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FACTORS INFLUENCING THE PRACTICE OF NEW GRADUATE NURSES: A FOCUSED ETHNOGRAPHY OF ACUTE CARE SETTINGS

Short running title: Factors Influencing New Graduate Nurses

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ABSTRACT

Aim: To explore the influence of an acute care setting on competency deployment of new graduate nurses (NGNs) from a competency-based undergraduate programme.

Background: In the last 15 years, nursing education has shifted to competency-based education (CBE). Few studies have focused on how NGNs from these reformed programmes use the competencies they have developed. To be paradigmatically coherent with the nature of a competence, studies should also examine how context influences nursing practice and competency deployment.

Design: A focused ethnography of three acute care units from one academic hospital in Canada.

Methods: Purposive and snowball sampling strategies were used to recruit 19 participants: NGNs (n = 4), nurse preceptors (n = 2), clinical nurse specialists (n = 9), and nurse managers (n = 4). Data were collected through individual interviews, focus groups, observation and documentation. Data were analysed according to Roper and Shapira's (2000) ethnographic nursing analysis framework.

Results: Organizational and individual factors were identified as influencing NGNs' competency deployment. Organizational factors are orientation, stability, workload, and the scientific culture of the unit. Personal factors have been linked to groups of professionals: for NGNs, personality and clinical placements during their initial education; for nurses working with NGNs, to be role models, to promote integration and to denounce bullying; and for other health professionals, to recognize nursing expertise.

Conclusion: One way to smooth the transition from academic to clinical settings for NGNs is by offering transition or orientation programmes that will provide them with stability and a reduced workload, allowing them to progressively deploy their competencies.

Relevance to clinical practice: Organizational and individual factors influence how new graduate nurses deploy their competencies. Clinical educators and nurse managers can help new nurses by acting on these factors.

This study conforms to the COREQ Research Reporting Guidelines for qualitative studies.

IMPACT STATEMENT

What does this paper contribute to the wider global clinical community?

- This study identified organizational and individual factors that influence the competency deployment of new graduate nurses from competency-based education nursing programmes.
- Clinical educators and nurse managers can support new nurses by offering transition programmes that will offer them stability and an adapted workload.

INTRODUCTION

Following recommendations from the Institute of Medicine (IOM, 2003) and the Commission on Education of Health Professionals for the 21st Century (Frenk et al., 2010), many health science education programmes have been transformed to prepare health professionals to work in an inter-professional system. Both organizations concluded that there was a need to revise programmes using a pedagogical approach based on the development of core competencies and that this transformation could improve the quality of care.

In the last 50 years, there have been different calls to competency-based education (CBE), but what some authors call the 'second generation CBE' (Goudreau et al., 2009) seems more consistent with the integrative pedagogy advocated by the IOM and others (Benner, Sutphen, Leonard, & Day, 2010; Frenk et al., 2010). This generation is based on cognitivism and constructivism (Billings & Halstead, 2016) and uses a holistic definition of competency which Gonczi and Hager (2010) describe as the combination of knowledge, skills, and attributes that are used in a professional practice. Thus, a competency is broader and more complex than a mere technical skill and is bound to the context in which it is employed. Although there is no international agreement on a specific set of competencies, many second-generation CBE nursing programmes have a similar competency framework, with competencies such as patient-centred care, collaboration, critical thinking, clinical leadership and evidence-based practice (Cronenwett et al., 2007; Forbes & Hickey, 2009; Goudreau et al., 2009; Lenburg, Klein, Abdur-Rahman, Spencer & Boyer, 2009).

To this day, few studies have specifically looked at how the context in which new graduate nurses (NGNs) work influences their practice. In this paper, NGNs refer to registered nurses holding a bachelor's degree. Moreover, fewer studies identify the specific educational background of the NGNs, so it is still unknown whether NGNs from a CBE programme can demonstrate their competencies at the beginning of their professional journey. Paradigm coherence with the nature of a competency and of nursing practice is critical; therefore, studies should look at how context influences nursing practice and competency deployment (Blanchet-Garneau, Lavoie, & Grondin, 2017), which is often not the case.

BACKGROUND

It is no longer enough to educate expert clinicians; we need to educate change agents who will be able to practice together in health systems based on the needs of the population (Frenk et al., 2010). This major transformation requires that health professionals develop high abilities for reflective practice, critical thinking, and ethical decision-making. This aim could be achieved by CBE programmes built around core competencies for every health professional but adapted to the specific context of each discipline (Frenk et al., 2010).

When NGNs start their professional practice, they are expected to use the competencies they developed during their education in an effective way, which is referred to as the deployment of competencies. Many studies have reported on the development and deployment of competencies in the first year of graduate practice (Higgins, Spencer, & Kane, 2010; Kantar, 2012; Lima, Newall, Kinney, Jordan, & Hamilton, 2014; Safadi, Jaradeh, Bandak, & Froelicher, 2010). However, many of these studies did not look specifically at the context in which NGNs were deploying their competencies or at factors that might influence their practice.

