AN INSTITUTIONAL ETHNOGRAPHIC EXPLORATION OF THE TRANSITIONAL EXPERIENCE OF REGISTERED NURSES ENTERING THE LONG-TERM CARE ENVIRONMENT

By
Emily Ellen MacDonald

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Supervisor: Rose McCloskey PhD, Faculty of Nursing, UNB

Committee: Heather MacDonald PhD, Faculty of Nursing, UNB

Examining Board Chair: Janice Thompson PhD, Director of Graduate Studies, Nursing Lisa Keeping-Burke PhD, Associate Dean of Health Research Carmen Poulin PhD, Associate Dean of Arts

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ABSTRACT

As the Canadian population advances in age, and the proportion of citizens’ aged 65 years and older increases, greater strain is placed on the health care system, particularly the long-term care (LTC) sector. Registered Nurses (RN) are vital members of the LTC team; however, little is known about the transition period for them into the LTC environment. Understanding the lived experiences of RNs who transition into LTC will not only support the development of strategies to positively impact recruitment and retention, but will also enhance the quality of care and life for LTC residents. The purpose of this research was to investigate the lived experiences of RNs who are transitioning, or have transitioned, into the LTC environment. Dorothy Smith’s Institutional Ethnography (Smith, 1987) was adopted as a creative approach to the issue under study. The experiences of RNs who transition into LTC and the social, political, historical, and economic factors that influence their role and experiences were explored. Findings from the study reveal a complex transition period for RNs and the social and ruling relations that mediate their everyday/everynight lives and shape their transitional experience were identified.
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CURRICULUM VITAE
CHAPTER 1

INTRODUCTION

Gerontological nursing is my passion. My interest in nursing began when I was a young girl, as I was immersed in the long-term care (LTC) environment while regularly visiting family who lived and worked in a local nursing home. I was fascinated by the unique stories of the elders, daily work of the committed care team, and the close-knit community of family within the home. When the time came, the decision to pursue my Bachelor of Nursing (BN) degree was a natural one. I was immediately captivated by the knowledge I was gaining in the program and found myself continually seeking more.

After completing the first year of the BN program, I gained casual employment at a LTC facility as Resident Attendant (RA) and remained in the position throughout the remainder of my degree. This provided me with an opportunity to become an active member of the LTC team and provide basic care to the geriatric population while developing an excellent bedside manner. Additionally, I was able to enhance my time management, communication, and prioritization skills. I gained an appreciation for the elderly population and their complex care needs, while strengthening my interest in the field of gerontological nursing.

Following completion of my BN degree, I transitioned into the role of the Registered Nurse (RN) in LTC and worked part-time in the same facility, along with working casual in surgical nursing. After gaining experience in various other areas and becoming a well-rounded nurse, my passion for gerontological nursing was reaffirmed. While practicing in different areas during the first few years of my nursing career, and gaining valuable knowledge and experience, my curiosity grew. I found myself
frequently inquiring why things were done the way they were and reflecting on strategies that I felt could improve nursing practice and enhance patient outcomes and quality of life. Subsequently, I developed a strong desire to enhance my research evaluation skills for evidenced-informed nursing practice and obtain the foundational knowledge for performing research contributing to the body of knowledge specific to the nursing profession. Given my clinical area of interest, it was evident that I would be dedicating my future research endeavors to improving the quality of care and enhancing the quality of life of the geriatric population. Thus, my journey into graduate education began.

Selecting one single topic to focus my thesis research on proved to be a difficult task. Confirming that this project was only the beginning of my career in nursing research certainly guided me in terms of narrowing my topic. Reflecting on my previous experience as a new graduate nurse transitioning into the role of the RN in a LTC facility, I vividly recall finding the transition challenging. I was astounded to discover that new RNs within the facility were allotted only minimal orientation of between three and five shifts. My familiarity with the facility, daily routines, staff, residents, and family members certainly served as an advantage for me during the transition period.

I perceived my new role to be unique to any other clinical rotation that I had experienced. While LTC was a clinical placement within my undergraduate program, it occurred during the first year of the program and the emphasis was on basic bedside care as opposed to the multidimensional role of the RN in LTC. In my experience, few new nurses were interested in entering gerontological nursing, and I often had colleagues inquire about my motivation for pursuing the field. Another trend that I noted was, of those RNs hired part-time or casual, few chose to remain in the position. This raised
many questions for me concerning the role of the RN in LTC and more specifically, the transition experience for them.

My interest in Institutional Ethnography (IE) as a potential method of inquiry for my graduate research originally emerged from my personal curiosity of the method. After a brief introduction to IE through a graduate research course, I subsequently pursued an independent study focused on qualitative inquiry and IE as a research method. After a critical analysis of the current literature surrounding the RN in LTC, presented in chapter 2, followed by the development of appropriate research questions to guide my investigation, I determined that IE would be a relevant approach to address the research question. IE offers a unique opportunity to identify the wider social, economical, historical, and ideological constructions of the LTC environment, as well as the social and ruling relations that mediate the everyday/everynight life of the RN in LTC. IE also provides an opportunity for further exploration into how these constructions and relations shape the transition experience of RNs.

**Critical Reflection**

Campbell and Gregor (2008) highlighted the importance of teaching students, or novice institutional ethnographers, to utilize their own experiences as the core for beginning reflective processes. They described that institutional ethnographers are required to consider how their own interests and experiences situate them relative to what the scholarly discourse of their research topic suggests (Campbell & Gregor, 2008). Additionally, significant emphasis is placed on the importance of recognizing how researcher’s personal and professional experiences position them as ‘knowing subjects’ that can investigate what truly occurs to both themselves and others (Campbell & Gregor,
2008). Working through such processes is viewed as a prerequisite for the institutional ethnographer to further identify the social and ruling relations within the everyday world under investigation (Campbell & Gregor, 2008). Thus, acknowledging that my interest in LTC and gerontological nursing has been inspired by both personal and professional involvement, critical reflection of my experiences is a crucial component of the research process to begin in the early stages.

I realized that my previous experience in gerontological nursing would benefit me in terms of having an understanding of institutional language. This is supported by DeVault and McCoy’s (2006) claim that participant use of institutional language and a researcher’s unfamiliarity with it is a potential challenge to using institutional ethnography (IE) as a research method. However, further critical reflection on my experiences has led me to discover various assumptions that I was able to identify and analyze. Brookfield (1995) referred to the journey of becoming critically reflective as complex and highly focused on “hunting assumptions” (p. 2). Thus, I explored my assumptions through reflecting upon my experiences with transitioning into and working in the role of RN in LTC. To accomplish this, I posed appropriate questions to myself and subsequently documented, in detail, my thoughts and responses to each question. Creating an environment of contextual awareness subsequently led me to analyze my assumptions surrounding the activities of RNs in the setting, philosophies of care, staffing policies, team models of care delivery, and leadership styles. Through further imaginative speculation and reflective skepticism, I affirmed that such characteristics of LTC environments were likely to vary considerably depending on the facility.
Significance of the Issue

The proportion of Canadians aged 65 years and older is 16.1% and this percentage is expected to steadily increase as the population of baby boomers advance in age (Statistics Canada, 2015). This baby boomer population is presenting with complex health challenges, greater longevity, and increased care needs. Subsequently, greater strain on the healthcare system is anticipated. This population also presents with enhanced knowledge; thus demonstrating significant potential to actively challenge prevailing practices and approaches.

Perhaps more concerning, recent reports have confirmed that the province of New Brunswick has the highest proportion of Canadians aged 65 years and older, exceeding the national proportion, at 19% (Statistics Canada, 2015). Although governments are focusing on supporting seniors to stay in their homes as long as possible (Government of New Brunswick [GNB], 2014), the need for LTC facilities will by no means diminish.

Despite increased population life expectancy, rise in care complexity, and the known association between RN staffing and enhanced resident outcomes, the RN to resident ratio in LTC has not been reflective of such changes (Registered Nurses Association of Ontario [RNAO], 2010). Through their systematic review of nursing homes (NH) staffing standards, of six countries, Harrington et al. (2012) found that the majority of countries did not have acuity-adjusted staffing standards in NHs. Furthermore, the CNA (2015) confirmed that 4,400 fewer RNs are employed in Canadian LTC settings today, compared to 2005.

Quality of care and quality of life concerns related to LTC facilities have been receiving increasing attention over the last few decades (Hirst, Lane & Miller, 2015).
Research has identified the relationship between RN staffing and improved resident outcomes (RNAO, 2010). However, further research is required to strengthen the body of evidence validating and describing the role of RNs in LTC and to identify strategies to retain and enhance these nursing positions. One avenue of investigation into this complex area of study could be the RN transition into employment within LTC facilities.

Setting the Context

To understand how RNs experience the transition to LTC and how their everyday life within their new role is organized, it is important to first gain an understanding of various concepts foundational to the discourse surrounding the subject. In this section I will describe the LTC environment and review characteristics including type of residents and typical staffing within such facilities. This will provide a foundation to understanding the area under investigation in this study for those unfamiliar with the LTC environment. Chapter 2 will expand on this section by presenting a more detailed description of the role of the RN in LTC and explore what the relevant literature offers in terms of the RN transition into the LTC environment.

Defining Long-Term Care

Long-term care (LTC) facilities, also referred to as nursing homes or personal care homes, are residential facilities that provide 24 hour care to seniors and/or those living with chronic health conditions who require assistance to self-manage (Canadian Institutes for Health Information [CIHI], 2013). Although residents admitted to nursing homes are medically stable and do not require hospitalization into an acute care facility, the level of care they require is not available through community resources (CIHI, 2013). LTC Services in New Brunswick are defined as “a range of personal support, physical,
social and mental health services required by individuals who, because of long term functional limitations need assistance to function as independently as possible” (GNB, 2015, p. 1). The Department of Social Development (DSD) assists primarily by assessing individuals for LTC, determining eligibility, and guiding persons to access appropriate services.

The DSD highlights that their services in nursing homes “emphasize the resident’s physical, social, and psychological independence” (np, 2016). Given that LTC does not fall under the Canada Health Act, individuals who have the financial resources to pay, contribute in part or whole, the costs of LTC services are required to do so. In circumstances where citizens cannot afford the costs of LTC services based on their family income, government assistance will be provided.

The population residing in nursing homes often have multiple chronic health conditions and can also be living with cognitive and functional impairments. Residents typically require assistance from nursing staff with several activities of daily living (ADLs). For example, in 2013 “95% of residents needed at least some assistance with activities of daily living such as bathing, dressing or eating; more than 80% of these residents needed extensive assistance with these activities” (CIHI, 2014, p. 2). From a local perspective, there are currently 65 nursing homes in the province of New Brunswick (New Brunswick Association of Nursing Homes [NBANH], 2015) with a total of 4455 beds (GNB, 2015) and average resident age of 85 years (CIHI, 2013).

**Staffing in Long-Term Care**

In addition to nursing professionals, additional support staff in LTC include dieticians, kitchen, recreation, personnel in laundry and housekeeping, rehabilitation,
maintenance and administration (GNB, 2015). Nursing staff in LTC facilities typically consists of Registered Nurses (RN), Licensed Practical Nurses (LPN) and Personal Support Workers (PSW). It is important to recognize that PSWs in the LTC environment are frequently referred to as Resident Attendants (RA). The regulated nursing workforce in LTC includes RNs and LPNs, while PSWs represent unregulated care professionals. Although the NBANH (2003) described the minimum staffing requirement ratio to be 20% RNs, 40% LPNs, and 40% PSWs, CIHI (2014) reported that time worked by regulated professionals in nursing homes in 2013 was less than half of total hours worked. PSWs or RAs provide the majority of direct care today including assisting residents with bathing, dressing, and other ADLs. RNs function in charge nurse positions and are responsible for the overall direction of nursing care within the LTC facility. The Nursing Home Act mandates that facilities have a minimum of one RN in the building at all times (NBANH 2003).

**Purpose of the Study**

**Research Goals**

The purpose of this study was to investigate the lived experience of Registered Nurses (RN) who are currently transitioning or have recently transitioned into the LTC environment, as well as their everyday and everynight activities within their new role. As chapter 2 will demonstrate, the relevant literature is focused primarily on the transition for new graduate nurses into acute care settings. Attention to the lived experiences of nurses transitioning into the LTC environment is absent from the research. The underlying goals of this study were to:

i) perform a thorough review of the social, political, historical, and economic factors
that shape the role of the RN in LTC and which influence their transition experience;

ii) explore institutional policies, practices, and priorities that shape how the RN functions within the LTC environment and how these influence their transition experience;

iii) identify strategies for the development of interventions to enhance the transition experience for RNs and subsequently improve recruitment and retention of RNs into LTC

Research Questions

The research questions that guided this investigation included:

1. What are the everyday/everynight experiences of RNs who transition to the into the LTC environment?

2. In what ways do prevailing social, political, historical and ideological constructions of the LTC environment shape the transition experiences of RNs?

3. What are the social and ruling relations that mediate the everyday/everynight life of the RN in LTC, and how do these relations shape the transition experience for RNs?
CHAPTER 2

REVIEW OF THE LITERATURE

To understand the transitional experience for RNs into the LTC environment, it is important to first understand the role of the RN in LTC. In Canada, LTC falls within provincial jurisdictions resulting in diversity in how LTC is organized and delivered across the country (Armstrong et al., 2009). Furthermore, Armstrong and colleagues (2009) highlighted the paucity of comprehensive LTC pan-Canadian analyses and the subsequent struggle in pursuing any discourse at the national level. Exacerbating this issue is the reality that the senior population is steadily advancing in age, along with an increase in complexity of care needs. As a result, LTC environments are enduring significant transformations across the globe. More specifically, the role of the RN in LTC is continually evolving and researchers have been endeavoring to define this essential and unique role for quite some time now. Literature pertaining to the role of the RN in LTC, gerontological nursing as a career choice, and the transition of the RN into LTC was reviewed for this study. Relevant transition theories were also reviewed.

The Registered Nurse in Long-Term Care

National and Provincial Role Description

Similar to the organization and delivery of LTC in Canada there is variation and ambiguity both nationally and internationally, in terms of a standardized job description for the RN in LTC. From a national perspective, the Canadian Nurses Association (CNA, 2013) recently released a position statement presenting solutions for caring for Canada’s older adults. However, their focus is on innovative roles outside of the charge nurse role in LTC. For example, they introduced nurse-led outreach teams and mobile emergency
teams to address gaps in care services for older adults (CNA, 2013). Such roles are both exciting and promising; however, the focus of the current study is on the role of the RN within the LTC facility. Fortunately, the Canadian Gerontological Nursing Association (CGNA, 2010) provides specific nursing competencies and standards of practice for gerontological nurses in Canada. Essentially, the competencies serve as general guidelines for many gerontological nursing practice areas. Although the CGNA (2010) highlighted various roles that gerontological nurses assume in daily practice, such as clinician and educator, no descriptions in terms of job profiles in specific practice areas such as home care, LTC, geriatric clinics, and geriatric rehabilitation were identified. Correspondingly, no national role definition for the RN specifically practicing within the LTC setting was discovered during the search at the national level. Thus, further exploration of provincial publications was performed.

In 2005, the New Brunswick Association of Nursing Homes (NBANH) presented a document outlining the roles and responsibilities of the RN in LTC. The primary roles and responsibilities were categorized as those pertaining to organizational, nursing care, leadership, and health and safety (NBANH, 2005). Each of the 4 roles and responsibilities were further described in terms of key components and skill sets unique to each. Although the document promotes provincial standardization of the RN role in LTC facilitates, LTC environments have experienced numerous changes since the document was released. Today, a decade later, there is no evidence of provincial reevaluation of the RN role in LTC. RN job descriptions in each participating New Brunswick LTC facility will serve as a significant source of data for the current study.

Conversely, other provincial associations have published more recent documents
defining the role of the RN in LTC (ARNNL, 2013; SRNA, 2015). For example the Association of Registered Nurses of Newfoundland and Labrador (ARNNL, 2013) recently released a position statement outlining the RN roles in LTC. The six roles comprised of leader, coordinator, practitioner, advocate, mentor, and program planner (ARNNL, 2013, p. 1). Further strengthening the case for the importance of the RN in LTC, the Registered Nurses Association of Ontario (RNAO, 2010) declared, “The evidence is clear that in long term care homes RNs are more effective in improving resident outcomes and reducing costs” (p. 3). Thus, despite the dearth of a standardized role description it is evident that provincial bodies concur in terms of the uniqueness and value of the RN in LTC.

The lack of a universal definition and overall ambiguity concerning the RN in LTC prompted further investigation into international literature. As anticipated, emphasis of the RN as a crucial member of the LTC team was a persistent finding. For example, European researchers Bedin, Droz-Mendelzweig, and Chappuis (2013) concluded that the RN contribution to overall institutional functioning constitutes them as the “linchpin” (p. 113). Therefore, despite the absence of a common role description for the RN in LTC, other important themes surrounding characteristics, primary responsibilities, and dominant activities are embedded throughout the relevant literature. These themes were further examined and a description of the findings is provided below.

**Complex and Unpredictable**

Using qualitative inquiry, Canadian researchers explored how RNs in charge nurse positions within LTC facilities view their role and themes reflecting a complex and unpredictable nature emerged (McGilton, Bowers, McKenzie-Green, Boscart, & Brown,
In addition to completing routine daily duties, RNs are required to further distribute their time to meet competing requests of residents, staff, family, management, and regulatory demands (McGilton et al., 2009). Frequent unpredictable interruptions, as well as being responsible to fill in for management and administrative office duties, added to the already heavy workload of charge nurses and increased the need for reprioritization (McGilton et al., 2009). Thus, for RNs to function within their roles, they must become “master adapters” (McGilton et al., 2009, p 740). Bowers, Lauring, and Jacobson (2001), previously described similar unpredictable interruptions throughout the daily work of RNs in LTC, the impact on time, and the subsequent shift that participants referred to as “must do” work to “should do” work (p. 490). Bower’s et al. (2001) described “must do” work as tasks that the nurse was directly accountable for such as completing paperwork as well as administrating treatments and medications (p. 490). Whereas, an example of “should do” work, also noted to add value to their work, was taking time to communicate with and get to know residents (Bower’s et al., 2001, p. 490).

Roles and Daily Activities

Although the role of the RN in LTC has been commonly described as complex and unpredictable, the categorization of primary activities and roles varies considerably throughout international research. Themes of the RN supervisory roles that emerged from McGilton et al.’s (2009) Canadian study included, “against all odds, getting through the day”, “stepping in work”, “leading and supporting unregulated care workers” (p. 731). Whereas, a study conducted in Sweden investigated RNs perception of their professional work in nursing homes and home-based care and revealed rather different categories: “establishing long-term relationships”, “nursing beyond technical skills”, and “balancing
independence and a sense of loneliness” (Carlson, Ramgard, Bolmsjo, & Bengtsson, 2014, p. 764).

A variety of other international studies also reflect diversity in terms of RNs description of common roles and activities in LTC. For example, an Australian study found that the most frequent activities of RNs in LTC included, “organizing their own workload” and “devising an individualized plan of care”, while the least frequently reported activities were, “developing policies in response to changes in legislation or clinical practice”, and “introducing appropriate research findings into practice” (Hunter & Levett-Jones, 2010). Whereas, a study conducted in Switzerland described the primary role of the RN in LTC to be coordination of activity (Bedin, et al., 2013). This role was further categorized into three areas: “organization and innovative activities”, “autonomous, person-centered activities”, and “ethical tension activities” (Bedin, et al., 2013, p. 114). Congruent with many aspects of the RN in LTC, international research suggests primary roles and activities vary considerably.

An expert consensus study currently in press, identified competencies that distinguish baccalaureate-educated RNs from other nursing staff working in LTC (Backhaus, Verbeek, Rossum, Capezuti, & Hamers, 2015). Researchers identified and invited experts from several countries to take part in the study. Consensus was reached on 16 desirable competencies for future baccalaureate-educated RNs employed in nursing homes. The authors highlighted that historically, significance was placed on competencies that reflect both expert knowledge and skills; however, results from this study revealed that competencies related to leadership, role modeling, and coaching were more prominent (Backhaus et al., 2015). Findings also indicated the importance of other
competencies, including those pertaining to communication, client assessment, geriatric expertise, and evidenced-based practice (Backhaus et al., 2015). The authors discuss that although the LTC environment is continually changing and its future is uncertain, focusing on the identified unique competencies of RNs in LTC could lead to enhancements in quality of care (Backhaus et al., 2015). This study presents a foundation for both national and international discourse surrounding essential competencies and qualities for RNs in LTC. Subsequently, the opportunity to standardize competencies and redefine job descriptions for RNs in LTC emerges.

