Transition to practice experiences of first and second career nurses: A mixed methods study

Abstract

Aims and objectives: To explore the transition to nursing practice experiences of first and second career nursing students.

Background: To address the nursing shortage, alternative educational programs have been increasingly developed and implemented with to help individuals with prior career experiences transition into a career in nursing (second career nurses). However, we know little about the transition to practice experiences of second career nurses.

Design: This mixed methods study utilized qualitative interviews with nurses who had completed a year of practice and a longitudinal survey of nurses' perceptions of stress, coping and burnout throughout their first year of nursing practice.

Methods: Qualitative data (n=15) was analyzed using latent thematic analysis and following COREQ guidelines. Descriptive and effect size analysis of quantitative data (n=122) was conducted in order to assess for significant differences across time points.

Results: The thematic analysis identified three themes: Stressors and Coping, Prevalence of Burnout and Presenteeism, and Difficulty Describing Nursing's Role. The quantitative findings showed that participants' self-compassion decreased over their first year of practice. Levels of stress, presenteeism and burnout increased by the year mark. These increases were meaningfully significant between time points.

Conclusions: Differences in the stressors and coping of first and second career nurses should be considered in developing transition to practice programs for new nurses. Increasing rates of

stress, burnout, and presenteeism, highlight the ongoing need to address these issues. Improving the nurse work environment may aid in the transition to nursing practice of both first and second career nurses.

Relevance to clinical practice: First and second career nurses have increasing rates of stress, burnout and presenteeism that need to be addressed. However, there are differences in stressors and coping between first and second career nurses.

Introduction

The World Health Organization (2017) estimates there is a global nurse and midwife shortage of 9 million. One of the strategies to address the nursing shortage is to attract "mature applicants," such as those with prior vocational qualifications or work experience (Buchan & Calman, 2005). As a result, there has been an influx of individuals with prior careers and education entering nursing as a second career or pursuing nursing as a second degree (American Association of Colleges of Nursing, 2010). To accommodate these individuals, who often have many transferable job skills, many nursing programs have created alterative educational pathways (e.g. accelerated programs or entry-level master's programs). These programs are aimed at adult learners, capitalize on their strengths and offer shortened program lengths. Regardless of their educational pathway, second-career nurses are typically more motivated, older, and excel in classroom and clinical experiences (Bentley, 2006; Cangelosi, 2007; WK, 1995). Second-career nurses also plan to stay in their first nursing positions longer and are often called upon to pursue leadership roles in nursing practice and education (American Association of Colleges of Nursing, 2010; Brewer et al., 2009). The little that we currently know about second-career nurses is encouraging that they will positively impact nursing. However, we know little about their stress, coping, and burnout during the transition to practice. Knowing more about their experiences during this difficult time can provide insight into their strengths and challenges, and how to prepare them for a successful career in nursing.

Background

At 1.6 million, registered nurses (RNs) are the largest group of healthcare providers in hospital settings in the United States (Bureau of Labor Statistics, 2016). Nurses are often responsible for providing direct patient care in hospitals, and nurse performance, education and

staffing levels have been linked to multiple negative outcomes for patients, including patient mortality (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). However, hospital organizations often lack the nurse staffing and education levels they need to meet patient care demands. The average RN vacancy rate is 8.1%, although this varies greatly by state (NSI Nursing Solutions, 2016). Additionally, there is high turnover among nurses. As of 2015, the nationwide nurse turnover rate in the United States was 14.6% (NSI Nursing Solutions, 2016). This rate is even higher among new nurses. One in three (33.5%) new nurses leave their first position within two years of becoming a nurse (Kovner, Brewer, Fatehi, & Jun, 2014). Compounding this is the impending departure of the baby boomer nurse generation. This has worried some researchers who warn of the loss of nursing knowledge and experience (Beurhaus, Skinner, Auerbach, David, & Staiger, 2017). In order to combat the current vacancies and nurse shortages in different parts of the country, nursing education programs have expanded, and new programs have been developed.

New programs to increase the size of the nursing workforce include accelerated programs and entry-level master's programs. In 2016, the American Academy of Colleges of Nursing (2016) reported there were 17,725 students enrolled in accelerated baccalaureate program and 6,991 enrolled in entry- level master's programs. Both programs often take prior work experience and/or educational training into account and attract students who are seeking employment opportunities, financial stability and desire to become nurses (Wu & Connelly, 1992). Studies comparing student outcomes of traditional baccalaureate and accelerated nursing degree programs have compared second-degree students to traditional students. Studies have found similar NCLEX pass rates and that students in both types of programs have similar attitudes about nursing (Bentley, 2006). Second-degree students have been found to be highly

motivated and focused regardless of attendance in traditional baccalaureate or accelerated program (Cangelosi, 2007). Accelerated programs have been successful at increasing the number of nurses; however, they are not available in all states and entry into these programs is very competitive. This leads some second-degree students to attend traditional nursing baccalaureate programs. Some second-degree students have prior work experience in another career while others are entering nursing right out of their first degree program. Nursing students coming from different career fields bring with them prior work and educational experiences. These experiences make them prized by both hospitals, who pay them more than traditional baccalaureate graduates, and nursing schools who see them as potential future faculty members to address the faculty shortage (American Association of Colleges of Nursing, 2010). However, there is very little formal evaluation of the experiences of second-career nursing students as they enter the workforce in comparison to traditional nursing students. Studies comparing both groups need to be conducted in traditional rather than accelerated programs because traditional nursing students do not meet the criteria for accelerated programs.