Some studies have specifically looked at factors influencing NGNs' practice. In a longitudinal study, Fox, Henderson, and Malko-Nyhan (2005) used focus group discussion with new graduates to explore what they perceived as supportive during their transition. The results indicate that manager support, enough nurses, and the attitudes of other professionals are key components to ensuring that NGNs are fully integrated into their new work environment. While Fox et al.'s (2005) methodology fostered the emergence of themes with open-ended questions, their sample was exclusively composed of new nurses; other key actors could have identified other forms of support offered to new nurses. Using a quantitative correlational design (N = 318 NGNs), Numminen, Leino-Kilpi, Isoaho, and Meretoja (2015) concluded that individual (empowerment and occupational commitment) and organizational factors (practice environment and ethical climate) influenced NGNs, with empowerment being the strongest factor. While their methodology was rigorous, the variables were predetermined, preventing the emergence of new factors.

In Canada, most NGNs work in a hospital delivering acute and critical care (Canadian Institute for Health Information, 2017). Acute care settings can be defined as units specialized in the general and short-term treatment of acute physical illnesses, such as medical and surgical units. It excludes intensive care and emergency rooms (which are considered critical care units), psychiatric, palliative, and maternal units. Duchscher and Myrick (2008) argued that acute care units harbour a culture that produces prescriptive dominant behaviours that are intellectually oppressive and cognitively restrictive, and which negatively influence the practice of NGNs. Based on data from previous studies, Duchscher (2009) identified negative impacts of the acute care setting that lead NGNs to doubt themselves, to be confused about their role and to be disoriented in early practice. Other authors describe a similar deleterious atmosphere that prevails in some acute care units (Kelly & Ahern, 2009; Laschinger, Grau, Finegan, & Wilk, 2010). Without specifically speaking about culture, Roch, Dubois, and Clarke (2014) studied the influence of organizational climate on nursing practice through a mixed-methods study combining questionnaires (N = 292), individual interviews (N = 15), and analysis of documents available. Unlike the abovementioned studies, these authors report a generally positive organizational climate, but still acknowledge that the organizational climate has an impact on nursing practice.

Even though studies have looked at the competencies deployed by NGNs and the factors influencing their practice, there is still a knowledge gap on the specific experience of NGNs that were educated in CBE programmes. Most studies that have examined the experience of NGNs are based on the clinical settings in which the NGNs work, rather than on the nursing education programme from which they graduated. This lack of evidence does not allow us to conclude whether the reform to CBE in nursing programmes has resulted in the desired outcomes. To study the outcomes of CBE nursing programmes on NGNs' competencies, one must not only look at the deployment of competencies but must also consider the context and other factors that could influence nursing practice.

To guide this study, a conceptual framework was designed (Charette, Goudreau & Bourbonnais, 2018) by integrating Benner's novice to expert model (1984) and her pedagogical vision (Benner et al., 2010) into CBE. This model of development and deployment of competencies in nursing practice (Figure 1) shows a strong link between nursing education and nursing practice. It also considers the importance of using active teaching-learning strategies, describing the competencies to be developed (during and after education) and their level (real and expected), considering the influence of the context of care, as well as never losing the focus on the quality of care provided to patients. A detailed description of the model was submitted for publication (Charette, Goudreau & Bourbonnais, 2018).

This paper is drawn from a larger study that sought to describe the competencies of NGNs from a competency-based undergraduate programme in a French-speaking Canadian university in an acute care setting and to explore the influence of the acute care setting on the practice of NGNs. Findings regarding NGNs' deployment of competencies have previously been published (Charette, Goudreau & Bourbonnais, 2019), and NGNs were able to deploy all but one (health promotion) competency they developed during their undergraduate programme (refer to Table 1 for the competency framework of this programme). The main aim of this paper is to explore the influence of the acute care setting on the competency deployment of NGNs. The research question was as follows: *What factors influence (positively or negatively) the competency deployment of NGNs in an acute care setting?*

METHODS

DESIGN, SETTING, SAMPLE, AND DATA COLLECTION

A focused ethnography design was used to address the overall study aim. Recent literature from the past decade supports this design's usefulness in nursing research and more specifically when looking at the influence of the context (Cruz & Higginbottom, 2013; Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000). Ethnography can help immerse the researcher in the culture to uncover specific factors that affect the way people behave. Since the object of this study was centred on NGNs and their practice, a focused ethnography was deemed more appropriate. Focused ethnography helps the researcher answer predetermined narrow research questions and involves a more restricted data collection period than conventional ethnography (Higginbottom et al., 2013; Roper & Shapira, 2000).

The study setting was three acute care units of a French-Canadian academic hospital affiliated with a university containing a CBE undergraduate nursing programme. Purposive and snowball sampling were used to recruit participants (N=19) from four groups: NGNs (n = 4), nurse preceptors (n = 2), clinical nurse specialists (CNSs; n = 9), and nurse managers (n = 4). Nurse preceptors are nurses who, in addition to their clinical duties, supervise a nursing student or an NGN. CNSs are nurses who do not work on a specific unit but are rather in charge of developing new care protocols or continual professional development sessions for nurses. Finally, in this study, nurse managers were either unit managers or nursing education managers.

The decision to include these different groups was made to collect different perspectives on the competencies of NGNs, as nurses who supervise them (such as preceptors, CNSs or managers) could have different perceptions of the NGNs' competencies or on the cultural context of the acute care settings. To attain data saturation, Leininger (2001) suggests that 4 to 6 participants per group is usually sufficient. Our objective, therefore, was set at 5 participants per group. Even if our objective was not met for all groups, data saturation was attained by triangulation between groups and with other data collection methods described in this section.

