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What newly licensed registered nurses have to say about their first experiences

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To understand factors that promote retention of Newly Licensed Registered Nurses (NLRNs) and those that contribute to turnover, a survey of a national sample of NLRNs was conducted. This article describes the content analysis of 612 NLRN comments about their work life. Using Krippendorff's[1] technique, 5 themes were discovered. *Colliding expectations* describes conflicts between nurses' personal view of nursing and their lived experience. *The need for speed* describes the pressure related to a variety of temporal issues. *You want too much* expresses the pressure and stress NLRNs feel personally and professionally. *How dare you* describes unacceptable communication patterns between providers. *Change is on the horizon* suggests optimism for the future as NLRNs speak of transforming the systems where care is provided. This content analysis reveals that the working environment where NLRNs begin their career is in need of reform. Suggestions are offered from the nurses themselves.

In 2005, almost 85 000 new nurses graduated[2] but limited research reveals that these new registered nurses (RNs) leave hospital positions within 1 year of starting work,[3,4] which is sooner than more experienced RNs. Reported turnover rates of Newly Licensed Registered Nurses (NLRNs) vary from 13%–70%.[5,3] Determining how to predict and prevent turnover in RNs is an important goal for both health managers and policymakers. While nursing school enrollments and graduations have increased[6] and employers have tried many ways to retain RNs,[7-9] reducing the nursing shortage by retaining new nurses will depend on finding a suitable match between nurses' personal needs, career goals, and their first employers.

Researchers have developed a considerable body of literature on organizational and RN turnover. There are several literature reviews[10-14] and meta analyses[15,16] of RN turnover. Factors such as job stress, social and supervisor support, opportunity, fairness or justice, collegial RN-physician relations, autonomy, variety, and work-family conflict (or it's reverse, family-work conflict), and work motivation have been shown to be important predictors of satisfaction and organizational commitment which, in turn, predict intent to stay and, ultimately, actual turnover.[17]

Less work has been done using qualitative methods. Duchscher's[18] phenomenological study of 5 Canadian RNs' first 6 months of work described the frustration experienced by new graduates across a variety of issues including physician relationships, inability to provide effective care, and insufficient support mechanisms. Others report feelings of personal inadequacy and an unsupported environment that demands an unrealistic workload[19] and a difficult transition to "real nurse work."[20] The former study was conducted on NLRNs in South Australia, while the latter was with American nurses. In an effort to obtain a clearer understanding of the experience and attitudes of NLRNs in the United States, this study was conducted.

The purpose of this article was to explore the perceptions of 612 NLRNs' nascent experiences as reflected in their comments provided in a national survey that sought to gain a better understanding of the work life of NLRNs. Insight into their comments can help illuminate how managers and policymakers could prioritize efforts to retain NLRNs.

METHOD

Design

The findings reported here are a secondary analysis of a nationwide data set in which NLRNs were surveyed about their work environment. The parent study is described in detail elsewhere.[5] Data were collected by a cross-sectional mailed survey of NLRNs from 34 states and the District of Columbia. The sample selection methodology was designed to result in a nationally representative sample. The sampling strategy employed

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stratified sampling by region and states within each region. City size variation was also represented by creating a separate stratum for Metropolitan Statistical Area (MSA) size (small, medium, and large). Fifty-one MSAs were randomly selected, as were 9 rural areas and then, within those areas, NLRNs were randomly selected. This method assured representation of the full range of health care delivery systems, community cultures, and market differences. "Newly Licensed Registered Nurses" was defined as RNs who passed the National Council Licensing Exam (NCLEX) for the first time between 6–18 months prior to completing the survey. The human subject's committees at New York University (NYU) and the University of Buffalo approved the study. This article reports the findings in response to the open-ended question, "If you would like to make any other comments about the survey, please feel free to write below or on the back of this booklet."