There are stressors during the transition to nursing practice that may be similar to other professions, such as adjusting to co-workers, supervisors and company policies. Exploration of areas related to transition to a first job versus transition to nursing may guide future interventions to prepare nursing students for the transition based on their prior career experiences. A majority of work on transition to practice experiences has focused on the whole new nurse population rather than looking at specific sub-groups of the population (e.g. second-career or second-degree nurses). The transition to nursing practice has been previously identified as a difficult time for new nurses who often experience lack of confidence, workplace incivility, and role strain (Beecroft, Dorey, & Wenten, 2008; Shatto & Lutz, 2017). These experiences have been tied to

stress, burnout and insufficient coping, which can lead to decreased job satisfaction (Chang & Hancock, 2003). Decreased job satisfaction has been linked to turnover, which makes addressing stress, burnout and coping among new graduate nurses important (Booth, 2011; Liu et al., 2012). Efforts to address stress and lack of coping during the transition to nursing practice have included the development of residency programs, mentoring programs, and additional educational opportunities. Published literature supports such programs as improving the transition experiences of new nurses (Rush, Adamack, Gordon, Lilly, & Janke, 2013; Trepanier, Early, Ulrich, & Cherry, 2012). However, the impact of residency and mentoring programs on the experiences of individuals with prior career and/or educational experience has not been studied. One study examined the differences between traditional and second-degree new graduate nurses in a nationwide sample and identified that second degree students experienced higher family-work conflict, lower workgroup cohesion, and planned to stay in their first job indefinitely (Brewer et al., 2009). In that study, over half of the second-degree new graduate nurses had careers prior to becoming nurses with 54% having prior non-healthcare work experience and 56% having prior healthcare work experience (Brewer et al., 2009). The make-up of the Brewer et al. (2009) stratified national sample shows that second-career nurses are a large group within the new nurse workforce. Studying these individuals during the transition may provide insight into how hospital organizations and nursing programs can improve retention.

The purpose of this mixed methods study was to explore the transition to practice experiences of first career and second career new nurses. Hereafter, second-career new graduate nurses will be referred to as SCGN, and traditional new graduate nurses who did not have prior careers will be referred to as TGN. Specifically, this study focused on experiences adjusting to the new work environment, stress and coping strategies, and future education and career plans.

The specific objectives of this study were to 1) assess if there are differences in stress, coping and burnout between SCGN and TGN as they transition to nursing practice; and 2) explore the transition to practice experiences of SCGN and TGN.

Design

Design. The present study utilized a mixed methods design that paired qualitative interviews with a survey. The interviews were conducted at a single time point while the survey was conducted longitudinally across three time points between April of 2015 and May of 2016. Separate groups of participants took part in the qualitative and quantitative portions of the study.

Methods

Study subjects and Setting. Both groups of participants were recruited via convenience sampling. Participants for the interviews were recruited from a large Midwestern Academic Medical Center with an accredited transition to practice residency program. Participants were recruited through an email listserv of residency program graduates who had been practicing as nurses for between one and two years. The interview inclusion criteria consisted of: 1) participants had between one and two years of experience as a registered nurse, and 2) participants either had a career prior to nursing or did not have a career prior to nursing. For the purposes of this study, a career was defined as working full time for a period of over a year while not taking educational courses to pursue another degree. A total of fifteen semi-structured interviews were completed. Participants were given $20 for participation in an interview. Attempts were made to recruit as many SCGN as possible.

Participants for the surveys of both SCGN and TGN were recruited through in-class announcements about the study by the primary author during their final month of coursework at two traditional baccalaureate nursing programs in the midwestern region of the United States.

Participants were then emailed a link to participate in the survey by their instructors. After completing the survey, participants had the option of providing their email addresses to the study team to be contacted for follow-up surveys at 6 and 12 months. Participants in subsequent follow-up surveys at 6 and 12 months had the option of being entered in raffles for two $50 gift cards at each time point.

Data collection. Qualitative data was collected using in-depth semi-structured interviews conducted during the summer of 2015. All interviews were conducted by the first author in a private interview room in an academic building at the authors' institution. Interviews were scheduled at the participant's convenience. Interviews lasted between 42 and 60 minutes. After the interview consent statement was read and participants agreed to have the interview recorded, the interview audio recording commenced. The interviews started with the question, "Tell me about how you decided to become a nurse?" Participants were then asked questions about their experiences during their first year of nursing practice, their strategies for coping with any stress during the transition to practice, and their prior work experiences and future educational and professional plans. Interview recordings were transcribed word-for-word by a HIPAA-certified transcriptionist. The transcriptions were reviewed for accuracy by the first author. The COnsolidated criteria for REporting Qualitative research (COREQ) checklist was followed (See Supplementary File 1) (Tong, Sainsburg & Craig, 2007).

