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New graduate nurses' delivery of patient care: A focused ethnography

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Abstract

Aim: To explore factors influencing newly graduated nurses' delivery of direct care in acute care hospital settings.

Design: Qualitative study using focused ethnography.

Methods: During the period from March to June 2022, a total of ten newly graduated nurses were purposively sampled, and data were collected through 96 h of participant observation as well as ten semi-structured interviews. This research took place in a large hospital located in Denmark. Data were analysed using LeCompte and Schensul's ethnographic content analysis.

Results: Three main structures were developed from the data: 'Contrasting Intentions and Actions for care delivery', 'Organizational Constraints Block Interpersonal Aspects of Nursing Care' and 'Newly Graduated Nurses' Suppressed Need for Support Constitutes Delay in Care Actions'.

Conclusion: Newly graduated nurses were committed to delivering high-quality care but were aware they sometimes provided compromised care. The paradox between a commitment to care and compromised care delivery was borne out of tensions between newly graduated nurses' professional beliefs and nursing values, a desire to integrate patients' needs and preferences, and organizational constraints on everyday practices where newly graduated nurses often worked alone without the support of a more experienced nurse. Critical reflection on cultural, social and political forces that influence direct care delivery might support newly graduated nurses to deliver direct patient care more intentionally.

Relevance to Clinical Practice: Establishment of onboarding programs and other support activities for newly graduated nurses to cope with contrasting intentions and actions that must address organizational constraints is essential. These development programs should include how critical reflection competency is supported to address value inconsistencies and emotional distress to ensure high-quality patient care.

Reporting Method: The reporting adhered to the COREQ guidelines.

Patient or Public Contribution: 'No Patient or Public Contribution'.

KEYWORDS

acute care setting, clinical competence, focused ethnography, new graduate nurses, patient care, professional practice, qualitative research

1 | INTRODUCTION

Newly graduated nurses' delivery of direct patient care requires competence in clinical decision-making and clinical leadership (Ernstmeyer & Christman, 2021). Yet newly graduated nurses who do not feel prepared for or confident in making clinical decisions are overwhelmed with emotional distress and need support in their transition into clinical practice (Kaldal et al., 2022). In response to newly graduated nurses' need for support, a variety of onboarding initiatives have been developed internationally to strengthen competencies, readiness for practice, well-being and retention (Kenny et al., 2021). However, research continues to report low levels of job satisfaction and high levels of sick leave and intention to leave among newly graduated nurses, indicating a contemporary challenge that needs to be addressed. Combined with the fact that the clinical context of nursing care is rapidly changing (Hallaran et al., 2022), it is necessary to recognize and explore how social, cultural, economic and political factors in the context of delivering direct care influence newly graduated nurses' direct care delivery. Understanding the factors influencing newly graduated nurses' direct care delivery could facilitate the development and implementation of beneficial onboarding and other solutions that support newly graduated nurses' transition to practice and ultimately the delivery of patient care.

What does this paper contribute to the wider global clinical community

- Newly graduated nurses find themselves in a paradox of being committed to care whilst providing compromised care.
- There is a need to consider how critical reflection competencies can be supported and embedded in a culture where newly graduated nurses tend to work alone.
- Experienced nurses, mentors and nurse managers play a central role in establishing a culture where inquiry and inquisitiveness related to the delivery of direct care are considered prerequisites for high-quality patient care.

2 | BACKGROUND

Newly graduated nurses' direct care delivery encompasses interventions that involve personal contact with patients (Ernstmeyer & Christman, 2021). However, the experiences of direct care delivery for these nurses are not uniform and heavily depend on contextual factors, such as their perceptions of professional and personal identity and the level of support they receive (Kaldal et al., 2022). It is essential for newly graduated nurses to possess the necessary competencies to identify and integrate the physical, psychosocial and relational needs of their patients into their clinical decision-making processes. Moreover, they are entrusted with practical problem-solving and delegation responsibilities (Guibert-Lacasa & Vázquez-Calatayud, 2022).

Direct care delivery encompasses making informed decisions in response to patient needs using critical thinking skills and knowledge gained from education and experience (Modic, 2013). Clinical decision-making is a reflective reasoning process that draws upon all available data, is informed by an extensive knowledge base and results in appropriate responses to patient needs and care delivery (Connor et al., 2022). Several studies have shed light on the various factors that influence the development of competence and clinical decision-making among newly graduated nurses. Organizational and cultural factors such as educational preparation, transition into clinical practice, stability, workload, norms and standards, and the explicit values exhibited by colleagues have been identified as key influences (Charette et al., 2019; Voldbjerg et al., 2017). These external factors interact with individual nurses' knowledge and skills, shaping their ability to deliver optimal care and make informed decisions.

