Sociopolitical Knowing: A Secondary Analysis of New Graduate Nurses Transition During the Covid-19 Pandemic

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Abstract

Background: Pre-pandemic, the transition from student nurse to new graduate nurse (NGN) was described as predominantly stressful with a multitude of challenges impacting transition including: chronic underfunding, chronic nursing shortages, and overcrowding of hospitals. The Covid-19 pandemic created new healthcare challenges for nurses, specifically NGN, as they navigated enter into the profession in a time of unprecedented times in both their professional and personal lives. There was an increase in high level decision making (government, healthcare CEOs), which often did not capture the voices and realities of nurses working in clinical environments. These decisions, mediated by social and political entities, drastically impacted nurses and their work, including new graduates. Little is known about how new graduate nurses navigated entry to practice during this unprecedented time. Furthermore, even less is known about how new graduate nurses potentially understood or enacted socio-political knowing during this transition to practice.

Objective: (1) To better understand and communicate the ways in which second entry new graduate nurses spoke about nursing during the Covid-19 pandemic (2) To describe how second entry new graduate nurses understood and enacted socio-political knowing

Methods: Using Thorne's interpretive description approach, a secondary thematic analysis using qualitative data of eight second entry undergraduate nursing students was undertaken in order to attend to the research questions. White's (1995) work on socio-political knowing theoretically guided the study.

Findings: Three themes emerged. *School vs. Reality* illustrated areas of disconnect between nursing education and the reality of nursing practice, whereby schooling created a narrow understanding of nursing and associated nursing work (tasks). *Becoming a Nurse* was illuminated in the data through participants speaking to their individualized experience of purposely choosing particular nursing jobs that, in this study, demonstrated socio-political knowing. The theme of *Critical Reflections* suggested that being older and having previous life experience fostered a sense of independence, self-awareness, and boundary setting which participants mobilized socio-political knowing to protect themselves against burnout and psychological distress they were readily witnessing in their NGN transition.

Conclusion: Socio-political knowing continues to be neglected in nursing education and entry to practice supports, despite nurse researchers indicating a deep seeded need for all nurses, including nursing students, to have exposure to, and engagement with socio-political knowing. Participants in this study did however exhibit aspects of socio-political knowing, but believed these skills came from previous life experiences outside of their nursing education and were critical of the absence of this way of knowing in their training, both formally in nursing education, and in the workplace. Future research is needed to explore this topic among a larger sample of NGNs.

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Table of Contents

List of Figures

List of Abbreviations

CASN	Canadian Association of Schools of Nursing
CCRNR	Canadian Council of Registered Nurse Regulators
CFNU	Canadian Federation of Nurses Union
CIHI	Canadian Institute for Health Information
CNA	Canadian Nurses Association
CNO	College of Nurses of Ontario
NGN	New Graduate Nurse
ONA	Ontario Nurses Association
RN	Registered Nurse
RNAO	Registered Nurses' Association of Ontario

Chapter 1: Introduction

There is a current demand for Registered Nurses (RNs) across Canada (Canadian Federation of Nurses Union [CFNU], 2022). The aging nursing workforce and aging population with increased care needs are a driving force for the growing demand for nurses (Canadian Institute for Health Information [CIHI], 2020; Labrie, 2021; Statistics Canada, 2022c). At the same time, nurses are leaving the profession at alarmingly high rates for a variety of workplace issues including but not limited to short staffing and excessive workloads which were amplified by the Covid-19 pandemic (Registered Nursing Association of Ontario [RNAO], 2022; Statistics Canada, 2022b). The Canadian Nursing Association [CNA], has called upon Canada's policy-makers, educational and professional organizations, and/or regulatory bodies to address the current and forecasted nursing shortage, as nurses play an integral role in the healthcare system (CIHI, 2020; CNA, 2009). The current Canadian healthcare system is failing to meet the current and increased demand that arose from the pandemic and failing to deliver optimal work environments for nurses, including new graduate nurses (NGN), who are a vital health human resource (CNA, 2022a; Regan et al., 2017; RNAO, 2022b; Stelnicki et al., 2020).

The Covid-19 pandemic was a catalyst for nurses to collectively speak out about the poor nursing work environments that are actively contributing to attrition through a variety of ways which include media platforms (radio, television, and social media), petitions, and organized action (Crawford, 2022; Helmer, 2023). During the pandemic, nurses and the public witnessed this increase in political action by and for nurses, which resulted in healthcare and the nursing profession become more dominant in public discourse (Cingel & Brouwer, 2021). A subset of nurses that will be the foci of this research is New Graduate Nurses [NGNs], as currently there is a lack of literature regarding how NGNs understood the complex interplay of social and political

factors affecting the nursing profession during their entry into practice in the midst of the Covid-19 pandemic.

The normative assumption that nurses are apolitical and do not engage with the social and political dimensions of nurses work undermines the valuable contribution and influence nurses have in politics and policy-making (Buck-McFadyen & MacDonnell, 2017; Rasheed et al., 2020; Salvage & White, 2019; Wilson et al., 2020). Nursing is inherently political, yet the way nursing knowledge is predominantly structured by academic institutions, professional organizations, and regulatory bodies often lacks critical engagement with the socio-political way of knowing (Buck-McFadyen & MacDonnell, 2017; Florell, 2021; Madsen, 2008; White, 1995). It remains unknown how NGNs engage with socio-political knowing as they transition into practice, notably during a time when nurses have been in the public spotlight for their enactment of this particular way of knowing. This study will contribute to the body of knowledge that examines how socio-political knowing is understood and enacted by NGNs during their transition into nursing practice.

1.1 Thesis Outline

This thesis will contribute to the body of research addressing the socio-political way of knowing in the nursing profession. This chapter will include the rationale for this study, the research objectives, and the research question. Chapter 2 will describe the chosen frameworks that guided this study. I acknowledge this is not a traditional way to structure chapters, however it was done to sensitize the reader to the terminology and provide a clear theoretical understanding of concepts first before discussing the literary review. Chapter 3 begins with a review of the literature addressing several key concepts including socialization to the nursing profession, facilitators and barriers to socio-political knowing, a review of the nursing crisis and

impact the pandemic had on NGNs transition into practice, followed by a contemporary overview of socio-political knowing and agency. Chapter 4 describes the methodology used in this study, including the philosophical paradigm, design, setting, sample, recruitment, data collection, data analysis, trustworthiness, and ethical considerations. Chapter 5 presents the findings of the study. Chapter 6 discusses the context of the study's findings and its relation to the current body of literature, the implications of the findings, the study's strengths and limitations, and concludes by discussing the knowledge translation plan.

1.2 Research Purpose

This study is a secondary data analysis of the qualitative study conducted by Kim McMillan and her research team titled: *New Graduate Nurses Navigating Entry to Practice in the Covid-19 Pandemic.* The purpose for which the data was originally collected (in 2021) was to gain knowledge about how NGN transitions had been impacted by the Covid-19 pandemic. As well, this data provided insight into whether there were any additional supports this group of NGNs needed to support their successful transition into the nursing profession during a notably tumultuous time in healthcare. The research question that guided this original study was: 1) What are the experiences of new graduate nurses transitioning into their roles as registered nurses in the midst of the Covid-19 pandemic in Ontario, Canada? An incidental finding from this study found that each participant demonstrated socio-political knowing in a variety of ways. Most notable was their deliberate early career decision-making aimed at protecting participants against burnout and poor mental health (McMillan et al., 2023). Since an examination of this phenomenon (socio-political knowing) was not part of the original research purpose, a secondary analysis served to re-analyze the data more robustly to explore how this particular group of NGNs spoke about and enacted socio-political knowing during their transition into the nursing

profession during a global pandemic. It is also significant to note that all participants, likely due to snowball sampling used in the original study, were second-entry nursing graduates, also referred to as accelerated, fast-track, compressed, and advanced entry (Canadian Association of Schools of Nursing [CASN], 2019). This offers yet another opportunity to further explore a unique subset of NGNs not traditionally studied as a stand-alone group of NGNs.

1.3 Research Objectives

The objectives of this secondary analysis were: (1) To better understand and communicate the ways in which second-entry new graduate nurses spoke about nursing during the Covid-19 pandemic (2) To describe how second-entry new graduate nurses understood and enacted socio-political knowing.

1.4 Research Question

The question that guided this study is: How do second entry new graduate nurses in Ontario understand and enact socio-political knowing during their transition into the nursing profession in the midst of the Covid-19 pandemic?

Chapter 2: Theoretical Framework

The work of Judy Boychuck Duchscher (2008) and Jill White (1995) guided this research study from a theoretical perspective. Duchscher is a Canadian nurse and researcher who has over a twenty year history of working directly with NGNs in transition and conducted several qualitative and mixed-methods research studies in the area of NGNs professional role transition (Duchscher, 2001; 2007; 2008; Duchscher & Corneau, 2023a; 2023b). In 2007, Duchscher graduated with her Doctor of Philosophy (PhD) in Nursing from the University of Alberta (Duchscher, 2007). At the time of her doctoral work, the theoretical constructs of the NGN transition were based on antiqued research that may not have represented the contemporary nursing practice and healthcare organization context, therefore Duchscher attempted to describe the NGN's journey into the 21st century workplace (Duchscher, 2007; 2008; 2012; Duchscher & Windey, 2018; Kramer 1974). Duchscher identified her research could "further contribute to a substantive theory of role transition to professional nursing practice by distilling and distinguishing the salient, unavoidable, and necessary aspects of transition into acute care nursing" (Duchscher, 2007, pg.6).

Aside from Kramer's (1974) *Reality Shock* theory, Duchscher's theory is one of the first transition theories to formally acknowledge the significance of the contemporary work environment, and the social and political aspects of the role of transition (Duchscher, 2008; Kramer, 1974; Murray et al., 2019). Therefore, equally important and highly applicable to the transition process was White's conceptualization of socio-political knowing in nursing (White, 1995). Expanding upon Barbara Carper's (1978) original patterns of knowing in nursing, White identified socio-political knowing as a core strength of professional nursing (White, 1995). Although this way of knowing is not robustly utilized in nursing literature, it complemented and

further developed the idea of socio-political knowing aspects found in Duchscher's theory. Together these theories created a congruent theoretical framework which provided the researcher with a greater insight into the journey of NGN transition and also provided a way to conceptualize socio-political knowing within this study.

2.1 Development of Duchscher's Transition Theory

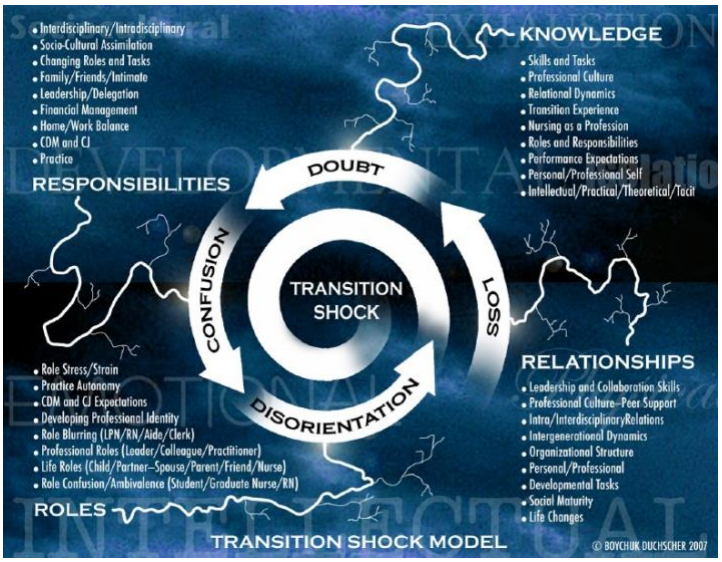
During Duchscher's doctoral work, an interpretive inquiry approach with grounded theory methods was used to explore the initial twelve month journey taken by NGNs into acute care settings (Duchscher, 2007). The study was conducted over eighteen months with in-depth interviews held at 1, 3, 6, 9, 12, 18 month periods, along with focus groups, and monthly exercise such as letter writing, picture drawing, reflective journaling, and ongoing email communication with all participants (Duchscher, 2007). The findings revealed two emergent core themes entitled (1) *Transition Shock* and (2) *Stages of Role Transition (Doing, Being, Knowing) (See Figure 1 and 2)* (Duchscher, 2007).

Duchscher attempted to elucidate the journey of NGN transition into stages (*Doing, Being, Knowing*) because at the time of her research, few studies formalized NGN transition into stages (Duchscher, 2007). In the studies that did, Duchscher identified lapses in the timelines identifying that it makes it difficult to strategically apply and effectively utilize the theoretical findings in practice (Duchscher, 2007). The durations presented in Duchscher's *Stages of Role Transition* are by no means linear or prescriptive, or strictly progressive and should be noted that the timelines associated with the stages are fluid and should be individualized (Duchscher, 2007). However, the stages (Figures 1 & 2) "offer new graduates, seasoned nurses, nursing managers and educators, and healthcare administrators a theoretically comprehensive, time-

specific, process-oriented framework for understanding and supporting the introduction of new nursing professionals to their acute-care careers" (Duchscher, 2007, pg. 29).

Figure 1

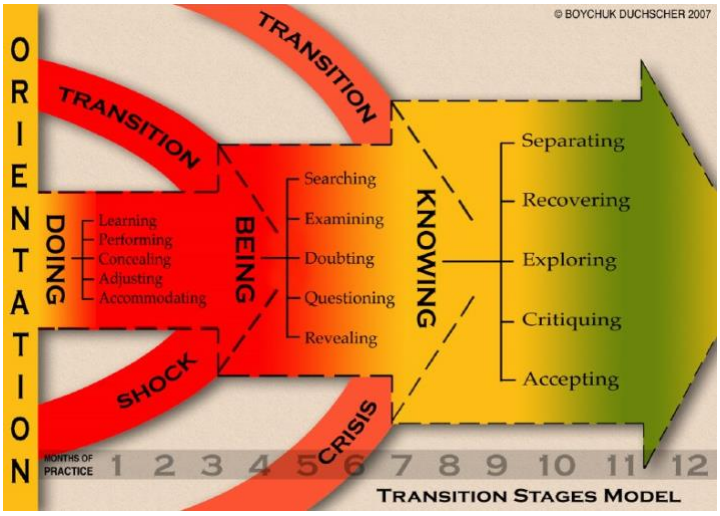
Transition Shock Model



Note. Permission to use Figure is in Appendix A.

Figure 2

Stages of Transition Theory



Note. Permission to use Figure is in Appendix A.

2.2 Stages of Transition Theory

The first stage, *Doing*, encompasses the first three to four months of practice after graduation and registration as a nurse where the NGN has little energy and time to lift their gaze from the immediate issues and tasks set before them (Duchscher, 2008). It is at this stage that NGNs are faced with a broad range and scope of emotional, physical, intellectual, and socio-cultural changes in both their personal and professional lives (Duchscher, 2008; 2009; 2012). Given that so much of what the NGN is experiencing is new, it contributes to the dominant steep learning curve that is noted in this stage (Duchscher, 2008). This may fracture any sense of solid professional identify that may have been present at the end of their undergraduate degree, resulting in feelings of stress, performance anxiety, and self-doubt (Duchscher, 2007). For example, a few weeks after orientation NGNs are found to be required to assist with, or perform procedures for which they had no to little experience with, or they are assigned full patient assignments, which is defined by Duchscher as an equal patient load to those of their senior nursing counterparts (Duchscher, 2007; 2008). NGNs are noted to not have developed strategies yet to manage the complex clinical scenarios at this stage as "their minds are consumed with completing tasks and routines within the rigid timeframes imposed by the structure of the unit where they work" (Duchscher, 2007, pg. 126).

During the first stage, *Doing*, NGNs are susceptible to transition shock (Duchscher, 2008; 2009). Transition shock is experienced as an NGNs transitions from their role of a student (which is familiar and known to them) "to the relatively less familiar role- that of the professional registered nurse" (Duchscher, 2009, p. 1105). It represents the most immediate and acute stage in the process of professional role adaptation where the NGN transitions from being a student into having the full responsibility of a solo RN along with transitioning into the structure

of their new work environment (Duchscher, 2009). The design of this theory subsumes elements of reality shock, cultural shock, as well as theory related to professional role adaptation and change theory (Duchscher, 2009; Kramer, 1974). It serves to explain the physical and psychological experience of transition encompassing the contrast that exists between roles, responsibilities, knowledge, and relationships required in an academic environment and those in clinical practice settings (Duchscher, 2008; 2009; Duchscher & Windey, 2018). Transition shock is noted to incorporate feelings of doubt, confusion, disorientation, and loss (Duchscher, 2009). For many, the phenomenon of transition shock is felt most intensely during the first few months post-orientation and lasts for approximately two to four months (Duchscher & Windey, 2018), however, the first eighteen months of practice can be exhausting and burnout may occur among NGNs (Duchscher, 2009). Initial and ongoing clinical supervision and support during the early months are noted to alleviate stress and anxiety experienced by NGN at this time (Duchscher, 2008; 2009; Mellor & Greenhill, 2014).

The *Being* stage occurs during the next four to seven months and is classified by the consistent and rapid advancement in their thinking, knowledge level, and skill competency (Duchscher, 2007; 2008). NGNs are found to look for clarification and conformation of their own thinking, compared to the first transition stage where they required prescriptive direction as to what should be done in a particular clinical situation (Duchscher, 2007). As the NGN becomes more comfortable with their professional role and responsibilities, they begin to lift their gaze from the immediate task before them and notice the inconsistencies and inadequacies within the healthcare system that challenge their idealistic pre-graduate notions of the profession (Duchscher, 2008; 2012). They begin to develop an increased awareness of themselves professionally and become comfortable with their roles and responsibilities (Duchscher, 2007).

This comfort permits them the confidence to questions, speak up, search, reveal, accept, all on their terms (Duchscher, 2007). A desire for greater independence is noted in this stage and they may no longer want or need a preceptor; however, it is a delicate stage as "the desire to hold on and let go were equally strong leaving them conflicted, confused and sending discordant messages to those around them" (Duchscher, 2007, p. 131).

Around 3-6 months after orientation, NGNs are placed into leadership roles that are beyond their clinical competence and comfort level at this stage (Duchscher 2007; Graf et al., 2020). For example, clinical leadership positions such as charge nurse roles and orientating new staff or students too soon, often resulting in inappropriate and unsafe situations causing the NGN discomfort (Duchscher, 2007; 2008; 2012; Graf et al., 2020). Around seven months post orientation, the NGN begins to find a middle ground between their experience as a student and current experience as an Registered Nurse [RN] (Duchscher, 2008; 2012). They acquire a sense of mastery over daily routines, become more confident in speaking up for themselves, making clinical decisions, as well as reacquainting themselves with their personal aspirations since less energy (physical, emotional, and intellectual) is required at work now that they are experiencing repeated familiar procedures and clinical situations (Duchscher, 2008).

The final stage, *Knowing*, lasts from the previous stage through the twelfth month of practice (Duchscher, 2008). It is during this stage when the NGN has the time and energy to begin a deeper critique of what they are learning and feel comfortable exploring the professional landscape such as beginning to actively engage in aspects of their social and political environments (Duchscher, 2008). For example, NGN may express dissatisfaction with shift work, the conditions of their work environment, and their relative powerlessness to effect change

(Duchscher, 2007). A quote from Duchscher's (2007) doctoral research of a NGN who was headed into their eighth to ninth month articulated:

> On a general day, I take care of 10 patients. If one patient has a lot going on, the others really suffer and whoever is making these decisions obviously has no idea what goes on in a nursing unit. I think it comes down to money and keeping those surgical wait lists down. I feel like the hospital is being run more like a business than a caring community. It's disheartening to think that this is what it's become. I find the whole nursing thing a bit disheartening and that's so sad because I love nursing. I never thought that as a NG [new grad] I would have 16 patients on nights and when I do, I find I can barely even say hello to them. I feel bad for the patients and I feel bad as a nurse that I'm representing this. Lots of times I ignore it and just think "Well, that's the way it is." I admire the dedication of the senior nurses. I do think we respect one another as nurses; we have this unspeakable bond I think. But as nurses, we don't speak up about the working conditions enough. I tried to speak to a senior nurse about a staffing issue that concerned me. The three nurses that were scheduled to work nights were myself and two of my classmates. The most senior nurse had just over one year experience! Apparently, when the manager was asked what she considered senior staff she replied, "Anyone that has worked on the ward for 6 months." Anyways, the nurse that I was speaking to about that staffing situation replied, "That's just the way it happens sometimes," as if to say "Suck it up - deal with it." To me this is jeopardizing patient safety. Not to say that we aren't capable or competent, but only on a novice level. This is huge stress to place on these staff. It's not really fulfilling knowing that you're leaving something out or you're missing something. No wonder nursing grad burnout rates are so high. (pg. 126)

As evident in the passage, this stage is when NGNs were found to have the ability to view and critique the complexities within the healthcare system (Duchscher, 2007; Graf et al., 2020). This significantly impacts their transition experience and ultimately their decision to remain in (or leave) the nursing profession (Duchscher, 2009).

Duchscher's *Stages of Transition Theory* provides a robustly detailed way of understanding how NGNs enter the nursing profession with a predominantly linear approach to thinking and over time become aware of the external factors affecting their transition. This theory is intended to understand and describe the transition experience of the 21st century NGN and be used among nurses, nurse educators, managers, and hospital administrators during recruitment, orientation, and mentorship to help facilitate a successful integration of NGNs into

the workplace (Duchscher, 2007; 2009; Murray et al., 2019). Healthcare institutions and universities must begin to recognize and respond to the factors that are causing the high rates of attrition among NGNs (Duchscher, 2009), to safeguard the nursing profession in years to come. In recent years, these factors have been socially and politically rooted – yet little is known about how NGNs navigate their social and political worlds in relation to their work.