The survey included questions about participants' current and future work and education plans, as well as multiple reliable and validated instruments measuring coping, stress, burnout and presenteeism. We used a sample size calculator to determine an ideal sample size of 118 for our initial time point based on the size of the two nursing programs we recruited from, and our desire for a 95% confidence interval and 5% margin of error (Qualtrics, 2018). As with other

longitudinal surveys, we did anticipate lower response rates at subsequent time points. All of the instruments utilized in this survey have been previously utilized to measure these constructs within a nursing population and have been found to be valid and reliable. Survey data was collected for a two week windows in April/May 2015, November 2015, and May of 2016. Coping was measured using the Self-Compassion Scale, which has been used in the nursing student population (Crary, 2013), to measure an individual's level of compassion for himself or herself (Neff, 2003). Stress was measured using the Perceived Stress Scale (PSS). The PSS was developed to measure an individual's perception of how stressful life situation are (Cohen, Kamarck, & Mermelstein, 1983). The PSS has been widely used in prior studies on perceived stress level among nurses (Applebaum, Fowler, Fiedler, Osinubi, & Robson, 2010) and nursing students with a Cronbach's alpha of 0.87(Crary, 2013). Burnout was measured using the Maslach Burnout Inventory (MBI). The MBI measures three kinds of burnout: emotional exhaustion, depersonalization and personal achievement. The MBI has been widely used to measure burnout among nurses and across professions with previously published Cronbach's alphas for each subscales of 0.90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal achievement (Leiter & Maslach, 2009; Poghosyan, Aiken, & Sloane, 2009). A license for the MBI-Human Services Survey version was purchased and used in this study (Maslach & Jackson, 1981). As data collection progressed, an instrument for presenteeism was added to the survey for the six and twelve months post-graduation collection time points based on findings from the interviews. Presenteeism is when an individual is physically present at work, but is not fully engaged or performing (Rainbow & Steege, 2017). In this survey we were particularly interested in presenteeism related to transitioning to practice, so we selected a measure that looked at job-stress presenteeism. The job-stress-related presenteeism scale measures when cognitive energy is

diverted from work due to job stress and has a previously published Cronbach's alpha of 0.91 (Gilbreath & Karimi, 2012). The scale has been used in nurses in a prior study (Karimi et al., 2017).

Data analysis. Thematic analysis was utilized for the qualitative analysis of the semi-structured interview transcripts. Specifically, latent inductive thematic analysis was selected due to its flexibility, focus on patterns within data, and goal of identifying themes absent a theoretical model (Braun & Clarke, 2006). Analysis of the qualitative interviews was carried out by the first author and an honors' nursing student. In accordance with the steps of thematic analysis, both members of the team read through all transcripts (Braun & Clarke, 2006). The team then met to generate initial codes based on the data and themes identified during the first reading and subsequent discussion. The transcripts were then uploaded into Dedoose (2016), an online cloud-based qualitative data analysis tool along with the list of the codes generated by the team. The transcripts were then all coded by the first author. In order to ensure rigor in the coding, the honors' student coded five of the interviews that were also coded by the first author. The honors' student and first author met and went through line-by-line to ensure codes were applied correctly on the five transcripts that were coded by both to member check. The two discussed the codes and how themes could be created from these codes. The themes were then presented to a group of nurse researchers along with quotes to support each theme. The themes were named and presented at various nursing research conferences for discussion and feedback.

The reliable and validated quantitative survey measures for each data collection time point (one month prior to graduation, and at 6 months post degree completion and 1-year post-degree completion) were scored using the published guidelines for each scale. Participants who did not complete all items were not given a score for the scale. The first aim of our study was to

look at difference in stress, coping and burnout across time points. In order to assess if there were significant differences, we chose to analyze effect sizes. Effect sizes measure the magnitude of differences between groups or time points, which aligned with our aim (Sullivan & Feinn, 2012). Specifically, we computed Becker's (1988) effect sizes for participants who completed the survey at multiple time points and answered codifier questions across time points.

Ethical considerations. This study received approval from the institutional review board (IRB) at both universities prior to data collection. Participants in the interviews were read an IRB-approved consent script and verbally consented to participate in the interview and for the interview to be recorded. Survey participants were presented with an IRB-approved consent statement prior to beginning the survey. Participants were able to discontinue participation in the study at any time and to skip any questions that they did not wish to answer, including questions to track participants across timepoints. All data was stored securely, and participant confidentiality was maintained.

Results

Of the 15 participants in interviews, thirteen were female. Five participants had a career prior to entering nursing, which included banking, carpentry, and waitressing, and were considered as SCGN for the following analysis. Additionally, one participant pursued a nursing degree after completed a baccalaureate degree in another discipline. However, she did not have prior full-time work experience, and therefore, was classified as a TGN for this analysis. There were three themes that emerged from the analysis of the interviews. The three overarching themes were Stressors and Coping, Prevalence of Burnout and Presenteeism, and Difficulty Describing Nursing's Role. Each theme described experiences common across participants.

