple behaviors fell into the category of intimidating and disruptive behavior as noted by the ANA (2015b) and The Joint Commission (2008). Specifically, NGLPNs spoke of LPNs disregarding questions and comments in the LTC during first semester clinical experiences. The NGLPNs witnessed foul language, disruptive, and
intimidating communication between the staff (LPNs and CNAs). The NGLPNs also observed these actions directed towards the residents during initial clinical rotations in the setting.

After transitioning to work in the LTC setting, NGLPNs spoke of behaviors such as the CNAs not being receptive to their requests for help or not carrying through with assigned duties. The CNAs also told Kathleen, “We do what we want.” Staff LPNs orienting new LPNs were noted to have a “mean attitude.” Elizabeth stated that the staff LPN that followed her reported her for every mistake that she made. Lisa spoke of doctors disregarding concerns that she had about residents. One of the physicians stated, “I have like three seconds to listen to this.” Kathleen spoke of family members of her resident threatening, yelling, and cursing her.

Both the Joint Commission (2008), the American Nurses Association (2015), and the Center for American Nurses (2008) have issued statements regarding this problem in healthcare settings. These organizations all agree that these behaviors negatively impact quality of care.

The intimidating and disruptive behaviors, as defined by the Joint Commission (2008), are very similar to other terms used to describe similar behaviors in the workplace. According to Lachman (2015), “Incivility, bullying, and horizontal/lateral violence are examples of workplace mistreatment that injure individual nurses and the ethical climate of the organization” (p. 58).

Incivility is another term reflecting intimidating and disruptive behaviors in the workplace. According to the American Nurses Association (2015),

Incivility can take the form of rude and discourteous actions, of gossiping and spreading rumors, and of refusing to assist a coworker. All of those are an affront to the dignity of a coworker and violate professional standards of respect. (p. 2)

The American Nurses Association (2015) has also addressed the problem in the workplace with a new position statement, *Incivility, Bullying, and Workplace Violence*. Their position is:

RNs and employers across the health care continuum, including academia, have an ethical, moral, and legal responsibility to create a healthy and safe work environment for
RNs and all members of the health care team, health care consumers, families, and communities. (p. 1)

The ANA (2015) viewed the issue related to the intimidating and disruptive behaviors as an ethical issue. The ANA (2015a) Code of Ethics speaks to the issue of incivility, indicating that the RN is to “create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect” (ANA, 2015a, p. 4). Although the ANA (2015a) Code of Ethics applies to RNs, the ANA asserted that this issue is applicable to all healthcare workers and stakeholders, stating that “stakeholders who have a relationship with the worksite also have a responsibility to address incivility, bullying, and workplace violence” (p. 1). In their position statement, Incivility, Bullying, and Workplace Violence, the ANA (2015b) asserted that nursing will no longer tolerate these behaviors in nursing practice.

The Center for American Nurses (2008) asserted that all healthcare organizations should adopt a zero tolerance for lateral violence and bullying. They also emphasized that these organizations should adopt educational and behavioral interventions to help nurses deal with these behaviors.

The NGLPNs spoke of the feelings that they had because of the intimidating and disruptive behaviors experienced in the LTC setting. Curtis, Bowen, and Reid (2007) studied horizontal violence experiences for 152 BSN students with a questionnaire and found themes of “humiliation and lack of respect, powerlessness and becoming invisible”. The NGLPNs spoke of similar feelings, resulting from the intimidating and disruptive behaviors in the LTC setting.

Kathleen spoke of several instances where she felt disrespected. The first time she mentioned this was in regard to her LTC clinical experiences as a practical nursing student. She stated that she felt like the LPNs disregarded her comments due to the fact that she was a student
and she realized how a student can slow the nurse down. Kathleen also felt disrespected by the CNAs, when they refused to help her with care of a resident when she asked them to help. The other situation occurred when a resident’s family member threatened, yelled, and cursed at her shortly after her orientation ended. Kathleen stated that she felt like this was due to the resident’s declining condition, which the family member blamed on Kathleen and threatened to call the state to report her. Kathleen spoke of how she reacted to this treatment. She cried all the way home. She said that she cried on the way to work every morning for several months after starting her position in the LTC setting. The intimidating and disruptive behaviors had a negative impact on her transition to the LTC setting.

Elizabeth also spoke of several instances of feeling disrespected during her transition to the LTC setting. The first occurrence was when she was in orientation. She said that the nurses on the unit were “mean looking, just mean” on her first day to the rehabilitation unit. The other instance was with a nurse on the unit who was very intimidating, looking for all of her mistakes, and reporting her to her supervisor for anything that she missed or did not handle right. She said that these issues have come up since that time with a nurse on her unit and she has chosen to educate her. Elizabeth said that she found herself having feelings of not wanting to go to work. She said if the nurse was not there, she felt a lot better.

