**EDITORIAL**

**THE GREAT RESIGNATION, NEWLY LICENSED NURSE TRANSITION SHOCK, AND EMERGENCY NURSING**

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The Great Resignation

There is a phenomenon occurring across all employment settings in the United States that is aptly termed The Great Resignation. Anthony Klotz, an organizational psychologist and business professor, named this trend in 2019, the year before the COVID-19 pandemic, when annual worker turnover reached an all-time high. Although the rate plateaued in 2020 with the advent of the pandemic, turnover again set new record levels both in 2021 and 2022, leading to extensive nationwide job vacancies. Nursing turnover is no exception in The Great Resignation trend. The origins of the present nursing turnover problem predate COVID-19 and center on factors broadly attributed to nursing burnout. Solutions that focus solely on building nursing resilience and exclude workplace-related causes are particularly short-sighted. This approach targets the nurse without the necessary organizational due diligence to identify correctable issues in the practice environment that contribute to burnout. The end result risks creating a false mindset that the nurse and not the system must be fixed.

The Joint Commission published a preponderance safety brief in July of 2019 on combating nursing burnout. The Joint Commission warned that burnout could affect cost, patient satisfaction, and clinical outcomes. This report drew upon results and recommendations from a wide variety of sources, noting that emergency nurses are at higher risk for burnout. In addition, in 2019, ECRI (formerly called the Emergency Care Research Institute and now by the initials ECRI) identified “burnout and its impact on patient safety” as number 3 in their list of top 10 patient safety concerns. They emphasized the risks to patient safety in cases of health care professional burnout, as well as the association of depression and suicidal ideation in physicians, nurses, and allied health professionals experiencing burnout. ECRI boldly called out the impact of precipitating workplace factors stemming from electronic health records (EHRs), time pressures, heavy patient workload, patient complexity, rapid change, and limited resources on a workforce largely comprising high achievers. They emphasized the importance of listening to clinician concerns, leveraging change at the system level to address the underlying causes such as improper resource allocation, and ending the treatment of employees as “cogs in a wheel.”

In 2020, Dall’Ora et al examined 91 quantitative studies that looked at relationships between nursing burnout and work-related factors. Not surprisingly, their findings revealed that high workload, low control, inadequate staffing, and long shift length are notably associated with burnout. These researchers also identified a negative impact on nurses’ general health and more sickness-related absences; nursing work performance worsened with resultant declines in patient care quality, safety, and experience, as well as increased medication errors, adverse events, patient falls, and greater intentions to leave. Given these findings, it is ironic that health care institutions commonly employ a do-more-with-less business mantra as an overall financial strategy. This paradigm typically means that nursing leaders are expected to ratchet down staffing levels to the bare minimum, despite having no ready options to provide backup for sick time, leaves of absence, and resignations, particularly in specialties such as the emergency department. At the same time, expectations remain high for nurses working short staffed and with a resulting heavier workload to achieve the finest patient satisfaction, patient care quality, and publicly reported metrics.

The stressors inherent in being a frontline emergency nurse, even during nonpandemic conditions, are significant. As the 24-hour, 7-day-a-week entry point into hospitals and health systems for all-comers, emergency nurses regularly experience all of the factors identified by ECRI as...
contributing to burnout, including time pressures, heavy patient workload, patient complexity, rapid change, and limited resources.\(^3\) A poorly designed or implemented EHR that drives dysfunctional workflow rather than workflow driving EHR design also contributes to burnout.\(^6\)

Fast forward to 2022. A systematic review of academic studies that focused on emergency nurse burnout and resilience by Phillips et al identified steep burnout rates in emergency nurses; burnout was strongly associated with higher turnover in emergency nurses than in other health care specialties. Workplace elements solidly coupled with higher turnover in emergency nurses than in other health care specialties. Workplace elements solidly coupled with turning over and mobility placed new nurses entering the workforce in unprecedented unit instability and experiencing significant turnover. Existing workforce licensed nurses will become an ever-increasing proportion of the new emergency nursing workforce was composed of newly licensed nurses.\(^17\) The Transition Stages (Figure 1) and Transition Shock (Figure 2) models\(^18,20\) provide a holistic framework that can be used to increase our collective understanding of new nurse transition to practice. The insight offered by these constructs promises to illuminate areas where interventions are needed to support the newest members of our emergency nursing workforce at this especially vulnerable time. In the past, transition support for newly licensed nurses and nurses new to the specialty largely fell to unit-based preceptors, mentors, and educators. The prolonged pandemic disaster context exposed emergency nurses to additional risk factors for burnout, grief injury, fatigue injury, moral injury, and traumatic injury.\(^11,13,21\) In this time of insufficient and even rationed resources,\(^9-11\) while temporary and travel nurse staffing agencies have long filled a need for short-term nursing labor demands, the value and demand for nursing skills multiplied during the pandemic.\(^14,15\) For institutions that had undervalued long-term nurse employees and nurse retention, the pay gaps between loyal nurse employees and temporary or travel nurses created further backlash from employees, contributed to additional turnover, and saw institutional attrition spiral. Even before the pandemic, the largest portion of the new emergency nursing workforce was composed of newly licensed nurses.\(^16\) It is logical to anticipate that newly licensed nurses will become an ever-increasing proportion of the immediate postpandemic workforce. Existing workforce turnover and mobility place new nurses entering the workforce in unprecedented unit instability and experiencing significant gaps in support.