The transition from student to new graduate is recognized as especially challenging and emotionally exhausting for many new graduates within healthcare professions (Hallaran et al., 2022; Klitgaard et al., 2021). This period often gives rise to feelings of uncertainty and inadequacy, which, in turn, have been linked to lower levels of caring behaviours exhibited by nurses (Kosmidis et al., 2021). Given these challenges, it becomes imperative to establish constructive ways that can support newly graduated nurses during this period.

Newly graduated nurses are predominantly employed in hospital-based acute care positions (Schwartz, 2019). Acute care settings are defined as units specialized in the general and short-term treatment of acute physical illnesses, such as medical and surgical units. It excludes intensive care; emergency rooms (considered critical care units); and psychiatric, palliative and maternity units. The process of transitioning and training newly graduated nurses can vary depending on the healthcare system and country in which they work. In countries such as the United States and Australia, newly graduated

nurses typically undergo a national development program (American Nurses Credentialing Center, 2020; Australian Nursing and Midwifery Accreditation Council, 2019). In Denmark, the development program is linked to the specific hospital, where onboarding activities can be offered both centrally in a hospital-wide orientation program and/or locally at the unit level. Therefore, the ways in which graduates are supported vary locally and nationally. Despite the fact that most newly graduated nurses in Denmark are employed in hospitals, there is little evidence regarding the factors that influence their delivery of direct patient care in this context. The existence and nature of transition challenges is well-documented (Hallaran et al., 2022); however, the newly graduated nurses' perspective of how these transition challenges influence direct care delivery has not been explored. This study therefore explores the factors that influence the care delivered when a nurse is face-to-face with the patient. The evidence generated can provide valuable insight to inform organizations on how to develop or improve effective onboarding and orientation programs that promote professional development and job satisfaction for newly graduated nurses.

3 | METHODS

3.1 | Aim

To explore factors influencing newly graduated nurses' delivery of direct (i.e. face-to-face) patient care in acute care hospital settings in Denmark.

3.2 | Design

A social constructivist understanding was applied to generate insights into the ways in which social structures, relationships and practices shape newly graduated nurses' experiences and understanding of direct care delivery (Berger & Luckmann, 1966). The insights were created through social processes such as language, communication, and shared understandings between the researcher and the participants of the various factors influencing their direct care delivery. A focused ethnography was conducted with a particular focus on culture to understand individuals' behaviours and beliefs in their specific context and to utilize the researchers' insights into the field (Higginbottom et al., 2013). This research design allowed for an exploration of newly graduated nurses' delivery of care in everyday practice in acute care settings using participant observation and interviews.

3.3 | Participants and setting

The setting of the study was three medical and two surgical units in one university hospital in Denmark. Before the study, the first author met with the nurse managers of each unit to provide both oral and written information about the study and to gain access to the units. To address the research aim, a purposeful sampling technique was employed to enlist participants who possessed particular knowledge and experience in delivering direct care (Higginbottom et al., 2013). The inclusion criteria were that participants were newly graduated nurses (graduated within the previous 12 months) and working in acute care settings in Denmark. Participants needed to be in their first employment following graduation. Participants with more than 1 year of work experience as well as participants working in critical care units, and psychiatric, palliative, and maternity units or not holding a Bachelor of Science in Nursing were excluded. The nurse managers in participating units assisted with recruitment by providing potential participants with written information about the study. Nurse managers then passed on the contact information of interested participants to the first author who contacted the potential participants by email and provided further information about the study face-to-face.

Nurses in Denmark complete a Bachelor of Science in Nursing (BSN) program that requires 3.5 years of full-time study (European Commission/EACEA/ Eurydice, 2018). After graduation, newly graduated Danish nurses typically participate in a local nursing development program provided by their employer. The participants included in this study were promised participation in the hospital-wide development program, which includes six teaching days on specialized topics such respiration, circulation, skills simulation (e.g. insertion of peripheral venous catheter, bladder catheter, nutrition probes and arterial puncture) and medicine administration. They were also offered 8 h of teaching in documentation based on the Fundamentals of Care framework (Feo et al., 2017) and communication. Additionally, they were offered a mentor agreement, 10 h of clinical group supervision and three conversations with their manager during the first 3 months of employment.