**Gerontological Nursing: A Specialized Practice Area**

As evidenced by the existence of a national association, gerontological nursing is considered a specialty area of practice in Canada (CGNA, 2010). Accordingly, studies demonstrate that the profession of nursing views gerontological nursing as a complex and specialized area of practice (Dwyer, 2011; Hunter & Levett-Jones, 2010; McGilton et al., 2009). From an international perspective, participants from a Swedish study described their work as complex and essentially an advanced practice (Carlson et al., 2014). Participants in the study elaborated on these statements by discussing that their work was far more complex compared to acute-care settings. They also recommended that nurses obtain experience in acute-care prior to entering into the field of gerontological nursing (Carlson et al., 2014). Essentially, gerontological nursing as a specialized area of practice presents as a prominent theme within the existing literature.

**Advanced Practice**

The CGNA (2010) affirms that gerontotological nursing activities are performed while the nurse functions in a variety of roles including, professional, health system
(staff) member, clinician, communicator, collaborator, supervisor/lead, advocate, scholar, and educator. Interestingly, the CNA (2009) identified the five domains of practice for the Clinical Nurse Specialists (CNS), to include clinician, consultant, educator, researcher, and leader. Thus, in many ways, the gerontological nurse demonstrates qualities of an advanced practice nurse in their everyday roles and responsibilities. However, it is acknowledged that careful comparison is warranted as the CNA (2009) distinctly states that the CNS, as an advanced practice nurse, possesses both expertise in a clinical nursing specialty and is prepared at the master’s or doctoral level. The shared quality that most distinctly presents itself between the gerontological nurse and advanced practice is that of leadership.

A review of the relevant literature revealed that leadership and management skills are indicated as fundamental to the everyday role of the RN in LTC. The RN is typically in a charge nurse position in LTC facilities, as they supervise both licensed and unlicensed nursing personnel and are responsible for the overall delivery of care. As legislation governing LTC in some Canadian provinces requires one RN be on the premises at all times, RNs manage the care delivered in facilities 24 hours per day. Leadership characteristics of the RN play an imperative role in the overall operation of LTC environments. This premise is supported by Dwyer (2011) who highlighted, “leadership is the hallmark of effective management and retention within the service” (p. 389).

Accordingly, RNs are distinguishable as team leaders and are readily available for clients, families, and other members of the LTC team (ARNNL, 2013). In fact, findings from an Australian study confirmed that the RN in LTC has transformed into the job of
“specialized care facilitator” (Hunter & Levett-Jones, 2010, p. 527). This particular description could also be inclusive of what is often referred to as case management. Furthermore, a recent consensus study highlighted the extent to which international experts feel leadership is required as core competency for RNs in LTC (Backhaus, et al., 2015). Bedin et al. (2013) elegantly reflect the leadership role of the RN in LTC when they metaphorically referred to them as the “orchestra conductor” (p. 118). Although leadership is an expected role of the RN in LTC, Dwyer (2011) draws attention to the consideration that leadership within each facility is likely to vary depending on the preferred leadership style of the RN in charge at any given time.

An interesting finding by McGilton et al. (2009) about RNs in LTC, is that they do not directly articulate their daily activities as representing leadership. However, findings from their study revealed that elements of leadership were in fact heavily embedded within the RNs stated activities (McGilton et al., 2009). Some activities described included, mentoring, delegating, developing schedules, following up on tasks, and advising staff of what is important to keep an eye out for. The unexpected finding that RNs do not always recognize their leadership role was concerning given findings also show that how ones perceives their own leadership role shapes how they interact with other team members (McGilton et al., 2009). These findings expose important areas for further investigation, such as how institutional job descriptions compare to the RN’s description, and the resulting influence on the daily activities of the RN and other team members.

**Challenges**

As with any job and workplace, RNs in LTC are faced with daily challenges. RNs
in LTC report heavy workloads exacerbated by competing responsibilities, which often leads to chaotic work environments (McGilton et al., 2009). Similarly, RNs in LTC reported wearing multiple hats, which frequently removes them from their ‘nursing’ (Hunter & Levett-Jones, 2010). Correspondingly, experts have acknowledged that RNs in LTC facilities are performing tasks that are better suited for management or other members of the care team (Backhaus et al., 2015). Evidence also suggests that although RNs in LTC appreciate the autonomous aspect of their role, they express feelings of loneliness and isolation in relation to their everyday work (Carlson et al., 2014; Carryer, Hansen, Blakey, 2010). Additionally, McGilton, Boscart, and Brown (2014) discovered that concerns surrounding the impact of heavy regulated work environments on overall role functioning, paucity of active leadership, and sense of an underfunded system were significantly influential on licensed LTC staff’s decision to leave their position.

Researchers have also expressed concern related to findings that RNs in LTC integrate minimal involvement of evidence-based practice into their work (Hunter & Levett-Jones, 2010). However, no detailed investigation into the facilitators and barriers of incorporating this expected competency into everyday practice, specifically in LTC, was recovered. Finally, a lack of opportunity for continuing education and career progression was identified by RNs in LTC (Carryer et al., 2010; Dwyer, 2011). Nevertheless, authors identify the importance of specialized education in LTC and some propose national gerontological nursing certification as an approach to decrease staff turnover and ultimately strengthen quality of care (Cramer et al., 2014).

The majority of the identified challenges noted above were highlighted as
significantly impacting the overall functioning of LTC facilities. Thus, the reported challenges served as the focus for researcher’s recommendations in terms of future research. Authors have also demanded timely evaluation of the current care delivery models (Dwyer, 2011) and responsibilities and overall workload of RNs (McGilton et al., 2009). The need for thorough revision of RN job profiles in LTC has also been voiced (Backhaus et al., 2015).

Despite the challenges associated with the everyday lives of RNs in LTC, the literature implies that they possess both resilience and a strong sense of commitment (Dwyer, 2011). A review of RN’s experiences in LTC revealed that gerontological nurses are motivated “to be proactive and support innovation and change because they were committed to providing quality care for residents” (Dwyer, 2011, p. 392). Such characteristics are critical to meet the demands of the ever-changing nature of LTC and for future success with implementation of new models of care for LTC facilities.

**Long-Term Care as a Career Choice**

Reflecting on the aging population and current nursing shortage, recruitment and retention for gerontological nurses is imperative. Career decisions for nurses are generally identified during the undergraduate student experience (Neville, Dickie, & Goetz, 2014) and researchers have extensively investigated the reasons for undergraduate nursing student career preferences. Many scholars express concern that is has become commonplace for new graduate nurses to be reluctant to consider gerontological nursing as a career choice (Bedin et al., 2013). Other organizational methods directed at RN retention in LTC are also discussed throughout the literature. In depth exploration of such studies were not within the scope of this review; thus a brief overview of findings are
described below.

Neville et al. (2014) conducted a literature review and confirmed that undergraduates do not rate a career in gerontological nursing highly and discovered that, unfortunately, this is not a new trend. Some of many reasons students provided for not being interested in gerontological nursing included: viewing it as an uninspiring career; poor nurse to patient ratio/inadequate staffing; negative stereotypes; not technical, acute or challenging enough; poor working conditions; low pay; and limited clinical and theoretical experiences with older adults. Therefore, Neville et al. (2014) concluded, “modifying societal attitudes, evaluating undergraduate nursing curricula together with a comprehensive clinical placement review, and addressing working conditions are essential in promoting gerontological nursing as a desirable career preference for undergraduate students” (p. 26). Thus, it is evident that a collaborative multi-sectoral approach is required to adequately develop successful recruitment strategies for gerontological nursing.

In terms of organizational strategies for retention of RNs, it has been emphasized that significant changes in the LTC sector are immediately required (McGilton et al., 2014). This is supported by findings from a recent Canadian study investigating perspectives of licensed LTC nursing staff in relation to their intentions to remain in their positions (McGilton et al, 2014). Some of the reasons participants identified as influential on their decision to leave their positions included, “impact of regulations on role flexibility and professional judgment, the perception of an underfunded LTC system, and the absence of supportive leadership” (p. 921). Subsequently, researchers have emphasized that positive and sustainable changes to the
working conditions in LTC are a critical step toward strengthening recruitment and retention (McGilton et al., 2014).

**Registered Nurse Transition into Long-Term Care**

**Transition to Practice**

The challenges accompanying the transition from education to practice for new graduate nurses are well documented in the literature. For example, the concept of “reality shock” is described as a common experience for new nurses within the first six months of practice (Kramer, 1974; Missen, McKenna, & Beauchamp, 2014; Schmalenberg & Kramer, 1979). Missen et al. (2014) describe, “during this time, dissatisfaction begins to occur and graduate nurses start to lose their idealized perceptions of the nurse’s role, become disillusioned and no longer want to stay in their new profession” (p. 2430). Subsequently, various transition to practice programs for nurses have been considered as a method of easing this transition period and supporting new nurses in overcoming the associated challenges.

The expanding body of evidence confirming transition to practice as a challenging period of time and the positive effects of transition to practice programs has led to national calls for standardized programs including nurse internship and residency programs (Institute of Medicine [IOM], 2010; Villeneuve & MacDonald, 2006). Despite recommendations from creditable national associations, many countries, including Canada, are reluctant to implement a standardized transition to practice program. The majority of the literature on transition to practice programs primarily focus on adoption for acute care settings; however, recent literature urges the implementation into nonhospital settings including LTC (Spector et al., 2015).
**Literature Gap**

Findings in the literature that focus directly on the RN transition to LTC environments are scarce. One qualitative study performed in Australia, investigated the experiences of new graduate nurses in aged care (Fussell et al., 2009). However, the study appears to report on participants that were involved in a national program for graduate nurses. The researchers found that only 4 of the 11 participants reported a desire to work in aged care. Whereas, the other 7 participants unenthusiastically accepted the graduate position they were offered, with some expressing disappointment. Themes that emerged from the study include, lack of medical technology in aged care, role confusion, and lack of professional support (Fussell et al., 2009). Another important finding was that the participants who desired to work in aged care reported they found their work both fulfilling and satisfying (Fussell et al., 2009). Such findings led authors to recommend that recruitment of RNs into aged care be paired with the personal desire to practice in the area (Fussell et al., 2009). Due to international inconsistencies in government-funded programs for graduate nurses, it is important to question generalizability of the findings for this particular study.

Of the few existing studies pertaining to transitions and the LTC setting, the focus remained on the development and implementation of transition to practice programs for new graduate nurses, primarily at the pilot project level. Target outcomes from such studies included fiscal savings, direct impact on recruitment and retention, and program curriculum development strategies (Aaron, 2011; Spector et al., 2015; Xiao et al., 2009). None of the relevant studies investigated the transition experience to LTC from the RN’s
perspective. Furthermore, no studies endeavoring to explore the transition for experienced RNs into the LTC setting were found.

Transitions: Theoretical Perspectives

A review of relevant transition theories was performed to explore the theoretical perspectives surrounding transitions. Transition theories were identified and reviewed until it was determined that a thorough comprehension of relevant theoretical perspectives pertaining to transitions was obtained for the study. First, the history of transition theory in nursing was reviewed. Specifically, Meleis’s theory of experiencing transitions, as well as Patricia Benner’s from Novice to Expert was reviewed. William Bridge’s transition theory was also explored. A description of the three theories reviewed for the study is presented below.

The definition for the concept transition varies significantly throughout the literature. Through their concept analysis, Chick and Meleis (1986) stated “transition, as passage from one life phase, condition, or status to another, is a multiple concept embracing the elements of process, time span, and perception” (p. 25). Despite variations in definition, the concept of transition has been an interest of nurse clinicians, theorists, and researchers for several decades (Schumacher & Meleis, 1994). In-depth explorations of human transitions resulted in nursing leaders declaring transitions as a central concept for their discipline. In fact, the concept further advanced from the concept of transitions to theoretical models of transition experiences (Meleis, 2010). Meleis and Trangenstein (1994) highlight the interrelatedness between nursing and transitions by defining nursing as “being concerned with the processes and the experiences of human beings undergoing transitions where health and perceived well-being is the outcome” (1994, p 257). Thus,
the nurse has a crucial role in caring for and guiding humans through transition experiences in order to enhance best possible client outcomes (Meleis, 2010).

Schumacher and Meleis (1994) reviewed the nursing literature related to transitions to further support the claim of the concept of transition as essential to the nursing discipline. Their review of the literature revealed that there are multiple types of transitions explored in the discipline of nursing including, developmental, situational, health-illness, and organizational (Schumacher & Meleis, 1994). They further emphasized that although different types of transitions exist, given the complex nature of transition periods, these categories are not mutually exclusive. Despite this diversity of transitions, they also identified the presence of universal transition properties (Schumacher & Meleis, 1994). Such defining characteristics of transitions include the notion of transitions as processes that happen over time that involves “development, flow, or movement from one state to another” (as cited in Schumacher & Meleis, 1994, p. 121). The third universal property of transitions described by the authors was a change in fundamental life patterns. In addition to universal properties, Schumacher and Meleis’s (1994) synthesis found factors and conditions such as, meanings, expectations, emotional and physical well-being, level of knowledge and skill, and the environment, to be significantly influential on transitions.

**Experiencing Transitions: Meleis’s Middle-Range Theory**

Building on previous decades of nursing research exploring transitions, Meleis et al. (2000) developed a middle range theory “Experiencing Transitions”. Their theoretical framework is comprised of, types and patterns of transitions, properties of transition experiences, transition conditions (facilitators and inhibitors), process indicators,
outcome indicators, and nursing therapeutics. The well-defined model serves as the primary theoretical underpinning for many nursing researchers investigating transitions. This particular model provides nurses with a foundational understanding of the transition experience, while emphasizing the role of the nurse in preparing clients for and guiding them through transitions using appropriate nursing interventions. Ultimately, the majority of transition theories within the nursing discipline focus heavily on the role of the nurse in guiding clients through various transitions. Given that the focus of the current study is on the nurse experiencing transition into the workplace, further exploration of transitional theories was pursued.

Patricia Benner’s ‘From Novice to Expert’

Patricia Benner’s application of Dreyfus’s model of skill acquisition (Dreyfus, 2004) to nursing clinical practice is well known as a substantial contribution to the nursing discipline. Benner (1984) studied nursing practice and subsequently identified and defined the transition through five competencies of clinical nursing practice including, novice, advanced beginner, competent, proficient, and expert. Benner (1984) explained that knowledge is embedded in expertise and she distinctly differentiates each of competencies of clinical nursing practice.

Benner’s (1984) sentinel work states, “any nurse entering a clinical setting where she or he has no experience with the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar” (Benner, 1984, p. 21). This concept is particularly important for the current study as it supports the principal investigator’s decision not to exclude participants based on their previous experience. Thus, potential participants include “novice” nurses entering the LTC
environment directly upon graduation, as well as experienced nurses transitioning from other clinical practice areas who may be at various stages of Benner’s described clinical competencies.

**William Bridge’s Transition Model**

William Bridge’s theoretical work on transitions focuses on the experiences involved in the transition process and strategies for managing and enhancing organizational transitions (Bridges, 1991). Foundational to his model, is the acknowledgement that change and transition are different concepts (Bridges, 1991). Bridges (1991) highlighted that change is primarily situational and external; whereas transition is internal and can be defined as “the psychological process people go through to come to terms with a new situation” (Bridges, 1991, p. 3). He elaborated on this distinction by explaining, “unless transition occurs, change will not work” (Bridges, 1991, p. 4).

Essentially, there are three phases involved in Bridge’s transition theory including, the ending, neutral zone, and beginning (Bridges, 1991). However, it is important to recognize that the boundaries between the three phases are not distinguishable as the phases essentially overlap (Bridges, 1991). Thus, individuals may be experiencing multiple phases at any given time (Bridges, 1991). A brief summary of each phase is provided below.

The first phase involves the letting go, ending, or loss of something, which essentially marks the beginning of a transition (Bridges, 1991). Although endings are often undesired, they are prerequisites to new beginnings and thus are essential to transitions. According to Bridges (1980), a natural ending is comprised of four elements
including, disengagement, disenchantment, disorientation and disidentification. Bridges (1991) confirms the importance of endings by explaining that the most common reason for organizational failure in change is caused by them neglecting to consider endings and methods to manage the resulting impact on people.

The second phase is known as the neutral zone, which Bridges described as “no-man’s-land between the old reality and the new” (1991, p. 5) and “a time of inner reorientation” (1980, p. 130). Bridges (1991) further explains that the neutral zone is the core of the transition process and is a time in which the old way is no longer present but the new way has yet to feel comfortable. People often lack an understanding of the neutral zone and this stage becomes challenging (Bridges, 1991). However, it is crucial that people comprehend the neutral zone in order to prevent speeding through it and to provide clarity that although confusion is felt, it does not mean there is something wrong. Additionally, Bridges (1991) highlighted that employees in transition who are unaware of the neutral zone will often try to escape, which essentially ends the transition for them. Accordingly, Bridges (1991) notes that in organizations, proper management of the neutral zone is important to decreasing staff turnover rates.

The third phase of Bridge’s transition theory is the new beginning. Bridges explains that a common mistake is starting with the new beginning and ignoring the endings as opposed to starting with the ending. Thus, successful entrance into this stage is permitted only after the person has experienced an ending and spent time in the neutral zone (Bridge, 1991).

**Transition Theory Summary**

Although the above transition theories are clearly distinguishable, exploration of
each selected theory was essential to development of a comprehensive understanding of theoretical transitional perspectives. Pursuing an understanding of transition theory in the nursing discipline served as a practical starting point. This led to investigation of Patricia Benner’s work on the transition for clinical nurses. Given that the population of interest for the current study is RNs transitioning into a new clinical specialty and environment (gerontological nursing in LTC), Benner’s work provides important knowledge in terms of the experiences of novice nurses and the processes involved in their transition to clinical expertise. Finally, Bridges transition model was explored. It was noted that Bridges model is intensely focused on the human psychological experiences of transitions, which has potential in terms of applicability to RNs’ lived experiences.

**Summary of Literature Findings**

This review of the literature demonstrates that no universal job profile for the RN in LTC exists and daily roles and activities vary considerably. However, findings also indicate international consensus that the RN is a crucial member of the LTC team. Findings from the review also reveal that LTC is not a preferred career choice for new graduates and challenges associated with the LTC environment are clearly evident. Finally, in terms of the transition for RNs into the LTC environment, findings from the current review indicate a significant literature and research gap.

Investigation into the lived transition experience of RNs entering the LTC environment is essential to develop effective strategies to address the challenges specific to LTC. Such exploration will provide insight into the relationship between organizational job profiles and the everyday activities of RNs. Furthermore, such investigation is also required to detect the prevailing strengths of RNs in LTC. The
identified strengths can subsequently be built upon to positively impact both recruitment and retention in the LTC sector. This research has potential to significantly contribute to the body of evidence supporting standardization of RN job profiles, competencies, and orientation programs in LTC. Most importantly, the study results will potentially influence future initiatives to improve quality of care and enhance quality of life for residents in LTC facilities.
CHAPTER 3
THE RESEARCH METHOD

The philosophical underpinnings of Institutional Ethnography (IE) as a research method constitute the core of this chapter. The major tenants of IE will be explored, along with techniques for data collection and analysis traditionally pursued in an IE investigation. Subsequently, this chapter describes the design of the current study including, population and sample, participant recruitment, data collection, and data analysis. Finally, rigor for the study and ethical considerations are presented.

Philosophical Underpinnings of Institutional Ethnography

Institutional Ethnography (IE) is a unique research method originally developed by Canadian Sociologist Dorothy Smith. She describes her method as an approach that incorporates views from Marx’s materialist method, Garfinkel’s ethnomethodology, and feminist practice (as cited in DeVault & McCoy, 2006). Essentially, this method of inquiry seeks to provide the general population with clarity as to how everyday life is socially organized (Campbell & Gregor, 2008). Institutional ethnographers believe that complex relationships exist between people and events that occur, thus they strive to incorporate the socially organized qualities of daily life to proceed with more comprehensive investigations (Campbell & Gregor, 2008).

Problematic and Standpoint

Smith (1987) emphasized that the concept “problematic” should not be confused with the term problem. Institutional ethnographers view the lived experiences of other’s daily lives as the problematic (Smith, 1987). Identifying the problematic aids in establishing and focusing an investigation (Smith, 1987). It is important to recognize that
the problematic often emerges when the researcher discovers a disconnect between what is expected to occur and what actually occurs (Campbell & Gregor, 2008). The preferred approach to identifying the problematic is to delve into the selected research area and pursue an extensive understanding that would reflect that of the experts or those who are living the experience (Campbell & Gregor, 2008).