Newly Licensed Emergency Nurses

Retaining seasoned nurses is essential to high-quality patient care, and we will focus editorial content on the occupational health of the current emergency nursing workforce in future issues. As late spring and summer are hallmark seasons for nursing school graduation and subsequent newly licensed nurse hiring, we focus this May issue editorial on entry to practice for the newest members of our specialty. The unpredictable, complex, and intense nature of emergency nursing presents special challenges to nurses who enter the specialty directly after graduation.\(^17\) The Transition Stages (Figure 1) and Transition Shock (Figure 2) models\(^18,20\) provide a holistic framework that can be used to increase our collective understanding of new nurse transition to practice. The insight offered by these constructs promises to illuminate areas where interventions are needed to support the newest members of our emergency nursing workforce at this especially vulnerable time. In the past, transition support for newly licensed nurses and nurses new to the specialty largely fell to unit-based preceptors, mentors, and educators. The prolonged pandemic disaster context exposed emergency nurses to additional risk factors for burnout, grief injury, fatigue injury, moral injury, and traumatic injury.\(^11,13,21\) In this time of insufficient and even rationed resources,\(^9-11\) while temporary and travel nurse staffing agencies have long filled a need for short-term nursing labor demands, the value and demand for nursing skills multiplied during the pandemic.\(^14,15\) For institutions that had undervalued long-term nurse employees and nurse retention, the pay gaps between loyal nurse employees and temporary or travel nurses created further backlash from employees, contributed to additional turnover, and saw institutional attrition spiral. Even before the pandemic, the largest portion of the new emergency nursing workforce was composed of newly licensed nurses.\(^16\) It is logical to anticipate that newly licensed nurses will become an ever-increasing proportion of the immediate postpandemic workforce. Existing workforce turnover and mobility place new nurses entering the workforce in unprecedented unit instability and experiencing significant gaps in support.

Transition Stages and Transition Shock Models

The first year of professional nursing is profoundly transformative.\(^19\) Assuming supported and evolutionary developmental knowledge and skill pathways were offered during nursing education, one might expect that new nurses would be able to anticipate a relatively stable postgraduate period rather than the steep, dynamic, and tumultuous learning curve they actually find.

The Transition Stages Model is organized by months of nursing practice postgraduation; the transition experience depicted therein occurs within 3 stages over the initial 12 months of practice. The model conceptualizes the stages as (1) doing, (2) being, and (3) knowing.\(^19\) Rather than just focusing on the professional knowledge and skill that a nurse must acquire to function in the job, the model holistically integrates the impact and influence of cognitive, emotional, sociodevelopmental, physical, and personally relational factors that span the new nurse’s work and personal life. Information about how the model was developed and the characteristics of each stage is published in detail elsewhere.\(^18,20\) The model is briefly summarized here.

The first stage of transition has been coined the doing stage.\(^18,19\) New graduate nurses enter the work environment with varying levels of familiarity with practice expectations and the workplace culture, often experiencing it as unstable.
and unpredictable. Facilitating realistic professional expectations should focus on assisting the graduates in acquiring a routine for the shift while providing preceptorship and mentorship. Meanwhile, backup and mutual support are required for situations requiring skill development and evolving clinical judgment. A narrow focus on task completion and time management should be expected and augmented with preceptor and team nursing support. While investing substantial emotional and cognitive energy into appearing competent to gain coworker acceptance and approval, the new nurse often arrives to their new practice environment with minimal tacit knowledge. The new nurse may face patient complexity, change of condition, and unfamiliar patient presentations with little or no experiential knowledge to guide them. In an environment fraught with immense pressures to rapidly become an independent clinician, quality and safety might be compromised if the new nurse hides their need for dependence on their experienced colleagues. The new emergency nurse may struggle to balance their important learning and status-seeking needs with feeling burdensome to the clinical team. This developmental hurdle can, during the initial practice months, translate into vulnerable levels of care competency if the graduate does not feel safe exposing their inadequacies.

