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ORIGINAL ARTICLE

'It was quite a shock': A qualitative study of the impact of organisational and personal factors on newly qualified nurses' experiences

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Abstract

Aims and objectives: To explore how newly qualified nurses' work experiences are constructed through the interplay between self, workplace and home-life influencing their retention.

Background: Nurses are critical to achieving the goal of universal health coverage. However, shortages of nursing staff are endemic. Of particular concern, newly qualified nurses are more likely to leave the nursing workforce. The point of transition to working as a newly qualified nurse is a time of vulnerability. Most studies attempt to discover why nurses leave. This study uses the concept of job embeddedness to examine the experience of this transition and first two years of practice to understand what might help newly qualified nurses stay.

Design: Qualitative approach using semi-structured telephone interviews.

Methods: Self-selecting sample of nurses (n = 23) who participated 1-year (n = 12) and 2 years (n = 11) post-qualification. Participants were part of a larger longitudinal cohort (n = 867) study which has followed them since September 2013 when they entered nurse education in two Scottish universities. Thematic analysis was used to understand the interplay between organisation/workplace and the individual.

Results: Three themes were developed: transition shock; workplace factors and work/life balance. Two further subthemes were developed: experience of support and belonging; and feeling unsupported and alienated. Eight participants had changed job or left, and two were looking to leave nursing.

Conclusion: This study highlights how the experience of transition shock can be positively or negatively impacted by the workplace environment, and how in turn this impacts the home environment. Ultimately, this impacts retention of newly qualified nurses.

Relevance to clinical practice: Having adequate support resources, such as staffing, supportive team morale, professional development and family-friendly work

environment, can create a work environment where they feel the purpose and meaningfulness of working as a nurse. This 'job embeddedness' can potentially enhance nurse retention. Reporting follows the COREQ checklist.

KEYWORDS
job embeddedness, newly qualified nurses, qualitative, retention, transition

What does this paper contribute to the wider global community?

- Newly qualified nurses feel that they do not fit with the work environment when they are thrown in at the 'deep end' in busy and stressed environments with little support, and where the work environment significantly impacts on home life.
- A lack of outlets for channelling negative work-related emotions impedes connections with colleagues and the organisation and negatively influences newly qualified nurses' psychological well-being.
- A supportive and family-friendly work environment enables nurses to cope with work-related stress and allows for a greater chance for professional development and developing a sense of community in a workplace.
- There are a number of points where interventions by employers and educators might enhance the experience of newly qualified nurses, increasing their sense of connection and enhancing motivation and care.

1 | INTRODUCTION

Nurses and midwives comprise half of the global healthcare workforce and are critical to the achievement of universal health coverage by 2030 (Crisp et al., 2018). However, there is currently a global shortage of nurses (Liu et al., 2016). Within England, United Kingdom (UK) recent figures identify that 93% of National Health Service (NHS) Trusts were experiencing a shortage in registered nurses (NHS Employers, 2015). Several large international studies (Aiken et al., 2012; Oliver et al., 2014) have identified an association between a shortfall of nursing staff and a negative impact on patient safety, satisfaction and quality of care.

Within the UK, newly qualified nurses (NQNs) are at high risk of leaving the profession within the first year of qualification (The House of Commons, 2018). The transition period from students to NQNs in the workplace is associated with increased stress and overwhelm (Feng & Tsai, 2012; Halpin et al., 2017), decreased sense of competence (Hoeve et al., 2018; McCalla-Graham & de Gagne, 2015) and confidence (Ortiz, 2016) and the potential to experience reality shock (Duchscher, 2009; Kramer et al., 2013) all of which may contribute to the heightened risk of burnout (Rudman & Gustavsson, 2011) in this group. Burnout is associated with attrition from the workforce (Boamah & Laschinger, 2016; Rudman & Gustavsson, 2011).

Whilst retention of NQNs is a global concern, the experience of transition is shaped by the socio-political context of the education and health systems in which NQNs are educated and work. The current body of evidence is predominantly developed outside the UK, most notably in Canada (Laschinger et al., 2015) and Taiwan (Sun et al., 2012). However, NQN retention in the UK continues to be problematic (Buchan et al., 2019). Understanding the experience of NQNs in the UK offers the potential for a contextually informed understanding of what organisations, educators and individuals can do to increase the retention of NQNs.

1.1 | Background

In comparison with experienced nurses, NQNs are more likely to experience burnout and intend to quit (Brewer et al., 2012; Cho et al., 2012; Kramer et al., 2013; Rudman & Gustavsson, 2011; Wu et al., 2012). Intention to quit has been identified as a reliable predictor of attrition (Brewer et al., 2012; Murrells et al., 2008). Boamah and Laschinger (2016) identified the key mediating role of burnout in their examination of the relationship between workplace factors and turnover intention of NQNs. Studies focusing on the reality shock experienced by NQNs found increased stress, loss of self-confidence and competence and poor retention outcomes (Duchscher, 2009; Higgins et al., 2010; Kramer et al., 2013). Laschinger and colleagues' Canadian longitudinal study of NQNs' experiences has examined the association of various personal and situational factors with retention outcomes (Laschinger et al., 2016) identifying the complex relationships between personal and workplace variables (Boamah & Laschinger, 2016; Laschinger, 2012; Laschinger et al., 2015).