Accordingly, it is the researcher’s standpoint that preserves their dedication to extend what can be known about the area under investigation (Rankin, Malinsky, Tate & Elena, 2010). Although there are various possibilities in terms of selecting a standpoint, it is imperative that the researcher selects only one. Generally, the researcher assumes the standpoint of the experts who are experiencing the issue, in order to position themselves to attain a true understanding of the organization of their daily routines (Rankin et al., 2010). For example, a Canadian Sociologist Timothy Diamond took the standpoint of nursing aids as a means of truly representing them within his investigation into the living and working conditions of nursing homes (Diamond, 1995). Diamond (1995) returned to school to train as a nursing aid, sought employment in the LTC sector, and immersed himself in the work environment as a means of collecting data. However, it is important to note that Institutional Ethnographers use a variety of data collection techniques, depending on which are most appropriate for the specific study (Campbell & Gregor, 2008). Therefore, direct participation or participant observation is not a prerequisite for IE research, nor is it required for the researcher to assume a particular standpoint.

**Social Relations**

One fundamental belief of Institutional Ethnographers is that because the world is consistently social, we are only truly present in the universe as “social beings” (Campbell
Social life is described as predominantly organized, stemming from people’s performance of daily activities, and continually occurring although we may not always be cognizant of our participation (Campbell & Gregor, 2008). The term social relation is defined as “something happening that links individuals together” (Rankin et al., 2010, p. 335). However, such links are not limited to one particular setting, as they often involve a number of individuals at various locations who may have yet to be acquainted (DeVault & McCoy, 2006). Without IE’s inquiry into such relations, it is quite possible that their relations would remain concealed. As researchers investigate social relations, it becomes apparent how activities that occur in one setting forms, or is formed by, what happens in other settings (McCloskey, 2011). Rankin et al. (2010) provided a detailed explanation of this concept as they explained that the work of a nurse educator, whose work with students occurs during a specific time and place, is inseparably connected to several standards of practice within health agencies, professional, and educational institutions. The social relations in this context are the institutional policies and documents that direct the nurse educator’s daily activities, such as assessment forms and evaluation activities (Rankin et al., 2010).

**Ruling Relations**

Intensive investigation into social relations to determine their potential to rule is of particular significance to Institutional Ethnographers (Rankin et al., 2010). Ruling relations is a complex concept that Smith (1987) defines as one that “grasps power, organization, direction, and regulation as more pervasively structured than can be expressed in traditional concepts provided by the discourses of power” (p. 3). Rankin et al. (2010) simplified this definition by explaining that a ruling relation can be considered...
a practice that takes place within a local setting that integrates institutional or extra-local priorities into the setting. Thus, researchers using IE generally extend their investigation from the frontline level toward larger institutional practices and polices that organize the local environment (Smith, 2006). For example, Campbell (2001) analyzed texts and nursing action, to identify ruling relations and the resulting consequences for the future of the nursing profession. Through her analysis, she discovered the power of textually mediated practices, the complex ruling relations, and the subsequent domination of both knowing and acting for nurses. Another example of ruling relations, provided by Benjamin and Rankin (2014), is provincial standards for LTC mandating that residents be offered two baths per week. Benjamin and Rankin (2014) elaborated ruling relation characteristics of this example by highlighting that although this may not always be considered practical in real-life situations for various reasons, employees in LTC acknowledge this as a best practice that must be adhered to.

**Texts**

Great emphasis has been placed on the role of texts and documents, via any form, in organizing, representing, and providing meaning to the world through social and ruling relations (Smith, 1987). Smith (1999) described a text as “a material object that brings into actual contexts of reading a standardized form of words or images that can be and may be read/seen/heard in many other settings by many others at the same or other times” (p. 7). Thus, texts could include, but are not limited to, policies, protocols, reports, emails, memos, organizational forms, radio, advertisements, movies, and other electronic media (Rankin et al., 2010; Smith, 2006). It is evident that society relies heavily on texts to accomplish daily activities, thus making text in all forms a valuable data source for IE
research (Campbell & Gregor, 2008). Essentially, texts serve to connect multiple people and their daily activities, most often in an invisible manner.

Campbell’s (2001) investigation of community nursing work demonstrates how routine provincial LTC assessment forms influence nurse’s daily activities and interactions with clients. Campbell further clarified how a ruling relation is founded as clients are “written up” (p. 231) using organizational texts. Subsequently, this process steers the interaction away from the explicitly stated case management value of client-centered care, which is contradictory to the nurse’s intents (Campbell, 2001).

Furthermore, Bell and Campbell (2003) demonstrated the power of texts as they performed a textual analysis of health care providers’ records to investigate a child’s death. The authors concluded the investigation by advising caution be taken in terms of allowing textually-mediated practices to prevail over other significant patterns of knowing in health care.

**Data Collection**

Unlike traditional qualitative and quantitative methods, IE researchers refrain from utilizing theories and models to guide their studies (Rankin et al., 2010). Subsequently, researchers must transform their thinking and alter their approach to data collection and analysis (Rankin et al., 2010). The intent of IE research is not to understand the individual experiences rather to understand how everyday experiences are shaped by regimes of ruling (Smith, 1995). Thus, IE researchers must recognize that the experience of a transition is socially organized and shaped by external forces.

Campbell and Gregor (2008) described two levels of data collection for IE that combine to accomplish the fundamental goal of explicating ruling relations. Entry-level
data is focused on the local setting and provides entry into the problematic under investigation, whereas level-two data aims to explain the problematic via further exploring the organizational or external factors that influence local functioning (Campbell & Gregor, 2008). In fact, Campbell and Gregor (2008) highlighted, “it is the analytic use of both levels of data that distinguishes institutional ethnography from its ethnographic cousin” (p. 81).

It is important to note that regardless of the level of data the researcher is collecting, their standpoint remains constant (DeVault & McCoy, 2006). Although there are multiple methods for collecting data in IE, researchers typically select which techniques are expected to provide the required information for analysis (Campbell & Gregor, 2008). It is common for researcher’s to dedicate a great deal of time to the collection of entry-level data. Appropriate techniques for data collection at the entry-level includes, interviews or focus groups, the researchers reflection of their experience, and participant observation (DeVault & McCoy, 2006). As the investigation expands to broader institutional and extra-local areas, collection of level-two data is required and researchers may adopt additional techniques at this point (Campbell & Gregor, 2008). DeVault and McCoy (2006) described some techniques at this stage to include, examination of institutional work processes via texts, text and discourse analysis, and observation followed by analysis of language data to explore institutional processes. It is, however, imperative to be cognizant of the significant role interviewing plays at all levels of IE data collection (DeVault & McCoy, 2006). In fact, some researchers prefer to use to term “talking with people” to describe interviewing as a data collection method because
in IE interviews can be performed both formally or informally, for example an opportunity may present during participant observation (DeVault & McCoy, 2006, p. 22).

**Data Analysis**

Given that traditional techniques such as categorizing, coding, and thematic analysis are not practiced in IE (Rankin et al., 2010), analyzing data can be viewed as both a challenging and exciting task for IE researchers. Such techniques are avoided in order to ensure that focus remains on people, their doings, and how their activities relate to other people (Benjamin & Rankin, 2014). Campbell and Gregor (2008) further explained that IE data analysis essentially “uses what informants know and what they are observed doing for the analytic purposes of identifying, tracing, and describing the social relations that extend beyond the boundaries of any one informant’s experiences (or even all informants’ experiences)” (p. 91). Accordingly, continuous reflection on the primary purpose of IE, to expose and unambiguously describe the social relations of a specific setting, is a crucial part of the analysis phase (Campbell & Gregor, 2008). Although various methods of analysis specific to IE exist, such as analytic writing (Campbell & Gregor, 2008) and mapping sequences of work and texts (Turner, 2006), the primary goal of data analysis in IE remains to explain the social and ruling relations of a local setting (Campbell & Gregor, 2008).

**Summary**

IE is a powerful research method that seeks to explore the ways in which everyday life is organized through ruling relations. Due to the unique qualities of IE, researchers are required to shift to a specialized way of thinking and adopt non-traditional approaches to data collection and analysis. Successful research guided by IE requires a
thorough understanding of the major tenants as outlined by founder Dorothy Smith including the problematic, standpoint, social relations, ruling relations, and texts. Although IE historically presented as a method of feminist research, it has been used to investigate various aspects of LTC (Benjamin, 2011; Diamond, 1995; McCloskey, 2011). IE is the ideal research method to investigate the experiences of RNs recently transitioned in the LTC environment, the social and ruling relations present in the local setting, and the various social, political, economic, and institutional influences that shape their everyday experiences.

**Study Design**

**Population and Sample**

The population under study was RNs who experienced employment transition into the LTC setting. Accordingly, the standpoint for was of RNs who transitioned into the role of the RN in LTC. Those who have transitioned within the past 3 years into a New Brunswick LTC facility were initially invited to participate. The decision to originally limit inclusion criteria to RNs who transitioned within the last 3 years is supported by Patricia Benner’s (1984) work on clinical competencies in nursing. Benner (1984) emphasized that it takes between two and three years of working in one setting, dealing with similar events, for a nurse to reach the stage of “competent”. However, the majority of nurses who expressed interest in participating in the study had transitioned into LTC over 3 years ago. As this challenge in participant recruitment continued, the inclusion criteria was expanded to include RNs who have transitioned within the last 6 years.

Participants for this study were selected by using a combination of purposeful and snowball sampling techniques. RNs with various educational credentials and professional
nursing experience were invited to participate. In order to meet inclusion criteria, a participant’s transitional experience must have been the first experience of employment in LTC in a clinical role. Thus, RNs who previously worked in LTC, whether they departed and returned to the same or different LTC facility were excluded from the study.

After a thorough review of published IE studies, it was determined that a sample between 7 and 9 participants would be ideal for the current investigation. However, Morse and Richards (2002) emphasized that the achievement of data saturation provides certainty of a solid analysis and builds the researcher’s confidence that findings are correct. Townsend (2002) highlighted that in IE “saturation occurs when sufficient data are collected to record how everyday practice actually works within an institutional framework” (p. 19). In this study, 11 were interviewed before saturation occurred.

Campbell and Gregor (2008) emphasized that as an IE research project progresses and a researcher gains more insight into the area of interest, he/she subsequently determines what additional questions should be answered and from whom the required data can be gathered. While the standpoint for this study was everyday experiences of RNs transitioning into LTC, it was discovered that second level participants may have unique perspectives to contribute to the investigation. Two additional nurses were recruited as second level informants. These second-level informants included nurses in non-clinical roles within LTC such as a Director of Nursing (DON) as well as a Unit Manager (Appendix C, F). In keeping with the research method, the semi-structured interview guides for second-level informants emerged from the data obtained from primary interviews.
Participant Recruitment

To gain access to the LTC facilities, administrators and DONs of 3 New Brunswick LTC facilities were approached. Specifically, a letter requesting a meeting between the researcher and the DON to describe the study was be placed in a sealed envelope and delivered to each facility (Appendix A). DONs who were interested in learning more about the study were required to contact the researcher and a meeting was arranged to discuss the study. Institutional ethics review and approval for this study was obtained from the 3 LTC facilities.

Upon gaining entry into the facility, potential participants were contacted using a purposeful sampling and snowball sampling technique. The researcher requested that the DON forward the participant recruitment letter to potential participants within their facility (Appendix B). Additionally, posters advertising the research with the researcher’s contact information were posted in common areas in the facility such as the nursing units and employee lunchrooms (Appendix D). Potential participants who were interested in the study were required to contact the researcher. Subsequently, a meeting was arranged to discuss the study, confirm participant eligibility, and proceed with the informed consent process (Appendix E). Only those who provide informed consent were included in the study. The majority of participants (n=9) were from one of the three facilities, and the remainder (n=2) were recruited through snowball sampling.

Data Collection and Analysis

Given that IE researchers refrain from utilizing theories and models to guide their studies (Rankin et al., 2010), I decided to pursue this investigation in the absence of a
specific theoretical framework. The transition theories described in Chapter 2 demonstrate the range of existing transition theories as well as the complexity of transition processes; however, they were not integrated into this research. Patricia Benner’s (1984) work influenced decisions during the planning phase of this research project, particularly concerning the original inclusion criteria. However, no specific theory directly influenced the research activities or findings in this IE study. Any relevant linkages between existing theory and study findings is presented in the discussion section of this research.

In terms of data collection and analysis, the basic principles of the qualitative research process as outlined by Morse and Richards (2002) and van den Hoonnaard (2015) were followed. Specifically, their work describing essentials for interviewing participants, analyzing institutional documents, confirming methodological congruence, enhancing study rigor, and writing up qualitative research, was incorporated into the research activities for this study. Providing that one of the major distinguishing factors for an IE study is multiple level data collection, the collection and analysis of both entry-level and second-level data for this study was performed.

**Entry-Level Data.** The primary method of collecting entry-level data in this study was interviews with RNs exploring their transition experience. A significant amount of time was dedicated to the collection of entry-level data. Data was collected from participants via semi-structured interviews. The researcher developed questions to guide these interviews by incorporating both the literature findings and previous personal experience as a RN in LTC (Appendix H). DeVault and McCoy (2002) emphasized that the purpose of interviews in IE is to “investigate widespread and discursive processes” (p.
Thus, open-ended broad questions were designed to promote comprehensive and original descriptions of participant’s transitional experiences. All interviews were be audio-recorded. Additionally, demographic information in terms of age, sex, education, clinical experience, etc., was collected for all participants (Appendix G).

**Second-Level Data.** Following the interviews with RNs, semi-structured interviews with second level participants were conducted. Interview questions for second-level informants emerged from entry-level data collected in the study. The recruitment letter for second-level informants (Appendix C) was forwarded, via email, to potential participants. Those interested in participating were expected to contact the researcher for further information. After initial contact, review of key study details, confirmation of eligibility, the informed consent process was completed (Appendix F).

Additionally, a significant source of data at this stage in the research involved examination of a variety of textual documents. Specifically, I was interested in textual documents that guide the orientation or transition for RNs, as well as those that direct how RNs function in their everyday roles and activities. Any textual data that participants identified within their interview, was collected and analyzed. Such documents included institutional RN job description (Appendix K), policies, protocols, and orientation manuals, documents used by RNs to perform their everyday activities. Access to such documents was requested during the initial meetings with DONs and approved by institutional ethics review boards. Extra-local textual documents relevant to the study included: the NB Nursing Home Act (2014), Canadian Gerontological Nursing Competencies and Standards of Practice (CGNA, 2010), NB Department of Social Development documents including the NB Nursing Home Standards Manual (2017),
Collective Agreement between the NB Nurses Union (NBNU) and New Brunswick Association of Nursing Homes, and facility external job postings used for recruitment purposes.

**Data Analysis.** During the data analysis phase, I sought to uncover the social relations that shape the transitional experience for RNs into LTC. Methods of analysis specific to IE as described by Smith (2006) as well as Campbell and Gregor (2008) were used to guide the data analysis of this study. The process of data analysis was labor intensive and was completed by the primary researcher.

First, primary informant audio-recorded interviews were reviewed for clarity, transcribed verbatim, and re-read multiple times to ensure accurate understanding by the primary researcher. In cases where the researcher was unclear about a statement, participants were contacted and clarification was sought. Data from both individual interviews and across participants were analyzed for recurrent phrases, work activities, perceptions of the transitional experience, as well as inconsistencies. After identification of these, they were grouped accordingly, and relevant data from each participant interview were identified and placed in the appropriate group.

Second-level informants were identified during review of primary interview data. Semi-structured interview guides for the identified second-level informants (DON and Unit Manager) were developed as primary informant interviews were further analyzed and key questions emerged. Audio-recorded interviews were reviewed for clarity, transcribed verbatim, and re-read for accuracy by the primary researcher. Second-level interview data was then analyzed using the same process described above for primary interviews.
Interview data from all study participants was then reviewed and analyzed again to ensure all recurrent phrases, work activities, perceptions of the transitional experience, as well as inconsistencies were identified. At this point, textual documents that were directly or indirectly referred to by participants were identified, collected as data, and analyzed. For example, participants frequently talked about the “RN binder” and facility policies and procedures. Analysis across themes was then performed to assist in discovering how work processes are socially organized.

It was at this stage that mapping sequences of work and texts as described by Turner (2006) was adopted. According to Turner (2006), mapping such sequences “extends ethnography from people’s experience and accounts of their experience into the work processes of institutions and institutional action” (p.139). In this particular study, the experiences of RNs transitioning into the LTC environment extended into institutional work processes. For example, RN’s transition experiences were found to be influenced by institutional policies and procedures including staffing policies (ie: process for working short staffed) and checklists for common tasks such as admissions, transfers, and application for special authorization. Additional institutional influences on RN’s transition experience will be explicated in Chapter 5.

Finally, the above findings informed the analytic writing process. Using the groups identified during review of interview data, I began the writing-rewriting process as described by Campbell and Gregor (2008).

**Rigor**

Lincoln and Guba (1985)’s alternatives for establishing trustworthiness of naturalistic inquiries was applied to establish and maintain rigor in the study. Lincoln and
Guba (1985) describe these criteria to include, creditability, transferability, dependability, and confirmability. In addition to defining these criteria, Lincoln and Guba (1985) provide descriptions of various techniques used to meet the criterion, which was used as a guide for this study. Morse and Richard’s (2002) guidelines for ensuring rigor throughout all phases of qualitative research was also adopted. For example, I consistently revisited the key criteria for methodological cohesiveness specific to IE in order to promote optimal validity (Morse & Richards, 2002).

Prolonged engagement with participants contributed to the creditability of this study. The majority of interviews lasted over 30 minutes, with some reaching over an hour in length. Following the scheduled interviews, I followed up with participants via email or telephone, with their permission, to confirm data as necessary. On several occasions, participants reached out to me after their initial interview, via email or telephone, to provide additional information regarding their transition. During data collection I listened to participants attentively and, with the permission of each participant, audio-record the interview session. This ensured that participant narratives remained the primary focus of my attention, while also permitting me to ask questions and seek clarification throughout the interviews.

Rigor was further enhanced by utilizing a variety of data sources including participant interviews, collection of demographic information, and analysis of textual documents, to promote triangulation (Lincoln & Guba 1985). Interviews with primary informants, RNs, and second-level informants, DONs and RN mentors, were used for this study. As described above, another significant source of data for this study was textual documents, which were analyzed to gain an understanding of the social relations within
the local setting. Textual documents collected and analyzed in this study included local texts such as orientation manuals and role descriptions, as well as extra-local texts such as the Canada Health Act (1985) and the New Brunswick Nursing Home Act (2014).

In terms of dependability and confirmability, I maintained a detailed audit trail, as described by Lincoln and Guba (1985) and Morse and Richards (2002), throughout the entire research process. Morse and Richards (2002) highlighted that it is crucial for researchers to perform memo writing, regardless of the research method adopted, as a technique to expand thinking when working with data. Specifically, they encouraged researchers to document memos in the first person. For example, Morse and Richards (2002) explained the importance of clear and comprehensive memo writing by reporting “what I did” and “what I saw” in the data (p. 138). Thus, all research activities for the current study were recorded and stored as study documents. Research activities included all communication with participants (face-to-face, emails, telephone) and documentation of all decisions made throughout the research process in terms of data collection and analysis. Such activities were meticulously documented via memo writing and stored with in a secure location with all study data.

Ethical Considerations

The Canadian Tri-Council Policy Statement (TCPS2) on Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, National Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2014) and the Code of Ethics for Registered Nurses (CNA, 2008) served as the foundation for this investigation. Van Den Hoonoord and Van Den
Hoonaard’s (2013) text highlighting essentials of thinking ethically in qualitative research was also used as a reference to ensure the ethical conduction of this study.

Prior to commencement of the research study, an application was submitted to the University of New Brunswick’s Research Ethics Board (REB) to obtain ethical approval. Ethical approval from each participating facility was also obtained via submission of a research application to the facility’s REB. No research activities began until ethical approval was granted from relevant REBs.

I only communicated with those who showed an interest in the study and contacted me via email or telephone. Informed, written consent was obtained from each study participant prior to the interview. The study was explained to each potential participant and all information pertaining to the study that was required to make an informed decision to participate was provided. As part of the informed consent process, participants were made aware that data collected during the study may be subjected to secondary analysis in the future. Participants were given an opportunity to ask the researcher questions at the time of informed consent. In addition to receiving a copy of the signed consent form with the researcher’s contact information, participants were provided with contact information for an individual not directly involved in the study. Participants were informed from the onset that they could refuse to answer any questions asked during the study. Consent was considered an ongoing process throughout the research. The researcher explained to each participant that their participation is entirely voluntary and they may withdraw their consent at any time during the research.