Ten newly graduated nurses were recruited. All participants were female with different levels of clinical experience ($\mu = 6$ months) and age (mean = 26 years). All had graduated with a bachelor's degree from a School of Nursing in Denmark within the previous 0–12 months. All participants were enrolled in the hospital's development program. Participants were assigned a mentor from their unit, engaged in supervision with other newly graduated nurses and were promised an individualized induction from their nurse manager when they were employed. The participant characteristics are displayed in Table 1. At the beginning of the data collection, participants had 1–9 months of work experience. At the time of the interviews, they had 4–12 months of work experience. The patients who received nursing care from the newly graduated nurses had a variety of health conditions.

3.4 | Sample size

Given the focused aim of the study, the sample size (10) was considered adequate to generate sufficient information for description and further exploration (Higginbottom et al., 2013). Yet openness to recruiting more informants depending on the analysis was acknowledged.

TABLE 1 Participant characteristics.

Participant	Age	Hospital setting	Clinical experience at the time of observations	Clinical experience at the time of interviews
NGN 1	30	Surgical	1 months	4 months
NGN 2	24	Surgical	1,5 months	5 months
NGN 3	26	Surgical	2 months	4 months
NGN 4	24	Surgical	2 months	5 months
NGN 5	26	Surgical	2 months	5 months
NGN 6	27	Surgical	2 months	5 months
NGN 7	24	Medical	3 months	4 months
NGN 8	23	Medical	3 months	5 months
NGN 9	41	Medical	9 months	12 months
NGN 10	28	Medical	9 months	11 months

3.5 | Data collection

The data were collected iteratively. The research aim was explored using both participant observation and interviews. Each observation built upon the gained insights from the previous observation and each interview built upon the gained insights from observations and previous interviews to obtain data saturation (Fusch & Ness, 2015). As data were collected and analysed, preliminary interpretations and insights were used to refine the data collection plan for the next round. The focus of the data collected was refined over time, and the data collection was conducted until a point of saturation was achieved, indicating that the emerging patterns were sufficiently supported by the data and no new information contradicted these patterns (Bazeley, 2020; Fusch & Ness, 2015).

3.5.1 | Participant observation

The study involved observing participants for a total of 96 h, split over 26 shifts, which included daytime, evening and night. The observation period lasted for 3 months, from March to May 2022. Each observation session lasted for 3–4 h, and participants were followed two or three times on different days, depending on their individual preferences for being observed. The participants knew the research aim and the first author's background and interests. They were aware that their delivery of direct patient care was being observed using the 'observer as participant' approach. The observer (first author) wore a nurse uniform and followed the participants. When encountering patients, she introduced herself as a researcher and placed herself in the room in a 'non-central place', yet being able to observe the care actions carried out. The observer did not participate in care delivery and refrained from providing guidance and supervision in situations where the participants requested this. This approach was chosen due to the hospital's insurance policy and to avoid losing objectivity and altering the behaviours of the newly graduated nurses. Observations were recorded in field notes that were transcribed in a narrative format. To document the research process, participant observations were recorded in field notes using Sunstein and Chiseri-Strater (2012) approach. The observation guide had six categories, including date/time/place of observation, specific details, sensory impressions, conversation summaries, personal responses and questions for future investigation. The field notes were transcribed into narrative format using participatory jottings and daily consolidated notes. The field notes included descriptions of structures, human behaviours, value-laden language and quantities like time spent with patients. These notes informed the ongoing observations and the semi-structured interview guide used in the ethnographic interviews.

3.5.2 | Ethnographic interviews

The ten participants who were observed were invited to take part in an individual semi-structured interview about their experiences and perceptions of nursing care delivery and the factors influencing this delivery. The first author conducted the ethnographic interviews after the observations and transcriptions of field notes to (1) minimize the likelihood of the observer's questions or comments influencing the participant's actions and responses, leading to inaccurate or unreliable data; (2) obtain richer insights; and (3) enhance the credibility and trustworthiness of the research findings (Hammersley & Atkinson, 2007). An interview guide was developed in Danish by the first author. To ensure the validity and clarity of the questions, the interview guide underwent content validation by two researchers from the author team. The validation process involved extensive discussions regarding the clarity of each question and their relevance to the study's purpose. Both authors who validated the interview guide are native Danish speakers holding a BSN degree and a research degree. The interview guide was composed of open-ended questions that explored factors observed during the study and those known from existing literature, specifically focusing on their influence on newly graduated nurses' delivery of care in surgical and medical settings. The interviews were structured with inspiration from Spradley's question types: descriptive, structural and contrast (Higginbottom et al., 2013). Examples of types of questions are displayed in Table 2.