However, specific experiences related to each theme differed based on prior career experiences, specific work unit, and prior healthcare experiences.

Theme: Stressors and Coping

All of the participants expressed that the transition to nursing practice was stressful. Both SCGN and TGN identified the feeling of additional responsibility of being a nurse as a primary stressor. In particular, the responsibility and stress of repeated life and death situations was a common thread.

> I just don't want to talk about work anymore because it's depressing honestly. A lot of the cases, again I think it's where I work, but a lot of the patient cases we have are super sad. It's really young people with super sick little kids or that died and you're in super stressful situations, code situations... I try not to talk about it anymore because it's not something I want to focus on my days off, but it's hard because I just feel tired all the time (Participant #4).

The weight of life and death situations on participants was evident in that these were the most commonly highlighted situations by participants when they were asked to tell a memorable experience for the past year that would stay with them for life. Participants had different strategies for coping with these situations that included strategies taught in the residency program and learned elsewhere. Participants' residency program included multiple classes on different coping strategies, like journaling, and opportunities to de-brief with other new nurse residents. Participants stated they found classes on coping strategies helpful. When asked if they employed these coping strategies outside of the classes, participants were divided on if they employed the strategies with some stating they had used the strategy (e.g., journaling) prior to learning about it in the residency program. Participants discussed how learning coping strategies in nursing school would have been helpful prior to the transition. However, they explained that nursing school was a very stressful time and teachings on self-care strategies may have been viewed as busy work rather than as useful for their future transition to practice. In the above

quote by participant #4, the coping strategy described was avoidance which was not a strategy taught by the residency program.

While all participants talked about the increased responsibility and life and death situations as stressors specific to healthcare and nursing, there were differences between the additional stressors and coping strategies employed by TGN and SCGN. TGN expressed difficulties in adjusting to their first career job while SCGN faced pressure to make their new career work. In the following quote, a TGN discusses a few stressors she faced during her transition.

> Even things as silly as I mean insurance plans and benefits and I had no idea. I don't know any of that…. I think those were big stressors that just all fed into that first year. I definitely think that and as nurses I mean you go into such a, a role of responsibility that sometimes I'll take a step back and oh my goodness I am 23 years old and like I am doing all this stuff and I'm also figuring out all this stuff in my adult life…. And yet, I am trusted to take care of this child with cancer and administer chemotherapy. I think it's such a role of responsibility. That for some of us comes so early on in life. I think that probably contributes to stress a lot too (Participant #6).

This participant's discussion of how adjusting to the workforce and making life decisions was an added stressor during the already difficult transition to nursing was echoed by other TGN participants. Meanwhile, SCGN expressed that there were similarities between the adjustment to a new career in nursing and their prior careers. In particular, they highlighted how prior work experiences allowed them to work well with a variety of people.

> You run into people with all sorts of different personalities and like I said doing customer service and learning patience and how to be diplomatic, so I feel like those things I brought with me to nursing. And also being able to multi-task and being able to think on your feet was something that I brought with me. So it was nice to be able to translate that into nursing. I feel like the biggest difference is that with nursing you feel so much more responsibility. It's almost like a different pressure when you're coming in and you're starting on the floor because if I forget to send in somebody's application for credit for a class that they took, I can send it in tomorrow and it's no big deal, I mean unless it's the end of the year and then it's a little tight with the deadlines. But if I forget to give somebody their medication or if I forget to check medication compatibility before I give a medication, it's got greater repercussions (Participant #15).

Participant #15 described how her prior work experiences were useful in her interactions with others, completing tasks, and thinking on her feet. While ability to work with others was universally acknowledged as a transferable skill by SCGN participants, other skills varied based on prior career. Participant #15 also highlights how the stakes in nursing of making a mistake are different than in other careers. The stakes of making a mistake in nursing was discussed by both SCGN and TGN as an additional nursing responsibility stressor. SCGN discussed additional pressure to make their career as a nurse work. Participant #2, "I also felt a tremendous amount of pressure just to be successful and to make this career change work. [To] be able to stay on the unit that I was [working] on and work well under the management that I was working for. Just an incredible amount of pressure." This pressure was often described by SCGN participants as resulting from the financial and time sacrifices made by their families to support their transition to nursing. SCGN were invested in staying in their positions and organizations for the long-term often due to family and life commitments (e.g., home ownership) outside of work. While family and life commitments added additional pressure on SCGN to make nursing work, they also were often instrumental as part of the SCGN's social support coping network.

When asked what coping strategies they employed during the transition, there were differences between SCGN and TGN. Many SCGN described using the same coping strategies during their prior career, nursing school and the transition. TGN described developing new coping strategies for the new stressors of nursing. One common coping strategy sought by both groups was identifying social support to aid in coping with the stressors of nursing. SCGN had social support structures in place before the transition while TGN sought to continue forming social support structures during the transition. For many TGN this need to continue building social support structures was due to difficulties sharing their daily stressors with friends and

family members due to the life and death nature of their work stressors described above. This led

TGN to seek social support relationships with coworkers who understood what nursing entailed.