2.3 Situating Socio-political Knowing

Barbra Carper (1978) identified four fundamental ways of knowing (*empirical, esthetical, personal, ethical)* that represent formal nursing knowledge and have been pivotal in shaping the profession and nursing curriculum (Butts & Rich, 2017; Newton, 2000). These patterns of knowing serve as a guide for the profession and have given rise to a broad range of knowledge approaches that provide a comprehensive and holistic view of nursing knowledge and practice (Butts & Rich, 2017; Carper, 1978). However, they are missing a critical foundation of knowledge for nurses to build upon to understand their relationships outside of the nurse-patient relationship as it pertains to direct care provision (White, 1995). For example, a means by which nurses can come to know and understand how the social and political environments influence the nurse patient-relationship, but also how these elements shape nursing work and work environments (Carnago & Mast, 2015; White, 1995). Traditionally when this subject matter is discussed, the default theoretical lens in *emancipatory knowing*. Emancipatory knowing is further built upon Carper and White's work and is rooted in critical social theory and practice (Chinn & Kramer, 2011). However, from my positionality and understanding of the concept, socio-political knowing serves as a precursor to be able to engage fully with emancipatory knowing. This is how I operationalized this concept throughout the thesis, which is why socio-political knowing was chosen as the second theoretical framework. Also in the interest of a

Master's thesis with an aim of producing something novel, choosing a lesser known framework had the potential to offer a unique understanding of the data when reanalyzed.

2.4 Socio-political Knowing

There are two levels to conceptualize this pattern of knowing as outlined by White (1995). The first level involves conceptualizing the socio-political relationship between the nurse and the patient with a focus on cultural location (White, 1995). Examples of cultural location include language, heritage, and identity which influence perceptions of health and illness (Carnago & Mast, 2015; White, 1995). This type of understanding goes beyond personal knowing identified by Carper (1978), as it is rooted in archaeological and historical issues that influence the current world (White, 1995). The second level of socio-political knowing involves the "context of nursing as a practice profession, including both society's understanding of nursing and nursing's understanding of society and its politics" (White, 1995, p.84). Although both levels were discussed by White, the second level was the level utilized in this thesis because of its proximity to the research question and aim, and is further explained below.

Within an increasingly economically driven world, White developed socio-political knowing to encourage nurses to explore other dimensions of nursing practice to prepare for the complexities of working in healthcare. White (1995), argued that Carper's patterns of knowing provided answers to the "who, what, and how" of nursing practice, but not the context, or the "wherein" (pg.83). Socio-political knowing was deliberately conceptualized to situate outside of the immediate, bio-medically mediated nurse-patient relationship, rather focusing on the social, political, economic, cultural, and environmental context that mediates nursing work and patient care (Clements & Averill, 2004; White, 1995). By analyzing, reflecting on, and questioning assumptions about the nursing profession, nursing practice, and health policies used in nursing

care, nurses actively engage in this pattern of knowing (White, 1995). White described that the entirety of the nursing profession must support enactment of in this pattern of knowing to have a voice in the future of healthcare (White, 1995).

In summary, the application of Duchscher (2008) and White's (1995) work provided a novel framework to conceptualize the NGNs transition experience as they intersect with the engagement and enactment of socio-political knowing during the Covid-19 pandemic. Duchscher's transition theory and White's socio-political knowing served in the context of this study to be quite complimentary to each other and addressed a theoretical perspective that the other did not represent. This provided me (the researcher) with greater insight into the journey of NGN transition, and also provided a way to conceptualize socio-political knowing within the data set. Socio-political knowing was a central guiding concept in this thesis, and together these theories supported the development of the research question and continued to inform the research process.

Chapter 3: Literature Review

The following literature review served as a foundation for my inquiry to explore existing literature regarding nursing transition and socio-political knowing. A preliminarily broad search of the literature was completed to situate myself with the current literature as this was a new topic of interest for myself. The following terms and their synonyms were used: new graduate nurse, second-entry new graduate nurse, transition, socialization, and socio-political knowing. The initial literature search was completed using web-based sources, such as CINAHL, Medline, PubMed, and Pro-Quest-Nursing to retrieve articles that were related to these concepts. Then a comprehensive literature search was conducted with the support of a health science librarian to assist in the systemic search of relevant databases (See Appendix B for Search Strategy). Date limits were not applied to the search, which facilitated a comprehensive understanding of the changes over time in the nursing profession and within the healthcare setting.

The literature review also incorporated grey literature to include relevant professional databases (eg. CASN, CNA, RNAO), and Ontario's licensing body's websites (CNO). Additional sources also included pertinent news reports from websites (eg. Canadian Broadcasting Corporation (CBC)), about nursing, healthcare, and the Covid-19 pandemic in light of their sheer volume and visibility during the pandemic.

The literature review is organized into three sections. The first section defines socialization in nursing through nursing education programs and guiding practice documents. The second section is a summary of the facilitators and barriers to socio-political knowing, which is a central concept to this thesis that is intrinsically linked with socialization. Lastly, the third section is an overview of current knowledge on the nursing crisis and the impact Covid-19 had on NGNs entry to practice.

3.1 Socialization in Nursing

3.1.1 Socialization

Socialization is the process during which individuals acquire new knowledge, skills, and values to interact in a new role when transitioning between one social role to another (Bauer & Erdogan, 2011; Dinmohammadi et al., 2013; Ellis et al., 2015; Vanderspank-Wright et al., 2019). It is a constant and ongoing process, and in some cases, a lifelong process (Ellis et al., 2015). Most research focuses on the process of socialization through nursing education programs and transition into practice, however, socialization into the nursing profession begins prior to being enrolled into a nursing education program, for example through movies and television shows or through having experience with a family member who is a nurse (Duchscher, 2012; Price et al., 2018). This gives people an impression as to what nursing is and allows the development of preconceived attitudes and beliefs about what nurses do and do not do (Duchscher, 2012). Socialization can be further divided into professional and organizational socialization.

Professional socialization is a dynamic process of coming to know a professional role (Price et al., 2018). The process transpires when students begin to learn and exchange the knowledge, attitudes, and behaviors for those of the nursing profession through formal and informal interactions with others to fulfill a professional role (Dinmohammadi et al., 2013; Duchscher, 2008; Duchscher & Cowin, 2006; McKenna et al., 2009; Price et al., 2018). While organizational socialization is the process of new employees entering the workforce and moving from being an outsider to an insider member (Bauer & Erdogan, 2011; Vanderspank-Wright et al., 2019). It is at this stage where new employees are mainly focused on job-related tasks important to the new setting, follow organizational protocol, begin to learn the norms of the

organization, and gaining a supportive network among colleagues (Bauer & Erdogan, 2011; Duchscher & Cowin, 2006).

During the process of organizational socialization, new employees are vulnerable to the influence of their immediate surroundings (McCloughen et al., 2020). Therefore, social interactions among mentors, colleagues, educators, and managers, during the transition into practice are critical in shaping NGNs entry to practice experience and decision to remain in or leave the profession (McCloughen et al., 2020; Vanderspank-Wright et al., 2019). Vanderspank-Wright and colleagues (2019) studied a group of NGNs transitioning into the intensive care unit (ICU), where their findings suggested the NGN transition was multifaceted and required both an acquisition of new skills and knowledge, as well as confidence and desire to be a nurse in the ICU. NGNs are found to have an increased job satisfaction when they are in their first job of choice and have an understanding of their role (Lalonde & McGillis Hall, 2017). Further, the work environment is another factor influencing the socialization of NGNs (Lalonde et al., 2021). Current literature suggests that making changes at the system level and in the work environment may improve NGN's job satisfaction (Lalonde et al., 2021).

Literature reveals nursing education programs are integral in socializing students to work within the increasingly complex healthcare environments (Bauer & Erdogan, 2011). Nursing programs are where students develop and expand their understanding of the role and have the opportunity to integrate learned theoretical knowledge and skills in settings such as classrooms, simulation laboratories, and clinical placements (McCloughen et al., 2020; McKenna et al., 2009).

3.1.2 Baccalaureate Nursing Education Programs

There are several pathways to obtain an RN license in Canada, the most common programs being the 4-year Bachelor of Science in Nursing (BScN) program and the 2-year second-entry BScN program (CASN, 2019). Traditionally, students who enroll into the 4-year program enter directly from high school, whereas second-entry students come as mature adult learners with prior degree knowledge and work experience (Johnson & Johnson, 2008; McCloskey et al., 2023). Second-entry programs recognize previous education experiences allowing students to reach their career goal of being a nurse in a shorter amount of time (CASN, 2019; Johnson & Johnson, 2008). Other terms referring to second-entry include: accelerated, fast-track, compressed and advanced entry programs (CASN, 2019).

The nursing literature describes second-entry students differently compared to the 4-year nursing education program students as discussed below. Literature describes second-entry nursing students as exhibiting greater maturity and motivation compared to their 4- year program counterparts (Codier et al., 2015; Penprase, 2012) and as exhibiting high emotional intelligence, maturity, and ambition (Oermann et al., 2010; Shatto et al., 2016). A qualitative study conducted by Dames, (2020), explored personal resiliency factors among NGN (n= 8) practicing in British Columbia, Canada. The study found that participants with a previous degree or who had work or travel experience prior to entering the nursing profession developed a sense of identity in a role outside of nursing, enabling participants to feel more congruent in oneself which acted as a buffer against stress during unfamiliar situations in practice (Dames, 2020). This example provides an understanding about the factors that potentially make second-entry students different than the traditional 4-year nursing program students. However, a gap remains in our understanding of the transition experience of the second-entry students, because nursing

literature often does not make a clear distinction between traditional entry and second-entry NGN. What does appear to remain constant between both traditional and second-entry program graduates, is the way they transition into the profession through a significant adjustment to personal and professional experience of responsibilities, knowledge, roles, and relationship changes (Duchscher, 2008; 2009). A focus on exploring how second-entry NGN understood such changes within a socio-political context will be explored, but first a review of how students are socialized to this concept will be discussed. Integrating documents that guide nursing education and practice into the literature review serves to examine if students are supposed to be socialized to socio-political related concepts in both a Canadian and Ontario context via influential nursing organizations that serve to structure both nursing education and nursing entry to practice competencies.

3.1.3 Guiding Practice Documents

Nursing Education Program Approval. In Canada, the CASN is the national voice for nursing education representing baccalaureate and graduate programs (CASN, n.d.). Canadian nursing programs and schools must meet the academic accreditation requirements outlined in the CASN Accreditation program framework to obtain accreditation, which is required to offer recognized nursing education in Canada (CASN, 2020). However, as of 2019, Ontario entry-level nursing education programs (practical nursing, baccalaureate nursing and nurse practitioner) must now receive program approval from CNO through their monitoring and evaluation process called the Nursing Education Program Approval (CNO, 2019b). This regulation “supports [CNO’s] public protection mandate to ensure that individuals who enter the nursing profession have the knowledge, skills and judgment to practice safely, ethically and competently” (CNO, 2019b, p. 3). The program approval framework is divided into three main

standards (structure, curriculum, and outcomes) which are reviewed and evaluated during the program approval process (CNO, 2019b). When critically critiquing the Nursing Education Program Approval document (CNO, 2019b), what appears to be lacking from the document are standards that speak to activities in a broader context of healthcare practice. Incorporating curriculum on health policies, student leadership, and professionalism contexts into the program standards and framework of Canadian nursing curriculum is necessary given that Canadian nurses are responsible to advocate for social justice and health policy (Mundie & Donelle, 2022). Providing students with intentional opportunities to learn about the impact of the collective voices of nurses has been shown to improve student's awareness, confidence, skills, and passion to engage in activities that are outside of the traditional nurse-patient relationship (Mundie & Donelle, 2022).

Canadian Code of Ethics. The CNA's *Code of Ethics* (2017), is a guiding document intended for all nurses practicing in Canada (clinical practice, education, research, and policy). It is in place to protect public safety and inform the public about the ethical values and responsibilities of nurses (CNA, 2017). The current CNA *Code of Ethics,* (2017), defines seven primary values that describe the central nursing values and ethical responsibilities that ought to drive ethical nursing practice. The *Code* also highlights the importance of individual and collective action to improve systems and societal structures to create equity for all, by maintaining up-to-date information about current issues and concerns as well as being strong advocates for fair policies and practices (CNA, 2017). Advocacy is defined as supporting a cause or course of action, and the need to improve systems and societal structures both individually and collectively to create greater equity and better health for all (CNA, 2017). The language used in the *Code of Ethics* claims that nurses in all contexts and domains of practice, including NGN, are

responsible to advocate at a micro, meso, and macro level for conditions that support nursing practice to benefit individuals receiving care and for each other (CNA, 2017).

Entry-to-Practice Competencies. In Canada, nursing is a self-regulated profession, thus regulatory bodies across all Canadian provinces and territories must ensure that nurses are practicing in a safe, competent, and ethical manner (Canadian Council of Registered Nurse Regulators [CCRNR], 2023). This is achieved through mandated regulatory activities such as registration and licensure, setting standards governing nursing practice and education, defining scope of nursing practice, and developing entry-to-practice competencies required for nursing practice (CCRNR, 2023). Baccalaureate nursing education programs are guided by these standards and entry-to practice competencies to guide the learning content of educational curriculum development (Belita et al., 2021; CCRNR, 2023; CNO, 2018; Jager et al., 2020). While accomplished differently across Canadian jurisdictions, nursing regulation in Ontario is determined by the Nursing Act (1991) and the Regulated Health Professionals Act [RHPA] (1991) and governed by the CNO (CNO, 2020a, 2020b). The RHPA (1991), applies to all of Ontario's self-regulated professionals, and the Nursing Act (1991), defines the scope of nursing practice and establishes the mandate of the CNO (CNO, 2020a, 2020b). The CNO is the regulatory body for nursing in Ontario, and as of June 2023, there were approximately 117, 605 RNs, (184,574 nurses including RNs, RPNs, and NPs), who were registered with CNO that provide nursing services across the province (CNO, 2023).

The CNO entry-level competencies are the foundation for nursing practice for RNs to meet upon initial registration with CNO and entry to practice in Ontario, serving to ensure safe nursing practice (Belita et al., 2021; CNO, 2018). The entry-to-practice competencies consist of nine overarching roles nurses assume when providing safe, competent, ethical, compassionate,

and evidence-informed nursing care, each supported by competency statements (101 in total). The multiple roles nurses assume include: 1) Clinician; 2) Professional; 3) Communicator; 4) Collaborator; 5) Coordinator; 6) Leader; 7) Advocate; 8) Educator; 9) Scholar (CNO, 2018). Upon reflection of the entry-to-practice competencies, it is noted the competencies are discussed in terms of the nurse-patient relationship, rather than focusing on the socio-political context that encompasses nursing work and patient care. For example, RNs are defined as leaders by "influencing and inspiring others to achieve optimal health outcomes for all" (CNO, 2018, p.7), and the role of an advocate is defined by supporting clients to voice their needs and those who cannot advocate for themselves to achieve optimal health outcomes (CNO, 2018). The language of engagement supports general nursing action, whereas the nursing literature heavily articulates that political awareness is needed among nurses to advocate for the profession (Buck-McFadyen & MacDonnell, 2017; Florell, 2021; MacDonnell, 2009; Mundie & Donelle, 2022), yet these RN entry-to-practice requirements and guiding practice documents do not reflect this kind of competency.

Belita et al., (2021), states that modernization of practice standards to include nurse advocacy in a broader context of healthcare will provide a guide for nursing curriculum to better foster the unique skills and capacity nursing has to influence healthcare within the direct care of clients and broader communities. Through a development of entry-to-practice competency documents promoting both the contribution of caring and socio-political knowing within nursing, there is hope to better recognize the dominance nursing can have within policy and politics, as it relates to driving supportive and sustainable holistic health care delivery (MacDonnell, 2009). It is critical for nurses to be socialized to and engage with the social and political agencies to increase awareness and knowledge of how important it is to participate in public policy and

advocate for the profession at a micro, meso, and macro level to support day-to-day nursing practice (CNA, 2009; Duchscher, 2008; Florell, 2021; Zauderer et al., 2008).

Integrating the guiding documents of nursing education and practice into the literature review served to highlight the weak language used related to the socio-political related competencies in both a Canadian and Ontario context. Nursing is inherently political, yet the way nursing knowledge is structured by educational and professional organizations and/or regulatory bodies often lacks critical engagement with the socio-political way of knowing (Buck-McFadyen & MacDonnell, 2017; Florell, 2021; Madsen, 2008; Mundie & Donelle, 2022; White, 1995). Nursing education programs and organizations play an integral role in socializing nursing students into the profession (Bauer & Erdogan, 2011), and for this to be fully effective, such socialization must acknowledge the social and political dimension of knowing (Dames, 2019; Nairn, 2019).

3.2 Socio-Political Knowing in Nursing

3.2.1 Facilitators

Facilitators to enacting socio-political knowing in nursing include having a personal interest in politics and policy, academic and collegial socialization to the pattern of knowing, and involvement within a professional nursing organization (Florell, 2021; Mundie & Donelle, 2022; Taylor, 2016). Terry et al., (2019), states that nurses begin to become mindful of their role in leadership and activism after encountering or observing a noteworthy event such as an ongoing injustice that could have been prevented by changes in the system. Confidence with public speaking and having a systems level understanding of healthcare allows nurses to feel assured in oneself when speaking and engaging in discussion among policy-makers, educational and professional organizations, and/or colleges (Mundie & Donelle, 2022).

3.2.2 Barriers

An overview of two main overarching barriers to political advocacy (stemming from socio-political knowledge acquisition) in nursing will be detailed below.

Limited Nursing Education. The development of advocacy and leadership skills is a critical component of student learning (CASN, 2020), yet there is a gap between nursing scope of practice, education, and the development of advocacy and leadership skills (Mundie & Donelle, 2022). Nursing education is identified in the literature as being inadequate to prepare students to practice and engage with socio-political knowing (Buck-McFadyen & MacDonnell, 2017; Falk-Rafael, 2005; Florell, 2021; Madsen, 2008; Mundie & Donelle, 2022; Taylor, 2016; Topola & Miller, 2021). It is noted that the philosophical values and beliefs of the nursing faculty and the program courses place a greater focus on empirical knowing (Eisenhauer, 2015; Falk-Rafael, 2005; Snyder, 2014), consequently creating a lack of exposure to a critically examination of the social and political contexts on healthcare (Falk-Rafael, 2005). Taylor, (2016), provides an example of this by articulating that "just as nurses know the importance of monitoring vital signs, they should know how to monitor a bill becoming law" (p.244). Taylor, (2016), further elaborates stating that nurses should know who their district representatives (elected or appointed) are and engage in communication on behalf of patients and community populations, just as nurses escalate the chain of command in emergent situations (Taylor, 2016).

A historical scoping review was conducted by Wilson et al., (2020), to identify if, as well as why, when, and how nurses became involved in meso-level politics or political action. A total of 25 articles were included in the review, five of which had a research aim or study purpose about undergraduate nursing students or NGN (Chan & Cheng, 1999; Foreman & Monkman, 1998; MacDonnell & Buck-McFadyen, 2016; Olsan et al., 2003; Rains & Barton-Kriese, 2001;

Wilson et al., 2020). Of these five articles, findings revealed that there is limited knowledge and awareness among nursing students and NGN about how to engage with and exert influence in political and system level structures in healthcare (Wilson et al., 2020). One qualitative study from the scoping review explored the political competence of 9 undergraduate nursing students and 8 political science students in the United States. Findings revealed the nursing students viewed politics as something other people do and a barrier rather than a liberating mechanism for change and empowerment (Rains & Barton-Kriese, 2001). In contrast, the political science students enriched their knowledge from a variety of courses to develop personal opinions and perspectives, and were confident when discussing politics, however had less community involvement compared to nursing students, therefore displaying a limited understanding of practical application (Rains & Barton-Kriese, 2001).

More recently, an exploratory mixed methods study conducted by Topola and Miller (2021), explored the perceptions of nursing students enrolled at two Western Canadian Universities. The study consisted of two cohorts: 221 first year nursing students and 165 fourth year nursing students (n=386). The aim of the study was to explore their perceptions of the role of an RN and to describe their willingness to participate in roles that embody leadership and political action. Participants in this study indicated that being a leader of healthcare system change is within the scope of the RN but did not view the RN role as a position of authority, therefore was unlikely to be a leader. Among both cohorts, a common theme was that although RNs have an important influence on decision making, they personally are not interested in exerting influence, “It has to be done, and someone has to do it, but I just don’t want that person to be me” (Topola & Miller, 2021, p. 4). Another participant stated, “I understand the importance of politics and I love that there are nurses that are willing to advocate for us, but that is not

something I am passionate about at all" (Topola & Miller, 2021, p. 4). Specifically, within the fourth-year cohort, students perceived RNs as facilitating teamwork versus leading a team. The study concluded that nursing students (first and fourth year) see the value of leadership and political action but have a limited desire or willingness to participate in activities that align with leadership and political action in RN practice. Therefore, development and implementation of strategies to support this way of knowing among NGNs is needed to prepare future nurses who are interested in politics and will participant in leadership and healthcare transformation (Topola & Miller, 2021).

