

NEW GRADUATE NURSES AND DEMENTIA CARE IN ACUTE CARE

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Abstract

Background: With the increasing older adult population, new graduate nurses will be providing care for patients with dementia more frequently and should be supported to care for this population during their transition period.

Purpose: The purpose of this thesis was to explore the experiences of new graduate nurses providing care for patients with dementia in acute care environments.

Methods: An interpretive descriptive qualitative study explored eleven Ontario new graduate nurses' experiences providing dementia care in acute care environments. A thematic analysis was conducted.

Findings: The thematic analysis resulted in three themes and several sub-themes: building of vision and values, clash of vision and values, and “make do with what you have”.

Discussion and Conclusion: Facilitators to providing dementia care in acute care were supportive colleagues and early exposure to dementia care. The barriers identified were similar to the barriers experienced by nurses in the literature.

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Glossary of Terms

Acute care environment: A short-term hospital inpatient care unit for patients who have acute medical or surgical needs (College of Nurses of Ontario [CNO], 2016a). Acute care inpatients are primarily admitted to medical or surgical units where they receive 24-hour care provided by nurses and other allied health professionals (CNO, 2016a).

Competence: “The demonstration of integrated knowledge, skills, abilities and judgment required to practice nursing safely and ethically” (CNO, 2014b, p. 11).

Dementia: A progressive and degenerative neurologic disorder (Canadian Nurses Association [CNA], 2016b). Dementia results from an accumulation of beta-amyloid plaque on neurons in the brain which causes impaired cerebral neuron connections, cellular death, and brain tissue atrophy (Health Canada, 2014). Medication can be used to slow the progression of beta-amyloid plaque build-up, however, there is no cure for dementia (Alzheimer Society of Canada, 2017). There are several types of dementia including Alzheimer’s disease, vascular dementia, frontotemporal lobe dementia and Lewy Body dementia. Of these diseases, Alzheimer’s disease is the most prevalent (Ministry of Health and Long-Term Care, 2015). The onset and progression vary depending on the type of dementia, although most types of dementia occur in older adults (Health Canada, 2014). All types of dementia results in impaired memory function and memory loss, behavioural changes, impaired judgment and reasoning, and a decrease in functional abilities to perform activities of daily living and instrumental activities of daily living (Alzheimer Society of Canada, 2017; Health Canada, 2014).

Dementia care: Care provided by nurses to patients with dementia.

New graduate nurses: A Registered Practical Nurse (RPN) or a Registered Nurse (RN) who has completed a nursing education program and is practising nursing with less than 12-months experience (Duchscher, 2012).

Nurse transition program: An orientation program where a new graduate nurse is paired with an experienced preceptor, for a duration of three to 12 months (Kramer, Halfer, Magurie, & Schmalenberg, 2012; Salt, Cummings, & Profetto-McGrath, 2008).

Person-centred care: A philosophy of providing care that is holistic, individualized, respectful, and empowering (Morgan & Yoder, 2012).

Registered Practical Nurse: A Registered Practical Nurse (RPN) is a practical nurse in the province of Ontario. The term RPN only applies to licenced practical nurses in Ontario, however, their education and roles are similar to Licenced Practical Nurses (LPN) in other Canadian provinces (Nursing Health Services Research Unit [NHSRU], 2009). RPNs have an average of a two-year college level education and care for stable and predictable patients (NHSRU, 2009). RPNs in this thesis will refer to Registered Practical Nurses and not Registered Psychiatric Nurses. Internationally, there are other roles that may be similar to RPNs, however, different titles are used, such as Licenced Vocational Nurses in the United States, and the roles may be operationalized differently.

Responsive behaviour: An undesirable behaviour exhibited by a patient with dementia in response to an unmet need (Alzheimer Society Ontario, 2014; Baillie, Cox, & Merrit, 2012a). A responsive behaviour can be wandering, exit seeking, agitation, yelling or physical aggression (Alzheimer Society Ontario, 2014). A patient with dementia may demonstrate a responsive behaviour in response to physical needs (e.g., pain, hunger), intellectual needs (e.g., unable to do a task, unable to communicate), emotional needs (e.g., anxious, lonely), environmental needs

(e.g., noise, brightness) or any other need (Alzheimer Society Ontario, 2014, Baillie et al. 2012a; Fukuda, Shimizu, & Seto, 2015). Many of these behaviours are disruptive to other patients (e.g., wandering into other patients' rooms, yelling and calling out) or to nursing staff (e.g., wandering into nursing work environments, require more time from staff to supervise the patient, aggressive behaviour). Responsive behaviours are a concern for acute care nursing staff because patients are at risk of falling, injuring themselves or injuring others (Baillie et al., 2012a).

Self-concept: One's understanding of who they are based on their values, beliefs, and interactions with others (Feil & Altman, 2004).

Sense of connectedness: A positive emotional and/or spiritual connection between individuals or an individual and a population and/or environment in which one feels valued and engaged. Meleis (2010) suggested that feeling connected is essential to any transition. For example, new graduate nurses can have sense of connectedness with patients with dementia, with their work environment, and/or another colleague.

Transition: "A passage from one fairly stable state to another fairly stable state, and its process triggered by change" (Meleis, 2010, p. 11).

Vision of care: The way in which a nurse plans to implement the philosophy of person-centred care into their nursing practice. Nurses' vision of care includes how they organize their day and the way they interact with their patients. Each nurse's vision of care is unique to the individual, however, the individual's vision of care is built upon the nursing values of person-centred care.

Chapter 1: Introduction

This master's thesis will draw upon the philosophical underpinnings of the discipline of nursing to explore the experiences of new graduate nurses providing care to patients with dementia in acute care. This thesis will expand the knowledge of the discipline of nursing and will provide insight into ways the discipline can support the future generation of nurses. The following is a story of Clare, a new graduate nurse caring for patients with dementia in acute care.

Claire is a new graduate nurse who has been working on a combined medical/surgical unit for five months. She finished her three-month nurse transition program and is now practising on her own. After graduating from school, she started a full-time job in a new city. This is the first time Claire has lived away from her family and friends and adjusting to the new responsibilities of paying for her apartment, new car, and student loans. She finds her acute care work environment demanding: admissions, discharges, transfers, critical and unstable patients, and working with families. Her critical thinking, communication, and organizational skills are developing.

Claire arrives to work for her day shift and receives report from the night nurse. She has a busy day ahead of her: one patient is being discharged home, one patient is going for a test and another is going for an appointment, her fourth patient requires a complex dressing change, and her fifth, a palliative patient, has family at the bedside. She takes a deep breath and plans her day. After assessing her second patient, she hears her other patient's bed alarm go off. It is John. He has dementia. He fell at home last week and fractured his arm. He is getting out of bed. John yells, 'I need to get to school'. Claire approaches John and tries to calm him down, but

John becomes more restless and agitated. He frantically leaves his room and walks unsteadily down the hall, looking for an exit. 'Where are you Mom? I can't miss the school bus'!

Claire's story is not unique. New graduate nurses across Ontario have shared similar experiences: the challenge of balancing the transition from a student to an independent practising nurse, along with caring for a specific patient population. This thesis has analyzed the experiences of 11 new graduate nurses like Claire's and will discuss ways to help support them through their journey.

1.1 New Graduate Nurses

New graduate nurses experience a transition as they leave their role as a student and start their new role as a professional nurse (Duchscher, 2012). Nursing theorists Kramer (1974), Benner (1982), Meleis (2010), and Duchscher (2012) have helped influence the researcher's understanding of new graduate nurse transition and the challenges new graduates experience during their first year of work. During this transition period, new graduate nurses experience a steep learning curve, stress, and shock as they enter and adapt to their new profession (Duchscher, 2012; Kramer, 1974). Support during this time is paramount. The outcomes of a transition are different for every nurse. However, each individual is on a spectrum between a successful transition and an unsuccessful transition, depending on their ability to adapt to their new role and identity as an independent practising nurse (Meleis, 2010).

1.2 Dementia Care in Acute Care

There are a growing number of older adults with dementia in Canada (Health Canada, 2014). Patients with dementia are admitted into acute care environments more frequently, for longer durations, and experience poorer outcomes than the general population (CNA, 2016b). Nurses have reported that caring for patients with dementia in acute care environments is

challenging, because patients with dementia often require more time to provide care, they may be difficult to communicate with, and they may exhibit responsive behaviours which can be difficult for nurses to manage (Ericksson & Saveman, 2002; Fukuda et al., 2015; Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2011). The acute care setting is a busy and fast-paced environment, comprised of unstable and acutely ill patients (Grinspun, Harripaul-Yhap, Jarvi, & Lenartowych, 2016). Nurses working in acute care are often faced with frequent admissions, discharges, and transfers, contributing to the demanding workload for nurses (Moyle et al., 2011). As a result, speed, efficiency, and productivity are prioritized by acute care (Moyle et al., 2011). Since patients with dementia sometimes require more time from nurses than non-dementia patients during nursing care, they are often treated as a lesser priority (Baillie, Cox, & Merrit, 2012b; Cowdell, 2010; Moyle et al., 2011). However, the literature suggests that when patients with dementia are admitted into acute care, they experience higher rates of adverse events (e.g., falls, sepsis, pressure ulcers) and higher mortality rates than non-dementia patients (Alzheimer's Association, 2010).

1.3 The Study Problem

This thesis merges the two constructs of dementia care in acute care and care delivered by new graduate nurses during their transition period. Despite the complexity of both constructs, new graduate nurses are often assigned to care for patients with dementia in acute care (Moyle et al., 2011). At this time, there is a dearth of research on the experience of new graduate nurses when providing care to patients with dementia in acute care settings. As such, this phenomenon was explored in this study using Thorne's interpretative description (Thorne, 2008), a qualitative research methodology. The research question for this thesis was, *what are the experiences of new graduate nurses when providing care for patients with dementia in acute care environments.*

1.4 Study Purpose

The purpose of this thesis was to explore the experiences of new graduate nurses when providing care for patients with dementia in acute care environments.

1.5 Study Objectives

The study was guided by the following objectives: to explore: (1) the challenges or barriers new graduate nurses experience when providing care for patients with dementia in acute care environments, and (2) the facilitators or enablers new graduate nurses experience when providing care for patients with dementia in acute care environments. The results of this thesis may contribute to: (1) the knowledge of dementia care provided by new graduate nurses, (2) recommendations for undergraduate nursing programs to help better prepare graduates to provide dementia care and enter the workplace, and (3) the development of supportive interventions for new graduate nurses as they enter the nursing profession.

Chapter 2: Literature Review

The following chapter describes the current literature on new graduate nurse transition and dementia care within the context of acute care. The first section of this chapter discusses the search strategy method used for the literature review. The second section of this chapter is a review of the literature on: (1) new graduate nurse transition, and (2) dementia care in acute care. Reviewing the literature helped the researcher create a theoretical foundation to aid in his understanding of the phenomenon under study. This understanding is a part of the theoretical scaffolding of an interpretive descriptive study (Thorne, 2008), as is described in Chapter 3.

2.1 Literature Review Search Strategy

The purpose of this literature review was to systematically explore the literature to gain a comprehensive understanding of the concepts under study. The research question was, *what is the experience of new graduate nurses when caring for patients with dementia in acute care environments?* The concepts, inclusion and exclusion criteria, and rationale are identified in Appendix A.

An overview of the literature search is outlined in Appendix B. In consultation with key experts (e.g., nursing faculty), Kramer (1974), Benner (1982), Meleis (2010), and Duchscher (2012) were identified as relevant nursing theorists. The researcher then completed a database search using the following search terms: new graduate nurs*, dementia, and acute care (Appendix A). The Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed were searched because both databases index nursing and allied health research. The searches in CINAHL and PubMed yielded 226 and 341 results, respectively. The researcher reviewed the articles by reading the title and abstracts to decide if they met the inclusion criteria. After screening the titles and abstracts, 30 CINAHL and 32 PubMed articles were obtained for

full-text review, with a total of 12 and three articles meeting the inclusion criteria, respectively. Next, a preliminary search in Scopus and PsycInfo using the same search strategy was completed. This search produced the same 15 articles. The overlap was suggestive that the literature review was exhaustive. A search of the grey literature was also completed using Google where 27 documents were obtained. A total of 42 articles were selected from this search.

The original search yielded no literature that sampled Registered Practical Nurses¹ (RPNs), therefore a second literature search was conducted that specifically examined RPNs in the context of the research question (Appendix C and D). Seven articles from the database search met the inclusion criteria, as well as four grey literature publications. However, there was no literature exclusively on the RPN transition or RPNs and dementia care in acute care. A total of seven articles were selected from this search.

Finally, the references from the selected articles from the two searches were screened for relevance. Of those, 89 articles meeting the inclusion and exclusion criteria were obtained using the ancestry and descendancy approach. Therefore, a total of 138 articles were included in this literature review.

2.2 Literature review

This thesis is comprised of two main concepts: new graduate nurse transition and dementia care in acute care. It was paramount for the researcher to obtain a deep understanding of both concepts independently because each is complex and both are comprised of multiple theoretical underpinnings. The following section summarizes the seminal theoretical perspectives on new graduate nurse transition and the current literature on new graduate nurse transition and dementia care in acute care environments.

¹ See definition in the Glossary of Terms.

2.2.1 New graduate nurse transition theory.

The following section focuses on the main theories pertinent to new graduate nurse transition; the seminal works of Marlene Kramer (1974), Patricia Benner (1982), Afaf Meleis (2010), and Judy Duchscher (2012) and how their work applies to the new graduate nurse transition in the context of this thesis. The second part of this section is a synthesis of the new graduate nurse transition theories where five themes are presented.

2.2.1.1 *Marlene Kramer: Reality Shock.*

The concept of new graduate transition was first coined by Marlene Kramer in her *reality shock* theory. Kramer (1974) defined reality shock as the *clash* between new graduate Registered Nurses' (RNs) education-based values (values based on theoretical/*textbook* education) and the values of their new practice environment. The clash between these two values resulted in conflicting emotions and shock. Kramer used the term shock to emphasize the “total social, physical, and emotional response of a person to an unexpected, unwanted, or undesired [situation], and in the most severe degree of the intolerable” (p. 3-4).

New graduate nurses experience conflicting emotions as they learn there is a difference between what their new practice environment's values would want them to do and what their education-based values have taught them to do (Kramer, 1974). For example, a new graduate nurse on a surgical unit is aware that their patient with dementia requires extra time to be assisted with feeding and the provision of personal hygiene care. However, the new graduate nurse has the competing task of discharging a surgical patient to ensure the post-operative admission has a bed when they arrive on the unit. The new graduate nurse is conflicted between their perceptions of what their new practice environment's values would want them to do (quickly feed the patient and postpone personal hygiene care in order to discharge the patient on time) and their

perceptions of what their education-based values have taught them to do (prioritize the care needs using a person-centred care approach). These conflicting values and emotions may result in reality shock.

Kramer (1974) categorized reality shock into three phases: (1) the honeymoon phase, (2) the shock and rejection phase, and (3) the resolution and recovery phase. The honeymoon phase occurs at the beginning of professional nursing employment when new graduate nurses are immediately immersed into an isolated new world, where they are oblivious to the reality of their new practice environment's values, and their roles and responsibilities as new graduate nurses. During the second phase, Kramer suggested that new graduate nurses experience conflicting values. They may protect themselves from conflicting values by disengaging from the culture and values of their new practice environment, which may result in hostility towards nursing colleagues and criticism towards the workplace. For example, the new graduate nurses' education-based value of person-centred care may clash with the new practice environment's values of efficacy, speed, and productivity. In the final stage of reality shock, new graduate nurses achieve biculturalism (Kramer, 1974). Biculturalism occurs when new graduate nurses have not neglected their education-based values, nor have they conformed to the new practice environment's values, but have instead found unity in both (Kramer, 1974).

Reality shock affects new graduate nurses' ability to fulfill their job requirements. Kramer (1974) suggested that "reality shock is one of the major reasons why new graduate nurses don't carry their weight for at least six months" (p. 8). To minimize reality shock, Kramer explored the concept of sociological immunization as a way of protecting new graduate nurses' professional values from the values of the workplace. Kramer proposed that if nursing students were *immunized* during school with the workplace environment's values, they would be more

resilient to their influence during their transition. She proposed that this can be achieved through the implementation of an anticipatory socialization program for undergraduate nursing students.

Anticipatory socialization theory originated from Stouffer (1949), whose research discovered that World War II soldiers were more successful adjusting to their new role when they were well prepared, had an understanding of the role requirements, and assumed the new role before the required time. Kramer (1974) hypothesized that if nursing students practiced the same theory, they too would have a successful adjustment and be less influenced by their new workplace's values. Kramer developed an anticipatory socialization program that was evaluated using a quasi-experimental approach. A group of fourth-year undergraduate nursing students participated in the program and a control group did not. The program consisted of an early introduction to the workplace environment's values and provided education on topics such as how the healthcare system works and conflict management skills. Kramer observed that students who participated in the anticipatory socialization program had higher graduation rates and higher role deprivation scores than the control group. To this day, Kramer's research is foundational to the development and implementation of new graduate nurse transition programs worldwide (Kramer, Halfer, et al., 2012; Kramer, Maguire, et al., 2012).

2.2.1.2 Patricia Benner: From Novice to Expert.

The acquisition of skills of RNs was explored by Patricia Benner in her novice to expert model (1982). Benner's model outlined five levels of proficiency for nurses: novice, advanced beginner, competent, proficient, and expert. The stages of Benner's model are described in Table 1. Benner (1982) validated Dreyfus' Model of Skill Acquisition and applied it to nursing by interviewing 62 nursing students, new graduate, and experienced nurses. Benner's model has

been extensively used in the nursing profession as a model to understand how nurses progress throughout their career.

Benner's model has two fundamental principles (1982). The first principle focuses on ones' ability to gain knowledge, understanding, and skills, allowing nurses to transition from a novice to an expert practitioner. The second principle focuses on ones' reactions to an unknown experience or situation. For example, an expert will perceive a new situation as less complicated and demanding than a novice, because an expert nurse uses both clinical experience and theoretical knowledge to navigate unfamiliar situations. Together, these two fundamental principles guide Benner's model.

New graduate nurses may move through various stages of the model during their transition. Their knowledge and skills will continuously evolve, with some aspects evolving at different stages than others. Benner's novice to expert model helps explain how new graduate nurses acquire nursing skills. Although this model is not specific to new graduate nurse transition, the researcher has used this model to assist in his understanding of the transition process for new graduates.

Table 1.

The Stages of Novice to Expert (Benner, 1982)

Stage	Description
Novice	A novice nurse has no experience with the tasks they are required to perform; they are aware of rules but do not incorporate context within their decision-making because of a lack of experience (Benner, 1982).
Advanced Beginner	An advanced beginner incorporates their clinical experience with learned rules to aid in decision-making and “can demonstrate a marginally acceptable performance” (Benner, 1982, p. 403). The advanced beginner uses the limited experience they have, as well as their theoretical knowledge, as a reference point to make decisions. However, because of their lack of experience with clinical situations, the novice and advanced beginner requires support in the clinical setting via mentorship and/or preceptorship from a competent, proficient or expert nurse, as well as clinical educational in-services (Benner, 1982).
Competent	A competent nurse is a nurse that has been practising for two to three years in a similar practice setting (Benner, 1982). A competent nurse can make holistic decisions that will benefit their patients in the short and long-term. Benner suggests that it takes time to acquire this knowledge (Benner, 1982).
Proficient	The proficient nurse continues to develop a broader holistic understanding of clinical situations and starts to anticipate the normal, abnormal, and identify subsequent actions for adverse situations (Benner, 1982). Proficient nurses draw on their growing experience of similar situations and theoretical and clinical knowledge to support their decision-making.
Expert	The expert nurse is a highly skilled nurse who no longer recognizes their decision-making process as their clinical experience and theoretical knowledge has transformed into tacit knowledge (Benner, 1984). Their tacit knowledge makes it difficult to articulate the rationale for decisions as an expert “no longer relies on an analytical principle (rule, guideline, maxim) to connect her/his understanding of the situation to an appropriate action” (Benner, 1982, p. 405).

2.2.1.3 Afaf Meleis: Transitions Theory.

Transition is a central concept to nursing (Meleis, 2010). Although Meleis’s transition theory was not developed within the context of new graduate nurses, the researcher has drawn

upon the properties and contributing factors of her theory to develop an understanding of the transition from student to independent practising nurse.

Meleis's work on transition began in the late 1960s. Meleis (2010) defined transition as "a passage from one fairly stable state to another fairly stable one, which is a process triggered by a change" (p. 11). Meleis identified four types of transition: developmental, health/illness, organizational, and situational. Meleis defined a situational transition as a change that "involve[s] the addition or subtraction of persons in a pre-existing constellation of roles and complements" (p. 15). New graduate nurses experience a situational transition due to the addition of new roles and responsibilities, a steep learning curve, and may experience the loss of their student identity as they start their roles as professional nurses. Meleis's transition theory suggested that new graduate nurse transition would start with a change from their fairly stable state as a student, and would end with the acceptance of a fairly stable state as an independent practising nurse (Meleis, 2010).

Throughout her research on transition, Meleis and her colleagues Sawyer, Im, Hilfinger Messias, and Schumacher (2000) identified two goals of a transition: "mastery of new skills needed to manage a transition and the development of a fluid yet integrative identity" (p. 23). New graduate nurses achieve mastery of skills when they can independently manage and cope with new situations by using the skills they have acquired during their transition (Meleis et al., 2000). The second goal of a transition is the development of a fluid identity (Meleis et al.). Meleis et al. used the word *fluid* to emphasize that one's identity is never stagnated, but it is always changing and adapting. This also means that although new graduate nurses are no longer students or new graduates at the end of their transition, they have not lost nor forgotten the

identities they once wore; they have built on them and grown with them to create a new, fluid, dynamic identity as independent practising nurses.

A healthy transition might occur when the new graduate nurse develops the knowledge, skill, and judgment required to perform as an independent practising nurse and the competence to care for their patient population. Whereas a new graduate nurse who does not develop the skills or an understanding of their new role might experience an unhealthy transition. According to Meleis (2010), unhealthy transition results when one does not achieve mastery of skills or a fluid identity. Meleis et al. (2000) recognized that not everyone would achieve the same level of mastery in their transition, suggesting that the outcomes of transition are not dichotomous (healthy vs. unhealthy). Instead, Meleis (2010) proposed that new graduate nurses may be somewhere on a spectrum between healthy and unhealthy based on their ability to engage in the properties and contributing factors of transition.

Meleis et al. (2000) identified five properties of a transition: (1) awareness, (2) engagement, (3) change and difference, (4) time span, and (5) critical points and events. The level to which new graduate nurses understand these properties will determine the extent to which they will achieve a healthy transition (Meleis et al.). Several contributing factors to transition were also identified by Meleis et al., such as a sense of connectedness, interactions, and developing confidence and coping mechanisms. The development of a sense of connectedness can occur between new graduate nurses and their nursing colleagues, preceptors, their workplace environment, the nursing profession, or their patients (Meleis et al.). Throughout these interactions, new graduate nurses can determine “the meaning of the transition and the behaviours developed in response to the transition were uncovered, clarified, and acknowledged” (p. 24). The development of confidence is associated with the development of skills and

knowledge and feelings of connectedness. New graduate nurses develop coping mechanisms to aid in their adaptation to their new role and responsibilities (Meleis et al., 2000).

2.2.1.4 Judy Duchscher: Transition Stages Model.

Nursing theorist Judy Duchscher (2012) built and expanded on Kramer's (1974) reality shock theory and Benner's (1982) novice to expert model in her transition stages model. Duchscher proposed that new graduate nurse transition is more than reality shock, as described by Kramer (1974), new graduate nurses also experience psychosocial challenges during these transitions that are independent of their professional nursing role (Duchscher, 2012). Duchscher developed her model from her qualitative research with new graduate RNs. This is currently the only model that is aimed specifically at new graduate nurses. Duchscher identified three stages of new graduate nurse transition: *doing*, *being*, and *knowing*. The three stages each occur over approximately four months, resulting in a total 12-month transition from the start of professional nursing employment to an independent practising nurse.

In the first stage, *doing*, new graduate nurses experience the difference between their role as a student and their role as a nurse. New graduate nurses experience a sense of surprise during their orientation and preceptorship about the roles and responsibilities of nursing, resulting in transition shock (Duchscher, 2008). They experience the "initial struggle (anywhere from two weeks to two months) to adjust to their new reality" (Duchscher, 2012, p. 15). After the stage *doing*, new graduate nurses enter the stage of *being* where they are working independently or with limited supervision. They experience stress from their professional roles, such as demanding workloads and a steep learning curve (Duchscher, 2008). Near the end of this stage, new graduate nurses experience transition crisis (Duchscher, 2008). The final stage of the

transition, *knowing*, occurs when they develop a new sense of identity and confidence in their role (Duchscher, 2012).

Aside from the three stages, the model depicts two transition events: (1) transition shock, and (2) transition crisis. Transition shock is defined as “the experience of moving from the known role of a student to the relatively less familiar role of professionally practising nurse” (Duchscher, 2008, p. 1105). Duchscher (2012) used the term shock to encompass the impact the psychosocial changes can have on all aspects of new graduate nurses’ lives as they transition from student to nurse. For example, a new graduate nurse may be starting their first professional job, but during the same time, they may be adjusting to a new city, leaving friends from school, paying bills, or starting a family now that their undergraduate education is completed.

Transition shock occurs during the transition from the *doing* to *being* stage, after new graduate nurses have completed their hospital orientation and preceptorship program (Duchscher, 2008; 2012). Although Kramer’s (1974) reality shock is similar to Duchscher’s transition shock (Duchscher, 2008; 2012), Kramer only focused on the professional nursing practice aspect of transition, whereas Duchscher incorporates the whole psychosocial aspect of being a new graduate nurse.

Duchscher (2012) described the second transition event as *transition crisis*. Transition crisis occurs after transition shock, during the transition from the *being* to *knowing* stage at approximately five to seven months into the new graduate nurse transition (Duchscher, 2008). As new graduate nurses practice independently after their orientation is completed, they frequently encounter experiences and situations in clinical practice in which they feel underprepared (Duchscher, 2008). During that time, Duchscher (2008) described that new graduate nurses experience a “crisis of confidence, mitigated by the intersection of insecurities regarding their

practice competency and their fear of failing their patients, colleagues, and themselves” (p. 446). Recovery occurs approximately six to eight months after orientation is completed, by self-affirmation including self-reflection on why they chose to be a nurse, why they are in this profession, and reminding themselves of the services they are providing (Duchscher, 2008).

Duchscher’s transition stages model emphasized that new graduate nurses not only experiences shock from the changes that they experience from their transition from student to nurse, but they will also experience shock as a result of changes in their personal lives as well (2008; 2012). This theory has been used to enrich the researcher’s theoretical understanding of the transition of new graduate nurses.

2.2.1.5 Transition theories in the context of new graduate nurse transition.

This section is a synthesis of the four nursing transition theories from Kramer, Benner, Meleis, and Duchscher in the context of new graduate nurse transition. Each of the transition theories is unique, however, they all share five common themes that outline and explain new graduate nurse transition: (1) transition trigger, (2) shock, (3) support, (4) phases of transition over time, and (5) outcomes (Table 2).

Transition trigger.

Each theorist identified that new graduate nurse transition begins with a trigger for change; a change occurring as a result of graduating from a nursing program and starting professional nursing employment. During this change, new graduate nurses experience the development of knowledge, self-awareness, adjustment to a new role, and the experience of shock.

Table 2.

New graduate nurse transition themes across theories

Themes	Kramer (1974)	Benner (1982)	Meleis (2010)	Duchscher (2012)
Transition Trigger	Starting role as professional nurse.	Development of new skills and knowledge.	Change causing one to leave their stable state.	Starting role as professional nurse.
Shock	Reality shock.	New and strange environment.	Development of coping mechanisms in reaction to change.	Transition shock and transition crisis.
Support needed throughout transition	Nurse transition programs.	Emphasis on orientation and mentorship.	Sense of connectedness.	Orientation, preceptorship, developing relationships with colleagues and the nursing profession.
Phases of transition over time	Honeymoon phase, shock and rejection phase, resolution and recovery phase.	Novice, advanced beginner, competent, proficient, expert.	Individualized based on contributing factors.	Doing, being, knowing.
Outcomes	Biculturalism.	Gaining success occurs after each mastery stage, but one is always adapting and changing.	Development of a fluid yet integrative identity.	New sense of identity and confidence.
Applies to new graduate nurse transition	Yes	Yes	Yes	Yes

Shock.

Shock occurs from feelings of being overwhelmed as a result of the changes new graduate nurses experience. Kramer (1974) and Duchscher (2012) describe the term *shock* as

reality shock and transition shock. Benner (1982) suggested that novice and advanced beginners perceive their environment as new and strange. Meleis (2010) highlights that individuals develop coping mechanisms as a result of the change.

Support.