Confidentiality and anonymity was strictly maintained throughout the entire research process. All interviews were held at a time and place convenient to each
participant. If preferred by the participant, the interview took place at a location away from the workplace. The use of names was avoided in the audio-recorded interviews and participants were assigned a unique identification number. Following transcription, audio-recorded interviews were destroyed when they were no longer needed. Identifiable information, such as consent forms, field notes, and demographic sheets, were kept separate from all other study documents. All identifiable study documents were stored in a locked office and electronic study data were kept on a password encrypted USB. Study documents were only accessible to the researcher and study committee. All study documents will be kept for 7 years. Participants were also made aware that their name and any identifiable information will not be included in any reports or publications that result from this study or future studies that perform secondary analysis of the data.
CHAPTER 4

SETTING THE CONTEXT

The main purpose of this research was to gain a better understanding of the transitional experience of RNs entering the LTC environment. This chapter will first provide an overview of the demographic profile of the study participants. To assist the reader in comprehending the complexities involved in RNs transitional experience, I will also introduce each participant and highlight the diverse range of factors that influenced their decision to pursue employment in LTC. By first explicating how and why RNs entered the LTC environment the standpoint for the current study will be exposed to the reader.

Demographics

Study participants (N=11) included 9 clinical RNs who had transitioned into a New Brunswick LTC facility between 2012 and 2014. Additionally, 2 RNs in managerial roles in the LTC environment were interviewed. Participants were predominantly female and 50 years of age and over. The majority of RNs were employed casual or part-time and many reported also having another job elsewhere. As demonstrated in Table 1, the majority of participants’ highest level of educational preparation was a Bachelor of Nursing degree. Participants brought a diverse range of nursing experience with them as they transitioned into their role. Self-reported areas of expertise included acute care (ie: surgical, medical, critical care, emergency, and pediatrics), health research, and health care administration. Interestingly, only 3 participants reported previous gerontological nursing experience prior to entering the LTC setting.
**Table 1** *Descriptive Statistics for Nominal/Ordinal Variables of RNs in LTC (N=11)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency (n)</th>
<th>Valid %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
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<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>Female*</td>
<td>10</td>
<td>90.9%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
<tr>
<td>20-29</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>30-39</td>
<td>2</td>
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<tr>
<td>40-49</td>
<td>1</td>
<td>9.1%</td>
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<tr>
<td>50+*</td>
<td>7</td>
<td>63.6%</td>
</tr>
<tr>
<td><strong>Education (highest level)</strong></td>
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<td></td>
</tr>
<tr>
<td>RN- Diploma</td>
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<td>18.2%</td>
</tr>
<tr>
<td>BNRN- Bachelor Degree*</td>
<td>7</td>
<td>63.6%</td>
</tr>
<tr>
<td>MN – Master Degree</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td>PhD – Doctoral</td>
<td>1</td>
<td>9.1%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>3</td>
<td>27.3%</td>
</tr>
<tr>
<td>Part-time</td>
<td>3</td>
<td>27.3%</td>
</tr>
<tr>
<td>Casual*</td>
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<td>45.4%</td>
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<tr>
<td><strong>Other nursing jobs</strong></td>
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<td>5</td>
<td>45.5%</td>
</tr>
<tr>
<td>No*</td>
<td>6</td>
<td>54.5%</td>
</tr>
<tr>
<td><strong>Previous Gerontological Nursing Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>27.3%</td>
</tr>
<tr>
<td>No*</td>
<td>8</td>
<td>72.7%</td>
</tr>
</tbody>
</table>

*Note: * = Mode

**Beginning from Nurses’ Perspective**

The goal of this study is not to generalize individual experiences of the nurse participants, rather it is to uncover “the ruling relations that organize and coordinate the local experiences of informants” (Campbell & Gregor, p. 89). In order to accomplish this, it is necessary to begin from the standpoint of the study participants. Pseudonyms will be used for each of the study participants. Explicating the everyday/evrynight transitional
experiences of these nurses is important for facilitating the discovery of social and ruling relations that are embedded in their transitional experiences.

**Viewing the Role through Rose Colored Glasses**

The first 3 participants that will be introduced are Kendra, Michelle, and Cathy. These nurses pursued employment in LTC due to job availability in the sector and/or personal convenience. Although they each practiced in a variety of nursing areas, they had no previous gerontological nursing experience. Their reasons for entering LTC reflect a belief that nursing in this environment would be “easier” than their previous nursing positions. Their individual journeys that put them on the path to LTC are described below.

Kendra had recently made the decision to resign from her full-time coordinator position in the area of clinical research. Although she thoroughly enjoyed her permanent coordinating job, family circumstances required her to step down from her demanding position and seek casual employment. Kendra’s clinical background was heavily focused in emergency nursing and she had no previous experience in gerontological nursing. Kendra had heard that there were nursing homes searching for casual RNs, found a posting in one particular facility, and decided to apply.

Michelle, a younger nurse, had just returned from traveling and working as an RN in various locations. Upon her return, she was not interested in searching for a permanent or full-time position, as she stated she was “just looking to pick up some shifts”. Upon searching for positions in her preferred area of pediatric nursing, she realized that the hospital was not recruiting casual RNs at the time. Coincidently, a peer mentioned the option of applying to a nursing home. Michelle remembered thinking “ohhh maybe I will
give that a try, at least it might give me some hours”. Although she had no experience with the geriatric population in her nursing career, she reflected on her undergraduate program and recalled enjoying “geriatric rotations”. This solidified her decision to apply for a casual position in LTC.

Similar to many other nurses, Cathy already held a permanent position in another facility. She was an experienced clinical nurse, with a background in emergency and surgical nursing. For the last 10 years, she had been working in various leadership positions within acute care. Her desire to concurrently work in a clinical environment to maintain skills and competencies led her to pursue casual employment in LTC. Cathy emphasized the challenge of searching for a casual position when she already held a full-time position, which meant that her availability would be quite limited. As an experienced RN, Cathy had social connections with other RNs in leadership positions, including those that had transitioned into the LTC sector. She highlighted that these connections aided in her search for employment in LTC: “I contacted her and just asked her if she needed any nurses. She said yes and I went to an interview.” After learning more about the position through conversation with the DON Cathy concluded, “I felt that it was something that would give me that connection with skills giving patient care, providing that nursing component of it. So that is why I chose to do it.”

Essentially, Kendra, Michelle, and Cathy entered their positions in LTC due to job availability in the sector and/or personal convenience. Interestingly, they choose to pursue a position in gerontological nursing with no experience in the clinical area.

Challenging Assumptions

Riley, Heather and Tara came from the acute care environment, at various points
in their nursing careers, and for different reasons. Of these nurses, only one expressed a true interest in working with older adults. Interestingly, although each of these nurses described experiencing feelings of ambiguity and naivety in terms of the role they were entering, they willingly choose to apply for the positions in LTC.

Riley was a new graduate who was already working part-time in an acute-care setting and was also seeking employment in the LTC setting. Riley described thoroughly enjoying working in the acute-care setting but also emphasized a keen interest in the LTC environment and essentially, a desire to work in both settings. Riley had worked as a Resident Attendant (RA) in a LTC facility prior to completing the Bachelor of Nursing (BN) program and had an interest in the geriatric population. Riley explained that the role of the RN in LTC was much different than the RA position that she previously held:

> Working as an RA, you know you kind of come and perform all your everyday duties, which of course is basic care and all that. Ummm, and I didn’t know what I was going to get into as a registered nurse...so I didn’t know exactly what the job entailed. From what I was hearing from people, you know fellow students, they were like oh you know, you don’t get to do much- sitting there maybe paperwork.

Thus, Riley was unaware of the role she was entering and felt that the only information she had to rely on was what the advice peers were offering and her previous experience working as an RA in LTC.

Tara, who was currently working in a management role within LTC, originally transitioned in LTC as a casual nurse. She came from an acute care setting and reflecting on her experience now, she realized that at the time she was “burnt out” from many years of nursing in the acute care surgical environment. Although Tara admitted that at the time of her decision to transition into LTC, she did not realize that she was “burnt out”. She highlighted that what she did know was that “nobody had epidurals, nobody had PCAs,
nobody had chest tubes and 10 drains on their body and to me anything would have been easier.” Thus, despite not having any previous gerontological nursing experience or interest in the geriatric population, Tara pursued LTC in search of something “easier” than the areas where she had spent her entire nursing career.

Similarly, Heather’s background was acute care and she was currently in a managerial position in LTC. After many years of nursing on the floors, Heather proceeded to work in various leadership positions in the acute care setting. Although she did not specify why she decided to apply for a position in LTC, she highlighted:

I really knew nothing about dementia. I believe I was given this position not because of my long-term care experience but because of my leadership experience. So that is what I brought to the table. I knew nothing really about long-term care. I had never worked in a long-term care facility so it was up to me to educate myself.

This narrative provides one of many examples of RNs entering the LTC setting with no interest or experience in the geriatric population.

In summary, Riley, Heather, and Tara entered their role in LTC for different reasons. These nurses came from the acute care setting and their clinical experiences and years of practice varied considerably. One key commonality in these nurses’ stories is that they entered LTC unaware of what they were “getting into”. Their experience will be further investigated in the subsequent findings chapter.

Financially Motivated

Shirley and Tracy were experienced nurses who were already employed full-time in other settings. Although Shirley and Tracy had extensive experience in various clinical areas of nursing and practiced in a variety of leadership positions, neither had experience
in gerontological nursing nor a true interest in pursuing the area. For example, Tracy indicated this as she explained:

…. it was sort of a quandary with me because I, as I mentioned, I really was not a person that really thought very much of geriatric nursing. I was, you know, it was never, it was always like I wanted to make a difference and help people towards their health, not as I said babysit...That’s how I felt before.

Tracy later indicated that her primary motive for seeking casual employment in LTC was for financial reasons. Given that she already held a full time position, the casual position she was pursuing would essentially supplement her current income. This motive was evident in Tracy’s explanation:

…consequently I have found that I needed to earn more money so I opted to look for jobs elsewhere and much of the nursing jobs are owned by the organization around here and all this kind of stuff. Even though I worked a lot of overtime there, you are penalized for the overtime. So that’s how I ended up going to long-term care.

This explanation clearly indicates that Tracy intentionally sought a casual nursing position outside of her current employer’s organization as a strategy to ensure she is not “penalized” for overtime and in turn, has a supplemental income. Similarly, Shirley already held full time position in another area of nursing and was seeking employment in LTC in addition to her current position. Shirley explained that she had no intentions of leaving her position in LTC. She speculated:

Like to be honest with you I would like to get more hours because if I am going to work here I would like to recruit something out of it. Kind of like a pension of some sort.

Similar to Tracy’s reasoning, this statement presents financial incentive for pursuing additional employment in LTC to supplement her full-time income. However, Shirley later clarified:
I know I said at the beginning of the interview that it is for the money but that is not what it is really about. It is but it isn’t. I don’t go in there saying ‘I don’t care’, you know it’s someone else’s shift and I am walking away—that’s not the way I work.

This statement suggests that although some nurses seek casual employment in LTC for financial reasons, they remain dedicated to their professional responsibilities and the clients they work with and choose to remain in their positions. Similar to many other study participants, Shirley and Tracy had no previous experience in gerontological nursing and, interestingly, still choose this setting as a means of earning extra income.

**Clocking Out**

The final participants that will be introduced are Joan, Mary, and Cindy. These women were experienced nurses who had successful careers and worked in many clinical and administrative leadership positions. They described entering LTC primarily because of the type of nursing the environment offered. Joan and Mary revealed that they had some experience with gerontological nursing throughout their career and were passionate about the geriatric population. Although Cindy did not have previous gerontological nursing experience she expressed a keen interest in the older adult population due to her personal experiences with loved ones with dementia. These nurses, who were either retired or nearing retirement, had stepped down from their full-time positions and actively sought employment in LTC as they entered the final stages of their careers. Metaphorically speaking, they viewed this transition into LTC as the first steps of clocking out of the profession.

Joan and Mary both had a strong desire to provide hands on nursing care for patients but also had no desire to return to the acute care setting. Joan further explained her reasoning for this decision:
My beliefs about acute care are that it is different now than when I was practicing in acute care. So I felt that by going into the nursing home setting, long-term care that I would be able to really nurse in a fashion the way that I believe is the way that nursing ought to be.

Similarly, Mary also noted the changing dynamics of care settings and her beliefs about LTC include the notion that “there is still the respect there for the Nurse”. Mary further highlighted a recent trend, in her nursing colleagues and other nurses nearing retirement, toward choosing to transition into the LTC setting.

Cindy, who could be considered part of the group nurses approaching retirement, had recently moved to the province and felt that she was not quite ready to retire. Given that she had not been actively practicing in a clinical area for quite some time, she felt that LTC may be a reasonable area for her to return to nursing. Reflecting on her nursing experience, she reasoned:

I have to work. It had been a long time since I had worked in acute care and I thought about that and I went: you know what, I don’t want to go back into acute care. So I thought, well I could do community, and I thought you know what, I have a friend who works in LTC and you know she was talking about it and I thought, I think I would enjoy that.

Ultimately, Joan, Mary, and Cindy entered LTC as avenue for staging out of their nursing careers or taking a position that would be “easier.”

**Chapter Summary**

There are a variety of unique factors embedded in nurse’s stories that provide context for their transitional experiences. Together these accounts highlight many parallel motives. It is clear from nurse’s stories that a complex interplay between social, historical, and economic constructions of the LTC environment impact their decisions to enter the setting. The introduction of participants that was provided in this chapter facilitates the audience in comprehending the standpoint for the current study. It is under these conditions
that nurses’ transition experiences occur. The proceeding section on the study’s findings will explore the social and ruling relations that shape the transitional experience of nurses entering LTC.
CHAPTER 5

FINDINGS

Using nurse’s experiences as an entry point, I will uncover how prevailing social, historical, and ideological constructions of the LTC environment shape the transition experiences of RNs. By focusing my attention to the study of work processes, rather than individual experiences, I was able to map the social and ruling relations that mediate the RNs everyday and everynight life as they transition into the LTC setting. These findings will be presented within three interrelated themes.

Entering LTC: Up & Away

As discussed in chapter 4, the majority of participants in this study did not have an interest or experience in gerontological nursing upon accepting their new positions. For the most part, nurses had a wealth of experience in other clinical areas and made a conscious decision to go into LTC as a means of clocking out of their careers, landing a casual job, escaping from the stress of acute care, or supplementing their income. Nurses’ accounts reveal how both societal and personal preconceived, and misguided views of nursing in LTC significantly influenced their transition experience. Participant descriptions highlight the complexities of the everyday life of RNs in LTC. It is evident that these accounts contradict their previously held ideological constructions of nursing in LTC. This disconnect is explicated below.

Expectations Revisited

Reflecting on their professional opinions prior to entering the LTC environment, many nurses, in retrospect, described a misguided perception of nursing in LTC. For example, Riley was a recent graduate nurse who was also actively practicing in an acute-
care setting. Riley stated that she was surprised to discover that the role was much more of an undertaking than originally anticipated. She described this surprise as “shock.”

Similarly, Kendra reflected on how misguided perceptions of nursing in LTC impacted her transitional experience.

Riley: So it came to me as a shock during my orientation to this new position of an RN in long-term care. So, I didn’t know exactly what the job entailed. From what I was hearing from people, they were like oh you know you don’t get to do much- sitting there maybe paperwork. But it is more than that, in fact it’s even….not as busy as the acute care setting but there is a lot to do in terms of caring for residents. Now, you take it to another level, because you are responsible for, in some units’ 48-49 residents, over 20 residents.

Interestingly, findings reveal that new graduates were not alone in experiencing a difficult transition into LTC. Nurses with many years of clinical experience who entered LTC also reported a challenging transition period.

Kendra: I found it really stressful. It wasn’t as easy as when people think someone is working at a nursing home that it is simple and all the nurse does is paperwork, umm that is very misleading.

These narratives demonstrate not only the disconnect between participants’ preconceived ideas of the RN role in LTC and the subsequent lived reality, but also the common misconception that others hold in relation to working in LTC.

Tara, coming from a long career in surgical nursing, also felt that she was not entirely aware of the full scope of the role she was entering. However, in Tara’s transition, she did not experience disconnect immediately after she began her new role. Interestingly, she entered LTC and continued to think that her new job was easy, which was consistent with her original assumptions. She explained that as a new casual nurse, “people might have cut me a little bit of a break because they weren’t asking or requiring
anything extra of me.” She further reflected on how this mislead her to believe that her new job was a breeze:

So I just didn’t get the full picture, I didn’t understand, I just thought that this was… and then very slowly over time I started to realize okay this isn’t quite as easy as I thought. But at the time, I came from a place that I now in retrospect realize that I was burnt out and probably in a really bad place. And again, I didn’t recognize it in myself at the time so all I knew was that nobody had epidurals, nobody had chest tubes and 10 drains on their body and to me anything would have been easier. But as time, you know then you started going and you have residents with mental health issues which I had no experience with. And I have learned a lot, A LOT, since I have come here just medical wise.

Despite practicing many years in acute care, Tara stressed the degree to which her knowledge base has expanded since beginning her role in LTC. To Tara’s surprise, she was required to reevaluate her understanding of the role of the RN in LTC. Initially, she equated the skills and tasks she regularly performed in the acute care setting to the nursing role; however, she eventually realized that the LTC setting required her to draw upon different skills.

Similarly, Heather, who was working in a management position in LTC, highlighted the inaccurate image of the RN in LTC that nurses in other specialties endorse including, it is easier, nothing to do, and less responsibility. This misconception has potential to significantly impact the transition period for nurses entering LTC, which was evident in many of the transition stories shared by nurses.

Heather: I think there is a misconception as I said before when they come from acute care as a frontline nurse to long-term care that they really think there really isn’t a big role like that. I actually see it, coming from both areas, that the role is actually bigger because it is really you doing all the case management.

Michelle: I know people probably think like oh yeah, LTC RNs, they don’t do anything. But when you actually spend a day in their shoes and
realize wow, they don’t stop at all.

Correspondingly, Heather emphasized advanced critical thinking as an imperative quality of RNs in LTC.

They really need to be thinking broader than that. They need to be thinking case management. They need to be thinking you know why is this person like this today? So if all of a sudden somebody has had 3 falls, WHY? It’s not just a matter of filling out that falls investigation form, tick-tick-tick, and putting it aside. It is about following it through going oh my god, first of all why did they have 3 falls, is this new, is this different, what are their medications, do they have an infection of some sort, is their footwear okay, why are they falling now and they weren’t falling before?

The above narrative reflects the importance of RNs in LTC possessing critical thinking skills as opposed to being task-oriented practitioners who rely on textual documents to inform their everyday practices. Heather alluded to practitioner reliance on checklists to direct care in her example of the falls investigation form as she highlighted the action of “tick-tick-tick”.

Interestingly, Heather further clarified her position that the RN role in LTC is “bigger” than the charge nurse role in the acute care setting. She elaborated by stating that the RN role in LTC is “really about the case management and about looking at the whole picture.” Accordingly, the case management role of the RN in LTC, as described by Heather, was embedded throughout the majority of nurse’s narratives.

The specialized knowledge and skill required to work in gerontological nursing was highlighted as an area of expertise by study participants. This specialized knowledge included assessment of residents with complex medical comorbidities and various degrees of cognitive impairment. The critical skill of monitoring behavior in the older adult population was also highlighted.
Michelle: …most of your residents can’t tell you I’m not feeling well today or I have a headache today. It’s really up to the RN to deduce that, okay something is not right… I wonder what is going on? Is it a headache, is it a stomachache, maybe they have a UTI, maybe they are having chest pain. It’s almost crazy, but I think you almost use more critical thinking than acute care because your patient can tell you, oh you are in pain- I am going to give you some pain medication. Whereas, in the nursing home your resident is lashing out and angry and they are not themselves and you are thinking hmmm, I wonder what is going on. And so you have to be a little bit of a detective thinking oh okay, they stopped drinking as much, they are coughing a lot, oh maybe they have a bit of a lung infection.

Cindy: It’s challenging because you are trying to figure out, when you see a change in behavior, what’s behind that. You know? Is it progression of disease? Is it because they are in pain? Are they hungry? Are they wet? OR what’s up?

The above accounts clearly differentiates the unique approach to resident/patient needs that nurses adopt in LTC as compared to acute care. Interestingly, Michelle’s proclamation that nurses in LTC use “more critical thinking than acute care” is preceded by the statement “it’s almost crazy”. This reveals the complexity of nursing in LTC and alludes to the common misconception that an advanced level of critical thinking would not be required in this setting.

Evidently, nurses unknowingly entered a new role that differed significantly from their original expectations. Various opinions expressed within participants’ social networks masked the true role of the RN in LTC, ultimately contributing to a difficult transition period. In the following section, I will continue to explore additional influences on nurse’s transition period.

Officially Irrelevant

As highlighted in Chapter 1, in order to appreciate the complexities of the transitional experience, it is critical to understand the role that RNs are transitioning into. It is possible that participants’ inaccurate perceptions were shaped by the misguided
belief that that experience and interest in gerontological nursing was not necessary for the position they were applying for. In this section, I will explore how the role description of the RN in LTC may have nurtured their preconceived notion that previous gerontological nursing experience was officially irrelevant for the position they were pursuing and reinforced beliefs that the job would be easy.