Lisa also spoke of feeling disrespected and invisible during her transition to the LTC setting. She spoke of treatment by the CNAs: “I got yelled and cussed, and asked to get out of the room at one point. It made me cry, I’m like, oh my gosh, what have I gotten in to.” She also spoke of how she felt disrespected when some LTC staff in the kitchen asked her why she was eating with a fork and not chop sticks, since she was Chinese. She spoke of feeling invisible when she wanted to speak to some of the doctors about her residents. She said that she was the
nurse working with them every day and she felt like she knew her residents well. She said that in one situation, the doctor said, “I have like three seconds to listen to this.”

The intimidating and disruptive behaviors in the workplace have an impact on the organization and resident outcomes and “when these behaviors are allowed, nurse job satisfaction and even retention are affected” (Lachman, 2015, p. 41). Aiken et al. (2011) also found a connection between work environment, staffing, and safety outcomes for the patients.

Some of the instances of intimidating and disruptive behavior was by CNAs toward the NGLPNs. According to Corazzini et al. (2011), the regulation of LPN practice by nurse practice acts influenced quality of care. Corazzini et al. (2011) studied LPN supervision and delegation in NPAs for all 50 states and the District of Columbia, comparing results to the CMS data for US LTC facilities. They found that the states where the NPAs did not allow LPNs to supervise and delegate had better quality outcomes. Licensed practical nurses generally have 3 semesters of education. The curriculum usually involves therapeutic communication skills, but with the amount of content to teach in the 3 semesters, the time is limited. NGLPNs need more education on supervision and delegation when that is an expected role.

Communication is an important aspect of practice for nurses. Ortiz (2016) found that new graduate RNs, both associate and bachelor’s degree prepared, had issues with communicating in the acute care setting. These nurses spoke of instances of communication difficulty with the patients, physicians, and preceptors. Ortiz found that this takes time and the new graduate nurses needed to make mistakes in order to develop this skill. The NGLPNs noted similar issues with communication. Recall from Chapter IV, Kathleen was discussing her communication issues with the CNAs on her unit. Kathleen stated, “Just trying to find that happy medium and to find that happy medium that took just a little bit.” Lisa stated, “Getting exposed and learning on
techniques for communicating with the residents, because it was intimidating at first.” Lisa also said the following regarding communicating with the CNAs, “You just have to learn that to communicate properly with them and still treat them with dignity and make more unity.” Elizabeth indicated that she did not have any problems communicating with the CNAs. The NGLPNs comments were in line with Ortiz’s (2016) findings. These findings were in line with the learning that is gained through socialization to a new environment. Positive relationships with colleagues positively influence recruitment and retention of new graduate nurses (Martin & Wilson, 2011; Thrysoe, Hounsgaard, Dohn, & Wagner, 2012).

A study on RN and LPN transition to practice to nonhospital settings determined that transition to practice programs need to be tailored to settings. Spector et al. (2015b) also found that the LTC facilities were reluctant to participate, but had the highest turnover rates. They also said that ongoing engagement with the LTC facilities was a challenge because of some of the CMS regulation changes that occurred at the time. The study was a qualitative, descriptive study that used telephone interviews and focus group sessions. Although the turnover rate was 35% for LTC facilities, the TTPM group had better retention rates (40% as opposed to 29%) than the control groups in the LTC setting (Spector et al., 2015b). They used the same modules used in hospital settings in nonhospital settings for the RNs. Nurse educators who educated LPNs modified the modules for the LPNs. However, Spector et al. (2015b) also found that one size does not fit all for the program and that the modules needed some content specific to the setting.

The NGLPNs practicing in LTC in the current study did not have a formal transition program during their transition to practice in the LTC setting. They each spoke of having approximately 2 weeks of orientation, including about 2 days in the classroom and the rest of the time on the nursing units, working with more experienced LPNs. The NGLPNs described their
experiences orienting with LPNs. Kathleen said, “There are some nurses who do not want an orientee and they let that be made known.” Elizabeth described her orientee as “mean looking” and she stated that this described their attitudes. Lisa said,

There is actually some of the nurses here that are new, they don’t last. I was wondering if that’s part of it too. They don’t last. They just don’t stay and so we keep on hiring people and keep on hiring people.

This participant alluded to the fact that the lack of an effective orientation process could have had a negative impact on the NGLPNs retention.

Bauer and Erdogan (2011) defined organizational onboarding, a process through which new employees move from being organizational outsiders to becoming organizational insiders. They assert that the process of socialization through this onboarding can improve retention of new employees, when it is effective. This process would provide the employees with support to deal with the intimidating and disruptive behaviors encountered through their transition to the practice setting. There was no evidence to support the fact that LTC facilities have transition to practice programs. The NGLPNs in the current study received about 2 weeks of orientation.

Phillips, Esterman, and Kenny (2015) studied organizational socialization theory. They modified a theory developed by Bauer and Erdogan (2011). Phillips et al. (2015) found that effective socialization occurred for new graduate nurses through a continuous and enduring transition program that continued for 1 year. The new graduates’ transition was effective, when the new graduates received feedback in a respectful manner that focused on improving their confidence and competence.