Specific to Ontario, Buck-McFadyen & MacDonnell, (2017), conducted a qualitative study exploring the impact nurse educators have in fostering political practice among students. Nine educators and nine nursing students from six Ontario postsecondary institutions participated in individual interviews. Findings highlighted one of the challenges for teaching political action is the significant variation of how the idea is taught and supported across nursing programs. For example, one educator stated they believe their school does not inspire political activism but needs to; another educator stated despite institutional support to teach political action, there is no effort to enforce or regulate (Buck-McFadyen & MacDonnell, 2017). This is problematic as nursing faculty and educators have been identified as key to fostering the skills, values, and enthusiasm for socio-political knowing concepts among the next generation of nurses (Buck-McFadyen & MacDonnell, 2017; Zauderer et al., 2008)

Nursing faculty play an integral role in introducing and preparing students, subsequently NGN, to the values, attitudes, and beliefs of the profession (Buck-McFadyen & MacDonnell, 2017; Strouse & Nickerson, 2016). The values of the nursing profession are complex, however, are often associated with trust, respect, honesty, and caring, along with a moral and ethical

commitment to protect human dignity (Florell, 2021; Gill & Baker, 2021; Horton et al., 2007; Kelly, 2020). These values are encouraged, yet some authors suggest there is a heavy focus on care informed by evidence-based knowing, often lacking discussion of the broader healthcare context (Buck-McFadyen & MacDonnell, 2017; Florell, 2021). This may hinder nursing students' ability to realize their influential capabilities to advocate for the profession in a role outside of promoting health and well-being among patients (Zauderer et al., 2008). Nursing faculty and educators need to help increase the number of politically active nurses (Zauderer et al., 2008). Through engaging with and teaching about socio-political knowing to support awareness among NGN regarding the legitimacy and importance of social and organizational activism in nursing, students may be encouraged to think in this way throughout their degree and into their professional practice (Buck-McFadyen & MacDonnell, 2017; Taylor, 2016).

Gender, Power, and Associated Traits. Internationally, nurses are viewed as one of the most respected professions, representing the largest proportion of healthcare workers (Jackson et al., 2021; Tomblin Murphy et al., 2022), and is one of the top trusted professions, placing nurses in an advantageous position to address healthcare policies and inequities (Buck-McFadyen & MacDonnell, 2017; Duncan et al., 2014; Falk-Rafael, 2005; Reutter & Kushner, 2010; Snyder, 2014). Despite nurses being well positioned with large numbers and a trusted professional reputation, (Buck-McFadyen & MacDonnell, 2017; Falk-Rafael, 2005; Rutter &Kushner, 2010), these factors have not translated into the power to consistently influence structural and political change in healthcare (McGibbon & Lukeman, 2019). There is also a lack of representation of nurses in government to influence and shape health policy (Rasheed et al., 2020). Nursing continues to be a female dominated profession, as evidenced by 91% of Canada's nursing workforce being female (CNA, 2021). It is essential as a feminized profession to acknowledge

and engage in the social and political aspects of nursing, given that nursing is inherently political, and is also shaped by the politics of gender (CNA, 2021; Florell, 2021; Lingel et al., 2022; Rasheed et al., 2020; Shariff, 2014).

The founder of modern nursing, Florence Nightingale, envisioned nursing to be a female orientated profession as Nightingale viewed caring behaviors to be more appropriate among the female gender (Prosen, 2022). Other historical gendered stereotypes about women and nurses include being nurturing, caring, and comforting (Armstrong et al., 1993; Boulton et al., 2021). Although important to the nursing profession, such gendered beliefs, attitudes, and stereotypes do not align with social or political engagement which are the foundations of enacting socio-political knowing (White, 1995).

Nurses who have engaged with socio-political knowing and agency in their practice have spoken out about nursing shortages and unsafe work environments for decades, but their voices have been systematically muted (Rankin, 2006). Institutional power structures have silence nurses' voices for years when speaking out about the safety of nurses, patients, and workplace environment, placing emphases on the invisibility of nurses (Storch, 2005). For example, the 2003 Sudden Acute Respiratory Syndrome (SARS) outbreak saw media coverage of nurses' voicing the changes that needed to occur to provide a safe working environment and retention of nurses (Rankin, 2006). However, despite the heightened media focus, nurses' voices had minimal impact on policy-makers to create organizational change (Rankin, 2006). Subsequent power imbalance(s) often leaves nurses feeling powerless in their work, leading to disempowerment when trying to engage with organizational level change. These barriers cause problems for not only nurses working in these environments, but for individuals, families, and communities accessing healthcare.

Acknowledging that change occurs through complex social, political, cultural, and economical structures, is essential for nurses and NGN to engage in ways of knowing that support their aptitude within these structures (Madsen, 2008), given that both nursing care and nursing work are mediated by these constructs in incredibly complex ways. The current healthcare climate, which includes a nursing crisis creates an urgent need for the public and nurses to rethink and understand nursing actions in respect to the larger social and political environment.

3.3 The Nursing Crisis

The Canadian nursing crisis was first identified nationally in 1997, in a report published by the CNA, projecting a shortage of RNs by the year 2011 (CNA, 2001). No action for potential solutions was taken by the federal government, instead, focus was placed on balancing the public sector budget (Little, 2007). In Ontario, this amounted to a loss of 7,300 RNs with more than 5,500 positions cut between 2013 and 2016 (Ontario Health Coalition, 2016). Ontario's ratio of nurses per capita continues to rank at the bottom of national average for nurses per capita, number of hospital beds, and hospital funding (Ontario Health Coalition, 2016; Ontario Nursing Association [ONA], 2016). With a growing and aging population, Ontario hospitals have been running overcapacity, exceeding bed occupancy rates, at times exceeding 100% (Drummond, 2002; Ontario Health Coalition, 2016). To note, if hospitals operate with a bed occupancy rate at above 90%, there is possibility of crisis (Bagust et al., 1999). Pressure to find space for the influx of patients has resulted in unconventional (and unsafe) bed space utilization across hospitals in Ontario, such as lounges or hallways (Janus, 2017). The subsequent increased pressure on nurses has a rippling effect on staff safety and in turn patient safety (Reichert, 2017). Absenteeism rates among nurses are driven higher due to illness and injury presumably from the unsustainable

workload and emotional toll on mental well-being, further exacerbating the existing staffing crisis (Gohar et al., 2020; RNAO, 2010; Reichert, 2017).

When the Covid-19 pandemic was declared in 2020, the nursing crisis went from bad to worse. Ontario entered the pandemic with a shortfall of 22,000 RNs (RNAO, 2022a). With the nursing workforce untenably short, working overtime became necessary, with some provinces such as Quebec, implementing mandatory overtime (CFNU, 2022). Ontario and Quebec had the largest increase in nurses' average of overtime hours per week, compared to the rest of Canada, which is reflected in these provinces also having the largest increase of Covid-19 cases across Canada during this time (Statistics Canada, 2020). Ontario had an average of 9.8 hours of weekly overtime in May 2020 compared to 4.7 hours in May 2019 (Statistics Canada, 2020). Excessive overtime and unstable work environments have greatly impacted the mental health and wellbeing of nurses and NGN (CFNU, 2022).

A robust body of literature and mainstream media platforms have highlighted the compounding effect the pandemic has had on nurses and the healthcare system. The Canadian nursing workforce reported intensifying levels of burnout, occupational stress, and exhaustion, with feelings of decreased job satisfaction and rising levels of stress, anxiety, and moral distress (British Columbia Nurses' Union, 2021; Catton, 2020; New Brunswick Nurses Union, 2021; RNAO, 2022b; Stelnicki et al., 2020). The increased demands of the pandemic resulted in nurses being exposed to new vulnerabilities and risks, such as working with high rates of confirmed or suspected Covid-19 cases with limited and at times conflicting and ever evolving information about the virus transmission and precarity of access to personal protective equipment (PPE) (Boulton et al., 2021; Catton, 2020; RNAO, 2022b; Stelnicki et al., 2020). In the early stages of the pandemic nurses reported the guidelines for PPE protocols were being changed frequently,

sometimes daily, and at times, the nurses felt the changes were made based on availability of supplies rather than new evidence and knowledge (Naylor et al., 2021).

Moral distress was heightened during this time due to the risks nurses had to face caring for patient's lives as well as their own (Birt et al., 2023; Riedel et al., 2022). Moral distress can be defined as "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p.6). Visitor restrictions were noted to be a moral stressor for both established nurses and NGN, as it was difficult to reconcile the visitation guidelines and the moral duty to let families be with their ill loved one (Birt et al., 2023; McMillan et al., 2021; Riedel et al., 2022), especially concerning dying patients (Riedel et., 2022). The moral conflict of providing nursing care during these tumultuous times with new vulnerabilities have been normalized as inevitable events in nurses work (Mohammed et al., 2021; RNAO, 2022b). The pandemic brought nurses into public discourse as heroes, but behind the scenes, many nurses were experiencing a disconnect between the public expectation and professional experience (Boulton et al., 2021). The hero narrative was used as the reward for nurses, disregarding the lack of support from the meso and macro levels to influence change for the nurses' work environment and overall patient safety (Boulton et al., 2021). To date, the hero discourse actually serves to portray the social and economic imbalances in society relating to unfair wages, gender discrimination, and increasing managerialism (Mohammed et al., 2021). The toll the pandemic has had on nurses is significant and far reaching, causing an increase in nursing turnover and vacancy rates, ultimately not fostering a supportive environment for NGNs (CFNU, 2022).

3.3.1 Impact of Covid on NGN Transition

A constellation of studies spanning the last 10-15 years have associated the transition process among NGN with a variety of challenges including feelings of inadequacy, fear, anxiety, lack of confidence, and frustration (Dwyer & Hunter Revell, 2016; Dyess & Sherman, 2009; Edwards et al., 2015; Irwin et al., 2018; Lalonde et al., 2021; Pellico et al., 2009; Vanderspank-Wright et al., 2019; Wing et al., 2015). The literature also demonstrates the transition process takes at minimum twelve months, sometimes longer (Benner, 1984; Chappell & Richards, 2015; Duchscher, 2008; Graf et al., 2020; Pellico et al., 2009). It is recommended that NGNs be provided with stability, predictability, familiarity, and consistency during this phase in both professional and personal life for at minimum six months to ensure a healthy flow during the transition (Duchscher et al., 2021). When these elements are attended to, Duchscher et al., (2021) suggests the NGN is better in control of their transition experience. During the pandemic, NGNs were not provided with a stable or predictable environments and faced a multitude of challenges affecting their transition including but not limited to unit/site redeployment, having to engage with patient's families through social distancing measures, enforcing visitor restrictions and policies, adapting to heavier workloads, and constant use of cumbersome PPE (Duchscher et al., 2021; McMillan et al., 2021; RNAO, 2022b). Some NGNs were found to have their orientation cut early or be placed into leadership roles (eg. charge nurse roles, training new staff) without proper training or support to fill staffing vacancies and loss from the collective nurse burnout (Duchscher et al., 2021; Duchscher & Corneau, 2023b; McMillan et al., 2023). These factors created new vulnerabilities and sources of stress for NGN to navigate among the existing healthcare challenges, adding additional sources of stress for NGN on top of an already stressful

period in their career (CFNU, 2022; Duchscher et al., 2021; Duchscher, 2008; 2012; Kramer, 1974; Pellico et al., 2009; RNAO, 2022b).

Understanding the challenges faced by NGNs during their transition into professional practice can optimize collaborative responses between education and government entities to assist the provinces in recruiting and retaining the next generation of nurses in Canada (Duchscher & Corneau, 2023a). Retaining nurses, notably NGNs, should be a priority while handling the healthcare crisis, as NGN are the main supply of annual nursing labor force increases (CIHI, 2020; CFNU 2022) and they are a vital health human resource (Regan et al., 2017). This, however, was not the approach taken by the Ontario provincial government (CBC, 2023). In 2019, in the spirit of austerity, Premier Doug Ford's government implemented Bill 124, which moderated salary increases for public sector employees (including nurses) at one per cent annually for three years (CBC, 2023). Although this legislation was deemed unconstitutional by the Ontario Superior Court in November of 2022 as it infringed on the charter of rights guaranteeing freedom of association and collective bargaining (RNAO, 2022c; CBC, 2023), the Ford government has since appealed the Court's decision (CBC, 2023). This was understood as a lack of appreciation for nurses and for public sector workers, serving as an insult to the advancement of the nursing profession as well as retention in securing NGN to support the Canadian healthcare system (RNAO, 2022c; CBC, 2023; Xing, 2020). Nurses, particularly in the early stages of their career, were seen leaving the publicly funded nursing profession and with lack of systematic planning of human resources alongside Bill 124, the staffing crisis is unlikely to improve (RNAO, 2021a, 2022b). The latest court decision in 2024 confirmed the unconstitutionality of Bill 124, highlighting the severity of impact on nursing and healthcare professionals since 2019 (Casey & Jones, 2024).

3.3.2 Contemporary Impetus for Socio-political Knowing and Agency

Over the course of the Covid-19 pandemic, nurses have collectively spoken out about the realities of nursing work we see today and of blame the decades of mismanagement on a systematic level. Their collective voices have been brought into public discourse during the pandemic. Nurses are currently speaking about the realities of the profession through a variety of ways; including media platforms (radio, television and social media), petitions and organized action, for example, protesting at the provincial legislature in Ontario, and various other locations around Ontario (Crawford, 2022; Helmer, 2023; RNAO, 2021b). This suggests that nurses do view both caring and political activism as morally necessary in the nursing profession. Of late, we have also seen collective actions outside of Canada, of note, members of the Royal College of Nursing in England engaged in rotating strike days (the first nurse strike action in the history of England) (Duncan, 2023; Royal College of Nursing, 2023), and thousands of nurses in the state of New York had been on various strikes in 2022 and 2023 (New York State Nurses Association, 2023). Nurses who use these various platforms demonstrate the utilization of nursing advocacy, leadership, and demonstrate socio-political knowing and agency. Nurses must develop skills in socio-political knowing and agency to be able to adequately influence the direction of healthcare delivery, not only to protect the health of the public, but to safeguard the profession, which is currently in crisis (Rasheed et al., 2020; RNAO, 2022b).

The literature review provided a foundation to understand how NGNs are being socialized to the nursing profession, socio-political knowing, and the current healthcare system. This literature review also provided evidence of the systemic failures that have led us to the current nursing and healthcare crisis (Drummond, 2002; Janus, 2017; Little, 2007; Rankin, 2006; RNAO, 2022a, 2022b). Despite the increasing awareness and magnitude of these varying

concerns within the profession, nursing education programs and guiding practice documents often do engage in such topics (Buck-McFadyen &MacDonnell, 2017; CASN, 2020; CNA 2017; CNO, 2018). Re-analyzing data collected during the Covid-19 pandemic with the purpose to disseminate knowledge on how NGNs, specifically second-entry NGNs, understood and potentially engaged with socio-political knowing may provide insights into how this generation of nurses may potentially shape the future of nursing.

Chapter 4: Methodology

The purpose of this secondary analysis was to explore how a group of second-entry NGNs from Ontario spoke about and engaged with socio-political knowing during their transition into the nursing profession in a global pandemic. The study was guided by the following research question: How do second-entry new graduate nurses in Ontario understand and enact socio-political knowing during their transition into the nursing profession in the midst of the Covid-19 pandemic? This chapter provides a summary of the methodology of the original project, as well as the methodological approach for this secondary analysis including the philosophical underpinnings, research design, data utilization, and analysis along with ethical considerations.

4.1 Summary of the Methodology of the Original Project

To situate the current secondary analysis, the methodology for the original study is described below. Data for the original study was collected between June and July of 2021.

4.1.1 Purpose of the Original Study

The purpose for which the data was originally collected was to gain knowledge about how NGNs' transitions had been impacted by the Covid-19 pandemic, and to examine if there were any additional supports this group of NGNs needed to support their successful transition into the nursing profession during this unique time in healthcare (McMillan et al., 2023).

4.1.2 Design of the Original Study

The design of the original study was interpretive description (Thorne, 2016), which is an approach designed to provide practice-relevant knowledge for clinical nursing. The original study was theoretically guided by both the social-ecological model (Crosby et al., 2013; McLeroy et al., 1988; Stokols, 1996) and relational ethics (Bergum, 2004; Bergum & Dossetor,

2005). A qualitative approach was used to garner an in-depth understanding of NGN's experiences of transition during a unique and historic time (pandemic).

4.1.3 Setting of the Original Study

The study was conducted virtually over a secure Zoom meeting, with the interviews lasting between 50 and 70 minutes.

4.1.4 Sample for the Original Study

Sampling for the original study was accomplished using convenience sampling, which resulted in snowball sampling. Convenience sampling is a non-probability sampling method, that consists of using the most conveniently available members of the target population that meet the inclusion criteria of the study (Polit & Beck, 2017). Snowball sampling (also called network sampling) uses early sample members to refer other people who meet the eligibility criteria (Polit & Beck, 2017). NGNs from the Winter 2020 graduating cohort of nursing degree programs working in any healthcare setting in Ontario was invited to participate in a single interview about their experience of transition during the Covid-19 pandemic. Additional inclusion criteria included participants being able to participate in an interview in English and having access to a working internet connection. All participants in this study were second-entry program graduates from multiple Ontario post-secondary institutions, meaning they completed a non-traditional nursing degree stream in which students enrolled already hold a bachelor's degree and therefore complete the nursing degree in an accelerated timeframe. The sample size was eight NGNs, as data saturation occurred at participant eight.

4.1.5 Recruitment for the Original Study

Recruitment for the original study occurred via social media and through personal, academic, and clinical nursing networks across the province of Ontario (Appendix C). A consent

form was sent to participants before being interviewed and the signed form was obtained before the start of each participant interview (Appendix D).

4.1.6 Data Collection for the Original Study

Semi-structured interviews comprised of six open-ended questions were used to guide the interviews (Appendix E). All interviews were conducted by the original investigator (Kim McMillan) and supported by one of two trainees (an undergraduate nursing student and a graduate nursing student). As the interviews evolved over time, additional information was gained from the last 4 participants as they were asked an additional interview question. The additional question focused on what will keep them in the nursing profession. Data collection occurred at a time that was convenient for the participant. The original study did not ask for the participant's specific employment details and did not have contact with the participant's employers in relation to this project. No information was collected about the participant's age or gender. In total, eight interviews were conducted over Zoom and lasted between 50 to 70 minutes in length. Due to the time-sensitive nature of the inquiry, interviews were recorded and analyzed directly using an inductive approach (Thorne, 2016) to create an interpretive synthesis of each participant's interview to generate meaningful disciplinary knowledge.

4.1.7 Data Analysis and Interpretation for the Original Study

An inductive approach was used to view the recordings multiple times by the original investigator and research assistants. Reflections on the data as it related to the aims of the research and theoretical underpinnings were captured and notes of salient points and preliminary insights were made. An in-depth analysis of each participant's interview was performed. The ways in which participants engaged with, and navigated, the complexity of the various environments outlined by the social-ecological model (Drew et al., 2016; McLeroy et al., 1988)

structured the data analysis process. Analysis was further nuanced by examining the quality of relationships in those various environments and how participant experiences embodied relational practice. Subsequent codes specific to segments of discourse that provide partial answers to the research question were applied. Four salient themes emerged from the data; (1) *Virtual Didn't Cut It;* (2) *Go Where You Know*; (3) *Picking Up the Pieces* and (4) *Knowing When to Say No and Let Go* (McMillan et al., 2023).

4.2 Philosophical Paradigm

A paradigm is a group of philosophical assumptions that guides how one looks at the world (Mackenzie & Knipe, 2006). Paradigms influence the philosophical assumptions that guide researchers' thinking and action, therefore it is important to acknowledge the researcher's paradigmatic positioning early in the research process as it guides the initial steps of the research process such as the study's objectives, design, and knowledge being produced (Mackenzie & Knipe, 2006). A constructivist paradigm philosophically guided this study. Guba & Lincoln, (1994), identified the ontological positioning of constructivism as supported by relativism, meaning multiple realities. There is an understanding that reality is individually constructed, with many subjective realities and personal experiences (Scotland, 2012).

The constructivist paradigm resonated because I (the student researcher) believe there are multiple co-existing realities, constructed truths, and unique perspectives. A relativist ontology is aligned with how I view reality, such that everyone sees the world and interactions differently. This holds true in my research wherein it was understood that there were different realities and truths uncovered between participants, as well as what I saw in the data compared to what the original researcher saw, which supports the relativism assumption (Mauthner et al., 1998; Ruggiano & Perry, 2019). There was a belief that there was no one fixed understanding of the

phenomenon being studied, and it was expected to have multiple varied truths among the study participants and researchers who analyze the data (Scotland, 2012).

4.3 Study Design

Interpretive description (Thorne, 2016) was utilized for this secondary analysis study design. Interpretive description is a qualitative research approach designed with epistemological roots from within nursing science to provide practice-relevant knowledge for clinical nursing (Thompson Burdine et al., 2021; Thorne, 2016). It may also be appropriate to serve as the methodological guide for qualitative research in other applied disciplines, including but not limited to education, community development, human geography, and the health professions (Thompson Burdine et al., 2021; Thorne, 2016). This method was developed from the need for an applied qualitative approach that was able to address multifaceted questions arising from the applied disciplines while producing practical outcomes (Thorne, 2016). Using an inductive approach, the research was aimed at capturing the subjective experience of a population to generate meaningful knowledge about a phenomenon to inform practice-based disciplines, such as nursing (Thorne, 2016; Thorne et al., 2004).

Social sciences including anthropology, sociology, and psychology, generated the conventional social science methods we know today as ethnography, grounded theory, and phenomenology (Thorne, 2016). These qualitative research methods are grounded in theoretical and empirical curiosity rather than practical problems, meaning that it works well for social sciences, however, it creates challenges and tension with the applied disciplines for useable knowledge (Thorne, 2016). Conventional methods are unable to answer the pragmatic concerns of the practical disciplines, causing researchers to at times break traditional methodological rules (Thorne, 2016). Thorne (2016) states that interpretive description is not a “prescriptive,

circumscribed sequence of steps that will reliably lead to new discoveries" (p.38). Rather this method provides researchers with a non-categorical method that is not attached to the formal methodological traditions of the conventional social science methods (Thorne, 2016). Interpretive description allows the researcher to borrow techniques from conventional methods without taking along the complete theoretical methodology to generate meaning in qualitative nursing research.