The inclusion criteria for the NGNs was that they had graduated 6-24 months prior to data collection. This decision was made to ensure the study would not affect the NGNs' employability while they were on probation during the first months of their new work environment. For participants other than NGNs, they had to be working in the acute care setting and had supervised or worked closely with NGNs over the last two years. Meetings with managers and CNSs were held to explain the project, and letters were sent to NGNs and preceptors.

Data were collected using different methods, as is often the case in qualitative research and more specifically in ethnography and focused ethnography (Fetterman, 2010). This diversity of methods helps the researcher to gather rich data to answer the research questions and understand the cultural context. In this study, passive observation, individual interviews and focus groups were performed, and clinical documentation was gathered.

A total of 40 hours of passive observation (Spradley, 1980) was completed by the first author (MC) on three acute care units. Observation sessions lasted between 1 and 3 hours and were performed on all three shifts (daytime, evening and night). During observation, field notes were taken in accordance with an observation guide developed before the study based on the study framework and on Spradley's work (1980). This well-known anthropologist stated that a culture could be observed through social situations, composed of the people, the activity being performed and the space/setting in which the activity is taking place. The observation guide was therefore divided into six categories: physical setting, general activities occurring, behaviours of NGNs, communication and collaboration of NGNs with other health professionals, emotions expressed by NGNs and clinical documentation/references present. For each category, the observer could record field notes and memos.

NGNs, preceptors, managers and one CNS participating in the study were asked to undergo one individual semi-structured interview (N = 11 interviews; min 25 minutes, max 89 minutes, mean 52 minutes). The remaining CNSs (n = 8) were asked to participate in one focus group interview and were divided into two groups based on their availability. The first group was composed of 6 CNSs (89 minutes), and the second group included 2 CNSs (62 minutes). An observer was present during the

first focus group who took notes on group dynamics. This observer was a research assistant who signed a confidentiality agreement. All participants completed a demographic questionnaire (age, sex, education background, nursing experience, preceptorship experience). During the interviews and focus groups, participants had access to a summary of the competency framework used in the programme from which the NGNs had graduated, including a definition of the eight competencies presented in Table 1 and the expected level at the end of the programme.

An interview/focus group guide was developed and validated by nursing education experts from the CBE programme through discussion about the clarity of each question and their relevance to the purpose of the study. The guide was composed of open-ended questions about the factors present in the acute care setting that influence the practice of NGNs; refer to Table 2 for the interview guide that was used with the NGNs. The questions were adapted accordingly for the participants of the other groups. All interviews and focus groups started with a reminder of the aim of the study and about the confidentiality of the interview. Interviews and focus groups were audio recorded, fully transcribed by an independent consultant (who signed a confidentiality agreement) and verified by the first author (MC) against the audio recording before analysis. All interviews and focus groups were moderated by the first author (MC), who was a registered nurse (RN) completing a PhD at the time of the study. He had clinical experience in acute care settings, but not in the hospital where the study took place.

Finally, clinical documentation and any documents related to the orientation of NGNs were collected to better understand the context and the orientation programme in which the NGNs were enrolled. This study conforms to the COREQ research reporting guidelines for qualitative studies (See Supplementary File 1).

ETHICAL CONSIDERATIONS
Ethical approval was granted by the Institutional Review Board of the hospital where the study took place (#15.056). Participants signed informed consent upon recruitment and were free to withdraw at any time. Raw data were kept in a secure file, and participants were assigned an alphanumerical code to prevent direct identification (NGN: new graduate nurse; CNS: clinical nurse specialist; P; nurse preceptor; NM: nurse managers). All participants received a $20 gift card as compensation.

DATA ANALYSIS
An ethnographic content analysis inductive method (Roper & Shapira, 2000) was used to answer the following research question: *What factors influence (positively or negatively) the competency deployment of NGNs in acute care settings?* This framework has five general steps that are not to be performed linearly but circularly, even though we will refer to them as steps 1, 2, 3, 4, and 5. The first step is coding for descriptive labels. At this point, all transcripts, field notes (including observation) and clinical documentation were coded, using codes that are close to the actual raw data. All data were coded and analysed by the first author (MC). After the first round of coding, inter-judge validation was performed with 20% of the interviews with JG, who has 20 years of experience as a qualitative researcher with a focus on nursing education and CBE.

Codes were then regrouped into categories that led to the second step, which is sorting for patterns that emerge from the data. Throughout these steps, it is important not to dismiss outliers, but to identify them and see how they make sense or explain the data (step 3). The categories that emerged from these steps were iteratively compared with the raw data. Matrices were used to

identify a semantic relationship between categories; cross-referencing categories led to the emergence of subthemes that were then regrouped into two main themes of factors: organizational and individual factors. A subsequent inter-judge validation was performed with JG and AB by discussing the preliminary themes that emerged (AB is a researcher who has experience doing ethnography). Themes and subthemes were refined and compared to the existing literature, theories and construct, as well as with the framework of the study (step 4) to explain the results. The last step of Roper and Shapira's framework, memoing, was used throughout data collection and analysis to record impressions, questions and ideas. The analysis was done using QDA miner (version 4.1.16).