Sample

The sample in the parent study included 3266 nurses for a response rate of 56%.[5] An option to provide comments was offered at the end of the survey. A total of 1195 participants (37%) responded to the request for comments. Comments unrelated to the research resulted in removal of 583 participant comments, resulting in an analytic sample of 612. Examples of comments that were removed included: "Thank you for the survey," "new address" information, or specific reference to editing of an item.

The NLRNs who provided comments had a mean age of 33.4 years. They were primarily white (81.7%), women (92.6%) whose entry into practice was an associate degree level (56.2%), baccalaureate (36.9%), diploma (5.2%), and master's or doctoral degree (0.5%). Most respondents worked full-time (84.3%) in non-magnet (75.3%) inpatient hospital settings (80.2%). The NLRNs who responded were similar to the NLRNs who responded to the parent study.

Measures

In the parent study, a 16-page survey that consisted of 207 items included 8 demographic questions, valid and reliable scales to assess RNs' attitudes about work, questions about the RNs' intention about future work, work attributes, job opportunities and an option to provide additional comments. The survey is described in detail elsewhere.[5]

Data Analysis

In this secondary analysis, the qualitative findings of the remaining comments will be presented. Content analysis was performed using Krippendorff's[1] technique with his unit of analysis of themes. The RNs' written comments were typed into an excel spread sheet and reread for accuracy. Analysis began by the first author reading the nearly 25 000 words of written comments so a sense of the whole could be determined. The text was then coded, noting phrases or sentences that related to novice nurses' work experience. Passages were selected, enumerated, and categorized. Comparisons were made and attention paid to unique comments as well as recurrent passages. Phrases and sentences were clustered to identify data that shared some characteristics. An audit trail that recorded personal reflections and methodological decisions was created and reviewed by the other authors. Dendrograms or tree-like diagrams (Table 1) were created to illustrate how data were collapsed into clusters.[1]

Findings

This content analysis revealed 5 themes. All statements contained within the themes are from female RNs unless otherwise stated.

Theme 1: Colliding Expectations. Participants' comments noted conflict between their personal view of the profession and the lived experience as a novice RN. The inconsistencies were seen in their personal image of nursing, beliefs about professional behavior, and colleagueship. A disconnect between what participants were taught in nursing school and had subsequently internalized about the power and prestige of the nursing profession versus personal experience in practice was observed. One nursing graduate from Maine vividly related the incongruity between personal professional expectations and actual clinical practice:

> Nursing is a profession but we are not treated like professionals. We are used, manipulated, and disrespected—nameless. We are treated like "school girls" who just need a job when the truth is we hold peoples very lives in our hands on a daily basis! The in-depth education I have acquired (with a 3.96 GPA) does not make any difference because I am not given any autonomy to use it. Administration dictates number of patients, organizes my routine and yet does not provide equipment needed.

Novice RNs reported a lack of voice in the structure and function of the healthcare institutions where they were employed. One nurse explained, "It is very frustrating when your employer does not include nursing thoughts or ideas when purchasing new equipment related to your field." Comments about novice nurses' inability to be heard by the "medical bureaucracy" ranged from subjects such as the availability of supplies to the acquisition of new technology. Not surprisingly, given the universal experience of caring for a higher acuity patient population, high patient-to-nurse ratios were a particularly dominant source of stress for the nurses and an area where nurses felt they exerted little influence. A male RN from the south wrote:

Table 1. Exemplar of Partial Dendrogram for Theme: The Need for Speed

There is not enough time to get everything done.	
	Lack of time impacts quality of care
There is not enough time to get to know the patients.	
	Lack of time impacts their sense of worth
Many times I could do better if I had more time.	
Many times out of the 6 pts there may be 2 or 3 pts with a high activity level that requires a lot of my time, leaving little time for my other patients.	
	Urgency in clinical
There is a requirement to move patients out and up.	
Management have never offered to decrease patient load or even acknowledge a different time frame for any new nurse to operate under.	
	No differentiation for novice versus expert
My workload is the same as a veteran of 20 years.	
Educators in orientation state that new nurses need time to develop speed.	
	Contradictions in time needed to improve skills
While I can completely handle my duties by skill—the speed of doing so will take time.	
The length of orientation was way too short (less than one month) and poor quality.	
They push you through all of the things you'd expect from a seasoned nurse Advanced Cardiac Life Support (ACLS)—then basic telemetry and soon Pediatric Advanced Life Support (PALS).	
	Pressured to perform in time and task
They have the nerve to reprimand me for leaving late.	