The interviews took place at convenient times and locations for the participants. The participant and the first author were the only ones present during the interview. Interviews were audio recorded and averaged 45 min. All interviews were moderated and transcribed by the first author, who is a registered nurse and senior lecturer in the Bachelor of Nursing Program at a Danish University College and completing a PhD. Her clinical experience as a nurse was not related to the care settings in the hospital where the study took place.

3.6 | Data analysis

An ethnographic method of analysis inspired by LeCompte and Schensul (1999) was used to address the research aim. LeCompte and Schensul's approach uses a four-phased approach. The in-field analysis (first phase) involved reflections, preliminary analysis and initial interpretations of data from participant observations, which

TABLE 2 Examples of types of questions.

Type of question	Example of question
Descriptive	Can you describe what kind of nurse you are and how you deliver nursing care to the patients admitted to the unit?
Structural	What facilitates/constrains your direct care interventions?
Contrast	What is the difference between uninterrupted and interrupted interventions when you are delivering direct care to your patients?

TABLE 3 Example of the relationship between theme, subthemes and codes in theme one.

Theme	Patterns and structure	Code
Contrasting Intentions and Actions for Care Delivery	Task-oriented vs. relational care Patient centred vs. round routine Patient contact vs. organizational needs (charting, rounds) Failure to delegate vs. appropriate use of time	Commitment to nursing care Delegation Focus of direct care actions Nurse behaviours Nurse patient contact Prioritization Responding to patients needs Values of nursing care Work conditions

guided the subsequent participant observations and individual interviews. In the second phase, all field notes, plus transcripts of the observations and interviews, were organized and coded by the first author using NVivo 12 Pro software. Transcripts were read and reread by the first author several times to develop insight into the data. Descriptions of care delivery within the data were then coded to better understand the contextual influences on care delivery and the meanings ascribed to this care delivery by each participant. Reflective notes and questions which arose during the coding process were recorded and later incorporated into the analysis to guide the development of patterns.

To attain validity, the first round of coding was presented and discussed with the co-authors, who are all experienced qualitative researchers, to refine and shape the initial codes. To identify patterns and structures (third phase), codes were gathered systematically by the first author into themes representing patterns and structures within the data. The themes identified were iteratively compared with the raw data (both observations and interviews) and discussed with all authors. The process was iterative with possible patterns emerging and requiring further exploration of the data. The reflections, preliminary analysis and initial interpretations from phase one supported a reflective approach and enriched the identification of patterns. Table 3 provides an example of the analytical process and the relationship between codes and patterns and structures in theme one. Finally, the authors refined and compared (fourth phase) the retrieved patterns and structures within the context of health care and nursing education and discussed them in relation to other studies and relevant theories.

3.7 | Ethics considerations

The study was approved by the Unit of Information Security of the hospital where the study took place (ID number F2022-035) and conducted according to the principles of the Declaration of Helsinki. Furthermore, approval from hospital management to conduct the study and consent from the ward management for participating in the study were obtained. Participants were given oral and written information about the project and provided written consent before participating. Participants were informed that their participation was voluntary and that they could withdraw from the project without further explanation. The participants were not offered any reimbursement for their time. Two newly graduated nurses, both employed in medical units, chose to withdraw after the dates for observation were confirmed but before the consent form was signed. The participants withdrew because of demanding work schedules. The patients who became part of the observations were asked for oral consent before they were observed. No patients disagreed. As they were not the focus of the data collection, no written consent was needed. The other staff in the unit were informed of the study by the nurse managers, and a written notice regarding the study and the observer was displayed in the staff room prior to observations. Several strategies were undertaken to ensure the confidentiality, integrity and availability of data. First, all data (i.e. field notes and interview transcriptions) collected during the study were stored securely on a password-protected computer that was only accessible to and shared with the members of the research team. Second, the organization's system was used to secure storage media (UCNemDok), with regular data backups to prevent data loss. Third, digital recordings were securely deleted to prevent any unintended access or use of the data. Finally, the participants were assigned a numerical code to prevent identification (Participants 1, 2, 3, etc.).