The NGLPNs in the current study felt supported by their RN supervisors. Despite the fact that they had a limited orientation process, they each spoke of the positive aspect of their job being the support that they received from their supervisors. This was different form their
experiences with the nurses that oriented the NGLPNs. The NGLPNs also reflected on their experiences of having inconsistent preceptor assignments. They spoke of rotating to different units in the LTC setting every few days. The LPNs orienting the NGLPNs also exhibited intimidating and disruptive behaviors toward the NGLPNs.

Another negative theme that emerged was death and dying. The subtheme was unprepared, as the NGLPNs spoke of not having experiences with death and dying within their practical nursing program. Only one NGLPN had experienced the death of a loved one, Lisa was the caregiver for her mother, when she was dying in the Philippines.

The NGLPNs did not care for a dying client during their brief clinical experiences in the LTC setting. The students went to the LTC setting about 4 days during their first semester, focusing on ADL care. They went to the LTC setting for approximately 4 days during the last semester of their LPN program with the focus being on shadowing the LPN. The NGLPNs did not care for a dying client during their acute care clinical experiences. The primary concerns of the NGLPNs regarding death and dying related to the emotional issue of caring for the family members, during this time.

The NGLPNs also spoke of issues with their own emotions, during and after the experience of caring for their resident and family members. Recall from Chapter IV that Kathleen mentioned how the first death that she experienced was not peaceful. She said that this was because of the reaction of the family members. Kathleen said, “I wasn’t anticipating the screaming, the hollering, the crying, the shouting, the shaking. I was not anticipating that at all.” She went on to say, “I don’t think I was really prepared for that, mentally or anything like that. I wasn’t prepared to see someone pass. So, that would have been good, if we were kind of prepped on that more.”
Lisa also shared about her feelings about caring for her dying resident. Her concern was with being the last nurse to administer Morphine to the dying resident. She stated, “I felt like I was an instrument for her to die faster.” Lisa was very conflicted about this issue when caring for the dying resident. She stated that she spoke to her supervisor about her concern and her supervisor explained that it is necessary to administer the medication in order to prevent the resident from suffering during the dying process.

Elizabeth had concerns about her first and only resident’s death, because she stated that dying is not a usual occurrence in the rehabilitation setting of the LTC facility. She said, “Death, death, somebody dying, we didn’t get prepared for that (laughed) in school.” She stated that she felt unprepared, but the other staff, including her supervisor helped her. She said that that helped a lot. She also said, “Now, I knew how to do CPR, of course, but I think it was the emotional part.” She said that she was not prepared for the emotional part of the death experience. She was speaking about her own emotions.

Anderson, Salickiene, and Rosengren (2016) studied the experiences of bachelor’s prepared nurses with 6 months to 2 years of experience in the setting. The aim was to describe the experiences of the nurses caring for dying clients. Similar to the current study, they found that these nurses were “personally affected by caring for a dying client and they did not feel prepared for this experience” (Anderson et al., 2016, p. 146). They also found that being supported by nurses with more knowledge of caring for clients and family members at the end of life helped. Two of the NGLPNs, Elizabeth and Lisa, spoke of talking to their supervisor regarding their feelings about caring for dying clients. One of the NGLPNs, Kathleen, spoke of reflecting on the experience with a friend, after they had both experienced the death of their first client.
Anderson et al. (2016) found that the nurses “describe strategies to manage their feelings, e.g., by talking to colleagues and friends outside work” (p. 147). They also found that caring for clients having peaceful deaths was more satisfying for the nurses. Kathleen shared that the difficult part of caring for her resident that died was the fact that the family’s reaction prevented the client from having a peaceful death. Kathleen also spoke about getting support from a classmate that worked in another LTC facility, after they had both experienced the first death of a resident.

Feeling unprepared to care for dying clients and their family members is not a new issue. Feeling unprepared, due to not having adequate practice experience and no exposure to death and dying during their nursing education, new graduate nurses feel uncomfortable in providing care for dying patients and family members (Anderson et al., 2016; Caton & Klemm, 2006; Sherman et al., 2005).

The American Association of Colleges of Nursing’s End-of-Life Nursing Education Consortium (ELNEC) project is a national education initiative to improve palliative care. According to the American Association for Colleges of Nursing (2016),

The project provides undergraduate and graduate nursing faculty, CE providers, staff development educators, specialty nurses in pediatrics, oncology, critical care and geriatrics, and other nurses with training in palliative care so they can teach this essential information to nursing students and practicing nurses.

Dobbins (2011) found that an End of Life Nursing Education Consortium (ELNEC) curriculum-based elective course, which included lecture/discussion, field trips, and the viewing of Wit, a film about a 48-year-old female professor, diagnosed with terminal cancer, significantly decreased aspects of death anxiety and improved the attitudes of nursing students toward caring for dying patients. The NGLPNs in the current study spoke of having minimal content in their curriculum on end of life issues.
Positive Aspects of the Transition to LTC

The positive aspects of the NGLPNs’ transition to the LTC setting involved having relationships and feeling supported. A subtheme of caring emerged from the relationship theme.