RESULTS

Organizational and individual factors were identified as influencing the deployment of competencies of NGNs. Organizational factors are the orientation programme, the stability on a unit or a work shift, the workload perceived by NGNs, as well as the scientific culture of the unit. Individual factors are related to groups of individuals from the clinical setting: for NGNs, their personality and the clinical placements completed during their initial education; for nurses who work with NGNs, to be role models, to promote integration and to denounce bullying; and for other health professionals, to recognize nursing expertise. These themes are supported by transcripts (originally in French). Table 3 shows demographic data such as age, nursing experience (in years), and number of preceptorship experiences (as a preceptor) in the last year. It should be noted that 3 NGNs had been preceptors since they were hired, one of them having supervised as many as 5 nursing students or other nurses. The number of preceptorship experiences is high for CNSs, because as part of their duties, they oversee many preceptor-preceptee tandems. Since all participants were female and to reflect the female predominance of the nursing profession, the feminine will be used in the following section to designate participants.

ORIENTATION PROGRAMME: A CRUCIAL PERIOD
When NGNs are hired to work on acute care units, they start an orientation programme that allows them to be integrated into care unit teams. In the research setting, this programme was completely revised a few years ago to better meet the needs of the acute care units. It consists of 5 days of theoretical classroom activities and 19 days of preceptorship orientation on a unit. Some participants expressed that this programme, although longer than its previous version, is still too short. One preceptor criticized that the duration of the programme is the same for all NGNs, regardless of the unit they are assigned to and of their experience. Although officially flexible (additional days can be added if deemed necessary), this is often interpreted negatively and even rejected by the administration. A nurse manager explained that the addition of extra days has a cost:

> I know that some CNSs would like more days of preceptorship orientation, [...] but the programme is very expensive, and at one point, I think that if an NGN needs more days, maybe there is something that does not work, maybe it's her or the education she has received. (NM-1)

Participants mentioned that the duration of preceptorship orientation influences the integration of NGNs and the deployment of their competencies. They also mentioned that the number of different preceptors supervising an NGN during her orientation can influence her negatively. Although an

effort is made to have as few preceptors as possible to supervise an NGN, all NGNs in this study specified that they had several preceptors, up to five different preceptors in seven days. While being mentored by multiple preceptors may have an advantage in terms of learning different work methods, participants noted concerns regarding the lack of follow-up from one preceptor to the next and the difficulty in adaptation for the NGN. One NGN also believed that the nurse manager wanted her to finish her orientation as quickly as possible to be given a full workload:

> I had 5 different preceptors in 19 days. [...] The nurse manager wanted us to finish our orientation as quickly as possible, so she changed the schedule because I would have finished later. So, to be 'functional' faster, well, I was switching from one preceptor to the other. (NGN-4)

Finally, another element regarding the preceptorship orientation is that in some cases, nurse managers impose the preceptor role on a nurse who may have the clinical experience but is not interested in being a preceptor or lacks the supervisory skills to do it. A preceptorship training programme has been developed and is supposed to be completed by all nurse preceptors, but participants said it was not always possible to release nurses from their clinical duties to follow the preceptorship programme. Participants from all groups expressed that when an NGN is paired either with a preceptor who does not want to be one or who does not have the skills for it, it negatively affects the support and the integration of the NGN, which can influence her nursing practice.

STABILITY: A CRUCIAL ELEMENT TO SMOOTH THEIR TRANSITION
To help with the integration of NGNs into acute care units, participants mentioned that the stability on a care unit or on a shift positively influences the deployment of many competencies, such as professional collaboration, clinical judgement, and clinical leadership. By staying longer on a unit, NGNs said that it was easier to collaborate with nurse colleagues and other health professionals, as they were getting to know them personally. A mechanism was in place to allow NGNs to stay on the same care unit for the first three months of work after which they were sent on the floating team. This period allows them to get to know the intra-professional team and interact with different nurses who may become role models. Some participants expressed that this three-month stabilization period should be extended to help NGNs consolidate their competencies:

> They need to be stabilized so that they stop searching for themselves. When you constantly change and work on different units, it's hard to find your own way of working. I wish we could keep them for another three months, because their working method is not yet consolidated enough. I think three months is the minimum [...] If we were able to stabilize them longer, at least another three months, I think it would be even more profitable for them. (NM-3)

While on the floating team, an effort is made to assign NGNs to a specific unit, but it cannot be guaranteed, as their assignation depends on the specific needs of each unit. Therefore, they still may be required to work on different units each day. NGNs felt a lot of stress and pressure while they were floating. One NGN felt that, even though she learned a great deal from her floating experiences, she always felt excluded from the rest of the team and felt she was assigned a heavier workload than she would normally have:

> Constantly changing units, teams, specialties, it is very stressful. When you go back on the same units, you start to know the teams, so it's easier. I often worked on evening shifts, so I started to know the evening teams. But I was definitely feeling that I was not part of any team. And sometimes you know that you have the heaviest patients and that you would not have that section if you were a part of the regular team. (NGN-1)

These elements pushed some NGNs in the first months to question their choice to become a nurse and nourished an intent to leave the profession. This feeling faded later, especially when they succeed in obtaining a permanent position on a care unit and left the floating team.

While an effort was made to stabilize NGNs on a unit during their first three months of practice, it seems that shift stability is less sought after. Participants reported that NGNs were required to work on two and even sometimes all three shifts (day, evening, night). These different shifts have different routines and requirements. Some participants questioned whether the night shift is the most appropriate for new nurses trying to deploy their competencies and continue their development. Since night teams are small, the support offered to NGNs is limited, despite some strategies implemented by the hospital, such as assigning a CNS to the night shift. In addition, inter-professional collaboration becomes an asynchronous collaboration through reading the patient file and writing notes for the different professionals. Some participants, including two NGNs, recognized that the night shift allows more time for NGNs to read the file, do research, and ask questions; this can help them exercise elements of their clinical judgement or scientific rigor.