3.8 | Trustworthiness

To ensure trustworthiness of the study findings, we used a process of triangulation. This involved cross-checking the findings of the

analysis with multiple sources of data such as field notes, interview transcripts and participant feedback. The researcher verified her observations by asking participants during interviews if these observations reflected their experiences (e.g. 'It surprised me to see that the face-to-face contact you have with your patients was so limited. Do you share the same experience?'). Additionally, the research process included multiple sources of data to enhance objectivity, truth and validity (Fusch & Ness, 2015). Transcriptions of field notes, the reflexive journal and interviews were continuously produced and shared with the research team to ensure consistency in field notes and interview techniques, as a form of investigator triangulation (Adler, 2022). Notes from the observations were retold during the interviews, allowing participants to provide feedback from a native perspective, as a form of member-checking (Adler, 2022). The recruitment of participants stopped after 26 shifts and ten individual interviews as no new codes were emerging and thus data saturation had been reached.

Various translation strategies when translating from Danish to English were applied to avoid a simplification of the nuances in the data and to maintain the original intent of participants' own words. This included verbatim transcription of the data and analysis in Danish by the first author, in addition to the translation of concepts and categories into English and agreement on the final English version by the co-authors. The contributions of the co-authors strengthened the study's confirmability, clarifying the interpretations of data and dissemination of findings.

A reflexive approach was adapted to mitigate the influence of the researcher's positionality and ensured that the research was conducted in a rigorous, transparent manner. This involved reflecting on and acknowledging the researcher's (1) prior knowledge, (2) insight into the field, (3) own education and practice as a nurse, and (4) experience as a nurse educator and student counsellor. The researcher's positioning of *'being an insider'* was reflected upon by the research team, hence, forming the researcher's internalized beliefs and values (Higginbottom et al., 2013). The observation guide included a designated space for 'personal responses' where the researcher recorded her thoughts, feelings and interpretations of events. The reflexive notes were shared with the other researchers on the author team, facilitating the opportunity for challenging and defending data collection decisions. The reflexive process was used in discussing observations, feelings and addressing potential areas of unconscious bias.

This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). See Appendix S1.

4 | FINDINGS

This section presents the three main structures that were derived from the analysis: 'Contrasting Intentions and Actions for Care Delivery', 'Organizational Constraints Block Interpersonal Aspects of Nursing Care' and 'Newly Graduated Nurses' Suppressed Need for Support Constitutes Delay in Care Actions'. The three structures are described separately but are interconnected. The description of the structures is supported by extracts from the field notes and citations from the interviews.

4.1 | Contrasting intentions and actions for care delivery

Newly graduated nurses' direct care delivery was characterized by contrasting intentions and actions in the way they reasoned and delivered their care. On the one hand, when asked about the values of nursing care delivery in the unit, the nurses spoke of the importance of person-centred care and specifically patient involvement, co-operation, autonomy, conscientiousness, dignity and justice. As one nurse expressed:

> The patients are at the center, and they must be involved. We must cooperate with them and take their wishes into account. If they have special preferences, then it is also something we include to organize the care in the best possible way… I like the fact that we are constantly thinking about what is it that the patient wants.
>
> (Interview, NGN 5)

The nurses were knowledgeable about and motivated to commit to nursing care that focused on patients' individual needs and on patient involvement. On the other hand, when observing the newly graduated nurses' delivery of direct care, there was a contrast between the reported ideals of patient-centred care and the care actions performed. Following an observation, one nurse was asked to reflect on a situation where she provided wound care without looking at the patient:

> I was completely blindsided. I just thought about that one thing and then forgot everyone around me. It damaged the relationship because I forgot that it was a human being, and the task became more important than him [the patient].
>
> (Interview, NGN 2)

A predominant focus on instrumental care emerged as the newly graduated nurses focussed on isolated actions and often did not observe the patients' non-verbal reactions. The newly graduated nurses had difficulty in observing, responding to and integrating patients' physical, psychosocial and relational needs to ensure patients' physical and psychosocial well-being. When prompted by the researcher and given the opportunity to reflect and evaluate the care delivered, the newly graduated nurses demonstrated insight into how their care delivery potentially impacted (1) the relationship between them and their patients and to what extent they (2) integrated the patients' needs in their actions in (3) the specific care context. However, they were rarely challenged to reflect on the assessment of specific care needs by their colleagues as they often worked alone, and these learning situations became absent.