Relationships emerged as theme of the positive experiences in transitioning to the LTC setting. The Apprenticeship for Relationship-Centered Care “positions caring, therapeutic relationships with patients, families, and communities and professional relationships with members of the health care team at the core of nursing practice” (NLN, 2010, p. 27). The NGLPNs spoke of the relationships that they encountered in the LTC setting. Their experiences were similar to those found by Knecht et al. (2015) that studied LPN job satisfaction and dissatisfaction in the LTC setting. Their sample included LPNs with 0-2 years of experience up to 20 years of experience. Those participants with 0-2 years of experience constituted only 8% of the study sample.

Value was one of the themes that emerged from the study by Knecht et al. (2015). Value involved “how the words and actions of residents, family members, and administrators contribute to their satisfaction” (Knecht et al., 2015). This related to how the current study participants indicated they felt in regard to relationships on the unit.

Recall from Chapter IV the comments about relationships with the residents. Kathleen stated how the comments from her residents made her feel. She said that the residents made her feel “special” through their response to her decorating their doors and giving special gifts. She spoke about a resident that cried when Kathleen was out of work for surgery and the residents were so excited to see her return. She also reflected on the residents saying “love you” at night before bedtime.
Lisa also spoke of her relationships with the residents that she cared for, promoting her satisfaction. She seemed amazed that she could get payment for making a difference in the lives of the residents. She said that she has the opportunity to make a difference in someone’s life and she gets paid.

Elizabeth had similar thoughts on relationships. She reflected on times that she does not want to go to work. She said that when she arrives at work and starts caring for the residents, she regains motivation to be there. The residents are her motivation to work in the setting.

Real connection, another aspect that brought satisfaction to the LPNs, was defined by Knecht et al. (2015) as: “A relationship based on a deep, ongoing bond with residents, families, and coworkers. A team-like atmosphere in which people provide mutual support, was described as essential for job satisfaction” (p. 19). This aligned with the NLN (2010) ECM Apprenticeship for Teamwork. Teamwork, according to the ECM, “means to function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality patient care” (p. 30). The NGLPNS not only demonstrated a connection with their residents, they also spoke of how they developed effectively to be able to work with the interprofessional team members.

Kathleen spoke of how her relationship with her CNAs required some work, during the transition, but stated,

They [the CNAs] taught me how to do things, when it comes to changing linens and things like changing people to make it easier on myself. You know we are taught that in school, but they teach me the tricks of the trade and things like that. I always tell them, “You need to go back to school, go back to school!” We have great relationships now with all of my CNAs.

Kathleen spoke of how she had developed a great relationship with her CNAs. She spoke of how they helped her learn how to do some things that she found difficult, like in cleaning her
residents. She also spoke about how she encouraged her CNAs to go back to school. Kathleen also spoke of the bond that she developed with her RN supervisor and the Nurse Practitioners that she worked with on the unit.

Lisa spoke of similar relationships that made her transition easier:

Yes, there are a lot of supervisors that are willing to help you and even just not the supervisors. It could be a housekeeper. It could be some kind of information that you need and how you could take care of your residents or your patients. It could be a janitor, a maintenance, but they are there. If you need help, they are there to help you. It could be in the kitchen. It could be a dietary manager. It could be anybody in the work field. It could not be just the nurse, even the residents themselves or the family members themselves, they could help you out too. It’s just on, you pretty much have to learn how to communicate.

Lisa’s comments also reflect her self-determination to find help for situations occurring in the LTC setting. She indicated that she could always find resources to help her handle issues on the LTC unit.

Lisa also reflected on her thoughts about the impact of these experiences:

If there are some people at work that you look forward to working with, man, that could make a big difference in going back to work. But if you don’t like the people that you work with, I mean it’s hard to be happy. You kind of like have to force yourself to have positive attitude and put yourself back to work, even though you feel like, “I don’t want to work with these people.” These are you coworkers. You gotta learn to open up to them and not everybody can be receiving to you and it’s ok. You just pick somebody that would like you back and would help you out, and you would help them. It’s teamwork.

Lisa’s comments reflected how she developed a positive relationship that made her want to go to work. Her comments reflected the idea of having a real connection, which she said can make you want to go to work.

Elizabeth’s comments about her transition experiences also reflect how she made real connections:

I think other people [those NGLPNs that did not make it long in the LTC setting], it’s not the patients, it’s not the residents, it’s the people that they work with. That is why they
didn’t make it throughout the year. I think that it is the environment as far as their supervisors [and] as far as their CNAs. I think they make it hard for the nurses to work. Elizabeth’s comments reflected her ideas about why other NGLPNs did not make it the entire year in the LTC setting. She also said that her supervisor made it “easier” on her. She indicated that the nurses that resigned did not receive the same kind of support that she received from her supervisor.