Support was a central concept of transition amongst the four theorists. Kramer (1974) described support as the process of instilling resilience in nursing students through nursing education programs that prepare new graduates for the reality of their new nursing environment. Benner (1982) also highlighted the need for mentorship and preceptorship for novice and advanced beginners suggesting that they need to be supported while they are adapting to their new roles and responsibilities. Meleis (2010) identified that *feelings of connectedness* with individuals and the environment offered a form of support for the individual throughout their transition. Although Meleis was the only theorist to explicitly use the term *feelings of connectedness*, Duchscher (2012) described the need for new graduate nurses to develop relationships and a sense of belonging to the profession, colleagues, and employer. Kramer's later work on healthy work environments suggested there was an association between environments where new graduate nurses felt respected by their peers and with higher new nurses' job satisfaction, less reality shock, and higher retention rates (Frink, Casey, Krugman, & Goode, 2008; Kramer, Brewer, & Maguire, 2011; Rush, Adamack, Gordon, & Janke, 2014). Although the concept of support in the context of new graduate nurse transition is ambiguous and ill-defined, these four theorists have emphasized the importance of support for new graduates during their transition period.

Phases of transition over time.

New graduate nurses transition through different phases over time. Kramer (1974), Benner (1982), and Duchscher (2012) suggested that new graduate nurses transition in a linear, stepwise approach through the different phases of transition, with time being an important variable. Although Meleis (2010) suggested that a transition occurs over time, she emphasized that each transition is a unique and individualized experience; as such, she did not explicitly identify different phases. Instead, she suggested that individuals experience different critical points and events during their transition.

Outcomes.

The final theme of new graduate nurse transition is the outcome of the transition process. Meleis (2010) explained that a transition ends somewhere on a spectrum from healthy to unhealthy. Where one ends their transition will be determined by the degree to which they master their new role (Meleis). The outcome of Benner's (1982) model focuses on nurses' ability to achieve mastery of their new role in which they use the skills they developed to be an independent practising nurse. Kramer, Benner, and Meleis also described that developing a new identity was an outcome of transition. Kramer (1974) discussed biculturalism as new graduate nurses' ability to merge their education-based nursing values with their professional employment's values, thus creating a new identity. Meleis (2010) and Duchscher (2012) also highlighted the importance of new nurses' ability to develop a new identity. At the end of the transition, the nurse is not the same nurse as when they started. They entered their transition with a preconceived idea of what it would be like to be new graduate nurses; an identity that was developed based on their education. By the end of this transition, new graduate nurses establish

new identities, which have been influenced and moulded by their experiences during their transition and over time.

The seminal works of Kramer, Benner, Meleis, and Duchscher have aided in the development of the researcher's understanding of the concept of new graduate nurse transition. Although the four theories do not explain new graduate nurse transition in its entirety, there are five common themes among the theories and each adds an important dimension and greater understanding to the concept as a whole.

2.2.2 New graduate nurse transition literature.

In addition to the theoretical understanding of new graduate nurse transition, it was important for the researcher to understand the practical experience of new graduate nurses. This section of the literature review describes the current literature on new graduate nurses' experiences during their transition, risk of turnover, and highlights their need for support.

2.2.2.1 New Graduate Nurse Experience.

New graduate nurses have reported their transition experience to be stressful (Flinkman & Salanterä, 2015; Laschinger, Wong, Regan, Young-Ritchie, & Bushell, 2013; Lavoie-Tremblay et al., 2008; McCalla-Graham & DeGagne, 2015). The two main antecedents to the experience of stress were the new graduates' perceived lack of preparation for their role as an independent practising nurse (Flinkman & Salanterä, 2015; McCalla-Graham & DeGagne, 2015) and their work environment (Flinkman & Salanterä, 2015; Laschinger et al., 2013; McCalla-Graham & DeGagne, 2015). New graduate nurses often felt that their nursing education did not adequately prepare them for the roles and responsibilities as a nurse and they often felt they had entered practice with a knowledge deficit (Flinkman & Salanterä, 2015; McCalla-Graham &

DeGagne, 2015). This lack of preparation resulted in feelings of shock, as their perceptions of nursing did not match the reality they experienced (Duchscher, 2008).

The literature reported that new graduate nurses found their work environment to be stressful; they felt they were often understaffed and were required to care for more patients than they anticipated (Flinkman & Salanterä, 2015; McCalla-Graham & DeGagne, 2015). They reported their work environment was busy (Flinkman & Salanterä, 2015). The busy environment, coupled with the lack of staffing, led new graduate nurses to perceive the care they were providing was inadequate and below their standards (Flinkman & Salanterä, 2015). This caused new graduate nurses to feel “emotionally exhausted” (McCalla-Graham & DeGagne, 2015, p. 125) and to have “moral distress” (Flinkman & Salanterä, 2015, p. 1053). Lavoie-Tremblay et al. (2008) reported that 43.4% of Quebec new graduates experienced high levels of psychological distress stemming from their workplace. The participants felt the highest levels of psychological distress occurred from effort-reward imbalances, high psychological demands, and elevated job strain (Lavoie-Tremblay et al., 2008). Laschinger et al. (2013) reported that not having a sense of belonging to their work environment had a negative effect on new nurses’ mental health.

2.2.2.2 Turnover.

The literature suggested that if new graduate nurses are not supported during this time of stress, they are at risk of leaving their place of employment or the profession entirely (Dwyer & Revell, 2016; Kovner, Brewer, Fatehi, & June, 2014; Li & Jones, 2013; Unruh & Zhang, 2014). Kovner et al. (2014) estimated the one-year new graduate nurse turnover rate to be 17.5%, and the two-year turnover rate to be 33.5%. Unruh and Zhang (2014) reported that 32% of newly licensed RNs (<24 months’ experience) had left their first job and 16% had left their second job within the first 1.5 to 2.5 years of work.

The cause of new graduate nurse turnover is multifactorial. Unruh and Zhang (2014) observed that “high workload (15%), poor management (13%), too stressful (12%), and difficulty providing good care (10%)” (p. 226) were the top reasons for turnover, followed by personal reasons (9.6%) and relocating (7%). Flinkman and Salanterä (2015) reported that new graduate nurse turnover rates were attributed to a poor work environment and lack of support. New graduate nurses left their place of employment because they felt they were forced to provide care that was unethical and against their moral values due to the busy nature of acute care environments and the lack of staffing within them. They did not want to work for an organization that did not share their values (Flinkman & Salanterä, 2015). Turnover was associated with new graduate nurses’ reports of inadequate orientation, poor inter-professional relationships, and feelings of a sense of abandonment from nurses (Flinkman & Salanterä, 2015).

Nurse turnover also has a negative economic impact on our health care system. A literature review by Li and Jones (2013) reviewed ten studies that examined nursing staff turnover between 1990 and 2010. They reported the cost of turnover for new and experienced RNs and RPNs between 2004 and 2010 was \$21,000 to \$80,000 per nurse. They suggested that the cost of nurse turnover in the United States was between \$5.9 and \$8.5 million annually.

In summary, new graduate nurse turnover is a result of the stressful experience encountered during their transition and it is critical to ensure that new graduate nurses provide the care they envisioned and stay in the nursing profession (Dwyer & Revell, 2016).

2.2.2.3 Support.

Support is not defined as a single intervention, but a concept with the goal of ensuring that new graduate nurses experience a healthy transition. There are several definitions of support in the literature, and multiple interventions are used to ensure new graduate nurses feel

supported. Implementation of nurse transition programs (Hatler, Stoffers, Kelly, Redding, & Carr, 2011; Kramer, Halfer, et al., 2012; Kramer, Maguire, et al., 2012) and advance practice nurse (APN) involvement (Adams et al., 2015; Glynn & Silvia, 2013; Hatler et al., 2011; Strauss, 2009) were identified as the two most common ways of providing support to new graduate nurses.

A nurse transition program is an orientation program where new graduate nurses are paired up with an experienced preceptor, for a duration of three to 12 months (Kramer, Halfer, et al., 2012; Salt et al., 2008). During that time, new graduates share the roles and responsibilities of their preceptor's patient assignment (Salt et al., 2008). The development and implementation of nurse transition programs were based on Kramer's research on reality shock (Kramer, 1974; Kramer, Halfer, et al., 2012).

Multiple studies have reported an improvement in new graduate nurse retention rates following the implementation of nurse transition programs (Chappel, Richards, & Barnett, 2014; Kramer, Halfer, et al., 2012; Salt et al., 2008). Chappell et al. (2014) concluded that new graduate nurses' were 21 times more likely to stay with their current employer if they participated in a transition program for 24 weeks or longer, compared to a transition program of 12 weeks or less.

In Ontario, the New Graduate Guarantee Initiative (NGGI) is a nurse transition program developed by the Ministry of Health and Long-Term Care (MOHLTC) as a public policy initiative to ensure RPNs and RNs have guaranteed full-time employment and orientation lasting 12 to 18 weeks (Health Force Ontario, 2015). In 2009, 51% of all new graduate nurses in Ontario (RN = 2910; RPN = 2229) participated in the program (Baumann, Hunsberger, & Crea-Arsenio, 2012). Baumann et al. (2012) studied nurses that participated in the NGGI from 2009-2010 ($N =$

1358) and reported that 79% of participants rated their experience as good, very good, or excellent. They did not report turnover and retention rates.

APNs are clinical nurse specialists or Nurse Practitioners with a graduate-level education and in-depth nursing knowledge that is optimized to improve patient, family, and community health outcomes (Canadian Nurses Association [CNA], 2008). APNs practice in the domains of clinical consultation and collaboration, leadership, research, and education (CNA, 2008). There is still a lack of APN role clarity in the nursing literature as they are often viewed as clinical nurse educators (specifically non-Nurse Practitioner APNs).

Despite the lack of role clarity, the use of APN's has been identified as a support strategy for new graduate nurses (Adams et al., 2015; Glynn & Silvia, 2013; Hatler et al., 2011; Strauss, 2009). APNs were observed to support new graduate nurses throughout their transition (Adams et al., 2015; Glynn & Silvia, 2013; Hatler et al., 2011; Strauss, 2009). APNs have been used as an educational resource to help meet new graduates' knowledge deficits (Strauss, 2009). APNs can support new graduate nurses by creating individualized learning plans (Hatler et al., 2011). Additionally, APNs can indirectly support new graduate nurses through their mentoring relationships with and support of preceptors (Adams et al., 2015; Glynn & Silvia, 2013; Strauss, 2009). Clinical nurse specialists have been involved in the successful development, implementation, and evaluation of nurse transition programs in specialized nursing units, such as emergency departments and critical care units (Adams et al., 2015; Glynn & Silvia, 2013). A program evaluation by Hatler et al. (2011) concluded that when an APN was involved in the development and implementation of new nurse transition programs, new graduate nurses used the APN as a resource throughout their transition. Furthermore, when an APN was visible in the

early stages of the new graduate nurses' transition, new graduates developed rapport with the APN and felt comfortable accessing and seeking their knowledge (Hatler et al., 2011).

The overarching theme of the new graduate nurse transition literature is that new graduate nurses find their transition stressful. Furthermore, when new graduate nurses do not feel supported in their new role, they often change jobs or leave the profession, leading to poor retention rates. For these reasons, it is paramount that new graduate nurses are supported by other members of the nursing profession during their transition.

2.2.3 Limitations of the literature on new graduate nurse transition.

The concept of new graduate nurse transition was inconsistently defined in the literature. Duchscher's theory (2008) suggested that new graduate nurse transition occurs over 12 months. Benner (1982) identified that a nurse is not considered competent until practising in a similar practice setting for two to three years. Meleis (2010) did not provide a timeline for a transition, suggesting that each transition is unique and is influenced by many internal and external factors. Kramer (1974) did not specify the length of the new graduate nurse transition.

The lack of a clear understanding of the concept of new graduate nurse transition has created confusion when reviewing the literature and comparing results. For example, both Unruh and Zhang (2014) and Kovner et al. (2014) reported the turnover rates for their samples of new graduate nurses. However, Unruh and Zhang (2014) defined new graduate nurses as a nurse working less than 24 months whereas Kovner et al. (2014) defined new graduate nurses as a nurse working between 6 and 18 months. Therefore, transferability of the findings in the literature can be difficult because many studies used the same language but with different time referents. For the purpose of this thesis, a new graduate nurse is defined as a nurse who has been working as a nurse for less than 12 months (Duchscher, 2012).

The studies focusing on APN support for new graduate nurses poorly defined the role of APNs (Adams et al., 2015; Glynn & Silvia, 2013; Hatler et al., 2011; Strauss, 2009). This limits the transferability of those findings because APNs sometimes practice in the nurse educator role. Therefore, it is unclear if new graduate nurse support is truly associated with APNs, or just specific aspects of the APN role.

New graduate nurse transition has historically been studied in the context of RNs. The seminal works of Kramer, Benner, and Duchscher were based on the study of RNs as they transitioned from a student to an independent practising nurse. Currently, there is no literature on the transition of new graduate RPNs, despite a significant number of new graduate RPNs in Ontario. In Ontario in 2014, there were 7,434 newly licensed RPNs and RNs registered with the College of Nurses of Ontario (CNO) after completing an Ontario nursing education program (CNO, 2016b). Of those, 47% ($n = 3,460$) were RPNs (CNO, 2016b). From 2010 to 2015, the total number RPNs in Ontario had increased from 36,588 to 48,881, respectively (CNO, 2011, 2016a). During that same time, the total number of RNs in Ontario had decreased from 113,332 to 105,427, respectively (CNO, 2011, 2016a). Although both use the title “nurse”, there are differences in their scopes of practice. Nonetheless, this lack of theoretical and empirical knowledge and evidence on the transition of new RPNs is an important limitation of the current literature.

2.3 Dementia Care in Acute Care

The following section is a review of the literature on dementia care in acute care environments. The number of people living with dementia in Canada is increasing (Health Canada, 2014). In 2011, there were 747,000 Canadians diagnosed with dementia, and that number is estimated to double to 1.4 million by 2031 (Alzheimer’s Society of Canada, 2017).

The Canadian Nurses Association ([CNA] 2016b) has called this rise a future healthcare epidemic. In Ontario, one in ten seniors over the age of 65 has dementia (MOHLTC, 2015). The current cost of providing dementia care in Canada is \$15 billion annually, and will continue to rise with the aging baby boomer generation (CNA, 2016b).

As the prevalence of dementia increases, the number of people with dementia admitted to acute care hospitals will increase (CNA, 2016b; Andrews, 2010). In Canada, 66% of hospitalized inpatients are 65 years or older, and it is estimated that between 13-20.4% of hospitalized inpatients have dementia (CNA, 2016b; Royal College of Psychiatrists, 2005). Patients with dementia are admitted to acute care more frequently and for longer durations than the general public (Alzheimer's Australia, 2014). On average, one in four patients with dementia are admitted to acute care hospitals once a year, and their average length of stay is 16.4 days; almost twice as long as other patients at 8.9 days (Alzheimer's Australia, 2014). Patients with dementia require acute care admissions for management of chronic comorbidities, acute illnesses, or traumatic injuries (CNA, 2016b).

Patients with dementia have a higher risk of adverse events than patients without dementia admitted with the same acute care diagnosis (Alzheimer's Association, 2010). Alzheimer's Australia (2014) reports that patients with dementia in acute care are five times more at risk of mortality with a hospital admission, and are more likely to fall, develop a pressure ulcer or sepsis compared to patients without dementia. Patients with dementia experience physical and mental deconditioning during their hospital stay from lack of ambulation, stimulation, and a change in their environment and daily routine (Andrews, 2010; Zekry et al., 2009). This often results in a need for an increased level of care upon discharge, increasing their length of stay or requiring them to move to an assisted care centre (Bail et al., 2013).

The following sections discussed the three themes that emerged from the literature review: (1) the philosophy of person-centred care, (2) nurses and dementia care in acute care environments, and (3) nursing students and dementia care.

2.3.1 Person-centred care.

Person-centred care is a philosophy of care that is often applied when caring for patients with dementia (Brooker, 2003; Cowdell, 2006; Keady & Jones, 2010; Love & Pinkowitz, 2013). Several definitions of person-centred care have been articulated including: care that “focuses on the individual needs of a person rather than on efficiencies [for] the care provider; builds upon the strengths of a person; and honours their values, choices, and preferences” (Love & Pinkowitz, 2013, p. 23); “care [that] is to respect personhood despite cognitive impairment” (Clissett, Porock, Harwood, & Gladman, 2013); care that values the individual and their loved one, care that is individualized, empathizing with the individual viewing the world through them, and supporting an environment in which the individual can experience well-being (Brooker, 2003); and care that is holistic, individualized, respectful, and empowering (Morgan & Yoder, 2012). The later definition by Morgan and Yoder (2012) will be used in the context of this thesis for its simplicity and inclusivity.

The concept of person-centred care was first theorized by Kitwood and Bredin (1992) as personhood; the meaning of being a person. Kitwood and Bredin (1992) recognized there was a growing number of people living with dementia and that caring for patients with dementia was difficult for caregivers. Kitwood (1997) challenged the status quo medical model of care, which focused on the disease and often neglected the whole person. Kitwood advocated for dementia care to concentrate on the individual, their experience, and their needs, in turn, restoring the forgotten assumption that people with dementia are still valuable social beings. For example,

Kitwood (1997) suggested that caregivers (nurses) need to have knowledge about the whole individual in order to provide person-centred care and to preserve personhood. Nurses caring for patients with dementia should have knowledge about the patients' functional abilities, care needs, sleep routine, dietary preferences, anxiety-producing behaviours, relaxation techniques, and background knowledge of their psychosocial history, interpersonal relationships, and their support system to ensure the nurse can provide care that is respectful, empowering, and tailored to the individual person (Kitwood, 1997; Morgan & Yoder, 2012).

The CNO and the CNA support the person-centred philosophy of care (CNA, 2017; CNO, 2009). The CNO defines person-centred care as care that “involves advocacy, empowerment, and respect for the client’s autonomy, voice, self-determination and participation in decision-making” (2006, p. 4). Additionally, the CNO Ethics Standards (2009) and the CNA’s Code of Ethics (2017) focus on the underpinnings of person-centred care, as defined by Morgan and Yoder (2012). The CNO’s ethical values consist of nursing care that focuses on client well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness, and fairness (CNO, 2009). The CNA’s nursing values consist of nursing care that is safe, compassionate, competent and ethical; care that promotes health, well-being and informed decision-making, care that preserves dignity, maintains privacy and confidentiality, and care that promotes justice (CNA, 2017).

2.3.2 The experience of nurses caring for patients with dementia care in acute care environments.

Nurses have reported that caring for patients with dementia in acute care environments is challenging and frustrating, particularly as responsive behaviours often make it difficult to complete nursing care (Ericksson & Saveman, 2002; Fukuda et al., 2015; Moyle et al., 2011).

Responsive behaviours include: attempts at elopement, non-purposeful walking, agitation, and yelling or physical aggression (Alzheimer Society Ontario, 2014). When patients with dementia do not have the cognitive ability to communicate their needs, they may exhibit responsive behaviours in response to physical needs (e.g., pain, hunger), intellectual needs (e.g., unable to do a task, unable to communicate), emotional needs (e.g., feeling anxious or lonely), environmental needs (e.g., noise, brightness) or any other need (Alzheimer Society Ontario, 2014; Baillie et al., 2012a; Fukuda et al., 2015). Many responsive behaviours are disruptive to other patients in acute care environments (e.g., wandering into other patients' rooms, yelling and calling out) or to nursing staff (e.g., wandering into nursing work environments, require more time from staff to supervise the patient, verbally and/or physically aggressive) (Alzheimer Society Ontario, 2014). Responsive behaviours are often labelled as problematic in the acute care environment because they can increase the amount of time required by staff to complete nursing tasks, as well as compromise the safety of patients and nursing staff (Cowdell, 2010; Ericksson & Saveman, 2002; Moyle et al., 2011).

Responsive behaviours are a concern for acute care nursing staff because patients with dementia may fall, injure themselves or injure others (Baillie et al., 2012a; Cowdell, 2010; Ericksson & Saveman, 2002; Fukuda et al., 2015; Moyle et al., 2011). In order to manage responsive behaviours, nurses often use excessive monitoring or chemical (e.g., sedative medications) or physical (e.g., wheelchair seatbelts, waist belts) restraints (Ericksson & Saveman, 2002; Moyle et al., 2011). Providing care to patients with dementia who are experiencing responsive behaviours in acute care has been reported by nurses as frustrating, leading to feelings of powerlessness (Ericksson & Saveman, 2002).

Nurses perceived that they have a dementia care knowledge deficit regarding techniques to manage these responsive behaviours (Cowdell, 2010; Fukuda et al., 2015; Gandesha, Souza, Chaplin, & Hood, 2012). A large study by Gandesha et al. (2012) surveyed 2,211 acute care medical and surgical nurses, physicians, and personal support workers in England and Wales. They reported their participants felt they were insufficiently educated in dementia care, dealing with responsive behaviours, restraint use, communicating with patients with dementia, dementia palliative care, and pain assessment. The authors reported that this knowledge deficit exacerbated feelings of frustration and being overwhelmed among their participants (Gandesha et al., 2012). A cross-sectional survey evaluated Taiwanese acute care nurse's ($N = 124$) dementia care knowledge in relation to their education approach and knowledge toward dementia care (Lin, Hsieh, & Lin, 2012). Participants included nurses with a 2-year college education and a 4-year university education, with both groups reporting having difficulties differentiating between dementia and delirium.

The literature suggested that the acute care environment is fast-paced, with frequent admissions, discharges, and higher acuity patients (Ericksson & Saveman, 2002; Grinspun et al., 2016; Moyle et al., 2011). Labo (2010) suggests that “hospitals are essentially becoming large intensive care units with increasing acuity, chronic conditions and decreasing length of stay” (p. 22). This environment creates a demanding workload for acute care nurses (Ericksson & Saveman, 2002; Grinspun et al., 2016; Moyle et al., 2011). As such, nurses must prioritize their nursing care (Cowdell, 2010; Moyle et al., 2011). Several studies have reported that the busy demands of the acute care environment often resulted in psychosocial care needs of patients with dementia being treated as a lesser priority, despite their acute diagnosis (Baillie et al., 2012a; Cowdell, 2010; Moyle et al., 2011). Cowdell (2010) suggested that dementia care as lesser

priority is a systemic problem and reported that “people with dementia are often viewed by society as unimportant, and this lack of value tends to extend to clinical staff” (p. 46). Moyle et al. (2011) also supported this by stating, “the focus of care in the hospital environment was strongly geared towards acute problems, and patients suffering from dementia were viewed as low-priority cases” (p. 422).

Two observational studies were conducted to observe how patients with dementia interacted with their acute care environment and the nursing staff (Cowdell, 2010; Norman, 2006). Both studies found that nurses seldom individualized nursing care for these patients and gave limited or no choice to patients, which often left the patients scared and upset (Cowdell, 2010; Norman, 2006). Both studies reported that the environment itself appeared inappropriate for this patient population, because they were scolded when they attempted to explore the unit. Patients were also observed to be distressed by the noisy and distracting acute care environment (Cowdell, 2010; Norman, 2006). The nurses reported that they were aware of the suboptimal care they were providing (Cowdell, 2010) and that “people with dementia are not always provided with care that takes into account their individual needs” (Moyle et al., 2011, p. 426). As a result, nurses were not always able to provide person-centred care to patients with dementia in acute care environments (Moyle et al., 2011).

Two systematic reviews summarized the literature on dementia care in hospital settings (Dewing & Dijk, 2016; Moonga & Likupe, 2016). Both reviews included all the articles discussed in this current literature review. Moonga and Likupe (2016) reviewed 14 studies and Dewing and Dijk (2016) reviewed 53 studies. Moonga and Likupe (2016) reported that acute care nurses perceived caring for patients with dementia as challenging as a result of the patients’ responsive behaviours and nurses encountered ethical dilemmas while caring for patients with

dementia. This may lead to nurses feeling emotionally burdened as a result of dementia care in acute care. Moonga and Likupe (2016) also reported that the acute care environment was unsuitable to care for patients with dementia and that nurses identified a lack of training in dementia care.

Dewing and Dijk (2016) conducted a similar review regarding dementia care in general hospitals; however, they did not limit their review to the discipline of nursing. The authors reported one main theme from their review, that there are negative consequences for dementia patients when they are admitted into a hospital setting. In addition, the authors found four subthemes: (1) the acute care environment is not suitable for dementia patients, (2) culture of dementia care in acute care and the attitudes of acute care staff have negative effects on dementia care, (3) hospital staff reported having a knowledge deficit regarding dementia care, and (4) hospital staff (including nurses) and the caregivers (family) find caring for patients with dementia in acute care to be challenging.

Moyle et al. (2011) were the only authors to discuss novice hospital staff in the context of dementia care in acute care. They reported that hospital staff, “usually the most junior”, were often assigned to care for patients with dementia (Moyle et al., 2011, p. 423). Moyle et al. (2011) did not specify whether ‘junior hospital staff’ referred to nurses or nursing support staff.

2.3.3 Nursing students and dementia care.

The following two sections focus on: (1) nursing education and dementia care, and (2) the experience of nursing students and dementia care.

2.3.3.1 Nursing education and dementia care.

There are two different bodies that govern the Ontario nursing curriculum: the Canadian Association of Schools of Nursing (CASN) and the CNO. CASN’s role is to ensure consistency

across undergraduate (RNs) and graduate nursing programs across Canada (CASN, 2014), while the CNO is responsible for approving Ontario's entry-to-practice nursing programs (practical nursing programs and baccalaureate nursing programs). Currently, CASN does not outline a required amount of teaching or clinical hours for gerontology or dementia education; however, they are currently working on entry-to-practice competencies for geriatric nursing (CASN, 2014; Gould, Dupuis-Blanchard, & MacLennan, 2015). This decision to create entry-to-practice competencies for gerontological nursing is supported by the CNA (2016b) and the Registered Nurses Association of Ontario (RNAO; 2016), that suggested it is imperative that gerontological care and dementia care be a focus of all nursing programs.

The second governing body of Ontario nursing curriculum is the CNO. The CNO's Practice Standards, Practice Guidelines, and entry-to-practice competencies are the foundation of all Ontario nursing programs (CNO, 2016c). Therefore, every nurse who graduates from an Ontario nursing school will have met competencies required to practice nursing in Ontario (CNO, 2014a; 2014b). Nurses entering practice in Ontario must demonstrate this foundational knowledge by passing two registration examinations: 1) either the National Council Licensing Examination for RNs (NCLEX-RN) or the Canadian Practical Nurse Registration Examination for RPNs (CPNRE) in which candidates demonstrate an understanding of the CNO's entry-to-practice competencies; and 2) the jurisprudence examination (both RNs and RPNs) in which candidates demonstrate an understanding of the CNO's Practice Standards and Guidelines.

Nursing graduates demonstrate the foundational knowledge outlined in the entry-to-practice competencies by passing the National Council Licensure Examination-Registered Nurse (NCLEX-RN) or Canadian Practical Nurse Registration Examination (CPNRE). There are 100 entry-to-practice competencies for RNs and RPNs (CNO, 2014a; 2014b). Two of the RN entry-

to-practice competencies can be applied to gerontological nursing and dementia care (#25 and #65) and one competency (#58) specifically states dementia care (CNO, 2014b). The competencies for RPNs do not specifically mention gerontology or dementia care. Instead, the competencies discuss care across the lifespan (CNO, 2014a). The gerontological focused competencies for Ontario entry-to-practice are listed in Table 3.

Table 3.

College of Nurses of Ontario Gerontological Related Competencies

Registered Nurses Competencies	Registered Practical Nurses Competencies
Specialized Body of Knowledge Domain - Competency 25. <i>“The entry-level registered nurse demonstrates a body of knowledge from nursing and other disciplines concerning current and emerging health care issues (e.g., health care needs of older adults, vulnerable and/or marginalized populations, health promotion, obesity, pain prevention and pain management, end-of-life care, addictions, mental health)”</i> (CNO, 2014b, p. 6).	Assumption Domain – Assumption 3. <i>“Entry-level Registered Practical Nurses are prepared to practise safely, competently and ethically in situations of health and illness with individuals across the lifespan”</i> (CNO, 2014a, p. 3).
Content Application of Knowledge Domain - Competency 58. <i>“The entry-level registered nurse applied nursing knowledge when providing care to clients with acute, chronic, and/or persistent health challenges (e.g., stroke, cardiovascular conditions, mental health and addiction, dementia, arthritis, diabetes)”</i> (CNO, 2014b, p. 8).	Assessment Domain - Competency 3. An entry-level Registered Practical Nurse <i>“collaborates with clients across the lifespan to perform a holistic nursing assessment”</i> (CNO, 2014a, p. 6).
Content Application of Knowledge Domain - Competency 65. <i>“The entry-level registered nurse supports clients through developmental and role transition across the lifespan (e.g., pregnancy, infant nutrition, well-baby care, child development stages, family planning and relations, geriatric care)”</i> (CNO, 2014b, p. 8).	

Next, nurses entering the nursing profession in Ontario demonstrate their understanding of the CNO's Practice Standards and Guidelines by passing the jurisprudence examination (CNO, 2014d). The CNO's Practice Guidelines and Standards are a collection of documents that outline the expectations of all nurses to practice safe and ethical nursing care (CNO, 2013). The CNO's values are: client well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness, and fairness (2009). These values resemble Morgan and Yoder's (2012) definition of person-centred care. Within the Ethics Practice Standard, the CNO discusses that it is nurses' duty and responsibility to provide care that promotes client well-being and prevents harm (2009). Nurses are accountable to their patients; therefore they must not abandon or neglect their patients, and nurses should strive for fairness by providing, "equal attention, regardless of [the patient's] needs" (CNO, 2009, p. 16). In situations where the nurse feels they do not have the resources to provide care that meets the Ethical Practice Standards, they are to advocate for changes, while providing "the best possible care under the circumstances" (CNO, 2009, p. 14).