> The #1 complaint I hear from other nurses is the patient workload. It doesn't allow a nurse to take care of patients the way it should be. There will always be a nursing shortage because of this reason. This is why so many nurses quit nursing.

While some nurses actively sought the assistance of superiors when conflicts were felt between their personal caring philosophy and clinical reality, other nurses' comments reflected a sense of helplessness. The ranges of remarks are presented in the following 2 quotes from nurses in Ohio and Illinois:

> Before going to work every day, I vomited daily. I went to higher managers and no one would help me, so I had to quit.

> I strongly feel not enough people are concerned about RN's and our work load. This is a very stressful field that I feel over worked and under paid and that I jeopardize myself and my patients on a daily basis. Help please!

Additionally, the goal of caring for and impacting the lives of patients and their families was inconsistently experienced in this first year. Some RNs noted verbal abuse from patient and families as well as colleagues. Respondents wrote of disillusionment about the nursing profession because of the incongruity noted between the belief that nursing would make a positive impact on the individual, family, community and professional contemporaries and their work experiences. The novice nurses expected their role to be "appreciated and respected with adequate resources and support." Three different nurses from (in order) West Virginia, Nevada, and Florida described the internal clash between role expectations and reality that led to feelings of frustration, dissatisfaction and uncertainty with the RN role:

> I love working in the hospital setting but in less than a year I realize the frustrations that go along with the job. Nurses are overworked, underpaid, and underappreciated (especially by doctors and upper management). Some days I love my job, and some days I don't.

> Every day that I work I am disappointed by one thing or another. I now hate what I do.

> Sometimes, I don't know how I feel about my career. Hopefully I will come to enjoy it more.

Many novice RNs' comments revealed a sense of holding out hope for success and satisfaction within the nursing profession. "I don't get the 'warm fuzzy' feeling from nursing like I thought I would. Hopefully a change of setting will do the trick." A male RN from the south with both an associate degree and baccalaureate degree commented: "Trying to find a 'happy place'

in nursing—where not overworked and underpaid—where appreciated and respected with adequate resources and support—a dream—huh?" Over 80 respondents' comments noted a love of the nursing profession. One nurse from Georgia wrote "I am just fortunate to have found 'my home' and I have had to make adjustments in my schedule to make my gross income . . . So yeah, things could/should be easier for the pace and amount of work I do, but overall, I love being a nurse."

Another source of conflict between role expectations versus clinical encounters was attributed to the academic institutions that prepared the students for practice. Nursing schools were frequently seen "as inadequate in training of clinical skills." As noted by an accelerated bachelor degree RN from Connecticut, "I began my first job as an RN without ever having placed a foley or even doing a complete assessment on a real patient as opposed to my healthy 25 year old lab partner." Comments of clinical deficiencies added to the stress of the new RN. A nursing student from New Jersey stated "Lab is a waste; students should be checked off for skills in the clinical setting, on real people. Longer clinical days with more in-depth clinical, elimination of time spent in pre and post conferences, more "hands on" in clinical would have better prepared me for my nursing career."

Orientation programs for new RNs and internship programs were seen as essential for providing nurses with needed clinical skills, judgment, confidence and support. In addition, classes on delegation, conflict resolution, and anticipatory guidance of the work environment were seen as crucial curricular content to be included in educational programs. "I wish someone would have prepared me for the natural 'let down' that happens after graduating from school. It's a difficult transition."