Having real connections with their supervisors and administrators contributed to satisfaction for the LPNs (Knecht et al., 2015). The NGLPNs also reflected on how “feeling supported” contributed to their positive experiences. The common theme that emerged for the NGLPNs in the current study was the fact that they each had supported supervisors.

Mutual dialogue and empowerment are characteristics that Rubin et al. (2009) studied. The study supported development of a model of communication between nurses, RNs and LPNs, and nursing aides, or unlicensed assistive personnel, including “active listening, compassion, respect, trust, empathic curiosity (knowing peoples’ stories), intuition, need to be understood, cultural sensitivity, and nonjudgmental attitudes” (p. 830). This is a method of communication have benefited the participants.

Kathleen share about her reflection on her transition to practice. She was empowered by her RN supervisor and she also empowered her CNAs and orientees. Elizabeth and Lisa also spoke of empowering their CNAs on the unit. Kathleen said that her RN supervisor taught her how to critically think. She said that she would catch herself saying, “I need to get a nurse” and quickly reminded herself that she was the nurse. She said that her RN supervisor also encouraged her in this manner. Lisa spoke of feeling empowered, when her RN supervisor allowed her to have more responsibility. Elizabeth said that her supervisor encouraged her and that she encouraged her peers and CNAs.
Transition to Practice in the LTC Setting

As a nurse educator and former LPN educator interviewing the NGLPNs, the nurse researcher was able to help the NGLPNs draw meaning from their experiences. The three interview structure facilitated this process. Anecdotal stories were used to facilitate generation of the meaning for participants’ experiences of transition to practice. Van Manen (1990) asserts that “anecdotes can be understood as a methodological device in human science to make comprehensible some notion that easily eludes us” (p. 116). Van Manen (1990) emphasizes that including anecdotal narrative in phenomenological writing creates a “tension between the prereflective and the reflective pulls of language” (p. 121). Van Manen (1990) states the outcome is illuminating the “structural features of the phenomenon” as a way to make the essence of the phenomenon visible.

The meaning that was drawn from the essence of the participant stories was personal growth and human flourishing. During the final interview, the NGLPNs were asked the following question, how do you make sense of your practical nursing experiences in the LTC setting? Personal growth and HF was a theme that emerged as an outcome of the positive and negative experiences transitioning to the LTC setting.

The meaning that the participants drew from their reflection on the transition to practice experiences was one of personal growth and HF. Growth is defined as “the process of developing physically, mentally, or spiritually” (Oxford English Dictionary, 2016). The NLN (2010) ECM asserted that HF “is loosely expressed as an effort to achieve self-actualization and fulfillment within the context of a larger community of individuals, each with the right to pursue his or her own efforts” (p. 33). The NGLPNs each made comments that reflected the fact that they did achieve self-actualization and fulfillment within the LTC setting and this was a process of
developing over time in the setting. Each of the participants stated that they wanted to continue their education, based on the experiences in the LTC setting.

Recalling from Chapter IV, each of the NGLPNs reflected on the meaning of their experiences. The meaning they drew came from both the negative and the positive experiences of practice in the LTC setting. This is a significant finding as no studies have related HF to outcomes of transition to practice studies.

Each of the participants reflected on the meaning that they drew from their transition to practice experiences. Personal growth and HF was the theme related to these experiences.

Kathleen shared the following regarding the meaning that she drew from her experiences:

After I graduated and got my job, I learned a lot. I do know that . . . I’m more confident in my giving medications, more confident in my treatments, more confident in my nursing decisions, and nursing thought process and when the doctor needs called; when they don’t need to be called; when the supervisor needs to be involved; when they don’t.

Elizabeth drew similar meaning from the experiences:

I feel good about it. I mean I have had some good experiences. I think I made the right decision. I think it is for me. I have had a lot of good experiences and bad experiences, but I have learned from a lot of things within a year of working from now. From last year, I feel like I am a great nurse compared to where I was when I first started. You just learn how to do things. You learn your way of doing things. You just make sense of a lot of stuff throughout the time of working. This experience is definitely going to make me continue my education to get my RN and to get my BSN and MSN.

Lisa’s comments also reflected personal growth and HF:

It made me want to go back to RN program, like that’s why I am going back to RN program this May. I know this is what I want to do. That positive experience I have from my job, from nursing job, it made me like maybe in the future, I am gonna go to BSN program.

Recall from Chapter IV that each of the participants stated that they were glad that they went the route to become an LPN and practice in the LTC setting. This is significant, because this was not the original plan for two of the participants. Kathleen and Elizabeth started their
educational path in universities. They did not start their educational journey wanting to become an LPN. However, the path allowed the NGLPNs to become an LPN and they can now continue their education in an RN mobility program. While this was not the path originally chosen, it was the path that helped them achieve their goal of becoming a nurse.