The CNO recognizes that each nurse has their own set of unique values and when a situation occurs that the nurse is providing care that goes against these values, they should try to arrange for an alternative caregiver (CNO, 2009). If an alternative caregiver is not immediately available, then the nurse must continue to provide care until an alternative solution is implemented. If there is a long-term conflict between the values of the nurse and the values of the place of employment, the CNO suggests that the nurse seeks employment where their values are upheld by the employer (CNO, 2009). The Ethics Practice Standard also emphasize the importance of being honest and truthful with patients and families, as an untruthful statement not only compromises the therapeutic nurse-patient relationship, but is also unethical (CNO, 2009).

Although the CNA is not responsible for governing the nursing curriculum, schools of nursing are also required to teach students the CNA's Code of Ethics (2017). The CNA's nursing and ethical responsibilities are to: provide safe, compassionate, competent, and ethical care, promote health and well-being, preserve dignity, and be accountable (CNA, 2017). The CNA's code of ethics is parallel to the CNO's nursing values (2009) and the theoretical underpinnings of person-centred care (Morgan & Yoder, 2012).

Nursing students in Ontario graduate with foundational nursing knowledge and understanding of ethical care. The CNO's Practice Standards and Guidelines are embedded in Ontario's nursing curriculum, therefore once new graduate nurses are practising, they have adopted the CNO's ethical values of client well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness, and fairness (CNO, 2009).

2.3.3.2 The experience of nursing students in dementia care.

Researchers suggested that students have mixed perceptions and experiences about gerontological nursing and dementia care (Baillie et al., 2012b; Gould, Dupuis-Blanchard, & MacLennan, 2015). Gould and colleagues (2015) interviewed 20 Canadian baccalaureate (RN) nursing students about their overall experience of gerontological nursing in school. The authors reported that students perceived gerontological nursing to be boring, routine, and considered it *less than* other nursing specialities. They also suggested that their negative view was influenced by their preceptors. These participants reported gerontological care to be *basic* and should be delivered by less qualified nurses, such as RPNs or personal support workers (Gould et al., 2015). In the same study, some students had positive experiences, reporting they enjoyed establishing therapeutic nurse-patient relationships with patients with dementia.

Baillie and colleagues (2012b) interviewed 20 undergraduate nursing students in the United Kingdom who reported that their perception of dementia care was negatively influenced by their clinical preceptors. The authors reported that their participants stated that their preceptors suggested gerontological and dementia nursing was not a valued or respected nursing specialization. This experience left the participants feeling that dementia patients are less important than other acute care patients. In a second study, Baillie et al. (2012a) interviewed United Kingdom undergraduate nursing students ($N = 24$) and reported that students had unrealistic expectations of the amount of time they could spend providing care to patients with dementia. Students reported eating their own lunch with patients to ensure the patient had adequate intake and spending their mornings bathing patients (Baillie et al., 2012a). Although these students found ways to provide person-centred care, they limited their own breaks, thus not creating a realistic expectation of care for when they practice as new graduate nurses. Additionally, students often are only responsible for one to three patients, therefore as new graduate nurses, they may not have the time to provide the type of care they provided as students.

2.3.4 Limitations of the literature on dementia care in acute care.

There were several limitations to the literature on dementia care in acute care. There were a limited number of studies focusing on students and gerontological/dementia care context. Not all authors specified the designation of the nurses sampled in their research, therefore, it is unknown if the literature regarding the experience of nurses providing dementia care included RNs, RPNs, or both. This limits the transferability of the findings because it is unclear which type of nurse the findings apply to. Additionally, of the studies that did state the type of nurse

sampled, no study explicitly stated they sampled RPNs. Therefore, it is unclear if RPNs have been included in previous nursing studies.

There was a gap in the literature regarding new graduate nurses and dementia care in acute care environments. One study by Moyle et al. (2011) reported that junior staff are often assigned to care for patients with dementia. However, the author did not define junior staff, therefore it is unclear if junior staff refers to new graduate nurses or nursing support staff. Again, this limits the transferability of the findings. Given the challenges nurses' experience when providing care to patients with dementia in acute care, nurses with all levels of experience, including new graduate nurses, should be explored.

2.4 Summary of the Literature

It is evident that nurses struggle to provide person-centred care to patients with dementia in acute care environments because they experience a knowledge deficit regarding dementia care interventions, lack of time to provide care, and experience difficulties dealing with responsive behaviours. The literature suggests that nurses may find themselves providing care that goes against their nursing values, resulting in feeling frustrated and overwhelmed. The busy demands of the acute care environment can lead to patients with dementia being treated as a lesser priority. Nursing students also reported similar challenges.

New graduate nurses experience stress during their transition from nursing students to their new role as professional nurses and as a result, require support during this time to ensure they have a successful transition. Being a new graduate nurse is a complex experience with many challenges. With the increasing number of patients with dementia in acute care settings, there will be an increasing number of new graduate nurses caring for this patient population. Currently, little is known about the experience of being a new graduate nurse caring for patients

with dementia in acute care. A research study on this topic is warranted to explore how the nursing profession can best support and prepare new graduate nurses to provide person-centred care for patients with dementia in acute care.

Chapter 3: Methodology

This chapter will discuss the methodology used to assist the researcher in answering the research question: *What is the experience of new graduate nurses when providing care for patients with dementia in acute care environments?* The philosophical paradigm, research design, conceptual framework, and theory used to guide this thesis will be discussed. Additionally, the research methods, ethical considerations, and rigour will be outlined.

3.1 Philosophical Paradigm

The research question was approached through a constructivist lens. Constructivism involves the social construction of knowledge through the subjective lived experiences of the individuals who experience a phenomenon (Guba & Lincoln, 1994). Constructivism arose during the postmodernism cultural era and emphasized the deconstruction of experiences to allow for the reconstruction of new knowledge (Polit & Beck, 2012). Constructivist researchers embrace the existence of multiple realities within a phenomenon; these realities are considered truths in the context of the individuals describing them (Guba & Lincoln, 1994). A constructivist approach was chosen for this thesis because there is little known about the experiences of new graduate nurses caring for patients with dementia in acute care environments. Through a constructivist lens, the researcher collaborated with participants to create a rich understanding of this unknown research topic.

The constructivist paradigm has unique ontological, epistemological and methodological underpinnings that guide its application in nursing research. Constructivism assumes a relativist ontology (Guba & Lincoln, 1994). A relativist ontology is the understanding that reality is comprised of multiple subjective experiences (Polit & Beck, 2012). Many people may encounter

the same phenomenon, however, each individual will interpret their subjective reality slightly differently (Polit & Beck, 2012).

The second philosophical underpinning in the constructivist paradigm focuses on the relationship between the researcher and the research participants (Polit & Beck, 2012). This is referred to as the epistemology. Both the researcher and the participants are fundamental to the construction of new knowledge. For example, in an interview, the researcher is required to socially interact with the participant, which will develop the research findings (Appleton & King, 1997; Guba & Lincoln, 1994).

Lastly, methodology refers to how evidence is obtained (Polit & Beck, 2012). In the constructivist paradigm, evidence is constructed by collecting the participants' subjective experiences (Polit & Beck, 2012). Common methods used to obtain this knowledge include individual or group interviews, observation, and written responses to open-ended questions (Polit & Beck, 2012). Knowledge obtained from these processes is not considered a fixed reality but a construction of reality as it exists for individuals experiencing it within the context of their environment (Guba & Lincoln, 1994). For example, all of the participants in this thesis will have experienced being a new graduate nurse caring for patients with dementia in acute care. Their collective experiences will be used to illuminate our understanding of the experience of the phenomenon. However, the knowledge created cannot be considered fixed because subjective experiences evolve and change under the influence of context, environment, and time (Guba & Lincoln, 1994). The knowledge created in this thesis can be considered truth within the context of the study participants (Polit & Beck, 2012).

3.2 Methodology: Interpretive Description

Situated within the constructivist paradigm, interpretive description is a qualitative research methodology developed and theorized by Sally Thorne in 1997 (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997). Interpretive description was developed for practice-based applied health disciplines, such as nursing (Thorne, 2013). This research design emerged as a methodological approach to better understand nursing's complex clinical-based phenomena and to produce knowledge that advances the nursing discipline (Thorne, 2013).

The aim of interpretive description is to look beyond the pure description of the phenomenon and to discover patterns, associations, and relationships within the phenomena (Thorne, 2008). This is achieved using methods that allow for thematic analysis or thematic summary. Interpretive description does not offer a *prescribed qualitative method*; instead, it allows the researcher to assess the state of knowledge and borrow appropriate qualitative techniques that will contribute to the development of practice-based knowledge (Thorne, 2008). Therefore, the researcher used the thematic analysis method by Braun and Clarke (2006) for this thesis.

3.3 Conceptual Framework and Theory

Thorne (2008) suggests that a study's a priori theory is composed of the researcher's understanding of the literature and their personal experience of the phenomenon under study. Researchers using interpretive description come from applied health disciplines and may situate themselves within the theoretical underpinnings of their discipline (Thorne). As a result, the researcher needs to be aware of this prior to entering the research field to ensure their preconceived theoretical stance of the phenomenon under study does not contribute to bias. Thorne has termed this self-awareness as *theoretical scaffolding*.

Theoretical scaffolding encompasses the researcher's knowledge of the literature specific to the nursing problem and also how the researcher situates themselves in the research and occurs in two parts. The first part involves a comprehensive understanding of and critical reflection on the literature about the phenomenon under study. The literature that the researcher used to develop his theoretical stance was presented in Chapter 2.

The second part of theoretical scaffolding involves locating ones' self within the discipline and the theoretical world. Thorne (2008) suggests that the researcher uses a reflective journal to create self-awareness about their philosophical lens. The purpose of a reflective journal is to ensure the researcher's preconceived knowledge of the phenomena under study (from experience or literature) does not mislead the researcher as the research instrument during data collection and analysis (Throne, 2008).

As the researcher, I situated myself within the theoretical world by immersing myself in the discipline of nursing through a comprehensive reflection of the theoretical works of Kramer (1974), Benner (1982), Meleis (2010), and Duchscher (2012). Furthermore, I have critically reflected upon my personal experiences with the discipline of nursing and my personal experience as a new graduate nurse caring for patients with dementia care in acute care settings.

My mother is an RN and I grew up listening to stories about her work. These stories highlighted both the positive and negative aspects of the nursing profession, and helped prepare me for what to expect before entering the nursing profession. I also had a close relationship with my three living grandparents. My grandpa was diagnosed with dementia when I was in high school. During nursing school, my grandpa moved into long-term care and passed away shortly after.

During the summers while in nursing school, I worked as a personal support worker in long-term care. It was there where I first learned how to care for patients with dementia and developed organizational and inter-professional teamwork skills. My experience in long-term care helped me to recognize my passion for gerontological nursing.

I was employed as a clinical extern at a local rural hospital during the summer of my third year of nursing school. As a clinical extern, my role was to shadow and observe my RN mentor. During this summer job, I was socialized into acute care nursing by shadowing RNs on a variety of units including: medical and surgical, labour and delivery and maternal child, emergency, complex continuing care, and perioperative care. During that time, I also shadowed a community Nurse Practitioner who specialized in the care of older adults and patients with dementia.

My final clinical placement during my undergraduate education was on an orthopaedic and general surgical unit at the hospital where I wanted to work upon graduation. This additional experience at my future workplace allowed me to socialize into the work environment prior to starting my transition. Upon hire, I participated in a six-month new nurse transition program where I felt welcomed and supported by staff, engaged in out-of-work social functions, and became friends with many colleagues during my first year of employment. During my new graduate transition, I cared for many patients with dementia on the busy surgical unit. I found that patients with dementia were sometimes challenging to care for; they wandered around the unit, were difficult to communicate with, were often restless, refusing care or trying to get out of bed. When a patient with dementia became at risk of injuring themselves, they were often restrained in their bed or chair and moved to the hall or nursing station for closer observation

when family members were not present. During my time as a new graduate nurse, I completed a certificate in dementia care.

After working on the acute care surgical unit for 18 months, I started work at a large urban teaching hospital in the cardiovascular intensive care unit. Although I was no longer a new graduate nurse, I experienced an unhealthy transition. The new unit was an unsupportive work environment and I did not develop relationships with colleagues or a sense of connectedness to the team. I only worked there for seven months before leaving to return to graduate school.

The majority of my four years of practice as an RN in Ontario was spent on medical/surgical units at three different acute care hospitals. During that time, I worked collaboratively with RPNs. The RN to RPN ratio varied from 1:1 to 1:2. RPNs cared for patients with dementia as often as RNs, if not more often.

It is through these personal experiences, professional practice, nursing education, and review of the literature that the writer developed a theoretical perspective of the phenomenon under study. This theoretical understanding served as the theoretical scaffolding of this interpretive descriptive study.

3.4 Methods

This thesis is a qualitative research study using interpretive description. The following section presents the methods used for sampling and recruitment, data collection, and data analysis.

3.4.1 Sampling.

Purposive and snowball sampling methods were used to obtain participants that had experience with the phenomena under study (Polit & Beck, 2012). The inclusion criteria for the study required that participants were: (1) English speaking, (2) employed as RNs or RPNs in

Ontario, (3) currently working on medical and/or surgical units in acute care hospitals, (4) had provided care for patients with dementia independently, and (5) have been working as a nurse for three to 12 months (Table 4).

Table 4.

Participant inclusion criteria and rationale

Participant Inclusion Criteria	Rationale
English speaking	The key informants were Anglophone nurses who worked at English speaking hospitals in Ontario, therefore it was suspected that participants would be Anglophone. Additionally, the researcher was unilingual, as such, he would not be able to conduct an interview in French and analyze data analysis in French.
Registered Nurses or Registered Practical Nurses	Although RNs and RPNs have a different role and scope of practice (CNA, 2016a; CNO 2014c), they both work in acute care and both can experience the phenomenon under study. By selecting RNs and RPNs, the researcher used person triangulation to collect data from both nursing levels, validating the data through multiple perspectives (Polit & Beck, 2012). Ontario nurses were selected based on the geographical feasibility. By selecting participants from multiple sites across Ontario, space triangulation was used to get a variety of experiences and test for data consistency (Polit & Beck, 2012).
Working in medical/surgical units in acute care hospitals	Phenomenon under study.
Cared for patients with dementia	Phenomenon under study.
Working for three to 12 months as a nurse	The range of experience of the new graduate nurse for sampling is three to 12 months. Duchscher (2012) described that during the first three months of professional employment as a nurse, new graduate nurses are being introduced to “workplace structure and function including orientation to professional roles and responsibilities within a work environment” (p. 166). During this time, new graduate nurses may not have independent experiences with patients with dementia to reflect upon for the study (Duchscher, 2012). However, as suggested by Meleis (2010), transition is a fluid experience that varies for everyone, therefore the researcher included one participant that expressed interest in participating and whose experience was two months, and they met all of the other inclusion criteria.

3.4.2 Sample size.

The targeted sample size was between eight and twelve participants. The researcher chose this sample size because he wanted to obtain a rich set of subjective experiences from both RNs and RPNs. During data collection and data analysis, the researcher assessed for patterns and themes using the first steps of Braun and Clarke's (2006) thematic analysis method (Table 5). Determining the sample size is often guided by data saturation, however, Thorne (2008) suggests that this common goal is unlikely to occur in applied health disciplines, such as nursing. Therefore, achieving a variety of subjective experiences of the phenomenon was valued over data saturation to guide sample size for this study. After each interview, the researcher discussed the transcripts with the committee to determine if there were new themes. After the 11th interview, there were no new emerging themes. Furthermore, the participants had provided a variety of subjective experiences. It was determined at that time that the researcher had enough data to analyze the phenomena under study and answer the research objectives.

3.4.3 Recruitment.

Recruitment occurred over eight months from July 2016 to February 2017 using multiple recruitment methods. The recruitment strategy overview, timeline, and outcomes are outlined in Appendix E. The recruitment strategies selected allowed for purposive and snowball sampling methods (Polit & Beck, 2012). First, key informants were used to obtain a snowball sample (Polit & Beck, 2012). The researcher developed a recruitment poster (Appendix F) which was distributed to key informants via email and the social media platform Facebook. The key informants were hand selected by the researcher as individuals who had access to a network of new graduate nurses working in acute care in Ontario. The key informants were asked three times to forward the recruitment poster to their network to facilitate snowball sampling (Polit &

Beck, 2012; Thorne, 2008). Key informants were used to ensure the researcher did not make participants feel obliged to participate in the study because of their relationship to the researcher (nursing colleagues). The relationship between the researcher and each key informant was a past or present professional nursing colleague. Eight RNs and five RPNs working in various locations throughout Ontario were selected as key informants. Key informants were not participants in the study, and they were under no obligation to forward the recruitment poster to their networks. The informants did not know who was participating in the study; interested participants were asked to contact the researcher directly.

The target sample size was not achieved using snowball sampling via key informants, therefore several other recruitment strategies focused on purposive sampling were applied. The second recruitment strategy involved posting the recruitment poster on 22 Ontario colleges and 17 Ontario university 2015-2016 nursing alumni Facebook groups. The recruitment poster was posted by the researcher between one and three times in each group. This strategy was chosen to purposely target Ontario new graduate nurses. Next, the researcher distributed 94 recruitment posters at the Registered Practical Nurses Association of Ontario's Conference in September of 2016. This conference was chosen to purposely recruit new graduate RPNs as, during this phase of recruitment, there were fewer RPN than RN participants. Lastly, the researcher posted a recruitment advertisement in the Registered Nurses Association of Ontario and the Registered Practical Nurses Association of Ontario journals (Appendix G). These journals were selected to purposely target new graduate nurses as this population received free subscriptions.

Nurses who were interested in participating in the study contacted the researcher via email or Facebook Messenger. The researcher selected participants based on the inclusion criteria described on a first-come-first-served basis until the target sample size was met (Polit &

Beck, 2012). A total of 12 participants contacted the researcher. One participant was declined because she has been working for 18 months, which was outside of the inclusion criteria.

3.4.4 Data collection.

Data collection and analysis were iterative processes that took place simultaneously. Interviews were conducted between July 2016 and January 2017. All interviews took place over Skype or Facebook video chat. Semi-structured interviews were used to extract subjective, first-hand knowledge of the phenomenon from participants (Thorne, 2008). This ensured that the researcher obtained data pertinent to the research question, but also allowed for flexibility for the participants to share their experiences (Polit & Beck, 2012; Thorne, 2008). An interview guide aided the researcher during data collection (Appendix H) and the researcher provided the participants with context to each of the questions to ensure that they were aware of what was being asked (Thorne, 2008).

All interviews were audio-recorded and transcribed by the researcher. Interviews ranged from 30:12 to 57:32 minutes in length, with a mean of 45:32 minutes. Transcriptions were verified for accuracy against the audio recordings. The researcher maintained field notes during the interviews, such as passionate expressions, phrases with emotions, and information pertaining to the phenomenon under study (Polit & Beck, 2012). These field notes were used to help the researcher organize his thoughts during the interviews. Additionally, comments in the field notes were used to help the researcher flag passionate expressions and phrases with emotions in the transcripts. After the interviews, the researcher reflected on his experience in his reflective journal. The researcher had his thesis supervisor review the first two transcripts to provide feedback and advice on his interviewing technique.

3.4.5 Data analysis.

As per Thorne (2008), the goal of data analysis in interpretive description is to develop a thematic analysis and summary of the clinical phenomena and to identify patterns and relationships within the data. Thorne (2008) does not specify a specific approach for data analysis and suggests that researchers borrow appropriate techniques that will assist them in best answering the research question. Therefore, the researcher used the thematic analysis method by Braun and Clarke (2006) to produce a rich interpretation and analysis of the data (Thorne, 2008). Braun and Clarke (2006) outlined a 6-step process for data analysis. These six steps are described in Table 5 along with how Braun and Clarke's method was applied to data analysis in this study.

Table 5.

Data Analysis Steps

Step	Objectives	Data Analysis
Step 1: Familiarizing yourself with your data	<p>To immerse yourself in the data to become familiar with it. This can be done by transcribing the interviews and re-reading the transcripts.</p> <p>During reading, start taking notes about ideas for coding (Braun & Clarke, 2006).</p>	<p>Like Braun and Clarke (2006), Thorne (2008) recommended familiarizing oneself with the data by transcribing and re-reading the data corpus. Thorne also recommended flagging and harvesting interesting pieces of data into categories that can be easily refined and adapted.</p> <p>The researcher transcribed the audio recordings after each interview. Once the transcript was typed, the researcher read the full transcript while listening to the audio. During the first read, the researcher situated himself in the data and looked at the data set as a whole and made notes about commonalities in the data.</p>
Step 2: Generating initial codes	<p>To make a list of initial ideas arising from the data and determine what is interesting about them.</p> <p>Step 2 ends when all data has been coded (Braun & Clarke, 2006).</p>	<p>Thorne (2008) discussed the different option to coding data. Although very similar, she prefers the term <i>flagging and harvesting</i> as more consistent with interpretative description's evolving analytic process.</p> <p>During the second review of the corpus data, the researcher highlighted the word documents and made notes of ideas, similarities, and commonalities among the data. From this highlighted data, the researcher made a collection of the different codes. A total of 23 codes were produced (Appendix I).</p>
Step 3: Searching for themes	<p>To sort through codes to determine potential themes.</p> <p>To make a visual depiction to help represent how the potential themes are related. Thorne (2008) supported the concept of developing a visual map to</p>	<p>The researcher reviewed the codes and organized them by using a concept map. Several drafts of the concept maps occurred as he organized and reorganized the codes together. This resulted in a concept map where the codes were organized into potential major themes and several sub-themes. There was also a group of codes that did not fit into these potential themes. When this occurred, the researcher would discuss the outlier data with his supervisor to</p>

Step	Objectives	Data Analysis
	<p>assist the researcher in organizing and interpreting the data. She suggested visual maps help depict relationships within the phenomena.</p> <p>To think about the different relationships between the themes, different levels of themes.</p> <p>Step 3 ends with the potential themes organized into main themes, sub-themes and other data (Braun & Clarke, 2006).</p>	<p>determine where the data belonged.</p>
<p>Step 4: Reviewing themes</p>	<p>To review potential themes: some may merge together, some may become two separate themes, others may not be themes (Braun & Clarke, 2006). There are two parts to step 4.</p> <p>Part 1: Review all the coded data within a potential theme. Is there a coherent pattern? If yes, then go to part 2. If no, rework the theme (remove data extracts, create a new theme, return to corpus data).</p> <p>Part 2: Reread the entire data set to determine if the potential themes fit into the entire set and to code any additional data which may have been forgotten. Do the potential themes fit into the thematic network/map?</p> <p>Step 4 ends with a good understanding of</p>	<p>Once the preliminary themes were discussed, the researcher compared each theme to the others to determine if there was overlap and if the data fit in multiple places. During this process, the preliminary themes were revised and refined. Once the data fit into the themes, the researcher returned to the data corpus and reread the entire data set to determine if the themes represented what the participants said. During this process, the researcher also extracted data that was missed during the previous steps. The researcher was in frequent communication with his supervisor and committee during this process.</p> <p>Thorne (2008) stressed the importance of spending enough time with the data to ensure that the research identifies patterns and relationships within the data.</p>

Step	Objectives	Data Analysis
	the different themes, their relationship to one another and to the overall data (Braun & Clarke, 2006).	
Step 5: Define and naming themes	<p>To define and refine the themes by describing the essence of the theme.</p> <p>To organize the collected data extracts, identify what is significant about them and why. Analyze each theme by itself and in relation to other themes. Determine what is a major theme, sub-theme, and not a theme (Braun & Clarke, 2006).</p> <p>Step 5 ends with a clear definition of what each theme is and what it is not (Braun & Clarke, 2006).</p>	The researcher defined each theme using participant data. Once each theme was defined by itself, the researcher determined which themes represented the overall data (themes) and which themes represented parts of the data (sub-themes). Once finalized, the thesis committee reviewed the researcher's interpretation and description of the data.
Step 6: Producing the report	<p>To tell an interesting account of the complete story using vivid data excerpts (Braun & Clarke, 2006).</p> <p>Step 6 ends with the final analysis, write-up, and manuscript (Braun & Clarke, 2006).</p>	Using the theoretical underpinnings of interpretive description (Thorne, 2008), the researcher created a report (thesis document) that can be used by nurse clinicians to advance clinical knowledge. Within this report, the researcher discussed implementations for practice, the nursing education curriculum, research, and advanced practice nursing.

3.5 Rigour

Lincoln and Guba's framework for trustworthiness (1985) was incorporated into this research study to ensure the research results remained trustworthy and integral. Measures were taken to ensure credible, dependable, confirmable, and transferrable results were produced (Guba, 1981; Lincoln & Guba, 1985). The purpose of credibility is to ensure "confidence in the truth of the data and interpretation" (Polit & Beck, 2012, p. 585). To ensure the credibility of the research findings, the researcher used person triangulation (Polit & Beck, 2012). Data triangulation, including person and space triangulation, is the use of multiple methods to obtain conclusions (Polit & Beck, 2012). Person triangulation is the use of different types of participants which help "validate the data through multiple perspectives of the phenomenon" (Polit & Beck, 2012, p. 590). Person triangulation was utilized by including both RNs and RPNs with varying experience. Space triangulation was used by recruiting participants from multiple hospitals with the purpose of validating the data (Polit & Beck, 2012). Peer debriefing (Guba, 1981) was also used throughout the research process between the researcher and his thesis advisor and committee, and he remained in frequent contact with them during data collection and analysis.

Dependability refers to the ability of the data collected to be replicated in the future, within the same context (Polit & Beck, 2012). Lincoln and Guba (1985) suggested establishing an audit trail to allow for other researchers to identify the steps taken by the researcher during the research process in order to create transparency. The researcher recorded his data collection process in a word document and reflected upon his experiences in his reflective journal to serve as the audit trail for this study.

Confirmability is the accuracy of the data and the congruency between the results and the experience of participants in the study (Lincoln & Guba, 1985; Polit & Beck, 2012). Guba (1981) asserts that data must reflect what the participant said and not the bias of the researcher. Guba (1981) proposed that data triangulation and reflective journaling helped ensure confirmability of the research findings. Along with reflective journaling, the researcher was interviewed by a colleague using the interview guide to help explore his theoretical lens prior to the study (Polit & Beck, 2012). The researcher also interviewed two colleagues to practice his interviewing technique and assess the utility of the interview guide (Polit & Beck, 2012). All of these practice interviews were discussed in the researcher's reflective journal.

Transferability refers to how the researcher's findings can be applied to other settings within the same context (Polit & Beck, 2012). To ensure transferability, the researcher spent a sufficient amount of time with the data to ensure he had a thorough understanding of the data before interpretation occurred (Thorne, 2008). The researcher also assured that inclusion and exclusion criteria for the study were clearly outlined to provide research consumers with a clear understanding of the context of the research (Polit & Beck, 2012).

3.6 Ethics and Human Participant Protection

Ethics approval was obtained from the University of Ottawa's Research Ethics Board.

3.6.1 Informed consent.

Informed consent was obtained by the researcher before each interview (Appendix J). Once the participants contacted the researcher and requested to participate in the study, the researcher emailed them the consent form. This allowed the participants time to review the consent form and ask questions prior to signing it. The researcher reviewed the consent form

with each participant prior to starting the interview and obtained audio-recorded verbal consent. See Appendix K for the script used to obtain verbal consent.

3.6.2 Anonymity.

Personal identifiers were collected on a master list. The personal identifiers collected were: participants' name, preferred method of contact (telephone or email), classification (RN or RPN), size of hospital they work in (rural, community, urban), and how many months they had been practicing nursing. The master list was stored on the researcher's password-protected computer in a password-protected file. The master list was stored in a file separate from the data. The researcher replaced participant names with pseudonyms in the thesis.

3.6.3 Data storage.

The interviews were recorded on a password-protected digital audio-recorder. Following each interview, the researcher transcribed the interview in a password-protected file stored on the researcher's password-protected computer. When transcription was complete, the audio recording was deleted from the digital audio-recorder.

During data collection and analysis, a copy of the transcripts was stored on a password-protected external hard drive that was locked in the researcher's thesis supervisor's office. After the researcher defends his thesis, the transcripts and audio recordings will be deleted from his password-protected computer.

The transcripts and audio recordings will be stored on a password-protected external hard drive for five years after the thesis is accepted. They will be stored at the University of Ottawa in a locked drawer in the researcher's supervisor's office. After the five-year conservation period, the data will be deleted.

Chapter 4: Results

This chapter describes the journey of 11 new graduate nurses as they entered the nursing profession and cared for patients with dementia in acute care settings. The first section of this chapter presents the participants' demographics and employment characteristics that provide a description of the sample of new graduate nurses studied. The second section presents the results of the qualitative thematic analysis. The analysis yielded three themes and multiple subthemes. The three themes are: (1) building of vision and values, (2) clash of vision and values, and (3) "make do with what you have".