Theme 2: The Need for Speed. New nurses frequently complained about the need for them to function quickly as a skilled, seasoned RN. Comments about being "forced off orientation early" and "pushed" into the role of primary care provider before feeling ready added to their stress level. For some, there was no transitioning into the RN role; many novice nurses commented that they began with full patient loads from day one. The additional pressure to assume charge nurse responsibilities compounded these nurses' fears. A Pennsylvanian RN from a bachelor's program shared:

> The most significant drawback to my success as a new nurse in the ED is the requirement for speed. To see patients due to medical urgency but also speed to move patients out and up as well. While I can completely handle my duties by skill—the speed of doing will take time. While the educators in orientation states their awareness of new nurses needing time to develop speed-management (charge nurses) have never offered to decrease patient load or even acknowledge a different time frame for any new nurses to operate under. My workload is the same as a veteran 20 year on the job nurse and the speed of working is the same requirement as well—suspiciously given under the guise that the nurse needs the experience. Orientation began with full patient load-full speed and has lead to full burnout as well.

Along with this theme of acceleration of orientation, skill, and practice was the notion that administration was also rushing the RNs to "get in and get out." One nurse described the dilemma of punching in and out during the required time period so that "no fractional overtime pay" was accrued, despite actual work hours. The pressured pace impacts the nurses' ability to "get to know the patients." There was simply no time. An RN from Utah explained, "I often feel dissatisfied because I am not able to do my best at work due to lack of time to spend with patients. Other nurses on my floor are too busy with their own patients to be able to assist me a great deal, but they are also doing the best they can."

Theme 3: You Want Too Much. External forces from employers, insurance companies or other stakeholders combine to demand much from the NLRN. These respondents reported too much work, responsibility, and pressure with too little rewards. A RN from Colorado wrote:

> The job is stressful. I'm on my feet for 36 hours in a week. It is hard work. I don't always like it. I don't like the huge responsibility. I sometimes want another job. Anything with less physical and mental strain. I have 2 degrees—a BSN and a BA. I do an exceptional job at work.

Workload issues included complaints of high patient-to-nurse ratios couched within a call for help by creating national maximum staffing ratios. Complaints of inability to take breaks, have lunch or even to sit down during work hours were noted. A nurse from New Jersey offered additional areas for researchers to consider if concerned about the nursing shortage, as well as a warning:

> Basic working conditions and staffing, how much break time does an RN have for meals? Is it uninterrupted? Is coverage available so that the RN can take this time to de-stress? Can the RN go to the bathroom? . . . . I am fortunate enough to come to nursing as a second career after a successful career in business. It is a choice and a gift to have this opportunity and I would not trade it but if nursing is to ever attract some of the best and the brightest and certainly retain RN's and/or diversify to include males, nursing needs to really consider how it treats its employees. There is no way people in business would stand for it and I

> am aware that I work for a very good organization. In some ways hospitals have adopted the business model to survive, but because the model is too lean, ultimately we will lose.

Documentation was also noted as a workload issue that prevented nurses from spending time with their patients. "The amount of charting (double/triple) paperwork I have on the job leaves very little time for patient care." Many participants complained of too much paperwork while others complained of too much time on the computer. The nurses' comments suggest that the problem of documentation itself has not been addressed; rather, the vehicle has simply changed in some institutions from the pen to the keyboard. Others put the blame of increased workload on nurses on the backs of federal and state regulators. An RN from California shares:

> JHACO heavily regulates nursing and continuously adds more and more responsibilities for nurses. The more regulations they create the more difficult and stressful our "nursing" tasks become. It's getting ridiculous- all the paperwork we have to do and all the strings/ politics we have to deal with just to care for patients. Are the patients even the primary focus in health care? They should be. The people at JHACO should be required to work as floor nurses when and before making new regulations.