Very few studies addressed LPN practice experiences in long term care. Knecht et al. (2015) studied key attributes of LPN job satisfaction and dissatisfaction in long-term care settings. The LPNs in the study did not feel that they were allowed to practice to their full potential in their position. The role was delineated by the scope of practice and job descriptions. The team meeting to discuss care planning was an area from which most LPNs were excluded. The LPNs felt that they had knowledge to contribute.

The NGLPNs in the current study also spoke of not being involved in the care planning team meetings other than when the different RN staff members came to ask them specific questions regarding the plan of care. This was not noted to be a negative experience for the NGLPNs. However, Lisa spoke about one negative issue encountered when a physician disregarded her when she attempted to talk to him about a problem with a client. This one issue that she spoke of had to do with a resident’s blood pressure being low and she voiced concern about this issue. She said that she had to contact the RN supervisor to get her to speak to the physician regarding the issue.

All of the NGLPNs spoke of having great relationships with the nurse practitioners that make rounds in the units for the physicians. They said that they are able to easily contact them when they encountered problems with residents in the LTC facility.
In the study by Knecht et al. (2015), supervisor micromanagement was an issue that kept the LPNs from being able to problem solve about issues related to their client’s condition. Lisa also spoke of this being an issue for her. She shared the following:

Working in the nursing home, I’ve seen supervisors that are micromanagers, they micromanage you. They want to know what you’re up to, and they want to get involved with your decision style. It’s just, it’s good, especially if you are still new, but because of that it doesn’t allow you to pretty much grow in your skills, to pretty much think. I want to decide things. We have the supervisor that I’m working with right now (in rehab). I love it (clapped). I love her (clapped). She lets you do the things (snapped twice) you need to do, you know, and she would check on you.

Lisa stated that supervisor micromanagement did not let her grow in her skills. She spoke of being very inquisitive, looking up concepts and lab values that were unfamiliar to her. She really appreciated the fact that she was able to function more autonomously with her new supervisor, which she implied allowed her to grow. This positive experience enabled her to be more satisfied with her role.

Implications for Nursing Education

The NLN (2010) ECM promotes civility, diversity, and ethics as core values. The NLN also has several apprenticeships within the ECM that relate to the current issue. These ECM apprenticeships can be used as a guide to help ensure that these concepts are integrated into the curriculum.

The Apprenticeship for Relationship-Centered Care is an integrating concept that emerges from the NLN (2010) ECM. According to the NLN, the integrating concepts are bands around program types, emerging from the core values of the model and “have an enveloping feedback mechanism that acknowledges the ongoing advancement of nursing education, as new graduates return new learning, gleaned from multiple sources, to nursing practice through nursing education” (p. 8). The Apprenticeship for Relationship-Centered Care “positions caring,
therapeutic relationships with patients, families, and communities and professional relationships with members of the health care team at the core of nursing practice” (NLN, 2010, p. 27). This NLN ECM apprenticeship “integrates and reflects respect for the dignity and uniqueness of others, valuing diversity, integrity, humility, mutual trust, self-determination, empathy, civility, the capacity for grace, and empowerment” (p. 27).

The other NLN (2010) ECM apprenticeship that related to the issue of intimidating and disruptive behavior was the Apprenticeship for Teamwork. This apprenticeship, according to the NLN, is crucial to all the other apprenticeships and to patient outcomes. Teamwork is to “function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care” (p. 30). One of the practice outcomes associated with this apprenticeship is to “act with integrity, consistency, and respect for differing views” (p. 30). Practical nursing programs should consider adopting the NLN (2010) ECM as their model to support curriculum revision. The ECM addressed issues of intimidating and disruptive behaviors and suggests objectives to build into programs to help students prepare for encountering these issues in practice.

The ACEN has recommended that qualitative data be included in the outcome evaluation process concerning new graduate satisfaction. The semi-structured interview process used in this study (Appendix C) worked well to help elicit the new graduate LPN’s experiences of transition to practice in the LTC setting. By focusing on the negative and positive experiences related to transition to practice, the nurse educator was able to draw on these experiences to relate them to the outcome of personal growth and ultimately HF, indicating successful transition.

Additionally, practical nursing programs should consider increasing the clinical contact hours in the LTC setting. The LTC setting is one of the primary practice areas for LPNs. The
participants in the study all stated that they wished that they had had more time in the LTC. One participant also stated that she felt that it would have helped her peers to be able to have more time in the setting. She relayed that this experience might have helped NGLPNs realize that practice in the LTC was not for them prior to accepting a position and resigning within a short amount of time.

New graduate LPNs need to develop a better understanding of their scope of practice. Having more time in the LTC could facilitate this process. Nurse educators should implement simulation scenarios related to communication to help prepare student to address intimidating and disruptive behaviors.

Finally, nurse educators should consider activities to better prepare nursing students for caring for clients, during the death and dying process. Implementing the ELNEC training into their curriculum on death and dying should be implemented in LPN programs and transition to practice programs in LTC settings. Theater is another collaborative learning opportunity available in most colleges.