4.1 Sample Demographics and Employment Characteristics

The participants' demographics and employment characteristics are outlined in Table 6. The sample included seven Registered Nurses (RNs) and four Registered Practical Nurses (RPNs). Twelve participants contacted the researcher to participate, however, one participant had been working for 18 months, and did not meet the inclusion criteria. The majority of the participants were female ($n = 10$). The participants' nursing experience ranged from two to 12 months, with a mean of 5.4 months. All participants worked on medical and surgical units in Ontario at ten different acute care hospitals dispersed throughout the province, with representation from eight of the provinces 14 Local Health Integrated Networks (LHINs). Six participants practiced in community hospitals and five practiced in rural hospitals. All participants received their nursing education in Ontario. Three participants had paid work experience in long-term care as students; two worked as a personal support worker and one as an activation and physiotherapy assistant. Two participants took the Gentle Persuasive Approach course during their time as students (not part of their nursing curriculum).

Table 6.

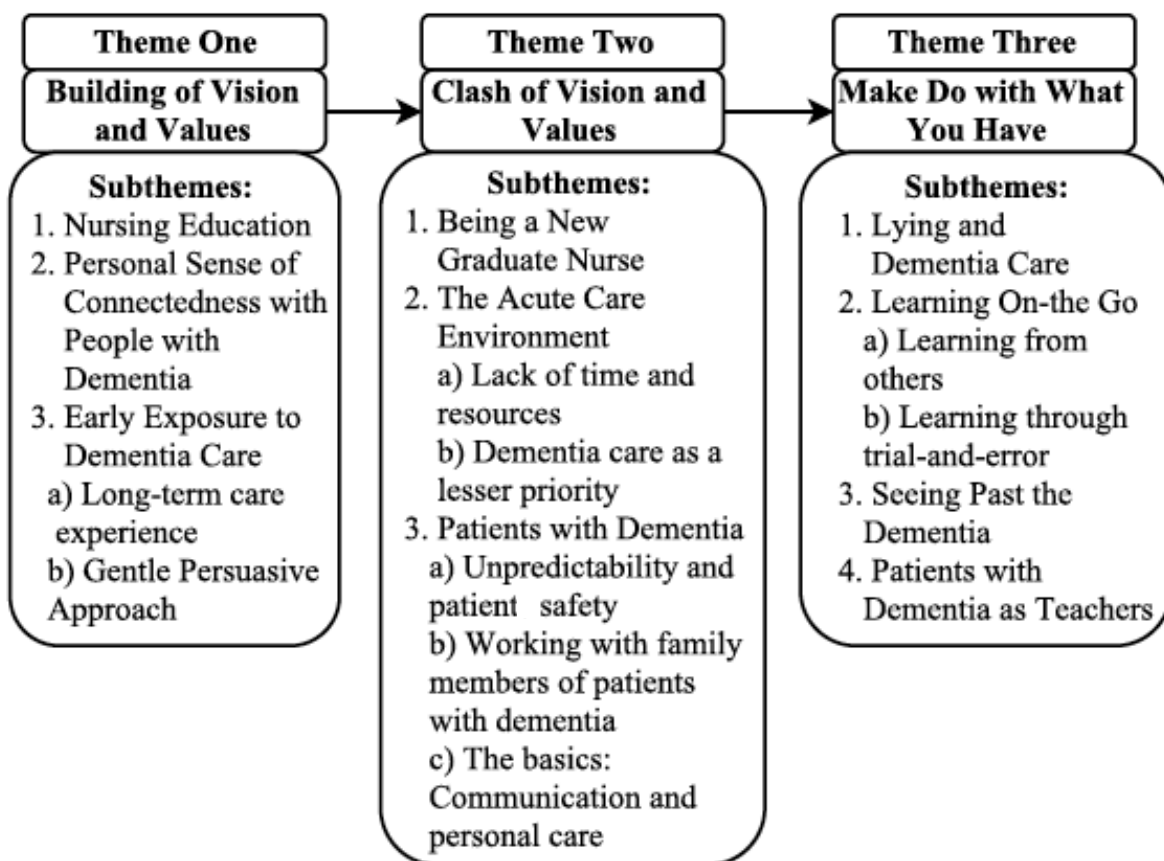
Sample Demographics and employment characteristics

Characteristic	n	%
Type of Nurse		
Registered Nurse	7	63
Registered Practical Nurse	4	36
Sex		
Male	1	9
Female	10	91
Experience (months)		
2	1	9
3	4	36
5	2	18
8	3	27
12	1	9
Location of Employment According to the Ontario LHINs		
North Eastern	1	9
North Simcoe Muskoka	1	9
South West	3	27
Central	1	9
Central East	1	9
Mississauga-Halton	1	9
Waterloo-Wellington	1	9
Champlain	2	18
Hospital Type		
Rural	5	45
Community	6	55
University-Affiliated	0	0
Paid Work in LTC as a Student		
Personal Support Worker	2	18
Activation and Physiotherapy Assistant	1	9
No Paid Work in LTC	8	72
Gentle Persuasive Approach Course		
Completed as a Student (not part of nursing school curriculum)	2	18
Completed as Nurse	1	9
Not completed	8	72

4.2 Overview of Themes

The overarching themes in this study outline the transition that the participants encountered during their early work experiences as new graduate nurses caring for patients with dementia in acute care environments. Within their transition, the participants encountered experiences and events, which were identified as subthemes. Figure 1 provides an overview of the themes and subthemes.

Figure 1. Themes and Subthemes.



4.3 Theme One: The Building of Vision and Values

Prior to starting their role as new graduate nurses, the participants were building their vision of care and learning the values of the nursing profession. All of the participants were

taught the same set of nursing values in school – the values of person-centred care. Person-centred care is defined as care that is holistic, individualized, respectful, and empowering (Morgan & Yoder, 2012). These values became the fundamental principles that guided their nursing practice.

In addition to these learned values, each participant developed a unique vision of care that was underpinned in the philosophy of person-centred care. Their vision of care reflected how they wanted to implement the values of person-centred care. For example, their vision of care included how the participants organized their day and the way they interacted with patients and families. This vision was slightly different from one participant to the other, however, each new graduate nurse's vision was built upon the nursing values of person-centred care. Within this theme, the participants describe their nursing values through nursing education and discuss how their vision of care was influenced by a sense of connectedness with family members with dementia and from an early exposure to the complexity of dementia care.

4.3.1 Nursing education.

Nursing students are taught the values of person-centred care during nursing education. For a nursing program in Ontario to obtain accreditation by the College of Nurses of Ontario (CNO) and the Canadian Association of Schools of Nursing (CASN), schools educate students to provide safe and ethical care as outlined by the CNO's Practice Standards and Guidelines, as well as entry-to-practice competencies (CASN, 2014; CNO 2014a; CNO 2014b). Additionally, schools must also educate students within the context of the Canadian Nurses Association's (CNA's) Code of Ethics (CNA, 2017). Accordingly, the participants were taught the CNO's (2009) nursing values of patient well-being, client choice, privacy and confidentiality, respect for life, maintaining commitments, truthfulness, and fairness. Furthermore, the participants were

also taught the CNA's nursing and ethical responsibilities: to provide safe, compassionate, competent, and ethical care, promote health and well-being, preserve dignity, and to be accountable (CNA, 2017). The participants were required to demonstrate a comprehensive understanding and application of these nursing values by passing their licensing examinations. As a result, it is assumed that all nurses graduating from an Ontario nursing program will demonstrate and practice these values. The values outlined by the CNO and the CNA reflected the values of person-centred care; care that is holistic, individualized, respectful, and empowering (Morgan & Yoder, 2012).

Providing person-centred care required nurses to know the medical aspects of care (e.g., pathology, pathophysiology, and pharmacology) as well as the psychosocial aspects of care (e.g., emotional, mental, and spiritual well-being). Meredith recalled how her nursing education taught her the importance of providing care that not only met her patient's medical needs, but their psychosocial needs as well. She stated, "*In nursing school, it's like 'this is the proper way to look after someone and you have to look after all of their needs'*". Similarly, Li describes being taught the importance of knowing the '*whole picture*' of her patients in order to provide person-centred care. She suggested that the '*whole picture*' meant knowing about her patient's likes, and dislikes, their routine, and their family. She elaborated:

I understand what it means to give my patient the whole picture, the whole care. Taking that time to learn about that patient. Especially if you're going to do a care plan on them. You kind of need to know what their psychosocial [care needs are], if they're religious too?

In addition to learning the values of person-centred care, the participants discussed what they were taught in school about caring for patients with dementia. The participants felt that,

although they were taught the values of person-centred care, they did not learn how to implement person-centred care in the context of specific patient populations or diagnoses, such as patients with dementia. Although psychosocial care is a large part of providing person-centred care, the participants felt the education they received about dementia focused on the medical aspects of care (pathology, pathophysiology, and pharmacology), rather than psychosocial care. Li reflected on her dementia education: *“Dementia in undergrad is more looking at it in a pathophysiology way. Like ‘this is dementia, these are different forms of dementia’”*. Jocelyn shared a similar reflection: *“We have been prepared in school to focus ... on the medical part, the pharmacological part”*. Darleen also shared a similar insight: *“You learn the scientific part of dementia and Alzheimer’s and what goes on in the brain, but you don’t really learn communication skills”*.

Alison recalled that her program did discuss how to implement person-centred care for patients with dementia, however, she suggested it was not a significant proportion of the curriculum. Alison questioned whether it was, *“for the simple reason [that the schools] have so much that they need to cover in such a very short period of time”*? Asha also reflected and wondered if her nursing program thought that students already knew how to provide person-centred care to patients with dementia, *“I think it just kind of becomes an assumed thing that you know how to work with patients with dementia”*.

The participants knew the importance of understanding the medical aspects of care. For example, airway, breathing, and circulation (ABCs) issues are always high priorities for nurses, regardless of the patient’s diagnosis. These critical issues can be life or death and it is paramount that nurses understand the importance of this medical care knowledge. As such, the participants

learned to prioritize medical issues. Laura recognized and knew it was her duty to prioritize the most acute and unstable patients:

Studying for the NCLEX and stuff, you always get those prioritization questions like 'you have four patients, which one are you going to see first?' ...A dementia patient who has been there for a while or a dementia patient with the only diagnosis of dementia, they automatically become your last priority because usually, you have other patients.

Mary shared a similar experience. She discussed how acute medical issues, such as blood sugar management, had serious consequences if not managed correctly. She elaborated:

I feel like if I didn't give proper care to diabetics, that person could go critically low or critically high and we're in a crisis. But say if I don't have the education to give proper care to a dementia patient, they are going to be the same tomorrow.

Mary further discussed that she was taught specific interventions to provide medical care, while psychosocial interventions for dementia care received less attention:

[I can] do things for a diabetic patient, [I can] do proper care, make sure [there are] no pressure ulcers. I find that with dementia, there is no stem of different problems. Like dementia: You will get it and you will get worse. Where diabetes: you will get it and we'll maintain it. We will help you, we will give you this, we will give you that and with that person, they understand that. Dealing with dementia is kind of like, 'you have dementia, that sucks'.

For the participants to provide person-centred care, they needed to understand the medical and psychosocial aspects of their patient's care needs. The participants believed they had a thorough understanding of the medical needs of patients with dementia; however, they felt they

had limited knowledge about the psychosocial care. Despite the imbalance in their dementia education, the participants shared the values of providing person-centred care.

4.3.2 Personal sense of connectedness with people with dementia.

Mary, Alison, Asha, and Li had developed a personal sense of connectedness with older adults and people living with dementia through their interactions with their own family members and loved ones. These interactions shaped their vision of care for patients with dementia once they entered the workforce.

Alison's mother had dementia. She described her experience being her mother's caregiver and the challenges she faced when caring for her mother at home. Her mother, like many other patients with dementia, experienced responsive behaviours. At times, her mother would become physically violent. Alison stated, "*she unfortunately got to the point where she became violent so it wasn't safe for her or myself, my husband, or my kids [to be] in the same house. So she has to go to a nursing home*". During this time, Alison would often read literature from the Alzheimer's Society of Canada "*on how to work with dementia patients*". Alison joked that her reading gave her an "*unofficial background in dementia care*".

Mary had a close relationship with her grandmother, so when her grandmother was diagnosed with dementia, it had a profound impact on her, even influencing her decision to pursue a career in nursing. Mary explained, "*When she got diagnosed with dementia was when I wanted to be a nurse*". This experience shaped her vision of care; she knew the nurse she wanted to be and the quality of care she wanted to provide. Mary summarized her vision of care: "*I see it as if I give care to someone, or the care I give to everyone, is the care I hope my grandma gets*". For Mary, dementia was more than a diagnosis; it was an influential factor in her decision to pursue a career as a nurse.

For these participants, providing care for patients with dementia extended beyond caring for a patient with a diagnosis, it was described as personal. Li and Asha were also close to their grandparents. Li felt that she had an increased sense of accountability when caring for all patients with dementia. She explained, “*We think of these people as our grandparents, or this is somebody’s mom, somebody’s grandparent*”. Asha knew what it was like to be a family member of an older adult, therefore providing care that her family would be proud of was apart of Asha’s vision of care:

If that was my grandpa for example, how would I want them to be treated? ...that influences a lot of like ...my perception of them and how you want them to be seen by their family when they come in.

Mary, Alison, Asha, and Li’s interactions with family members and loved ones helped them develop a personal sense of connectedness with older adults and people with dementia. These interactions shaped their vision of care.

4.3.3 Early exposure to dementia care.

Several of the participants had experiences as students that gave them a glimpse of what it would be like to provide care for patients with dementia and contributed to shaping their vision of care for this patient population. These experiences consisted of: (1) paid work in long-term care as a student, and (2) taking the Gentle Persuasive Approach course.

4.3.3.1 Long-term care experience.

In Ontario, nursing students can work in long-term care homes as personal support workers or as support staff after they have completed one year of nursing school. Both Mary and Li were employed as personal support workers during their time as students. They worked under the supervision of registered nursing staff and provided direct personal care to residents in long-

term care settings. Catherine was employed as an activation and physiotherapy assistant in long-term care during her time as a student. In this role, she assisted individual residents with passive range of motion exercises and led group activities. Together, Mary, Li, and Catherine had experiences of caring for patients with dementia outside of their nursing education thereby exposing them to some of the realities of dementia care. These experiences also shaped their vision of care.

Working in these settings provided the participants with the opportunity to be exposed to the psychosocial aspects of dementia care, as well as the psychosocial needs of this population. This exposure made them aware of their current knowledge deficit regarding psychosocial care for patients with dementia. They felt their nursing education thus far was heavily focused on the medical aspects of dementia, with limited attention on psychosocial care. As such, they felt they had limited knowledge about how to implement person-centred psychosocial care techniques for patients with dementia, as well as how to manage responsive behaviours. Mary started working as a personal support worker after her first year of nursing school. She shared her first experience of caring for a patient with dementia who was having a responsive behaviour in the long-term care home where she worked:

Dealing with someone with dementia for my first time, I cried, because this lady was very aggressive and called me every name in the book ...So when that happened to me, it made me so sad, and I just feel like school, in a sense, didn't really get me ready to deal with mental health and a mental illness like that because I didn't know how to approach it.

Mary was emotionally upset by the patient's demeaning language towards her. She felt she was not prepared to deal with responsive behaviours. To address her knowledge deficit, Mary did her

own research, *“I found I didn’t know anything ...I felt like I wasn’t helping that person at all, and I really hate that feeling ...I did a lot of Googling”*. During her research on the Internet, she discovered an educator on YouTube that shared instructional videos focused on teaching health professionals how to care for patients with dementia when they had responsive behaviours.

“There was this one lady on YouTube ...I’ve watched her and she showed how [people with dementia] feel, how you talk with them”. Although Mary was only in the second year of her nursing program, her experience led her to explore psychosocial care techniques, thus making her feel more prepared to provide psychosocial care and influencing her vision of care.

Catherine reflected upon a similar experience. While working as an activation and physiotherapy assistant in long-term care, she cared for patients that experienced unpredictable responsive behaviours. Catherine stated that, *“The behaviours of people in nursing homes ...people are going to say and do things and you have no idea of where it came from”*. Catherine was also exposed to the psychosocial aspects of dementia care. These early exposures to the reality of caring for this patient population prepared Catherine for her practice as a new graduate nurse. Her experiences taught her lessons about dementia care that she did not learn in school:

“It definitely taught me not to take everything to heart because people are going to say some awful things to you when they don’t trust you and they don’t understand why you’re there”.

Catherine found a sense of comfort in this preparation: *“I think it would be scary to be a nurse with people with dementia if you had never done it before, if you didn’t know this is how things typically go in a nursing home”*.

Li also felt her experience working in long-term care made her more prepared to face the realities of caring for patients with dementia as a new graduate nurse:

I have a little bit of a geriatric background, so I spend more time with [patients with dementia], versus ...some new grads [that] have never worked in long-term care or as a personal support worker in long-term care. They don't really get that workplace experience with dementia ...I think it's really important for nursing students to work as a personal support worker.

Li's experience helped provide her with tools to implement psychosocial care and tools to manage *sun-downing* (a phenomenon in which patients with dementia exhibit responsive behaviours in the afternoon and evening which often presents as searching to 'go home'). Li's experience taught her that person-centred care was not a one-size-fits-all approach. She learned that she had to tailor interventions to manage each patient's sun-downing behaviour. When asked how her experience prepared her, Li replied, "*half of your patients have behaviours. And I did a lot of evening shifts and a lot of them sun-down, so I've learned what to do when they sun-down. Like what are some interventions based on the patient*". After working in long-term care as students, Mary, Li, and Catherine felt they were better prepared to face the realities of dementia care as new graduate nurses.

4.3.3.2 Gentle Persuasive Approach.

The Gentle Persuasive Approach course is a one-day workshop designed for healthcare providers that interact with patients with dementia. The eight-hour course focuses on the psychosocial aspects of dementia care, tools to manage responsive behaviours, and techniques to protect oneself from verbal and physical abuse (Schindel-Martin et al., 2014). Meredith and Li both completed the Gentle Persuasive Approach course as students. Although this program was not part of their schools' formal nursing curriculum, they had the opportunity to take the course outside of their nursing programs. Meredith enrolled in the course because her school was

offering it as a voluntary workshop. Li took the course because it was offered at the long-term care home where she was working. The Gentle Persuasive Approach course exposed Meredith and Li to the realities of caring for patients with dementia. They developed an appreciation for the challenges involved with caring for this patient population. Additionally, they learned the skills, tools, and interventions to provide psychosocial person-centred care for patients with dementia. Li illustrated a learning experience that helped her empathize with older adult patients:

We did this dementia experiment where they put cotton balls in your ears, so you couldn't hear anything. They had these big glasses that were all mushed up with Vaseline, so you couldn't see anything. And you had weights in your shoes, so you had to walk around and talk to somebody and it was so hard! It made me understand that no wonder they're having a hard time understanding me!

Meredith gave an example of a learning experience she had while taking the Gentle Persuasive Approach course. Her instructors provided her with a vivid example of how the actions of a nurse can escalate or de-escalate a patient with dementia's responsive behaviours. This experience influenced her vision of care: she wanted to be able to de-escalate her patient's responsive behaviours:

They had an example of a patient, he thought someone was knocking on his door at night and the nurse was like 'no one is knocking on your door', and it escalated to the point of throwing a chair. That's the example they gave us in the course ...the thought was if they just said, ...you kind of just go with it, like take them back to their room and be like 'oh I don't know, I don't see anyone knocking here', and more saying lets go back to your room and have a snack or something and then maybe that would de-escalate it or something or he would forget about it. But because the nurse engaged in this conflict with

them, it escalated to the point of him becoming violent. So that made an impression on me in terms of sometimes you have to roll with it ...like don't try and get into an argument with them.

Li also discussed the techniques she learned to manage responsive behaviours while taking the course. She shared that, *“The nice thing about [the] Gentle Persuasive Approach [course] ...is that if [a patient with dementia] get's a little aggressive or agitated, [the course] shows you techniques”*. The course taught her how to be prepared to protect herself from physically aggressive patients. She stated she was surprised to learn that, *“when a dementia patient grabs hold of your hand, they can cut off circulation”*.

Similar to the participants that were employed in long-term care as students, the participants who took the Gentle Persuasive Approach course felt more prepared to care for patients with dementia in acute care as new graduate nurses. Meredith considered the course an asset and explained, *“I found the Gentle Persuasive Approach course the most helpful; more than any other actual nursing courses that I had to take...To new nurses, I would say if you haven't taken it, take it for sure”*. Li expressed a similar sentiment, suggesting that all *“[nursing] students should take [the] Gentle Persuasive Approach [course]. I feel like they need to take that course. Like there needs to be a course on geriatrics in the nursing school program”*.

The participants felt they were better prepared for the realities of what it was going to be like to provide care for patients with dementia in acute care. They felt the course provided them with more tools to provide the person-centred care they envisioned.

The eleven participants in this study finished their nursing education with the same set of nursing values: to provide holistic, individualized, respectful, and empowering person-centred

care. Several of the participants also had experiences that were outside of the context of their nursing education. These experiences shaped the participants' vision of care.

4.4 Theme Two: Clash of Vision and Values

The participants entered the nursing profession with the vision of providing person-centred care. However, the participants struggled to provide the kind of care that was congruent with their nursing values. This second theme represents the 'clash of vision and values' that the participants experienced as they struggled to implement person-centred care. Three challenges to providing person-centred care were identified: 1) being a new graduate nurse; 2) the acute care environment; and 3) the patients with dementia themselves.

4.4.1 Being a new graduate nurse.

Once the participants started practising as new graduate nurses, they found it challenging to provide the care they envisioned because they were novice nurses in a new role with new responsibilities; they were no longer students. Laura described herself as "*nervous*". Li recalled her "*first [few] shifts alone [were] nerve-racking*". In addition to the anxiety that came with their new responsibilities, the participants found it challenging organizing day-to-day nursing care that met their nursing values and fit with their vision. Jocelyn found that her inexperience made "*prioritizing and multitasking*" a struggle. Catherine also battled with "*juggling everyone's needs*". Alison admitted that her "*time management sucks*". It was evident that being a new graduate nurse challenged the participants' ability to provide person-centred care to their patients.

The participants recognized that they had not mastered the skill of time management. They felt that they were slower critical thinkers with a limited knowledge base as compared to their more experienced nursing peers. They were aware that they required more time to complete

tasks. Darleen suggested, *“There is a big difference between a new grad and an older nurse ... We’re slow and they’re quick and they know a lot more than you”*. Laura reflected on how her time management skills were still developing:

I think because I’m a new grad ...I probably don’t work as fast as other RNs that have been working, that have experienced, like little stuff, like organization. I’m still trying to look back and be like, ‘oh I could have done this simultaneously and made that a little bit quicker process’ or still find sometimes I need to step back for a minute and think critically about something and like that will take me a little bit of extra time compared to someone who has been working a little bit longer. So I think I work in general at a slower pace and that might also be how I work too. But I think mostly it’s because I don’t have as much experience and I think I’m still working on organization and prioritization.

Darleen described how her thinking process around IV medication administration was slower than her experienced colleagues. She discussed how her colleagues would administer a common IV medication without having to look up its compatibility, infusion rate, indication, or side effects. While her colleagues would be able to complete that task with little hesitation and inquiry, Darleen would have to *“go to a book and find that all out”*.

The participants also tried to rationalize and explain why they were slower compared to their more experienced colleagues. As novice nurses, the participants focused on completing tasks in a systematic order, as they had learned in school. They focused on their theoretical nursing knowledge and meticulously applied theory to the appropriate situation. Rama described that she approached care as a checklist, stating: *“I feel like as a new graduate, you want to complete a checklist: Bath your patient, do mouth care, get them sitting up in the chair for lunch”*. Alison added that *“you have to do everything by the book”* and suggested that the care

that she provided was the *“formal way that you’re supposed to do it”*. The participants perceived themselves as being slow and inexperienced, as such, they felt they had less time to provide the person-centred care they envisioned.

The participants felt nervous and anxious in their new role. They felt they were slower than their more experienced colleagues. Being a new graduate nurse was their first challenge in providing the person-centred care they envisioned.

4.4.2 The acute care environment.

In addition to perceiving themselves as slow and inexperienced, the participants found themselves working on busy, hectic, and demanding medical and surgical units. These acute care environments seemed to value speed, efficiency, and productivity. The participants often had several acutely ill patients to care for; Li and Catherine, for example, reported being assigned to care for eight to nine patients at the same time. Their patients were receiving acute care interventions, such as blood transfusions, continuous bladder irrigation, wound care, and postoperative care. Catherine recalled a time when one of her several unstable patients was experiencing a life-threatening emergency. When this type of event occurred, the acute care environment can change from busy and hectic, to chaotic. All available staff stop what they are doing and work together to prevent a patient from harm and death. These situations are exhausting for the most experienced nurses, let alone a new graduate nurse. During this emergency, Catherine was still responsible for caring for her seven other patients. However, because all of the nursing team’s energy was focused on saving Catherine’s patient’s life, Catherine, and her colleagues, were unable to attend to the care needs of her other patients.

From the start, the new graduate nurses felt that the acute care environment’s values of speed, efficiency, and productivity clashed with their values of person-centred care. This created

a tension between the participants and their workplace. This tension resulted in the dichotomy of values between the participants and their new work environment. The participants were taught to provide person-centred care, however, enacting such care requires time. In this subtheme, the participants discussed the clash of vision and values they experienced between themselves and the acute care environment. The participants struggled with having a lack of time and resources, which resulted in their perception that they were treating patients with dementia as a lesser priority.

4.4.2.1 Lack of time and resources.

Providing person-centred care required time. To create an individualized and tailored plan of care that was centred around their patient's needs, the participants needed to understand their patients' medical and psychosocial care needs. In contrast, the acute care environment valued speed. As such, the participants experienced tension in that they felt they did not have enough time to implement the person-centred care envisioned. Rama suggested, *"When you have seven patients you just don't have the time to devote to that patient"*. Asha emphasized that she was always in a *"time-crunch"*. Rama felt the tension between her values and the values of her work environment. She wanted to be able to sit down with her patients to get to know them, to understand their needs. However, Rama struggled with this as she felt *"there is never an unlimited amount of time to spend with one patient"*. Laura shared a similar perspective. She wanted to be able to provide the care she envisioned, but this took time: *"The biggest problem I face with caring for dementia patients is I feel I'm not giving them enough time"*. Similarly, Meredith recognized time was an issue for two reasons: her inexperience as a new graduate nurse and the high acuity of her patients. She elaborated, *"You don't have time. Depending on the*

acuity of the other patients. Especially as a new grad because you're still working on your time management".

The new graduate nurses also felt that their acute care environments lacked human resources. They perceived that there were not enough nurses working, and as a result, their time was further divided as they were required to care for a greater number of patients. The participants were responsible for caring for six to nine patients at one time. Li discussed how she was unable to provide the care she envisioned for her patients with dementia because she was caring for seven other patients at the same time. She felt she was not able to provide care that was individualized or holistic. In this instance, her patient with dementia was trying to pull out his Foley catheter:

I wish I spent more time like to inform him, like tell him you can't pull it out because they don't understand why and I don't really have the time to explain why they can't take it out. Like I don't have that time to give them the extra explanation that they deserve, because I have eight people.

Laura felt that she did not have the support she needed to care for her patients with dementia because her colleagues were also busy caring for an increased number of patients. She explained:

I remember the first couple of months I started there it wasn't a fun experience. I was always really really stressed out mostly because of how many patients I had ...I couldn't be in all places at once and it's only me and another RN and she has 10 patients so it's not like I can really get her help.

The busy and hectic demands of the acute care environment and the perceived lack of human resources affected the participants' abilities to provide the care they envisioned. The participants felt they had no other option but to provide care for patients with dementia that was

below their expectations and standards. As a consequence, they felt their care was incongruent with their nursing values. Rama found herself rushing through her care. For example, she wanted to take her time bathing her patients with dementia so she could use the time to learn about their past, their family, and their needs. Instead, she washed her patient as quickly as possible because she had other patients that needed nursing care. Rama reflected, *“I feel like you just don’t get the time to provide the care that you want to. The care that’s needed always gets done, but it’s not in the way you feel fulfilled about doing it”*. Rama found this experience difficult and explained, *“You are still in [that] new grad moment [where] you want to be the superstar nurse, and you can’t really do that to those patients”*.

The participants expressed feelings of *“frustration”*, *“guilt”*, and *“helplessness”* when they were not able to give the care they wished to provide. In addition to their struggles to provide the person-centred care they envisioned, they also felt the care they were providing was incongruent with the CNO and CNA’s ethical guidelines (CNA, 2017; CNO, 2009). Li reflected on how she felt when she was not able to provide the care she envisioned to her patient with dementia after a transurethral resection of the prostate (TURP) due to the busy acute care environment and lack of time. She felt she was infringing her ethical principle of ensuring client’s well-being and providing safe care:

I felt guilty. I feel like a shitty nurse, to be honest. I feel like a shitty nurse every single time. And I talk to my co-workers about it and they’re like ‘honestly if you didn’t have eight patients it would be different’, but you have eight patients and technically, you shouldn’t have eight patients.

Jocelyn also described an upsetting experience that occurred as a result of competing demands on her busy acute care environment. Her patient with dementia required the assistance of two

nurses to use the bathroom. However, Jocelyn was aware that her colleague was busy providing acute care to their patients. As such, she felt she did not have the resources to assist her patient to the bathroom, so she asked the patient to urinate in her diaper:

They lose dignity ...we'll just tell them to, 'go in your brief. It's OK.' You know? That's very demeaning as a human being to just say dirty yourself. Physically it's much easier for me to just clean you up in bed opposed to getting you up and to the washroom, especially if you're a two-person assist. I need to get a buddy nurse, who is probably hanging blood.