To mitigate the impact of transition to newly qualified practice transitional support programmes have been implemented in a number of countries including Canada (Rush et al., 2015), USA (Ackerson & Stiles, 2018), UK (Banks et al., 2011) and Australia (Phillips et al., 2015) where programmes have also been developed to meet specific needs of NQNs working in rural areas (Aggar et al., 2017; Lea & Cruickshank, 2015). A systematic review of international transition programmes identified variation in their length and content

(Missen et al., 2014). Core values of transition programmes are to provide support to NQNs and develop their confidence through relationship-building between NQNs, experienced nurses and the organisation (Kang et al., 2016; Rush et al., 2015). Across the UK transitional programmes are the responsibility of the healthcare provider and generally offered to NQNs in their first position as a registered nurse. However, there is variation in provision and some NQNs find that they are not able to access a place until they have been in their first post for some time (within our sample there were NQNs who were 6 months in their post before being offered a place). These programmes focus on clinical practice, leadership, research and facilitating learning through a mix of critical reflection, educational sessions and individual support and coaching from an allocated mentor or preceptor (HEE, 2015; NES, 2017) and are not specific for rural or hospital-based nursing. Recent publication of the *Principles for Preceptorship* (NMC, 2020) aims to standardise the content of these programmes across the four countries of the UK. Transition programmes are generally associated with positive outcomes: smoother transition into the workforce, reducing burnout and reducing turnover intention (Ackerson & Stiles, 2018; Baumann et al., 2018; Kang et al., 2016; Missen et al., 2014). Despite the current endeavours to understand and promote nurse retention, existing accounts fail to unpack the complex interplay between the NQN and their work and home environments. Therefore, this qualitative study aims to explore how NQNs' work experiences are constructed through the interplay between self, work and home influencing their retention within the workplace.

1.2 | Job embeddedness

Focusing on retention, the concept of job embeddedness, developed in the business management context, is helpful to consider what might make it more likely that people remain in a job (Mitchell et al., 2001). Mitchell et al. (2001) conceptualise job embeddedness as a 'net' or web of connections that holds the employee in their job. In particular, this concept addresses the links and fit that an individual has with their work organisation and their home community, and the sacrifices (or cost), in terms of breaking these connections, if that individual was to move job (Mitchell et al., 2001; Reitz & Anderson, 2011). It has been found to be significantly associated with voluntary turnover (Dawley & Andrews, 2012; Sun et al., 2012; Zhao et al., 2013).

There is limited exploration of job embeddedness in the nursing literature. However, in a study of 1966 nurses in 16 private hospitals in Thailand it was found to be significantly associated with the quality of employee relationships with 'supervisors', and significantly related to staff turnover (Dechawatanapaisal, 2018). Sun et al. (2012) examined the relationships between psychological capital, performance and job embeddedness in a cohort of 733 nurses in Chinese hospitals. They found significant relationships between psychological capacity and performance with job embeddedness mediating the effect. They suggest that high levels of psychological capital increases embeddedness as people are able to make more connections to the institution and subsequently perform better. In a study of 191 newly qualified paediatric nurses, Halfer (2012) found significant differences in questions related to 'fit' with the organisation between the group who remained and those who left the organisation (n = 14), although the sample size of those who had left was small. She also found that community factors were not significantly different between both groups. This finding is supported by those of Dawley and Andrews (2012) who found that community factors were more weakly associated with turnover intention. However, Battistelli et al. (2013) found that community embeddedness was strongly associated with retention.

Although there is still only a small amount of nursing research literature examining job embeddedness, it appears that this concept is useful in understanding the relationship between the employee, their employing organisation and voluntary turnover. This study has drawn on the conceptualised interplay between employee and organisation, and home and work life of the job embeddedness concept to support the analysis of qualitative data on the experience of the NQN participants.

2 | METHODS

This qualitative study aims to explore how NQNs' work experiences are constructed through the interplay between self, workplace and home life, influencing their retention. The research questions guiding the study were: what is the experience of working as a nurse? What organisational factors support or challenge NQNs in the first two years post-qualification? How does work-life impact home life? How might the experience of transition from student to NQN be supported? What enables NQNs to stay in their posts and overcome challenges? Reporting of the methods follows the COREQ checklist (see File S1).