Nurse educators could partner with college theater department to incorporate black box theatrical performances on death and dying. This intervention allows theater students and practical nursing students to collaboratively learn, while simulating a death scenario. Communication with family members during the dying process is an important process that could be simulated. Having theater students portray the family members and the patients would make this more realistic for the nursing students and they could also be involved in the performance. Theater collaboration was incorporated by nursing faculty at the University of Alabama in Huntsville, Alabama, who partnered with the theater department to provide more realistic family member representation in end of life simulation scenarios (LaChance, 2015). In
black box theater, the audience is on the stage. This supports an intimate setting that facilitates learning how to communicate practices of caring for dying resident and family members. Learning in this type of environment would be a powerful collaborative teaching activity that would benefit both the theater and nursing students. Observation and active learning would help facilitate meeting objectives to improve communication and care of the patient and family at end of life.

Interpretive phenomenology has pedagogical significance. Van Manen (1990) asserts that anecdotal stories can be used to teach. Van Manen (1990) sees these stories as “experiential case material on which pedagogic reflection is possible” (p. 121). This form of narrative has implications for nursing education. According to Van Manen (1994), “personal identity can be brought to self-awareness through narrative self-reflection” (p. 159). This was demonstrated in the current study. Each of the participants stated that reflecting on their experiences with the researcher was helpful to them. Based on this notion, nurse educators should consider teaching self-reflection to help student nurses develop critical skills as a nurse.

Implications for Nursing Practice

The issue of intimidating and disruptive behaviors in the LTC setting reinforces what the American Nurses Association (2015), The Joint Commission (2008), and the Center for American Nurses (2008) are working to end. The ANA position statement on the problem of incivility, bullying, and workplace violence set the tone to address the issue. The current study highlights the fact that the problem is experienced by NGLPNs transitioning to practice in the LTC setting.

Practice environments should use the ANA position statement to address these behaviors. Tools can help facilitate the process. A civility toolkit is available for use by nurse managers and
leaders of healthcare organizations to facilitate changes (Adeniran, R. et al., 2015). The toolkit, developed with Robert Wood Johnson funding, includes videos for discussion.

The Joint Commission is an organization that accredits healthcare organizations regarding quality and safety criteria. According to The Joint Commission (2008), “Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments” (p. 1). In 2008, The Joint Commission issued a Sentinel Event Alert, Behaviors that Undermine a Culture of Safety. A Sentinel Event Alert is an event that raises awareness to issues impacting safety in healthcare organizations. The focus is on preventing future occurrences through study of the events that can lead to the issue. This particular alert focused on behaviors that are intimidating and disruptive “to assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team” (The Joint Commission, 2008, p. 1). The intimidating and disruptive behaviors mentioned in the alert include verbal outbursts, threats, passive activities, and uncooperative attitudes. The Joint Commission implemented leadership standard (LD.03.01.01) in response to the sentinel event alert. These standards are “EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors. EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors” (pp. 1-2). They also issued a directive for the medical staff standards that included six competencies that address professional behavior and professionalism.

Nursing administrators should look to these resources to work to prevent intimidating and disruptive behaviors in the LTC setting. Nursing administrators in the LTC setting can also
utilize the Adeniran et al. (2015) tool-kit work on addressing the issue in their facility. Nursing administrators in LTC settings should also work with nurse educators to build transition to practice programs for nurses transitioning to practice in the LTC setting. These programs can help improve NGLPN satisfaction and retention.

Implications for Nursing Research

This study adds to the literature on transition to practice. No phenomenological studies on LPN transition to practice were noted in the literature review. This study provides data to support LPN curriculum development and transition to practice programs. More qualitative studies are needed to provide data to support the development of the practical nursing curriculum and transition to practice programs. Studies need to be conducted to further the subjective understanding of transition to practice experiences for NGLPNs.

Practical nurse educators and nursing administrators from LTC settings should collaborate to develop modules for transition to practice programs for the LTC setting. These modules should include information on how to deal with intimidating and disruptive behaviors in the workplace. The ELNEC curriculum should also be a part of the modules. Research studies are needed to evaluate the effectiveness of the new programs for NGLPNs transitioning to practice in the LTC setting.

Limitations

The limitations of the study relate to the method. Phenomenology does not allow the researcher to generalize as is done in empirical research. The value of the phenomenology is to be able to obtain rich data to understand the unique experiences of the participants. The small sample size was also a limitation. Three participants met the criteria in the study setting. The participants stated that there were two of their peers from their practical nursing programs that
did not flourish in the setting, resigning within 2 months after starting practice in the LTC setting.

Recommendations for Future Research

The current study allowed the researcher to derive meaning from the experiences that the new graduate LPNs encountered during their transition to practice in the LTC setting. The interviews of NGLPNs provided rich details of their experiences transitioning to practice in the LTC setting. The new graduates spoke of peers that did not experience HF in the LTC setting. They resigned shortly after starting the LPN position.