Transition shock (Figure 2) is the initial experience of leaving the familiar student experience and entering the unpredictable and unfamiliar context of the professional practice realm. This period can last days or weeks and is commonly accompanied by feelings of profound doubt, loss, confusion, and disorientation. Figure 2 outlines key areas of imbalance that may lead to stress and transition shock in the nurses’ personal and professional roles, responsibilities, relationships, and knowledge. Many of these issues are amenable to assessment and intervention, such as clarifying realistic and developmentally targeted performance expectations and clinical growth ladders, offering structured and unstructured peer support networks, and matching graduates with role models who exemplify success on key professional issues such as navigating a work-life balance, striving for and advancing practice standards, managing their time amid competing priorities, and working collaboratively with inter- and intradisciplinary colleagues. Transition shock is as personal as it is professional; graduates will oftentimes be struggling to find their independence as
young adults, including managing their own finances and initiating new or more complex relationships (ie, marriage, cohabitation, or parental responsibility). Likewise, we suggest that unit and institutional leaders and professional organization support networks can offer formative needs assessments based on the various stressors depicted in the Transition Shock model. These assessments can be used to inform priority areas where holistic support can be offered to ease the shock and transition for the newest members of the profession (see examples in Table).

The second stage, coined by Duchscher as the being stage, finds the new nurse experiencing frustration and discontent with their own professional performance gaps. This relative expression of inadequacy can progressively turn outward as criticisms of the unit practice standards or further to health care system deficiencies and failures. The nurse’s thinking can shift from a sense that they as an individual only need to acquire more knowledge and skill to address practice realities on to accepting the realities of professional nursing as overall quite different from what they had envisioned when they chose nursing. This can lead to the nurse questioning whether the nursing discipline was the right career choice for them. This is one of the most at-risk stages of new nurse transition for both job turnover and for leaving the profession. This crisis of confidence can cumulate into a transition crisis as the new nurse moves from the being to the knowing phase approximately 6 to 8 months after orientation. Monitoring the new nurse during this stage for signs of disillusionment or expressions of disappointment in the profession is paramount to guiding them to a new level of acceptance of practice realities in health care.

The final stage in the Transition to Practice model is identified as knowing. In this stage, the nurse begins to fully integrate work-life balance, recovers from the steep initial learning curve, and commonly finds a sense of personal normalcy and professional identity. After 12 to 18 months of practice, the nurse may be fully ready to engage by leading unit improvement projects, precept others, and contribute beyond the individual clinical patient assignment. Although the models discussed here were developed on the basis of data from new graduate nurse transition, there may be broader applications to other emergency nurses as well.
Experienced nurses working in novel contexts can also experience transition shock, but it is largely muted and abbreviated from that of a newly graduated nurse. The work demands of the pandemic with staffing shortages and challenging workloads have resulted in a daily clinical shift that is nearly unrecognizable to many when compared with prepandemic workflows. This means that even the most experienced nurse may feel a profound loss of professional mastery and identity. The Stages of Transition and Transition Shock Model can also be tested for their applicability to any emergency nursing career transition. These career transitions may range from transferring to a new unit, position, or specialty to a profoundly altered work situation in one’s long-term employing unit. The 6-month “WHAT AM I DOING?” transition crisis and the imposter syndrome that Duchscher elegantly describes may have much broader applications to consider in career transitions and assuming new leadership responsibilities along the entire professional continuum.

Supports and Interventions

Given the urgent and timely need to recruit and retain high-quality emergency nurses, best-practice pathways for new graduate nurses entering this specialty must be developed, refined, and shared. The availability of mentors, preceptors, and coworkers experienced in the specialty and the employing unit are likely to be limited, given pandemic turnover and stressors. It is not unusual to hear seasoned nurses share stories of situations in which they had to succeed by their own individual efforts or fail the patient and professional challenge entirely. There is a common theme in the Rubicon of sink or swim as it related to career moments in our professional socialization as emergency nurses. Survivor bias can enter these stories where we are profoundly missing the voices of those who had a crisis moment without support and left emergency nursing after experiencing the resulting negative patient and professional outcomes. The Stages of Transition theory and Transition Shock model presented here frame the stressors and stress reactions of adapting and assimilating to professional nursing as normal, expected, and even embraced developmental phases. These frameworks can help remove unnecessary blame and shame from the nurse experiencing these crises and shock reactions from our collective norms. The models can also aid preceptors, managers, educators, and coworkers to set realistic and transition-appropriate professional expectations, rather than applying the traditional and largely dysfunctional sink or swim mentality. The models can also be very useful in anticipating and addressing relatively predictable stress reactions to support the newly licensed nurse or any transitioning nurse practicing in the emergency