Cherry picking and method slurring have been concerns of this approach (Thorne, 2016). However, Thorne developed this approach to have integrity within nursing research and to produce high-quality qualitative research that maintains epistemological underpinnings of the applied disciplines, regardless of which methodology traditions the research is conducted with (Thorne, 2016). It is amendable to various data collection and analysis processes so long as the researcher demonstrates philosophical coherence, and clear interior logic through every step of the design, and the research is conducted with integrity (Thorne, 2016). Interpretive description is a viable methodology that offers an accessible and theoretically flexible approach to analyzing qualitative data (Thompson Burdine et al., 2021; Wall et al., 2019).

Drawing on interpretive description qualitative methodology for the re-analysis of data allowed for a rich re-examination of the data with fresh eyes and questions. In the case of this secondary analysis, it offered a new understanding of how this particular group of NGNs understood and enacted socio-political agency. Interpretive and constructivist epistemologies frame reality as socially constructed and subjective, which allowed for the ability to re-interpret the data at a later period, which produced novel findings in the context of current social and political landscapes (Guba & Lincoln, 1994; Ruggiano & Perry, 2019; Thorne, 2016; Walters, 2009).

4.4 Sample

Given the secondary analysis design, convenience sampling was used (Polit & Beck, 2017). All eight interviews conducted in the primary study were included in this secondary analysis. The inclusion criteria of the primary study met the inclusion criteria for the secondary analysis, which included English speaking, graduated from a Nursing degree program in the Winter of 2020, and working in any healthcare setting in Ontario. All participants in the primary study were second-entry graduate nurses from multiple Ontario post-secondary institutions practicing in Ontario at the time of data collection.

4.5 Recruitment

Participant recruitment was not necessary given that this study was a secondary analysis. Please refer to the above section for recruitment strategies used in the primary study.

4.6 Data Collection

Given that the original study had a small sample size and all participants in the original study met the inclusion criteria for the secondary analysis, all eight interviews were used for the secondary analysis. The interview guide that was used in the original study was the same interview guide for this secondary analysis (Appendix E). All questions were included as participants referenced socio-political dimensions of their work and nursing practice in different aspects of their answers. As the interviews from the original study were already conducted, data collection for this secondary analysis had already occurred. The next section will focus on the data analysis strategies that were utilized for the secondary analysis.

4.6 Data Analysis

Participants' audio interviews were analyzed thematically in their entirety according to Braun and Clarke's (2006) thematic analysis, now termed reflexive thematic analysis (Braun &

Clarke, 2022). Thematic analysis refers to a process for encoding qualitative information to provide the researcher with a guide to develop themes fully grounded in qualitative philosophy (Boyatzis, 1998). Thematic analysis is not bound to a particular ontological or epistemological framework making it suitable for a range of epistemological approaches (Braun & Clarke, 2006). For this study, data analysis was guided by the theoretical work of Duchscher and White (Duchscher, 2008; White, 1995). Thematic analysis is amendable to this inquiry and is congruent when using a constructivist approach and the inductive analytical requirements of interpretation description (Braun & Clarke, 2006; Kiger & Varpio, 2020; Thorne 2016).

The initial definition of thematic analysis by Braun and Clarke (2006), state it is "a [qualitative analytic] method for identifying, analyzing and reporting patterns (themes) within data" (pg. 79). It is an approach that minimally organizes and describes the data set, going beyond this by offering various interpretation aspects of the identified patterns focused on the content of people's thoughts and feelings about the phenomenon under study (Braun & Clarke, 2006; Joffe, 2012). These perspectives shape how the data is interpreted, coded, and analyzed. To ensure reflexivity, the researcher must be clear on their philosophical assumptions during the research process, which for this study was identified early in the research process. The theoretical flexibility of thematic analysis does not mean that it is an atheoretical approach, rather it is an approach that can be located in any of the paradigmatic orientations, although the focus and outcome will be different for each orientation (Braun and Clarke, 2006). Thematic analysis is appropriate for researchers at all levels to understand experiences, thoughts, and behaviors throughout the data set (Braun & Clarke, 2012; Kiger & Varpio, 2020).

A code is a descriptive word or phrase that is assigned a meaning to the data related to the research focus, and a theme is constructed from the process of selecting codes to represent a

specific pattern from the data set illuminating the most important meanings to describe the phenomenon under study (Braun & Clarke, 2006; Joffe, 2012; Kiger & Varpio, 2020). The themes may be semantic (descriptive), for example directly observable in the data; or latent (interpretive), meaning the theme goes beyond what was explicitly said leaving space to reveal underlying assumptions and conceptualizations within the data (Braun & Clarke, 2006; Campbell et al., 2021). Considering both sematic and latent themes in the analysis has shown to be beneficial to the researcher despite previous assumptions that thematic analysis had to focus only on one type of theme (Braun & Clarke, 2006; Campbell et al., 2021). Both sematic and latent themes were used during data analysis.

This secondary analysis drew on an inductive approach to analyze the raw data which brought the most salient patterns of content in the interviews to light (Braun & Clarke, 2020; Joffe, 2012) as they related to the research question. To begin, the six phases of thematic analysis served as a guide during the analysis process (Braun & Clarke, 2006).

4.6.1 Six Phases of Thematic Analysis

The steps to engage in thematic analysis were not viewed as a linear or procedural approach to conducting analysis, but rather a recursive process (Braun & Clarke, 2022). Meaning at any time during data analysis, I was prompted to circle back to an earlier step for further investigation of new data or emerging themes. The following describes the phases of how data analysis was conducted in an attempt to answer the research question and objectives with the theoretical frameworks guiding data analysis.

First, I immersed myself with the entire data set by actively listening and taking notes about the audio-recorded interviews to familiarize myself with the data set and identify initial patterns (Braun & Clarke, 2006; 2022). Engaging with the audio-recorded data provided the

opportunity to listen to the voices of each participant, allowing a deeper understanding of meaning conveyed by each participants, which honors the spirit of qualitative research (Chandler et al., 2015). After I listened to and reviewed the interviews multiple times to become familiar with the data, an interpretive synthesis of each participant's interview was written and read together with my thesis supervisor. This prompted me to develop and label preliminary codes, using terms such as, but not limited to: *gaze is lifted, nursing school to Med-surg pipeline, institutional shortcomings, nurse martyrdom complex.* This phase allowed for comparison between the data and illuminated a deeper meaning to the phenomenon of interest. This was a fluid and organic process of collecting data relevant to semantic and/ or latent codes (Braun & Clarke, 2006; Campbell et al., 2021).

Initial codes were then examined and collated into potential themes generated from the data to provide a broader significance (Braun & Clarke, 2006). I consulted with my supervisor where we reviewed the emerging themes from the data, and I provided her with text and direct quotes asking for her interpretation to compare and contrast conceptualizations of themes to ensure trustworthiness of the analysis. After the meeting with my supervisor, I went back to the data to refine my initial themes. This non-linear process continued throughout the data analysis and involved periods of immersion, as well as periods of distance and reflection. It was at this stage where I had to purposefully think about how the narratives addressed my research question, while maintaining flexibility to the process regarding what themes were going to be kept, discarded, or modified for the final analysis (Braun & Clarke, 2006).

The fourth phase is described as a two-level analytical process (Braun & Clarke, 2006). The first level of analysis involved reviewing the coded data within each theme to ensure it is a rich theme and a proper fit. Then, the second level of analysis included going back to the data to

make sure the generated themes are reflective of the data set as a whole (Braun & Clarke, 2006). Concept mapping techniques such as drawing a concept map and color coding were used during this stage to identify patterns from the coded data (Braun & Clarke, 2006). Main themes were organized around the research question and objectives to which they pertained. Several concept maps were utilized and reviewed with my supervisor throughout data analysis. This process was a collective approach with ongoing support from my thesis supervisor.

During the fifth step, clear names for each theme were generated, along with a description of how and why the themes provided importance to the research question and objectives (Braun & Clarke, 2006). Writing the report and description of the findings was an integral and ongoing part of data analysis that started during the first phase (Braun & Clarke, 2006). The final stage of data analysis involved selecting compelling narrative data extracts that illustrate key features of the themes and their importance to the broader theme and relate to the research question (Braun & Clarke, 2006, 2012). In summary, data analysis proceeded in a collaborative manner with support from my thesis supervisor to ensure trustworthiness of the analysis. Findings were shared with members of my TAC to obtain further support and insight that is offered by the diverse range of expertise among TAC members.

4.7 Trustworthiness

Given that this thesis is a secondary analysis, claims to rigor and trustworthiness are not rooted in the personal, such as “I was there so I know” (Camfield, 2019, p. 607). Therefore, I analyzed the data alongside guidance from the primary researcher of the original study (my thesis supervisor), which added value and credibility to my analysis as the primary researcher was aware of how the raw data was generated. Thorne (2016) offers a framework to ensure trustworthiness in interpretive description which was used in this thesis. This framework

includes epistemological integrity, representative credibility, analytic logic, and interpretive authority (Thorne, 2016).

4.7.1 Epistemological Integrity

Epistemological integrity refers to a justifiable line of reasoning that conveys epistemological coherence throughout the entire study (Thorne, 2016). This was demonstrated through analytical decisions that aligned with the constructivist epistemological position in the study design. Using the constructivist lens, I was aware there were multiple realities and truths in the obtained data. Revealing any assumptions and personal biases that emerged throughout the analysis was acknowledged, documented, reflected upon, and discussed with my supervisor. Given I am a novice researcher, being supported by my supervisor who is well versed in the constructivist approach was instrumental in ensuring epistemological integrity.

4.7.2 Representative Credibility

Representative credibility refers to theoretical claims being consistent with the sampling strategy of the phenomenon under study (Thorne, 2016). Representative credibility is enhanced through "prolonged engagement with the phenomenon […] and some form of triangulation of data sources" (Thorne, 2016, pg. 234). Triangulation of data sources in this study occurred at three levels. First triangulation was achieved through the narrative data of the NGNs which contributed to the credibility of the study. Second, investigator triangulation was achieved during analysis by working alongside my thesis supervisor and two TAC members to offer a different analytic view to enhance representative credibility of the findings and for peer review (Farmer et al., 2006; Thorne, 2016). Third, triangulation occurred at a theoretical level where two theoretical frameworks were used together to view research findings- Duchscher's transition theory and White's socio-political way of knowing. In doing so, together it contributed to the

validity and completeness of the research findings (Duchscher, 2008; Farmer et al., 2006; Thorne, 2016; White, 1995).

4.7.3 Analytic Logic

Analytic logic refers to the researcher's explicit reasoning and decision making from the forestructure of the study (Thorne, 2016). An audit trail was maintained throughout the study to reflect this and detail how I made interpretations and knowledge claims about the data (Thorne, 2016). The audit trail was kept organized and visible throughout the study demonstrating critical reflection and comparative analysis of data to confirm and validate the findings and maintain the trustworthiness of the data (Thorne, 2016). This study also used verbatim descriptions from the data to illustrate context and ground the interpretive claims within the findings (Thorne, 2016).

4.7.4 Interpretive Authority

Finally, trustworthiness was maintained through interpretive authority, which respects that all knowledge is subjective and contextual (Thorne, 2016). During data analysis, I aimed to illustrate participants' statements fairly with the intention to reveal knowledge about the realities during their transition into nursing practice during the pandemic. Given the secondary analysis research design, the data findings were not cross-checked with participants. Therefore, I engaged in dialogue with my supervisor to have confidence in the findings, themes, and interpretation of data to prevent biased claims. I maintained a reflexive journal throughout the study and engaged in self-reflexive actions during the research process to make sense of the data by documenting personal opinions, thoughts, questions, and ideas that occurred throughout the research study (Braun & Clarke, 2022; Finlay, 2002).

4.8 Ethical Considerations

I obtained consent and permission from the principal researcher of the original study to use the data for this secondary analysis (Appendix F). The original research study was granted ethics approval from the University of Ottawa in 2021. Since this secondary analysis asks a new research question and is using qualitative data involving human subjects, ethics approval from the University was sought (Thorne, 2016) and garnered (Appendix G). Following ethics approval, I obtained access to the anonymized audio-recorded interviews to commence data analysis. The physical safeguards used to securely store the dataset included keeping physical data in a secured locked cabinet in the thesis supervisor's office. The technical safeguards that were used included passcode protecting digital documents and continuing to store the data on the University of Ottawa secure network for seven years as per the original study's ethics approval. As per Research Ethics Board (REB), I- the student researcher, will have access to the data until mid 2024. This will coincide with the completion of my thesis and then all my data will be safely destroyed by shredding the physical data and deleting all files used during the research study. As per the original study's REB certificate, the current data will be safely destroyed following the retention period in June of 2028 by deleting all files used during the research study – this will be done by the original researcher (Kim McMillan). No data identifying where participants worked was collected. Participants were assigned a unique study number (e.g., Participant 1 (P1), Participant 2 (P2), etc.) during the analysis of data, and their identities were not known to anyone outside of the original research team (my supervisor). Participants were able to withdraw from the original research study at any time with no repercussions. No participants withdrew their consent from the original study. Information that may identify a participant or their workplace was not utilized in any dissemination materials.

Chapter 5: Findings

5.1 Introduction to the Findings

This chapter presents the findings of the secondary analysis exploring how a particular sample of second-entry NGNs spoke about and enacted socio-political knowing during their transition into the nursing profession. It is of merit to define what is meant in this study by the term "enacted", as a reference to the term is made often. What is meant by "enacting" socio-political knowing in the context of this secondary analysis is being able to recognize, reflect upon, and in some instances, take action that demonstrates a meaningful understanding of the social and political dimensions that shape nursing and nurses' work and transition experiences into the nursing profession.

The original researcher interviewed eight participants who were available to answer the interview questions provided in Appendix E. Through the use of Braun and Clarke's (2006; 2022) thematic analysis, I re-analyzed the eight audio interviews from the original study. Duchscher's (2008) Transition Theory, and White's (1995) socio-political knowing, theoretically guided the analysis of the data and subsequently the findings presented in this chapter. The NGNs in this secondary analysis spoke to their transition experience entering the nursing profession in the context of a global pandemic. In exploring how these NGNs enacted socio-political knowing, three themes were illuminated: *School vs. Reality; Becoming a Nurse*; and *Critical Reflections*. This chapter will begin with an overview of the participants' demographics to help situate the reader within the findings.

5.2 Participant Demographics and Career Entry Points

All eight participants were second-entry NGNs, who graduated with a nursing degree from a university in Ontario in 2020 and were currently practicing nursing. Before enrolling in a

nursing program, each participant had previous life experiences which included completing a previous degree, and previous work experience relating to that previous degree. The majority of participants had one university degree before enrolling in nursing, with the exception of one participant having four university degrees. Two participants spoke about their past work experience, one participant had experience working in research studying healthcare systems specifically in long-term care settings, and the other had experience working as an allied health professional. Two participants took a year off after their first degree before applying to nursing school. At the time of the interviews, each participant had worked as an RN for under a year, and when asked to describe their current work environment, 6 of the 8 participants had two or more work environments to discuss. Participants in this study represented various hospital and community settings including the following inpatient services: trauma-neurosurgery, orthopedic rehabilitation, general medicine, labor and delivery, mental health, and community settings including public health, sexual health, and Covid-19 assessment centers. The participants worked with a range of populations: pediatrics, adolescents, adults, and geriatrics, in urban and rural settings. Lastly, two participants received the new graduate guarantee incentive program which consisted of three months of orientation funded by the government. Despite the variations among their career entry points, common threads were identified and will be discussed below.

5.3 Theme 1: School vs. Reality

A disconnect between nursing education and the reality of nursing practice was illustrated in the data as participants spoke to the ways in which schooling created a narrow understanding of nursing and associated nursing work (tasks). The nursing curriculum, as understood by participants, prepared students for the technical skills needed to work in acute care, lacking

engagement in critical discussions to develop skills to navigate the complexities of the nursing role and work environment.

During their transition, the latter is where participants identified struggling with the most. This was expressed in P1's interview when they stated they were not worried about perfecting all the hands-on nursing skills, as those would come with time and practice. The unsettled feeling was related to being underprepared to navigate the interpersonal and ethical situations that would arise in nursing practice:

> The skills, I wasn't super anxious about because I knew they would come. It was more of the interpersonal and psychosocial stuff, like dealing with these very complex, ethical situations… I think those are areas specifically in the psychosocial interpersonal relations would have been nice [to have received education about]. (P1)

P2 reflected on their education and spoke to missing out on learning and experiencing the actual work of what nurses do, such as navigating attitudes among co-nurses, residents, and doctors, and not experiencing what a good work environment and safe staffing ratios look like. Such social and political aspects of nursing practice were identified by participants as not being taught or discussed during nursing education and consolidation, which were virtual in response to the Covid-19 pandemic, creating fears for NGNs entering the nursing workforce. Navigating an unsupportive unit culture and advocating for self and patients were the tasks that participants discussed most often and struggled the most to navigate in their transition. The ability to reflect on these workplace complexities and acknowledge profound gaps in their education highlights their engagement with socio-political knowledge.

5.3.1 Empty Promises

Another disconnect between school and reality was revealed when participants spoke about the empty promises they were given. Due to Covid-19, participants spoke to specific

interruptions during schooling that widened their entry-to-practice knowledge gap and left them feeling underprepared to start their careers:

> I wish nursing school prepared people more realistically for what the profession is like. Our school knew that there was a gap… theory-practice gap. Which was pretty big during the pandemic, especially with how nursing staff were sometimes taken advantage of, underpaid, or redeployed to places that weren't safe. Yeah, I definitely wish that was addressed [in our training]. (P2)

With the pandemic affecting all but one participant's final consolidation placement, these students lost invaluable in-person training experience, and revealed feeling thrusted into the reality of nursing with limited support from their respected university to navigate the complexities of nursing work:

> The program is only two years, it's accelerated and the whole time it's advertised to you that you learn everything in consolidation… that's where you'll put it all together, that's where you'll learn everything, that's where you start to feel that stage of the identity formation, and you'll feel like a nurse. And then they [academic institutions] were like, turns out, you don't need that. You guys can just consolidate online. We did online simulations for three months, which was painfully boring, and they were not very realistic. It didn't really teach you time management or task management. (P5)

University staff reassured students that workplaces would understand and be able to provide additional support during their transition. In reality, this was not their experience:

> Towards the end of our [virtual] consolidation, we were talking with our course instructors…everyone was very stressed about starting work without a consolidation. And they were…no offense, but the academic institutions lying to students being like, oh, no, the institutions are aware that you didn't have a consolidation, you'll be very well supported. And I didn't feel like that was the case at all. (P5)

Participant 7 also reflected on how neither the school nor the workplace took accountability in addressing and remedying knowledge that was not acquired due to pandemic related interruptions to senior level nursing student education:

> I think the biggest thing to me is I just don't feel like it was acknowledged. I don't think it was handled very well, the communication amongst schools, to employers, and vice versa. I think the expectations were very murky. And I understand why it happened that way, because things were really crazy last year [2020], and I don't think anyone knew

> what to do. But you know, I remember when our consolidation was cancelled, we were very concerned. And a lot of students raised points to our faculty saying, like, we don't feel comfortable becoming nurses without this consolidation. And our faculty was very supportive and said, you know, your employers will understand this, they will extend orientations, because they recognize that you lost this. But that wasn't communicated to employers, I think it was the expectation that employers would just get it, or that we would have to advocate for ourselves for that. But employers didn't recognize that. And so, I think it was kind of taken advantage of. Well, we're desperate for nurses, we can't extend this any longer. So, you'll just have to figure it out on your own. (P7)

These empty promises were described as "a bit of a slap in the face" by P5. This participant felt disappointed and surprised by the actions of the academic institution and identified that it added to the stress of their transition experience.

In this study, seven of the eight participants began their nursing career in an acute care setting. Even if a participant entered nursing school wanting to work in a specific nursing specialty, many felt a sense of pressure during school to start their career in an acute care setting to gain the necessary skills of becoming a nurse before venturing into a specialized setting. P7 shared their experience of this by stating:

> The idea that you're consistently told in nursing school to be a real nurse you have to work in a hospital. […] Everyone would always tell me I have to work in a hospital for at least a year before I can consider going into public health because I won't have the right skills or I'm not a real nurse if I don't have that skill set to begin with.

Participants quickly became critical of this notion once they entered acute care settings and noticed how little support NGNs had in these particular environments. An example of this is when participants described their orientation as inadequate. During P5's transition, they were preceptored by a NGN and felt it did not provide enough support and mentorship in ways they needed during their entry to practice:

> When I was first hired, we had a new grad preceptor assigned to us. And my preceptor was not very experienced. She was barely at a year of experience. And it wasn't a very good fit. We were very different in terms of how much information I needed about things. She was kind of like whatever just get the job done… we don't really care about that when asking you about sterile things or best practices. She was just like, oh, I don't

> know, whatever. She didn't really give me answers that helped me understand how I was supposed to do my job.