WORKLOAD: EXPECTATIONS NOT ALWAYS ADAPTED TO THEIR SKILL LEVEL

Participants said that nurses have a significant workload on acute care units. They defined this workload as the number of patients, the complexity of their situations and their care. Participants attributed this significant workload to the limited financial and human resources of the organization; some participants talked about a work overload that was even felt by experienced nurses:

> I work on the evening shift, and I constantly see that nurses are overloaded, and it is due to the context of care, which is more and more complex. Experienced nurses already have difficulty doing everything they have to do and finishing on time, and I'm not even talking about when they are preceptors. (CNS-3)

In this context, it then becomes difficult or even impossible to adapt the orientation period and the first weeks of autonomous work to the rhythm and level of expertise of each NGN in a progressive manner. Some participants expressed that after their 19-day orientation period, NGNs should not have the same workload as other nurses, but that their load should be progressively increased over a few more weeks. However, according to participants, contextual factors preventing this are recurrent:

> In a perfect world, after the orientation period, we would like to gradually increase the load [...] But then, for example, on the first autonomous day of the NGN, someone calls in sick and we can't find anyone to replace her. Because we are understaffed, the NGN must take on the same workload as the other nurses. Reality catches up with us [...]; even if we judge that the

> NGN should not have, let's say, six patients, but should rather start with four for a week and then we progressively increase, we consolidate; well, that is not the reality we have to deal with. (CNS-8)

Some participants added that this intense workload causes stress that inhibits NGNs in the deployment of certain competencies, such as clinical judgement and scientific rigor, by preventing them from acting in a holistic manner and rather requiring that they focus on specific tasks that need to be done.

Another element of the workload that participants emphasized is the management of the intra-professional team with the license practical nurse (LPN). On acute care units, registered nurses (RNs) are paired with an LPN. The RN remains in charge of the patient's care, while specific tasks are delegated to the LPN, who has a limited scope of practice. According to participants, an effort is made on some units to not pair NGNs with an LPN so that they can consolidate their skills before having to manage this type of team work, but this is not always possible, and some nurse managers expect NGNs to be able to oversee the work of the LPN as soon as the 19-day orientation period is over. Some participants mentioned that NGNs may not have sufficiently developed leadership skills, self-confidence, and professional identity to be able to meet this requirement in the first months of their practice:

> The nurse is supposed to be the leader of that team with the LPN, but the newly hired nurse freshly out of school doesn't have a well-developed sense of leadership and she has little confidence in her actions and in herself. Whereas some of the LPNs working here have been here for a long time, so she will try to lead the NGN, she will make decisions she is not supposed to. And the NGN will let her, because she wants to be a part of the team. (CNS-3)

The last aspect of the workload expressed by participants is the administrative burden inherent to the nursing role. According to participants, a considerable volume of documentation must be completed for each patient. Although this documentation is essential to ensure the continuity of care, one nurse manager said that the number of forms to complete constantly increases and can have a negative impact on direct care:

> There are so many forms and paperwork. When a patient is admitted, they have 13 forms to fill out! [...] All this paperwork takes the nurses away from direct care to patients. (NM-3)

SCIENTIFIC CULTURE: ESSENTIAL TO MAINTAIN AND DEVELOP NGNS' COMPETENCIES
While official policies of the clinical settings promote a scientific culture through continuing education, ongoing competency development, and evidence-based nursing practice, participants expressed that it was not shared by all nurses. On some acute care units, the prevailing culture is rather one of imitation: the practice of a colleague is reproduced without questioning if it reflects the best practice and without referring to the established guidelines:

> Nurses still rely a lot on their initial education, even if it's been 25 years [...]; what we often see is that, instead of looking up the guidelines, they will rather seek the oldest nurse and ask her how to do it. (CNS-1)

This practice can negatively influence NGNs' competency development, since they are not encouraged to maintain the scientific curiosity they developed during their initial education and their habit of looking to the guidelines or literature when they had questions. Participants said that the nurse manager and her assistants can influence the scientific culture on the care unit by creating an atmosphere that encourages an evidence-based nursing practice as well as continuing education:

> The scientific culture really varies from one unit to another. […] Depending on the nurse manager, what she preaches, what she looks for, what she encourages. Because some managers don't really promote a scientific approach to care. […] And you know, when you graduated 15 years ago, maybe it's time to update your practice. (CNS-3)

An example of creating such an atmosphere could be observed on one of the units: scientific posters from medical and nursing conferences were hanging on the walls. Another example was the nurse manager's support of the implementation of a reading club for nurses on one of the units.

Participants said that nurses, including NGNs, who stand out—try to have or keep a more scientific approach of care and base their practice on evidence—can sometimes be left out by colleagues. This can limit the deployment of competencies of NGNs, because to be accepted by their colleagues, some NGNs will do anything to blend into the group:

> If the NGN is the only one to look up guidelines or the literature, she will be left out, she will be categorized as 'not part of the team.' So, you know, to blend in, to get accepted, to be their friend, NGNs will do as the others are doing. (CNS-2)

Therefore, the culture of the unit where the NGN works, whether it is a scientific culture or an imitation culture, can influence her practice, as well as the practice of all other nurses on this specific unit.