Jocelyn knew that providing person-centred care implied an ethical responsibility to preserve dignity. The participants never envisioned providing care that went against their nursing values, but in some instances, they felt they had no other option. They were novice nurses with developing time management and organization skills in an environment that did not have the human resources to allow them the time they needed to learn and to provide person-centred care.

4.4.2.2 Dementia care as a lesser priority.

The participants' acute care medical and surgical work environments were comprised of acutely ill and unstable patients. In school, the participants were taught the importance of prioritizing unstable patients. Medical issues involving airway, breathing, and circulation (ABCs) are always the first priority for nurses because they are life-threatening issues. Psychosocial issues, such as managing the responsive behaviours of a patient with dementia, are also important issues, but are not as high as medically unstable patients. Shane explained why he prioritized medically unstable patients first: "*People with respiratory issues, they [become very sick] really fast in my opinion. They're more likely to [have a respiratory or cardiac arrest] than a patient with dementia*". Shane was aware that ABC issues were his top priority and required

his immediate attention. The participants suggested that in school, they learned that attending to the needs of medically unstable patients, urgent physician orders, blood transfusions, intravenous (IV) infusion management, medication administration, and dressing changes were the top priorities; if they did not attend to these needs first, then their patients would likely have negative consequences. However, the new graduate nurses' acute care environments were comprised of acutely ill and unstable patients, thus the participants felt they always had several competing top priority tasks. Meredith described the struggles she faced, *"It's hard because obviously, I want to do a good job. I want what's best for the patients, but it's always that juggling everyone's needs basically and deciding what's the greatest need"*. Laura felt as though she was being pulled in multiple directions. She found it difficult to decide how to manage the care needs of her medically unstable patients and attend to the psychosocial care needs of her patient with dementia. Laura elaborated on a time when her patient with dementia was exhibiting a responsive behaviour:

I don't have enough time to deal with the person who is like showing some critical symptoms and deal with this lady who is getting out of bed and is going to fall and hurt herself. Like I can't do it all!

The participants found themselves faced with many high priority issues requiring their attention. This led them to feel that they had even less time to provide person-centred care for patients with dementia, resulting in their psychosocial care needs becoming a lesser priority. Catherine did not envision labelling the psychosocial care needs of her patients with dementia as a lesser priority, and as a result was struggling to fulfill her ethical reasonability of fairness. Catherine wanted to ensure that all of her patients received equal attention. She explained:

It's frustrating as a nurse because you want to be there for them but you know so-and-so needs their IV started right now ...then that becomes your priority as a nurse because you want to do the most you can for all of your patients but ... unfortunately, the dementia patients aren't your first priority.

Similarly, Jocelyn reflected on the needs of patients with dementia as a lesser priority:

Medical concerns take priority over psychological concerns. That's the way our system works. We feel we can handle the psychological concerns in long-term facilities ...but in the hospital, all we want to do is, 'Oh your heart's beating fine, your white blood cells are OK, you don't have a UTI anymore, you're OK to go home'. No matter the fact that somebody is still in distress, that somebody is psychological, mentally, they're not stable to return home, they're constantly confused, or they keep screaming, or climbing over. That's not the issues that we tend to. So I think just the way that our system works is, what is viable we fix that, and then off you go home. The rest is the family's problem or the long-term facility's problem.

As a result of the high acuity of their other patients, the participants believed that they were not able to meet the psychosocial care needs of their patients with dementia. Darleen reflected, *"They're just walking up and down the hallways all day"*. Not having enough time to provide person-centred care for patients with dementia did not align with the participants' nursing values; they wanted to be able to provide person-centred care to all patients, regardless of their diagnosis.

Their inability to meet the care needs of their patients made the participants feel *"frustrated"*, *"helpless"*, and *"guilty"*. When Asha was not able to meet her patient's care need, she shared that, *"It makes you feel kind of guilty [that] they have kind of been pushed aside"*.

Jocelyn had a similar outlook. She recognized that her lack of time and resources to provide person-centred care to all of her patients was exacerbated by the fact that she was a new graduate nurse. She felt that she *“let that patient down. Especially because there’s a huge learning curve for me to get over but I just feel helpless”*. The participants’ vision and values of person-centred care were clashing with their acute care environment.

4.4.3 Patients with dementia.

Being new graduate nurses came with the tasks of navigating their new roles and developing time management and organizational skills. Additionally, the acute care environment was busy and hectic with limited human resources and required them to care for several unstable patients at once. This challenged the participants’ abilities to provide person-centred care. They also felt their care was incongruent with their ethical responsibilities as nurses. Furthermore, patients with dementia added another layer of complexity. The participants struggled to ensure these patients were safe. Additionally, they found working with family members and providing basic nursing care difficult.

4.4.3.1 Unpredictability and patient safety.

The participants found that patients with dementia were unpredictable in many ways. These patients did not always have the cognitive ability to know and understand their physical limitations. As such, they often attempted to ambulate without waiting for the assistance of a nurse, which increased their risk of having a fall. For example, a patient with dementia admitted with a fractured hip may not be aware that they need assistance ambulating, leading them to try and ambulate, resulting in a fall. Additionally, patients had unpredictable verbal and physically aggressive responsive behaviours, causing the participants to become concerned about their own well-being. The unpredictability of patients with dementia made it difficult for the new graduate

nurses to provide the care they envisioned. Laura expressed that she is always “*worried about patient safety*”. She “*always feels like [she’s] on the brink of someone having a fall*”. Li understood that patients with dementia were at risk for a fall, therefore she implemented several interventions:

If they came in with a fracture because of a fall I make sure I put in a million interventions, like put their bed low, bed alarm on, may have a sitter (a staff member to sit one-on-one) or I will make sure they have a sitter.

The participants understood that it was their ethical responsibility as nurses to keep their patients safe. Despite this understanding, they struggled to ensure their patients with dementia were safe. Laura discussed how the layout of the acute care environment and her lack of time compromised her ability to keep her patients with dementia safe. She explained:

If you’re in an isolation room down the hall and you hear a [bed] alarm go off you’re like ‘Oh my God’, ...you can only get there so fast. So a lot of the time I feel like I’m not doing enough to keep my patients safe.

Meredith felt that the busy acute care environment also prevented her from having time to ensure patient safety. She elaborated, “*It can be frustrating just because you know sometimes they’re trying to get out of bed and they’re falling. And you don’t really have time to properly look after them*”.

Even when the participants had time to ensure their patients were safe, patients with dementia still injured themselves. Rama received a report from the previous shift on her patient with dementia. She learned that her patient was able to ambulate from bed to the bathroom independently using a walker. Although she knew her patient was able to ambulate on their own, Rama knew her patient was a falls risk. Therefore, when she noticed her patient walking to the

bathroom on their own, she decided to assist them, just to be cautious. Her patient walked steadily to the bathroom and sat on the toilet without assistance. Rama felt it was clear that her patient was independent and safe, thus, she proceeded to assist another patient,

...then two minutes later I heard a big crash and he fell and hit his head off the sink.

...It's very disheartening because it feels like you fail your patients as a nurse ...The family wasn't pleased at all, but I felt like I couldn't do too much more than that because he was ambulating well. There was no reason for me to be hovering over him, but sure enough, the minute I turn my back, he had fallen.

The participants knew that their patients with dementia were unpredictable and needed frequent care to ensure they were safe. However, with the competing demands of the acute care environment and the lack of time and human resources, they struggled to provide this care. The participants felt they had to constantly watch patients with dementia to ensure they were safe. However, they did not have the time or staffing to accommodate that. Their other option was to have family or a “sitter” be with the patients at all times, but this was not always feasible. At times, they had no other option but to physically restrain their patients to ensure their safety.

Using physical restraints was not part of the person-centred care they envisioned and they felt that the use of restraints went against their ethical responsibilities of providing dignity and ethical care. Jocelyn felt providing the care she was providing was “*dangerous and unethical in many ways*”. Li also felt she had no other option but to use physical restraints: “*You have to use a restraint, which is terrible and wish I didn't have to use the restraint, but I feel like in hospital you don't have a choice*”. Laura felt guilty using restraints, “*I don't think it's fair to the patient, but we didn't have enough nurses ...I felt kind of, what am I doing for this patient?*”

The participants also did not envision being scared of patients with dementia, but at times, they were. They found that the patients were at times unpredictably physically and verbally abusive as a result of their impaired cognitive insight. Darleen noted that her one patient would, *“grab onto your arm and get really really aggressive and mean, and then within 10 minutes, he [would] be the sweetest man”*. Catherine also illuminated the unpredictability of this patient population:

You can have really sweet people, and you have people that want to bite your head off every time you go in the room. You know, you have to be on-guard more when you have somebody with dementia because they are more unpredictable.

Rama explained that she never knew *“if they’re going to be angry at you, happy; you never know because they’re so unpredictable”*. She found that patients with dementia had *“such a wide range of functioning with that disease that you don’t really know what you’re going to get yourself into”*. These interactions left the participants feeling scared and on-guard. Darleen added, *“you just never know when you go up and talk to them what they’re going to be like. So it’s kind of nerve-racking dealing with them”*.

Catherine described an event when she was caring for a large, tall, male patient with dementia when he unpredictably became violent. Catherine stated, *“When they become violent, it’s on the nurse to call a code white (physically violent person). And it’s mostly females working in the hospital”*. In order to de-escalate the situation, Catherine and her colleagues decided to use a chemical restraint (antipsychotic and sedative medication):

I believe we gave him Haldol. Just to get him to calm down a little, and he is punching and biting and we’re handling a needle trying to give this man [his] needle to calm him down. It’s dangerous for the nurse because we’re at risk of a needle stick injury. It’s

dangerous for the patient because we literally had to each grab a limb and put him in the chair. And it's awful because you recognize that this is a human being; who wants to be tied to a chair like this? But when you weigh their safety vs. how many staff you have on, for each nurse, they were assigned nine patients. When you have nine patients on nights, you can't necessarily sit with someone for an entire night when you have eight other people to worry about.

Catherine and her colleagues did what they felt was best in the situation, but she still felt as though she was not providing the person-centred care she was taught in school, nor was she preserving her patient's dignity.

Dealing with the unpredictability of dementia care was even more difficult for the participants as they felt their education did not prepare them. As Darleen explained, *"It is a huge challenge in a day when you're a new person and your patient is yelling and screaming and you're looking at them like, 'I don't know what to do'"*! Catherine reflected on having to restrain her patients with dementia. She felt she was not taught in school about having to use restraints, yet they were becoming part of her practice:

You are told, 'don't use restraints, try every other means possible so you don't have to get to that point', but you have to make do with what you have. And if anything, you don't leave a shift like that feeling good about yourself ...they don't prepare you for that in school, saying that 'you may have to do this, you may have to do this', they don't really talk about your mental well-being as a nurse in regards to that subject.

4.4.3.2 Working with family members of patients with dementia.

Communicating with the family members of this patient population was not what the new graduates expected. The experience made them feel intimidated, overwhelmed, and nervous.

Asha mentioned, *“You don’t really know how to deal with each family, sometimes they’re overwhelming”*. They felt they did not know how family members were going to react to the care that their loved ones were receiving. Darleen suggested that it was a *“learning experience every time you do talk to families just because it can be very different and sometimes they can be quite rude”*. Darleen reflected on her experiences discussing a patient with dementia’s responsive behaviours with the patient’s wife over the phone. *“As a new person, I don’t necessarily know ...how to explain that ‘your loved one is grabbing young nurses’ hair, their butts’? How do you call the loved ones and tell them that their husband is grabbing us”*? Rama reflected on her first experience as a new graduate nurse providing health teaching and support to a family member: *“I was scared shitless, dealing with my first family. It was a very nerve-racking experience especially since the family is taking what you’re saying word-for-word and they are trusting you so, it was nerve-racking”*.

Jocelyn had a family member who thought she was not giving their loved ones enough time and the care that they deserved. Jocelyn explained:

So when they come and you know it’s only been 10 minutes since the breakfast came, but I haven’t gotten to the tray because I’ve been with other people, well I’m the bad nurse for not taking care of their mom or neglecting [her], but they don’t understand that I have three other patients, of which two more have dementia and one is wandering off somewhere.

This was particularly difficult for Jocelyn to deal with because she too was aware that the care needs of patients with dementia were sometimes not prioritized as high as other acute care patients. Jocelyn wished she had the time, resources, and organizational skills to ensure all of her patients were set-up for breakfast on time and to get them up in a chair.

4.4.3.3 The basics: Communication and personal care.

In addition to all of the challenges of providing person-centred care for patients with dementia, the new graduate nurses were faced with another barrier - providing basic nursing care to this patient population. From the start of nursing school, the participants were taught how to communicate with patients and how to provide personal care. Dressing, bathing, assisting patients to the bathroom, medication administration, and therapeutic communication were not challenges that these new graduate nurses anticipated. However, the patients' cognitive impairment made these basic nursing tasks a struggle.

The disease process of dementia sometimes prevented patients from comprehending what was being asked of them. Therefore, they would often not respond appropriately. Alison expressed her struggle when communicating with a patient with dementia:

You can sit there and explain everything and be as clear as you can possibly be and you're praying at the end that they will accept what you have said. But unfortunately, sometimes they just don't think rationally. Paranoia is a big thing with dementia patients, so I think that to me is very tough because I'm screaming in my head, 'that's not what I said!'

Meredith shared a similar experience where she felt frustrated when she struggled to communicate with her patient. Meredith stated, *"You can't reason with them ...no matter what you say, it's the wrong thing and they're not going to do what you ask them to do ...it's just kind of like 'I don't have time for this'!"*

Asha recognized that communicating with a patient with dementia was *"just so much more complex than someone who you can say something to and know what they're understanding exactly what you're saying"*. Asha suggested that communicating with patients

with dementia was challenging because “*you are taking things so much slower and you’re explaining things clearer*”. She felt this took “*much more time*”. Meredith recalled a time when her patient with dementia was refusing to take their medication. Her communication efforts were unsuccessful which left her feeling frustrated and helpless:

You feel bad when they’re refusing everything, and then you’re stressing about, ‘OK, they didn’t get their [medications] because they’re refusing them’ and like, or you have to go back again and try, ‘Hey you really need these pills’. And then hope in that moment, they’re like ‘OK’. Because otherwise, you’re kind of like ‘Now what?’

Darleen echoed a similar frustration:

Their reality is what they think, not what I think what it is, so it's frustrating and it definitely slows me down and throws the rest of the shift off because they require more attention. So yeah, time-consuming and it's frustrating.

Jocelyn described her experience trying to assist her patient with dementia to change out of his soiled clothes:

They could have five pairs of pants on and you can, like you ask them ‘OK you need to remove those pants, like you should only have one pair on.’ ‘Nope, nope’ ... You can feel frustrated, definitely, when you’ve tried and asked them three or four times.

Jocelyn thought her education prepared her to provide basic nursing care to all of her patients. However, when she began her practice, she felt frustrated and helpless as she did not envision providing basic nursing care for patients with dementia would be a struggle. She added:

I feel sometimes that I’m the dumb one in that situation, because I don’t know what to say that will make that patient feel relaxed and calm and it can be frustrating because I want to help. I just don’t know how to. I don’t know how to say, what to say, to make things a

bit easier...Nobody teaches us how to provide support, emotional support, but not only for the patients but for yourself, because it's exhausting! I mean, I went home that day and I doubted, is this my calling? You know? Should I really be a nurse? Am I doing the right thing?

Jocelyn then took a deep breath, exhaled, and paused for a moment before stating:

I still feel that I'm not ready, just to be a nurse taking care of patients by myself, then you add this aspect. It's challenging because if that patient also has a medical concern, then I'm taking care of two different things. You know? And as a new grad, there is so much you have to learn. There is so much you don't know. And when you add something that is exhausting in that matter, it's, very very very challenging...I just feel that I'm still not ready to be taking care of them ...I didn't expect the transition from a student nurse to a Registered Nurse to be this challenging.

The participants struggled to provide the person-centred care they envisioned. They were faced with multiple barriers: being new graduate nurses, the clash of values with the acute care environments, and feeling unprepared to meet the medical and psychosocial care needs of patients with dementia.

4.5 Theme Three: “Make Do With What You Have”

The participants felt frustrated and helpless after struggling to provide nursing care that reflected their values. Their vision of person-centred care clashed with the values of acute care. Despite the barriers they faced, the participants knew they had to continue to try to fulfil their nursing values and provide the care they envisioned for their patients with dementia. They moved forward with a new awareness of the challenges and looked for strategies to overcome them. As Catherine suggested, you “*make do with what you have*”. The participants were going

to do the best that they could in the situation they were in. After all, the participants still had high expectations and valued person-centred care. They felt as though they could not give up. The four subthemes that emerged were: (1) lying and dementia care, (2) learning on-the-go, (3) patients with dementia as people, and (4) patients with dementia as teachers.

4.5.1 Lying and dementia care.

The participants continued to find themselves struggling to communicate with patients with dementia. They encountered situations where they did not know how to respond when patients were exhibiting responsive behaviours and were becoming distressed. During these times, patients would often be disorientated, thinking they were in a different place or in a different time period. For example, the patients sometimes believed they were children; children in an unfamiliar environment and surrounded by strangers. During these moments, they would become distressed as they searched the acute care setting for their mother or father. In such circumstances, the participants wanted to help reduce their patients' level of distress and de-escalate their responsive behaviours. However, as dementia impacts patients' cognitive abilities and memory, they often are unable to remember life events, such as the death of a loved one. As such, being truthful in this situation may evoke unnecessary emotional distress. During these moments, the participants revealed that they sometimes lied to patients with dementia with the goal of having a calming and therapeutic effect. Meredith shared an example of when she lied to a patient with dementia, *"There is always the example of the patient who is like 'where's my mom'? ...So you have to tell her that her mom is not around anymore ... Sometimes re-orienting them can get them more mad"*. Darleen suggested that she would lie to a patient with dementia when they were disoriented and were trying to leave the hospital. Her purpose of lying was to de-

escalate their responsive behaviours. She explained, *“they can get agitated very quickly when you say ‘no, you can’t go outside, or no, you can’t leave’”*.

The participants did not want to lie to their patients. They knew truthfulness was an ethical principle; lying went against the principles of person-centred care. However, when they were faced with patients with dementia who were having escalating responsive behaviours because they were disoriented, the participants felt they had no other option but to lie. Darleen explained her dilemma:

Under the standards, you can’t really lie to them, but you almost do... In some cases, the lies, you do have to say them because there’s really no other option in the circumstances ...I mean you can never be not truthful with a patient because it’s their right but in cases where they’re completely acting out and hitting you because they want to see their mother, what are you supposed to say to that? How do you get around that?

As the participants had not previously envisioned having to lie to any of their patients, they felt guilty about their actions. Li explained the conflicting emotions she had, *“You always want to be honest with them ...I feel guilty telling them a lie; I prefer not to tell them a lie”*.

The participants knew lying to patients with dementia was not ideal and they were aware that they were infringing on their ethical responsibility of truthfulness. However, when they were faced with a situation where a patient with dementia was having an escalating, responsive behaviour because they were looking for their loved one who was deceased, the new graduates felt helpless. However, knowing it was not ideal, they lied. They felt they were doing the best that they could given the situation they were in.

4.5.2 Learning on-the-go.

In theme two, the participants became aware of their knowledge deficit regarding psychosocial care for patients with dementia. They felt their lack of knowledge hindered their abilities to fulfill the psychosocial aspects of person-centred care. Moving forward, they were going to make do with what they had by attempting to fill their knowledge gaps by learning from others and through trial-and-error.

4.5.2.1 Learning from others.

Once the new graduate nurses realized they struggled to provide psychosocial care for patients with dementia, they became resourceful. They knew their experienced colleagues were managing their patients' care needs, so they looked to their colleagues for help. Asha explained, *“One of the biggest challenges of being a new nurse is just seeing what the other nurses are doing because they have already seen these patients' multiple times a lot of the time”*. Mary found learning from her experienced colleagues to be beneficial, *“[Learning from other nurses] it is the best teaching ever. I've learned way more working than I did in school”*. Darleen shared a similar outlook and suggested, *“It's a really great learning experience working with older nurses because sometimes they know tricks that you don't learn”*. Laura also found she learned *“little tips and tricks”* from experienced nurses.

However, the participants indicated that learning from others was not always a positive experience. Many times, the new graduate nurses would observe their colleagues providing care that did not match their nursing values or fit their vision of care. Meredith thought back to her experiences observing one of her colleagues become frustrated and yell at a patient with dementia who was experiencing a responsive behaviour. After observing her colleague, Meredith

knew her colleague's behaviour did not fit her values of person-centred care, therefore, she knew she did not want to provide care that resembled her colleague. Meredith explained:

I guess just sometimes watching what other nurses do. Sometimes watching what they do and not doing that. Like the odd nurse you're like oh, they're kind of yelling at them and like that's not what you're supposed to be doing. And then finding that more senior nurse is really good with dementia patients and watching what they do and copying that sometimes.

Rama also reflected on her experience observing another nurse providing care that did not fit her vision of person-centred care. Like Meredith, Rama also studied her colleague's care techniques. She elaborated:

There was one nurse, in particular, that was very no nonsense, like 'cut to the chase' and said, 'Hey, I'm not putting up with your nonsense.' And she had quite a backlash from that person whereas I'm typically soft-spoken. I try to understand the feeling that they're having behind that behaviour, and I had a better response with them.

The participants in this study were a mix of new graduate RNs and RPNs. Each participant reported that they worked with both RNs and RPNs in their acute care settings. The participants discussed the benefits of working with a staff mix of RNs and RPNs in acute care environments. Two of the RN participants discussed how they benefited from observing the experienced RPNs' dementia care techniques. Laura, an RN, viewed the experienced RPNs on her unit as role models for dementia care. She felt they had more experience with dementia care because her RPN colleagues also worked in other non-acute organizations where they frequently care for patients with dementia. Laura elaborated:

RPNs are amazing with the care that they provide and I learn a lot through them. In terms of like patient care, because a lot of them have worked in LTC, or palliative care units, or dementia care units or they'll come from home care nursing, so the way that they care for patients is amazing. They are real role models for myself as a new nurse because they are assigned patients that are, more of the dementia patients or the more stable patients ...I find just watching them through my couple of months working and umm, I definitely look up to their practices with personal care and dementia patients. Because they just know what to do and they're so good at it and they make the patient feel so comfortable and it's so natural for them.

Asha, another RN, shared a similar perspective about learning from experienced RPNs. She looked up to her RPN colleague as an expert who was knowledgeable about the different tools to provide psychosocial care. Asha explained:

I think that when it comes to like an RN caring for that [dementia] patient vs. an RPN, sometimes the RPNs are maybe, I don't want to say better with them, but they understand more maybe, I don't know if it's that they have more experience with it or they just seem to have more patience with it ...I can just think one nurse in particular who just seems to relate to them more and like get to know them better and then gets to figure out what works with them better. She's just really good with figuring out those tricks with each individual patient that has dementia.

Jocelyn and Darleen offered insight as to why the participants perceived experienced RPNs as role models with dementia care. Jocelyn, an RN, suggested that RPNs have more experience caring for patients with dementia. She stated, “*RPNs don't get patients who are medically acute. They will most likely end up getting patients with dementia or any other psychological illness*”.

Darleen, an RPN, shared a similar perspective. She suggested that at *“times it is RPNs that are dealing with [patients with dementia]”*.

4.5.2.2 Learning through trial-and-error.

Once the participants developed knowledge of the different therapeutic interventions through observing and working with experienced nurses, they practiced their new skills and continued to learn through *“trial-and-error”*. Asha explained, *“You kind of see what works, and then what doesn’t through trial-and-error. It’s individualized to each patient too, to figure out what you can do to care for them best”*. Laura suggested, *“The more time you have with dementia patients, the more understanding you become and you see, and learn, from one patient to another”*. Learning on-the-go helped the participants develop tools, skills, and interventions that empowered them to provide the care they envisioned. They seemed to feel a sense of relief now that they knew what to do in previously unfamiliar circumstances.

The participants were aware of the limitations of learning about dementia care through observation and trial-and-error, and it was unclear if they were satisfied with the care they were providing. Laura reflected on learning through trial-and-error: *“I find a lot of the things I’ve learned have been through other nurses. Like little tips and tricks and stuff. Although sometimes they’re not the best-practice. They’re sometimes the most practical at the time”*. Jocelyn also added that, *“we make up our own ways to deal with it and maybe they’re not always the best ways”*. Although the participants felt the care they were providing was not always evidence-based, they were trying to make do with what they have.

4.5.3 Seeing past the dementia.

Once the participants learned tools to provide psychosocial person-centred care for patients with dementia, they found they were able to have more opportunities to connect with

their patients. The new graduate nurses found these experiences rewarding. When they were able to have these moments, the participants felt they were implementing their values of person-centred care and providing the care they envisioned. Rama still found her work environment busy, hectic, and demanding. She explained that she did not “*always get that extra ten minutes to sit and talk with your patient*”, but when she did, she found her “*time connecting rewarding*”. Li enjoyed moments when she was able to “*sit down and take my time and hear about their lives. You’d be surprised what kind of stories they have*”. In these moments, Laura felt she was providing the care that she envisioned:

I think like the relationship between a nurse and a dementia patient is different than other patients, obviously. Sometimes it can be easier to make a connection with a patient without dementia, but at the same time, I find that with dementia patients, the communication is just so much more basic, that it’s almost like when you do have that connection it feels almost more genuine and you as a nurse feel better about it.

Catherine also found these experiences rewarding:

I love working with the elderly. It’s almost a fun challenge, when you know when so-and-so hates to take their meds, but if you can find that common ground where they can work with you. It’s so rewarding. Like ‘I got Charlie to take his meds today’!

During these moments of connection, the participants reflected on humorous interactions with patients with dementia. They associated these humorous interactions as positive experiences. Shane recalled a time when one of his patients with dementia was a retired physician. His patient was disoriented and believed he was an attending physician on the acute care unit. Shane explained, “*I had a patient once that was a doctor and he did rounds on the unit. That was funny*”. Catherine also highlighted an experience where she found humour when

working with patients with dementia. She elaborated, “*When you get a marriage proposal from a ninety-year-old man, you can’t help but laugh*”. The participants identified these humorous interactions as a positive experience in which they felt they were connecting with their patients.

4.5.4 Patients with dementia as teachers.

As the participants reflected upon their journey of being new graduate nurses caring for patients with dementia in acute care, they realized that the skills, knowledge, and tools they learned from caring for patients with dementia also assisted them in caring for other non-dementia patients. Amongst the busy, chaotic, and hectic acute care environment, Darleen learned to be patient and gentle when providing care. She reflected:

I think having dealt with patients with dementia, they are time-consuming and you have to be patient and gentle with them and I think in some other cases you have a very agitated person and you just have to be gentle and patient and caring towards them. And I think dealing with dementia patients you do learn, you do learn that.

Laura recalled on her experience working with patients with dementia. Her interactions taught her to be present in the moment:

Working with dementia patients, it’s taught me to be patient and kind of, try to understand, like really really understand, what the patient is going through, because a lot of our work is based on skill based and you can easily forget that patients are very vulnerable when in the hospital.

Rama learned to be grateful for the simple things. After struggling to find ways to effectively communicate with patients with dementia, she became grateful when communicating with patients who were not cognitively impaired. Rama reflected:

You kind of become more grateful for the fact that people are able to understand the tasks that you're asking them to do and I don't know it just changes your perspective kind of and makes you appreciate more of the abilities that others do have.

The participants finally found the positive in their chaotic journey. They experienced many struggles along the way, such as struggling to provide care to patients with dementia, seeking knowledge to help them feel prepared to fulfill their nursing values and provide the holistic, individualized, respectful, and empowering care they envisioned, as well as struggling to fulfill their ethical responsibilities. Finally, after struggling for so long, they felt a little less helpless. They knew they were not always providing person-centred care, or the care that they envisioned, but they were making do with what they had.

4.6 Summary

The new graduate nurses experienced a journey as they cared for patients with dementia in the acute care environment. Each participant entered the nursing profession with the same set of nursing values and a goal to provide person-centred care. Several of the participants had additional experiences that shaped their individual vision of care. Although their education focused on the medical aspects of dementia care, they felt prepared to provide person-centred care.

However, once they started their role as new graduate nurses in acute care, they realized that caring for patients with dementia was not what they expected. Being new graduate nurses carried its own challenges, as did the busy and hectic acute care environment. They felt they did not have the time or the resources to provide the care they wanted. Their values did not match the values of their acute care environment. Finally, patients with dementia added an additional layer of complexity; they were unpredictable and the participants struggled to provide

psychosocial care. They struggled to fulfill their vision of care and to fulfill their ethical responsibilities.

Despite their challenges and barriers, the participants moved forward. They “made do with what they had”. When they were faced with distressed patients, they sometimes resorted to lying in order to reduce their patients’ level of distress. They learned how to provide psychosocial dementia care from their colleagues. They no longer felt helpless in unfamiliar situations. The participants took what they learned from patients with dementia and used it to assist them with the care of other patients. In moments, they had time to connect with patients with dementia. They knew the care they were providing was not always evidence-based practice, but it was the best care they could provide in the situation they were in.