Other participants were pulled off orientation early, advanced into leadership positions sooner than comfortable, and were re-deployed to other departments with little to no support from their management, senior leadership, or union during this period. Participants' orientation varied from as little as two hours at a community assessment unit to four to eight shifts in acute care units, with the longest orientation being twelve weeks (about three months) in a specialized acute care unit. After completing workplace orientation, five of the participants spoke of not feeling ready to enter independent nursing practice without the continued preceptorship of another nurse. Participants felt as though their orientation to the new job served as their missed final consolidation placement, as opposed to employee orientation:

> Yeah, so the way I look at it is we pretty much flew into nursing practice. Then that three-month orientation period, I almost considered my consolidation experience. (P1)

Two participants working in adult acute care took action by approaching their manager to negotiate for a longer orientation. These participants did not feel prepared to start solo practice (for the safety of their license and patients), demonstrating critical awareness that they can stand up for themselves and not settle for a work environment that does not meet their needs as a NGN. This demonstrates their ability to use their power as a professional RN to stand up for themselves even if it goes against the typical practice:

> They were set to only give me four shadow shifts before going solo and I asked for more because it just didn't quite make sense. Especially when the first two were kind of me not really getting the reins of the unit. That added to the stress, but I really needed to emphasize that I didn't feel safe, comfortable, and quite able to tackle the demands of the unit that I was on. (P4)

Another participant reflected on the way they advocated for more orientation:

> I sent them [management] an email and really highlighted the fact that during nursing school, my last year, I had missed five months' worth of clinical skill sets [due to the

> pandemic]. It had been eight months since I had even stepped into a hospital when I started my orientation. So, I still felt like a student, I didn't feel like I was comfortable. And I had said for the safety of the patients, I don't feel comfortable. (P7)

The solutions their managers presented were discouraging and unsupportive: one participant was granted two extra orientation shifts and the other was granted an extra two weeks - but ended up being pulled off those extra orientation shifts early due to staffing shortages. Participants believed nursing curriculum prepares students for a role in acute care without being transparent about the reality of nursing practice and the lack of supports in place for NGNs, and nurses. These NGNs quickly recognized the lack of support in these settings.

P1 was an exception to this, as they purposefully chose to begin their career in a pediatric setting instead of an adult acute care setting because of their knowledge of the adult and long-term care workplace structures. They believed the lack of management and organizational leadership places employees at a risk for psychological distress when working in those environments, for example, the high mortality seen in long-term care during the Covid-19 pandemic. P1 expressed that they knew these work environments were bad pre-pandemic, and Covid lifted the veil exposing the broken Canadian healthcare system that nurses were working in before the pandemic began:

> I knew [work environments in adult and geriatrics settings] were bad but Covid was really like the veil was lifted, there is nothing to hide, especially in Ontario knowing how low we are in nurse to patient ratios. Just in terms of burnout, staff retention, and everything like that, there is nothing to hide.

P1 spoke about how they envisioned their nursing career starting on an adult medical surgical unit because the needs are so prevalent but soon realized that pediatric hospitals also have great nursing needs. And because the societal value of caring for sick children appeared to be reflected in having more funding and better resources to support NGN transition, this participant began their career in pediatrics:

> I loved my pediatrics placement, so it was pretty much a no brainer to go into pediatrics. But it's just something I never had thought of before because I thought I would be more needed in these adults and long-term care, which is why I was going to start in adult's medical surgical, but the needs are just as big as they are in peds as they are in adults. The only thing is we get more funding, and we have more resources. And that's pretty clear to me.

The data illuminated various disconnects between school and the reality of nursing practice. When participants were asked how they could have been better supported in their entry to practice, three participants spoke about ways the nursing school curriculum could have prepared them more realistically for their transition and the role of a nurse. A documentation course was deemed necessary by three participants. P1 stated, “documentation was something I had to learn myself”, highlighting the need for this skill to be more accurately represented in their undergrad degree. P4 stated that in practice, they would refer to how other nurses chartered and laid out their progress notes because they were not taught this skill in school. In virtual consolidation, P6 stated they were not charting, and therefore did not learn documentation time management. Participants spent a lot of their work hours and after-hours ensuring their charting was written comprehensively and systematically without being too lengthy, yet, covering all the liability and accountability aspects (P1).

The second way nursing education could have better prepared these NGNs for their entry to practice is through a labor and union course. P2 described it as “actively harmful” to gloss over topics such as what unions are and how they exist, given that most nurses in Ontario belong to a union. This participant articulated that offering a labour and union class in the undergraduate curriculum provides opportunities to engage in discussion about the realities of current working conditions, how unsafe staff ratios and unsafe working conditions contribute to unsafe patient care and a lack of psychological safety for nurses, and how nurses can leverage available resources, such as relevant labour legislation and their positionality as a union member to

address workplace concerns. P2 further reflected stating that learning about labour laws, collective bargaining processes, and the importance of engaging in union activities introduces students to a side of nursing that is not consistently discussed in nursing school.

5.4 Theme 2: Becoming a Nurse

The second theme, *Becoming a Nurse,* was illuminated in the data through examples of these NGNs speaking to ways they engaged with and witnessed socio-political knowing during their entry to practice. Becoming an RN was viewed as a calculated career choice as participants spoke to their individualized experiences of intentionally and purposely choosing nursing as their new career. Motivation stemmed from the societal view and opinion that nursing is a well-respected profession and allows them to contribute to something bigger than themselves. The transferability of license (within and outside of Ontario, and flexibility to work in certain countries outside Canada) also drew participants into nursing. Many participants spoke to the nursing profession as being multifaceted, allowing them the opportunity to explore and work in different nursing specialties and among different populations:

> I really have interest in, honestly, quite a few areas, I feel like nursing is just so broad. And there's so much to try out. (P6)

As well as providing a blend between navigating medical complexities (biomedical) and more holistic aspects of nursing work:

> I came into nursing wanting to have both the medical and the psychosocial, just a more holistic way of approaching nursing. (P4)

Working for almost a year at the time of data collection, participants spoke to the highs and lows of entering nursing during the pandemic. Participants spoke to the social and political dimensions of nursing and how it impacted their transition into practice as NGNs. During the pandemic, participants spoke of feeling inspired to work alongside retired nurses who came back

into practice to help their community during times of uncertainty (P3). Another participant spoke with pride about the uniqueness of their work environment, and how the small hospital was able to provide medical care and "save the lives of people" who would not have typically sought care at a larger hospital during the pandemic out of fear of contracting Covid-19 (P2). Even though participant's spoke highly of the nursing profession, a deep self-awareness and critical insight was noted among all participants as they spoke to their experience navigating safety and unsafe work environments experienced as frontline providers during the pandemic.

5.4.1 What They Saw

As mentioned, the majority of these participants began their nursing career in bedside nursing on an acute medical surgical unit, where they experienced and witnessed the current state of healthcare firsthand. The most highlighted concern participants witnessed was the lack of respect the government has had for nurses' pre-pandemic (P7), which set the tone for the current work environments they saw as they entered practice. P1 and P7 highlighted that in Ontario, it was evident that adult and long-term care settings had non-existent leadership and support structures in place for staff, leading to poor staff retention and low nurse to patient ratios (P1). P1 identified these settings as being unacceptable work environments, especially for NGNs to start their career in. "It is not worth your license, and it's not worth the psychosocial distress that you're going into" (P1). P1 further elaborated:

> As many workers as [the government] can flood these places with, it doesn't make a difference unless you change the work environment, because [nurses] are not going to stay, you'll have all these people with all these [credentials], and they're not going to stay and they're not going to work.

The unacceptable work environments that were described led to participants identifying that several of the acute care units they started on were already understaffed pre-pandemic, which fostered an environment and unit culture steeped in burnout. The burnout that was already

experienced on the unit pre-pandemic compounded with Covid specific burnout was noted to be even more challenging as it created new demands for nurses. Participants stated this shaped their transition experience and made it difficult to adjust to the nursing profession. Participants spoke to working on units that were required to pull staff to other areas of the hospital leaving their home unit understaffed:

> [The unit was] very, very understaffed. It sounds like the baseline of their unit was already understaffed. And then the pandemic hit. And I think the hospital had thought that [this specific nursing specialty] was not as essential as some other units. So, one nurse a shift was getting pulled to the emergency room, and when you're already understaffed, and now you're very understaffed, it made for a very challenging work environment. (P7)

P5 elaborated that they witnessed a pattern of nurses being able to adapt to these new chaotic work environments. Further identifying that this demonstrates to the higher up stakeholders that nurses are able to adapt and manage in these new settings, despite increased reports of stress and burnout among staff, and the impact it has on patient care:

> I feel from what I've heard, this is kind of just a thing that happens in nursing. As soon as something happens and you [nurses] are able to manage okay, then that's just the norm. So, I think because… I mean we have been having more adverse outcomes and like more pressure injuries, more code whites, we've had like, a few code blues, and I didn't see any the first eight months that I worked there. So, something's happening. (P5)

Several other participants in this study spoke to the impact of working understaffed with increased levels of burnout, identifying that compromising patient care is not something they want to do:

> I don't want to compromise patient care, I don't want to make people feel that we [nurses] are incapable of doing things. But if there aren't structures that are put in place to help mediate that and alleviate that and just make it easier for all of us. I don't know. I want to be optimistic. I'm just a little concerned because you hear these reports of people striking and people leaving. Like we're already so short staffed. (P4)

P4 stated that structures need to change and the stakeholders who are in charge of hospital funding need to realize how important nurses are for healthcare. P5 echoed this assertion when

they identified that stakeholders who control the hospital budget did not increase funding to replace re-deployed nurses on the unit to ensure safe staffing ratios:

> The unit went through a bit of a transition in terms of supporting the ICU bed flow, and so the unit has a step down, and we've opened like a second step down, which pulled a nurse from the floor, and then the funding didn't allow for the nurse on the floor to be replaced. And so, we are working short, but we're not considered short anymore. All our patient assignments have just increased, and nothing about the population has changed. It's still the same amount of work for every patient. (P5)

These NGNs were critical of their workplace support and safety (lack thereof), but at times did not know about the resources that were available to them to accurately report what was occurring in practice. During orientation, P6 identified that they were never formally trained on how to file workload grievances, and what to do if there was an occupational hazard, further stating that they only learned what to do once it happened by nursing staff. P6 reflected:

> It is kind of intimidating to think that by the time I switched over to full time at [public health], I had been charge trained, and like, I had only learned these things a few months earlier. It's like, what if I was the most senior at the time, and I didn't know these things?

The positionality of these NGNs was such that they were susceptible to their respective unit culture, for example if on their unit there is a culture to advocate for self in ways other than documentation, they will learn how to do them. But if it is a culture to not, they will not get the opportunity to learn by watching and doing. Therefore, their unit culture dictated a lot of how they respond to the injustices they are seeing. P8 was the only participant in this study who spoke to witnessing and being a part of collective action among their unit as staff filed workload grievances each shift to protect their licenses. This collective action was not noted among other participants' experiences. P8's physical work environment was the most jarring, as they were staffing the new Covid overflow unit that was built to accommodate the growing needs during the pandemic. According to P8, the new unit was not up to code and was only allowed because it was during a state of emergency:

> It was very very isolating, especially because the unit was so big, and you couldn't hear anything either. Apparently, it's not even up to hospital code, it was only allowed because we were under a state of emergency. So, there was that problem as well. We had call bells that didn't work, all this other stuff. And it was kind of insane. Like so many times, I would call out of a room because I needed assistance with somebody and I would just be sitting at the door waiting because nobody was around because they were all dealing with literally the same thing.

P8 reflected on how the unsupportive work environment impacted the wellbeing of themselves, and colleagues, subsequently impacting patient care. These insightful reflections demonstrate engagement with socio-political knowing and agency during transition. Conversations were had with management about their concerns, but no leadership or action was taken by management to develop solutions, "the unit became everything management said it wasn't going to be. And that's where my issue started." (P8). Eventually the union became involved as there was an incident impacting patient care that occurred on the unit. The union representative expressed to the nursing staff that the only thing that would keep nurses safe and licenses protected was to continue filing workload grievances. P8 spoke to the importance of completing these grievances but felt that the reality was "you've [union] acknowledged the staffing positions are not safe, but you aren't doing anything". And with the chaos at work, they had to work outside of work hours to complete these workload grievances – identifying the invisible work of what nurses do and how that contributes to the burnout among nurses:

> One of the things that happened is that the union rep said because we were under a state of emergency and there was a redeployment order, the only thing that would really keep us safe and protect our license if anything further happened would have been doing the workload form. So that's why we were just submitting them all the time. It was kind of like a CYA [cover your ass] kind of thing, just because, like, you've acknowledged that these staffing positions are not safe, but you guys [employer and union] aren't doing anything. So, here's our workload form. And we're going to tell you why. So, it was basically a CYA thing…also it just adds to the stress because I'm doing my workload forms on my days off, I'm thinking about work when I don't want to be thinking about work. (P8)

These NGNs recognized that the current landscape of healthcare appears not to be getting better and in reality, only seems to be getting worse. Participants identified gender-based discrimination acts from the government; noting that they believed nursing was not a profession that was respected by the government, and this was intrinsically related to nursing being a female dominated profession, noting that other, more male-dominated front line providers (firefighting, policing, paramedicine) were not implicated by governments in the same way. Three participants (P1, P7, P8) spoke directly to Bill 124 without prompt, an Ontario bill whereby nurses' wages were capped at less than one per cent a year (breaching the ability of nursing unions to fairly bargain), describing it as "demoralizing" and stating "if you [government] have so much respect for us [nurses], pay us what we are worth. More than one per cent increase per year" (P8). P1 shared their view on how this law impacted their transition into nursing and acted as a catalyst for nurses and NGNs to leave the publicly funded healthcare systems:

> It's hard when you have these very difficult days, and you see things like Bill 124 being there. For the amount of distress I bring home some days, knowing that your wage isn't going to keep up with inflation it's very tempting to, you know, go back to school and leave the bedside. […] And it's unfortunate knowing that the government doesn't support you in the way that they should, compared to like other professions, when we've been the hardest hit almost, like, in a sense, with this pandemic. (P1)

P7 recognized that the majority of what they were witnessing in public discourse was focused on nursing wages, however, this participant offered additional critical reflection upon the (lack of) respect for the nursing profession:

> As somebody who just graduated nursing, it feels almost selfish to complain about my income, because like, it's the most money I've ever made in my life, like, how can I complain? So, to me, it wasn't necessarily about like, the yearly increases that we're [not] getting from the government, it was more so the fact that the government sees us so little, in comparison to firefighters and police officers, even though nurses have literally worked their tails off this past year. And that that wasn't being acknowledged, or even thought of. So, yeah, that was probably the sign that I knew it [nursing] wasn't a profession that was respected by the government.

At a societal level, participants spoke to the notion that society comprehends that nurses are strong, resilient, able to work in the harshest conditions, and can adapt to the demands of where they are needed (P4, P5, P7). Participants problematized these societal understandings, and to some extent, expectations of nursing as fostering the current landscape of nursing work that is seen today, in that nurses will adapt to their current environment and in doing so, nothing changes. During the time of data collection, participants did however witness collective nursing action; the coming together to raise concerns about Bill 124 and were also critical to question where support for the nursing profession was during these challenging times. P7 spoke in particular to the union's responses and their responsibility in advocating for the profession during the pandemic, and would have liked to witness a more active union and nursing association who were advocating and protecting their rights as a nurse:

> I think one of the most disheartening things about all those protests and stuff was that unions and nursing associations were nowhere to be found. And if you look at teachers, their unions are always fighting for them. And it didn't feel like that. And again, as a new grad, maybe it was just my experience, but I did not get that sense that my associations were fighting for my rights or protecting my rights as a nurse. Yeah, and so that's challenging in itself. […] I understand that, compared to teachers, our hands are a lot more tied, we aren't a profession that can strike. So, there's limited ability for them to fight for us. But I feel like there needs to be more communication of things that they are trying to actively fight for. Having that communicated to me would make me feel like I'm being respected and that they are doing things to try to make my job easier.

As a part-time employee (working full-time hours during onboarding orientation), P7 did not feel the union was supportive:

> It felt like as a nurse, I wasn't being supported even by the [nursing] college or union when they weren't able to advocate for [counseling and therapy] resources for new grads or part-time employees.

In contrast, one participant in this study began their nursing career at a non-unionized workplace. Although this participant did not put much weight into deciding to begin their career in a unionized or non-unionized position, they spoke to the non-unionized workplace as being an

“attractive place to work”. For example, offering health benefits and a comprehensive orientation, and they spoke to it being nice to not pay union dues. The non-unionized participant felt the environment was incredibly supportive throughout their transition experience and that it was because of the resources the hospital had they had not burned out yet.

Nurse attrition was witnessed by participants and impacted their transition into nursing practice. P4 spoke to a report by the RNAO regarding senior nurse attrition, which the participant described as “terrifying” because it is now typical for a “senior” nurse to have only two years of experience on a unit, whereas they view a senior nurse as having 15 years of experience on a unit or 20 years combined in nursing:

> There was this RNAO report that talked about senior nurses, like a good chunk of them were considering leaving after the pandemic, which is terrifying. So then, what does that mean? The most senior nurses, another nurse, another friend who's finishing consolidation right now is telling me one of the most senior nurses there has been there for what, two years, that's a senior nurse, that's a little funky. You know, what I mean, not to invalidate that person's two years of experience, but comparing that with someone who's been there 15 years or who's had 20 years combined on several units... That concerns me.

NGNs noticed that the hospital units were being staffed primarily by NGNs, lacking senior colleague support and mentorship. P8 spoke to their unit being staffed primarily by NGNs and P7 said their unit was half NGNs. P3 reflected on their experience in acute care and spoke about how their unit was staffed by young nurses, and despite the novice nurses being friendly and supportive; P3 acknowledged that it is scary knowing that senior nurses are leaving because it means junior staff will be working in areas where they will not get that mentorship or support from experienced nurses:

> That's just the circle of life in nursing. You need nurses who are experienced and know what they're doing to pass along that information down to the younger staff. It's gonna be hard for us to navigate and to truly build ourselves professionally if we don't have that.

Attrition also means that NGN had to fill leadership responsibilities that were above the scope of a NGN. P5 expressed how the nurse attrition impacted their transition into practice, and how they were placed in a preceptor role without formal training and without receiving a final consolidation for themselves. There was ultimately no space in acute care environments for other nurses to help NGNs in this new work environment because everyone was trying to stay afloat during their shift:

> I'm precepting a consolidation student right now because the staff, like the more experienced nurses, are all with new grads, or they're so like, burnt out from training new grads and training new people, because there's been a lot of turnover in the last year. Participants felt as though they were thrown into the nursing profession experiencing huge learning curve with no room to breathe.

NGNs expressed concerns with their current work life, for example, they described not getting breaks, consistently being offered overtime, and several had their vacation requests denied. P6's workplace would not let staff take any more than three consecutive days of vacation off in a row. NGNs were often left to navigate these situations alone because their units were understaffed and there was a lack of upper management support during this time. Out of the seven participants who worked in acute care, six reported they did not feel supported by their upper management, subsequently impacting their ability to effectively transition.

Through the above exemplars, participants demonstrated an acute awareness of the complexity of nursing, including the social, cultural, and political aspects of the profession. Conversations with participants illuminated what they saw during their entry to practice as well as what they did not see.

5.4.2 What Was Not Seen

Highlighting what was not seen during their entry to practice is important to note because this demonstrates a critical reflection of their work environment and their ability to identify what

is missing, and what they would have liked to see in fostering a supportive work environment. Among all participants, it was clear they did not see any changes or adaptions made to their orientation and onboarding process despite the situational interruptions to their final consolidation practicum. All participants spoke to wishing they had a longer and/or tailored orientation:

> I think a longer more comprehensive orientation would benefit a lot of nurses… it should be tailored to: what was your consolidation? Where are you coming from? What is your nursing background? If you've previously had experience? Then they [managers] can sort of tailor the orientation to how much experience you have and give you more or less training shifts and ask you how you're feeling at the end of orientation to see if you need more time or more support. (P3)

The New Graduate Guarantee Initiative was mentioned by all participants, wishing it was offered to more NGNs. Those who began their career in part-time positions wished it was inclusive to part-time employees as well:

> I would love it if the new nursing grad guarantee had also included people who wanted to be part time. Especially with a situation as spectacular as Covid, I don't think a lot of people want to have a full-time position as an option for them. (P4).

During the interviews, participants working in acute care were found comparing their transition experience to their friends who began their nursing career at a children's hospital. Participants in this study identified not having the same level of support from a systems level during their orientation. In this sample, it was illuminated that the children's hospitals referenced would treat NGNs as junior nurses for a set amount of time where they would not be asked to preceptor or train new staff:

> I know that they [children's hospital] have very rigorous new grad rules. I have a friend who started there, and she's saying, they are just barely allowed to have a full patient assignment. At this point, I think they have modified assignments for the first six months at least. They're kind of like junior [nurses], and they don't get students. They [new grads] are just supposed to focus on their own development. (P5)

This type of support was not reflected in P5's experience in adult acute care as they reflected:

> Whereas in my case, I have a consolidation student right now. I'm precepting a consolidation student because the more experienced nurses are all with new grads, or they're so burnt out from training new grads and new people because there's been a lot of turnover in the last year. So, I'm the next in line even though I barely know what I'm doing.

This participant was not provided with any formal preceptorship training on how to preceptor and received no information from the consolidation student's course leader. The participant questioned their role in acting as a preceptor for this student when they themselves did not have a final consolidation experience.

"Space to breathe" and decompress was highlighted as something not seen during their transition, resulting in internalizing of emotions:

> I don't have space to breathe […] so a lot of it [emotions] has been more internalized... Maybe [for] more of the veteran nurses, because they've been desensitized to the situation, it's just a typical day [for them]. […] But I've got to radical accept it. (P4)

P5 stated that management and spiritual care attempted to create a space for staff to go and decompress, however, it did not last a month until it was closed:

> Management and spiritual care opened a room on the floor as a place to go and spend some time, like a quiet room. And then after a week or two, they were like the room's closed. Please see us if you have any emotional issues. I don't know, it was very short lived and kind of superficial.