PERSONALITY AND CLINICAL PLACEMENTS: THEY WEIGH HEAVILY IN THE BALANCE
Participants mentioned that the personality of each NGN influences the deployment of their competencies, and more specifically their collaboration and leadership competencies. One nurse manager explains that some qualities, such as being proactive or having different life experiences allow some NGNs to integrate into their roles more easily than others:

> It is also a question of personality. You know there are some who will be resourceful, who have a different way of life. There are some who are go-getters, they know what they have to do, and it will be much faster for them to be able to manage their work days. (NM-3)

One NGN who is between 25 and 30 years old explains that her academic background (she holds a bachelor's and a master's degree in another field) has allowed her to gain some self-confidence and that she is able to express her point of view much more easily now:

> Well, I do not know if it's because I have a certain maturity and previous knowledge that makes me have a natural self-confidence, but it's easy for me to talk to doctors; I am not afraid to go talk to other professionals. Even though I'm still developing my judgement and assessments and I do not have a lot of experience, I'm not afraid to express myself and take my place as a nurse [...] I definitely did not have that self-confidence when I was 21 years old. (NGN-4)

Another factor related to NGNs that can influence the deployment of their competencies is their clinical placement experience. Some participants wondered about the specific settings of the placements, the support offered to students, and the way they take advantage of each placement opportunity:

> Last year we fired one NGN. She had potential, but she was like an empty container. When I started to look at the placements she did, she did them all, but they were definitely not optimal. For example, she did her surgery placement on an outpatient surgery unit. […] So, you know, she is not as equipped as someone who went on a 'real' surgery unit. [...] I asked her if she ever went to the emergency room and she told me, '*yes, but it was my first semester, so I was not allowed to touch IVs.*' But when I asked her if she at least looked at them, she told me no. Even in outpatient surgery, she was not even curious about the IV bags she was handling, because she was only taking them off. (CNS-8)

One NGN made similar comments about how some of her former student colleagues were not making the best decisions regarding their placements to optimize their experiences and develop their competencies:

> I also had the chance to really vary my placement settings, because I consciously made that choice. Also, during summer vacations I was working as a nurse extern, so I gained even more experience. Even though I did not master every procedure or technique, I had the chance to practice them all at least a few times […] But I have colleagues who had a shock because they had made less strategic choices [...] and they felt less prepared after graduation. (NGN-4)

BE A ROLE MODEL, PROMOTE INTEGRATION, AND DENOUNCE BULLYING

All nurses have a key role to play in promoting the integration of NGNs into the team, whether they are a licensed practical nurse, a registered nurse, a nurse preceptor, a nurse manager, an assistant nurse manager, or a CNS. By fully integrating them, NGNs feel more confident about deploying their competencies. To facilitate this integration, however, participants said that one must acknowledge the level of expertise of NGNs, i.e., that they have theoretical knowledge and some practical

experience but are not expert nurses and should not be expected to perform as efficiently as an experienced nurse:

> We need to recognize that NGNs are novices; we need to progressively increase expectations to where we want them to be. But they are not experts and you cannot expect them to be experts. (NM-2)

NGNs in our study often felt the expectations were unrealistic, which resulted in significant stress and did not help them to feel confident about their competencies. They also mentioned that, because they could not meet the expectations, some nurses made them feel like they were not part of the team or even that they should not be nurses. One CNS said that some preceptors who might feel threatened express high expectations to intimidate NGNs:

> [The integration of the NGN depends on] if the preceptor feels threatened or not. If the NGN has better skills, better scientific knowledge, believes in evidence-based practice, has good leadership, she will be perceived as a threat [...] It destabilizes the preceptor [...] Some preceptors will demean NGNs in front of other nurses and so NGNs will not be accepted or integrated by the rest of the team. Unfortunately, you see that often in nursing, that kind of competition or bullying. (CNS-3)

Other participants agreed that jealousy, disrespect, and bullying still exist today among nurses, including NGNs. These attitudes and behaviours influence the practice of some NGNs by preventing them from fully demonstrating their knowledge, as they would rather try to blend in with other nurses and not stand out.

RECOGNIZE THE ROLE AND EXPERTISE OF NURSES

Another factor influencing how NGNs deploy their competencies is the way other health professionals they work with recognize the role and professional expertise of the nurse in general, and more specifically the contribution of NGNs. Participants mentioned that most health professionals easily collaborate with nurses and NGNs and trusted their assessments and insights about patients. This respect encouraged and facilitated the inter-professional collaboration of NGNs. While most participants agreed with this, some of them had witnessed negative counter examples that can undermine a nurse's confidence in her competencies, especially if she's an NGN and is still building her professional identity:

> I think that NGNs do learn how to do a good physical and mental health assessment, but they do not have much chance to practice it. And even here, they do not have much chance to practice it because they have too many things to do [...] and even sometimes they are not encouraged to. I have witnessed a surgeon telling nurses '*I forbid you to do a lung assessment [pulmonary auscultation].*' (NM-1)

Although anecdotal, these episodes can have a huge impact on the confidence of NGNs to effectively use their competencies and on their role as a nurse.