Chapter 5: Discussion

In this chapter, the findings of this thesis are situated within the greater literature on new graduate nurse transition and dementia care in acute care. In addition, considerations for research, education, and all domains of advanced practice nursing are discussed.

5.1 Participants

The majority of this study's sample was comprised of women who worked in rural and community hospitals. The gender of the participants in this thesis was proportionate to the Ontario nursing population (CNO, 2015). Furthermore, all participants worked in rural or community hospitals, with no representation from university-affiliated hospitals. The key informants selected by the researcher for recruitment all worked in rural and community hospitals, as such, they would have snowballed the recruitment poster to their colleagues working in rural and community hospitals. Despite having rural and community key informants, the other recruitment strategies focus on the general Ontario nursing population (Facebook Alumni groups, RPNAO conference, RPNAO and RNAO journal). It is unclear why there were no participants from university-affiliated hospitals. As a result, the experiences of new graduate nurses working in university-affiliated hospitals may be different.

The nursing experience of the participants ranged from two to twelve months. The original inclusion criteria specified that nurses would be included if they had between three and twelve months of experience. The rationale for excluding nurses working less than three months was supported by Duchscher (2012), who described that during the first three months of professional employment as a nurse, new graduate nurses are being introduced to "workplace structure and function including orientation to professional roles and responsibilities within a work environment" (p. 166). During this time, new graduate nurses may not have independent

experiences with patients with dementia to reflect upon for the study (Duchscher, 2012).

However, Meleis (2010) argued that transition is a fluid experience that varies for everyone.

Therefore, the researcher included one participant with two months of experience because the participant met all other inclusion criteria and expressed interest in participating.

The results also supported Duchscher's (2012) definition that new graduate nurse transition ends after 12 months. One participant that had been working for 12 months discussed her transition using the past tense, suggesting that she no longer associated herself with being a new graduate nurse. Additionally, she expressed that she viewed situations differently now, compared to when she was "less experienced". All of the other participants had less than eleven months of experience and described their transition in the present. The sharing of events in the past tense suggested that the participant with twelve months of experience felt she was no longer a new graduate nurse.

5.2 Sample Size

The sample size of eleven new graduate nurses was within the sample size goal of eight to twelve participants. Thorne (2008) recognized that there will always be variance in the subjective experiences of individuals within a phenomenon, as such, data saturation and redundancy will rarely occur in applied-health disciplines, such as nursing. Instead of data saturation and redundancy as the goal of sampling, Thorne (2008) suggests that sampling should allow for the creation of a rich data set within a reasonable and feasible time limit. Although the participants shared similar experiences leading to the construction of themes, it is difficult to determine if data saturation and redundancy occurred. However, as per Thorne (2008) I felt that a rich data set was obtained, because the participants shared numerous subjective experiences. Within the data set, there were reoccurring experiences: the challenges of providing psychosocial

care, feelings of helplessness, frustration, and guilt with dementia care, and learning to make do with what you have. In addition to the recurring experiences, there were also experiences that were unique to each individual, suggesting that there was variance in the subjective experiences of the participants. For example, paid employment in long-term care, the GPA course, and lying and dementia care were only discussed by a few participants. Furthermore, the dataset provided an abundance of information to assist the researcher in answering the research question.

5.3 Sampling and Recruitment

The researcher had difficulty recruiting eight to twelve participants for this thesis. As such, multiple recruitment methods were implemented over eight months. The two most successful recruitment methods were nursing journal advertisements (four participants) and posting the recruitment poster on 39 nursing alumni Facebook groups (three participants) (Appendix E). The remainder of the participants were recruited through key informants (Appendix E). Because the majority of new graduate nurses are young adults (CNO, 2016b) who are presumably engaged in social media forums, such as Facebook, it is unclear why this strategy was less successful in recruiting new graduate nurses compared to the traditional form of print media. The use of social media as a recruitment method for nurses is a relatively new phenomenon (Stokes, 2016). The print media recruitment advertisement may have been more successful as it can withstand time longer than social media. For example, social media posts are shared in chronological order, in which the reader views the most recent post first. The majority of the Facebook alumni groups had multiple posts several times a day; thus the recruitment poster may have only been visible to the reader for a brief period. Additionally, the print recruitment advertisement may have been accessible to more potential participants as the journals were distributed across Ontario.

Further reasons for the difficulty to recruit new graduate nurses were highlighted through an informal conversation between the researcher and a key informant. The key informant shared with the researcher several factors that were contributing to her colleagues' lack of interest in participating in this study and explained that her colleagues felt the one-hour time commitment with no reward was cumbersome. Furthermore, the key informant suggested that her colleagues were experiencing a stressful transition and found their work environment demanding. She expressed that they did not want to 'talk about work' on their days off. She also added that one colleague was working on a temporary licence and spending her days off studying for the NCLEX examination. This key informant's perspective reinforces the complexity and challenges new graduate nurses experience during their transition.

The stress that these new graduate nurses were experiencing both inside and outside of work are highlighted in Duchscher's transition stages theory (2012). Duchscher (2012) emphasized that new graduate nurses also experience a psychosocial transition, in addition to their professional nursing practice transition. Duchscher (2012) argued that psychosocial changes that occurred outside of the clinical practice setting, such as studying for the NCLEX while working, relocating for employment, leaving school friends, and paying for student loans, all have an influence on new graduate nurses' professional nursing transition.

Researchers recruiting new graduate nurses should be sensitive to the complex dynamic of their transition experience and express appreciation when participants volunteer. It may have been beneficial for the researcher to provide a monetary gift (e.g., coffee shop gift card) as an incentive for the participants.

5.4 Overview of Themes

The three themes that emerged from this thesis were: (1) building of vision and values, (2) clash of vision and values, and (3) “make do with what you have”. This section will discuss an overview of each theme in relation to the nursing transition theorists. The first theme, building of vision and values, was unique to this thesis. Previous nurse transition theories did not recognize nursing education or personal family influences as part of the transition experience. Although it is unclear from this thesis when the transition began for the participants, it is clear that their experiences before starting their role as nurses were influential to their transition.

The second theme, clash of vision and values, was similar to the findings of Kramer (1974), Benner (1982), and Duchscher (2012). Once nurses are immersed in the clinical environment as new graduate nurses and are exposed to their work environments, Kramer suggested reality shock occurs and Duchscher suggested transition shock and transition crisis occur. In the second theme, the participants experienced a clash of vision and values with their practice environment, leading to feelings of shock. Furthermore, the participants’ experience resembled Benner’s novice to expert model (1984). In this theme, the participants demonstrated that they lacked practical experience, which limited their clinical thinking skills, suggesting that they were novice or advanced beginner nurses.

The third theme, “make do with what you have”, closely resembled Kramer’s (1974) reality shock theory’s resolution and recovery phase and the knowing phase of Duchscher’s (2012) transition stages model. During this phase, Kramer suggested that nurses recover from the reality shock of their new practice environment and they move forward, finding ways to manage barriers to care. During the knowing phase of Duchscher’s model (2012), nurses gain confidence as they learn to navigate their new role as an independent practising nurse.

5.5 New Graduate Nurse Transition

The participants in this thesis shared experiences about their transition that were echoed in the literature. The literature review presented in Chapter 2 identified five themes of transition theories: (1) transition trigger, (2) shock, (3) support, (4) phases of transition over time, and (5) outcomes. It is difficult to determine if the transition experienced by the participants of this thesis reflected each of the themes identified due to the nature and timing of the thesis. For example, data collection was cross-sectional and occurred during their transition, therefore transition trigger, different phases of transition, and outcomes were not discussed. However, all the participants discussed their experience with shock and the need for support.

The participants reported feeling a sense of shock when entering practice. Their perception of what it would be like to provide care for patients with dementia in acute care clashed with their expectation. Their experiences were similar to Kramer's reality shock theory (1974) and Duchscher's transition stages theory (2012). This shock resulted in feelings of stress, helplessness, frustration, and guilt. These feelings were exacerbated by the participants' inexperience (Benner, 1984). Benner suggested that new graduate nurses are considered novice nurses, as such, they have limited practical experience to complement their theoretical knowledge, making decision-making difficult (Benner, 1984). Benner also emphasized that novice nurses require support in the form of education and preceptorship.

The participants echoed the importance of supportive colleagues during day-to-day nursing care as well as moments of shock. For example, the participants relied on colleagues to assist them with day-to-day tasks such as intravenous medication administration. They also relied on their colleagues to support them during moments of shock, such as having difficulty

providing person-centred care for eight or nine patients. Although in moments of shock, the colleagues were not always able to intervene to resolve the new graduates' feelings; instead, they provided validation. Meleis (2010) suggested that during a transition, individuals benefit from having supportive individuals with whom they can develop a sense of connectedness. Supportive colleagues can assist the new graduate nurses in navigating their transition (Duchschnner, 2012).

The following sections will further discuss new graduate nurses' experiences of stress during their transition and ways of supporting them.

5.6 New Graduate Nurses and Stress

The participants described caring for patients with dementia in acute care as stressful and challenging. Their stories and experiences had vivid details, emotional attachments, and at times, describing traumatic events, such as physical and verbal abuse from patients. These experiences resulted in negative emotional responses: guilt, frustration, and helplessness. Kramer (1974) defined reality shock as an "emotional response... to an unexpected, unwanted, or undesired [situation]" (1974, p. 3-4). The participants' experiences were consistent with Kramer's reality shock theory developed over 40 years ago.

Despite the challenges the participants experienced, they collectively moved forward and did the best they could in the situations they were in. However, one participant seemed to respond to the challenges and stressors of their experiences differently. The accumulating negative experiences throughout her transition appeared to result in a build-up of negative emotional responses. Jocelyn made a statement regarding her new vision of care for patients with dementia:

As long as everybody is breathing, they're getting their medication, they're getting their interventions. You're doing your job but you're not doing it the best that you can ...But

now after the three months ...I realized, this is the normal here. It's bad, but I make sure the patients are safe and I do as much as I can in that time. I still feel guilty no matter what, I still feel guilty.

This participant appeared to have a different outlook on dementia care in acute care. As suggested in theme three of this thesis (“Make Do With What You Have”), despite all the struggles and challenges the participants experienced, they moved forward and strived to find ways to provide person-centred care that met their vision of care. In contrast, this participant appeared to be disengaging and normalizing their buildup of negative experiences.

The literature lends support as to why some new graduate nurses working in acute medical and surgical units may become disengaged (Buurman et al., 2011; Mealer et al., 2007). When providing care for patients with dementia in an acute care setting, nurses are exposed to traumatic events such as verbal and physical abuse, adding to the general stress of being new graduate nurses (Lavoie-Tremblay et al., 2008). If nurses are not supported when these events occur, they can lead to poor coping mechanisms such as disengagement, as well as mental health issues, such as anxiety and depression (Buurman et al., 2011; Lavoie et al., 2016; McKinney, 2011; Mealer et al., 2007). Furthermore, McKinney (2011) suggested that work-related stress can lead to poor quality of care for patients and higher nurse turnover rates. This evidence highlights the paramount importance of support for new graduate nurses.

There is a body of literature that has discussed the negative coping mechanisms for nurses who have experienced work-related stress (Buurman, Mank, Beijer, & Olf, 2011; Lavoie et al., 2016; McKinney, 2011; Mealer, Shelton, Berg, Rothbaum, & Moss, 2007). The literature suggests that work-related stress can be caused by negative experiences and events that leave nurses with feelings of fear and helplessness (Buurman et al., 2011). Work-related stress can be

caused by a failure to fulfil a vision of care as a result of not having control over ones' workload and environment (McKinney, 2011). These experiences can lead to the development of poor coping mechanisms such as disengagement and burnout (McKinney, 2011). Buurman et al. (2011) suggested that everyone responds to work-related stress differently and that only 10% of those exposed to work-related stress will develop mental health issues (e.g., anxiety, depression, post-traumatic stress disorder).

The mental health of nurses has traditionally been researched in the context of critical care nursing, such as intensive and emergency care (Epp, 2012; Morrison & Joy, 2016). However, two studies have addressed the mental health of nurses working on general medical/surgical acute care units (Buurman et al., 2011; Mealer et al., 2007). Mealer et al. (2007) determined that medical/surgical nurses have the same rates of anxiety and depression as intensive care nurses. Medical/surgical nurses also reported being less likely to assist colleagues with care compared to intensive care nurses, due to the increased nurse-patient ratios (Mealer et al., 2007). These findings suggest that some medical/surgical nurses may feel as though they are alone and are unable to rely on their colleagues for support. For example, they may not feel as though they can ask a colleague to assist them when they assist a patient to the bathroom because they know their colleagues are also providing care for a large number of patients. If nurses feel alone in the workplace, they may not develop a sense of connectedness with their colleagues, which Meleis (2010) has suggested is essential for a successful transition. Furthermore, patients may experience a decreased quality of care as a nurse may be reluctant to ask for help when assisting them.

In a second study, Buurman et al. (2011) assessed general internal medicine acute care nurses ($N = 66$) for the presence of traumatic events. Ninety-eight percent of nurses reported

experiencing traumatic stress at least once during their career. Eighty-seven percent of the sample reported experiencing verbal abuse and 43% reported experiencing physical aggression. Several participants reported experiencing verbal and physical abuse from patients with dementia while exhibiting responsive behaviours. The literature on new graduate nurses highlights the importance of support for new graduate nurses during their transition.

5.7 Support of New Graduate Nurses.

Support throughout the new graduate nurse transition is paramount to ensure nurses are able to practice independently (Duchscher, 2012). Support is not a single intervention, but a concept with the goal of ensuring a healthy transition. The participants experienced support from their colleagues leading to the development of a personal sense of connectedness with their colleagues.

The participants highlighted the importance of having supportive colleagues during their transition. When they were faced with an unexpected situation, such as caring for eight or nine patients, or providing care that was below their standards, they relied on their colleagues for emotional support to validate their feelings. For example, one participant confided in her colleagues that she felt she was not providing person-centred care to her post-operative patient with dementia because she had to care for eight other patients. Her colleagues validated her feelings, which helped the participant cope with her situation. Her colleagues made her feel as though she was not alone in this situation.

Experiences such as these, in which new graduate nurses have emotional connections with their colleagues led to the development of a personal sense of connectedness between the participants and their more senior nursing colleagues. Sense of connectedness has been discussed by Meleis (2010) within the context of transition. Meleis (2010) proposed that when an

individual has a positive emotional and/or spiritual connection with individuals within their transition, they are able to adapt to their new roles and responsibilities more effectively. Meleis' original research was not in the context of new graduate nurse transition, as such, this relationship requires further research with the new graduate nurse transitioning population.

Despite the limited understanding of feelings of connectedness with colleagues for new graduate nurses, Nolet, et al. (2015) explored the benefits of supportive colleagues for nursing students in a busy, fast-paced, and demanding long-term care environment. They reported that teamwork between nursing students and colleagues in a fast-paced long-term care environment with a demanding workload increased the student's confidence (Nolet, et al., 2015). This evidence suggests that developing a sense of between colleagues creates inclusivity and team building in which one feels valued.

Although the participants in this study did not specify if they participated in a nurse transition program, the literature identified that such programs support new graduate nurses through their transition (Hatler et al., 2011, Kramer, Halfer, et al., 2012; Kramer, Maguire, et al., 2012). When new graduate nurses have an assigned preceptor for an extended period of time, the preceptor can provide support by sharing dementia care skills and knowledge. Additionally, new graduate nurses may develop a trusting relationship, allowing them to express feelings and in turn, receive validation. This relationship may lead to the development of a personal sense of connectedness with their colleagues, aiding a successful transition. Ontario's New Graduate Guarantee Initiative (NGGI) transition program was developed in 2007 to provide new graduate nurses with 12 to 18 weeks of preceptorship (Health Force Ontario, 2015). In 2017, the Ministry of Health and Long-Term Care restructured the program and reduced preceptorship to a total of 12 weeks (Health Force Ontario, 2017). It is not clear why this change occurred considering

Chappell et al. (2014) reported that new graduate nurses' intentions of staying with their employer were 21 times more likely if they participated in a transition program for 24 weeks or longer, compared to a transition program of 12 weeks or less. This change poses an increased risk of turnover for new graduate nurses in Ontario.

The participants did not discuss the involvement of Advanced Practice Nurses (APNs) in their transition, however, the literature identified that APNs could be another intervention to support new graduate nurses (Kramer, Halfer, et al., 2012; Salt et al., 2008). APNs support new graduate nurses by providing specialized education to meet new graduate nurses' learning needs (Hatler et al., 2011; Strauss, 2009). APNs also support the preceptor with their learning needs (Adams et al., 2015; Glynn & Silvia, 2013; Strauss, 2009).

5.8 Registered Practical Nurses and New Graduate Nurse Transition.

The participants were comprised of Registered Practical Nurses (RPNs) and Registered Nurses (RNs). Collectively, the participants discussed similar experiences regarding their transition experience. Despite their collective experiences, I did not distinguish between RPNs and RNs in the context of new graduate transition, therefore it is unclear whether RPNs encounter the same new graduate nurse transition as RNs.

The literature review highlighted a gap in existing research regarding the RPN transition. In Canada, RPN's receive a two-and-a-half-year college education and care for stable patients with predictable outcomes by collaboratively working with RNs (CNA 2016a; Nursing Health Services Research Unit [NHSRU], 2009). In most Canadian provinces, RNs receive a four-year baccalaureate university education acquiring an increased knowledge breadth and depth to care for complex and unstable patients with unpredictable outcomes (CNO, 2014c; NHSRU, 2009). Although RPNs and RNs have different education, they both practice in acute care settings

(CNO, 2016). Furthermore, there is an increasing number of RPNs working in acute care compared to RNs (RNAO, 2016). Given the increasing number of RPNs working in acute care, it is important to consider their transition in this setting. To date, there has been extensive research on the new graduate RN transition, beginning with Kramer's work in 1974. At this time, no published, peer-reviewed literature in the context new graduate RPN transition was found. It is unclear whether transition for RPNs is the same as for RNs. Despite the gap in nursing research, the transition from an RPN to an RN has been explored in a number of studies. Like the RN transition, support from peers and colleagues was important for RPN to RN students (Suva et al., 2015). Students were more successful and confident in the RPN to RN program when they had a thorough understanding of the requirements of the program, experienced feelings of connectedness with their peers, faculty, and learning environments, and learned the culture of academia (Cubit & Lopez, 2011; Hutchinson, Mitchell, & St. John, 2011; Suva et al., 2015). Cook, Doverm, Dickson, and Engh (2010) reported that balancing family and work responsibilities, financial concerns, and finding adequate time to devote to school work were challenges for RPN to RN students during this transition. These findings are consistent with Duchscher's theory (2012) which states that new graduate nurse transition also involves psychosocial changes, in addition to the professional nursing transition challenges. Goodwin-Esola and Gallagher-Ford (2009) reported that the change in accountability from RPN to RN was a challenge, including communicating with physicians and delegating tasks to other RPNs. These findings are parallel with Kramer (1974), Benner (1982), Meleis (2000) and Duchscher (2012) because transition starts with a change in roles and responsibilities, leading to feelings of stress.

In the literature, there were two prominent similarities between new graduate RN transition and RPN to RN transition: (1) the need for support from peers and colleagues, and (2)

challenges adjusting to their new role and responsibilities. These two similarities reflected the experience of the participants in this thesis. The RN and RPN participants expressed that their transition from student to practising nurses was overwhelming at times as they adjusted to their new roles and responsibilities. They experienced challenges as their values and vision of care sometimes clashed with their acute care environment. These challenges highlighted the importance of having supportive colleagues. For example, the participants relied on their colleagues for support through validation when they were faced with caring for an increased number of patients at the same time. Colleagues also offered support by teaching the participant's dementia care techniques and with nursing tasks, such as intravenous medication administration.

5.9 Personal Sense of Connectedness with Dementia Care.

The participants developed a personal sense of connectedness with older adults and people with dementia from their interactions with their own family members and loved ones who were diagnosed with dementia. The participants suggested that their sense of connectedness had positively influenced their vision of care. A personal sense of connectedness is defined as a positive emotional and/or spiritual connection between an individual and another individual, a population, or environment in which one feels valued and engaged. The concept of sense of connectedness has been explored by Meleis (2010) in her transition theory. However, Meleis discussed this concept within the context of developing a relationship with other individuals (peers, colleagues) to ensure a successful transition. Therefore, the notion that a personal sense of connectedness between two individuals can influence the nurses' outlook and perception of a patient population is a new application of the concept found in this thesis.

The participants that developed a personal sense of connectedness with their own loved ones appeared to have an increased sense of accountability and responsibility to provide care that

matched their vision and values. Several participants suggested that the care that they wanted to provide was influenced by the care they wished their loved ones would receive. This lends support to the notion that the development of a personal sense of connectedness between new graduate nurses and patients with dementia may benefit patient care.

Although sense of connectedness has not been explicitly researched in the context of new graduate nurse transition or dementia care, studies have focused on nursing students and dementia care (Baillie, Merrit, Cox, & Crichton, 2015; McKenzie & Brown, 2014). These studies have discussed the variables that were associated with the outcomes of intention to work in dementia care (McKenzie & Brown, 2014) and increased confidence and expectations regarding dementia care (Baillie et al., 2015). A cross-sectional mixed-methods study conducted by McKenzie and Brown (2014) suggested that nursing students who were older and nursing students who had a positive view of older adults were associated with an increased intention to work in dementia care upon graduation. These findings support the results of this thesis. The participants that developed a personal sense of connectedness with loved ones appeared to have a positive view of older adults. Furthermore, Baillie et al. (2015) reported that nursing students who had pre-course contact with patients with dementia (e.g., family, friends, volunteering, work) had increased confidence with dementia care and higher expectations of care when working with patients with dementia, compared to students without any pre-course contact with patients with dementia. Although Baillie et al. (2015) did not define 'pre-course contact with patients with dementia', this study suggests that the development of a personal sense of connectedness between new graduate nurses and loved ones with dementia may have a positive influence on their vision of care; this is an important concept to further explore. Baillie et al.'s (2015) findings are aligned with the results of this thesis. The participants in this thesis who

developed a personal sense of connectedness to their loved ones with dementia felt they had an increased sense of accountability and responsibility, thus influencing their vision of care.

Two cross-sectional studies reported that nursing students' dementia care knowledge was not associated with having family members with dementia (Scerri & Scerri, 2013; Shin et al., 2015). This suggested that a personal sense of connectedness with loved ones with dementia may influence their vision of care, however, it does not influence their knowledge of dementia care. A personal sense of connectedness is associated with positive emotional and/or spiritual connections, sense of accountability and responsibility, and as suggested by Baillie et al. (2015), may be associated with confidence and expectations of care. Both studies by Scerri and Scerri (2013) and Shin et al. (2015) were cross-sectional, so although having family members with dementia was not associated with increased dementia care knowledge as a student, it is unclear whether these two factors are associated as they start professional nursing practice.

The development of a personal sense of connectedness may be linked to dementia care knowledge over time. For example, if one develops a personal sense of connectedness, they may not possess the knowledge to provide the type of care they envision. However, because they have an increased sense of accountability and responsibility, they may eventually seek knowledge to ensure that the care they are providing is meeting their expectations. Although having a connection with family members with dementia did not increase the dementia care knowledge for students (Scerri & Scerri, 2013; Shin et al., 2015), over time, nurses may acquire more knowledge as a result of the personal sense of connectedness they have with patients with dementia.

The results of this thesis suggest that the following variables may be important to the development of a personal sense of connectedness to patients with dementia: older nursing

students, a positive view of older adults (McKenzie & Brown, 2014), and pre-course contact with patients with dementia (Baillie, Merrit, Cox & Crichton, 2015). These outcomes have not yet been explored in the context of nursing students and dementia care.

5.10 Early Exposure to Dementia Care

The participants discussed how the Gentle Persuasive Approach (GPA) course and their paid employment in long-term care as students provided them with an early exposure to dementia care, thus helping them feel better prepared to provide dementia care as new graduate nurses in acute care. Both of these results support Kramer's (1974) reality shock and anticipatory socialization theory. Kramer's theory (1974) in relation to early exposure to dementia care will be discussed further in section 5.10.3: theoretical discussion of early exposure to dementia care.

5.10.1 The Gentle Persuasive Approach course.

The results suggested that the completion of the GPA course as students helped prepare new graduate nurses with the tools to manage responsive behaviours and to provide psychosocial care for patients with dementia. GPA is an Ontario developed, evidence-based, eight-hour workshop designed to provide frontline health care workers (e.g., nurses, allied health professionals, volunteers, clerical staff) with practical knowledge, skills, and tools to provide person-centred care for patients with dementia (Schindel-Martin et al., 2014). The program has four interactive modules: personhood, the brain and behaviour, the interpersonal environment, and gentle persuasive techniques (Schindel-Martin, 2014). The GPA program originated from the work of Schindel-Martin, Morden, Cetinski, Lasky, McDowell and Roberts (2003) from McMaster University in Canada. They developed a program for frontline long-term care workers with the purpose of providing them with “the knowledge, skill, and confidence to manage physical self-protective behaviours of cognitively impaired long-term care residents” (p. 273).

They reviewed 19 dementia care training programs to develop the one-day, small group (10-12 people) workshop and evaluated the educational program by conducting a randomized controlled trial. Forty staff members at a sixty-bed long-term care home were randomly assigned to the control group (no education) and intervention group (workshop). Pre- and post-tests were administered before and six weeks after the workshop to measure knowledge about crisis de-escalation intentions. Additionally, a self-reported evaluation of personal/emotional reaction to aggressive or out-of-control resident behaviours, and an objective structured clinical examination (OSCE) where participants role-played de-escalating an aggressive and physically abusive dementia patient were used to determine program effectiveness. There were 12 completed data sets for the control group and 13 in the experimental group. The experimental group reported improved knowledge ($p = .001$) and improved OSCE scores ($p = .001$), however, the participants self-reported confidence with dementia care was not influenced by the intervention ($p = .68$).

The GPA program uses Bandura's social learning theory that highlights the importance of social interactions among learners to facilitate the development and recognition of learners' values, beliefs, and norms. After the initial pilot test, the refined GPA program was pilot tested with front-line staff ($N = 205$) in seven long-term care homes in Southwestern Ontario (Schindel-Martin et al., 2010). In a pre-post study, staff reported an increase in confidence, competence, and knowledge regarding how to care for residents with responsive and aggressive behaviours after the workshop. Participants also developed a positive attitude toward the philosophy of person-centred care after the workshop (Schindel-Martin et al., 2010).

The GPA program has since been implemented in rehabilitation (Speziale, Black, Coatsworth-Puspoky, Ross, & O'Regan, 2009) and acute hospital settings in Ontario (Pizzacalla et al. 2015). Participants reported improved self-perceived behavioural management skills ($p =$

.01) (Pizzacalla et al. 2015) and increased knowledge and expertise to manage responsive behaviours (Speziale et al. 2009). Speziale et al. (2009) also reported a 50% decrease in physical aggression rates from patients towards staff 3-months post-training ($p = .001$) despite a homogeneous pre- post- patient sample. However, there was no change in occupational health staff injury rates.

The Ontario Local Health Integrated Network (LHIN) has recognized the value of the GPA program. The LHIN and the Regional Geriatric Programs developed the Ontario Senior Friendly Hospital framework in 2011. The purpose of this framework was to empower organizations to provide care and health outcomes to frail seniors who access care in hospitals (Senior Friendly Hospitals, 2014). The framework outlines five domains in which organizations can make improvements to ensure they are providing the best possible care to seniors:

(1) organizational support, (2) processes of care, (3) emotional and behavioural environment, (4) ethics in clinical care and research, and (5) physical environment. The Ontario Senior Friendly Hospital framework recommends the implementation of GPA education to all staff (Senior Friendly Hospitals, 2014). In 2014, 80% of hospitals in the LHINs added becoming a Senior Friendly Hospital to their strategic plan (Senior Friendly Hospitals, 2014).

In addition to hospitals recognizing the importance of the GPA program, the Registered Nurses Association of Ontario (RNAO) recommended that all nursing programs have a focus on gerontological nursing and dementia care to ensure new graduate nurses are prepared to care for our ageing population (RNAO, 2016). The majority of participants in this current study suggested that their nursing education provided them with pathophysiological knowledge of dementia, but lacked the practical therapeutic interventions required to provide psychosocial care for patients with dementia, as well as strategies to manage responsive behaviours. The GPA

program may meet the learning needs identified by new graduate nurses in this thesis. Currently, the Daphne Cockwell School of Nursing at Ryerson University in Toronto, Ontario is the only nursing school in Canada that is known to have incorporated GPA into their curriculum (Newman & White, 2016). Implementation of this program has not yet been evaluated.

5.10.2 Paid employment in long-term care as students.

Under the Long-Term Care Homes Act (2007), a student enrolled in a baccalaureate or diploma nursing program may work as a personal support worker in Ontario. Personal support workers are responsible for providing personal care to residents in long-term care homes. Their personal care responsibilities include assisting residents with all aspects of activities of daily living (e.g., personal hygiene and grooming, ambulation, nutrition, and psychosocial care). Personal support workers are responsible for providing this care for between 10 and 15 residents. The participants in this study who were employed by long-term care homes as students reported that their experience prepared them to care for patients with dementia in acute care as new graduate nurses. They felt they learned tools and interventions to provide psychosocial care and to manage responsive behaviours more effectively than they would have otherwise. Furthermore, they felt they benefited from their early exposure to dementia care.