Participants were a self-selected sample of 23 NQNs who were part of a larger longitudinal cohort (n = 867) study which has followed them from September 2013 when they entered nurse education in two Scottish universities (see Snowden et al., 2018). Two separate samples participated in semi-structured telephone interviews at 1-year post-qualification (T1: n = 12) and at 2-year post-qualification (T2: n = 11). Participants were asked to identify their willingness to be interviewed during the annual online quantitative data collection. Although participants had been in the longitudinal cohort for 5 years, they had not met RS and she had not been part of the institution where they were educated. Neither of the Research Associates (RAs) were known to participants prior to the interviews. Participants were male (n = 7) and female (n = 16), adult (n = 12), mental health (n = 8) and children's (n = 1) nurses, working in community (n = 6) and inpatient (n = 15) settings across the UK. Three participants (1 male 2 female) no longer worked in nursing but provided data based on their experience in their recent nursing posts. This data was included as it might provide insight into the reasons they had left nursing.

Telephone interviews offered flexibility for potential participants who were involved in shift-work and facilitated participants of a geographically dispersed sample. They were carried out by SSH (RA) and RS (lecturer and Principal Investigator), both of whom have doctorates and a nursing background, and a psychology Masters graduate who was the study RA at T1 only. All of these researchers were female and had received training in qualitative interview skills during their doctoral and masters education. The interview schedule was constructed by RS based on the literature and previous research work she had undertaken with NQNs. Interviews were digitally recorded and focused on the experience of transition, work–life balance and how participants coped with the demands of being newly registered nurses (see Figure 1). Additional questions relating to professional development opportunities and why participants remained in the workplace were added to the interview schedule at T2 to provide insight into the extent that participants experienced connection and fit with the workplace. The self-selecting nature of the sampling meant that participants in year one were not re-interviewed in year two, and therefore, it was not possible to collect linked longitudinal qualitative data. Because of this, the same semi-structured interviews were used, and data from T2 reflected back to the experience of transition as well as how they coped with it. All data were treated as a single dataset to increase the breadth of data upon which conclusions were drawn. However, for transparency, quotations identify the time point at which data were collected.

This research takes an interpretive approach, using Braun and Clarke's (2019) reflexive approach to thematic analysis to develop a contextually situated account of the NQNs' experiences. Transcription was carried out and transcripts checked with the recordings for accuracy To preserve context, meaning units were chunks of data, usually several lines long. Codes were developed and then brought together under thematic headings. The concept of job embeddedness was used as a lens through which to read the data and support the identification of codes and themes. Two researchers SSH and RS undertook independent analysis and met to agree themes. In this way, interpretive robustness was enhanced.

3 | ETHICAL CONSIDERATIONS

Ethical permission was granted by the University ethics committee. Participation was voluntary and participants were able to withdraw from the study at any time; however, none did so. Participant information sheets were sent to participants, and the information was reiterated at the beginning of interviews with the opportunity to ask questions prior to taking informed consent which was recorded. Transcripts were anonymised. All data were managed in accordance with the requirements of the European Union General Data Protection Regulation (GDPR) and university data management policies.

Q1: Can you tell me about your current nursing post? **Prompts:** Role; how long been there; care setting
Q2: What has it been like working as a qualified nurse over the past year? **Prompts:** particular challenges; ways of dealing with challenges; things that are supportive personal impact of challenges; impact of challenges on work; management of emotions **At T2 only:** any difference in experience of working now that you have been qualified for 2 years
Q3: Thinking about your work environment in terms of resources, the physical environment and also relationships with colleagues, how does your work environment support or challenge your ability to do your job effectively? **Prompts:** support and resources at work; impact on life outside work; support outside work
Q4: **There is a lot of talk about Work/Life balance in the literature and wider media nowadays. How do you feel that your work impacts on your life?** **Prompt:** what do you do to try and manage your work/life balance
Q5: In light of your experiences as a newly qualified nurse what could be done differently to improve future nurses' experiences of transition into the qualified role?
Q6 (T2 only): How does your job fit with your values as a nurse?
Q7 (T2 only): What are the opportunities for professional development?
Q8 (T2 only): What motivates/keeps you to continue working as a nurse at your workplace?

FIGURE 1 Topic guide for semi-structured telephone interviews

4 | FINDINGS

The NQNs in this study experienced many of the elements identified in Duchscher's (2009) model of transition shock. How well the NQNs navigated this experience of transition shock was connected to their experience of the workplace as supportive or unsupportive, the fit of the workplace with their values and the consequent sense of belonging, and on how they managed the impact of their work life on their home life. Many of the participants described significant impacts of working on their mental health.

Across the 23 participants just over a third (n = 8) identified that they had changed jobs (n = 5) or left nursing completely (n = 3) because of lack of support or the impact of nursing on their work/life balance. A further two participants identified that they were looking to leave the profession.

The findings are presented under the following thematic headings: transition shock; workplace factors and work/life balance.

4.1 | Transition shock

All participants recalled experiences that fit with the concept of transition shock (Duchscher, 2009). Many of the NQNs used terms such as 'horrendous' 'terrifying' and 'steep learning curve' to describe their initial experience of working as a NQN. However, some had made a strategic decision to take up a post in a clinical area where they had worked as a student nurse and found that the familiarity with routine and staff facilitated their transition.