However, some TGN were disappointed by the gossip of the coworkers on their units that they

perceived as about them which limited their ability to build a social support structure of

coworkers.

> I felt that people doubted me a lot when I first came off orientation and was really intimidated, even going to work. I would wake up in the morning and just kind of dread it. And then, I think finally I hit a point where I was like, I need to stop caring about what other people think and what other people are saying (Participant #9).

This participant was able to reframe her thoughts about the gossip that she perceived was

happening, which allowed her to focus on her work and increased her satisfaction. Gossip was a

described across hospital units. However, the effect of the gossip different by prior career

experience. One SCGN in particular discussed intervening when he saw new coworkers being

discussed by veteran coworkers.

> I definitely get that sense from other nurses that it's them against those new employees and I've intervened a few times. When the new employee isn't around trying to give them the benefit of the doubt and trying to get the usually the veteran employee, a little perspective on what it means to be a new employee. How difficult that can be you know, that everybody comes from different backgrounds but let's do some educating first before we jump to conclusions about what this person is like or who they are or what they represent. Let's give them the opportunity to be successful first and that's hard for some veteran nurses to accept (Participant #2).

SCGN were often viewed as veterans by patients and coworkers because of their age which

provided them the opportunity to act as mediators between new nurses and veteran nurses or to

blend in. This highlights that although the TGN and SCGN faced both similar and different

stressors during the transition that the groups did support each other. Both groups stated that their

stress level improved and they began to feel "above water" after they had been practicing

between 6 and 12 months.

Theme: Prevalence of Burnout and Presenteeism

When describing their work environment, both SCGN and TGN discussed seeing multiple co-workers who were burned out and exhibiting presenteeism. The amount of burnout and presenteeism described by participants varied based on hospital unit rather than prior career status. SCGN did express that both burnout and presenteeism are present in their other careers as well. Both SCGN and TGN discussed how they were aware of potential consequences of burnout and presenteeism to their unit culture, patient care and their own health. In particular, the consequences of burnout for the unit as a whole were discussed.

> I've seen some coworkers that are burnt out and it's hard cause you know that they're burned out. Their temper is so much shorter. It's a little frustrating sometimes and it's hard to not let that negative attitude affect you cause it's so infectious… Everybody kind of gets put in a bad mood. So you know I just, it's hard because, it's hard to deal with that too. The other part of it too is some of them are more experienced nurses that are definitely more burned out and they've been doing it for a long time. So you as a newer nurse don't necessarily feel comfortable saying hey, calm down, it's ok (Participant #15).

As described by participant #15, the new nurses did not know how to respond to coworker burnout. However, they realized the effects of the burnout on their own mood. Additionally, participants on units they described as having high burnout described high turnover on the unit as well. This awareness of the consequences of burnout led many to actively try to prevent themselves from being burned out and proactively address burnout.

> Because I know that if I work more than that I will get burnt out. If I do that consistently, I know that that will burn me out. I need to have my work life balance and if I am working too much overtime I know that I won't get that and I will suffer emotionally, mentally (Participant #6).

Participant #6 described prevention strategies to address burnout. This quote highlights the level of awareness of burnout that participants in this study had.

In addition to burnout, participants described that presenteeism due to both illness-related and stress was occurring on their units. Participants described how they observed presenteeism in both co-workers and themselves. Like with burnout, participants described how they were choosing to not be presentee and seeking assistance when they realizing they were presentee.

> Knowing that we're going to be short staffed so you don't want to like, screw over your staff that's there that day. I think about that a lot. Um, I feel like, there is some people who come to work like sick and it's like, why did you come? Like, go home. But me personally I really haven't (Participant #5).

> There were a couple times where there was just outside stuff going on in my life where I realized at work I'm like I'm not present. And I was able to just talk to the care team leader and I just told her I would really appreciate an easier assignment or an assignment that is not a fresh heart coming back where I'm gonna have to be on top of my game just because there's stuff going on and I know I'm not 100% present (Participant #10).

These quotes both illustrate that presenteeism is an issue in the nursing work environment and that factors like staffing, illness, and life outside of work all play a role in an individual's presenteeism behavior. As seen in both quotes, there was self-awareness of presenteeism risk and behavior among participants in this study.

Theme: Difficulty Describing Nursing's Role

All participants were asked to discuss how their understanding of nursing changed over the first year of practice. All participants, except those who had work experience as a certified nursing assistant, stated that they were not fully aware of all that nursing entails even after their clinical and educational experiences in nursing school. The divide was based on prior healthcare experience rather than career experience. Participants expressed that even when nurses and instructors tried to explain what their new career would entail that they were unable to grasp the information.