Although paid employment in long-term care as students has not been studied before, literature suggests that long-term care clinical placements: (1) increase students' nursing assessment skills and attitudes towards dementia care (Annear, Lea, & Robinson, 2014; Lea et al., 2014; Eccleston et al., 2015; Kimzey et al., 2016), and (2) prepares students for their role as new graduate nurses, and increases their intention to work in long-term care upon graduation (Nolet, et al., 2015). Furthermore, paid employment as students in any work environment (clinical or non-clinical), assists new graduate nurses during their transition (Phillips, Easterman,

Smith, & Kenny, 2012a; Phillips, Kenny, Smith, & Easterman, 2012b). New graduate nurses reported that paid employment as students help them develop time management skills that they used as nurses (Phillips et al., 2012a).

Undergraduate nursing students who participated in a long-term care clinical placement while in school reported an increase in their nursing assessment skills (Annear et al., 2014; Lea et al., 2014; Eccleston et al., 2015; Kimzey et al., 2016). Annear et al. (2014) reported that nursing students in long-term care worked alongside personal support workers who provided the majority of personal care for the residents. Part of the role of a personal support workers is to inform registered staff of any changes from the residents' baseline. For example, personal support workers would inform the registered staff if a resident was experiencing abnormal integumentary issues (e.g., rashes, reddened/broken down skin, saturated dressing), changes in routine bladder and bowel functions, signs and symptoms of pain, and changes in their neurological status. Therefore, the nursing students working as personal support workers would inherently develop assessment skills. The participants in this thesis would have had a similar experience while working in long-term care, allowing them to develop their assessment skills, which may have contributed to them feeling more prepared as new graduate nurses.

One study by Nolet, et al. (2015) suggested that a paid school internship in long-term care during the summer helped prepare students for their role as new graduate nurses and increased their intention to work in long-term care upon graduation. The students reported that exposure to a heavy workload, autonomous practice, fast-paced environments, and efficient teamwork increased their confidence and assisted them in feeling prepared to meet the demands of their future role as new graduate nurses. The participants in this current study described acute care as a busy, demanding, and fast-paced environment. The findings by Nolet, et al. (2015)

suggested that being exposed to a similar environment, regardless of the type of care being provided (acute vs. long-term), may help prepare nurses for the demands of an acute care environment. Therefore, may help improve the transition of new graduate nurses.

Long-term care experience may have prompted the participants to explore ways of organizing and prioritizing care for stable patients in a busy and fast-paced environment as students. Benner's model suggested (1984) that novice nurses require more time to provide care as they are applying theoretical knowledge to situations with limited clinical experience. The participants in this study reported feeling unorganized as new graduate nurses, resulting in the perception of having less time to provide care, compared to their experienced colleagues (Benner, 1984). However, the participants that worked in long-term care as students felt more prepared for the busy work environment of acute care because of their experience in long-term care. Their early experience in long-term care may have initiated the development of knowledge and skills (e.g., organization, prioritization, critical thinking) earlier than their colleagues that did not work in long-term care as students, thus helping them feel more prepared as new graduates.

Additionally, students with paid employment in a clinical setting (long-term care and acute care) developed confidence and clinical experience (nursing skills and assessments) by observing colleagues during patient assessments, communication with families and palliative care, and reported that their experiences helped them with time management and the mastery of basic nursing care (Phillips et al., 2012a). These findings echo the results of this thesis and Nolet, et al. (2015), and support the findings of this thesis.

5.10.3 Theoretical discussion of early exposure to dementia care.

The participants that had paid employment in long-term care as students and took the GPA course were exposed to the realities of dementia care before entering the nursing

profession. The participants expressed that these experiences helped prepare them to provide dementia care in acute care as new graduate nurses. For example, the GPA course taught one participant how to respond to physically abusive patients with dementia; a situation she was not aware could occur prior to the course. These findings are consistent with Kramer's reality shock and anticipatory socialization theory (Kramer, 1974). As Kramer suggested, the sooner nursing students are exposed to the realities of the nursing profession, the better prepared they will be as nurses in the practice environment (Kramer, 1974). Participants that experienced the realities of dementia care, in particular responsive behaviours, as students may have had less of an emotional response when they encountered them as new graduate nurses. As Benner (1984) suggested, the knowledge base of novice nurses is largely theoretical. However, when students had an early exposure to dementia care, they built their experience, which they could draw upon as new graduate nurses. As a result of their early exposure to dementia care, they were better able to incorporate theory with experience; a skill set that is designated for an advanced beginner or competent nurse.

The participants who were employed in long-term care as students reported a strong emotional response when they experienced physical and verbal abusive responsive behaviours from patients with dementia. If their first exposure to this was as a student, then when they encountered these experiences as new graduate nurses, it is possible that they would have felt more prepared and may have had less of an emotional response, leading to a lessened reality shock (Kramer, 1974). Furthermore, early exposure to dementia care may lead to the acquisition of additional knowledge. Two studies suggested that students had an increase in dementia care knowledge if they had previous dementia education (Scerri & Scerri, 2013; Shin et al., 2015), and provided care for patients with dementia during clinical placements (Shin et al., 2015).

5.11 Registered Practical Nurses and Dementia Care.

The participants viewed experienced RPNs as role models for providing care for patients with dementia and perceived them as experts regarding dementia care techniques. The notion that RPNs were perceived as role models for dementia care may be explained by further understanding where RPNs work, the patients they care for in these settings, and their nursing education. There is a greater proportion of RPNs working in long-term care, retirement homes, and as visiting nurses compared to RNs (CNO, 2016a; 2016b). In Ontario, 10,141 (8.9%) RNs and 19,676 (38.7%) RPNs worked in long-term care and retirement homes in 2016 (CNO, 2016a, 2016b). In Ontario, 3032 (2.6%) RNs and 3416 (6.7%) RPNs worked as visiting nurses in the community in 2016 (CNO, 2016a, 2016b). It is estimated that 45% of residents in residential long-term care facilities and five percent of people over the age of 80 living at home have dementia (Statistics Canada, 2016). This evidence suggests that RPNs may simply have more experience caring for patients with dementia as a result of an increased number of RPNs working in long-term care, retirement homes, and community care.

One participant suggested that her RPN colleagues in acute care were also employed in the community and long-term care. Patients in long-term care and community care are considered stable and are appropriate to be cared for by RPNs. Therefore, RPNs working in both acute care and non-acute care may bring their experience and skills working with stable patients with dementia into the acute care setting.

Furthermore, if long-term care, retirement homes, and community care predominantly employ RPNs, nursing curriculums for RPNs may place a greater emphasis on clinical placements in these clinical settings in an attempt to make new graduate RPNs marketable for employers. As such, RPNs may be exposed to an increased number of patients with dementia

during their nursing education, resulting in an increased experience and knowledge of caring for this patient population. Understanding where RPNs work, the patients they care for in these settings, and their nursing education may provide insight into why the participants perceived RPNs as role models for providing care for patients with dementia and perceived them as experts regarding dementia care techniques.

5.12 Challenges Caring for Patients with Dementia in Acute Care

This thesis highlighted the challenges that new graduate nurses experienced while providing care for patients with dementia in acute care settings. These challenges are echoed in the literature with samples of nurses with varying amounts of clinical experience (Dewing & Dijk, 2016; Moonga & Likupe, 2016). The following are challenges reported in the literature: the acute care environment is not appropriate for managing the care needs of patients with dementia (e.g., responsive behaviours, ensuring patient safety); responsive behaviours were challenging to manage, leading to feelings of frustration and guilt; busy and hectic acute care environments have competing demands that often left nurses having to treat patients with dementia as a lesser priority, often resulting in the use of physical or chemical restraints; and nurses had a perceived lack of education regarding therapeutic interventions for dementia care in acute care environments (Dewing & Dijk, 2016; Moonga & Likupe, 2016). These similarities suggest that caring for patients with dementia in acute care is a challenge for all nurses, regardless of their experience.

Although the participants' experiences were similar to the challenges reported in the literature, the participants' reactions to challenging experiences may have been exacerbated as they were encountering these challenges for the first time in their nursing career. Experiencing the challenges of responsive behaviours, the acute care environment, and treating patients with

dementia as a lesser priority for the first time may have resulted in a strong emotional response from the participants, such as feelings of helplessness, frustration, and guilt. The participants suggested they were not anticipating or prepared for these challenges, whereas experienced nurses may have encountered these challenges multiple times, allowing them to be prepared for when they arise. Therefore, even though the challenges the participants experienced are not unique to new graduate nurses, their reaction to the challenges may have been exacerbated by their inexperience.

Feeling unprepared for the challenges of caring for patients with dementia in acute care resembles the theories of Kramer (1974) and Benner (1982). As the participants suggested, they felt their nursing curriculum focused on the medical aspect of dementia care over the psychosocial aspect of care. As novice nurses, the participants would have relied on their theoretical knowledge to guide their decision-making (Benner, 1982). However, the participants felt they had limited education on psychosocial care. Therefore, the participants may lack the theoretical knowledge to respond to psychosocial care needs, thus making them feel unprepared.

Furthermore, as Kramer (1974) suggested reality shock results in negative emotional responses to an unknown or undesired situation, such as managing a patient with dementia's responsive behaviours. Kramer's (1974) anticipatory socialization theory could have been implemented to reduce the participants' negative emotional responses. The participants may have felt more prepared for these situations if they had taken the GPA course or had worked in long-term care as students.

5.13 Nursing Ethics

The following section focuses on four ethical situations that arose for the participants: (1) lying and dementia care, (2) humour and dementia care, (3) dementia care as a lesser priority, and (4) clash of values.

5.13.1 Lying and dementia care.

In this thesis, the participants used lying as a therapeutic intervention when patients with dementia were distressed about missing information. Although it was unclear where they learned this technique from, the participants suggested that lying was used to prevent and de-escalate responsive behaviours. For example, lying was used when patients with dementia were looking for their missing loved ones who were dead. However, despite their rationale for lying, the participants felt they were going against their nursing ethics code.

The CNO's Ethics Standard (2009) emphasized the importance of being honest and truthful with patients. The CNO (2009) states that a false statement compromises the therapeutic nurse-patient relationship and is considered unethical. Additionally, when a nurse withholds information from patients, they are infringing upon the principals of power and trust that are required to develop a therapeutic nurse-patient relationship (CNO, 2006). Therefore, when a patient with dementia was becoming distressed, the participants were faced with an ethical dilemma: to lie or not to lie.

Lying in dementia care is a relatively new concept in the literature and it is suggested that lying to patients with dementia is common. Sixty-nine percent of psychiatrists in the United Kingdom ($n = 29$) reported that they have lied to patients with dementia, and 69% of them had been asked to lie by caregivers of patients with dementia (Culley, Barber, Hope, & James, 2013). Ninety-six percent ($n = 108$) of staff working in a residential care home in the United Kingdom

have reported lying to patients with dementia (James, Wood-Mitchell, Waterworth, Mackenzie, & Cunningham, 2006).

The purpose of lying to patients with dementia is to reduce anxiety resulting in a calming effect (Tucker, 2012; Turner, Eccles, Simpson, & Elvish, 2016; Zeltzer, 2003). The main antecedents to a lie are: (1) responding to difficult questions, (2) attempting to manage responsive behaviours, and (3) the request to share medical information (Turner et al., 2016). The literature suggested that health professionals have four options when tempted to lie: (1) tell the truth, (2) referring the answer to another staff member, (3) distraction (most favourable but requires a lot of time and not always effective), or (4) to lie (Tucker, 2012; Turner et al., 2016). Staff also stressed that in order for a lie to be successful, the staff member needs to have a strong understanding of their patients' mental capacity, as the patient's cognitive awareness of a lie will determine if a lie will be therapeutic or not (Tucker, 2012; Turner et al., 2016).

There are two philosophies regarding lying in dementia care. One perceives lying as an acceptable intervention if it is in the best interest of the patient with a therapeutic effect of decreasing the patient's level of distress (Day, James, Meyer, & Lee, 2011; Turner et al., 2016). The other perspective is that lying to patients with dementia is a violation of their human rights and is an unethical practice, suggesting that validation therapy should be used instead of lying (Feil & Altman, 2004). Using validation therapy, the caregiver validates and explores the patient's emotions and feelings to distract and redirect their thoughts, which may result in a de-escalation of the patient's emotional behaviours. Proponents of this approach report that it maintains the ethical standards of truthfulness (Feil & Altman, 2004). Feil and Altman (2004) suggested that, based on Freud's layer of consciousness theory, all patients with dementia are aware that they are being lied to at some level, even if they do not express it through thought. As

suggested, even when a lie appears to have a calming and therapeutic effect and the patient appears to not be aware of the lie, Feil and Altman suspect that their subconscious is aware, thus damaging their self-concept. Self-concept is one's understanding of who they are based on their values, beliefs, and interactions with others (Feil & Altman, 2004).

A novel study by Day et al. (2011) focused on the perspective of lying of those being lied to: patients with dementia. Day and colleagues interviewed long-term care home residents with dementia ($N = 10$). They reported that patients with dementia considered lying to be appropriate if it was in their best interest. However, they stressed that the acceptability of the lie depended on the situation, the type of lie told, and the person telling it. For example, they perceived lies from family members and loved ones to have a greater negative effect on their self-concept than lies from staff members. They also emphasized that lies were only appropriate if the person with dementia did not know they were being lied to.

Day et al. (2011) highlight a person-centred approach to this ethical issue. If the health professional that is lying takes into consideration all of the factors involved in a therapeutic lie, then it may be appropriate to lie to patients with dementia (Day et al., 2011). However, if the health professional carelessly lies (does not consider the patient's mental capacity and awareness of the lie), then a lie will not be therapeutic and will have negative consequences (Tucker, 2012; Turner et al., 2016).

This leads to an additional discussion question: Is lying to patients with dementia a skill? If it is a skill, should it be included in health professional education? One study explored the concept of lying and dementia care education for health professionals. A pre-post quasi-experimental study in the United Kingdom assessed hospital staff's ($N = 195$) attitudes toward lying following an inter-professional education workshop on lying (Elvish, James, & Milne,

2010). The workshop included a critical-incident learning exercise in which they viewed lying and dementia care in popular culture, a review of the current literature, and had an open discussion around the ethical implications of lying and dementia care. After the workshop, participants were more accepting towards lying ($p = <.05$), admitted to lying more frequently ($p = <.05$), and there was an increase in the perceived acceptability of lying ($p = <.05$). This is the only study that has focused on lying and dementia care education. The concept of lying to patients with dementia as a skill is a new phenomenon that warrants further research and discussion.

The workshop by Elvish et al. (2010) may be beneficial in reducing the reality shock (Kramer, 1974) of new graduate nurses who provide care for patients with dementia in acute care, because lying is perceived as unethical. The CNO (2006; 2009) and the CNA (2017) supports that nurses must remain truthful and honest with their patients. Withholding the truth constitutes a breach in the therapeutic nurse-patient relationship and ethical standards (CNA, 2017; CNO, 2006; CNO, 2009). The participants in this study were aware of the implications of lying, thus resulting in a negative emotional response. Although discussing lying and dementia care with nursing students would be controversial, preparing students for the reality of caring for patients with dementia through anticipatory socialization may help reduce new graduate nurses' experience of reality shock (Kramer, 1974).

5.13.2 Humour and dementia care.

Participants discussed that they found humour in some of their interactions with dementia patients. It was unclear the purpose of this humour and if the humour was mutual between the new graduate nurse and the patient, or if it was at the expense of the patient. The participants found humour in two instances: (1) when a patient thought they were a physician, and (2) when a

patient proposed to the participant. If a patient with dementia was disorientated and unaware of their surroundings, offering someone their hand in marriage or practising medicine in a hospital would not be humorous. Therefore, humour in these situations may have been detrimental to the patients' self-concept. The other aspect to consider is the purpose of the humour. It is unclear if this humour is a coping mechanism for the new graduate nurse, or if it is benign.

Humour between professional caregivers and patients can have a positive impact on patients, often relieving stress and anxiety (Dean & Major, 2008; Jones & Tanay, 2016; McCreddie & Wiggins, 2007). Humour between professional colleagues has been associated with team building, supporting each other, and the development of a sense of connectedness (Dean & Major, 2008; Jones & Tanay, 2016; McCreddie & Wiggins, 2008). There is little evidence on the use of humour between professional caregivers and patients with dementia. The participants in this study highlighted that they found humour in the actions of the patients with dementia and it appeared that the patient was unaware that their actions were humorous (e.g., the patient with dementia who thought he was a physician). A literature review by McCreddie and Wiggins (2008) addressed humour among health care professionals ($N = 88$) and suggested that humour in the context of psychologically impaired individuals was unethical and inappropriate, as it can have a negative impact on patients' self-concept. For example, the patient who was a retired physician with dementia presumably practised medicine for his entire career and would have taken pride in the care he provided. The participant described that the patient with dementia was disorientated and reviewing charts. If the patient became aware that he was being laughed at, it may have been upsetting, demeaning, or embarrassing for *his colleagues* (nurses) to find humour in his actions. The CNO (2006) emphasizes that a therapeutic nurse-patient relationship is built upon respect, trust, and preserving dignity. Nurses need to be aware that although a

situation involving a patient may appear to be humorous, humour may be detrimental to the patient's self-concept and the therapeutic nurse-patient relationship.

Research has also addressed the use of humour by new graduate nurses. A literature review conducted by Jones and Tanay (2016) on nurses' perception of potential barriers to the use of humour in practice reported that new nurses were initially reluctant to use humour as they perceived the use of humour to only be acceptable for experienced nurses. New graduate nurses are aware that they are inexperienced nurses. Part of new graduate nurse transition is socializing into the profession (Duchscher, 2012), as such, when the participants found an opportunity to use humour or participate in humour, they may have done so in order to *fit-in* with their colleagues. By using humour or participating in humour, the participants may have felt more experienced, or 'part of the team'. Additionally, humour among colleagues promotes team building and a sense of belonging (Dean & Major, 2008; Jones & Tanay, 2016; McCreddie & Wiggins, 2008). The participants may have participated in humour to develop a sense of connectedness with their colleagues. However, the use of humour may not be the most appropriate response to patients with dementia. It is imperative that one must examine the purpose of humour with patients with dementia and its implications.

5.13.3 Dementia care as a lesser priority.

The concept of dementia care as a lesser priority emerged in this thesis. In the acute care environment, the participants cared for several acutely ill and unstable patients at the same time, as such, they had to prioritize care for the most unstable patients first. This often resulted in the participants perceiving the psychosocial care needs of patients with dementia as a lesser priority. For example, assisting patients to the bathroom or into the chair for meals, or providing psychosocial care to de-escalate a responsive behaviour, were sometimes less of a priority than

the medical needs of the participants' unstable patients. The participants felt guilty about their actions as they did not envision providing this type of care, and they felt their actions infringed upon the CNO's Ethical Standards (2009).

The CNO's Ethical Standards (2009) describes that it is the nurses' duty and responsibility to provide care that promotes patient well-being and prevents harm (2009). Nurses are accountable to their patients, therefore they must not abandon or neglect their patients, and nurses should strive for fairness by providing, "equal attention, regardless of [the patient's] needs" (CNO, 2009, p. 16). This statement by the CNO may explain why the participants felt guilty and frustrated. In addition to their struggle to implement their values of person-centred care, they felt they were breaching their ethical values.

The context of the statement by the CNO is unclear. The participants learned to prioritize care, with the most unstable patients receiving priority. As Benner suggested (1984), novice nurses use theoretical knowledge to make clinical decisions because of their lack of expertise. Furthermore, their lack of knowledge attributed to their difficulty prioritizing patient care (Benner, 1984). Although nurses should provide "equal attention, regardless of [the patient's] needs" (CNO, 2009, p. 16), an experienced nurse would understand the limitations of this statement, by integrating their experience with theory (Benner, 1984). However, novice nurses do not always have the experience to complement theory; therefore, they may interpret the statement by the CNO as they are not meeting the CNO's ethical standards. For example, one participant suggested that she provided more attention to her patient who was having a cardiac arrest, over assisting her patient with dementia from their bed to their chair for breakfast. This participant made the right choice, however, if the participants were to reflect upon the statement

by the CNO, they may have felt as though they infringed the CNO's ethical standards (2009), leading to a negative emotional response.

This ethical issue could be addressed using Kramer's (1974) anticipatory socialization theory. If students had the opportunity to discuss ethical issues in relation to the CNO's (2009) Ethical Standards before they occur, the students might feel better prepared when these situations arise.

5.13.4 Clash of values.

The participants were taught the values of person-centred care, the CNO's Ethical Standards (2009), and the CNA's Code of Ethics (2017). The participants felt that their values clashed with the acute care values of speed, productivity, and efficacy. They felt they did not have the time to provide the care they envisioned, as they were caring for up to eight or nine patients at the same time. They struggled to ensure the safety of patients with dementia and they felt they were treating patients with dementia as a lesser priority. This clash of values created a tension between the participants and their workplace. Furthermore, new graduate nurses are developing their time management skills making it difficult to prioritize and organize care (Benner, 1984; Duchschner, 2008).

The CNO (2009) recognizes that each nurse has their own set of values and they should work in an environment where their values can be upheld in order to maintain a commitment to themselves. The CNO states:

As people learn and grow, they develop their personal values and beliefs. Nurses need to recognize and function within their value system and be true to themselves. Nurses' values sometimes differ from those of other health care professionals, employers and

clients, causing ethical conflict. Nurses must provide ethical care while at the same time remaining committed to their values (2009, p. 9).

Although the CNO states that a conflict between the nurses' and employers' values can cause an ethical conflict, the CNO does not provide guidance for nurses should such a situation arise. Instead, the CNO addresses what the nurse should do if they have an ethical conflict with a patient or patient population. In this situation, the CNO (2009) suggests that nurses should arrange for another caregiver to provide care. Furthermore, if the ethical conflict is longstanding then "the nurse may have to leave a particular place of employment to adhere to her/his personal values" (CNO, 2009, p. 9). This statement may be problematic for new graduate nurses because their knowledge is based on limited experience and is largely theoretical (Benner, 1984). New graduate nurses who are experiencing a clash of values with their work environment may interpret that the CNO suggests that new graduate nurses need to find an alternative place of employment, leading to new graduate nurse turnover. However, it is unclear if that is the intent of the CNO. As new graduate nurses gain experience and further develop their time management skills, they will be better able to manage competing demands.

5.14 Implications for Research, Education and Advanced Practice Nursing

Several implications for the nursing profession have been highlighted from this thesis.

The following section will discuss the implications for research, education, and advanced nursing practice.

5.14.1 Recommendations for research.

This thesis has outlined several research gaps. Research is needed to provide a further understanding of: personal sense of connectedness, preparing new graduates through the GPA

course and paid employment in long-term care as a student, RPNs in nursing, support, and nursing ethics.

The concept of personal sense of connectedness emerged in this thesis. An understanding of the development of a personal sense of connectedness between both nurses and patients with dementia, as well as nurses and their colleagues needs to be explored. Several participants developed a personal sense of connectedness to patients with dementia stemming from their relationships with family members with dementia. This may have had a positive influence on the participants' expectations and vision of care. Although the current literature suggests that nursing students that have family members with dementia are not significantly more knowledgeable about dementia care (Scerri & Scerri, 2013; Shin et al., 2015), having family members with dementia may influence their sense of accountability, responsibility, confidence and expectation of care (Baillie et al., 2015). Thus, further research should explore which variables influence the development of a personal sense of connectedness with patients with dementia. Furthermore, the development of a personal sense of connectedness among colleagues warrants exploration. Meleis (2010) suggested that individuals who have feelings of connectedness with other individuals experience a healthy transition. New graduate nurses may have reduced turnover rates, higher transition scores, or increased job satisfaction if they develop a sense of connectedness with their colleagues.

Kramer's (1974) reality shock theory and anticipatory socialization theory supports that early exposure to dementia care through the GPA course and paid employment in long-term care as students may help prepare new graduate nurses to provide dementia care. However, further research is warranted to test this proposed relationship. If these early exposures to dementia care make new graduate nurses' feel more prepared for dementia care in acute care, then it would be

an additional reason to incorporate the GPA program into nursing curriculums. Furthermore, it may be beneficial to encourage nursing students to take paid employment in long-term care. In long-term care, students have the opportunity to learn skills from the interdisciplinary team, all while earning a competitive rate of pay. Further research needs to be conducted to evaluate outcomes, such as intention to work in geriatric nursing, confidence, and knowledge regarding psychosocial dementia care techniques, as well as nursing assessment knowledge regarding integumentary assessment, bladder and bowel assessments, and pain management (Nolet et al., 2015).

This thesis highlighted the large absence of research on RPNs in three main areas of focus. Firstly, it is paramount that new graduate RPN transition is explored. Currently, there is no literature on this topic, despite the growing number of RPNs in the Ontario nursing profession. It is unclear if RPNs experience the same transition as RNs, as such, it is unclear if they require different supports than RNs. This experience needs to be explored to ensure RPNs are effectively supported, reducing the risk of turnover. The second gap in RPN research is the experience of RPNs and dementia care in acute care settings. The participants in this study highlighted the same experiences as RNs in the literature, thus suggesting that RPNs have challenges with dementia care as well. Again, these experiences need to be explored to determine the best way to support RPNs while providing dementia care in acute care. Additionally, nursing research needs to specify which type of nurse they have sampled (e.g., RN, RPN, NP, APN). When the type of nurse is not specified, it is difficult to determine which type of nurse the research applies to. For example, if a study says ‘acute care nurses were sampled’, one is unable to generalize the findings, and it is unclear if they are transferable to RNs and/or RPNs or some other category of nurses.

Nursing research should also aim to examine the ethical topics of humour, lying and dementia care, and dementia care as a lesser priority. The purpose and the therapeutic effect of humour and dementia care are unclear. Moreover, the therapeutic outcomes of lying and dementia care need to be evaluated to determine the benefits versus ethical concerns when lying to patients with dementia. Further examination and clarification is required into the meaning and context of the CNO's statements regarding equal care for all patients, as well as how nurses are to manage when their values with their employer's values.

5.14.2 Recommendations for education.

The results of this thesis suggest that new graduate nurses may benefit from paid employment in long-term care homes as students. As such, nursing schools should encourage students to find employment in long-term care homes. Additionally, researchers need to evaluate the outcomes of nursing students who work in long-term care homes as personal support workers by assessing: dementia care knowledge and attitudes, intentions to work in long-term care homes/gerontological nursing, development of empathy, development of transferable nursing skills (e.g., time management, organizational skills, communication, dealing with difficult patients, dealing with families), and transition during their first year of practice. If the outcomes are favourable, nursing schools may consider developing a co-operative education program with long-term care homes as partners. Students could work in long-term care homes as a personal support worker over the summer to gain the practical dementia care interventions and skills and incorporate an academic component (e.g., online assignments regarding dementia care, person-centred care, ethical dilemmas allowing students to reflect on their experience), similar to the Wisconsin Long Term Care Clinical Scholars Program developed by Nolet et al. (2015).

Nursing schools should continue to explore ways to ensure their graduates have a successful new graduate nurse transition. Schools should implement Kramer's (1974) sociological immunization theory in which they prepare nursing students for the realities of nursing. They could implement this theory by having new graduate nurses invited to discuss their experiences of being new graduate nurses with third and fourth-year students, where new graduate nurses could highlight both the negative and positive aspects of their transition. This experience may help the students prepare for their transition.

Canadian nursing schools are constantly attempting to cover a large amount of content in a short amount of time. Instead of incorporating the GPA course into their curriculum, schools could make the GPA certification mandatory before entering the clinical learning environment. This workshop could be a prerequisite for clinical, similar to how CPR and a police record check are prerequisites. This way, students will learn therapeutic dementia interventions before clinical learning experiences, meeting the learning needs of nursing students, while not increasing the strain on the nursing curriculum. Not only would the course prepare the nursing graduates, but it may also make them more marketable to future employers.

Canadian nursing schools should continue to ensure their curriculum focuses on gerontological nursing to ensure graduates are prepared to provide care to our ageing population. Ethics topics such as lying in dementia care, use of humour, and dementia care as a lesser priority should be discussed in the context of the CNO's Ethical Standards and the CNA's Code of Ethics. Furthermore, the literature suggested nursing students' perception of dementia care was negatively influenced by their clinical preceptors (Baillie et al., 2012b). Nursing preceptors need to assess their own values and perceptions of gerontological nursing to ensure they do not deter students from choosing a career in gerontological nursing.

5.14.3 Recommendations for advanced nursing practice.

Several of the findings in this thesis are applicable to the role of an Advanced Practice Nurse (APN). An APN is a Registered Nurse with a master or doctoral degree in nursing that holds a position as a Nurse Practitioner or a Clinical Nurse Specialist (CNA, 2008). APNs practice within four core competencies: clinical, research, leadership, and consultation and collaboration (CNA, 2008). Although each competency is outlined individually, APNs must use all of the competencies simultaneously to have an optimal function within their role as an APN. In this section, specific recommendations for the clinical, leadership, and consultation and collaboration competencies for APNs are described. Lastly, research and the integration of evidence-based practice will be discussed.