Most participants described the sense of increased responsibility and accountability. Several identified feeling overwhelmed by having holistic, rather than task focused, responsibility for patient care: 'Like each individual task was definitely achievable within my skill set. It is more being responsible for everything [the whole patient] rather than just being given part of it [that is stressful]' (P10 T1).

However, for most the experience related to a feeling of responsibility for making decisions and being accountable for these:

> I think a lot of it is, you know, going from making decisions and asking for help and being supported as a student, then going to making the decisions because you are the professional now. And you are the one that has to make decisions as a nurse. And you know you have the back up of a doctor, you know, but… it's the responsibility, things that you would be you would have to get somebody else to overlook while you're a student. (P6 T1)

Reduced support for decision making is the primary rationale for the shock experienced by the above participant. However, some participants also identified their shock as emanating from the lack of opportunity to gain experience of the wider nursing role and healthcare culture whilst a student. Within the UK, students are required to be supernumerary (Nursing & Midwifery Council, 2018) to enable them to capitalise on learning opportunities. However, it is a common complaint that they are used as clinical support workers, particularly in areas where staffing is short.

> I think you are shielded quite a lot when you're on placement, by your mentor… because you're only in one place for, like, six or seven weeks at a time, you're skimming the surface, you don't actually get an understanding for what the culture is really like, until you've been there for longer than that. (P11 T2)

> …a lot of times in the hospital, your placements [when you are a student], you're not used as a nurse, you're used almost as a clinical support [worker]… you don't have the element of responsibility because you're not responsible for your actions, your mentor is. But then, when you qualify, you're responsible, nobody's responsible for you…. I was frightened. I felt a bit suffocated almost because of the pressure I felt, but as soon as you get into the role that eases away and you do realise you're doing everything correct anyway. (P8 T2)

Many of the participants described an initial lack of confidence linked to feeling unprepared by their university education often in terms of gaps in their knowledge or skills.

> It was quite a shock. You spend so much time in university doing theoretical work. So I found it quite a shock when I started my first post, despite 50% of it [education] being practical. I found it quite a jump and I found that transition quite difficult… you had no one to fall back on, you were the nurse, you were in charge. (P5 T1)

It might be that the responsibility and accountability associated with being a NQN leads the participants to review their knowledge base, and gaps which did not impact on their ability to work in the student role because they always had the comfort of qualified nurse support, become evident and problematic. However, some of the gaps were caused by learning opportunities, such as engagement with the electronic health record system and management of intravenous medications that are not available to students because of Health Board policy. These gaps left participants feeling that they lacked confidence and competence, and in the case of being able to manage IV infusions or access electronic health records, they were unable to do their role properly:

> …TRAK care, the computer system [electronic health records] that they use, as a student you don't have access to it and there's no training on it – I did get something on it eventually but that was 5 months down the line [after starting in NQN post]…. The second is

> talking to the relatives, you don't do much of that as a student either. You don't get the experience. And all of a sudden you're the one they're coming to and you're like "ooohh I don't know" cos you haven't been able to look at all the stuff on the computer, all the lab results and everything, so you can't give a proper update. (P11 T1)

Many participants reflected that their confidence increased at about 6 months into the role, and this was hastened where people experienced support. Confidence was also strengthened by personal and professional development opportunities which many experienced in the shape of formal preceptorship or similar newly qualified nurse programmes, and being supported to engage with educational courses and conferences.

Participants described the exhaustion they experienced as NQNs. Although all had done shifts whilst on student placement these had been interspersed with blocks of university attendance providing respite from the constant demand of placement.

> … I find when you go in at night you're quite tired working 9–5. I think shifts would be better but I've got a wee boy so it's good for me not having to work the holidays and things like that… you do your community placement and you think "that's great", but then you've got a couple of weeks off after it. But doing it continuously [is exhausting]. (P7 T2)

This led to many just sleeping and not doing much on days off and some disconnection from social groups as described in the section on work/life balance below.

Many of the participants described mental health issues connected to the stress of working as a NQN, ranging from anxiety to significant depression requiring antidepressants and the use of telephone helplines such as breathing space and Samaritans.

> There is nobody able to give you any support because even the boss is under pressure… you are dealing with any emotional issues coming up from the patients, in terms of being given really bad news, the diagnosis or somebody has become palliative, the end of life. You sort of supporting someone who is dying, their family and friends… I want to find a new job… I had to seek help at my workplace to try to deal with how I feel. I had counselling. I have gone to my GP [for a sickline]… because I couldn't face going back to work. (P2 T2)

> I didn't actually cope particularly well with it [stress of transition to NQN], if I'm honest. I actually ended up starting on antidepressants. I got, I kind of used a lot of, you know, like Breathing Space, those kind of things, like, kind of phone up support lines. (P5 T2)

4.2 | Workplace factors

Within this theme, there are two subthemes: *experience of support and belonging* and *feeling unsupported and alienated*.

4.2.1 | Experience of support and belonging

NQNs described benefitting from formal and informal support within the workplace. Several participants described how they found being part of formal preceptorship and similar newly qualified practitioner programmes supportive, particularly the allocation of a mentor or preceptor. A few talked about the benefits of being supernumerary for a short time during their transition to NQN.