> I just remember being a student and saying, when people would say your first year is going to be really hard, I would say, why are you saying that? Why don't you tell me something encouraging like you can do it, why are you making it sound like it's gonna be

horrible? And now I realize that they were trying to prepare me, but you can't. It's like being an adult talking to a teenager, you're never ever gonna be able to speak their language ever again because you're an adult now, you know? You don't know, you sound like an adult. So I don't know, I mean, I think that part of it too is that whole idea about nurses not being good at explaining what it is we do. You know, it is hard to explain (Participant #11).

Participants described that even in the position of being a nurse after the first year of practice that they were unsure of how to describe the first year of practice. While participant #11 discussed the inability to describe the first year to future nurses, other participants expressed the difficulty in explaining the first year to non-nurses. This was described in the context of seeking social support after stressful situations at work. In the case of TGN this limited their ability to receive this support from non-healthcare professionals.

The lack of understanding by other non-nurses of what nursing entails was a consideration that participants described in deciding if they would recommend nursing to others. In their responses, participants qualified that not everyone would make a "good nurse" and certain traits set apart "good nurses." These traits include: passionate, interpersonal skills, hardworking, self-sacrificing, organized and with common sense. The participants would consider if the individual had these personality traits when determining whether to recommend nursing or not. In addition to specific traits, they discussed how the multiple aspects of being a "good nurse" were difficult to manage and could contradict each other.

Yeah, I mean you have to be able to put someone else's needs above your own, to an extent…How am I supposed to take care of my patients if I haven't taken care of myself? And that can be really frustrating, but at the same time, if I have a bunch of things to do, I want to finish those up before I go eat my lunch. Does that kinda make sense? I think it's important to put other people's needs above your own to a certain extent (Participant #9).

The need to put the patient's needs completely above their own needs was a struggle described by participants as part of nursing. An individual nurse's decision about prioritizing their own needs and their patient's needs were central to determining the "goodness" of a nurse. This was

also viewed as a constant struggle that had the potential to be a stressor. Although participants were all happy with their decision to become nurses, the majority of participants did have plans to leave hospital bedside nursing and pursue further education or a less stressful position in the future.

Survey Results

There were a total of 122 participants at time point one (within 1 month prior to degree completion), 52 at time point two (6 months post degree completion) and 28 at time point three (12 months post degree completion). There were 16 SCGN at time point one, and three at time points two and three. Table 1 shows the mean scores and standard deviations for each instrument and number of participants at each time point. Due to the small sample size of the survey responses received, the second and first career groups could only be divided for timepoint one. Table 2 shows the scores of both SCGN and TGN for timepoint one. Demographic data collected on future career and educational plans highlighted the length of time that participants planned to stay in their first position and their future formal educational plans. After 1 year of practice, 76% of participants plan to stay in their current positions for 2 years or less and 97% of respondents plan to seek further formal education. The Cronbach's alphas for each scale in our sample were PSS=0.83, Self-compassion scale =0.73, Depersonalization 0.78, Personal Achievement 0.77, Burnout 0.90, and job-stress-related presenteeism = 0.88.

(Insert Tables 1 and 2 approximately here)

Survey participants had their highest level of stress prior to graduating. This rate fell at 6 months' post-graduation but rose again at 1-year post-graduation. Self-Compassion scores decreased between one month prior to graduation and one-year post-graduation. Presenteeism was measured using the job-stress-related presenteeism scale which utilizes a mean score.

Presenteeism rates rose between 6 months and 12 months post-graduation. Burnout rates rose over all three time periods.

Effect sizes were calculated that compared respondent scores between time points one and two, time points two and three, and time points one and three for respondents that completed each measure at both time points. We chose to calculate Becker's effect size because we had repeated survey measures and were able to track participant across time points (Becker, 1988). Table 3 shows the effect sizes. The effect sizes of the differences between MBI depersonalization between time points two and three (effect size =1.3) and one and three (1.3); job-stress-related presenteeism between time points two and three (1.1); and perceived stress between time points two and three (0.5) are all considered to have a moderate to large difference (Cohen, 1988). These changes in the levels of depersonalization, stress and job-stress-related presenteeism between the time periods are meaningfully different.

Discussion

The transition to practice experiences of those in this study mirror findings by other studies of new nurses (Booth, 2011; Boswell, Lowry, & Wilhoit, 2004; Duchscher, 2009). However, this study adds the unique experiences of SCGN to the body of literature on transition to practice experiences of new nurses. The qualitative analysis of interview data identified three themes across participants: Stressors and Coping, Prevalence of Burnout and Presenteeism, and Difficulty Describing Nursing's Role. Themes aligned with the findings of the quantitative portion of the study that identified increased stress, burnout, presenteeism and decreased self-compassion at one-year post graduation. There were meaningful differences detected in the levels of depersonalization, stress and job-stress-related presenteeism. This study identified some differences in transition to nursing practice experiences of SCGN and TGN related to stressors

and developing coping mechanisms but found differences in the other two themes were related to specific unit and prior healthcare experience rather than career experience. The findings of this study have relevance for nursing schools, transition to practice programs, hospital organizations and the larger nursing workforce.