Issues such as mandatory overtime also added to the new nurses stress level. The invasive nature of the RN job into one's personal life added to their disenchantment with the profession. "I think everyone should learn the value of hard work, it builds character, but their life shouldn't be centered around their work." Many comments related to how problematic the work schedule of nurses was on their personal life. Many enjoyed their work but the schedule demands of weekend and holidays, mandatory overtime and sacrifice on family and/or leisure time added to their discontent. Some nurses asked for the return of the 8-hour shift for patient safety, complaining that three 12-hour shifts are "dangerous." The call for having a balanced life was noted as an equally pervasive theme regardless of the nurses' sex. The following quote by an RN from California illustrates the pervasive problem with scheduling work hours:

> In nursing school, I was told that nurses could "set their own hours." I have not found this to be true. All of the hospitals want full-time, 12-hour shifts with rotating weekends. Nursing homes are looking for full-time second or third shifts or 12 hour weekend shifts. These shifts are difficult when you also have primary care of children. In addition, some nurses are working mandatory overtime or on-call. Some nurses have to stay past their shifts or come in on their days off to complete paperwork. If I had known this, I may have still gone into the nursing field. Nursing is an honorable profession. There are a lot of opportunities for people who have flexible schedules and the money is very good for a two year program. But nursing is not a family friendly profession and that is unfortunate. Because many of the people going into the profession are young, single, women who may someday get married and have children. I have always said, it is not the work that is hard, it is the juggle that is so difficult.

However, many part-time nurses wrote comments that nursing allows them flexibility in their personal life. As an RN from Alabama who changed careers noted, "I have remained in nursing due to the flexibility and availability of a part-time work not available in banking." Finally, novice nurses voiced frustration over the lack of financial remuneration for their services. Two nurses' comments capture these feelings of frustration when juxtaposing nurses' salaries against administration's salaries or private industry. The first nurse works in Maine and the second comment is from an RN in Pennsylvania:

> Being an RN personally is very rewarding but also extremely demanding and stressful. RN's are extremely underpaid considering the responsibilities and the patient load. Where are the fringe benefits? I don't even receive "time and a half" for most holidays! Also, I would like to attend a few seminars to further my nursing education and don't receive complete financial support for this. UPS offers more salary and benefits ("fringe" included) and doesn't even require a college degree; the responsibilities aren't as critical! There is something wrong with this picture.

> I work for a "non-profit" hospital that profited more than 200 million dollars last year. Somehow this company rarely has enough supplies available and is nearly always short staffed. The standard raise is two percent a year which for me was about 34 cents. As a college student I got a 50 cent raise as a Wal-Mart cashier. The CEO makes close to two million with countless benefits. The managers pull in large bonuses for cutting the budget. I do however love the people I work with and feel like I have learned and experienced so much as an RN thus far.

Theme 4: How Dare You? A dominant theme was the mistreatment new nurses perceived by their colleagues. Physician criticism, arrogance, and rudeness were seen as adding to the stress level and dissatisfaction of new nurses. An RN from North Carolina shared her experiences:

> I currently work in a world renowned medical institute. All verbal abuse I've experienced in the past year at this job has been directed at me by physicians—the great majority at the attending level. My nursing program certainly left me unprepared for the lack of professionalism amongst more than several M.D.'s. I have given notice and will leave this hospital because of this issue. I am otherwise satisfied with my position and were there a chance to address physician verbal abuse to nurses, nurses would stay employed at this hospital.

Seasoned RNs were also seen as abusive of novice nurses and elicited comments such as "nurses eat their young" and complaints that criticism was often harsh, cruel and viewed as traumatic. The following passages by 2 nurses, one from Ohio and the second from Pennsylvania, expressed their experiences:

> Many of the experienced (ten years of RN work) look down on new grads and give the worst assignments to the new grads. As an assertive person I have been able to survive, but when they won't help in training I was at a loss. Example, One of my preceptors said, "don't speak unless you are spoken to." This was the second preceptor at a new job. After having many problems with the first one I went to my supervisor and asked for someone new—and that is what I got—needless to say it led me to quitting that job.

> One major drawback to every nursing unit I have been a part of is that there are nurses who can be in all candor labeled 'mean' as opposed to 'friendly' and 'backstabbing' as opposed to 'supportive'. Unfortunately at the end of a shift, it is this group (mean, unsupportive) who has the ability to alter one's perception of job satisfaction—because we can in essence work from internal rewards and without others support, but it is difficult always to work in a culture of negativity and mean spirit.