> … there has been a lot of support in place such as the preceptor course that runs. Where the newly qualified nurse attends once a month. An education program that helps bring up competence levels and then you've got to write a eh a review of how you think you have proceeded and you have a meeting with your manager to discuss, as well as having clinical supervision through that. So the transition has been stressful at times but there has been a lot of support to help that transition be as smooth as possible. (P1 T1)

> …it was quite good because you were sort of learning the job for a certain amount of time with a sort of extra person, you were sort of supernumerary as such for a certain amount of time. And then after, you know, a week or 2 you were sort of part of the numbers. (P4 T1)

Many participants referred to the positive experience of close team working and informal support from colleagues. Some participants identified that they needed to ask for support, rather than it simply being offered. However, negotiating this informal support was dependent on the personalities in the team, as well as how busy the work environment was.

> We have a really tight team. We support each other. If a patient is unwell, I would help to jump in and they would help you too… You work together. That's the good team I have got in my ward… and I don't want to leave. I feel very comfortable. (P4 T2)

> … we kind of help each other, like, if you can't do a task, someone else will help you with it. If you don't know something, they'll help you out… But it's having the time to do that, really. But if your time is 100% taken up with your own patients, you don't have time to show someone how to do something, or help them with something, or another patient. (P5 T2)

Participants identified the positive impact on their competence and sense of belonging when they were supported to engage with additional learning opportunities such as conferences, seminars and formal educational programmes. Some identified how this support made them feel that the organisation was investing in them, providing opportunities for advancement.

> [My] manager has been supportive of me being interested in further study. I just started a professional doctorate… I have been funded by [NHS Board]… The manager has been positive, supportive. That has been part of development, very been keen to support my development and also support anything that can be fed back into the service from the study. (P1 T2)

Additionally, where the NQNs experienced congruence of their values with those practised in the workplace, they experienced a sense of belonging and engagement. This was reflected in these participants' articulation of the reasons that they remained within their current post or within the profession.

> … this post allows me more time with the people that I am caring for…I like the fact that you get more time than you get on the ward. When you get on the ward, the pace is much much faster. It's harder to feel that you provided the care maybe you wanted to provide, whereas in the community although it's busy and there are a lot of demands… you can focus on them [the family]. (P7 T2)

> … my values are quite simplistic I suppose, but they're in accordance with being a nurse… Integrity, candour, honesty, trust. I'm a very positive person, very motivated person… I love being able to, you know, get a smile on someone's face, who's experiencing problems emotionally… I always strive to try and get that feeling of contentment from another human being…. I really do enjoy working as a nurse. (P6 T2)

4.2.2 | Feeling unsupported and alienated

The lack of confidence and competence experienced by many of the participants contributed to NQNs' felt need for support. Around half of participants identified that they were either offered no support, the formal support on offer was experienced as unsupportive, or their attempts to access informal support were unsuccessful. In speaking about the lack of support, many acknowledged that their colleagues were under significant pressure due to staff shortages, sickness absence or the acute nature of the patients.

> While I did get given a mentor I didn't feel supported by him in terms of he didn't really know what I needed to do for my preceptorship I didn't feel he gave me any support or advice on how to go through my preceptorship. He was also supposed to do supervision with me and I didn't feel that the supervision I received with him was very supportive either… it didn't feel like I was getting the help that I felt I would have liked to receive in a more organised and less pressured environment. (P2 T1)

> …you are on your own. You are told you're going to get this support, you will get this and that, all this development, but that does not always happen. And that's quite difficult you know because you have to keep asking, and asking, and asking for a help, and [it] doesn't always come…. in terms of, you know, sort of, confidence and support, it's not always there. (P8 T2)

However, several NQNs recognised that as time passed they were less likely to be considered as requiring support.

> I think just having…when you were newly qualified, people sort of accepted that, and didn't put more pressure on you to do things you weren't necessarily comfortable with. But I think once you've been qualified six months or more, it's, you're kind of expected to take on that role. And accept it as part of your job, to do things that you don't necessarily want to do. (P3 T2)

Where NQNs felt unsupported they described feeling alone with their responsibilities and feeling that they were 'thrown in at the deep end' (P5 T2), 'left to their own devices' (P T) or that 'you almost get put on the ward from day one and off you go' (P2 T2) leaving them feeling frightened and unsafe. The consequence of experiencing lack of support for four of the NQNs was a choice to leave their post (n = 1) or the profession (n = 3).

However, a significant minority of NQNs identified workplaces where the culture and values were dissonant with their values. This created cognitive and emotional dissonance and contributed to the reasons that these NQNs chose to leave their posts.