<table>
<thead>
<tr>
<th>Transition shock stressor</th>
<th>Example support activity</th>
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<tr>
<td>Life roles: partner-spouse</td>
<td>Off unit mentor or role model who can discuss and help develop strategies to mitigate new home relationship strain created with first time working night and/or weekend shifts.</td>
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<tr>
<td>Skills and tasks</td>
<td>Nurse residency program, formal professional development onboarding, professional association courses, virtual or augmented reality skills practice, extra skills lab practice at home education institution.</td>
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<tr>
<td>Financial management</td>
<td>ENA Council meeting with financial planning speakers or vendors with content relevant to new nurse household budgeting, student loan repayment, and common early adulthood or early career financial goals.</td>
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<tr>
<td>Intergenerational dynamics</td>
<td>Off unit education lab or virtual reality simulation with facilitated role play activities to explore and develop better response, coping, or understanding of frustrating or puzzling intergenerational dynamics.</td>
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<tr>
<td>Life changes</td>
<td>Inclusive celebratory and acknowledgment events, rituals, and routines to recognize marriage, births, new homeownership, or other major life event.</td>
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<tr>
<td>Role stress/strain</td>
<td>Realistic expectations, structured and unambiguous orientation and onboarding pathway. Information for organization’s EAP and external therapists trusted by nurse coworkers if requested by new nurse.</td>
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EAP, Employee Assistance Program.
department setting. These frameworks also serve the specialty with key reminders to stay connected and updated on our newest specialty members’ key benchmarks throughout a healthy transition such that we can facilitate a satisfying and lengthy career in emergency nursing.

Shanafelt et al summarized the pandemic-related needs that frontline clinicians have expressed they need from their organizations as Hear Me, Protect Me, Prepare Me, Support Me, and Care for Me. These themes are derived from clinicians across the career span and not just new nurses as we discussed here. How inspiring to envision that we can collectively and individually structure support for one another through our organizations in this way and to know that we can be each other’s light despite the surrounding darkness of the pandemic. It is simply no longer reasonable, or honestly feasible from a human resource capacity perspective, to expect a seasoned clinical unit preceptor to bear a disproportionate amount of the burden for successfully onboarding new nurses, especially when facing their own risk of stress injury and burnout.

In addition to raising awareness and understanding about transition crises and its triggers in less-than-ideal work environments, we recommend that emergency clinicians at all levels of practice engage in dialogue and activities to build a shared understanding of the stages of transitions, clarify the impacts in your own workplace or professional social network, and craft interventions to support healthy transitions.

External resources to support the new emergency nurses’ knowledge acquisition include ENA University pathway for those new to the specialty, the ENA Nurse Residency Program, Board Certification for Emergency Nursing Learn, and other academic and professional organizational learning supports in your region. Certification and certification preparation are open to newly licensed nurses, which offer pinnacle professional identity support and validation. The ENA offers Emerging Professionals activities for leadership and social support tailored for those new to the specialty. We also encourage local chapter and council activities to welcome mentor role, responsibility, relationships, and knowledge holist learning needs of our newest members of the clinical specialty. Along with these onboarding efforts, retention of the new emergency nurses as well as the experienced nurses is critical. To reverse the flight of talent, we believe that health care leaders must actively address the organizational sources of stress and burnout and transform their operations to create gratifying work environments.

Key to this work is defining new evidence-based budget strategies that provide the human and physical resources necessary for safe practice and high-quality care delivery as opposed to relying on current industry benchmarks that do not adequately represent the clinical reality for frontline emergency nurses.

Given that there may be a dearth of available mentors, preceptors, and clinical educators owing to pandemic-era workforce turnover and vacancies, the time is ripe for creatively exploring algorithmic clinical guides for novices and virtual (including virtual reality and online simulation) and structured external supports for newly licensed nurse training and support. Preparing and retaining the next generation of emergency nurses in this moment in time is filled with challenges and barriers, but the innovation, perseverance, and culture of rising above the crisis and spirit of emergency nurses are poised to overcome to an even more promising future. We welcome rigorous program development, evaluation, and intervention testing manuscripts to address emergency nurse orientation and newly licensed transitions to the emergency department in the Journal of Emergency Nursing.

**Author Disclosures**

Dr. Castner is President and Principal of Castner Incorporated, a New York State woman owned business enterprise.

**REFERENCES**