DISCUSSION

Findings from this study show that many factors influence the competency deployment of NGNs from a CBE nursing programme. Our results suggest that NGNs from CBE experience similar challenges as NGNs from other types of programmes, such as how they are welcomed in the clinical setting and the orientation programme in which they are enrolled. Clinical institutions usually offer a transition programme to help new nurses adapt to their new reality. Edwards, Hawker, Carrier, and Rees (2015) identified four types of transition programmes in nursing: 1) residency programme lasting 6-12 months; 2) orientation programme lasting 1-20 weeks; 3) preceptorship-based programme without theoretical activity and of variable duration; and 4) high-fidelity clinical simulation programme of variable duration. These authors identified 30 studies analysing the effectiveness of such programmes on the deployment of competencies, self-confidence, levels of stress and anxiety, and job satisfaction of NGNs. They concluded that these programmes have a positive influence on all indicators, including on the deployment of NGNs' competencies, which has been corroborated by other recent systematic reviews (Ke, Kuo, & Hung, 2017; Whitehead et al., 2013).

In our study, NGNs benefited from a 19-day preceptorship-based orientation programme with an additional 5 days of theoretical activities. After that period, they are stabilized on the unit for a three-month period, after which they are sent on the floating team. Considering our findings and the literature, it is questionable whether NGNs could benefit from a longer orientation programme or stabilization period. Considering the results obtained by Lima, Newall, Jordan, Hamilton, and Kinney (2016), who observed a statistically significant increase in the level of competency deployment between 0-6 months, a six-month transition programme could potentially allow NGNs to better integrate into their environment and ensure optimal deployment of competencies. Higher costs are associated with longer transition programmes, but multiple studies have concluded that this type of investment has a positive impact on the retention rate of nurses, resulting in substantial savings for health facilities (Cochran, 2017; Healy & Howe, 2012; Hillman & Foster, 2011; Trepanier, Early, Ulrich, & Cherry, 2012). Cost-benefit analyses show annual savings could range from $300,000 to $800,000 (USD) for health facilities (Rush, Adamack, Gordon, Lilly, & Janke, 2013).

Our findings also indicate that the workload given to NGNs is not always adjusted to the fact that their competencies are at a beginner level. Our results show that NGNs from a CBE exhibit the characteristics of the "advanced beginner" level, as it was described by Benner (1982). However, some nurse managers and preceptors expect the NGNs they hire to be at Benner's third stage, "competent," immediately after their short orientation period. These high expectations, in the context of the beginning of their practice, can be perceived as work overload to NGNs, a conclusion also reached by Batch-Wilson (2016). Our study has pinpointed more specifically that NGNs are advanced beginners and shouldn't be expected to already be at the next stage of expertise development. Since many studies have shown that a work overload can negatively impact the quality of care provided by nurses (Chiang, Hsiao, & Lee, 2017; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016), it is essential to call into question what constitutes a suitable workload and what is the optimal gradual increase of workload for an NGN. To our knowledge, few studies have explored this aspect, which is nevertheless a key element of human resource management. The first months of practice are a transition period during which the NGN has much learning to do in relation to the

integration of her professional role (Duchscher, 2008, 2009). To deny the importance of this period may impede the professional development of the new nurse.

While the NGNs in our study graduated 11-16 months before data collection, 3 out of 4 had previous experiences as being a preceptor, which has not often been highlighted in other studies. Although, to our knowledge, there are no recommendations on exactly when a nurse would be ready to act as a preceptor, this decision seems inconsistent with the transition period that the NGNs are experiencing. It puts an unnecessary pressure on the NGN, who is already experiencing a stressful transition. One can also question the quality of the coaching that these NGNs can offer to a student or another nurse as well as the impact on the development and the deployment of competencies of the preceptor-preceptee tandem.

Some aspects of clinical placements done during the initial education can influence the deployment of competencies after graduation. Our results suggest that learning during clinical placements was not optimal for some NGNs. Three reasons were mentioned by the participants of this study. In some cases, the NGN herself failed to seize opportunities, which was explained by the NGN's personality and a lack of professional curiosity. In other cases, she was not placed in ideal learning conditions, which means that the care unit did not allow her to fully meet the placement's objectives. Finally, in other cases, the coaching by a nurse preceptor was not adequate, either because the preceptor did not have the competencies to coach or supervise, or because she herself had a work overload. Worldwide, academic institutions struggle to find placement opportunities for students (Lamont, Brunero, & Woods, 2015; Smith, Corso, & Cobb, 2010), and pedagogical supervision is often inconsistent from one preceptor to another (Stayt & Merriman, 2013), which may result in inequality in the students' learning. Several studies have stated that the need for proper supervision and support for students in clinical placements was essential to ensure learning (Cooper, Courtney-Pratt, & Fitzgerald, 2015; Doyle et al., 2017). Nonetheless, students are responsible for seizing the opportunities available to them to put their theoretical knowledge and technical skills into practice to foster the integration of their learning and deploy their competencies.

Our results show that NGNs, like other nurses, can experience bullying. This phenomenon and its negative consequences has been documented extensively in recent years, going from distrustful relationships between nurses and a lack of consideration to malicious behaviours, such as bullying and intra-professional violence (Birks et al., 2017; Kelsey, 2017; Laschinger et al., 2010; Simons & Sauer, 2013). Despite awareness of the problem for several years and initiation of institutional policies, it seems these behaviours remain present in the care units and are experienced by nursing students during clinical placements (Birks et al., 2017; Courtney-Pratt, Pich, Levett-Jones, & Moxey, 2018). These behaviours can lead to a negative impact on nursing practice, quality of care, and increase the intention to leave the profession (Vogelpohl, 2011). Our results show that some nurses legitimize bullying behaviours such as sarcastic comments, insults, and excessive reproach of NGNs to help them become more resilient to difficult situations, a phenomenon that Leong and Crossman (2016) called 'tough love'.