> '… my values are to treat human beings not diseases, to give the best care I can, to stick to your dignity, and privacy…. The reality is the job itself doesn't always enable that… I think at times I have to let go of my idealism and look at the realism of what's actually going on. (P2 T2)

The experience of cognitive dissonance can act as a warning and motivate nurses to improve the standards of care they provide (Stenhouse et al., 2016; Timmins & De Vries, 2015). However, for some of the NQNs their experience of the culture was such that they were unable to engage others in implementing change

or even allowed to practice in line with their ideals. This can either lead to 'downgrading' of standards and creation of new norms in order to be able to continue in the workplace (as is argued by Timmins & De Vries, 2015 to have contributed to the development of the poor cultures of care identified by Francis in his inquiry into the Mid-Staffordshire NHS Foundation Trust), or to leaving the workplace:

> …myself and another two staff nurses started at the same time and those two left after two months because you can't…you're not allowed to change anything. So, you're made to feel a bad person because you're challenging them [the staff]. You're accused of being disruptive when you want to do things in the way that you've been taught to do it. You're accused of…you're just wanting to waste time. (P9 T2)

For one participant (P6 T2), cognitive dissonance motivated them to lead change in processes and practices in the clinical area. This participant had worked in similar clinical areas prior to entering their nurse education and was very committed to that clinical speciality. It seems that this previous experience perhaps supported them in taking the required steps to instigate change. This experience seemed to increase their sense of belonging and embeddedness within the organisation.

4.3 | Work–life balance

Maintaining strict boundaries between work and home was experienced as very difficult by many of the participants who identified how their work life leaked into, and impinged on, their home life. In particular, participants identified the inability to switch off when not at work.

> I think when you do go home you do take work home with you because of the type of job you do. I don't think you ever fully switch off. If you've got a patient who is terminal you always worry about them when you do go home, are they going to be there the next day? Are they alright? I think sometimes that can impact you slightly or if you're seeing a patient with a condition and [your] family member gets that condition that can be quite worrying because you understand the path it's going to go down…. I'm not able to switch off. P8 T2

Whilst many were able to gain support through talking to family, several participants identified that it was only other nurses who really understood or were willing to listen to, the stresses of the work. However, NQNs were anxious about talking about work in case they inadvertently broke patient confidentiality risking their nurse registration. This meant that for many participants there were limited outlets for discussing the emotional impact of their work at home.

> It's a very hard job to talk about… Trying to keep their [patients'] confidentiality is difficult… it's part of the employer's expectation and part of your registration for the NMC. People who are civilian [not nurses] they don't want to hear … I cleaned a dead body… they don't want to hear about somebody's diarrhea or somebody being sick…. I need to detach myself from it…separate myself my role as a nurse, from the person I was before I became a nurse… I really want to talk about it [work] but I don't have outlet. So it's kind of catch 22. (P2 T2)

Most of the NQNs' stories included descriptions of the exhaustion that they experienced which led to many just sleeping and not doing much on days off, meaning that they felt they became disconnected from friends. Shift patterns and the rota format made it difficult for NQNs to plan to see friends or social activities.

> I am tired quite a lot … part of me is stressed, other part of me is just tired. I just can't concentrate on anything … all I want to do is rest but I mean, I am not being very productive outside of work. And I am not, I guess, not socializing enough, not sort of- looking after my… mental health. I'm throwing everything at the job and I am realizing now that I can't continue to do that because I will burnout. (P8 T1)

> I don't have a life. I've lost all my kind of regular friends, not lost them, but I've lost touch with a lot of people. Long hours, weekends, nightshifts, it's quite a bad work-life balance to be honest. (P6 T1)

That this is a feature of so many of the participants' stories perhaps points to the unrealistic experience of the working patterns experienced as students where they are only on placement for short periods of time, and therefore the impact on their energy levels and social connections is temporary.

For some who had families and children the shift pattern was experienced as particularly problematic, placing burden on the NQNs several of whom cited the sacrifice they had to make in their home life in order to remain in their job. Several NQNs cited the clash between shift patterns and family life as reasons for shifting to jobs in the community.

> Basically, I have gone out, before everybody is up. By the time I got home, my child was in bed. Those days I wouldn't see him. So I could go three days without seeing my child… I was so tired…. I felt I just didn't have the time or energy to give my family what they

> needed… I missed out simple things like having meals together…it got to the stage where I thought "I don't want to do these hours [13–14 hours] anymore" …I still want to be a nurse [moved to community job]. P7 T2

A few participants recognised the strategies that they used to manage their stress in their home life which included running, and other activities, and speaking to friends. However, the majority did not identify any positive strategies they used in their home lives.

> … I blow off steam at the weekend, maybe go out with friends, have a drink, my family. Try and keep the good social networks going, try and keep fit and healthy. So…that I don't sit and worry about things. (P1 T1)

The majority of the NQNs described some negative impact of working on their home life. For some, this was enough to motivate them to move jobs into settings where the hours fitted better with their home life. This seemed to be the case for several of the NQNs with children. Exhaustion, the inability to switch off, and the lack of perceived space or time to engage with self-care activities, are likely to have contributed to the NQNs' experiences of mental health symptoms (Maben & Bridges, 2020).