The final area of ill treatment was on the part of management. Novice nurses were offended by management that turned a blind eye to the mistreatment by physicians or other nurses. Some nurses commented that they felt nursing leadership was tolerant of negativity because of fear of these nurses also leaving which would further worsen the nursing shortage. "Nurses' bad conduct between themselves is often overlooked by management for fear these nurses if reprimanded will leave—the cycle continues."

Novice RNs expressed frustration over what was perceived as hospital micromanagement with clocking in and out regardless of what is happening on the unit as a means of limiting overtime pay. This "administration dictum of no fractional pay is degrading too." An example of poor working conditions was captured by the comments of this RN in New Jersey:

> My job is extremely stressful. They constantly bombard RN's with too much work, especially inadequate help, sometimes no help, including no nurse's assistants, unit secretaries and the patient load is overwhelming. Most nights, I am the only nurse on the unit, with a nursing assistant taking care of very sick cancer patients, and then they have the nerve to reprimand me for leaving late. RN's at my facility are being scrutinized under a microscope for overtime as they say it is not warranted. I love my job, but I am disgusted with the conditions I work under.

The nurses' comments suggest that they are not or would not stay in these institutions. Nurses were, in fact, leaving for other tertiary facilities, while others were leaving the acute care arena for practice in a community setting. For many, the notion that a new graduate must do "the year" in acute care setting was evident. However, after the year, the concern will be: do we lose the RN's out of the acute care arena permanently? "It is my goal to complete a year of employment despite the environment then I will seek a new position elsewhere." One reason offered for staying was because of "perks" such as loan repayment plan obligations.

Theme 5: Change is on the Horizon. Despite the enormous challenges novice nurses experience in the work place, a majority of the comments revealed hope for the future. Many note that it takes 1 year to transition from the student to the RN role, and this time is marked with emotional and visceral reactivity in the forms of tears, worries, and nightmares. An RN from New York describes the transition:

> Just a note about my experience in the first six months of my nursing career. I wanted to quit many times, went home crying everyday and struggled with the lack of compassion from the other more experienced nurses. This created a very difficult transition . . . After the first six months these struggles subsided. I love my job and it is very rewarding but those first six months came very close on many occasions as making or breaking me.

There was a resiliency noted in the NLRNs' responses that suggests future action on the part of the nurses. Nurses comment that they will "work to improve [work environment] rather than look for work elsewhere," ensure the "voices of new nurses are heard," and "love to be part of the change in nursing." An RN from Massachusetts writes: "Clearly much of the nursing profession is 'broken' and much thought and action is required to not only return [sic retain] good nurses but also contribute to an improvement in the overall healthcare system. I . . . desire to eventually

move into a position where I can help to "fix" the problem." While a nurse from Florida comments: "I believe we as nurses need to have a united voice in the work place to ensure quality patient care and safe working environment."

The new nurses frequently commented on their "love" of the profession and their specific work environment despite the "politics and working environment." They noted the rewards were "monetary, emotionally and intellectually" and view nursing as an "honorable profession." As noted by one nurse from Indiana:

> I enjoy learning and taking classes in nursing education. I enjoy the work and it's important to me and my life. I enjoy being a nurse. If I didn't work as a nurse I feel my life would be boring.

Incentives that new nurses commented on as beneficial included daycare at hospitals, extended orientation time, residency programs, tuition reimbursement, competitive salaries, continued scholarly development, collaborative relationships, expert nurse mentors, flexible scheduling, lower patient/nurse ratios, a voice in the organization, and support from administrators. Just as there is no single tactic to help student nurses transition to RNs, the organizational climate will require multiple approaches to improve the working conditions and work environment. A comment from an RN from Oregon attests to the ability of some institutions to create a magic formula that caused her to say "To be a nurse is to have the greatest job in the world. My individual position is a great one . . . but no matter what position I hold, I plan to be a nurse for the rest of my life."