New graduate nurses, including those in both the qualitative and quantitative portions of this study, experience new stressors. The level of perceived stress among survey participants meaningfully increased between time points two (mean score =12.5) and three (mean score = 15.1). This moderate effect size demonstrates that perceived stress may need to be monitored over time among new nurses. We hypothesize that some of this increase is related to the increased responsibility of being a nurse that many interview participants described. What makes this increase in stress worrisome is that it is coupled with a decrease in self-compassion. In a review of self-compassion literature, Neff and Knox (2017) highlight that high self-compassion has been linked to improved resilience, increased health-related behaviors, and improved relationships. Prior studies have also found self-compassion increases across the lifespan, and that increased self-compassion leads to decreased perceived stress (Allen, Goldwasser, & Leary, 2012; Neff & Germer, 2013). Our survey found that nursing students had higher mean self-compassion scores (3.4) when compared to published mean self-compassion score (3.1) of a general undergraduate student sample (n=222) in another recent study (Neff, Whittaker, & Karl, 2017). This higher score is promising; however, participants in this study had decreasing self-compassion scores during their first year of nursing practice (with a mean of 3.2 at both 6 and 12 months post-graduation). This could be tied to the process of developing new coping strategies described by TGN in the interviews. While SCGN had previously developed coping strategies, in particular social support systems and therefore did not have as strong of a need to connect to co-

workers for social support, many TGN described seeking to form new social support structures that were aware of nursing specific stressors. This aligns with Brewer et al. (2009)'s finding that second-degree nurses (of which over 56% had a prior career) had less workplace cohesion. Further exploration of stress, self-compassion and other coping strategies among new nurses over their first year of practice could yield valuable information about how to improve coping with the stressors of nursing.

One area that interview participants described actively using preventative coping strategies to address was burnout. Burnout and presenteeism prevalence was one of our thematic findings, and the importance and prevalence of burnout was also highlighted by the differences in rates of burnout over the first year among survey participants and the large effect size in levels of depersonalization across time points. According to Maslach et al. (1981) "average" burnout is signified by emotional exhaustion scores of 17-26, depersonalization scores of 7-12, and personal achievement scores of 32-38. Personal achievement counteracts emotional exhaustion and depersonalization (Maslach & Jackson, 1981). At one-year post graduation, participants in this study had average emotional exhaustion (mean = 24.5) and depersonalization (mean = 8.5) and higher personal achievement (mean = 40.6). We hypothesize that the rise in both depersonalization, emotional exhaustion and personal achievement are related to our interview findings of increased awareness of burnout and presenteeism, their prevalence, and their consequences. Presenteeism and burnout are related as they both decrease nurse performance and engagement at work. Nurses have been found to have higher levels of presenteeism than other professions in a prior study of presenteeism levels across work sectors (Aronsson, Gustafsson, & Dallner, 2000). Presenteeism has been linked to increased medication errors, missed patient care and patient falls (Cassie, 2014; Letvak, Ruhm, & Gupta, 2012). Burnout among nurses has been

linked to negative patient outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). It is promising that new graduate nurses in this study were aware of the prevalence of these issues and actively taking steps to avoid becoming burned out and being presentee, for example not accepting extra shifts and calling in sick when necessary. However, the large effect size difference in the level of job-stress-related presenteeism between six months and a year post graduation is signals that presenteeism has the potential to become an issue in this group. The increased level of awareness and rising levels of presenteeism may make new nurses the ideal target for future interventions to address burnout and presenteeism before they lead to negative consequences for patients, healthcare organizations, and the nurses themselves.

Interventions to address presenteeism and burnout may face barriers due to the culture of hospitals and nursing found in the literature and this study. The Occupational Safety and Health Administration (OSHA) (2013) has declared hospitals one of the most hazardous places to work due to the unique risks and culture. Nurses in this study described a desire to place patient needs above their own and how this made someone a "good nurse." Our participants described that struggle between one's own needs and the needs of their patient(s) has the potential to become a stressor and impact a nurses' own health and lead to burnout and presenteeism. The American Nurses Association (ANA) declared 2017 the year of the Healthy Nurse and encouraged nurses to take care of themselves in order to provide better care for their patients (Dawson, 2017). Decreased self-care can lead to health issues for nurses. In a recent study, over half of nurses reported suboptimal health and those nurses with health conditions were more likely to commit medical errors (Mazurek Melnyk et al., 2017). The ANA and other programs that focus on encouraging health care providers to take care of themselves in order to take care of their patients are important to counteract the belief among nurses that they need to place the needs of their

patients above their own regardless of the consequences. In order to create a healthy and sustainable work environment, nurses need to develop coping and self-care strategies and realize their own limits in order to provide the best care for their patients and to counteract the stressors of the job. The new nurses in this study were seeking coping strategies and actively working to prevent burnout and presenteeism, which is encouraging for the future of nursing.

This study explored the transition to nursing practice experiences of new nurses who had careers prior to pursuing nursing (SCGN) and those who were pursuing nursing as a first career (TGN). The generalizability of results of this study is limited due to the small sample size of the quantitative survey as well as the limited number of participants who had a prior career. As the survey component of the study was longitudinal, attrition in sample size is common. The results of this study echo results found in other studies, but also add a new qualitative perspective. We recommend that future studies look at the transition to practice experiences of SCGN as the number of these nurses is growing, and qualitative findings related to stressors and coping suggest that their experiences may be different, which can inform future programs to better support all new nurses in transitioning to practice.