5.14.3.1 *Clinical.*

APNs working in settings that have a high prevalence of patients with dementia should consider discussing therapeutic lying and dementia care during new graduate nursing orientation. It is evident that nurses working with patients with dementia will encounter an experience where lying may seem appropriate. The ethical dilemma of lying to patients with dementia warrants further attention and discussion, because it is difficult for new graduate nurses to enter practice with the expectation of maintaining truthfulness while balancing the psychological well-being of patients with dementia. The more education that one has about the controversial concept of lying and dementia care, the more open they are to the use of lying (Elvish et al., 2010). Therapeutic lying to patients with dementia may decrease and de-escalate emotional distress, when used appropriately (Zeltzer, 2003). APNs could implement a workshop that discusses the two philosophies of lying and dementia care, as well as the ethical implications (Elvish et al., 2010). Additionally, given the challenges that all nurses experience managing responsive behaviours,

APNs could empower nursing staff to provide person-centred care for patients with dementia in the clinical setting by implementing the GPA course.

5.14.3.2 Leadership.

APNs can provide support to new graduate nurses in the early stages of their transition, in turn, creating a sense of connectedness between new graduate nurses and their nursing profession (Rush et al., 2014). APNs can support new graduate nurses through mentorship and by assessing for a knowledge deficit in dementia care throughout their transition. This way, the APN can help create a learning plan and provide them with tools they require to meet their knowledge deficit, such as tools to manage responsive behaviours (Hatler et al., 2011). The development of an early relationship between the APN and the new graduate nurse has the potential to create feelings of connectedness for the new graduate nurse. APNs should continue to help facilitate nurse transition programs, including supporting the new graduate nurses' preceptor by meeting their learning needs (Adams et al., 2015; Glynn & Silvia, 2013). Furthermore, APNs should advocate for safe and appropriate nurse-patient ratios to ensure that all nurses are able to provide care that resembles their nursing values.

5.14.3.3 Consultation and collaboration.

The development of an APN led support group for new graduate nurses should be explored. New graduate nurses may benefit from developing a sense of connectedness with the APN and other new graduate nurses within their organization. The group could be a platform for new graduate nurses to bring up issues they are having with their preceptor, colleagues, work environment, or their transition. They would be able to receive informal support from their colleagues as well as formal support from the APN. The support group would also help the APN understand the challenges that new graduate nurses are experiencing during their transition.

APNs could collaborate with the new graduate nurses' nurse educators and nursing leadership to ensure that new graduate nurses are supported in their transition. Furthermore, APNs should collaborate with preceptors to ensure they feel supported in their role.

5.14.3.4 Research.

The use of evidence-based practice is paramount to the role of an APN (CNA, 2008). APNs possess the knowledge and skills required to evaluate the outcomes of programs and interventions within their clinical, leadership, consultative and collaborative roles (CNA, 2008). When developing and implementing programs and interventions, APNs should use evidence to guide the development and implementation of best practices. Additionally, rigorous evaluation strategies should be in place to determine the outcomes of the interventions. The knowledge generated through research should be shared with the nursing profession through conference proceedings and publications. An APN led synthesis of research on support groups for new graduate nurses could lead to developing and testing a support group intervention. After implementation, the APN could evaluate the support group by measuring retention rates, turnover intent, transition scores, self-efficacy, and sense of connectedness. These APN led initiatives are promising examples of how research can contribute to the improvement of transitions for new graduate nurses.

5.15 Limitations

There were three prominent limitations with this study. The first limitation is that qualitative research is comprised of the subjective, lived experiences of those who have participated in the study (Polit & Beck, 2012; Thorne, 2008). Therefore, the experiences of all new graduate nurses caring for patients with dementia in acute care environments may not be the same experience as the participants in this study. Additionally, there was no representation of

new graduate nurses that worked in university-affiliated hospitals, therefore the results of this study only represent new graduate nurses working in rural or community acute care hospitals and it would be difficult to transfer the findings to other environments.

The second limitation stemmed from the inclusion criteria for this study. All participants were Anglophone; therefore, the experiences of Francophone Ontario new graduate nurses may be different from the findings in this study. Furthermore, the results of this study are in the context of nurses educated in the province of Ontario. The results of this study may differ based on the provincial ethical framework outlined in other provinces. The third limitation was that the transition theories that were used to build the foundation of this study had only been used in the context of Registered Nurses (Kramer, 1974; Benner, 1982; Duchscher, 2008). Due to the absence of literature on the Registered Practical Nurse transition, these theories were applied despite not knowing if they were transferable.

5.16 Conclusion

This study has illuminated an unknown aspect of the nursing discipline: the experience of new graduate nurses caring for patients with dementia in acute care environments. The findings suggest that new graduate nurses caring for patients with dementia in acute care environments may experience a number of challenges during their transition. In addition, this study has added to the nursing profession's understanding of the process of new graduate transition within the context of dementia care in acute care. An important gap in our understanding of the transition for RPNs was identified. It remains unclear whether there are differences in the transition experiences between RNs and RPNs.

The results have also highlighted opportunities for the profession to further support new graduate nurses at the educational and the organizational levels. Academia can further prepare

new graduate nurses to care for this patient population by introducing the GPA course into nursing curriculums, advocating for students to engage in paid employment in long-term care, and continuing to implement Kramer's (1974) reality shock theory and anticipatory socialization theory into nursing curriculums. Furthermore, nursing curriculums and regulators should continue to integrate ethical concepts into nursing programs, including the ethics of using therapeutic lies and humour in dementia care.

Organizations that hire new graduate nurses need to support and empower new graduates in providing person-centred care. Organizations can support new graduate nurses by implementing nurse transitions programs and ensure new graduate nurses have access to APNs. These recommendations to nursing education and nurses' practice may help the future nursing generation feel better prepared for their role as caregivers for patients with dementia in acute care.

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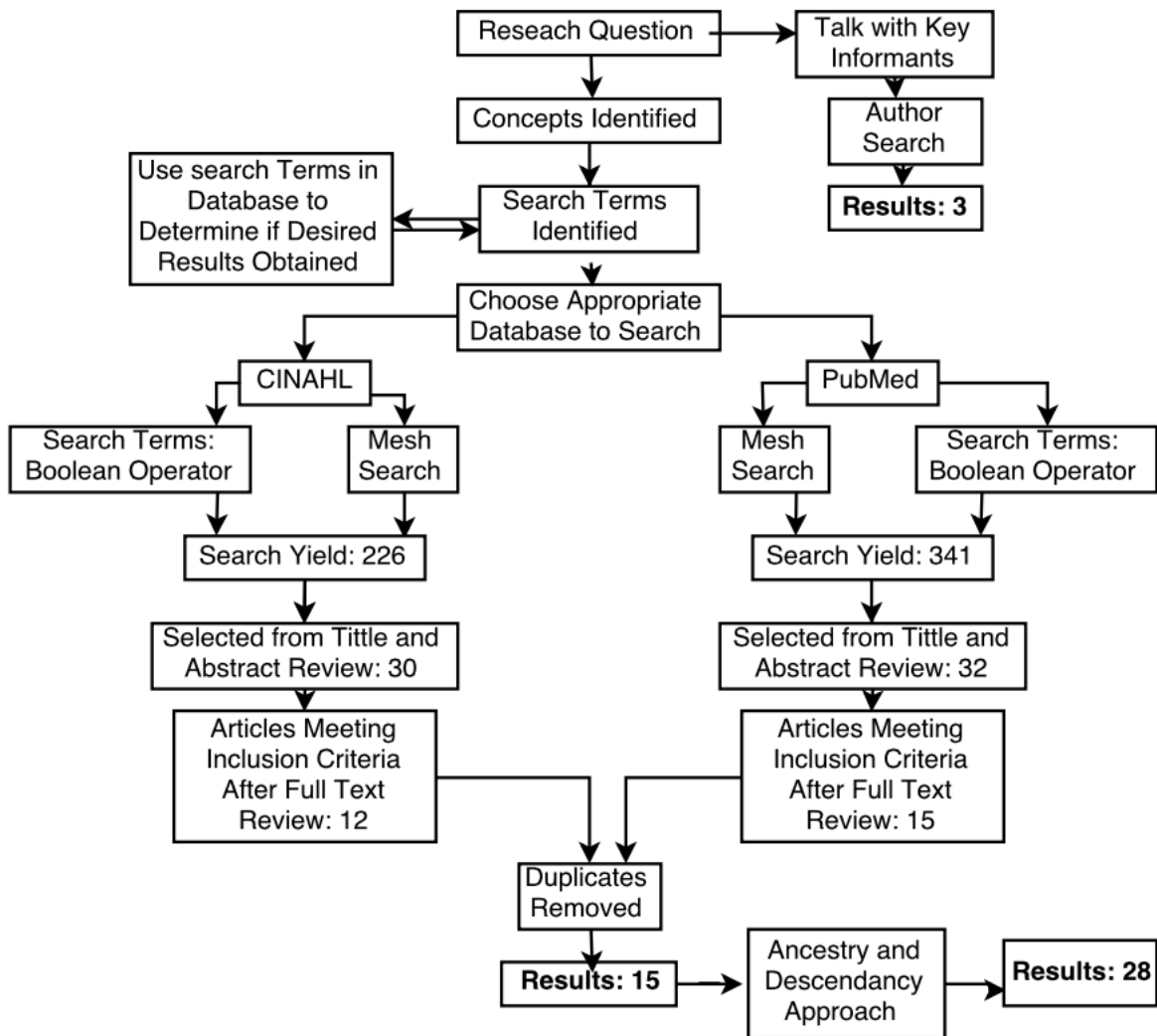
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Appendix A: Literature Search Inclusion and Exclusion Criteria and Search Terms

Research Question Concepts	Inclusion Criteria/Search Terms	Exclusion Criteria	Rational
New graduate nurses (population)	New Nurse New Graduate Nurse Graduate Nurse Nursing Student Student Nurse Nursing Educational Programs	Advanced Practice Nurses	The population of study is new graduate Registered Practical Nurses and Registered Nurses that have been practising from 3 to 12 months (Duchscher, 2012). Nursing students and educational nursing programs were included in the literature search to aid in understanding the new graduate nurses' education and experience with dementia care. Advanced Practice Nurses were excluded as they have already practiced as a Registered Nurse before their Advanced Practice role.
Dementia (population)	Dementia Alzheimer*	Delirium	Alzheimer's disease and dementia were chosen as a search term and all types of dementia were included under these terms (frontal temporal lobe, vascular, Lewis Body). Delirium was excluded as it has a different prognosis and requires a different type of nursing care (active treatment).
Nursing care (concept)	Nursing Care Nursing	-	The concept of nursing care was included to yield results on nursing interventions.
Acute care (setting)	Inpatient Hospital* Acute	Long-Term Care Nursing Home Retirement Home Community Dwelling	acute care hospitals were included, focusing on medical and surgical units. Setting exclusions were non-acute environments where patients with dementia frequently live, as well as outpatient units and non-acute/sub-acute hospitals (rehabilitation).
Experience and challenge (modifier)	-	-	A fifth concept, was introduced during the database search to help focus research results that yielded over 80 articles. This concept was called a modifier.
Other	English Peer Reviewed Full Text		Year limits were not included as the researcher did not want to exclude any dated pivotal research. Primary research, non-research literature, and grey literature were included.

Appendix B: Literature Search Outline

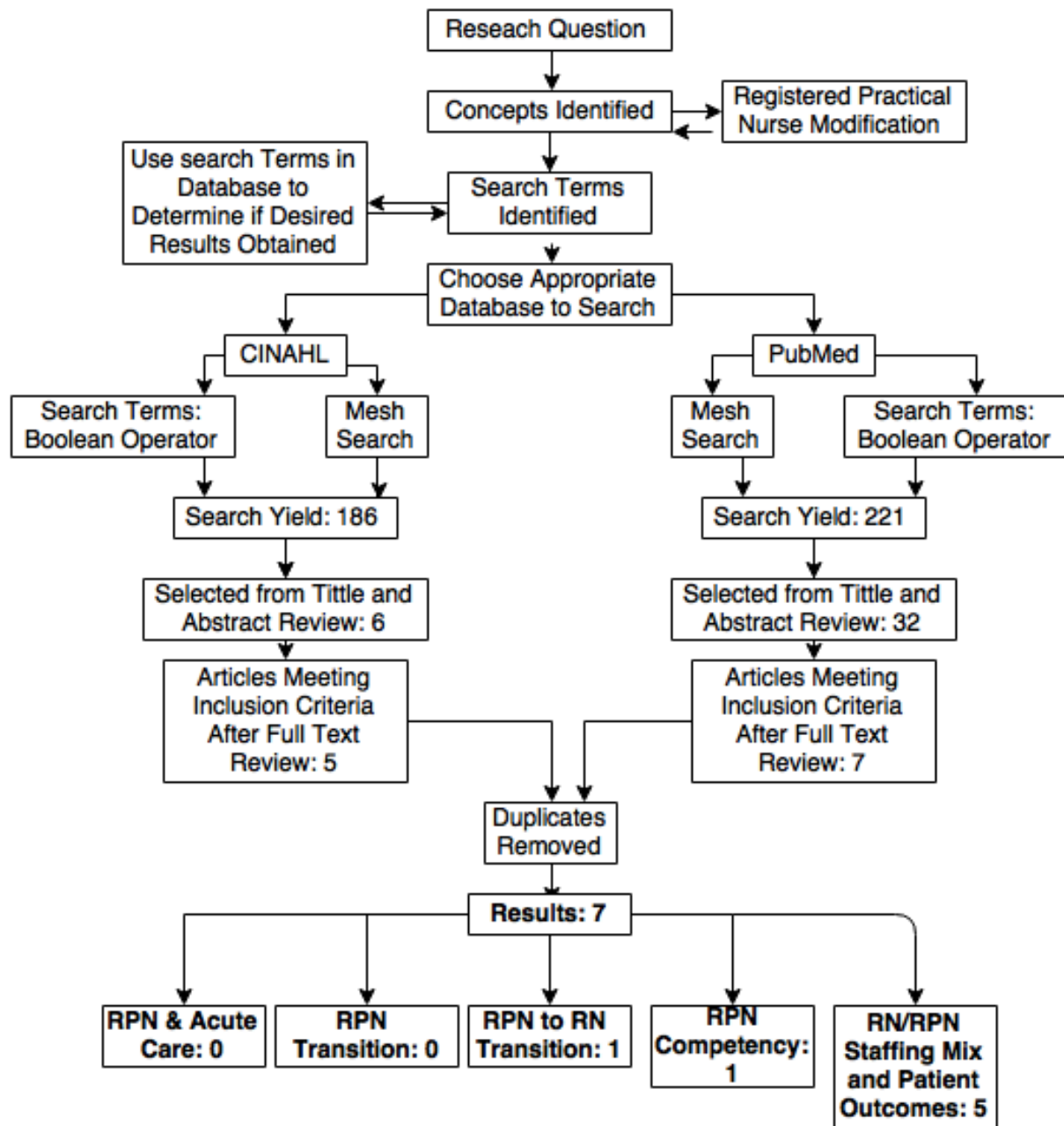


Appendix C: Registered Practical Nurse Search Terms and Rationale

Population	Population	Setting	Concept	Modifier
Registered Practical Nurs*	Dementia	In patient	Nursing Care	Experience*
Licensed Practical Nurs*	Alzheimer*	Hospital*	Nursing	Challenge*
Practical Nurs*		Acute		
Licensed Vocational Nurs*				
Vocational Nurs*				
Division 2 Nurs*				
State Enrolled Nurs*				
Enrolled Nurs*				
Nurse Technician				

Search Terms for Registered Practical Nurses	Country of Origin
Registered Practical Nurs*	Canada
Licensed Practical Nurs*	Canada, United States
Practical Nurs*	Canada, United States
Licensed Vocational Nurs*	United States
Vocational Nurs*	United States
Division 2 Nurs*	Australia, New Zealand
State Enrolled Nurs*	United Kingdom
Enrolled Nurs*	United Kingdom
Nurse Technician	Brazil

Appendix D: Registered Practical Nurse Literature Search Overview



Appendix E: Recruitment Strategy Timeline and Outcomes

Recruitment Strategy Attempts	Time Line	Outcome	Participants Recruited from Method
Facebook Informants	3 RPNs, 5 RNs	Two participants responded. All informants stated that they sent the poster to their network.	2
	1 st Facebook message sent July 25, 2016	One informant stated that she worked with many new graduate nurses but they did not want to participate because 'there is nothing in it for them'.	
	REB Modification # 1 (re-message Informants) Approved September 8, 2016		
	2 nd Facebook Message sent September 8, 2016 3 rd Facebook Message Sent September 22, 2016 4 th Facebook Message Sent November 9, 2016		
Informal Informants	5 RNs July 25 to Present	Poster sent to 5 RNs via email. Interaction occurred during informal conversations about the research study and recruitment. Informant emailed the poster to their network.	2
Nursing Alumni Facebook Group	REB Modification Approved #2 September 8, 2016.	Posted recruitment poster on 22 Ontario Colleges and 17 Ontario University 2015-2016 Nursing Alumni Facebook groups between 1 and 3 times. The amount of times the poster was posted depended on the frequency of other posts in the group. For example, if a lot of members were	3
	September 22 and Present.		

Recruitment Strategy Attempts	Time Line	Outcome	Participants Recruited from Method
		posting, my poster was quickly lost, therefore it was required to post it three times to that members could view the poster. Several groups had infrequent posts, therefore, if I was the last person to post, I did not post again. Instead I commented on the post, stating that I am still recruiting for the study.	
Canadian Nursing Student Association (CNSA)	Contacted to inquire about using them as an informant to access new graduate nurses in Ontario.	Not able to fulfill the request.	N/A
University of Ottawa Alumni Nursing Association	Contacted to inquire about using them as an informant to access new graduate nurses in Ontario.	Not able to fulfill the request.	N/A
Registered Practical Nurses Association of Ontario Conference	REB Modification Approved #3 September 29, 2016 Recruitment Poster (100 copies) available for distribution at conference on October 28, 2016.	94 posters distributed to RNs and RPNs attending the conference. All stated they worked in acute care and would post the poster that their work. No new graduate nurses attending the conference.	One RN confirmed that she forwarded the poster to her network of new graduate nurses. No new graduate nurses contacted me to participate.
Registered Practical Nurses Association of Ontario Journal Advertisement	REB Modification Sent #4 September 8, 2016. Distributed January 2017	Recruitment advertisement was published in the January/February issue.	1

Recruitment Strategy Attempts	Time Line	Outcome	Participants Recruited from Method
Registered Nurses Association of Ontario Journal Advertisement	REB Modification Sent #4 September 8, 2016.	Recruitment advertisement was published in the January/February issue.	3
	Distributed January 2017		

Appendix F: Recruitment Poster

· ATTENTION NURSES ·

ARE YOU A NEW NURSE WORKING IN HOSPITAL?

DO YOU CARE FOR PATIENTS
WITH DEMENTIA?

If you answered yes to both of these questions, you may be able to take part in a research study looking at the experience of new graduate nurses when caring for patients with dementia in acute care. We want to learn more about your experience!

Who: Registered Nurses and Registered Practical Nurses who have worked for 3 to 12 months and are working in acute care who have cared for patients with dementia.

What: A masters thesis study is being conducted by Benjamin Hartung at University of Ottawa. If eligible, you will be asked to participate in a 60 minute audio-recorded interview.

Where/When: Interviews will take place in person at a location that is convenient to you or over Skype.

Why: Ben Hartung, an RN and a masters student at the University of Ottawa is researching dementia care in acute care by new nurses. The research will gather information to improve how new nurses are orientated to hospital and will influence the gerontological concentration of the nursing curriculum.

How: Participation is selected on a first come/first serve basis. If you are interested in participating in this study, please contact:
Ben Hartung at [REDACTED]

Appendix G: Nursing Journal Recruitment Advertisement

NEW GRADUATE NURSES WANTED FOR NURSING RESEARCH

Have you been working as a nurse in Ontario for less than 12 months? Do you work in acute care and care for patients diagnosed with dementia? If you answered yes to these questions, your voice is wanted. Participation involves a one-hour Skype interview. Ben Hartung, RN, is a master's degree student conducting a research study for his thesis through the University of Ottawa. If interested, email [REDACTED]

Participants will be selected on a first-come, first-served basis.

Figure 1. RNAO Advertisement

NEW GRADUATE NURSES — YOUR VOICE IS NEEDED!



If you've been working as a nurse in Ontario for less than 12 months, and work in acute care and care for patients who have been diagnosed with dementia... Then we need your voice and would truly appreciate your assistance on a key research project.

Participation involves only a simple, one-hour Skype interview, which will help Ben Hartung, an RN and Master's student, develop a research study for his thesis through the University of Ottawa.

If you can help and want the chance to share your insights, please email [REDACTED]

Participation slots are limited, so please contact Ben soon.

Figure 2. RPNAO Advertisement

Appendix H: Interview Guide

Review Consent, Explain Interview Process and Answer General Questions

Ice Beaker/Descriptive Questions:

- What area of acute care do you work in?
- How would you describe your hospital (rural, community, tertiary centre, academic teaching centre)?
- How many months have you been nursing for?
- RN or RPN?

Open-Ended Questions Asked during Semi-Structured Interview:

I. Dementia Care

- Tell me about your experience when caring for patients with dementia in acute care?
- What are some of your challenging?
- What are some of your facilitators/positive experiences?
- What has helped you as a new nurse providing care for patients with dementia?
- What do you think would have been/would be helpful to you when caring for patients with dementia?
- How was your experience as a new graduate nurse been influenced by caring for patients with dementia?

- ##### II. Conclusion: Is there anything else you would like to add or share about this topic that you feel is important for me to know?

Thank you for your time and for participating.

Appendix I: Original Data Codes

Original Codes
Nursing Education: Pathophysiology
Dementia Focused Education: GPA
Nursing Education: Knowledge deficit leading to lesser priority
Lack of Dementia Focused education (No GPA)
Learning through Trial and Error: Lying
Mentorship: Supportive Colleagues
Learning to "Go-with-the-flow"
High expectations of self and care
Organizational Skills
Communication Skills: Families
LTC experience
Experience with caring for Family Members
Connectedness with Grandparents
Observing from Colleagues: Lying
Informal Education from colleagues
Staffing Issues
Competing Demands: Lesser Priority
Negative Attitudes of Colleagues
Feeling of Connectedness with Patients
Unpredictability
Verbal and Physical Abuse
Dementia-Related Behaviours
Ensuring Patient Safety

Appendix J: Consent Form

Title of the study: New Graduate Nurses and Dementia Care in Acute Care

Principal Investigator: [REDACTED].

MScN Student

School of Nursing

Faculty of Health Science

University of Ottawa.

Phone: [REDACTED]

Email: [REDACTED]

Thesis Supervisor: [REDACTED].

Assistant Professor

School of Nursing

Faculty of Health Science

University of Ottawa.

451 Smyth Road

Ottawa, ON, Canada

K1H 8M5

Phone: [REDACTED]

Email: [REDACTED]

Invitation to Participate: I am invited to participate in the *New Graduate Nurses and Dementia Care in Acute Care* research study conducted by [REDACTED].

Purpose of the Study: The purpose of the study is to understand the experience of new nurses when caring for patients with dementia the acute care setting.

Participation: My participation will consist of attending one 60-minute audio-recorded interview during which I will be asked questions and to reflect on my practice as a new graduate nurse caring for patients with dementia in acute care. The interview will take place face-to-face with the researcher or over Skype, depending on my geographical location. If I choose to participate in a Skype interview, I am encouraged to choose a private, confidential, and quiet space.

Risks: My participation in this study will entail that I volunteer personal information about my experience as a new graduate nurse. This may cause me to have feelings of frustration, anxiety, guilt, and stress, which might lead to emotional distress. I am aware of the resources available to me if I need to contact someone to talk about these feelings (see below). I have received assurance from the researcher that every effort will be made to minimize these risks. I am aware that I can stop the interview at any time and/or choose not to answer a question.

Resources for Participant:

Ontario Mental Health Helpline – Free Confidential 24/7 Hotline: [REDACTED]

Employee Assistance Program - Free Confidential 24/7 Hotline: [REDACTED]

*Phone Number for Shepell – Most commonly subscribed Employee Assistant Program by Ontario Hospitals.

Benefits: My participation in this study will help nurses understand the experience of the new graduate nurse when caring for patients with dementia in acute care. This research will offer insights for recruitment, orientation, and retention strategies for new graduate nurses in acute care hospitals and offer insight for gaps in nursing education regarding dementia care. My participation will allow me to express my feelings about my experience as a new graduate nurses providing dementia care in acute care.

Confidentiality and anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the information I provide will be used only to gain an understanding of the new graduate nurse experience when caring for patients with dementia in acute care. My anonymity will be maintained by not including any personal information (name or identification) in transcripts, publications, or conference presentation resulting from this research. I understand that what I say may be used in publications or conference proceedings.

Conservation of data: My data collected will be typed and stored in a password-protected file on a password-protected computer. A copy of my data will be stored on a password protected external hard drive locked at the university. Only the researcher and his thesis supervisor will have access to my information. The data will be stored for five years after the researcher has completed his thesis.

Compensation: There is no compensation for participation in this study. Your time is appreciated.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, I will decide if all data gathered until the time of withdrawal will be used or not.

Acceptance: I, _____ agree to participate in the above research study conducted by [REDACTED] from the School of Nursing, University of Ottawa whose research is under the supervision of [REDACTED].

Would you be willing to be contacted by the researcher between now and the end of 2017, if needed, to clarify any information?

Yes _____ No _____

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I 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

Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix K: Verbal Consent Script

To obtain verbal consent over Skype, the researcher will read the following script for obtaining verbal consent. The script is a revision of the consent form. This process will be audio recorded.

Script for Obtaining Verbal Consent:

In order to obtain informed consent before we start the interview, I will read the consent form to you. I encourage you to listen and follow along on the consent form provided. Please feel free to stop me at any time to ask for clarification or ask any questions.

The title of the study is: New Graduate Nurses and Dementia Care in Acute Care.

The Principal Investigator is: [REDACTED]

MScN Student
School of Nursing
Faculty of Health Science
University of Ottawa.

Phone: [REDACTED]

Email: [REDACTED]

My Thesis Supervisor is: [REDACTED]

Assistant Professor
School of Nursing
Faculty of Health Science
University of Ottawa.
451 Smyth Road
Ottawa, ON, Canada
K1H 8M5

Phone: [REDACTED]

Email: [REDACTED]

Invitation to Participate: You are invited to participate in the *New Graduate Nurses and Dementia Care in Acute Care* research study conducted by myself, [REDACTED].

Purpose of the Study: The purpose of the study is to understand the experience of new nurses when caring for patients with dementia the acute care setting.

Participation: Your participation will consist of attending one 60-minute audio-recorded interview during which you will be asked questions and to reflect on my practice as a new

graduate nurse caring for patients with dementia in acute care. The interview will take place face-to-face with the researcher or over Skype, depending on your geographical location. If you choose to participate in a Skype interview, you are encouraged to choose a private, confidential, and quiet space.

Risks: Your participation in this study will entail that you volunteer personal information about your experience as a new graduate nurse. This may cause you to have feelings of frustration, anxiety, guilt, and stress, which might lead to emotional distress. You are aware of the resources available to you if you need to contact someone to talk about these feelings (see below). You have received assurance from the researcher that every effort will be made to minimize these risks. You are aware that you can stop the interview at any time and/or choose not to answer a question.

Resources for Participant:

Ontario Mental Health Helpline – Free Confidential 24/7 Hotline: [REDACTED]

Employee Assistance Program - Free Confidential 24/7 Hotline: [REDACTED]

*Phone Number for Shepell – Most commonly subscribed Employee Assistant Program by Ontario Hospitals.

Benefits: Your participation in this study will help nurses understand the experience of the new graduate nurse when caring for patients with dementia in acute care. This research will offer insights for recruitment, orientation, and retention strategies for new graduate nurses in acute care hospitals and offer insight for gaps in nursing education regarding dementia care. Your participation will allow you to express your feelings about your experience as a new graduate nurses providing dementia care in acute care.

Confidentiality and anonymity: You have received assurance from the researcher that the information you will share will remain strictly confidential. You understand that the information you provide will be used only to gain an understanding of the new graduate nurse experience when caring for patients with dementia in acute care. Your anonymity will be maintained by not including any personal information (name or identification) in transcripts, publications, or conference presentation resulting from this research. You understand that what you say may be used in publications or conference proceedings.

Conservation of data: Your data collected will be typed and stored in a password-protected file on a password-protected computer. A copy of your data will be stored on a password protected external hard drive locked at the university. Only the researcher and his thesis supervisor will have access to your information. The data will be stored for five years after the researcher has completed his thesis.

Compensation: There is no compensation for participation in this study. Your time is appreciated.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions,

without suffering any negative consequences. If you choose to withdraw, you will decide if all data gathered until the time of withdrawal will be used or not.

Do you have any questions about what was just said?

Yes _____ **No** _____

Do you agree to participate in the above research study conducted by [REDACTED] from the School of Nursing, University of Ottawa whose research is under the supervision of [REDACTED]

Yes _____ **No** _____

Would you be willing to be contacted by the researcher between now and the end of 2017, if needed, to clarify any information?

Yes _____ **No** _____

If you have any questions about the study, you may contact the researcher or his supervisor.

If you have any 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

Email: ethics@uottawa.ca

Please keep the consent form I emailed you as a copy for yourself.

Thank you.