The organization where the majority of participants worked, listed a job description for recruitment purposes (Appendix K) which stated: “experience in gerontological nursing is desirable but not essential.” The job description clearly outlines the leadership, supervisory, and managerial aspect of the RN in LTC, as opposed to the direct resident-care and specialized knowledge component. For example, the description states that the RN must “act as a resource person to other team members and departments” and that the RN must “give direct nursing care when necessary.” The above statements that imply experience in gerontological nursing was not a requirement for the position may have contributed to RNs uncertainty of their new role.

The job description fails to mention the specialized knowledge and practice requirements of the unique role that study participants strongly and consistently emphasized throughout their transition stories. For example, Heather emphasized that dementia care is a unique expertise:

I think there is a misconception that long-term care is bouncing gums, which it is not. There is a true clinical expertise in dementia care especially and that it takes a special kind of individual and it’s not different, the expertise is no different than if I were to go into dialysis, it’s a specialty of it’s own…85% of our resident have dementia so I need to know the difference between dementia and delirium, I need to know about behavior mapping, I need to know about U-First approaches to care.
Thus, although many nurses in this study entered the LTC setting with a misguided image of the nurses’ role and the belief that experience in gerontological nursing was not a requirement for the position; their narratives suggest that they developed an appreciation for the specialized knowledge required to work in gerontological nursing after their transition.

The educational qualifications listed in the job description may have further contributed to the ambiguity surrounding the role of the RN in LTC and the lack of recognition of specialized nursing knowledge. For example, the description highlights qualifications to include: registration with Nursing Association of New Brunswick (NANB) plus graduation from an approved Bachelor of Nursing (BN) Program or graduation from an approved School of nursing with geriatric experience. This statement implies that experience in geriatrics is waived if applicants hold a BN; however, applicants who are not prepared at the baccalaureate level must have geriatric experience in order to be qualified for the position. This statement appears to be based on an assumption that baccalaureate programs provide what is necessary for gerontological nursing experience.

Specifically, the job description suggests that BN prepared nurses do not require gerontological nursing experience for the position due to their academic qualification and educational preparation for the role. However, many BN-prepared RNs in this study reported feeling unprepared for their new role in LTC. For example, when speaking of educational preparation, Kendra stated that “I was not prepared for that type of nursing experience” as she felt that “nursing school prepares you for the acutely unwell.” Similarly, when speaking of the high level of responsibility the RN in LTC has, Michelle
highlighted, “you felt like you had no extra training to have that responsibility.” Thus, participants who had their BN and no post graduate additional experience in geriatrics highlighted that their nursing program did not fully prepare them for the role they were entering. Thus, the qualifications for the job posted on the job description further complicated their uncertainty of their role as an RN in LTC.

Although other aspects of the RN’s role in LTC are emphasized throughout the job description, the specialized nursing knowledge that is critical to safely and effectively care for the older adult population, as well as carry out the other important roles and responsibilities, is not emphasized within the RN role description. Thus, the job description of the RN in LTC may have contributed to nurses’ inaccurate perception that gerontological nursing experience was not necessary for the position they were considering; which subsequently influenced their transition experience.

Summary

In this section of study findings, I have revealed how nurses entered the LTC environment with misguided preconceived notions of what their new role would entail. Not long after entering the LTC setting, nurses discovered that they would be required to dismantle their original assumptions and expectations as they transitioned into their new role. I have also explicated how the job description of the RN in LTC may have nurtured their original misconceptions. Next, I will further explore how nurse’s new role in LTC differed from their previous practice environment and how these distinctions may have unknowingly exacerbated the challenges of their transition period.
Two Worlds Collide

Despite years of experience working as an RN in the acute care setting, it was evident that nursing in LTC was a practice that was foreign to most study participants. Participants indicated, both directly and indirectly, the discrepancy between where they came from and the position they entered. Given that many nurses came from the acute care environment, participants frequently compared their work in this setting to their newly accepted role in LTC. Thus, the acute care and LTC settings are referred to as the “two worlds” in this presentation of findings. It was through the process of mapping relations that I was able to uncover how participants’ discourse, understandings, and everyday activities were permeated by such discursively-organized translocal relations.

The Policy Context

To appreciate the differences between acute care and LTC, it is important to first recognize the policy context in which each setting is located. Therefore, additional textual documents to assist in the analysis of interview data were collected. Such texts included documents specific to the Government of New Brunswick’s (GNB) Department of Social Development (DSD) and the Canada Health Act (1985). Analysis of these documents uncovered the ways in which decisions and activities that occur outside of the local setting directly, and in many ways invisibly, shape transitional experiences of RNs entering LTC.

The Canadian Health Act clearly defines a hospital as “any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care” (1985, p 3). However, the act later adds that this definition does not include “a facility or portion thereof that provides intermediate care service or adult residential care service, or
comparable services for children” (1985, p 3). Therefore, although acute care (or hospital care) is included under the Canada Health Act (1985), LTC does not fall within the universally insured health services. Responsibility for LTC falls with individual provinces.

In NB, the Department of Social Development (DSD) is responsible for LTC. Interestingly, the fact that LTC services fall under the DSD, as opposed to the Department of Health, appears to diminish the credibility of those who work in LTC. Tracy alluded to this notion while reflecting on her previous beliefs of gerontological nursing, “what I used to think that it was like just babysitting them to their death.” This statement implies that the RN in LTC was not viewed as a nursing role, but a social or babysitting role. Similarly, Riley talked about other nurses’ statements about nursing in LTC and recalled that they had emphasized “oh you know you don’t get to do much, sitting there- maybe paperwork”. Kendra further echoed this concern related to the misrepresentation of the RNs role in LTC: “people think someone is working at a nursing home that it is simple and all the nurse does is paperwork.” This notion of the RN simply doing paperwork in the LTC setting again highlights the prevailing assumption that RNs are not actually nursing in these facilities and are instead performing administrative and social duties.

I have explicated above how the policy context of LTC services influences the image of the RN in LTC and subsequently misguides nurse’s preconceived notions of nursing in this setting. Next I will explore additional ways in which the policy context described above shapes RN’s transitional experience. Specifically, I will uncover how
specific aspects of the organizational structure and functioning of the LTC setting directly influence RNs daily work processes and in turn, their transition experience.

Nurses described how the overall functioning of the LTC facility differed significantly from the acute care setting. For example, Shirley referred to acute care as “institutionalized work” where “everything is INSIDE, whereas in LTC “everything is outside.”

Shirley: I had to make sure that pharmacy got their information, that the doctor got the information, that is was written so the nurses… So it is just a huge change from when you put something in the computer, well then it is all transcribed there and people have, the nurses have it, the doctor has it, the pharmacy downstairs has it, any other department in the hospital will see those orders. Where here we have to be very cognizant of do they have it.

Interestingly, such processes were discovered to be directly influenced by the activities and decisions made outside of the local setting. Essentially, the Government of New Brunswick (GNB, 2016) defines LTC services as “a range of personal support, physical, social, and mental health services” (p. 1). Given that LTC facilities fall under the LTC Services branch of the DSD, as opposed to the Department of Health, they are essentially viewed as social programs. Although a holistic approach to care is emphasized in LTC settings, nurses’ narratives indicate that many services provided to residents in LTC settings are medically-focused. For example, staffing regulations stipulate the need for regulated health care professionals, such as RNs and physicians to be available to residents 24/7 (New Brunswick Nursing Home Act, 2014). While the need for social, spiritual, and therapeutic services are required, there are no similar standards specifying quantity, frequency or qualification require of these. This ambiguity, in relation to the nature of LTC facilities, essentially leads to complex everyday processes in LTC and
sends nurses “jumping through hoops” and ultimately impacts their overall transition period. This was evident as nurses directly identified the ambiguity as problematic to their practice: “that is all really complicated, the social development versus this… It is very difficult, it is very hard.” Next, I will further explicate specific work processes that RNs in this study described and demonstrate how such processes are ruled by both intra and extra local influences.

**Jumping Through Hoops.** Nurses shared a variety of challenges they encountered during their transition into LTC. Interestingly, a great deal of these challenges were attributed to various “processes of care” involved in the everyday functioning of the LTC setting, such as tasks with multiple complex steps that RNs were required to complete to ensure residents received needed treatment and care. Unlike the acute care setting where supplies are readily available, limited resources in the LTC setting often required RNs to complete a series of standardized processes and textual documents in order to ensure residents’ needs were met. These processes and documents often originated outside of the LTC facility and existed to satisfy regulatory requirements, but they permeated the everyday work of RNs and had a powerful impact on their transitional experience. These key findings are explicated below.

Many of the services that would be easily accessed and insured under the Canada Health Act (1985) for patients in a hospital setting, are also regularly required in the care of LTC residents. However, the difference in LTC is that the processes to ensure residents receive the proper care and treatment are increasingly complex and at times costly to the resident. This ultimately impacts the RN who is then required to complete a series of standardized documents to justify resident needs for nursing activities in LTC
through these complex processes. For example, LTC does not provide residents with ostomy supplies or mobility aids despite them being readily available in hospitals and required to meet residents’ most basic needs.

Study participants also described the limited resources available in the LTC setting in terms of staff and consultation services. Tara compared the resources, in terms of health professionals, in acute care and LTC and summarized “…and so now there is nobody to consult, it’s US. One doctor, one nurse.” The processes required to ensure the primary care team has the most accurate information is challenging enough. As Shirley described above, nurses have to be extremely cognizant that all of the correct individuals have the necessary information to ensure the resident receives the required care. To accomplish this, it is necessary, and more work, to initiate and complete standardized documents. For example, Joan shared a story of when a resident was diagnosed with a urinary tract infection on a weekend shift and the physician on call ordered a specific antibiotic that was very expensive. Joan described the complex process of ensuring that the resident received this medication in a timely and affordable manner.

So it was going through all of the rigmarole of trying to get this antibiotic paid so that the resident wouldn’t have to pay for it out of pocket, like it was just a whole, you know…and maybe during the weekday, you know, it could have been more easily solved. But when you didn’t have that knowledge base, it’s just going through the hoops with that. So it seems to me that the processes around care, um, seem to be more cumbersome.

What Joan is describing above is the process of requesting special authorization for resident medications. The DSD determines eligibility for LTC facility residents to obtain a drug from New Brunswick Prescription Drug Program (NBPDP). Although the NBPDP ensures eligible residents receive some medications at no cost, not all medications are covered. There are a number of common medications that are used in the
LTC setting that are not routinely covered by the NBPDP and require special authorization. Some of these medications may only be required for a short period of time such as antibiotics including ciprofloxacin and low molecular weight heparins such as Enoxaparin and Fragmin. Although these medications are described as often required by residents and consistently provided by the government when appropriate paperwork is completed, RNs are still required to complete standardized documentation forms when they are needed. As a result, when changes in residents needs take place, RNs must shift their focus away from residents and toward the completion of standardized documents. Nurses described these processes as source of heightened stress and responsibility.

Participants also described issues surrounding accessing the fundamental resources to perform everyday nursing functions. When describing the difficulty of locating necessary medical supplies such as syringes and needles, Shirley reflected and compared LTC to her previous acute care work environment and stated “because there is no distribution center in the home, it makes it difficult.” Mary echoed this notion as she shared a story of when it was necessary to catheterize a resident and it took “one complete hour to find the catheters in that facility”. Accordingly, Tara noted that nurses in acute care perform their daily activities without considering the cost or availability of supplies; whereas, in LTC it is a constant thought.

Tara: Governmental regulations are pretty strict compared to hospitals. Yes, you are given fractions and fractions. We didn’t worry about that at the hospital. We didn’t even know really that it was a big deal.

Interestingly, these nurses had worked nearly their entire careers in acute care and did not think twice about the cost of the supplies they use on a daily basis, until they entered the LTC setting.
In summary, the unfamiliar and complex everyday functioning of LTC facilities was perceived by participants as an important influence on their transition experience. I have explicated how these processes are connected and ruled by happenings outside of the local setting including the provincial and federal policies. Next, I will add to this distinction between the acute and LTC settings as I further present participants’ transition narratives that highlight the required mindset of practitioners in each setting.

**Turning off the Acute Care Brain**

Further exploration into nurse’s transition narratives revealed that their transition was not only a role transition, but they were also required to change their overall approach to nursing care and essentially how they viewed the essence of the nursing profession. Participants associated LTC with a more holistic approach to care compared to the acute care setting. In this context, one aspect of holistic care was described as the medical attentiveness to the whole body as opposed to a single acute health problem. This was evident as participants spoke of the one-system approach they were familiar with practicing in acute care.

Tara: You know when at the hospital, somebody had chest pain you consulted cardiology, if somebody had, you know you just broke apart the body. You dealt with the part of the body that was surgery, that they had surgery on, and the body was broken into pieces. So, it, you know if somebody’s kidneys weren’t working you consulted nephrology and if somebody, like you know what I mean?

This narrative echoes the medical model approach to health that has potential to become the primary focus across acute care settings. This particular model places emphasis on treating disease and ultimately views the human body as a machine to fix when broken. Whereas, the approach in LTC was highlighted as different and Tara explained “it’s the whole person now.”
Tara further reflected on her transition into LTC and stated “it is hard to turn off the acute care brain.” Similarly, a clear distinction was revealed as Shirley described the challenge of concurrently working in acute and LTC settings.

Shirley: So my transition was stressful, I must admit…and a lot of times with my shifts, I would pick up an evening shift so I would leave from the hospital and come right to the long-term care, which was completely I had to flip my head right around to a different way of thinking.

Thus, Shirley also emphasized the contrast in thinking processes that were dependent upon practice setting. Shirley’s statement that she had to “flip” to a different way of thinking when moving from one setting to the other is analogous to Tara’s mention of turning off the “acute care brain”. These participant reflections suggest that a distinct difference exists between the way nurses coordinate and implement care in acute and LTC setting. Specifically, it suggests that nurses are not expected to adopt a holistic approach in acute care. Tara later indicated that the “acute care brain” is not necessarily the most valuable approach to adopt when striving to provide quality care for residents with multiple morbidities and complexities of care. Further explanation of the challenge RNs encounter as they transition into LTC and must “flip” their way of thinking was provided.

I think that they are used to diagnosing everything, having a reason for everything, and [pause] if it is somebody who is at the end stages of their lives, you don’t need to know why they are having jerky movements and why they’re, we don’t need a CAT scan or MRI. It doesn’t matter. If the treatment is not going to change, why would we bother? And that is hard for people to get their minds around. We live in a world that diagnoses everything and we don’t, so that is hard for them….. Like we don’t necessarily, unless family push for something, but if families are just happy to leave it be then we just leave it be.

Analogous to this holistic and palliative approach to care, Tara also spoke of her facility’s attention to quality of life for their residents. When discussing the approach to
care in LTC compared to acute care, she stressed “it is HUGELY different. I look at them and I think what quality of life they have.” To assist in understanding the application of this philosophy of care focused on quality of life, participants’ shared stories and provided examples of the integration of facility philosophy to everyday life in LTC.

Tara: Well the girls (other staff) were so concerned that the residents could go outside themselves and they were worried about they being out too long that it was too much sun and it was like ‘just put more sunscreen on them !!!!!!! They LOVE it!!!!’ You know?

Cindy: Anyway, so it is that kind of thinking that okay, this is their home and if they REALLY don’t want to get up until noon then they don’t want to get up until noon. So, as opposed to acute care when it’s up you come!…it’s a different way of thinking when you are approaching someone’s care.

The above participant descriptions of LTC are reflective of facility values which integrate “a holistic approach to care”, “meaningful relationships”, and “a welcoming home-like atmosphere.” Tara further compared the acute care environment to LTC in relation to attention to quality of life and holistic care. In contrast, some nurses described the lack of focus on quality in the acute care setting.

Tara: …you cared for them, you cared, you rendered care and medical care but you didn’t loveeee or anything spiritual didn’t come into it. There was nothing spiritual about that and if someone died on our floor, it was unexpected or if they died and if it was expected it was because we couldn’t get them to palliative care fast enough. There was no bed, right? It was none of that kind of stuff. So there was never any good feelings to go with all the bad feelings.

It is evident that the opposing mindsets of practitioners in acute and LTC as well as the unique organizational and historical philosophies of care in each setting have significant impact on the transition experience for nurses. As nurses transition into LTC they are required to recognize the medical model approach to care, which they have come to know as the gold standard, as only one perspective and subsequently learn to “turn off
the acute care brain” and learn to approach their nursing practice from a holistic perspective.

**Summary**

Through presentation of this study theme, “Two Worlds Collide”, I have explicated how key distinctions between the acute and LTC practice environments have significant impact on nurses’ transition experience. I have demonstrated how the broader policy context of the settings impact nurses daily activities, often sending them “jumping through hoops” to ensure residents’ receive the required care. In doing so, nurses are required to shift their attention to textually-mediated processes as they carry out their everyday activities in their new role. Finally, I have explicated how nurses’ transition into LTC is not only a role transition but they are also required to change their approach to care and essentially their overall view of the essence of nursing.

**On the 6th Day**

The third and final theme will explicate study findings related to participants’ descriptions of their orientation into LTC as well as their continued transition after the orientation period. The maximum number of shifts that nurses reported receiving during their orientation period was 5; thus, the title “On the 6th Day” was selected to represent this theme of study findings. The complexities of this delicate period are explicated below as the social and ruling relations of nurses’ experiences are mapped.

**Orientation: A Missed Opportunity**

Throughout participant interviews it became evident that the orientation period had a critical impact on their overall transition. When questioned how they would describe their overall orientation to LTC, examples of nurses responses included: “poorly
handled”; “a lot to be desired”; “not a really great experience”; “a lot of learning very quickly”; “confusing”; “basically not enough”; “not a good one”; and “mindboggling.”

Below I will further explore the impact of the orientation period on nurses’ transition and explicate how these experiences are ruled by external forces.

For the most part, participants reported an orientation that consisted of three to five shifts, regardless of their academic qualifications and clinical experience. Through the process of mapping social and ruling relations, various external influences on the orientation period for RNs in LTC were identified. For example, New Brunswick Regulation 85-187 under the Nursing Homes Act (1985) broadly states that an operator must “establish a program with respect to the orientation and in-service training of all employees” (section 17, p 7). Accordingly, the DSD’s most recently published Nursing Home Services Standards Manual (August 2016) indicates the following as measures of compliance with section 17 of the Regulation 85-187:

The operator ensures that each employee receives: A. a general orientation that is current and relevant to the organization. B. an orientation program specific to each position description that is current and relevant to the specific department where the employee will be working (C-II-1, p 1).

Although it is mandated that all employees must receive an orientation, there is no direction as to what constitutes an appropriate orientation in respect to content and time. However, Article 40.03 of the current agreement between the New Brunswick Nurses Union (NBNU) and the New Brunswick Association of Nursing Homes (NBANH) specifically states: “For newly hired employees the minimum orientation shall be three (3) days and for employees who have never worked in a nursing home or where required to work rotating shifts, it is understood that orientation of a minimum of five (5) days will be required” (p.. 41).
In this study, both RNs in clinical and managerial roles agreed that the orientation is not adequate. Although the majority of nurses did not articulate the relationship between external factors such as funding, some nurses did acknowledge this.

Tracy: Because I mean it is all about money now. They don’t have the resources to spend the time to orientate you.

Tara: Well, I mean I know they do the best that they can with the budget that they have. Orientation is not what it used to be and they have 5 days to complete.

Heather: When I first started here, as an opportunity to recruit RNs and retain them, the nursing home services funded us for 10 days orientation. Which for LTC isn’t perfect, but it’s pretty good. They had taken, as funding has been cut and cut and cut and cut over the years they took that away from us many years ago. When I first started it was a pretty good orientation…so when it got cut down to the 5 days I had concerns.

Given the limited time allotted to orientate RNs in LTC, many participants described a less than desirable, overwhelming, task-oriented orientation. For example, Shirley vividly recalled “I remember sitting at the table and thinking that, there is no way that I can take this in.” Furthermore, nurses reported that they were assigned to orientate to multiple units within their facilities in only a few shifts and were mentored by different nurses each shift. This lead to further confusion and frustration for nurses, which significantly influenced their transitional experience.

Michelle: So each day you are in a different unit. So that day you are meeting brand new residents, brand new people. Another nurse, so you are trained by somebody different….So it wasn’t like you got to be mentored for that week with somebody and really got to dig deep with the resident. It was a different person every day and it was a different unit every day.