5 | DISCUSSION

This study aimed to examine the experience of the transition to the NQN role and the first two years of practice. In particular, it is focused on the interplay of individual, work and home factors and the impact of this on retention in the workforce. First, the finding relating to transition shock is explored in relation to current literature. The job embeddedness concept is then used to further explore the findings drawing out the interplay between the experience of work and home contexts and the individual.

5.1 | Transition shock

The findings indicate that the transition into the workplace as a NQN is experienced as stressful by participants, coherent with the experience of transition shock (Duchscher, 2009; Higgins et al., 2010; Kramer et al., 2013) and overwhelm (Feng & Tsai, 2012; Halpin et al., 2017) identified in previous studies. Despite having spent 50% of their undergraduate preparation in clinical practice, the participants in this study did not feel that their education had prepared them for their new role. This finding is supported by those of Kramer et al. (2013) and Lalonde and McGillis Hall (2017) reflect that their NQN participants did not draw on previous student experience of the hospitals/units they were now working in to reduce environmental reality shock. Additionally, Allan et al. (2011) proposed that student nurses' supernumerary status during hospital placements prevented them from becoming fully competent, a point made by some of the participants in this study. This is supported by Gerrish's (2000) study in which she compared the experiences of students graduating from a project 2000 programme and a traditional apprenticeship style training, finding that NQNs in the Project 2000 cohort (who had been supernumerary) experienced increased stress relating to organising care than the apprenticeship trained nurses.

This finding challenges the assumption that time spent in the practice learning environment (in the UK this is 2300 hours) facilitates socialisation into these environments which will in turn decrease reality shock and improve the transition experience of NQN. Nurse educators and those who develop policy and standards for nurse education need to rethink our understanding of the role of practice learning in the preparation of graduate nurses. Within the UK, the diverse range of models of nurse education, including graduate apprenticeship schemes, provide an opportunity to evaluate the impact of different approaches on preparedness of NQNs.

This finding is further important because despite having known about transition shock for decades NQNs continue to experience this. This is despite attention to this issue in the nurse education literature and therefore the opportunity for educators to work at programme level to increase preparation for the transition (ten Hoeve et al., 2020). The intransigence of this issue perhaps requires change to be actualised at a strategic level, a conclusion supported by the findings of ten Hoeve et al. (2020). For instance, should the binary nature of the transition become a more gradual transition, perhaps over a 6-month period with a sliding scale of support reducing as the NQN gains confidence and competence in the new role? Given that the Nursing and Midwifery Council (NMC) have now published standards for preceptorship (NMC, 2020) this might be about to happen.

5.2 | Job embeddedness

5.2.1 | Organisational connection

The experience of transition shock occurs at the point where NQNs also have a lack of connection to the new workplace. However, it is notable that the workplace environment creates a number of opportunities or barriers to develop connections. Barriers such as being short staffed and the busy-ness of the staff team led participants to feel unable to ask for help or support, and that they had to deal with the demands of the work on their own. Such workplace environments were also experienced as not supporting NQNs to deal with the emotional impact of their new role, leading to emotional and mental health problems, loss of motivation and burnout (Cho et al., 2012; Dixon et al., 2017). This highlights the need to ensure adequate resourcing of clinical areas to enable qualified staff to provide the intensive support required by NQNs around the period of transition (ten Hoeve et al., 2020).

Further barriers to connection were experienced where the culture or values of the workplace did not fit with those of the NQN, leading to distress and desire to leave. The findings reflect those of

Maben et al. (2006) and Kelly (1998) who found the negative impact of professional-bureaucracy conflict on nurses' intrinsic motivation for staying in the nursing profession at year one as well as year two. In particular, NQNs were reported to be less likely to stay in the first job after two years by Cho, Lee, Mark and Yun's longitudinal study (2012). This indicates that NQNs' sense of fit with the organisation could be determined in the first two years on the job. On the other hand, where participants articulated a sense of connection they identified that they were able to ask questions and the feeling that their colleagues took time to support them. This was part of a generally supportive culture where nurses were observed to support each other with workload, or leaders provided emotional support to teams following particular incidents or periods. Such findings can be understood in relation to Dechawatanapaisal's (2018) insight into the importance of the relationship between senior staff and their more junior colleagues and how this contributes to feeling connected and embedded in the organisation. This resonates with Phillips et al.'s (2017) finding that the development of a culture that facilitated questioning and feedback was a strong facilitator of smooth transition to newly qualified practice. Thus, retention might be strengthened by development of such supportive cultures (Boamah & Laschinger, 2016; Feng & Tsai, 2012; Hoeve et al., 2018).