DISCUSSION

The content analysis of the comments written by 612 NLRNs gives voice to the experience of entering practice. Although the study is limited to only those who chose to comment, it is important to note that the participants' educational preparation to nursing includes associate and bachelor degrees; hospital diplomas; and accelerated baccalaureate, master, and doctoral degrees. Additionally, the RNs' comments came from across the United States. In our sample, about 41% of the comments were negative. However, there is cause for some optimism, as over half of the NLRN comments were either neutral or positive statements and many reported that finding fulfillment in the RN role came during their first 18 months in practice. This finding has been supported by other researchers, who assert that 12–18 months are needed to develop comfort, confidence, and competence.[21,22] However, the participants in this study were employed for a period of 6–18 months and many of the remarks give reason for concern. Several NLRNs described widespread dissatisfaction with the work environment and our results support the work of those who call for fundamental changes to the practice environments in order to both attract and retain NLRNs.[9,18,5,22-26]

Findings of this study are consistent with the parent study where NLRNs expressed concerns about workload issues, support from management, collegial relations and family/work conflict.[5] In the larger sample, $>$ 80% of respondents reported that they work fast or hard at least 1–2 days per week. This is consistent with the theme "the need for speed." However, additional insight into the clinical realities related to time management was noted in this secondary analysis. Other researchers have noted "time stress associated with workloads," where participants felt even the most efficient nurse would be unable to accomplish workload demands.[27] This study revealed time complexities extended beyond workload and the decreased time to connect with patients to the institutions "rush to [be] push[ed] out of the preceptor program too soon"; "into charge responsibilities"' and to "save overtime dollars." Many of the nurses' comments spoke of having left their primary work environment already or were planning on leaving institutions that did not have shared values. In the parent survey, 37% indicated that they were ready to change jobs. According to Hayes et al,[12] the impact of turnover to institutions is estimated to "range from $10,000 to $60,000 per RN, depending on the nurse specialty." Clearly, the choice to "push" NLRNs off orientation early and into charge responsibility is not a viable solution.

Turnover

Despite 6 years of consistent nursing program enrollment gains,[6] the nurse shortage continues. Hospital leaders reported an RN vacancy rate of 8.1% in December of 2006 (116,000 vacant positions).[28] Reported turnover rates at year 1 for NLRNs varies widely from a low of 13–53% with a high of 70%.[5,29,3] In the Kovner et al study,[5] an additional 24% of NLRNs reported that they would resign their position by their second year of work. At least some of this turnover is avoidable. Turnover is an issue in other disciplines as well. For example, according to Darling-Hammond and Sykes,[30] the turnover rate for US inner city teachers was 30% in the first 5 years. One could make a parallel that the stresses of teaching in an inner city are similar to working in an acute care institution, where resources and support structures are limited.[31] The overall rate of turnover in the United States for teachers was 13.1% which is remarkably similar to the rate of NLRNs according to Kovner et al.[32,5] Given the enormous challenges faced by others in a "service field," perhaps we should have a more realistic expectation about what constitutes a reasonable turnover rate. That said, it was distressing to note that many of the findings of this study reflect conclusions noted over 3 decades ago with the publication of Kramer's book, *Reality Shock* (1974),

where a disconnect between work environment and nursing expectations was heralded.[33]

Work Environment

Recent initiatives into critically analyzing our work environment are an attempt to solve the revolving door phenomenon of RNs leaving the acute care setting.[34-39] It is clear that the context within which care is provided must be examined and is a vitally important first step in holding on to our newest nurses. Given the changes in staffing mix, increasing patient acuity, and decreasing economic climate, one worries that it is too easy to blame nurses for their lack of preparation or resiliency rather than begin to look at the work structure and whether the political climate values care. Additionally, it is distressing to note that nurses continued to complain of lack of supplies and basic technology such as glucometers along with an inordinate amount of paperwork. These are not new issues and beg the question of how seriously leaders have considered the concern of nurses at the bedside.