Cathy: I would have to say the orientation was more about tasks, rather than this is what an RN requires, this is what your role is, this is why we need RNs in the building.
Cathy also expressed concern that she did not spend an orientation shift on the unit her position required her to work on. Similar to many other nurses, Cathy spoke of the potential benefits of new nurses being assigned to one unit and one manager for a longer duration of the allotted orientation time. Riley also offered similar recommendations:

Sometimes I think when it comes to orientation probably you need like 1 person for 2-3 days at least to get familiar. Because when you change from one person to another then that also doesn’t help things. So I think it is a good idea if I had had one, just one assigned for the entire like 3 days.

Another common concern expressed by nurses was their first day of orientation to LTC. Nurses explained that this initial day primarily consisted of reading “policies” or “binders” and lacked any true contact with nursing staff and residents.

Michelle: I think my first day I read a whole lot of policies and that was fun.

Joan: The very first day that I went there I was met by the receptionist and I was put into an old examination room type of thing, so I was put in there with a chair and a bedside table and given about 8 manuals to read. So that was the first day and so that was it. So the receptionist basically did that first day orientation.

Nurses appear to believe this particular component of their orientation was not the most effective use of their time. Numerous other participants described similar beliefs and highlighted that much of the information that is read that first day is completely forgotten the next day. For example, Tracy elaborated:

The first day in general is a lot of reading and things like that and you know going through all the books that they have and the care plans, looking at the care plans, looking at the standing orders and all that kind of stuff. Which is great, but do you remember any of that stuff afterwards? NOOO. You don’t. You really don’t. ….I mean like you know, when you go in and read through all the books and documents; you don’t remember any of that stuff. It’s all gone. It’s all gone because you are so busy and then something happens and you are running around trying to find where is this book, where is that book, and stuff like that.
Other participants stressed how such textual documents were initially presented to new nurses as readily available tools to guide their practice. Shirley explained “it was presented like everything was easy access, like everything you need is in this book.” She then proceeded to discuss the challenges she later faced when situations arose and she was required to locate specific textual documents to guide her. Specifically, she reported how difficult it was to find the reference that was needed and she partially attributed this challenge to her status as a casual nurse who worked infrequently as well as to the inconsistencies between different units in the facility. Although some participants acknowledged this frustration as a major contribution to their challenging transition period, other participants praised the convenience and usefulness of such textual documents.

Joan: They do have a lot of policy laid out in long-term care to help the nurse.

Kendra: They have good manuals at the nursing home that I was in. They are available, they have one specific to nursing so those were things that I had to go to a lot.

Participants’ consistent references, both positive and negative, to “policies”, “binders”, and “books’ affirmed that nurses in LTC relied on texts to guide their daily practice as they transitioned. The LTC environment was described as a highly regulated environment that functions through rigid daily routines, consistent with the notion of becoming “task-oriented” practitioners who relying on textually-mediated processes.

Michelle: Policies, how the home is made up usually dictates how my day is going. Like who’s responsibilities are what. The home also has routines for each of their, I don’t want to say workers, but each of their employees….You have a set of routines, and if there is something that is abnormal from that routine, that’s usually when I go to my policy and procedure binder.
Mary: I mean I ran into a situation 2 weeks ago where a family brought in an optometrist from another city to see their family and this optometrist wanted to prescribe. And of course I had to say no, you are not allowed that is not policy and then I thought where is that policy. And there is a policy and procedure manual, don’t get me wrong, but I mean that was a very unique situation, that’s extremely unique. But I left a note for the charge nurse that said show me if there is a policy in regards to this, if not we need one.

The above narratives confirm that in situations of uncertainty, despite a breadth of clinical nursing expertise, nurses turn to textually-mediated processes rather than relying on their professional judgement. After further exploration into nurses narratives and work processes, it became clear how such textually-mediated processes were consistent with the task-focused orientation that nurses described.

**Baptism by Fire**

I have uncovered key social relations that rule the orientation period for nurses entering LTC. Next I will describe how the “less than desirable” orientation subsequently shapes nurses continued transition experience as they learn to function in their new role. Participants’ described their transition experiences extending beyond the initial orientation period. The majority of nurses described feeling unprepared entering their new role after their last orientation shift. Reflecting on this experience Michelle stated “so you (sigh) were kind of like ‘okay…’ (pause). After that you were kind of thrown into your position.” Correspondingly, when asked about the first shift after orientation Cathy stated: “I was scared to death actually. The first shift that I was on I had to kind of go get the book and go ‘okay what I you do on this shift?’”

Similarly, Tracy emphasized the struggle she experienced when beginning her new role in LTC as she stated: “I found it really difficult at first, going into it, I found it
really difficult at first”. Tracy metaphorically summarized her transition experience as “baptism by fire”. She described disappointment in the orientation process and concluded that what ultimately happens is “baptism by fire”. Tracy described a significant influence on nurses transition experience: “we are always trying to struggle our way through to find what needs to happen if something different happens.”

Consistent with the concept of “baptism by fire” nurses highlighted the uncertainty they experienced in their day to day lives when they were new to the role of the RN in LTC. Other nurses echoed Tracy’s above comment as they described how they also had to learn as situations arose, which was not always easy. Riley explained “it’s like you spend most of the time now trying to learn when you are expected to be performing.” This statement not only suggests that nurses are entering their roles unprepared, but also that they are being pulled away from their roles and responsibilities in order to focus their time and energy on learning the steps required to effectively function in their role. It became evident that such situations were a source of stress and at times frustration for transitioning nurses.

Tracy: I guess I will say how we have learned is when the crisis happens you deal with it. So that to me has been the most difficult part of it all.

Riley: Because it can be so frustrating when you feel like every time you have to ask what is going on… and that has to do with the orientation period because it is not sufficient enough to get to know the home better, to get to know exactly what the expectations are. So it takes, so long for you to get familiar with all the tasks.

Analogous to Riley’s above mention of frequently inquiring “what is going on”, the majority of nurses identified doing that same and emphasized that they often reach out to other RNs in the building. Essentially, they rely on each other as resources when they were uncertain of how to proceed with a particular situation.
Michelle: I did my orientation and then I started the week after. On my own. I remember though, relying within the first few months on the RNs beside me.

Tracy: THANKFULLY I have people, other nurses in the facility that I can help them out and they can help me out.

Interestingly, some nurses also reported that they relied on various other members of the care team, both regulated and unregulated, to tell them what their role was. Nurses attributed this confusion to a variety of factors including the poor orientation they received, being a casual or part-time employee, and inconsistencies between units in their facility in terms of the everyday activities of the RN.

Tracy: I’ll never forget the first day I came on and I said my name is Tracy and this is my first shift here. I said I am relying on you guys to tell me and this is the, there are the RA and LPN there. And I just said I like to work as a TEAM and I am here to umm and I am relying on you guys to tell me what I need to do.

In this example, Tracy was asking both regulated staff such as LPNs and unregulated staff such as RAs what the role of the RN in the facility was. She later reconfirmed the notion of teamwork and attributed her dependency on other members of the team to her position as a casual nurse.

Tracy: The RAs and LPNs are really good. And I have to say that they are very helpful to me too, if I struggle with anything. If there is something that I do not know I mean the staff that are there on a permanent basis are the ones that, they are the go to people. I always go to them and say help me out or what do I need to do in this care or what kind of paperwork do I have to do or what do I have to fill out in the computer and that kind of stuff.

Interestingly, Tracy was not the only nurse who stated that she regularly turned to staff members for guidance as to what the RN on duty should be doing. Other nurses described relying on both regulated and unregulated care providers to direct them as to
the nature their roles and responsibilities, as well as the day to day processes of the facility. For example, Shirley stated:

Shirley:  I don’t have a problem asking staff for help and I relied on them. I felt I was, do you know what I really felt and I still feel to this day, I felt I was stepping on their turf. That they are the ones who knew this place way better than I did and so I relied on them and still to this day still rely on them to tell me. So, and there has been some changes in the home in the last couple of years and again this year. So I just, I ask them like what happens now? What does the nurse do now?

Thus, despite being in a leadership position and expected to direct the overall care provided in the facility, during the transition period RNs clearly experience uncertainty in relation to their roles and responsibilities. Nurses consistently describe having to “figure your way through things” as situations arise and often rely on various members of the care team to for assistance in navigating their role.

**Learning to Stand on Your Own**

Although some nurses emphasized the importance of teamwork in LTC, other nurses expressed feeling isolated working in this environment. One distinction that nurses explicitly identified between acute and LTC was that RNs work in isolation and have a greater level of autonomy and responsibility in LTC. Despite having a wealth of clinical experience in other settings, nurses nevertheless struggled with the independent clinical decision making that the LTC setting supports. It became clear that this challenge indeed influenced RNs overall transition. Below, I will provided examples of how participants described this influence on their transitional experience.

All nurses indicated that when they worked a shift in LTC they were the only RN on the nursing unit for that shift. Depending on the shift (days, evenings, nights, weekends, etc.) nurses could be responsible for 2 units in their facility which could
amount to 75 residents. Unfortunately, this was something that participants stated happened more times than not. All participants, with the exception of one, identified safety concerns when they were obligated to be responsible for the overall care delivered for two nursing units. Interestingly, the one nurse who did not identify this as a concern was an individual who exclusively worked night shifts. This participant did not state additional stress when responsible for two units on a night shift.

Further mapping of social relations lead to Regulation 84-187 under the New Brunswick Nursing Home Act (1985), located on the DSD’s webpage. This act mandates that nursing homes with 30 or more beds have at least one registered nurse on the premises at all times. Given that LTC facilities must adhere to such regulations, this extra-local text rules everyday happenings in the local setting and shapes nurses’ transition experience.

In keeping with working in isolation, nurses consistently highlighted the increased stress that co-exists with increased responsibility. Many nurses compared this to their previous experiences as a student nurse or as a staff nurse in another setting.

Riley: There is some pressure which comes with that and as for trying to get used to the whole process of being in charge, because as a student of course you didn’t have that exposure or when working in the acute care setting, you have like a small assignment and you are usually with someone. But here in long-term care, you are taking responsibility, you are in charge.

Michelle: Because as a staff nurse, I feel like you are one of many. Whereas in the nursing home, you are the RN. You are the go to person...Literally, you went from being the staff nurse, working alongside RNs: so always having support, you are grouped together, you have a manager, to suddenly you’re the manager...

Despite admitting that she had to “get away” from the stress of an acute care environment, Michelle quickly realized that working as an RN in the LTC environment
came with other unique stressors. She elaborated by comparing LTC to the intensive care setting “but that is different. It’s not that pressure of ‘how do I prevent someone dying today.’” Thus, the stress that many participants referred to was attributed to working in isolation, which was not something they were not accustomed to doing. This ultimately resulted in intensified feelings of responsibility, which led to a larger degree of stress for nurses. For example, Riley referred to the high expectations that are put on the RN in LTC as they delve into their “in charge” role:

Riley: There were a few challenges of course, umm of which I didn’t expect. Because I used to have that mentality that in the LTC setting there’s nothing that can be challenging in terms of acuteness. I didn’t expect to have sick sick people in a nursing home. But I was surprised in my first few months, you know I had an experience where I had 2 or 3 residents within those 2-3 months who were really sick and everyone was looking up to me right? Because you are in charge, you are the RN. In this kind of setting you don’t have a doctor around to just grab and say come help me. It is up to you to do that kind of assessment and to make a decision whether you are going to send them to the hospital or not. So, you have that responsibility. So your assessment skills and everything now comes in too. So you have to really make a judgment call and your critical thinking and everything. So it’s not all about paperwork…Sometimes things can happen. Something can go wrong and you are responsible for that.

Interestingly, although nurses spoke of relying on other RNs in the building as a resource, some nurses also described the challenge of not having a second nurse present as a “backup.”

Shirley: I found just the fact of not having that resource of another RN which I have been used to for many many years of having a backup if you want to say for the sake of another word. This just wasn’t as simple as that.

Kendra: I gained some self confidence in relying on my own nursing skills, where before if I thought something was abnormal I would always get a second opinion, well in a nursing home you can’t really get a second opinion, so it fine tunes all those skills.
The above narratives suggest that nurses initially lacked confidence in their assessment skills and struggled with many of the decisions they were faced with in LTC. Essentially, nurses had to learn what one participant described as being “okay with your own head” and realizing that “you don’t need 5 people behind you to agree with you.” Interestingly these feelings were expressed regardless of the quality and quantity of previous clinical nursing experience.

**Chapter Summary**

Using nurse’s experiences as an entry point, I have uncovered how the prevailing social, historical, and ideological constructions of the LTC environment shape the transition experiences of RNs. Through mapping work processes the hidden social and ruling relations of nurses’ transition experiences were revealed and presented in this chapter through three interrelated themes. The first study theme “Entering LTC: Up & Away” revealed that majority of RNs entered the LTC environment with no experience or interest in gerontology coupled with a misguided preconceived notion of what their role would entail. The second study theme “Two Worlds Collide” highlighted the many distinctions between the acute and LTC settings and how these significantly impacted nurses overall transition period. The final study theme “On the 6th Day” presented nurses’ experiences as they participated in the LTC facility orientation program and proceeded into their new role. In the next chapter, I will use the key social and ruling relations to further discuss study findings and highlight implications for practice, policy, education, and research.
CHAPTER 6
DISCUSSION AND CONCLUSION

The purpose of this research was to uncover the experiences of RNs who transitioned into the LTC environment. As an RN who had experienced the transition into LTC, I was interested in encouraging others to share their experiences to enhance the understanding of this transition. Participants’ stories lead to the discovery of a rather complex transition period and further investigation revealed social relations that ultimately shaped RNs’ transition into LTC. The research questions that guided this investigation, and were answered in the previous chapter, include:

1. What are the everyday/everynight experiences of RNs who transition to the into the LTC environment?

2. In what ways do prevailing social, political, historical and ideological constructions of the LTC environment shape the transition experiences of RNs?

3. What are the social and ruling relations that mediate the everyday/everynight life of the RN in LTC, and how do these relations shape the transition experience for RNs?

This research has contributed to the development of new and existing knowledge in multiple ways. There is a breadth of literature and various theoretical frameworks that support the complex nature of transitions; however, investigations into transitions experienced by nurses have been limited to transitions into acute care settings with emphasis on new graduate nurses (Kramer, 1974; Missen, McKenna, & Beauchamp, 2014; Schmalenberg & Kramer, 1979). As far as I am aware, this is the first study that
has focused on the transition for RNs into the LTC environment, adopting IE as a lens for investigation. As a unique research method, IE allowed the investigation to extend beyond individual participant experiences and target the broader social and ruling relations that shape the RNs transitional experience.

Findings from this study suggest the RN transition into LTC is a complex transition not only for new graduate nurses but also for those coming with a breadth and depth of nursing experience. Patricia Benner’s (1984) work on the competencies of clinical nursing practice supports this position. According to Benner (1984), “any nurse entering a clinical setting where she or he has no experience with the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar.” (p. 21) It is for this reason the inclusion criteria for this study was not limited to new graduate nurses; rather, RNs’ transition must have been their first time entering a clinical role in LTC. Supported by Benner’s influential work, findings from this study suggest it is important that the “novice” within the experienced RN is recognized as they begin a transition into a new area of practice. This suggests that orientation programs into practice settings should not make assumptions regarding nurses’ orientation needs based solely on their years of nursing experience.

**Contributions to New and Existing Knowledge**

There are 3 prevailing contributions to new and existing knowledge that emerge from study findings. These contributions include the unexpected complexity of LTC, the ambiguous nature of the RN role in LTC, and the impact philosophical differences between acute and LTC care settings have on RNs’ transitional experiences. I will now
explore each of these contributions in further detail and subsequently identify study implications and limitations.

**Complexity of LTC**

The unexpected complexity of the LTC setting was consistently embedded throughout nurses’ transition stories. In the context of this study, this complexity was found to be an interplay of environmental factors within the LTC facility and a resident population with multiple and often overlapping health and social issues. The ways in which these factors shaped nurses’ transition into LTC will be explicated below.

**Environment.** Nurses in this study clearly indicated a perceived lack of support in LTC, compared to acute care. One summarized this challenge by stating, “because coming from institutionalized work (acute care) everything is INSIDE, this (LTC) is all outside”. Nurses described a lack of support in relation to accessibility of appropriate resources required to perform their job. These included human resources in terms of appropriate staffing as well as supplies to perform daily nursing tasks. Some nurses attributed this lack of support to inadequate funding.

Participants also described feelings of isolation, increased stress, and responsibility in their role in LTC. For example, participants reported they were the “go-to person.” Although many nurses in this study described having another RN in the facility they could draw upon for support and second opinions, this was not always the case. In NB, the Nursing Home Act (2014) mandates LTC facilities with 30 or more residents, have one RN in the facility at all times. Nurses in this study described the availability of support to be dependent on the specific shift (day, evening, night) and day of the week. What this meant is that RNs are often required to work alone, especially
during evening, night and weekend shifts. These findings are consistent with literature reporting RNs' perceptions of isolation and loneliness in their everyday activities in LTC (Carlson et al., 2014; Carryer, Hansen, Blakey, 2010).

Corresponding to the increased responsibility, participants in this study also highlighted concerns regarding skills mix in LTC. The Nursing Home Act (2014) states “appropriate ratios” of care staff are to be present in the home at all times (p. 7). However, appropriate ratios and skills mix are not clearly defined within this document. The most recent skills mix ratios for LTC facilities in the province of New Brunswick consists of 20% RNs, 40% LPNs, and 40% PSWs (New Brunswick Association of Nursing Homes in 2005). In 2016, the New Brunswick Department of Social Development (DSD) announced a proposed change in skills mix in the province’s LTC facilities. The changes included a decrease from the current ratio of 20/40/40 to 10/25/65; in other words, this change would mean a substantial decrease in regulated care providers (RNs and LPNs) and an increase in unregulated care providers (PSWs, also known as RAs). This proposal raised significant concerns for many, as evidenced by NBNU’s president writing a letter to the Minister of the DSD stating that the NBNU does not support the proposed changes given the lack of sufficient evidence to support the decision (NBNU, 2016). Similarly, study participants who talked about skill mix also expressed significant concern regarding the proposed changes to skill mix in the province’s LTC facilities. Participants primarily expressed concerns related to how the proposed change in skill mix would impact quality of resident care. The proposed decrease in regulated staff, whose education and scope of practice is more advanced than that of unregulated staff, would result in fewer staff available to perform key assessments and nursing
interventions for residents. These participant concerns are consistent with the literature that emphasizes the enhanced resident outcomes related to the RN role in LTC (RNAO, 2010). In the context of this study, the proposed change to skill mix would not only have an impact on resident care but could also further complicate the RN’s transitional experience. Fewer regulated workers would increase RNs responsibilities, decrease the number of staff who are qualified to perform assessments on residents, and further decrease availability of another RN for support. Such changes could ultimately negatively impact recruitment and retention efforts.

**Resident Population.** Participants in this study, particularly the more experienced nurses, also emphasized the unexpected change in the LTC resident population they encountered. Upon entering the LTC setting, nurses in this study were surprised to discover an enhanced level of acuity and complexity of residents. Participants in this study highlighted that they did not feel “prepared” for the transition as they had not originally anticipated the resident population to be so medically complex. For example, various RNs referred to the shock they experienced upon transitioning into LTC: “comorbidities are crazy” and “I was totally floored! I just couldn’t believe that the residents were as sick as they were.” Thus, the unexpected need to care for sick residents underscores the impact their assumptions of the RN in LTC only being required to do paperwork. Despite the many years of clinical experience and leadership training for most participants, nurses in this study struggled with managing the complex comorbidities that the residents presented with. Caring for residents with complex health needs was difficult for many reasons. Some nurses entered LTC to escape the need to care for sick residents and others were away from bedside nursing for long periods of
time and did not feel prepared to care for sick people.

Although many assume the population residing in LTC facilities are “stable” in terms of health conditions, the Canadian Institute of Health Information reports up to 57% of residents in Canadian LTC facilities exhibit signs of health instability (CIHI, 2016). Participants’ description of the resident population and lack of resources in this study are consistent with RNAO’s (2010) summary of the changing population in LTC facilities. As early as 2010, RNAO identified a rise in medical complexity and increased care requirements, and the identified association between RN staffing and enhanced resident outcomes, the RN to resident ratio has not been reflective of such changes. In 2015 the CNA (2015) reported: “4,400 fewer RNs are now working in nursing homes and LTC facilities than in 2005” (p. 1). On a practical note, a decrease in the number of regulated workers at a time when resident acuity is reportedly increasing (CIHI, 2016; RNAO, 2010) is counterintuitive. In the province where this study took place, the government threatened a decrease in regulated care providers. Therefore, although there is widespread recognition that the resident population is becoming more complex, the government is claiming that the number of regulated workers in LTC can safely decrease. One possible explanation for this is the lack of clarity of the RN in LTC as reflected in the job description (Appendix K). Furthermore, it is possible that nurses in LTC, like nurses who practice in other settings, are not always recognized for the contribution they make to resident care (Hardy, Titchen, Manley, & McCormack, 2006; Phelan & McCormick, 2016).