Additionally, opportunity for professional development within the workplace impacted the NQNs' feeling that the organisation invested in them, and therefore, their sense of belonging and connection to the organisation. Where there was little possibility of gaining development opportunities participants felt demotivated and identified the need to move on. This resonates with Murrells et al.,'s (2008) finding that development opportunities were strongly associated with turnover intention, much more so than pay or workload. Lack of opportunity for development was a strong motivator for looking for a new workplace and is perhaps linked to the nurse's sense of fit with the work environment. Such perceptions of development opportunities were also important to Mansour and Mattukoya's (2018) participants and could be managed through processes of mentoring (Woolnough & Fielden, 2017) and professional and personal development planning (Cooper, 2009). However, implementation of such processes requires some change in the context to make time for senior staff to meet with their junior colleagues. This requires a focus on resourcing/reorganising health services in order to make space for this process to occur and to provide resources to support staff to pursue development opportunities (Regan et al., 2017).

5.2.2 | Community connection

The interface between work life and home life was made visible as participants talked about the impact of working shifts on their ability to spend time with family. Nursing students are typically older than the general undergraduate population and remain predominantly female (HESA, 2019). There is therefore likely to be a much higher proportion of NQNs who have additional caring roles which must be accommodated within the work–life balance. Battistelli et al. (2013) also found increased turnover where there was tension between work and family life, suggesting that where work and family roles conflict, resentment towards the organisation develops and turnover becomes more likely. It is clear from the data that a lack of fit with the shift structure is a strong motivator for NQNs to move into more accommodating workplaces, leading to voluntary turnover. Conversely, where individuals felt that there was a fit between work patterns and their life outside work this supported a feeling of engagement.

The findings from this study build on the current NQN literature which has primarily focused on the experience of the transition with a focus on a range of different factors (Laschinger, 2012; Laschinger et al., 2015, 2016). However, this is the first study where a qualitative investigation of NQNs' experience has been framed by the concept of job embeddedness. The focus on job embeddedness provided a useful lens to view the complex interaction between individual, work and home contexts providing a nuanced understanding of the experience and its relation to retention. The findings suggest that there are key actions to be taken at key points by employers and educators to support the development and retention of NQNs.

6 | STUDY LIMITATIONS

There are a number of limitations specific to the design of this study. The self-selecting nature of the sample means that the participants will be those who are interested in the topic, and additionally may well be those who felt they had experienced issues that needed to be heard. However, the sample provides evidence of positive and negative experiences of newly qualified practice enabling us to gain insight into a spectrum of experiences. Additionally, there was some diversity in the sample across geographical location, field of nursing, inpatient and community contexts, and gender which has enabled some understanding of the impact of different contextual factors on experience.

The other key limitation is that data collection occurred over two years, meaning that the stories of the transition provided by participants in the T2 sample would be shaped by their experiences of the second year of practice. However, there was consistency across the content of these stories of transition providing some sense of confirmability of the data provided at T2.

On reflection, it would have been useful for demographic data to include the age of participants, as many made connections between their mature age and their experiences as NQNs. Additionally, specific data on whether individuals had engaged with formal newly qualified nurse programmes and the content of these would have been useful.

This study sits within the interpretive paradigm and the findings represent the researchers' interpretation of the data. Transparency of method and decision making is provided to enable the reader to make an assessment of the trustworthiness of the findings. Robustness of the analytic process was ensured through deep engagement with the data, sense checking and discussion between

FIGURE 2 Suggested organisational support

The Right Support	• Senior staff to mentor and support NQNs • Emotional support • Practical support • Development opportunities • Teamwork • Organizational flexibility in working patterns • Increased staffing levels
The Right Time	• Transition • Regular engagement • When incidents occur • Peaks in workload
The Right Place	• Workplace • External training

the two researchers involved in the analytic process to agree any interpretive discrepancies, and the use of the theoretical literature to support interpretation.

7 | CONCLUSION

This study interviewed a cohort of newly qualified nurses at year-one and year-two post-qualification to establish what it was like for them to transition from student to staff nurse. There has been a lot of work done to establish why nurses leave the profession at this vulnerable time, but less has focused on why nurses stay. The concept of job embeddedness turned out to be a useful lens to explain the complex web of factors that acted as positive support in this study. This is important because it helps employers, educators and colleagues alike to reflect on the degree to which their particular environment supports job embeddedness.

In more detail, the findings emphasise the importance of supporting newly qualified nurses to develop and grow through the first year, enabling them to develop competence and confidence in their abilities. The findings of this study add to the body of quantitative evidence of the vulnerability of newly qualified nurses in the first year of practice. The evidence points to a need for further exploration of the reasons why nurses feel unprepared for their transition to newly qualified practice to support the development of an educational response.

8 | RELEVANCE TO CLINICAL PRACTICE

The data provide evidence of the action that employers can take to ensure that their newly qualified staff feel that they are connected and fit with the organisation and that there is a healthy work–life balance. This might be conceptualised as providing the right support, at the right time and in the right place (Figure 2).

In the context of a global lack of nurses, it becomes increasingly important to support those nurses coming into the profession to enable them to grow through the first year of qualified practice and get to the stage where they are embedded in their organisations. This requires employers and educators to work together to prepare and support nurses in the transitional phase and across the first two years of newly qualified practice.

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CONFLICT OF INTEREST

We have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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