Occasionally round routines were given a higher priority than patients' individual needs for care. In the example below, a graduated nurse was asked about a situation where she was observed to prioritize 'standard procedure' rather than responding to a patient's acute care need:

> In the ward, I [observer] ask her [nurse] why she prioritizes the round rather than meeting the patient's need for care. I noted that she had checked and confirmed that she [the patient] had faeces in her diaper. She replies: "I know it's poor care, but if I don't do rounds now, it will have major consequences for me later where I must do the documentation.
>
> (Fieldnotes, NGN 10)

The newly graduated nurse was aware that she was providing low-quality care when she deliberately postponed addressing the patient's care need. In all included study units, it was standard procedure that nurses took an active part in the doctors' rounds. Newly graduated nurses placed great value on attending these rounds as it helped them to document future care plans, even if it meant not meeting patients' need for direct care actions.

Newly graduated nurses talked of nurse behaviours that encouraged patient contact and continuity in direct care. In the following quote, one newly graduated nurse reasoned her lack of delegation of direct care actions with the importance of establishing a trusting relationship with the patient:

> I find it difficult to delegate those little things you can do for the patient during the day and where you make contact and establish a relationship. I think patients are most comfortable with the fact that it is the same person that comes and does it all'.
>
> (Interview, NGN 3)

In general, the newly graduated nurses were observed to spend limited time with their patients during the shift. It did not seem to correspond the way they talked about their preferred choice of actions when asked by the interviewer. However, they had developed strategies for ensuring patient contact such as not delegating tasks or not accepting assistance offered by colleagues.

Contradictions between the way the newly graduated nurses talked about and perceived nursing care and the way they cared for their patients in the unit, indicated challenges in navigating the complexity of nursing care and translating professional care beliefs into clinical practice.

4.2 | Organizational constraints block interpersonal aspects of nursing care

Organizational constraints such as the number of patients, staff levels and lack of time were work conditions that blocked newly graduated nurses' intentions for patient care. Often the interpersonal aspect of nursing care was given a low priority by the nurses themselves. Newly graduated nurses shared experiences of bad conscience and feelings of incompetence when not being able to attend to the interpersonal aspects of care. As one nurse reported:

> We had people who had called in sick plus there were holidays, so we were very few at work. It was extra busy and then I had my first experience of a patient dying. That was my patient – one out of nine. I had a thousand tasks, and I just couldn't be everywhere at the same time and then I broke down and cried'.
>
> (Interview, NGN 9)

The newly graduated nurse was not capable of coping with the emotional pressure that arose from a sense of not being there for all the patients she had been allocated. Discrepancies between the number of patients, staff levels and newly graduated nurses' ideals in relation to patient care routinely deprived the newly graduated nurses of the opportunity to be present and compassionate. These discrepancies reduced the time to deliver direct care, meaning important information about patients' conditions was missed. When asked how the **number of assigned patients influenced direct care delivery, a nurse** answered:

> Nurse: As I said before, many patients plus few staff equals superficial nursing care. Then it's just about patient survival that day. Then the inner core of nursing will have to wait to another day when there are more of us at work.
>
> Interviewer: What do you mean by the inner core of nursing?
>
> Nurse: It's where you focus on the interpersonal aspect and where you show those love and care things. It's where you talk to the patient to make him feel comfortable.
>
> (Interview, NGN 6)

Due to staff shortages, the newly graduated nurse deprioritized interpersonal aspects of direct care delivery such as patients' emotional well-being and involvement. Newly graduated nurses distinguished between urgent care required for patient survival and non-urgent care required to support the patients' knowledge, mental health and well-being. Too many tasks resulted in direct care where newly graduated nurses predominantly focussed on the patients' physical needs despite recognising that this compromised the delivery of psychosocial and relational care and subsequently patients' well-being. Another nurse similarly expressed how requirements of documentation also reduced the time available for patient contact:

> I just feel that the nursing care the patients can feel – it is the care that is delivered face to face… I feel I could do so much more if there wasn't so much about

> documentation. Then I could spend much more time together with the patients.
>
> (Interview, NGN 7)

The newly graduated nurses emphasized the importance of establishing a good relationship with their patients but experienced that this commitment was compromised or sometimes completely disregarded in the specific care context. The limited time newly graduated nurses spend face to face with their patients constrained them from providing the care they believed patients needed and wanted.