Findings from this study identify LTC as a complex environment with an increasingly complex resident population and is consistent with the literature. As LTC
residents continue to present with an increase in care needs, it will be vital for staffing in LTC to be adjusted accordingly to optimize quality of care for the aging population. Further investigation is warranted, particularly research focused on resident outcomes, to inform evidence-based changes to skills mix in LTC.

**The RN in LTC**

Another important finding from this study is the ambiguous nature surrounding the RN in LTC. Not only do nurses enter their new role with misguided perceptions of what their job will entail, they also experience role confusion as they proceed to work independently after the orientation period. These factors were found to significantly influence the overall transitional experience for RNs. I will further discuss these influences below.

**Misguided Perceptions.** Although RNs in this study entered their positions for various reasons, the majority did not bring gerontological nursing experience or a passion for the older adult. As described in the previous chapter, RNs entered LTC with a preconceived notion of nursing being less demanding and stressful compared to other areas of nursing. These presumptions are consistent with health care practitioners prevailing attitudes towards older adults with research indicating that these beliefs may reflect broader societal attitudes towards older adults, or are nurtured during health care practitioners education (Almeida Tavares et. al, 2015; Eymard & Douglas, 2012; Kydd et al., 2014; Lui, Norman, & While, 2013). Through Liu, Norman, and While (2013)’s systematic review of the literature, it was determined that attitudes of both nurses and student nurses toward older people appear to be “less positive since 2000” (p. 1271). Although not all participants in the current study were new graduate nurses (n=1), the
preconceived notions of the majority of participants were found to be consistent with the 
literature related to undergraduate and new graduate nurses’ views of an under 
appreciation for the complexity of gerontological nursing (Bedin et al., 2013; King, 
Roberts & Bower, 2013; Neville et al., 2014).

Despite negative societal and professional attitudes towards caring for older 
adults, nurses in this study developed an appreciation for the specialized knowledge 
required for gerontological nursing after they entered LTC. This is concurrent with the 
literature which suggests RNs working in gerontological nursing recognize their work as 
a specialized nursing area (Dwyer, 2011; Hunter & Levett-Jones, 2010; McGilton et al., 
2009). Similarly, the Canadian Nurses Association (CNA, 2017) recognizes 
gerontological nursing as a specialty area and offers national certification to demonstrate 
practice excellence and expertise. Although the majority of nurses who work in acute 
care are also caring for large numbers of older adults, it is unclear why they do not 
recognize the complexity of gerontological nursing. While it is possible that the acute 
care needs take precedence in the hospital setting, it is equally possible that they do not 
recognize or value the specialized area of practice and consequently provide sub-optimal 
care in acute environments.

Role Confusion. Further perplexing the inaccurate image of the RN in LTC, 
findings from this study suggest as nurses’ transition into LTC they experience 
uncertainty in relation to their new role. RNs in LTC are in charge nurse positions and are 
responsible for the overall operation of the care unit, including direction of resident care. 
Yet, RNs in this study recalled approaching other members of the care team, including 
regulated and unregulated professionals, for direction in their daily practice. For example,
one RN mentioned approaching staff on the unit at the beginning of the shift to report “I am relying on you guys to tell me what I need to do.” Another RN recalled questioning other staff on the unit and stating, “what happens now? What does the nurse do now?”

Nurses in this study attributed such confusion to factors including receiving poor orientation and working less frequently as a casual employee. Such findings raise significant concerns. The need for RNs to have a clear understanding of their role is key in order for them to function to their full scope of practice in LTC and to guide other care providers in optimally functioning within their roles to enhance overall resident care and quality of life.

Extensive investigation into the role of the RN in LTC was not within the scope of this study, however the possibility of nurses’ role confusion being exacerbated by the complex nature of the role of the RN in LTC must be considered. For example, current literature highlights the role of the RN in LTC as both complex and unpredictable (Backhaus et al., 2015; Hunter & Levett-Jones, 2010; McGilton et al., 2009). Throughout the literature, RNs in LTC report heavy workloads exacerbated by competing responsibilities which leads to chaotic work environments (McGilton et al., 2009); in addition to wearing multiple hats, which frequently removes them from their ‘nursing’ (Hunter & Levett-Jones, 2010).

Correspondingly, experts have acknowledged that RNs in LTC facilities are performing tasks that are better suited for management or other members of the care team (Backhaus et al., 2015). The potential for role confusion to lead to an overlap in roles in of care team members in LTC and subsequently permit opportunity for missed care raises significant concern. Research suggests factors that also contribute to potential for missed
care include skills mix in LTC, complexity of care needs, and less than desirable work environments (Blackman et. al, 2014; Henderson, Willis & Backman, 2016; Knopp-Sihota et. al, 2015). Similarly, RNs in the current study identified many of the above as problematic in their everyday/everynight activities in LTC.

Interestingly, McCloskey, Donovan, Stewart, and Donovan’s (2015) observational study found in some NB LTC facilities RNs spend up to 60% of their time in direct-care activities and in other facilitate only 11% of the RNs time is spent on these activities. The wide variation in how RNs operationalize their role suggests a lack of role clarity. It is also possible that when unsure of the expectations of them, RNs perform roles that could otherwise be performed by less qualified providers (Bedin, et al., 2013; Carlson et al., 2014; Hunter & Levett-Jones, 2010; McGilton et al., 2009). Although one of the key strategies to introduce and clarify roles and expectations is a structured orientation program, RNs in this study described their orientation period as “basically not enough”, “confusing”, “mindboggling” and “not a good one.” The lack of a well-designed orientation program made have contributed to role transition difficulties. It is also possible that the inadequate orientation program is reflective of a broader lack of understanding of the RN role in LTC by administrators and policymakers, as reflected by the facility job description (Appendix K) and government staff regulations.

**Nursing across Care Settings**

Nurses in this study also described the difference between acute and LTC settings as contributing to a challenging transition. Participants described their experiences and role in LTC to be much different than any role they had experienced before in their nursing careers. Even nurses with many years of clinical experience acknowledged the
increased amount of responsibility, advanced assessment skills, and autonomous
decision-making and practice that is expected and essential in LTC. Key distinctions
highlighted by participants will be discussed below and recommendations for future
research will be presented.

Nurses identified the challenge of “turning off the acute care brain” or “flipping
my head right around” when they came from the acute care setting into LTC.
Participants’ statement reflected beliefs that the acute care setting predominantly focused
on the medical model which, sometimes unconsciously, had a significant impact on how
they practiced as nurses. One participant described the difference between the settings as
she explained that when practicing in acute care “the body was broken into pieces”. This
participant elaborated on this notion by stating, “if somebody’s kidneys weren’t working
you consulted nephrology.” Further reflecting this participant highlighted, “so now (in
LTC) there is nobody to consult, it’s us: one doctor, one nurse.” This is consistent with
the literature that suggests acute care is not the ideal environment to care for older adults
(Parke & Hunter 2014).

Nurses in this study also highlighted the difference between care settings in
relation to philosophical underpinnings. The concept of resident-centered care and
emphasis on quality of life was reiterated through participants’ transition narratives. For
example, one participant highlighted the difference between their previous experience in
acute and their new position in LTC, “it is HUGELY different. I look at them (residents)
and I think what quality of life they have.” Although some literature highlights the
advanced role of the RN in LTC in terms of the responsibility of overall management of
care (Dwyer, 2011; Hunter & Levett-Jones, 2010; McGilton et al., 2009), no research
comparing the philosophical differences in nursing across care settings, particularly between acute and LTC, was uncovered. Urban (2014) explored the work of nurses in hospital setting and reported “nurses remain socially organized by several power forces such as patriarchal ideology and the various institutional discourses within the hospital” (p. 76). Furthermore, Urban’s (2014) findings uncovered the hidden power relations that existed as nurses actively participated in the work of physicians and accepted this as an embedded part of their daily routines.

Results from the current study suggest further investigation of power relations is warranted in order to further explicate the differences between acute and LTC settings and how these impact the transitional experiences of nurses. Specifically, determining whether or not nursing in acute care today has unintentionally become too heavily focused on “breaking the body into pieces” with emphasis on completion of tasks and consultations is required. Specifically, research investigating nursing in acute-care and LTC settings is required to further explicate the significant challenges faced during RN’s transition into LTC. If the essence of nursing is caring as many would support (Watson, 2012), how does this translate to the daily activities and philosophies of care in various settings? Is the “nursing” function of nurses in acute care overwhelmed by the medical model?

**Study Implications**

The preceding discussion section of this chapter expanded on key study findings and highlighted contributions to both new and existing nursing knowledge. This study has multiple important implications. I will now present implications specific to nursing practice, education, policy, and research.
Implications for Practice

The primary implication for practice from this study’s findings is in relation to orientation programs in LTC. The collective agreement between NBANH and NBNU (2015-2018) indicates “for newly hired employees the minimum orientation shall be three (3) days and for employees who have never worked in a nursing home or where required to work rotating shifts, it is understood that orientation of a minimum of five (5) days will be required” (article 40.03, d). Whereas, the NBNU (2015-2018) collective agreement, in which acute-care settings fall, does not indicate a minimum number of shifts required for orientation. RN’s indicated that the minimal orientation to LTC was unlike any previous orientation they had experienced. Secondary sources of data, specifically nurses in managerial positions, also indicated that the orientation is not enough and, along with other participants, attributed this to budget cuts over the years. Based on analysis of data from both primary and secondary informant interviews, it became clear that nurses in managerial positions in LTC strive to provide the total 5 days of orientation. According to participants, the only time that new employees would not receive a total of 5 days would be if they previously worked in the building within a different role (ie: PSW or LPN) and had some familiarity with the facility.

There is a paucity of literature exploring the possibility of extending orientation for LTC or the idea of mentorship programs for this area, as the majority of recent research has targeted transition to practice, particularly in acute care settings, for new graduate nurses (Blanzola, Lindeman, & King, 2004; Missen, McKenna, & Beauchamp, 2014; Olson-Sitki, Wendler, & Forbes, 2012). However, in 2012 the province of Manitoba implemented a pilot project targeted to enhance orientation for nurses who are
new to LTC in the province (O’Rourke, 2012). One of the primary purposes of this program was to develop a level of consistency within provincial, Manitoba, LTC orientation programs. This pilot project included partnership with nurse mentors and a total of 6 clinical workshops implementing a curriculum of best practice clinical information. Results from the pilot project ultimately lead to permanent provincial funding for all LTC facilities to implement the enhanced orientation program (O’Rourke, 2012). Given findings from this study suggesting the orientation in LTC is currently not optimal, piloting a project similar to Manitoba’s (O’Rourke, 2012) in NB LTC facilities could be a serve as a reasonable starting point in the effort to enhance RNs overall transition into LTC.

Furthermore, because LTC is not entirely funded by the provincial government and does not fall under the Canada Health Act, it would be interesting to investigate LTC orientation programs across Canada, compare these provincially, and explore the possibility of standardized and enhanced programs. Subsequently, longitudinal studies investigating positive effects of such programs on recruitment, retention, fiscal savings, and quality of care would assist in maintaining sources of funding.

I have drawn from study findings related to the orientation period for RNs in NB LTC facilities is: a provincial evaluation of orientation programs for LTC facilities is critical. Although enhancing the transition experience through revision of orientation programs would be the obvious benefit of such reform, there is also potential to positively impact job satisfaction, recruitment, retention, and most importantly quality of care and quality of life for LTC residents.
Findings also raise questions about the impact of staffing patterns and skills mix on resident care. Although not within the scope of this study, findings point to a care environment that is characterized by complex residents with multiple health needs. The important contributions of the RN in this environment must be acknowledged and their presence maintained.

**Implications for Policy**

In addition to enhanced orientation programs, the current study has other implications for policy, particularly related to standardization of RN job descriptions in LTC. Participants in this study described experiencing a complex transition including regular periods of role confusion, despite the presence of an organizational job profile. As identified in Chapter 3, no national standardized role description for the RN in LTC was uncovered from the available literature. Moreover, although some provincial regulatory bodies do have position statements regarding the role of the RN in LTC (ARNNL, 2013; SRNA, 2015), no such position statements exist in NB.

In 2005, the New Brunswick Association of Nursing Homes (NBANH) presented a document outlining the roles and responsibilities of the RN in LTC. Although the document promotes provincial standardization of the RN role in LTC facilitates, LTC environments have experienced numerous changes since the document was released. Today, a decade later, there is no evidence of provincial reevaluation of the RN role in LTC. However, other provincial associations have published more recent documents defining the role of the RN in LTC. For example the Association of Registered Nurses of Newfoundland and Labrador (ARNNL, 2013) recently released a position statement outlining the RN roles in LTC.
Further strengthening the case for the importance of the RN in LTC, the Registered Nurses Association of Ontario (RNAO, 2010) declared, “The evidence is clear that in long term care homes RNs are more effective in improving resident outcomes and reducing costs” (p. 3). Thus, despite the dearth of a standardized role description it is evident that provincial bodies concur in terms of the uniqueness and value of the RN in LTC. In terms of moving forward, the Gerontological Nursing Competencies and Standards of Practice developed by the CGNA (2010) could serve as a key foundation for the development of standardized job profiles.

**Implications for Education**

Findings from this research also have important implications for nursing education. Only 1 nurse who transitioned into LTC as a new graduate was successfully recruited into this study; however, 82% of participants held a Bachelor of Nursing degree. This corresponds to the relevant literature that suggests new graduates nurses are reluctant to enter LTC as it is not viewed as a desirable area to work (Neville et al., 2014). Some participants in this study expressed a perception that their nursing education programs did not prepare them for their role as an RN in LTC. This finding suggests that nursing education programs should make a concerted effort to provide students with opportunities to develop leadership skills and prepare future nurses to assume the higher level roles such as that of the RN in LTC.

These findings have important implications for nurse educators and undergraduate nursing programs. Specifically, careful review of theoretical content pertaining to care of the older adult as well as appropriate placement of such content throughout the curriculum is crucial. In many undergraduate programs, student’s first clinical placement
is in LTC facilities where they focus on providing basic care to older adults and in some programs students do not have to opportunity to return to that setting later in their training. Lane and Hirst (2012) emphasized the importance of methodically planning when undergraduate curriculum integrates nursing home placements. Specifically, ensuring that the required theoretical knowledge is also provided and faculty selected to guide students in the clinical setting are strong leaders who are passionate about gerontological nursing (Lane & Hurst, 2012).

In terms of theoretical gerontological nursing content in undergraduate nursing curriculum, recent research has investigated the impact of stand-alone courses in gerontological nursing for undergraduate nursing students, which resulted in a positive impact on perceptions of working with older adults (Koehler et. al, 2016). Earlier investigations that combined older adult course content with general adult course content also resulted in positive impact on student’s knowledge and beliefs regarding caring for older adults (Baumbusch, Dahlke, & Phinney, 2012). Incorporating gerontology as a mandatory component of the University of New Brunswick’s nursing curriculum would be an important step in preparing nurses to care for older adults across care settings.

Based on the findings from this study, changes to the current recruitment process for RNs in LTC could assist in enhancing their overall transition. Given the complexity and specialization of gerontological nursing, clinical experience or CNA certification could be a prerequisite to work in LTC. This prerequisite would help dispel the myth that the job and environment is not challenging.

Continuing education for RNs in LTC is also an area for future development. Although previous research has identified that RNs in LTC express a desire for more
continued education for professional development (Carryer et al., 2010; Dwyer, 2011), this was not a significant finding in the current study. However, over 70% of RNs in this study did not report any previous gerontological nursing experience or education; yet the majority of RNs spoke of the specialized knowledge required for their role in LTC. Some researchers have already proposed national gerontological nursing certification as an approach to decrease staff turnover and ultimately strengthen quality of care (Cramer et al., 2014). Promoting gerontology as a specialty area of practice and employers offering incentives for attaining such prestigious recognition could serve as a practical starting point for enhancing continued education for RNs in LTC. It is especially important in the context of this study given the absence of any prior gerontological nursing experience prior to gaining employment.

Implications for Research

Findings from this study revealed 4 areas for future research, which were highlighted throughout the contributions to new and existing knowledge section of this chapter. These included the need for research related to appropriate skills mix in LTC, the role of the RN in LTC, orientation programs, and the differences between nursing in acute and LTC environments. I will now revisit the 4 implications for research and provide a brief summary of each.

The complexity of the LTC environment as well as the resident population was a key finding in this study. These factors were found to have a significant impact on the transitional experience of RNs as they entered the LTC environment. Further investigation into the complex nature of the LTC setting revealed the true role of the RN is in many ways invisible to the general public, other health care professionals, and key
stakeholders within the LTC and health sectors. The province of NB has suggested a change to the skills mix in LTC. Perhaps most concerning, is the lack of evidence to support such changes. Thus, rigorous research focused on identifying optimal skills mix in LTC, with emphasis on resident outcomes, is critical to inform evidence-based decisions related to appropriate staffing in LTC.

The ambiguous nature of the RN’s role in LTC also emerged as an important study finding that has significant implications for future research. Findings from this study suggest RNs enter LTC with a misguided perception of the role of the RN. Such beliefs lead to a complex transition period as RNs experienced significant role confusion as they attempted to function within their new position. As identified above, extensive investigation into the role of the RN in LTC was not within the scope of the current study; however, findings support the need for further investigation into the role of the RN in LTC. Furthermore, exploring the possibility of developing and implementing standardized role descriptions in NB nursing homes and creating position statements highlighting the importance of this role may be a crucial first step. Research evidence is a prerequisite to uncovering the true role of the RN in LTC and to assist in identifying the hidden aspects of nursing care that are included in RNs’ daily activities.

The requirement for provincial standardization of orientation programs and enhanced orientation was discussed in the implications for practice section of this chapter. In terms of recommendations for future research, investigation into commonalities and discrepancies in orientation programs across the province is warranted. Furthermore, pilot studies for enhanced orientation programs would be an important step in improving the transition experience for RNs and impacting recruitment
and retention in the LTC sector.

The final implication for future research is related to nursing across care settings. Findings from this study suggest the role of the RN in LTC is significantly different from that of the RN in acute care. Study participants highlighted many differences across these two care settings, primarily related to the philosophical underpinnings that define how the RN functions within the different settings. Additional research is required to determine if nursing in acute care has unintentionally become too heavily focused on “breaking the body into pieces” with emphasis on completion of tasks and consultations.

**Study Limitations**

Limitations that may have had an impact on the findings of this research study as well as the generalizability of the results do exist. In terms of limitations related to the methodology of the study, although IE uncovered various important findings, it is possible that different study methods may have uncovered different issues and perspectives. In addition, a different standpoint such as that of LTC residents or unregulated care providers may have offered different perspectives. It is also important to note that I did not have access to direct observation of RNs transitioning into LTC, which may have assisted in discovering additional insights in regards to the social organization of the RNs’ transition.

Furthermore, some participants who initially contacted the researcher to inquire about the study decided not to proceed with participating. These potential participants may have had very different transition experiences to share that could have provided additional insights to aid in the mapping of social relations. Furthermore, some potential participants who were not within the revised inclusion criteria of transitioning within the
last 6 years may have also had an important perspective to add.

Given that participants were recruited from 3 LTC facilities in NB, it is important to consider the possibility of differences between facilities in terms of overall philosophy, the role of the RN, institutional functioning, and orientation programs. Similarly, because LTC is regulated and governed by provincial standards and regulations, RNs transitional experiences may vary across provincial and territorial jurisdictions making generalizations difficult. Performing a full comparison of these potential differences was not within the scope of this particular study.

**Chapter Summary**

The purpose of this research was to explicate the transitional experiences of RNs entering the LTC environment. Adopting IE as a lens for this study permitted the discovery of social and ruling relations that shape RN’s transition experiences. Through this process, I have uncovered how the prevailing social, historical, and ideological constructions of the LTC environment shape the transition experiences of RNs. Interestingly, findings revealed the majority of RNs entered the LTC environment with no experience or interest in gerontology coupled with a misguided preconceived notion of what their role would entail. Various distinctions between the acute and LTC settings and how these significantly impacted RNs overall transition period were also identified. Finally, RN’s experiences as they participated in the orientation program from the LTC facility and proceeded into their new role were also used to map the social and ruling relations of the overall transition period.