Verbal Abuse

Although findings from the larger study revealed 62% of NLRNs reported verbal abuse, this study elucidated the parties involved and the extent of the mistreatment.[5] Similarly, 65% of nursing staff in a major southeast medical center experienced lateral violence among coworkers.[40] The pervasive prevalence of bullying or hostile behavior has been noted for years by nursing and government organizations and, despite position papers, guidelines, or white papers,[34,36,39,41-44] the study reported here revealed little impact on the frontline of clinical practice. Managers would do well to recall that poor communication is the root cause of the overwhelming majority of sentinel events.[39,45] Open and respectful communication should be an expectation in the healthcare industry. If NLRNs feel abused by colleagues[5,18] then advancement into collaborative relationships is unlikely to occur. In this era of competitive healthcare environments, the system that appears inflexible and disrespectful of the nursing role will lose, as the comments suggest—new RN's will go elsewhere. Although social engagement in work was seen as a critical factor in nurses' satisfaction, it alone will not ensure nurse retention.

Recommendations

The new nurses' comments revealed impatience with inefficient and ineffective healthcare systems and/or nursing curricula. While one participant commented "help please" to the survey developers, the overwhelming majority of nurses felt strongly that nursing was in a position to help fix many of the RN preparation and healthcare issues. The nursing profession can spearhead reform in both patient care and work environments. Magnet hospitals were viewed primarily as an indicator of a positive work environment. By far, however, novice nurses overwhelmingly seek lower patient-to-nurse ratios. It was seen as critical to improving the professional and personal satisfaction of nurses, and seen as beneficial for patient safety. Educational changes within schools of nursing suggested by the nurses in this study included: 8-hour clinical days, more realistic patient/nurse ratios, and communication activities. The communication activities included experience at giving and taking change-of-shift reports, delegating, rounding with physicians, and charting.

This study also supported the observation that there was a gap in RN readiness for practice,[18,46] which requires a re-envisioning of expectations for novice RNs and their education both during and after school. Orientation programs for NLRNs that demonstrate success reveal a cultural shift that extends outside of the classroom to include the practice setting and management team.[9,46] Our findings also support the work of Phillips,[47] whose study revealed the need for more orientation, capable preceptors, and adequate staffing for a first employer and a need for more clinical time, program content improvement, and a realistic view of nursing from the academic arena. There is no doubt that the educational system must look within to consider pedagogy and curriculum that will help with the transition from Graduate Nurse (GN) to NLRN, and employers need to consider more comprehensive residency and orientation programs. Younger RNs (ages 20–41) are more likely to develop institutional allegiance when the work environment accommodates the RNs' shifting expectations of balance of work demands, mentorship, colleagueship, tools that support practice, and autonomy.[40,48] The study reported here supports the notion that younger RNs have the comfort and confidence to resign positions that do not meet their needs. Over a decade ago, 3 questions were posed by Kupperschmidt[49] about Generation Xers—that is, those born between 1965–1982. The authors believe that the first question, "Are Generation X employees what nursing has been talking about and longing for: empowered, self-directed, flexible employees who are creative, innovative risk takers, and problem solvers?" can be answered in the affirmative. The second and third questions have yet to be answered—that is, "Do nurse administrators understand the dynamics of and challenges posed by Generation X employees?" and "Will nursing leaders adapt leadership strategies aligned with Generation X's work values and demands?"

What is clear from this content analysis is that the working environment where NLRNs begin their career is in need of reform. Issues of patient staffing ratios, smaller unit sizes, and decrease of mandatory overtime suggested by the NLRNs have financial implications. However, NLRNs turnover is also costly to healthcare institutions and may affect patient safety.[38] Curiously, the findings of this content analysis reveal complaints

that could be classified as perennial observations. This leads one to pose the question: If organizations agree that they want to improve NLRNs' working conditions, then isn't it time to begin listening to, hearing and heeding the words of our newest RNs?

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