Newly graduated nurses experienced that their competency to communicate with patients did not correspond with the time available in clinical practice. A nurse said:

> I don't think I have any problems communicating with patients – it comes easily to me, I know how to go in and talk to patients, but there's just no time for it.
>
> (Interview, NGN 1)

The newly graduated nurse felt confident to engage with patients but could not find the time to do so. The newly graduated nurses entered practice expecting that nursing care includes engaging with patients because of an educational focus on nursing theories highlighting holistic and individualized care. A nurse indicated that the ideals she was taught did not correspond to the practice she encountered:

> I've learned to provide holistic care. But now I just go in and do all these things. We're so busy, so I just hurry up to the relevant information that I need for rounds… It sounds completely crazy, but that's the way it is – unfortunately.
>
> (Interview, NGN 2)

The newly graduated nurse talked of a task-oriented approach where the information gathered from the patient was primarily intended for physician rounds. On the one hand, newly graduated nurses demonstrated their ability to target their data collection to accommodate their responsibility in interprofessional collaboration with the physicians. On the other hand, this represented a gap between learning theory and practical application as clinical practice did not reflect or demand the holistic approach taught in nursing education.

Newly graduated nurses' transfer of professional beliefs and actual care actions were contingent on policy (i.e. financial, quality and safety) and systems-level factors (i.e. resources and interprofessional collaboration) that reduced the time available to develop a relationship with the patient being cared for and to attend, in an integrated manner, to their physical, psychosocial and relational needs.

4.3 | Suppressed need for support constitutes delay in care actions

Inconsistencies between culturally conditioned behaviour in support practices and care commitment arose when the newly graduated nurses did not express their need for support or the relationship between nurse and patient was interrupted. The suppressed need for support was reinforced by the newly graduated nurses' expectations of independence, a reduction in the period allocated to training and introduction, postponed participation in hospital-wide orientation program for graduates, and cancellations of specialty-specific teaching sessions due to work conditions. Not asking for help and interruptions at the bedside distracted the newly graduated nurses, subsequently delaying care.

The newly graduated nurses believed that they were supposed to know how to solve problems and identify appropriate nurse intervention by themselves and found it hard to ask their colleagues for help. A nurse described:

> If you [nurse] are in doubt about a task and you think you are expected to know how but can't figure it out, then it can be very difficult to ask for help to get it solved or a suggestion for what you can do.
>
> (Interview, NGN 8)

Newly graduated nurses found it difficult to ask for support and guidance if they were in doubt about how to perform what was considered standard procedures in the unit. The newly graduated nurses were reluctant to ask for help due to their own expectations of autonomy. However, the field observations revealed that despite more experienced nurses being keen to offer their assistance at the beginning of the shift, the newly graduated nurses rarely accepted this help or returned to the offer later in the shift nor did the experienced nurses re-offer when that help was actually needed. When asked why it was difficult to ask for help in the middle of a shift, a nurse explained:

> Nurse: Getting a hold of someone is hard. I see my colleagues, but they walk around all the time. And again, I don't want to throw any burdens on anyone, and I don't want to be the one who doesn't do enough. So, if I judge that I can't do anything wrong with trying that out – I mean, if I can't make a bad mistake, i.e. a fatal mistake, then I just try.
>
> Interviewer: Do you think it harms anyone when you don't speak up?
>
> Nurse: 'Myself and the patient… That's not good, it's not the way it should be'.
>
> (Interview, NGN 4)

The newly graduated nurses expressed how the sight of colleagues who were rushing and their wish not to burden anyone meant that they sometimes forced themselves into actions they were unsure of how to carry out by themselves. Despite being promised mentoring and individual training and introduction in the unit, the newly graduated nurses sometimes experienced that their colleagues were unable to provide support, even if they plucked up the courage to ask for their help:

> The patient's peripheral venous catheter has gone sub. The nurse says she's not sure about inserting a new one. She considers trying it out by herself, as she finds it difficult to ask for assistance again. She already asked one of her colleagues two hours ago. The nurse ends up asking a second colleague if she can help, but she is busy as the condition of one of her patients has deteriorated, so it can only be done later. The nurse exhibits an apathetic and despairing expression
>
> (Fieldnotes, NGN 8)

The newly graduated nurses' own behaviour and/or that of their colleagues resulted in delayed direct care actions. When newly graduated nurses' needs for support were not accommodated, they appeared perplexed and could not make up their minds about what to do. Manifestations of culturally acceptable behaviour towards delayed nursing care occurred. Despite delays in care compromising the newly graduated nurses' ideals, they adapted to this accepted behaviour. A nurse said:

> Although it [the prescription] says that the medicine should be administrated at 12 o'clock. If it is not vital, I can also allow myself, like the others, to postpone it [medicine administration] and sometimes I do. But I am also afraid that if I choose to compromise my ideals, what will then happen in 5 years? The culture tries to dominate my ideals.
>
> (Interview, NGN 10)

The newly graduated nurse worried about being dominated by cultural behaviours that accepted postponing patients' needs of care.