Ultimately, findings from this study highlight the complexity of the transition for RNs entering LTC, and interestingly, challenges identified were experienced by most
RNs regardless of educational background and clinical experience and expertise. Study implications for practice, research, policy, and education were identified. While this research focused specifically on the transition for RNs in LTC, there may be implications for other aspects of LTC functioning as well as RN transitions into other care settings.
REFERENCES


Canadian Institutes for Health Information. (2013). *When a nursing home is home: How do Canadian nursing homes measure up on quality?* Retrieved from https://secure.cihi.ca/free_products/CCRS_QualityinLongTermCare_EN.pdf


Appendix A
Letter to Facilities (Director of Nursing)

Facility Name
Facility Address
Saint John NB, Postal Code

Date

Dear Director of Nursing,

My name is Emily MacDonald. I am a Master’s of Nursing student at the University of New Brunswick and I am doing a study on the transition experience for Registered Nurses into the long-term care environment. I am interested in understanding this transition experience for Registered Nurses and I will be using Institutional Ethnography as a research method. I am interested in recruiting staff at name of facility.

The study involves recruitment of Registered Nurses who have transitioned into the long-term care environment within the last 3 years, and Directors of Nursing, and Registered Nurses who mentor those transitioning into long-term care. The primary method of data collection will be interviews with participants. I will also be requesting access to facility documents pertaining to the orientation of Registered Nurses, as well as the facility job description for Registered Nurses and documents used by Registered Nurses to perform daily activities.

I would appreciate the opportunity to meet with you in person to discuss the study. Please contact me via telephone at (506) 608-4625 or email at emily.macdonald@unb.ca if you would like arrange a meeting. Please understand that your initial phone call or email does not mean that you or your facility consents to enter the study.

You may also call my supervisor Dr. Rose McCloskey at (506) 648-5546 or the Director of Graduate Studies in Nursing at UNB, Dr. Kathy Wilson (506 458-7640) if you have any questions or concerns. If you would like to speak with someone not directly involved in the study, you many phone Dr. Lisa Best, Chair of the Research Ethics Board, University of New Brunswick Saint John at (506) 648 5908 or email reb@unbsj.ca.

Thank you for considering this request.

Sincerely,
Emily MacDonald BN RN
Master of Nursing Student UNB

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
Appendix B  
Letter of Invitation for Registered Nurses-Transition Experience

Dear potential participant,

I am a Master’s of Nursing student at the University of New Brunswick and I am doing a study on the transition experience for Registered Nurses into the long-term care environment. I am interested in understanding this transition experience for Registered Nurses and I am looking for volunteers who are willing to talk to me about their experience.

If you are currently transitioning, or have transitioned into the long-term care environment within the last 3 years, I would like to interview you about your experience and activities in your new role. The interview will take approximately one hour, but the time length will be dependent upon how much information you wish to share. I would also like to collect some information from you about your present and past employment, as well as years of experience. Anything you tell me will be held in confidence.

I may need to talk to you more than once, especially if I think of more questions to ask about your transition experience or need to clarify the information you shared. Your participation is entirely voluntary and you may withdraw from the study at any time. Your job will not be affected by whether or not you participate in this study.

If you agree, the interviews will be audio recorded so that the experience you share can be transcribed and compared with those of other RNs. You can refuse to answer any question or stop the interview at anytime and no questions will be asked. Any identifying information in the tapes, such as names or workplaces, will be removed to protect anonymity and confidentiality.

If you are interested in learning more about this study, please call me at (506) 608-4625 or email me at emily.macdonald@unb.ca to ask any questions. Please understand that your initial phone call or email does not mean that you consent to enter the study. You may also call my supervisor Dr. Rose McCloskey at (506) 648-5546 or the Director of Graduate Studies in Nursing at UNB, Dr. Kathy Wilson (506 458-7640) if you have any questions or concerns. If you would like to speak with someone not directly involved in the study, you may phone Dr. Lisa Best, Chair of the Research Ethics Board, University of New Brunswick Saint John at (506) 648 5908 or email reb@unbsj.ca.

Thank you for considering this request.
Sincerely,
Emily MacDonald BN RN
Master of Nursing Student UNB

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
Appendix C
Letter of Invitation for Second-level Informants: Directors Of Nursing (DON) and Registered Nurse Mentors

Dear potential participant,

I am a Master’s of Nursing student at the University of New Brunswick and I am doing a study on the transition experience for Registered Nurses into the long-term care environment. I am interested in understanding this transition experience for Registered Nurses.

I would like to interview you based on your experiences in working with Registered Nurses while they transition into the long-term care environment. The interview will take approximately one hour, but the time length will be dependent upon how much information you wish to share. I would also like to collect some information from you about your present and past employment, as well as years of experience. Anything you tell me will be held in confidence.

I may need to talk to you more than once, especially if I think of more questions to ask about experience or need to clarify the information you shared. Your participation is entirely voluntary and you may withdraw from the study at any time. Your job will not be affected by whether or not you participate in this study.

If you agree, the interviews will be audio recorded so that the experience you share can be transcribed and compared with those of other participants. You can refuse to answer any question or stop the interview at anytime and no questions will be asked. Any identifying information in the tapes, such as names or workplaces, will be removed to protect anonymity and confidentiality.

If you are interested in learning more about this study, please call me at (506) 608-4625 or email me at emily.macdonald@unb.ca to ask any questions. Please understand that your initial phone call or email does not mean that you consent to enter the study. You may also call my supervisor Dr. Rose McCloskey at (506) 648-5546 or the Director of Graduate Studies in Nursing at UNB, Dr. Kathy Wilson (506 458-7640) if you have any questions or concerns. If you would like to speak with someone not directly involved in the study, you may phone Dr. Lisa Best, Chair of the Research Ethics Board, University of New Brunswick Saint John at (506) 648 5908 or email reb@unbsj.ca.

Thank you for considering this request.

Sincerely,
Emily MacDonald BN RN
Master of Nursing Student UNB

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
Appendix D: Recruitment Poster

Would you like to influence the future role of Registered Nurses in long-term care?

A graduate student from the University of New Brunswick is conducting a research study on the transition experience for RNs into long-term care.

If you are a RN who has transitioned into long-term care within the last 3 years and would like to learn more about this study or would like to participate, please contact Emily MacDonal.

Email: emily.macdonald@unb.ca
Telephone: 506-608-4625

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB#XXXX
Appendix E
Informed Consent for Registered Nurses

Investigator: Emily MacDonald, RN, BN; Master of Nursing Student, University of New Brunswick, Fredericton, NB

The purpose of this study is to increase the understanding of the transition period for Registered Nurses into the long-term care environment. I have agreed to participate in this research, and I understand that my participation is entirely voluntary. Although there are no known risks to taking part in this study and I will not benefit directly, the information I provide will help to further understand the transition experience and activities of Registered Nurses in long-term care.

I understand that during the interview I will be asked questions about my transition experience into the long-term care environment as well as my work activities. I understand that the interview will be audio recorded and I may refuse to answer any questions or stop the interview at any time without being asked any questions. I understand that I may withdraw my consent to participate at any time. I also understand that the researcher may contact me at a later time to obtain more information or to clarify something that I said.

I understand that my participation in this study is completely confidential and anonymous. The researcher, Emily MacDonald, will collect all study data and any identifying data, such as the consent form and demographic sheets, will be kept separate from the tape and transcription. All study documents will be kept in the locked office.

Emily MacDonald will write a report about what she has learned about Registered Nurses’ transition experiences into long-term care. Anything I tell the researcher will be kept in confidence and my name and any identifiable information will not be included in any reports. I understand that it is not my individual responses but the collective responses of all study participants that will be contained in the final report. The resulting report will be available to me if I request it and I am aware that the compiled results of the findings may be published. I understand that all study data will be kept for 7 years and may be subject to secondary analysis within this time period.

I have read this consent form and voluntarily consent to an interview with Emily MacDonald. The study has been explained to me, I have had the opportunity to ask questions, and I feel comfortable with the information that has been provided. I have been this consent form and voluntarily consent to an interview with Emily MacDonald. The study has been explained to me, I have had the opportunity to ask questions, and I feel comfortable with the information that has been provided. I have been

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
provided with a copy of this signed consent form and I understand that I may call Emily MacDonald (506 608 4625) at any time if I have any questions or concerns. I understand that I may also call the researcher’s supervisor, Dr. Rose McCloskey at (506) 648-5546 or the Director of Graduate Studies in Nursing at UNB, Dr. Kathy Wilson (506 458-7640) if I have any questions or concerns. If I would like to speak with someone not directly involved in the study, I understand that I may phone Dr. Lisa Best, Chair of the Research Ethics Board, University of New Brunswick Saint John at (506) 648 5908 or email reb@unbsj.ca.

I ____________________________ agree to participate in the research study described above.

Printed name of participant

Signature of participant ___________________________________

Date:________________

Signature of researcher ___________________________________

Date:______________

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
Appendix F
Informed Consent Second-Level Informants (DON and RN mentors)

Investigator: Emily MacDonald, RN, BN; Master of Nursing Student, University of New Brunswick, Fredericton, NB

The purpose of this study is to increase the understanding of the transition period for Registered Nurses into the long-term care environment. I have agreed to participate in this research, and I understand that my participation is entirely voluntary. Although there are no known risks to taking part in this study and I will not benefit directly, the information I provide will help to further understand the transition experience and activities of Registered Nurses in long-term care.

I understand that during the interview I will be asked questions about my experiences of working with registered nurses as they transition into long-term care environment, as well as other qualities and work activities of registered nurses in long-term care. I understand that the interview will be audio recorded and I may refuse to answer any questions, stop the interview, or withdraw my consent at any time without being asked any questions. I also understand that the researcher may contact me at a later time to obtain more information or to clarify something that I said.

I understand that my participation in this study is completely confidential and anonymous. The researcher, Emily MacDonald, will collect all study data and any identifying data, such as the consent form and demographic sheets, will be kept separate from the tape and transcription. All study documents will be kept in the locked office.

Emily MacDonald will write a report about what she has learned about Registered Nurses’ transition experiences into long-term care. Anything I tell the researcher will be kept in confidence and my name and any identifiable information will not be included in any reports. I understand that it is not my individual responses but the collective responses of all study participants that will be contained in the final report. The resulting report will be available to me if I request it and I am aware that the compiled results of the findings may be published. I understand that all study data will be kept for 7 years and may be subject to secondary analysis within this time period.

I have read this consent form and voluntarily consent to an interview with Emily MacDonald. The study has been explained to me, I have had the opportunity to ask questions, and I feel comfortable with the information that has been provided. I have been provided with a copy of this signed consent form and I understand that I may call Emily MacDonald (506 608 4625) at any time if I have any questions or concerns.

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
I understand that I may also call the researcher’s supervisor, Dr. Rose McCloskey at (506) 648-5546 or the Director of Graduate Studies in Nursing at UNB, Dr. Kathy Wilson (506 458-7640) if I have any questions or concerns. If I would like to speak with someone not directly involved in the study, I understand that I may phone Dr. Lisa Best, Chair of the Research Ethics Board, University of New Brunswick Saint John at (506) 648 5908 or email reb@unbsj.ca

I ____________________________ agree to participate in the research study described above.
   Printed name of participant

Signature of participant ________________________________
Date: _______________

Signature of researcher ________________________________
Date: ______________

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
Appendix G
Demographic Profile for Registered Nurses

UNB

AGE:  □ 20-29  □ 30-39  □ 40-49  □ 50-59  □ 60+

SEX:
□ Male
□ Female

EDUCATION: (select all that apply)
□ RN- Diploma in Nursing
□ BNRN- Bachelor’s of Nursing / Bachelor of Science in Nursing
□ MN- Master’s of Nursing
□ Additional nursing education
□ Additional non-nursing education

If you have selected additional nursing or non-nursing education please describe the education:
________________________________________________________________________
________________________________________________________________________

Year of Graduation from Nursing Program: ____________

EMPLOYMENT:
Status:  □ Full-time  □ Part-time  □ Casual

Approximate Year/Month of Hire at this LTC facility:
Year __________
Month __________

Other nursing jobs or positions currently held:  □ Yes  □ No

Previous Gerontological Nursing experience:  □ Yes  □ No

Clinical Experience (other areas of nursing practice/ # of years):
________________________________________________________________________

This study has been reviewed by the Research Ethics Board at the University of New Brunswick and is on file as REB #XXXX
1. Perhaps we can start by telling me a little bit about you? Tell me about your job and your decision to work in long-term care.

2. Tell me about your experience transitioning into or beginning your work as a Registered Nurse in long-term care?
   a. Overall, how would you describe this experience?
   b. What were the most positive aspects of the transition experience?
   c. What were the most difficult aspects of the transition?

3. How would you describe your role as a Registered Nurse in long-term care?

4. Tell me about the daily activities involved in your work as a Registered Nurse in long-term care.

5. What influences or guides you as you perform your daily activities?

6. Is there anything that I have left out or anything you would like to add?
Appendix I
Semi-Structured Interview Guide: Director of Nursing

1. Can you tell me about the hiring process for RNs in this facility?
   a. What do you look for in RNs? Why?
   b. What do you do if you can’t find what you are looking for?

2. What is your role in orientation?
   a. Can you describe a typical orientation for an RN?
   b. Are there any factors that influence how you tailor orientation for specific RNs?
   c. Orientation manuals: what is in these, who develops them and from what?

3. How you communicate with RNs during and after their orientation?

4. Do you see the role of the RN changing?
   a. Does this change the type of RN you are looking for?
   b. Does this change the orientation period?

5. There has been mention of an RN binder. Can you talk about what is included in this?
   a. Who decides what is included?
   b. Can anyone contribute to this binder?
   c. Are they the same for each unit?
   d. Are these updated? How often?
Appendix J
Semi-Structured Interview Guide: Unit Managers

1. How would you describe your role as a Unit Manager in LTC?
   a. How does this compare to the role of other RNs who work on the unit? Does the job description differ?
   b. What are your expectations of RNs who work on your unit?
   c. How do you communicate with RNs who work on your unit?
      o Can you provide an example of (verbal, written, email)

2. Can you tell me about your experiences in working with RNs who are new to the facility?
   a. What is your role in the orientation period for RNs?
   b. Are you the primary mentor for new RNs on your unit?
      o Can you provide an example of when you provided mentorship to a new RN?
   c. Can you tell me more about your role as mentor for new RNs in your facility?
      o What kind of mentorship do you find new RNs need?

3. In your experience, what are some of the positive aspects of the transition period for RNs who are new to the facility?

4. In your experience, what challenges have you seen in terms of the transition period for RNs who are new to the facility?

5. Is there anything that I have left out that you would like to share about your experiences working with RNs who are new to the LTC environment?
Job Title: Registered Nurse  
Department: Nursing  
Position: Permanent Part Time, Full Time and Casual  
Classification: RN-B  
Responsible to: Director of Nursing (DON)  
Salary: In accordance with the NBNU collective agreement.

Purpose of the Job:

Assumes the primary responsibility and accountability for the delivery and management of quality nursing care to all our residents in accordance with the written philosophy and mission statement of facility.

Practices nursing within the scopes of nursing practice as defined in the Nurse’s Act of New Brunswick.

Works cooperatively and collaborates with nursing personnel and other members in maintaining standards for professional nursing practice.

Assists the DON in the promotion, interpretation and application of that mission through all members of the nursing staff and throughout all departments.

Functions as a key member of the interdisciplinary team in a leadership role providing direction and supervision.

Qualifications:

• Graduation from approved Bachelor of Nursing Program and current active registration with N.A.N.B. or graduate of an approved School of Nursing with geriatric experience.

• Experience in geriatric nursing is desirable but not essential.

• Must demonstrate effective leadership skills, eg: interpersonal skills, supervisory skills, problem solving skills, administrative skills.

• Must demonstrate a commitment to the philosophy of facility and a desire to use and develop leadership and teaching skills.

• Must demonstrate a flexible and adoptive attitude conductive to the development of staff and residents as a team, and to dealing with families and the public.
• Must demonstrate an interest in continuing his/her education in the field of geriatrics in particular and nursing in general, and be prepared to become involved in community and professional groups as much as possible to further increase awareness of the needs of the elderly.

• Good physical work record and physically able to perform assigned duties.

• Current training in CPR and vein puncture.

• Ability to get along with fellow workers.

• Able to read, write and follow written and verbal instructions with minimal supervision.

• Good previous work record.

• Neat and clean in appearance.

• Ability to function as a team member.

• Proper regard to confidential information.

• Ability to relate to the elderly.

• Have a good attendance record.
EMILY E. MACDONALD

EDUCATION

Master of Nursing (thesis stream) In Progress
University of New Brunswick (UNB), Fredericton
Date of Convocation: October 20th, 2017

Nurse Educator Certificate (CCNE) 2017
Canadian Association of Schools of Nursing (CASN)

Clinical Instructor Certificate 2016
Canadian Association of Schools of Nursing (CASN)

Diploma in University Teaching (DUT) 2015
University of New Brunswick, Fredericton

Perioperative Registered Nurse Certification 2014
Horizon Health Network, Saint John Regional Hospital

Bachelor of Nursing 2012
University of New Brunswick, Saint John
Deans list: First Division

AWARDS & RESEARCH FUNDING

Interdisciplinary Fellowship Program 2016 04/16 – 04/17
Canadian Frailty Network
Host Institution: UNB, Supervisor: Dr. Rose McCloskey

Master's Studentship Award 09/15 – 08/16
New Brunswick Health Research Foundation (NBHRF)
UNB, Fredericton, Master of Nursing

Student Bursary 09/15 – 04/16
Alzheimer's Society of New Brunswick/ Dr. Jed B. Sutherland
UNB, Fredericton, Master of Nursing

Graduate Research Assistantship (GRA) 09/14 – 04/16
UNB, Fredericton, Master of Nursing
Colter Family Bursary 09/11 – 04/12
UNB, Saint John, Bachelor of Nursing

Dr. William MacIntosh, Chapter I.O.D.E Scholarship 09/10 – 04/11
UNB, Saint John, Bachelor of Nursing

Alumnae Undergraduate Scholarship 09/10 – 04/11
UNB, Saint John, Bachelor of Nursing

J. Fraser Gregory Scholarship 09/10 – 04/11
UNB, Saint John, Bachelor of Nursing

Scotiabank International Study Award 09/10 – 12/10
UNB, Saint John, Bachelor of Nursing

George L. White Memorial Scholarship 09/09 – 04/10
UNB, Saint John, Bachelor of Nursing

Horst Sauerteig Bursary 09/09 – 04/10
UNB, Saint John, Bachelor of Nursing

Colonel Henry Thomas Scholarship 09/09 – 04/10
UNB, Saint John, Bachelor of Nursing

Ward Chipman Founder's Scholarship 09/08 – 04/09
UNB, Saint John, Bachelor of Nursing

UNB Saint John Campus Scholarship 09/08 – 04/09
UNB, Saint John, Bachelor of Nursing

RESEARCH

Publications
Eamer, G., Gibson, J. A., Gillis, C., Hsu, A. T., Krawczyk, M., MacDonald, E.,

Eamer, G., Gibson, J. A., Gillis, C., Hsu, A. T., Krawczyk, M., MacDonald, E.,
Conference Presentations

Research Day, UNB, Fredericton, NB May 2017
Poster Presentation: The Social Organization of Registered Nurse’s Transition into the Long-Term Care Environment

Research Day, UNB, Fredericton, NB May 2017
Poster Presentation: Identifying the Needs of Family Caregivers in NB

Canadian Frailty Network National Conference, Toronto, ON April 2017
Poster Presentation: Surgical Frailty Assessment: A Missed Opportunity

Canadian Frailty Network Annual Conference, Toronto, ON April 2017
Poster Presentation: Maximizing the Impact of Community Outreach Programs through Integration of Research and Interprofessional Approaches to Care

Graduate Research Conference, UNB, Fredericton, NB March 2017
Poster Presentation: An Institutional Ethnographic Exploration of the Transition Experience of Registered Nurses Entering the Long-Term Care Environment

TEACHING EXPERIENCE

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<td>Fall, 2016</td>
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<tr>
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<td>Clinical</td>
<td>Winter, 2016</td>
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<tr>
<td>NURS 2041 Health Assessment (Teaching Assistant)</td>
<td>Lab</td>
<td>Fall, 2015</td>
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CREDENTIALS & PROFESSIONAL DEVELOPMENT

CPR Level C/ AED with Health Care Provider 2017
Heart & Stroke Foundation

BACK IN FORM (BIF) Training Certificate: Employee Level 2016
Work Safe New Brunswick

International Standards Training E Program Certificate (InSTEP) 2014
American Spinal Injury Association (ASIA)
Good Clinical Practice Certificate (GCP) 2014
National Institute on Drug Abuse, Clinical Trials Network

Government of Canada: Panel on Research Ethics

PROFESSIONAL MEMBERSHIPS & VOLUNTEER SERVICES

Canadian Association of Schools of Nursing 2015 – Present
Member, Atlantic Region

Canadian Gerontological Nursing Association (CGNA) 2015 – Present
Member, New Brunswick Chapter

Nurses Association of New Brunswick 2012– Present
Member

AIDS Saint John, NB 2012 – 2013
Volunteer

Volunteer