Several participants, including P6 spoke about how they would have benefited from facilitated debriefs and support sessions by their management or trained professionals:

> There is no shared safe space to just talk about things like I have seen in [public health, job #1] right now. And I feel we would probably benefit more from it here [mental health unit, job #2] because we do see a lot of traumatic things, and often it's pushed aside. We would have a debrief after a code white, but there's not much else. And we all kind of joke that, Oh I bet we all have PTSD [post-traumatic stress disorder] because of the things we've seen […] More debriefs would be good, also facilitated sessions from a manager or educator supporting the discussion. That stuff would be helpful I think. (P6)

Having clinical placements in different nursing settings provides students the opportunity to see what works well and what does not work in healthcare settings. An example of what P2 saw at a

previous clinical placement was Code Lavender. This participant spoke highly of the impact it has on staff and the value of accessible and in the moment therapy by a trained professional. They identified that perhaps not every staff member may like this of type service, but the option of having it available fosters a supportive environment for staff's mental health and wellbeing allowing staff the ability to pause and process what just occurred with a trained professional before going back to work:

> Code lavender was when they called their spiritual support person who was trained in providing counseling and it was all anonymous, and they would come up with tea, and you could just sit with them for a bit and sort of talk it out and decompress. It was a small thing, but it felt like more in the moment. It's nicer than waiting for a staff meeting in a week to discuss something or covering therapy out of your own pockets, or at least out of your allotted amount. It would be nice if that coverage was increased. I think post pandemic it really should be increased. That would be very nice. But yeah, sort of like an in the moment acknowledgement. (P2)

At the time of data collection, this participant was not aware of any in the moment therapy or therapy that the staff did not have to pay for out of pocket. The lack of mental health and wellness initiatives to support nurses and NGNs during the pandemic was recognized as fostering an unsupportive environment.

These participants recognized and reflected on the unit and system level shortcomings and the impact it has on NGNs' during their transition. The next section illustrates what they did to navigate challenges and perceived threats to their own wellbeing during their transition.

5.4.3 What They Did

Participants were aware of the collective burnout and psychological distress experienced by nurses and therefore took action to mitigate the tension experienced by senior and future NGNs. For example, P1 was a part of the nursing unit council on their unit where they focus on staff wellbeing and lifting morale on the unit through activities such as book clubs and themed events to build staff engagement and relationships on their unit. P2 identified a gap in their

workplace orientation that led to creating a project alongside management to improve the transition process for future NGNs at their community hospital. Other participants chose to mitigate the burnout and psychological distress by setting personal boundaries such as saying no to overtime and allowing themselves to fully recover between shifts:

> You have to put the brakes on and take time to recover. That's something that we had talked about in school… how it's important not to pick up over time and overdo yourself, especially as a new grad, because there's so much to learn and absorb. (P3)

Choosing to begin their career in a part-time role (P4) or 0.8 full-time equivalence (P1) were also identified as calculated choices participants made to protect themselves from the immense burnout and psychological distress that was evident in the profession. Despite the aforementioned actions, half of the participants in this study had already left their first nursing job (which happened to be in an adult acute care settings).

The decision to leave their first job was not made lightly and impacted participants on a personal level. Terms such as “leaving felt awful” and “felt guilty” were used by participants as they attributed their feelings to an internal belief that they were not a nurse if they could not stick out working in such difficult conditions. P7 reflected that despite feeling guilty, they viewed this act as encouraging to know they stood up for themselves. This level of self-assertion and confidence was noted among all participants when they recognized that their work environments did not foster the support they needed for their transition and wellbeing. After problematizing their work environment, participants began to look for nursing jobs that were more supportive and conducive to a healthier work-life balance:

> I switched [out of shift work] to trying to get back to some regular schedule hours because I felt like that was one thing affecting my mental health. (P6)

Not one participant considered leaving the nursing profession, instead, they were very clear in what they were looking for from future employers and workplace settings. One participant identified what they were looking for as green flags:

> I went to an interview with the specific health unit that I'm with now, and just really had a great interview. I had tons of green flags in the interview, and I just knew this seemed like a good place to work […] One thing that sold me on the job was they gave me my interview questions in a written format before I started. They told me that they'd be back in 20 minutes so I could collect my thoughts and answer the questions. So, to me specifically, as someone who has [an invisible disability], that was such an accessible thing for them to do when they didn't know that I had [an invisible disability]. I knew instantly that this seemed like a supportive environment. (P7)

Another participant spoke to their green flags as being socially aware by using gender neutral pronouns during their interviews:

> I had an interview for labor and delivery at a community hospital, and they were actually saying birth giving people. That really resonated with me because we're using that really progressive, wonderful language. (P8)

After actively searching for a new workplace, three of the participants (P3, P6, P7) left acute care to work in public health and the other participant (P8) was currently in the process of interviewing for a new workplace at the time of data collection. Public health was noted to have a supportive work environment, as P3 identified feeling well supported and ready to begin solo work by the time orientation was completed:

> To be quite honest, no [there is not anything more from public health that I would have liked in terms of orientation]. I felt fully supported. Even sometimes I felt like okay, I can get the ball rolling. We can get started. But they're like, no, no, no, we'll give you more time. I was ready to go before they even ended my orientation. (P3)

During the work days, participants illuminated that their new workplace in public health was fun, upbeat, and supportive among colleagues and management:

> My colleagues are really great. We have daily meetings with all the nurses and other people on the team as well that join in. And it's always fun and upbeat… And we're also in smaller teams where we have six of us with our personal supervisor. So that's nice to have too. We recently started doing support sessions so people feel more supported. So

> that's once a week. And generally, what happens is someone will share their story about some hardship they've been through, and then everyone's there to support and it gives that person a place to speak comfortably. So, it's a really fantastic team and I feel comfortable reaching out to them as well for questions. (P6)

Facilitated support sessions for those no longer working in acute care were frequently mentioned among these participants, along with having an open dialogue between management and team leads:

> I could always reach out to the specific mentor for case management, as well as my team lead and my manager. So, there were always at least three people that I could reach out to for questions. (P7)

Even with all the green flags of working in public health, P7 acknowledged that no job will be perfect. On a broader systems level, this participant stated that public health is reliant on funding from the government to have "all these amazing programs" and the lack of funding is frustrating when the programs cannot be run. Acknowledging the impact government funding has in all areas of the nursing profession demonstrates strong critical reflection and was a catalyst for one participant in this study to consider getting into politics. This will be further discussed in the next theme.

Navigating the pre-existing challenges of healthcare and nursing, participants reflected on what they saw, what they did not see, and their actions to protect themselves and advocate for change for the wellbeing of nurses and future NGNs. Socio-political knowing was demonstrated in the actions of these participants as they left unsupportive work environments, set personal boundaries, and became involved in change initiatives that sought to address these pressing issues. Early into participants' practice, it was evident these NGNs situated their nursing practice within the broader context of the social and political environments. Learning to become a nurse was noted to be overwhelming and even more so when one felt a disconnect between the image of nursing that was taught in nursing school and the realities they witnessed as they entered their

first nursing job. Participants began their nursing career having to advocate and negotiate for their safety, for the protection of their license, and the safety of their patients. These actions demonstrated ways each participant engaged with socio-political knowing during this first year of practice.

5.5 Theme 3: Critical Reflections

This theme was illuminated in the data set by actively listening to participants reflect on their transition experience between leaving their academic setting and entering their new organizational systems (nursing workplaces). Being older and having previous life experience prior to entering the nursing profession seemed to have fostered a strong sense of independence, self-awareness, and boundary setting that they mobilized to protect themselves against burnout and psychological distress that was seen by participants during their transition into nursing practice. Participant P5 illuminated this by stating:

> I feel like there's something when you have other experiences of living on your own, moving to a new place, having a new job, those kinds of things where you have to learn to be a little bit more independent and just figure things out.

In the academic setting, the majority of participants felt they were not presented with a realistic view of the work environment and role of a nurse before they entered the workforce, causing participants to describe their transition experience as stressful and overwhelming with emotions of nerves and jitters (P3). However, it was noted that the majority of participants spoke with a high level of insight whereby they acknowledged how their age and previous life experience acted as a buffer against transition shock and the healthcare stressors created by the pandemic. Being able to compartmentalize these feelings from their personal abilities and skills when entering a workplace in the middle of a global pandemic and ongoing Covid waves was a strength of these participants. P1 expressed that:

> Even if I do have a hard day, I'm able to come home and say, hey, you know what, like, that sucks, but it's not actually me. It's the system, and yeah, I don't think I would have had that insight and judgment had I been a brand new graduate in a four-year program.

These participants spoke to feeling the emotional toll of workplace burnout and stress, however, were readily able to acknowledge that it was not their own doing, but rather the workplace that was fostering the burnout and stress. It was evident these participants quickly acknowledged that employers, government, and the public must step up by respecting, valuing, and protecting nurses. These NGNs recognized that employers and the government need to provide greater support for mental health and wellbeing resources to prevent burnout among their workers. Participants identified that during their transition there was a lack of investment in these areas for NGNs during the early stages of the pandemic:

> Support for new grad nurses was put to the wayside because there are so many things to manage and handle [during the pandemic]. (P3)

This fostered a sink-or-swim experience during their transition (P2; P5). P8 also identified that the public must begin to step up and show their respect for nurses at the voting polls during provincial elections, as this was not seen in their opinion during the past election:

> I feel like the vast majority of the public does respect nurses, but then the same people who say they respect nurses will also vote for [a government that capped nurse's wages and interfered with their bargaining rights]. (P8)

P8 further reflected on the need for nurses to be properly represented at a political level because through their experience, they have witnessed how deeply intertwined nursing, healthcare, politics, and government are:

> We [nurses] need to be fairly compensated and fairly represented. I want to see more nurses go into politics, and I want to see more nurses be elected in local government. It's to the point where I'm kind of debating getting more involved in politics because this has affected me so much. I don't want a new grad to go through what I went through pandemic or not. (P8)

Such critical reflection demonstrated profound insight and acknowledgment of the diverse roles a nurse can have. It also speaks to the importance of collective action needed to let employers, governments, and the public know what nurses need. Advocating and speaking out about issues regarding nursing wages, proper training opportunities for NGNs, workplace conditions, patient safety, and mental health and wellbeing resources, in a larger platform is essential to create change to better the work environment and experience for future NGNs (pandemic or not).

A few participants also demonstrated critical reflection on their beliefs about the foundations of nursing and practice. P2 provided insight into what they were taught to believe in school, which was the notion that "nurses are educated with the mindset of having to save everything". This belief did not resonate with P2 as they further stated:

> The nurse martyrdom complex bothers me. That was the biggest thing transitioning during Covid that I wish nursing school stopped.

Fostering such ideals in nursing students created unrealistic expectations for NGNs when in practice, which contributes to the burnout that is currently being experienced. P7 spoke that collectively as a profession they are witnessing NGNs have a mindset that is *if this is not what I want then I am out:*

> I think it's good and bad to have this mindset. I think it's good because nurses have had a really tough go for at least a decade, from what I've heard from nurses. Sounds like this has been ongoing. I think it's only fair for nurses to realize that we are not martyrs and we are not here to serve this purpose, it's that we are human beings who are just doing a job… and that I'm not going to ruin my life because I signed up to be a nurse when I was 22 [years old]. I think it can also be negative because you can get a disinterest in the role and we are going to lose a lot of future nurses through that. I think a lot of NGNs won't put up with the situations they are put into and because of that, we will see a really high number of open nursing positions in the future. I've seen through social media that a lot of nursing students have left the program because they've seen what Covid has done, and they don't want to work in the field anymore, creating a really big challenge [for nursing and healthcare].

Understanding how this critical insight and boundary setting was garnered among participants was probed in the interviews, enabling participants to reflect and process how they acquired these traits. P7 articulated that being older allowed university professors to view the second-entry students more as peers, which they believed created the opportunity to talk about life experiences from situations outside of nursing which could then be applied to nursing which encouraged these critical reflections among students and peers. Other participants identified life experiences of advocating for themselves in previous careers and having an increased awareness of their own personal mental health and wellbeing which supported the creation and maintenance of boundaries that fostered mental health and wellbeing. Possessing a strong self-awareness in addition to maintaining personal and professional boundaries in their nursing practice was seen in this study as a political act, and serves to illuminate ways these NGNs engaged with socio-political knowing during their transition into practice.

5.6 Summary of Findings

While each participant has had their own unique experience transitioning into the nursing profession, the data shows that participants were collectively not afraid to leave an unsupportive work environment early on in their career, notably during their transition. This critical insight, awareness, and ability to leave their first nursing job, is understood in this study as having engaged with socio-political knowing and mobilized that knowing by not settling for unsupportive work environments. The need for urgent change in workplaces is illuminated in these findings as this cohort of NGNs has provided profound and meaningful reflections about the social and political dimensions that shape nursing and nursing work during their transition into the nursing practice.

Chapter 6: Discussion

The objective of this study was to undertake a secondary analysis of existing data to understand and communicate ways NGNs spoke about nursing during the Covid-19 pandemic, as well describe how second-entry NGNs understood and enacted socio-political knowing. The NGN participants clearly articulated their understanding of the role of nursing outside of the nurse-patient relationship and enacted what I believe to be socio-political knowing (as outlined by Duchscher and White) by analyzing, reflecting, and critiquing assumptions about the nursing profession, nursing practice, and political structures that shape nursing care (Duchscher, 2008; White, 1995).

Participants in this study were strategic in wanting to participate in the original research study. They spoke to wanting their voices heard and represented to raise awareness about areas they believe support is further needed during entry-to-practice and beyond. Based on the conceptualization of socio-political knowing for this secondary analysis, the act of engaging in this particular research study to have their voices heard can in and of itself be understood as enacting socio-political knowing. These NGNs allowed us, as researchers, to leverage their voices and contribute to the generation and dissemination of new knowledge on this cohort's transition experience. Nurse researchers have indicated a need for all nurses to engage with socio-political knowing for many years (Alhassan et al., 2020; Buck-McFadyen & MacDonnell, 2017; Florell, 2021; Mundie & Donelle, 2022), yet it remains an underdeveloped topic in the context of NGN transition experience.

The findings of the study, presented in *Chapter 5* sought to answer the research question: "How do secondary NGNs in Ontario understand and enact socio-political knowing during their transition into nursing practice during the Covid-19 pandemic?" Through the process of thematic

analysis, three themes emerged: '*School vs. Reality', 'Becoming a Nurse',* and *'Critical Reflections.'* The following section of this thesis provides a discussion of how these thematic findings are situated within current literature. Key points will include the academic institution's role in nursing knowledge development, NGNs transitioning outside of acute-care settings, and the role of preceptorship and mentorship in the transition experience. I will then discuss implications for nursing education, research, and the profession, followed by strengths and the limitations of the study. Lastly, I will articulate my knowledge translation plan and conclude with remarks about the importance of NGNs engaging with and enacting socio-political knowing to safeguard the nursing profession.

6.1 Academic Institution's Role in Nursing Knowledge

6.1.1 Curriculum

For decades, calls have been made by nurse researchers to integrate innovative educational strategies into nursing curriculum to develop educational preparedness among nursing students as it relates to the social and political dimensions of nursing (Alhassan et al., 2020; Boswell et al., 2005; MacDonnell & Buck-McFadyen, 2016; Rasheed et al., 2020). Incorporating these dimensions into nursing curriculum allows for socialization of student nurses in ways that allow students to gain increased political awareness, something which when absent, is currently cited as a barrier to enacting socio-political knowing (Alhassan et al., 2020; Vandenhouten et al., 2011). Participants in this study affirmed that the current structuring of nursing curriculum is problematic, describing it as a pipeline approach to work in acute care settings. Placing heavy focus on preparing students for acute care skills delivery fostered a lack of exposure to the other elements of nursing work, creating a narrow understanding and conceptualization of nursing (Buck-McFadyen & MacDonnell, 2017; Florell, 2021; Topola &

Miller, 2021; Wilson et al., 2020). More specifically, one participant identified it as being actively harmful to gloss over the political dimensions of nursing in the nursing curriculum because every nurse experiences the social and political dimensions of nursing practice, yet it is not predominantly discussed in nursing education.

Scholars critique nursing curriculum for placing a disproportionate emphasis on empirical knowing related to patient care (Clements & Averill, 2004; Fletcher, 2006; Mundie & Donelle, 2022; Topola & Miller, 2021). Empirical knowledge is quantifiable and factual knowledge that is systematically organized into general laws and theories for the purpose of explaining and predicting concepts related to the nursing discipline (Carper, 1978). Much emphasis of this pattern of knowing is placed in both historical and contemporary nursing literature and practice, such as through objective data collection and utilization (vital signs, laboratory values, and test results) (Carnago & Mast, 2015; Eisenhauer, 2015; Falk-Rafael, 2005; Snyder, 2014; Taylor, 2016). Although the foci of learning in nursing education centers on empirical knowledge acquisition, socializing students to nursing leadership, social issues, and policy issues is important and highly relevant nursing knowledge that should not be overlooked (Alhassan et al., 2020; Duchscher, 2000; Falk-Rafael, 2005; Salvage & White, 2019; Wilson et al., 2020; Taylor, 2016). Advancements of this way of knowing in nursing education (especially starting in undergraduate training) can lead to graduating more socially and politically conscious nurses which may better position nurses to fully engage with the social and political aspects of their work, and as such, engage meaningfully with the concept of socio-political knowing (Alhassan et al., 2020; McIntyre & McDonald, 2014).

6.1.2 Nurse Leaders and Educators

Along with the nursing curriculum, academic faculty (nurse leaders and educators) also play an integral role in socializing students to the other dimensions of nursing knowledge, including the socio-political contexts of nursing (Duncan et al., 2012; Rains & Barton-Kriese, 2001). It is important for nurse educators to be aligned with and have a shared vision in understanding their role and responsibility to graduate socially and politically aware nurses (Duncan et al., 2012). There are limited studies that examine how Canadian nursing educators understand activism and foster this type of knowing to their students (Buck-McFadyen & MacDonnell, 2017). There is significant variation in how activism and political topics are taught and supported across university programs, and there is little guidance for nurse educators to support student knowledge development when addressing the complex social issues (Buck-McFadyen & MacDonnell, 2017; Garland & Batty, 2021). Another reason why educators may not teach about social and political topics is fear of discussion and emotions (defensiveness) that might emerge during class without having the resources to engage in the topic at hand, and the potential of ramification of one's academic career (Valderama-Wallace & Apesoa-Varano, 2019).

6.1.3 Impact on Nursing Profession and Healthcare

Socializing students in socio-political ways which enables them to question and challenge their knowledge about social issues, laws, and health policy should be part of the nursing professions professional responsibilities and social mandate to strengthen the nursing profession and influence change at all levels and contexts of healthcare (Kirkham & Browne, 2006; Mundie & Donelle, 2022; Rains & Barton-Kriese, 2001). As evidenced in this study, NGNs were acutely aware of, and witness to, the social and political dimensions of nursing, even in their clinical

placements as students, but felt unprepared through formal nursing training to address these aspects of nursing work. The timing of recruitment and data collection may have an impact on the study's findings as these dimensions of nursing practice were in the forefront of public discourse during this time as the Covid-19 pandemic brought to light a variety of social and political dimensions of nursing work and healthcare delivery in general. Socializing nursing students to the social and political dimensions of nursing practice is necessary even during non-pandemic times because it exposes students and nurses to their roles outside of the direct nurse-patient relationship (Alhassan et al., 2020; Taylor, 2016; White, 1995).

Internationally and within Canada, there is a notable shift in the provision of healthcare, expanding services to primary and community care settings (Ashley, et al., 2018a). This approach is to meet the growing demands of the population as people are living longer with more complex comorbidities (World Health Organization, [WHO], 2022). Primary care is situated outside the traditional hospital setting and focuses on providing fiscally responsible access to primary care services, allowing for improved quality and appropriateness of care, focusing on prevention and management of chronic diseases, and lastly placing emphasis on patient engagement and self-management (Hutchison & Glazier, 2013). With the notable shift in healthcare, nursing organizations and academic institutions must recognize and answer the call to make changes to nursing curriculum to leverage awareness of the impact the nurse and collective action of nurses has on influencing the direction of healthcare within the Canadian context, notably *outside* of acute care environments. Nurses represent a large portion of healthcare workers and embody several qualities that foster leadership and political activism which include being excellent negotiators, communicators, problem solvers, and team players (Boswell et al., 2005; Des Jardin, 2001; Mundie & Donelle, 2022; Salvage & White, 2019; Wilson et al., 2020;

Taylor, 2016). As such, a critical shift in current teachings is necessary to leverage these skills in the context of socio-political knowing and in ways that expand beyond acute care.

Pre-pandemic, 65.3% of RNs in Ontario worked in a hospital setting (CIHI, 2022), however, there is no data to support what percentage of NGNs are represented in this number. Identifying where NGNs enter the profession, and where they work for the first few years of practice can allow for insight into this group of nurses allowing for interventions to best support their transition. It is often expected of NGNs to begin their nursing career on an acute care medical-surgical unit as a result of the way nursing curricula, clinical placements, and transition theories primarily focus on acute care nursing (Duchscher, 2008, 2012; Dyess & Sherman, 2009; Lukewich et al., 2023; Murray-Parahi et al., 2020). This narrative was evident in the study findings as 7 out of 8 participants began their career in an acute care medical-surgical unit. However, within less than a year, half of the participants had left their job in acute care after being exposed to the reality of the employment and workplace conditions, identifying it as a challenging and undesirable environment to transition into.