Limitations

Although many steps were taken to ensure the rigor of this study, a few limitations of must be noted. First, the study setting was one academic hospital experiencing a major administrative transformation at the time of data collection, which might affect the results' transferability. To

counter this limitation, a thorough and thick description of the context was made and can be found in the original thesis (Charette, 2018). Second, recruitment was a challenge, especially for NGNs, perhaps because several NGNs were working on ineligible units. Additionally, NGNs experiencing heavy workloads might not have been physically or psychologically available to participate. However, we attained saturation with data from other groups and by triangulation of data with the different methods used in this project, which provided rigorous results.

Doing a qualitative study and, more specifically an ethnography, means that the researcher was the main data collection tool. To ensure rigorous data collection and analysis, the principal researcher and first author (MC) was engaged in a reflective process throughout the study, including on the influence of his role and the emic-etic tension. This reflection was noted in a research diary and regularly discussed during meetings with his thesis supervisors. The emic perspective represents the perspective of the participants, whereas the etic is the perspective of the researcher, viewed as an outsider. Being an RN, the tension between the emic and the etic perspectives was not as distinct for the researcher as it could be in other situations. One advantage of this situation is to easily understand the language used by participants and an easiness in creating a trusting relationship with participants. However, it is important not to interpret through preconceptions or biases. Since the researcher had no previous knowledge or work experience in the specific setting of this study, it was easier to have an open mind about the data collected.

CONCLUSION

The study purpose was to explore the influence of acute care settings on the competency deployment of NGNs from a competency-based undergraduate programme. Using a focused ethnography design, the findings showed that organizational and individual factors influence the practice of NGNs. The organizational factors identified included the orientation programme, the stability on a unit and on a work shift, the workload felt by the NGN, and the scientific culture of the unit. Individual factors were divided according to groups of factors present on the unit: for the NGNs, personality and previous clinical placements; for other nurses, to be a role model, promote integration, and denounce bullying; and for other health professionals, to recognize the role and expertise of nurses. One way to smooth the transition from academic to clinical settings for NGNs is by offering a transition or orientation programme that will provide them with stability and a reduced workload, allowing them to progressively deploy their competencies. Although such programmes exist, very few have been evaluated using strong methodologies to determine the outcomes on NGNs' competencies, job satisfaction, or anxiety. More studies are needed to determine the optimal length and activities of these programmes to support NGNs; these studies should be done using a partnership approach between the researchers from academic settings and the clinical community, as decision-makers need more evidence to allocate the necessary budgets to implement effective transition programmes.

RELEVANCE TO CLINICAL PRACTICE

Organizational and individual factors influence how new graduate nurses deploy their competencies. Clinical educators and nurse managers can help NGNs by acting on these factors. One way to ease the transition from academic to clinical settings for NGNs is by offering extended periods on the same unit, a reduced workload that can be progressively increased, the support of competent preceptors who nurture and encourage the NGNs' scientific approach and, finally, by enforcing

institutional policies against bullying. All these goals could be achieved through a well-structured transition programme, allowing NGNs to progressively deploy their competencies.

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TABLES

Table 1: Competencies from the undergraduate program

	Complete statement	Abbreviated statement
1.	To care with humanism for a person	Humanism
2.	To act together with individuals, families, and groups to promote healthy communities	Health promotion
3.	To collaborate within a professional team	Collaboration
4.	To demonstrate clinical leadership	Clinical leadership
5.	To act in a professional manner	Professionalism
6.	To treat every activity related to the profession and discipline in a rigorously scientific manner	Scientific rigor
7.	To demonstrate clinical judgement	Clinical judgement
8.	To ensure continuity of care	Continuity of care

Source: FN-UdeM (2010)

Table 2: Interview guide for NGNs

Introduction questions
- When did you start to work here?
- Can you describe your experience since you graduated, including the units and shifts you were oriented on or worked on?

Main questions
- How did your undergraduate programme help you develop your competencies? Are the competencies valued in your work environment like the ones from your undergraduate programme?
- How are you able to demonstrate your competencies in your work environment? Can you give me examples?
- What competencies do you use most? Less? Can you give me examples?
- How does your work environment influence your nursing practice and your competencies?
- What elements of your work environment help your nursing practice or your competencies? Can you give me examples?
- What elements of your work environment stand in the way of your nursing practice or your competencies? Can you give me examples?

Closing questions
- How would you judge your nursing experience until now?
- Are there any elements about your education that could be changed to better prepare you?

Table 3: Sociodemographic data

	Group 1 NGN	Group 2 Preceptor	Group 3 CNS	Group 4 Nurse managers
N	4	2	9	4
Age (years)				
20-25	2	0	0	0
26-30	2	0	1	0
31-40	0	0	5	1
41-50	0	2	0	2
51 +	0	0	3	1
Experience (years)				
Mean	12 months	7	17	18
Minimum	11 months	6	3	3
Maximum	16 months	8	36	32
Preceptorship experiences in the last 12 months (as preceptor)				
Mean	2	12	33	0
Minimum	0	4	0	0
Maximum	5	20	55	0

Note: NGN: new graduate nurse; CNS: clinical nurse specialist.