Conclusion

This mixed methods study looked at the transition to practice experiences of TGN and SCGN. There were three themes that emerged from the thematic analysis of the qualitative interviews: Stressors and Coping, Prevalence of Burnout and Presenteeism, and Difficulty Describing Nursing's Role. Themes highlight that even with residency programs there still are issues within the nursing profession and work environment that make the transition to nursing practice difficult and stressful. Survey results illustrate that stress, presenteeism and burnout are present among both TGNs and SCGNs. We also found that self-compassion decreased over the first year

of nursing practice. Professional and work environment issues must be addressed before new

nurses are enculturated into these practices.

Relevance to Clinical Practice

Transition to nursing practice is a stressful time for all new nurses. TGN and SCGN have both

similar and different coping strategies and stressors. Differences in stressors and coping should

be considered in the development of transition to practice programs for nurses and in working

with new nurses. There also should be attention paid to the environment that new nurses work in

as the prevalence of burnout and presenteeism affect the transition to practice of new nurses.

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Table 1: Mean (SD) instrument scores for all participants at each time point

	Score Interpretation	Time point #1 Within month of graduation	Time point #2 6 months post degree completion	Time point #3 1-year post degree completion
Perceived Stress (scores range from 0-40)	Higher score = more stress	16.8 (5.3) n=119	14.4 (6.4) n=46	15.3 (5.7) n=28
Self-Compassion Scale (Mean score ranges from 1-5)	Higher score = more self-compassion	3.4 (.27) n=122	3.2 (0.7) n=47	3.2 (0.7) n=28
Job-Stress-Related Presenteeism Scale (Mean score ranges from 0-4)	Higher score = more presenteeism	Not collected	1.4 (0.7) n=47	1.7 (0.7) n=28
Maslach Burnout Inventory: Emotional Exhaustion (Scores range from 0-54)	Higher score = more emotional exhaustion	21.5 (11.2) n=122	20.7 (10.6) n=52	24.5 (9.6) n=27
Maslach Burnout Inventory: Depersonalization (Scores range from 0-30)	Higher score = more depersonalization	7.0 (5.3) n=123	6.0 (5.4) n=52	8.5 (5.4) n=28
Maslach Burnout Inventory: Personal Achievement (Scores range from 0-48)	Higher score = more personal achievement	35.7 (8.6) n=118	35.6 (12.8) n=52	40.6 (5.2) n=28

Table 2: SCGN and TGN instrument scores at timepoint #1 (prior to graduation)

	SCGN	TGN
Perceived Stress (scores range from 0-40)	17.3 (5.8) n=18	16.7 (5.4) n=98
Self-Compassion Scale (Mean score ranges from 1-5)	3.2 (0.8) n=17	3.1 (.6) n=104
Maslach Burnout Inventory: Emotional Exhaustion (Scores range from 0-54)	19.8 (12.7) n=17	22.0 (10.9) n=103
Maslach Burnout Inventory: Depersonalization (Scores range from 0-30)	3.2 (0.8) n=119	7.3 (4.9) n=104
Maslach Burnout Inventory: Personal Achievement (Scores range from 0-48)	36.6 (8.7) n=16	35.9 (7.9) n=100

Table 3: Effect Sizes

Instrument (time point, time point)	Becker effect size using bias correction factor	Lower 95% CI	Upper 95% CI
Perceived Stress (T1, T2)	-0.60	-1.03	-0.17
Perceived Stress (T2, T3)	0.52	-0.35	1.39
Perceived Stress (T1, T3)	-0.38	-0.98	0.22
MBI Emotional Exhaustion (T1, T2)	0.15	-0.22	0.53
MBI Emotional Exhaustion (T2, T3)	0.12	-0.43	0.67
MBI Emotional Exhaustion (T1, T3)	0.01	-0.43	0.45
MBI Depersonalization (T1, T2)	-0.05	-0.55	0.44
MBI Depersonalization (T2, T3)	1.35	0.60	2.10
MBI Depersonalization (T1, T3)	1.27	0.31	2.23
MBI Personal Achievement (T1, T2)	0.23	-0.20	0.66
MI Personal Achievement (T2, T3)	0.27	-0.52	1.05
MBI Personal Achievement (T1, T3)	0.50	-0.33	1.33

Self-Compassion (T1, T2)	0.14	-0.20	0.48
Self-Compassion (T2, T3)	0.37	0.01	0.72
Self-Compassion (T1, T3)	0.19	-0.39	0.77
Job-stress-related presenteeism (T2, T3)	1.07	0.25	1.88

Note: T1 = time point one, T2 = time point two, and T3 = time point three

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

- First and second career nurses have different coping strategies and stressors.
- Presenteeism and burnout in nursing work environment impact transition to practice.
- Stress, presenteeism and burnout increase over first year of practice.