Participants in this study were critical of, and able to recognize when a work environment was unsafe and unsupportive. Instead of leaving the profession they transitioned into roles that were outside of the acute care settings. It should be noted that nursing education and nursing faculty cannot possibly prepare students with every skill they will need to practice across all settings, as NGNs enter nursing practice with a generalist education, with a knowledge base to provide safe and effective care (Herron, 2018). Therefore, perhaps recognizing this and preparing students emotionally and psychologically for what to expect during their transition, might aid in mitigating the experiences of reality shock during the NGNs transition in a wide variety of practice settings (Sterner et al., 2023). There is a plethora of literature surrounding

NGN transition into acute care, yet the current literature lacks experiences about NGNs transitioning into roles outside of this setting (Ashley et al., 2018a; Lukewich et al., 2023; Murray-Parahi et al., 2016; Murray-Parahi et al., 2020; Siemon et al., 2018; Tingleff & Gildberg, 2014; Vanderspank-Wright et al., 2020).

6.2 Transitioning Outside of Acute Care Settings

There is a current call for greater investments in primary healthcare to meet the needs of the aging population and prevalence of complex comorbidities (Ashley et al., 2018a; Bloomfield et al., 2018; Murray-Parahi et al., 2020; WHO, 2022). RNs have been shown to be an integral member of the primary healthcare team with recent systematic reviews identifying high patient satisfaction, improved clinical outcomes, and cost-effectiveness when engaging with RNs in this capacity (Lukewich, et al., 2022a; 2022b; Matthys et al., 2017; Parkinson & Parker, 2013). With the noticeable shifting of healthcare service provisions into the primary healthcare settings, the number of nurses, including NGNs, working in non-hospital settings is expected to grow (Ashley et al., 2018a; Murray-Parahi et al., 2020; Siemon et al., 2018).

As mentioned, the majority of NGNs in this study began their nursing career in acute care, however, within less than a year, five of these participants left to work in primary healthcare settings. Bloomfield et al., (2018), conducted a cross-sectional survey consisting of quantitative data of 350 nursing students in their final year of study at 14 Australian universities. The findings demonstrated that mature aged students were associated with a strong intention and desire to work in primary care settings ($p < 0.001$), and participants who indicated that employment conditions were more important were significantly more likely to suggest an interest to work in primary care (OR=1.44) (Bloomfield et al., 2018). It would have been interesting if the study was expanded to include the career entry points of the NGNs instead of only their

intentions because the findings of this current study illuminated that several of the NGNs had a clear vision for what nursing specialty they wanted to go into which often included public health, community care, and pediatrics. However, because of the general belief that NGNs should begin their nursing career in acute care, that is where the majority of the participants chose to start their career.

The literature indicates that primary care nursing is perceived by nurses and NGNs as unattractive compared to other nursing specialties such as emergency department and pediatrics (Ashley et al., 2018a; Birks et al., 2014; Bloomfield et al., 2018; Lukewich et al., 2023). An explanation for such might be because primary care is viewed as having poor remuneration, there is fear of losing nursing skills, and lastly it is perceived as a pre-retirement choice lacking the professional challenges of acute care (Ashley et al., 2018a; Ashley et al., 2018b; Bloomfield et al., 2018; Lukewich et al., 2023). These reasons pose a potential barrier for the recruitment of NGNs into primary care settings, however, the cohort of NGNs in this study did not vocalize primary care as being less attractive compared to acute care settings. One participant did identify fear of losing acute care nursing skills but articulated that they are learning several new skills in public health that they would not have learned in acute care. Bloomfield and colleagues (2018), identified that showcasing skills and responsibilities of primary and community healthcare nurses to NGNs may help dispel such perceptions that it is a less skilled nursing area. This has been echoed in the literature suggesting that there needs to be a greater focus of primary care clinical placements to socialize students to these nursing roles, as it is known early socialization, for example through clinical placements, impact where NGNs begin their nursing career (Lukewich et al., 2023; McKenna et al., 2010; Murray-Parahi et al., 2020). The experiences of

working in primary care that are deemed attractive by nurses include the acquisition of new skills, autonomy, and valuing a good work-life balance (Ashley et al., 2018b).

It was evident from the narratives of the participants in the study that valuing a career that offered a good work-life balance was an important factor for choosing primary or community care. Price et al., (2018), identified a similar finding when studying six nursing students transitioning into the nursing profession after a four year nursing program, articulating that "participants described balance as imperative to career satisfaction and happiness in their personal life" (Price et al., 2018, pg.89). Participants were described as being active decision makers as it relates to employment options and were articulate about why they made the decisions they did to ensure a positive balance in their work and personal life (Price et al., 2018). This was a similar finding in this current study, which identifies that even pre-pandemic NGNs were self-aware and engaged in actions to protect themselves from exhaustion, increased workload demands and burnout (Price et al., 2018).

In Canada, nurses do not typically need special training or certification to work in primary or community care settings (Lukewich et al., 2023). The current study indicated that the learning needs during their transition into primary care were different compared to their transition into acute care. For example, participants highlighted certain tasks they were not socialized to during their undergraduate degree such as completing risk assessment for the purpose of contact tracing, knowledge about certain diagnoses and diseases that are more seen in the community settings, working with different computer databases, and working closely with interdisciplinary team members that are located outside the typical inpatient hospital setting (such as police). Despite these new learning needs, participants who transitioned outside of acute

care felt as though they were able to manage and tackle the challenges at hand with the support of their colleagues and management.

Literature describes transitioning into primary care settings with similar challenges that are identified in the transition into acute care. For example, personal factors included searching for a sense of belongingness in the work environment, feeling isolated and overwhelmed, and professional factors included issues with organizational knowledge and workplace familiarization, learning new technology, and unclear role expectations (Ashley et al., 2018a; Joseph et al., 2022). Less reported were workload concerns and fears regarding safety issues (Ashley et al., 2018a). The phenomenon of reality shock has been acknowledged for decades, and in later years Duchscher, (2008) built upon Kramer's (1974) work by developing a transition theory where she coined *transition shock* as the initial stage of role adaptation among NGNs. The main implications of these two pieces of research include that the ability for a NGN to transition from student to RN takes time (Duchscher, 2008; Kramer, 1974; Masso et al., 2022). Although participants in this study identified similar overarching difficulties in transitioning such as adjusting to the new work environment, participants in the non-acute care settings identified having time to be a novice nurse and become comfortable in their solo practice as a RNs. Narratives of participants in non-acute care settings included feeling well supported during orientation by colleagues and management, and one participant identified feeling ready for solo practice even before orientation was completed. Participants who transitioned into non-acute care settings were not being forced off orientation, nor were they thrust into leadership roles beyond their comfort level. This could be a reason for why these NGNs did not feel an overwhelming sense of reality shock or transition shock when transitioning into these non-acute care settings.

Thus, begging the question: Is it that NGN are not adequately prepared for their new role or is it that workplaces are not always ready to support the NGN in their new role (Masso et al., 2022).

6.3 Preceptorship and Mentoring

Discussions about preceptorship and mentorship within participants' workplaces also emerged in the data. In Duchscher's (2008) transition theory, the concepts of preceptorship and mentorship are used frequently throughout each stage of transition suggesting that preceptors and mentors act as socializing agents to assist the NGN in their new role as a professional nurse (Duchscher, 2012; Lalonde & McGillis Hall, 2017). Duchscher (2012) differentiates preceptorship and mentorship by stating mentorship is "a relationship between a novice and experienced practitioner and is intended to provide encouragement as well as support to the mentee, while simultaneously offering job satisfaction and fulfillment to the mentee" (Duchscher, 2012, pg. 189). This reciprocal collaborative learning process is noted to form a bond between the mentor and mentee creating a relationship that is expected to grow beyond the initial stage of formal mentorship (Duchscher, 2012; Gehrs et al., 2017). Preceptorship is described as "a practical or clinical support person who can orientate you [the NGN] to the routines, responsibilities, skills and procedures related to your work area" (Duchscher, 2012, pg. 189). In practice, preceptors and mentors may be the same person (Duchscher, 2012), but for the purpose of the discussion, these two terms will be discussed separately.

6.3.1 Preceptorship

A preceptor is usually an experienced nurse working in the practice area to which the NGN is transitioning into (Duchscher, 2012). According to Benner (1984), in the early stages of preceptorship, much time is spent on aspects of recognition, for example distinguishing between breath sounds and assistance with prioritization. Over time, the NGN begins to learn and perform

skills under the eyes and skills of their preceptor cultivating a sense of teamwork and building a sense of belonging (Duchscher, 2008). An ideal preceptorship includes the NGN working together with an assigned preceptor for a specified duration of time to assist the NGN in adjusting to their new role, performing tasks, gaining basic level of knowledge and skills, as well as adapting to the profession both socially and professionally (CNA, 2004). Preceptors play an important role in the socialization of new employees, and if successful, it can affect long term outcomes of the NGN (Lalonde & McGillis Hall, 2017; Saks et al., 2007). Conversely, Lalonde and McGillis Hall, (2016), identified that when the preceptor was under-prepared for their role and were unable to provide support in the ways that are required by the NGN, there was an increase in turnover reported. For this reason, the initial transition experience into the work environment is imperative for the retention of the new employee in the workforce and profession (Hallaran et al., 2023).

Differences between general orientations in hospitals and outpatient clinics, and larger agencies and smaller clinics were identified in a scoping review by Pasila and colleagues (2017). Therefore, for the purpose of this discussion, there is awareness that not all experiences of the NGNs are uniform, and were likely not all captured in this current study. Additionally, the realities of transitioning into these settings may have changed as a result of the pandemic. The pandemic created new challenges for preceptors and NGNs, for example, NGNs were not only worrying about mastering tasks (Frögéli et al., 2019), their fears expanded to include worrying about contracting Covid-19 and the consequence of infecting family and friends (González-Gil et al., 2021). Coupled with new workplace challenges of social distancing, increased nurse attrition, and the chaos and confusion during the beginning of the pandemic, made it challenging for NGNs to maintain a constant preceptor (Blanco et al., 2023; CFNU, 2022; RNAO, 2022b).

Pre-pandemic, Hallaran and colleagues (2023) collected survey data assessing the transition experience of NGNs (N= 217) in the province of Ontario, Canada. Open-ended questions were included to assess the facilitators and barriers of their transition experience into nursing practice. Through the use of thematic analysis, four barriers to transition into practice were identified (feeling unprepared; discouraging realities and unsupportive cultures; lacking confidence/feeling unsure; false hope). Expanding upon the theme of discouraging realities, it captured the experienced realities of having preceptors who were reported as "unsupportive, difficult to work with, and/or unapproachable" (Hallaran et al., 2023, pg. 130). Having a preceptor who was experiencing burnout was difficult for NGN, as burnout often leads to not being interested in teaching and being less passionate about the job (Hallaran et al., 2023), which inhibits the NGN from experiencing what a healthy preceptor-student or mentor-mentee relationship resembles. The increases in burnout and nursing shortages that was noted from the pandemic reinforces the need to prioritize retention strategies (Hallaran et al., 2023). The study also identified that several respondents wrote comments thanking the researcher for conducting the study and were eager to voice their feedback about their transition experience (Hallaran et al., 2023). This was a similar finding in the current study, demonstrating that based on the conceptualization of socio-political knowing in this study, NGNs are enacting socio-political knowing by engaging in research to have their voices heard.

Limited knowledge about second-entry NGNs and how they differ from traditional four-year program NGNs has been underpinned throughout the study, and again here, in relation to the dearth of literature on second-entry NGN transition. A mixed-methods study conducted in Sweden explored the transition of newly employed hospital nurses (n= 240-248) with less than four months of work experience (Sterner et al., 2023). These NGNs were obligated to attend a

one-year transition program, and through completion of questionnaires, the researchers investigated the perception or their preparedness, perceived challenges, and expectations of a transition program into the hospital setting (Sterner et al., 2023). The NGNs were stated to have completed a three-year nursing program, but none of the participants were identified as second-entry or known to have held a previous degree. The researchers did however, collect data on the age of the NGNs, with the median age being 27 (21-53) (Sterner et al., 2023). It was found that NGNs with an older age more consistently perceived the importance of support and a preceptorship program during a transitional stage, which might be explained by previous life and work experience (Sterner et al., 2023).

Preceptorship is often for a specific duration (CNA, 2004), and once the preceptee has been orientated to the work area, the preceptorship relationship has the opportunity to transition into a mentoring relationship (Duchscher, 2012). This next section will discuss the importance of mentorship and the influence that intrinsic generational traits have on enacting socio-political knowing.

6.3.2 Mentoring Within the Intergenerational Workforce

A Canadian scoping review referred to mentorship as a process that supports NGNs (mentees) as they enter the professional landscape with the support and enablement of an experienced nurse (Venkatesa Perumal & Singh, 2022). Mentorship can be an informal or formal relationship that supports NGNs by providing ongoing professional socialization and career development as well as maintaining a positive outlook during their transition and in turn, fosters retention of NGN in the workplace and profession (Price et al., 2018). Forming relationships with nurse mentors and peers that share similar ideas and model good nursing practice were found to be helpful in socializing NGNs to the nursing profession and career development (Price

et al., 2018). The nursing workforce today is made up of four different generations (Baby Boomers; Generation X; Generation Y; and Generation Z) (Statistics Canada, 2022a), where each generation brings a new perspective into nursing practice and the current workforce. A generation cohort is described as a group of individuals who share similar life stages and common exposures to formative events (political shifts, war, disaster) (Rudolph et al., 2021). Although the assumed characteristics of these generations are not homogenous, literature does describe individuals of each cohort to share common characteristics such as their work ethic and style (Buck-McFadyen & MacDonnell, 2017; Hart, 2006; MacDonnell & Buck-McFadyen, 2016; Price et al., 2018; Rudolph et al., 2021; Tan & Chin, 2023).

Baby Boomers, born between 1946 and 1965 and Generation X, born between 1965-1980 (Statistics Canada, 2022a), is suggested in the literature to embody a lesser need to challenge workplace norms (Tan et al., 2023), which makes some nurses in this generation cohort fearful of "losing our [nursing] core" (Buck-McFadyen & MacDonnell, 2017, pg.4) amidst the changing landscape of healthcare provision. A nurse educator in Ontario, Canada, identified the importance of advocating for the nursing profession, or else the changing of landscape will serve to narrow the role of a nurse to achieve efficiencies, for example, physician assistants pulling things away from the role of the RN, and replacement of RNs by Registered Practical Nurses (RPNs) for cheaper labour (Buck-McFadyen & MacDonnell, 2017). For these reasons, mentors are needed in formal and informal mentoring roles to foster political socialization and inspire political action among students and NGNs (Buck-McFadyen & MacDonnell, 2017; Snyder, 2014). If mentors value and practice within a critical paradigm, they are positioned well to engage their mentees in a meaningful discourse about this concept (Snyder, 2014). Mentorship is said to foster a collaborative and reciprocal learning relationship (Caine et al., 2016; Gehrs et al.,

2017), which allows mentors to benefit from having their wisdom and experience validated and recognized, as well as gain valuable communication and leadership skills (Burgess et al., 2018; Eller et al., 2014).

A work trait that was identified about Generation Y (Millennials), born between 1981 and 1996 (Statistics Canada, 2022a), was the importance of technology, a healthy work-life balance, and prioritizing mentorship opportunities (Hart, 2006; Price et al., 2018), which was supported in the current findings. Generation Z (Zoomers), born between 1997 and 2012 (Statistics Canada, 2022a), are also a part of the intergenerational nursing workforce that is critical in shaping the future of the nursing profession. Tan and colleagues (2023) concluded that the younger generations are willing to take responsibility to shape the profession through work values of power (being in control and to be in command of their tasks), leadership opportunities, and guidance through mentorship experience from the older generations. Considering generational traits and values of nurses and NGNs is a significant consideration when assessing facilitators and barriers during transition into nursing practice. Despite younger generations valuing a balance between work and personal life, there remains a drive for power and nursing leadership (Tan & Chin, 2023), which are traits that align with socio-political knowing.

Expanding upon traditional notions of formal mentorship, some scholars suggest it as a triad involving the mentor, mentee, and the organization (Hunsberger et al., 2013). Organization, in this context include hospitals and other nursing work environments, universities, and regulatory bodies, who play an important role in fostering successful mentorship and are considered to be an essential stakeholder in professional and personal development (Burgess et al., 2018). Therefore, deliberate actions are needed for the implementation and evaluation of mentorship work at the system and organizational level.

6.3.3 Organizations' Response(ability)

The transition between being a student and being a professional in a workforce is challenging for NGNs, and this period of transition could be regarded as a grey zone in which the responsibility for mentorship and knowledge opportunities for NGN are blurred. Preceptorship programs are implemented to formally address the challenges faced by NGNs (Lalonde & McGillis Hall, 2016). Organizations with strong mentorship programs are suggested to have increased rates of retention and decreased rates of attrition, (Zhang et al., 2019), and enhanced recruitment, retention of corporate knowledge, and develops nurse leaders who contribute to the mission and vision of the organization (RNAO, n.d.). Preceptorship and formal mentorship programs are also one of the ways the government and nursing organizations can strengthen their commitment to the nursing profession by investing and supporting NGNs. This section will discuss the actions RNAO and ONA has taken to improve mentorship within the organizations, as well as discuss further action needed to strengthen mentorship in the workplace.

During the pandemic, burnout and poor mental health rates were at an all-time high (Akoo et al., 2023; CFNU, 2022), and work conditions such as chronic staffing shortages and unsafe working conditions are to blame (CFNU, 2022). Participants witnessed collective burnout among experienced nurses, which they believed was in part due to experienced nurses consistently preceptoring students, NGNs, and new hires due to the high level of turnover on units. This was echoed in the RNAO's Nursing Through Crisis: A Comparative Analysis report, when a survey respondent stated "I feel no one in the health organization I work for cares about patients or staff. There is not enough senior staff for all the incoming international and junior nurses" (RNAO, 2022b, pg. 77). NGNs in the RNAO survey identified a need for better access to mentorship and preceptorship opportunities during their transition into practice, and reported an

intention to leave the profession if workplace supports are not in place (RNAO, 2022b). In the concluding statement, it stated “RNAO strongly advocates for supporting nurses through their career by expanding the Nursing Graduate Guarantee" (RNAO, 2022b, pg. 77), something participants in this study also believed would have better supported their transition.

As of late, RNAO resumed their mentorship program that was established in 2019 to provide Ontario’s nurses with the support and opportunity to interact and network with peers and experienced mentors to foster quality relationships (RNAO, 2023b). As well, the association states they are collaboratively advocating for the nursing profession with the government and employers to identify ways to support NGNs in response to their disrupted learning exacerbated by the pandemic (RNAO, 2023a, 2023b). One example includes calls for the expansion of the Nursing Graduate Guarantee to ensure access for all NGNs in recent policy documents, political action bulletins, and provincial election platforms (RNAO, 2023b). Another professional association in Ontario for nurses is ONA, which is the trade union that represents the majority of RNs throughout Ontario. Recently, the union was successfully in bargaining to have the mentorship premium increased from sixty cents per hour to two dollars per hour (ONA, 2023). The increase in premium is one of many strategies to enhance mentorship, and serves to acknowledge the invisibility of nurses’ work, knowledge, skills, and expertise that the mentors are bringing into the mentor-mentee relationship (McCormack, 2014).

Although the recognition in mentorship pay and calls being made to expand mentorship opportunities is important, continued leadership and advocacy for stronger mentorship in the work environment needs to become a priority. Current cited barriers to mentorship in the work environment include widespread burnout and poor mental health of nurses (Akoo et al., 2023; CFNU, 2022), therefore further action and responsibility is needed from the system and

organization level to bolster mentorship in the workplace by tackling these pressing issues (widespread burnout and poor nurse mental health). Additionally, current structures of organizational transition support and mentorship programs have been criticized in the literature as acting as a limitation for NGNs to transition into primary care as majority of the programs available to NGNs are focused in acute care not primary care settings (Bloomfield et al., 2018). This highlights another area of further action needed to examine the effectiveness of a preceptorship model for NGNs in non-acute care settings.

6.4 Implications for Education, Research, and Practice

The findings from this study led to several implications for nursing education, research, and practice.

6.4.1 Implications for Education

The participants in this study demonstrated considerable insight into nursing education. Throughout the interviews, participants shared they would welcome the opportunity to have nursing education include a greater focus on the social and political aspects of nursing practice. Nurses who engage in socio-political knowing strive to foster better work conditions for themselves and their colleagues through a variety of ways (calling out toxic workplaces, demanding adequate supports), and doing so also ultimately contribute to safer patient care (Buck-McFadyen & MacDonnell, 2017; MacDonnell & Buck-McFadyen, 2016; White, 1995). It is imperative for nursing education to be consistent in fostering perceived influence and leadership abilities within nursing and healthcare, as the profession cannot afford to graduate individuals who do not identify as leaders. This could be actualized, for example, by having regulatory bodies and accreditation standards to start mandating academic institutions to have social and political knowing standards.

Nursing competencies are the foundation for nursing practice to ensure the curriculum prepares graduates for their entry to practice (CNO, 2019a). Currently it is cited that nursing knowledge often lacks critical engagement with the socio-political knowing (Buck-McFadyen & MacDonnell, 2017; Florell, 2021; Madsen, 2008; Mundie & Donelle, 2022), and the CNO entry-level competencies were noted in the literature review (chapter 3) to use weak language when discussing social and political aspects of nursing practice (CNO, 2019a). In order for nurses to be socialized to this particular way of knowing, re-evaluating the competencies to better support socio-political knowing within the documents is necessary because socio-political knowing directly supports the CNOs mandate, which is to protect the public (CNO, 2019a). It would also be prudent for accrediting bodies such as CASN and CNO to implement this concept into the standardization and accreditation of nursing school education. It would then help safeguard the integration of socio-political knowing into curriculum nationally, while also offering structure and guidance for professors on the integration of such material.