Future research should also focus on the experiences of those new graduate LPNs that did not flourish in the LTC setting in order to understand their transition to practice experiences. It would also be beneficial to do a comparative case study between NGLPNs transitioning to practice in different LTC settings.

Conclusions

Although NGLPNs experienced negative experiences, personal growth and human flourishing was the overall theme of the lived experience of transition to practice in the LTC setting. This theme reflects the self-actualization and fulfillment achieved by the NGLPNs during transition to practice in the LTC setting. The themes that emerged from the negative experiences in the LTC care setting were intimidating and disruptive behaviors and death and dying. Subthemes of integrity, human dignity, self-determination, and caring facilitated the transition to practice and linked negative and positive themes. Feeling unprepared for the experience of caring for dying residents was a negative subtheme that reflects the need for more support during the transition and education during the practical nursing program. The themes reflected from the positive experiences were relationships and feeling supported. Caring was a
subtheme of the relationships. The positive experiences of relationships and feeling supported also helped the NGLPNs cope with the negative transition to practice experiences in the LTC setting. New graduate LPNs need transition to practice programs, when transitioning to practice in the LTC setting. These findings also support the need for practical nursing educators to incorporate the NLN (2010) ECM apprenticeships of Teamwork and Relationship-Centered care into the curriculum. The ELNEC curriculum should also be incorporated into modules on death and dying. Nurse educators should also implement simulation experiences including opportunities to care for dying residents. Black box theater could also be used as a collaborative learning activity with the college theater department.
REFERENCES


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Tagliareni, E., Cline, D. D., Mengel, A., McLaughlin, B., & King, E. (2012). Quality care for older adults: Advancing Care Excellence for Seniors (ACES) Project. *Nursing Education Perspectives, 33*(3), 144-149.


APPENDIX A

RECRUITMENT POSTER
Attention New Graduate LPNs

If you have been practicing nursing as a new graduate LPN in the long term care setting at this facility for at least six months and no longer than a year, you may be eligible to participate in a study. I am recruiting participants to share information about their experiences practicing as a new graduate LPN in the long term care setting. The purpose of the study is to learn information to help prepare future new graduate LPNs transitioning to work in the long term care setting. The study involves participating in three interviews with a nurse educator. The interviews will be confidential. Participants will receive a $30 Starbucks card in appreciation for their participation in the study, if they meet the study criteria and participate in three interviews. If you are interested in learning more about the study, please contact Julie Jones.
APPENDIX B

IRB APPROVAL
February 19, 2016

Julie Savage Jones
College of Education/College of Nursing
Box 870231

Re: IRB#: 16-OR-081 “The Lived Experience of Human Flourishing for the New Graduate Licensed Practical Nurse, Practicing in the Long-Term Care Setting”

Dear Ms. Jones:

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on February 18, 2017. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent forms to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,
Participant Interview Question Guide

First Interview

1. Please tell me about how you decided to become a practical nurse. Was there something that occurred growing up that helped you make the decision to become a practical nurse? Did you consider other nursing degree options, and if so, what influenced your decision to choose practical nursing?
2. Have you had any experience with LTC settings or elderly individuals before deciding to enter the practical nursing program?
3. Have you had any experience with healthcare settings prior to deciding to enter the practical nursing program?
4. Please tell me about your practical nursing program clinical experiences in the LTC setting.
5. Please tell me about your other clinical experiences in your nursing program and how you feel that these experiences prepared you for practice in the LTC setting.
6. Please tell me about any classroom experiences in your nursing program that you feel prepared you for practice in the LTC setting.
7. Please tell me about any negative experiences in your nursing program related to care of elderly clients.
8. Please tell me about any positive experiences in your nursing program related to care of elderly clients.

Second Interview:

1. The last time that we met, we discussed the events leading up until you finished the practical nursing program. We talked about what influenced you to enter a practical nursing program, and your experiences in your nursing program. Would you like to talk about anything that you have thought about since that time?
2. Do you feel that you were prepared for the role that you took on in the LTC setting? Please explain.
3. What practice experiences did you feel well prepared to handle?
4. What practice experiences did you feel unprepared to handle?
5. Do you feel that you were asked to carry out duties that you were not expecting to have to do, based on your practical nursing education? Please explain.
6. What was your employment orientation to the practical nursing role in the LTC setting?
7. What negative issues have come up, during your time practicing in the LTC setting?
8. What positive issues have come up, during your time practicing in the LTC setting?

Interview Three

1. The last time that we met, we discussed your experiences in your first year of practice in the LTC setting. Would you like to talk about anything that you have thought about since that time?
2. We have discussed your background prior to entering into practical nursing practice in the LTC setting. We also discussed your experiences in the first year of practice in the
long term-care setting. Given all that we have discussed, how do you make sense of your practical nursing experiences in the LTC setting?

3. Do you feel that it has been positive or negative overall?

4. How has this shaped your future employment/education decisions?