Strategies to prevent or alleviate reality shock for a new nurse

Most nurses who take a job in the hospital are partly motivated by an interest in working with and helping people. They tend to look forward to establishing a warm, although not intimate, relationship with deserving and grateful clients, and consider the nurse as the agent of society who extends a helping and trusting hand to its members. The new nurses are typically full of sympathy for clients' problems. However, from the literature it is apparent that new employees feel inadequately prepared and unable to function effectively in a hospital setting.

Kramer (1974) calls this phenomenon that university graduates experience ' reality shock'. She documents the disillusionment and frustration of new graduates when they enter the clinical setting. This work will consider the essential strategies that provide the psychological support needed to alleviate problems that can virtually wipe out any professional skills. Reality shock as defined by Kramer (1974) is the startling discovery and resulting reaction that school-bred values conflict with those in the work world.

In some cases the perceived disparity in values is so strong that the individual cannot adjust to or remain in the situation. Clinical or field experience in an applied program, for example, is likely to provide students with perceptions of and experiences in dealing with bureaucratic organizations that other sociologists may not acquire until they take their first professional position. Students from applied programs may experience less reality shock in adjusting to a first professional position or in doing consulting work in applied settings because they bring with them a prior understanding of such realities as paperwork, the privileges of rank, and the functioning of the informal organization. In most large hospitals there are

orientation programs for new employees, with instruction in hospital organization, policies and procedures. Following this period of orientation, which is usually one week, there is sometimes further informal instruction on the practical aspects of the nurse’s responsibilities in the ward.

However, this type of centralized orientation program provides an overview of the hospital but fails to provide knowledge and skills relating to the ward environment. Without adequate support, help and understanding, the physical and emotional cost of coping with change can be very high.‘ Preceptor’ is now a widely used term in the nursing profession and means a tutor or instructor. When used in the context of a preceptorship program, it describes a senior clinical nurse who carries out ward/unit duties such as providing nursing care to patients, as well as having the responsibility of orientating the new graduate.

This nursing staff member works with a new graduate on a one-to-one basis to provide guidance and supervision in the clinical area. The preceptor recognizes and accepts the knowledge, competences and personal characteristics of the preceptee. The preceptor’s behavior reflects warmth and friendliness, patience to allow the new graduate to develop through self-discovery rather than rote, and confidence to teach nursing practices. It is the human factor that is critical for the success or failure of the relationship. The preceptorship program, which is an integral component of the Graduate Nurse Program, has addressed some of the real issues facing nursing staff in large hospitals. The new structure was not without its heartaches and hazards, but since its embryonic stage in 1990, it has provided a rich opportunity for numerous nursing staff.

The crucial and substantive element is the preceptor and his/her preparation so that there exists a supportive framework for the preceptee. Together they capture and explore the real world of nursing and its complex responsibilities. The preceptor model responds to the needs of the hospital and the new graduate. It brings to life the untidy reality of daily work and its problems. Working together improves not only the preparation for the job by relevant clinical education, but also the day-to-day support and continuing education which such complex work demands in the acute setting.

Friendly relations with colleagues are a source of social support which helps reduce the anxieties and insecurities that arise in the work situation. Individuals who were somewhat isolated from colleagues, therefore, were expected to be less oriented toward case-work service than those with extensive informal relations with peers (Andre 1992). Indeed, this seemed to be the case. Two measures of social support from peers were the case-worker’s popularity in the organization (how often others named him as a colleague with whom they were friendly) and his integration in his work group (whether he was called by his first name by other members of his own work group). Whichever index was used, over one-half of the workers with social support from peers were service oriented, in comparison with not quite one-third of those without such social support. This suggests that social support from colleagues is significant for service to clients only as long as lack of experience engenders anxieties that impede service.

Since the worker who has become fully adapted to the organization and its procedures in several years of employment experiences little anxiety in his work, the anxiety-reducing function of friendly relations with peers has no

bearing upon his performance. These findings suggest that peer group support served to absorb some of the impact of the reality shock (Brian J. & Caldwell M. 1993).

The unintegrated worker, without such social support, experienced the full force of the reality shock, which constrained him to shield his ego by developing a hardened attitude toward clients. Ego support from integrative relations with peers made a worker less vulnerable, enabling him to cope with disagreeable experiences with recipients without feeling threatened and thus reducing his need for protecting his ego by becoming indifferent toward clients. Among unintegrated workers, therefore, the proportion who never worried increased from 11 percent during the first year of employment to 75 percent after three years, but there was no corresponding increase among integrated workers. Social support from colleagues helped integrated workers withstand the reality shock and thus permitted them to maintain a greater concern for clients and their fate (Brian J.

& Caldwell M. 1993). Moreover, workers whose interest in helping clients led to worrying and made them vulnerable had particularly strong incentives to seek social support by fostering integrative relations with colleagues. The data do not enable us to tell whether integration increased concern or concern enhanced the chances of integration, or whether both influences occurred.

In any case, however, they point to the conclusion that integration in the work group served to lessen the impact of the reality shock. In recent years there has been removal of nursing schools from hospital facilities to tertiary

institutions. This transition of basic education has further exacerbated a knowledge gap found in new graduates and the lack of coherence between education and practice. There is imbalance between ideals and reality for new graduates. Additionally, the issue of values and value conflicts is frequently mentioned in the nursing socialization literature. Overall, the growing ability to deal with value conflicts is seen as an integral part of the nursing socialization process and, indeed, as central to the ability of nurses to become empathic and sensitive to the dilemmas at the core of nursing practice.

Some observers, for example, clearly distinguish between the acquisition of critical thinking and problem-solving skills, and the internalization of certain values essential to the development of a professional nursing identity. The nursing profession and nursing educators have become so intent upon graduating well-educated nurses that nursing per se is left by the wayside. The actual conditions of nursing practice are ignored; therefore, upon graduation, nursing students expect the ideal situation. Instead they find something entirely different. Some of the same issues in the medical socialization literature are also present in nursing, such as reality shock between initial education and exposure to the real world of actual clinical practice.

If nurses are to continue to meet the challenge of quality care and cost containment in the acute care setting, the attraction and development of university nurses is paramount. The establishment and maintenance of a preceptorship model of orientation has been the first step in meeting the immediate needs of the novice and minimizing ‘ reality shock’. The preceptor

model of orientation for new graduates attempts to bridge the gap between education and practice by providing strategies to overcome ‘ troubled transitions’ in the acute care setting. Also, friendly relations with peers decreased the tendency of workers to confine themselves rigidly to checking eligibility, just as accumulated experience did.