6.4.2 Implications for Research

Most reviewed studies and guiding practice documents situate the current scholarly understandings of "knowing" in new graduates within the nurse-patient relationship centered around empirical knowing and skill formation (CASN, 2020; CNO, 2019a; Falk-Rafael, 2005; Frögéli et al., 2019), thus often lacking critical discussion about the social and political dimensions of nursing and healthcare (Buck-McFadyen & MacDonnell, 2017; Falk-Rafael, 2005; Snyder, 2014). Although nurses are well positioned to engage in leadership in their day to day practice and advance into formal leadership positions to address healthcare challenges (Snyder, 2014), the reality is that current nursing knowledge acquisition in undergraduate curriculum does not prepare NGNs for such work. The dominant academic to acute-care pipeline

approach cultivates NGNs to begin their career in traditional acute-care bedside positions, which fosters a narrow view and understanding of the nursing profession. This is detrimental to fostering a robust understanding of the array of available nursing experiences and capacities. In order to diminish such gap in understanding, researchers have begun to (re)consider nursing knowledge to include a shift in perspective outside of the nurse-patient relationship and focus on the broader dimensions of nurses' work and knowledge. It was interesting to note that in the findings participants highlighted problems within the broader context of the current healthcare system, but curiously did not speak in depth to any historical or high level structural reasons for these problems. Future research could therefore examine where NGNs situate the root of the current problems plaguing the healthcare system.

Nursing research is inherently dynamic and evolving (Thorne, 2016), therefore, there is considerable opportunity for researchers to engage with inquiry to better understand how NGNs engage in socio-political knowing during their transition into nursing practice. An example of future inquiry might include studying a larger sample of NGNs to see if they continue to demonstrate awareness and engagement with socio-political knowing post-pandemic. Building upon this, one could explore if there is a difference in how second-entry and traditional four-year program nurse graduates engage or do not engage with socio-political knowing into and beyond their transition to practice. Perhaps future research may examine if the younger generational cohort of nursing students and NGNs intrinsically embody the traits of socio-political knowing despite not being formally socialized to the topic in nursing education.

A barrier to implementing socio-political knowing into nursing education was the fact that nursing professors and clinical instructors did not have standardized teaching material or formal training on this topic (Buck-McFadyen & MacDonnell, 2017; Garland & Batty, 202; Valderama-

Wallace & Apesoa-Varano, 2019). Therefore, this particular study serves as a point of departure for future research that could seek to identify the needs of educators as it pertains to the integration of social and political knowledge within undergraduate nursing course work in hopes to translate this knowledge to students and future NGNs they might mentor. Lastly, looking at the topic of socio-political knowing from a critical feminist lens would provide another novel and relatively unexplored area of inquiry as a way to critically understand the influence gender has on the social and political dimensions of the profession, in particular NGN transition.

6.4.3 Implications for Practice

This study has revealed that NGNs are aware of and deeply attuned to their workplace structures and the influence the work environment has on their well-being. Current research and reports have noted the realities of current working conditions which include increased levels of collective burnout, and the need for greater emphasis on providing a (psychologically) safe working environment to encourage the retention of nurses (RNAO, 2022b). Organizations must begin to prioritize psychological safety and mental health among nurses, which was reinforced in participant's narratives throughout this current study, revealing that they will not settle for current nursing environments that do not support this. A particular evidence-based support tool that organizations could implement in their workplace includes a crisis intervention tool called Code Lavender, which is available to support hospital staff after they experienced a stressful event or series of stressful events (Stone, 2018). Although Code Lavender is not shown to prevent burnout or stress, it uses relaxation and restoration interventions to meet the immediate mental health needs of an individual, akin to psychological first aid (Stone, 2018). This crisis intervention tool was mentioned by a participant who had exposure to this during their clinical rotation as a student. Identifying the practicality and wider applicability of Code Lavender in

nursing practice could serve as a beneficial tool for healthcare workers working within the current healthcare system.

Healthcare is an extension of government, therefore, there is a need for nurses to have the profession's voice heard and respected in higher levels of decision making and leadership roles that may sit outside of healthcare organizations (for example, at various levels of government). When planning for future pandemics, nurses' voices should be included as they offer valuable insight into where support is needed to ensure a strong and healthy work environment, even through crisis (Gamble et al., 2022). Recently, the position of a federal Chief Nursing Officer's (CNO) role was reinstated, which adds a national nursing voice to conversations pertaining to Canada's healthcare system (CNA, 2022b; Government of Canada, 2022). This was significant for the nursing profession, as Canada's first CNO was appointed in 1968, and was eliminated in 2012 at a time when the "government was realigning resources across priorities" (Government of Canada, 2022, para. 5). The position was created for a period of two years, with the possibility of extension (Government of Canada, 2022) - and it will be eye-opening for the nursing profession to see if the Canadian government extends the position beyond the two year term or dissolves the position. There is the need for continued collective action and continued advancement in the status, support, and investment of nurses in all roles (RPNs, RNs, and Nurse Practitioners) to safeguard the profession, because without it advancements will be difficult.

6.5 Limitations

Although the use of Duchscher's (2008) transition theory and White's (1995) concept of socio-political knowing provided a novel approach to guide this study, the study is not without limitations. The study was philosophically grounded in constructivism and utilized a qualitative research design to solicit insight about NGNs transition into nursing practice during the

pandemic, therefore this study does not claim to reflect the experiences of all NGNs transitioning into nursing practice during the pandemic. Provided the study had a small sample size (n=8), and although participants identified transferring into a variety of nursing specialties and work settings, some perspectives of NGNs in particular nursing specialties may have been missed which could influence the transferability of results. Further limitations include, the study was conducted only in the English language, therefore limiting the experience of Francophone NGNs in Ontario. Additionally, given the secondary-analysis research design, the researcher had no control over data collection or the interview questions asked. Despite Ontario having the highest population of the Canadian provinces and territories (Statistics Canada, 2023), the findings are only representative of one Canadian province. Lastly, at the same time the uniqueness of the participant sample of second-entry NGNs are recognized, it may also serve as a limitation as we do not know if these particular NGNs experiences would resonate with those who completed the traditional four-year baccalaureate program.

6.6 Strengths

Despite its limitations, the study has several strengths. First, Thorne's (2016) interpretive description was selected as an appropriate method to guide this study as this method has epistemological roots in nursing, and the research question to this study is nested in nursing clinical practice. This study utilized the combination of two theoretical perspectives to provide a unique lens to re-examine the data for the purposes of a secondary analysis. Doing so allowed for a unique analytic structure that examined NGN transition from a different perspective, and one that is woefully underrepresented in NGN transition literature. The recruitment and data collection methods of the original study was completed virtually, which enabled for a wide geographical catchment of NGNs within the province of Ontario. This allowed for a diverse

representation of practice areas and settings including large urban hospitals, rural community hospitals, acute and community settings, public clinics, and virtual work settings all within eight participants. Additionally, the study's sample included a subset of NGNs who are not traditionally acknowledged in NGN research, which are second-entry NGNs. Therefore, this study contributed to novel findings regarding second-entry NGN. Another benefit of this study includes the opportunity to highlight things that are not often the foci of transition experiences, which for example, traditionally includes skill accusation. Lastly, there was support from a team of various experts, and data triangulation occurred throughout the study at different levels to contribute to the validity and completeness of research findings (Farmer et al., 2006; Thorne, 2016).

6.7 Knowledge Translation

Knowledge translation is an imperative step in the research process, as such it is warranted to briefly discuss how findings of this thesis will be disseminated. To date, I have written a lay summary to explain this research study to the Canadian Nurses Foundation (CNF) for awarding and funding purposes. Moving forward my knowledge translation plan is to disseminate the findings to interested audiences. I will work with my thesis supervisor to identify opportunities to disseminate the research findings in summaries/abstracts and/or conferences that will reach NGNs, nursing educators, nursing researchers, and stakeholders. I will leverage some of my supervisor's affiliations to do so (CNA, CFNU, CASN, Canadian Health Workforce Network). Additionally, I aim to prepare and submit a manuscript to a relevant journal to disseminate the research findings of this study.

6.8 Conclusion

The findings of this inquiry highlighted that this particular sample of second-entry NGNs are enacting socio-political knowing during their transition into nursing practice which was illuminated through their narratives that were multilayered and rich with meaning. Socio-political knowing remains to be elevated to a high priority in nursing education, however, I believe that socio-political knowing should become foundational in nursing education at all levels, including undergraduate. This will hopefully empower future NGNs to enact this way of knowing in their day-to-day work and to be critical of the historical stereotyping of nurses as apolitical, for the longevity of their career (Buck-McFadyen & MacDonnell, 2017; Rasheed et al., 2020; Salvage & White, 2019; Wilson et al., 2020). Ever-expanding bodies of knowledge and future health reforms will continue to demonstrate the importance of nurses in the healthcare system, and as these reforms become more complex, nurses will be required to increasingly engage with socio-political knowing to safeguard nursing work and nursing practice. Similarly to how nurses are taught to advocate for their patients, it is imperative that the future generation of NGNs are provided with the proper (socio-political) knowledge and tools to advocate for themselves professionally.

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Appendix A – Approval for Use of Figure

From: Judy Duchscher [redacted]
Subject: Re: Request for Permission to use Transition Theory Figures
Date: December 11, 2023 at 3:51 PM
To: Robyn Soulsby [redacted]
Cc: Kimberly McMillan [redacted] Michelle Lalonde [redacted]

JD

Attention : courriel externe | external email

Hello Robyn! [redacted]

You most certainly have my permission to use the Stages Theoretical Model and the Transition Shock Construct and Model. I am attaching them in jpeg and pdf formats so you can upload to your document.

Let me know Robyn.

[redacted]

Kukwstsetsemc (Thank-You),

[redacted]

Dr. Judy Boychuk Duchscher (she/her) RN, BScN, MN, PhD
Adjunct Associate Professor, School of Nursing
[redacted]
~~~
Director - *Nursing The Future*
[redacted]
~~~
[redacted]

I acknowledge the Secwepemc Nation, upon whose traditional and unceded land Thompson Rivers University is located (ne Secwepemcúl'ecw). I am grateful for the Secwepemc Nation's generosity and hospitality while we live, learn and work in their territory.

The only path forward for the survival of our species and perhaps even our planet is a path of nonviolence, of contemplation and action prioritizing justice and solidarity, an affirmation of Oneness and the interconnectedness of all things, which science confirms, and spirituality has always known on its deepest level.

Father Thomas Keating

Appendix B – Literature Search Strategy

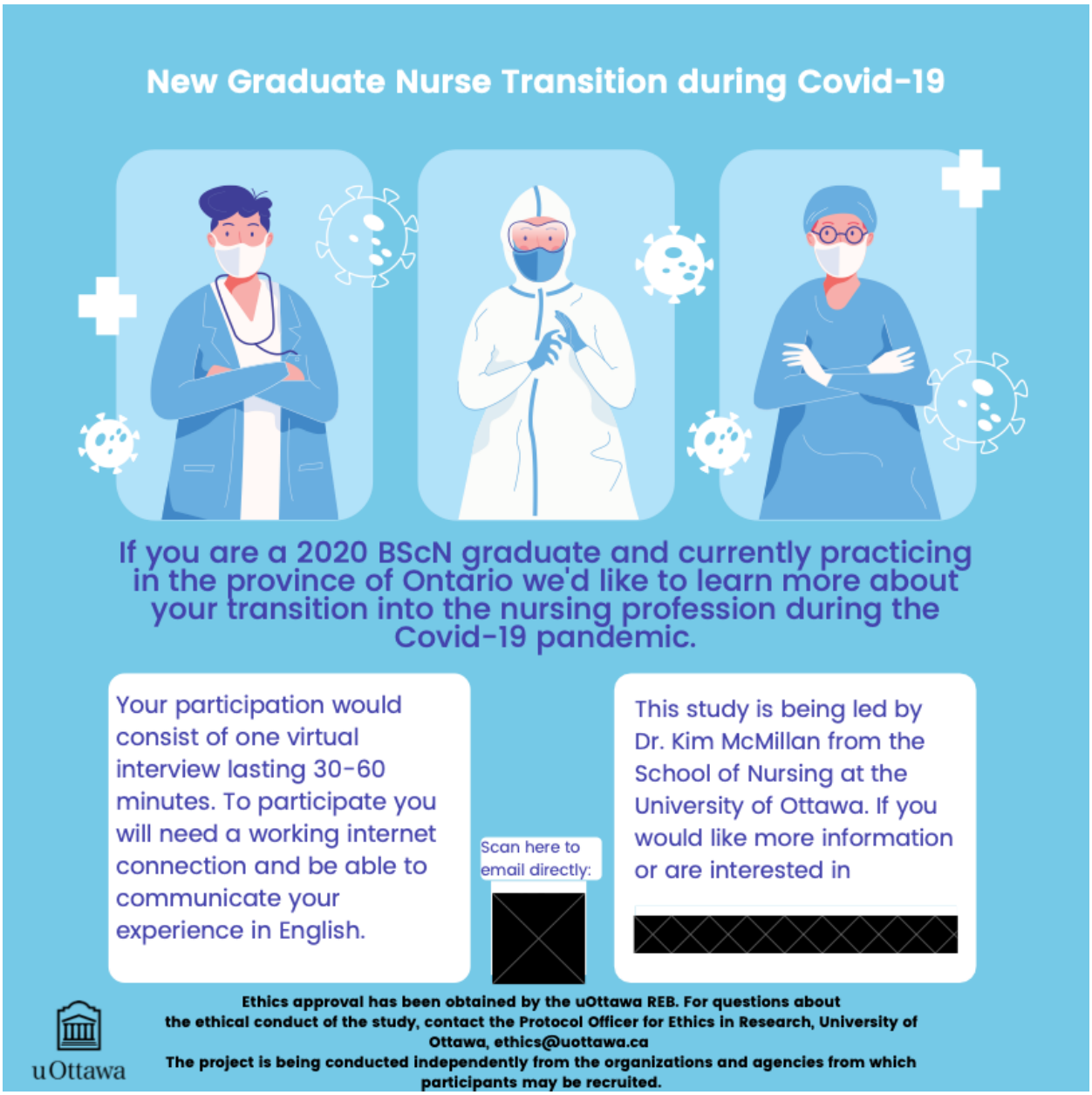
Table 1. Search terms used in databases (CINAHL, Medline (Ovid), PubMed, and ProQuest)

Concept or Term	Search terms used in databases
Second-entry New Graduate Nurse	Second entry, accelerated, fast track, compressed, two-year bachelor, new graduate nurse
Socio-political Knowing	Sociopolitical knowing, political knowing, political action, patterns of knowing

Table 2. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• English Language • Peer Reviewed • Full Text	• Language other than English

Appendix C – Recruitment Poster



Appendix D – Informed Consent

uOttawa

Université d'Ottawa
Faculté des sciences de la santé

École des sciences infirmières

University of Ottawa
Faculty of Health Sciences

School of Nursing

INFORMED CONSENT DOCUMENT

New graduate nurse transition: Navigating entry to practice amidst the Covid-19 pandemic

Investigator: Kim McMillan, RN, PhD, CHPCN (C)
University of Ottawa, School of Nursing
[redacted]

Researchers' Statement: We invite you to participate in a research study. The purpose of this form is to give you the information you will need to help you decide whether to be part of the study or not. Please read this form carefully. You may ask questions about the purpose of this research, what we ask you to do, the possible risks and benefits of participating, your rights as a participant and anything else about the research or this form that is not clear by contacting Dr. McMillan at the email addresses given above. You should keep this form for your records.

Background Information: The purpose of this research is to explore the perspectives and experiences of new graduate nurses in Ontario, who have entered the nursing profession during the COVID-19 pandemic. We are particularly interested in the transition experience, and what, if any additional supports new graduate nurses need during these unprecedented times.

Procedures: If you agree to be a participant in this research study, we will ask you to participate in one interview. All interviews will be conducted virtually via Microsoft Team, a virtual meeting platform that provides both audio and video. Interviews will be audio- and video-recorded for analysis purposes. We anticipate the interview will last between 30 and 60 minutes about.

Eligibility: You are eligible to participate in this study if you are a new graduate nurse from the 2020 graduating BScN cohort (both Winter and Fall) and are working in any healthcare setting in Ontario.

Risks and Benefits to Being in the Study: Your participation will involve talking about your experiences as a new graduate nurse entering the nursing profession during the COVID-19 pandemic. You may experience emotional discomfort during these conversations as they are of a sensitive nature. If you feel uncomfortable during the interview, we can stop at any time. You may choose to continue with the interview, reschedule it, or withdraw from the study. We will debrief at the end of our meeting. At that time, we can discuss options for psychosocial support within the current pandemic restrictions.

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There is also a risk of negative social repercussions for you if the comments you make in the context of this study become known, either to your employer, or within your professional community. However, please note, this project is being conducted independently from the organizations and agencies from which participants may be recruited. We will keep everything you tell us strictly confidential. We will not keep any record of who your employer is, and your identity as a research participant will not be known to anyone outside of the research team. It is up to you whether or not you choose to disclose to others that you are participating in this study. Potential benefits to being in this study include the opportunity to reflect on your perspectives and experiences about this topic. There is also a potential benefit to the nursing community in studying the impact that the pandemic is having on new graduate nurses.

Compensation: There is no compensation for participating in this study.

Confidentiality and Privacy: The records of this research study will be kept private and confidential. All research records, including audio recording and transcripts will be kept on a password secured computer in the home offices of the principal investigators. Access will be limited to the researchers, their graduate students, and project staff. All data (digital recordings, paper and electronic copies of the researchers' notes, and transcribed interviews) will be kept securely, stored in password protected electronic files and a secured cabinet in the principal investigator's office for at least five years. After this period, the data may be destroyed. This will be done securely through secure deletion and confidential shredding processes at the University of Ottawa. Data will be anonymized, in that numerical codes will be assigned to all participants; your name will not appear on any data relating to this study. Any and all dissemination of data in the form of presentations, webinars or scholarly publications will only include assigned numeric codes. All potentially identifying information will not appear in any dissemination materials.

Voluntary Nature of the Study: Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University or anyone associated with this project. There is no penalty or loss of benefits for not participating or for discontinuing your participation. You may choose to withdraw your participation from the study at any time. Should you choose to discontinue your participation after the interview has taken place, your interview data be promptly destroyed.

Contacts and Questions: The researcher responsible for this research is Kim McMillan. You may ask any questions you have now. If you have any questions later, you may contact the researcher at the contact information indicated on page one (1). If you have questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5; Tel.: (613) 562- 5387. Or by e-mail at ethics@uottawa.ca [1]

[1] During University closures related to the pandemic, e-mail is the best way to reach the Protocol Officer

Statement of Consent
(To be obtained verbally and audio-recorded immediately prior to the interview.)

Name of Participant _____ Date: _____

"I have read the above information. I have received answers to the questions I have asked. I am aware that my interview is being recorded. I consent to participate in this research. I understand that my participation is voluntary and that I can withdraw at any time."

Participants should keep a copy of this form for their personal records. If you wish, you can write your name/date on the lines above for your own records, but you do not need to send this form back to us.

Appendix E – Interview Guide

New graduate nurse transition: Navigating entry to practice amidst the Covid-19 pandemic

1. Can you tell me a little bit about your current work environment?
    - Primary care? Tertiary care? Particular specialty?

2. How long have you been working in this area?
    - In what capacity? Full time? Part time? Casual?

3. What has it been like entering the nursing profession during the pandemic?
    - Are there specific work experiences that come to mind as you reflect on your entry to practice thus far?
        - Specific interactions with colleagues? Patients?

4. In what ways have you been supported in your entry to the nursing profession during the pandemic?
    - What did your orientation look like? Do you know if this was different that non-pandemic orientations?

5. In what ways have you needed more support in your entry to the nursing profession during the pandemic?
    - Extra question: What will keep you in nursing?

6. Is there anything else that you'd like to discuss about your entry to the profession?

Appendix F – Permission to Use Data

uOttawa

Université d'Ottawa
Faculté des sciences
de la santé

École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Date: June 1, 2023

Re Applicant: Robyn Soulsby

Title of project: *Sociopolitical Knowing: A Secondary Analysis of New Graduate Nurses Transition During the Covid-19 Pandemic*

Dear: University of Ottawa Research Ethics Board review panel

I hereby give Robyn Soulsby permission to use my data from the study, *New graduate nurse transition: Navigating entry to practice amidst the Covid-19 pandemic* (UO REB certificate: [redacted]). The purpose of the proposed data use is a secondary analysis for Robyn's Masters thesis, which is being conducted at the University of Ottawa in the School of Nursing. Robyn will be using the data under my close supervision in my role as her thesis supervisor.

Please feel free to contact me should you have any questions, my contact information is noted below.

Sincerely,

[redacted]

Kim McMillan, RN, PhD, CHPCN(C)/Inf, PhD, CHPCN(C)
Assistant Professor/Professeure adjointe
Faculty of Health Sciences/Faculté des sciences de la santé
School of Nursing/École des sciences infirmières
University of Ottawa/Université d'Ottawa

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Appendix G – Ethics Approval

15/06/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-06-23-9207
Titre du projet / Project Title	Sociopolitical Knowing: A Secondary Analysis of New Graduate Nurses Transition During the Covid-19 Pandemic
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	15/06/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	14/06/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Robyn SOULSBY	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Kim MCMILLAN	University of Ottawa	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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15/06/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Kim THOMPSON
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

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