The way staff members sometimes communicated with each other reflected conflicting attitudes and disagreements on care priorities for how and when to respond patients' care needs. As a result of this negative behaviour among staff, the newly graduated nurses became less committed (e.g. not focusing on the patient being care for) when delivering direct care. As one nurse reported:

> I get annoyed when they [the other nurses] start slandering each other. It's so exhausting to listen to. Then I feel annoyed and snappy. Not that I'm shouting at my patients, but I'm just absent-minded. I become easily irritated and then I don't want to be there'.
>
> (Interview, NGN 5)

The way colleagues interacted with each other disrupted the way newly graduated nurses interacted and engaged with patients. Electronic devices (e.g. telephone or paging receivers) and nursing students or interprofessional colleagues were observed to interrupt direct care delivery. When a nurse was interrupted whilst delivering direct care, it distracted her focus on the patient:

> 'As the nurse was about to give the patient the first spoon of hot porridge a student nurse comes in to give a message. The nurse stops the action and turns her face away from the patient and continues her conversation with the colleagues who are coordinating the rest of the morning routines. All the while, the patient falls asleep to the sight of a spoon of porridge.
>
> (Fieldnotes, NGN 9)

Disruptive behaviour among staff was often related to getting the most out of the staff resources available. In most cases, the disturbances were directed towards the planning and coordination of other tasks or because the nurse's presence was in demand elsewhere.

5 | DISCUSSION

The findings of this study demonstrate that newly graduated nurses' direct patient care delivery in acute care settings is influenced by three interconnected structures: 'Contrasting Intentions and Actions for Care Delivery', 'Organizational Constraints Block Interpersonal Aspects of Nursing Care' and 'Newly Graduated Nurses' Suppressed Need for Support Constitutes Delay in Care Actions'. The structures generated from field observations and interviews described how newly graduated nurses were confronted by a paradox of being committed to care whilst simultaneously providing compromised care.

When talking about delivering care for their patients, newly graduated nurses demonstrated shared professional nursing values that placed the interests of the patient at the centre. However, when it came to enacting their beliefs and values in practice, a dissonance between thoughts and actions arose. The newly graduated nurses used their professional beliefs and values to articulate their motivation and commitment as a caregiver. This finding contradicts those of Kosmidis et al. (2021) who in a recent review found that nurses have low knowledge and awareness of their professional values. The origins of newly graduated nurses' beliefs and values were difficult to determine in the present study. On the one hand, the nurses appeared to rely on their knowledge of theoretical and conceptual frameworks introduced during their nursing education. On the other hand, the newly graduated nurses talked of a '*we*' when addressing the values of nursing care delivery in the unit. Hence, newly graduated nurses' beliefs and values stemmed from the model of care within their unit or from the nursing theories taught in the undergraduate curriculum, or a combination of both. Awareness of professional values might reinforce newly graduated nurses' professional identity and performance (Poorchangizi et al., 2019). However, this study indicated that although newly graduated nurses had strong values, they also articulated limited competence to translate these values into care actions to ensure high-quality care. This was because the context of care delivery dominated and blurred their commitment. This conflict has been described elsewhere as conferring a risk for moral injury (Rowlands, 2021).

In this study, the newly graduated nurses experienced a theory-practice gap when delivering patient care. It is expected that newly graduated nurses have sufficient knowledge of the nature and ethics of the profession to independently ensure the quality of nursing care and assess it (European Federation of Nurses Associations, 2015). The gap between knowledge and practice has been a metaphor used within nursing research for many years and has often been identified as a trigger for newly graduated nurses' challenging transition into clinical practice (Lee & Sim, 2019). In this study, newly graduated nurses found themselves in situations where they were not able to connect their commitment to care to their practice and therefore risked compromising aspects of patient care (e.g. interpersonal care) because they had not been prepared for the organizational priorities to dominate their ideals. The inability to connect theoretical knowledge to clinical practice and the subsequent impact on patient care has been reported elsewhere (Ocloo et al., 2021). The present study showed that the newly graduated nurses' commitment to care was a significant component of how they reasoned their delegation and prioritization of patient care. They prioritized physical care but were aware they should be providing interpersonal care. However, newly graduated nurses' prioritization of care that led to nurturing of the nurse–patient relationship explained their reluctance to delegate tasks to colleagues. The fact that the participants in this study did not want to delegate care and that they prioritize the relationship (at least internally anyway but not in terms of their actions) was not addressed in a recent review on deficient clinical leadership skills by Guibert-Lacasa and Vázquez-Calatayud (2022). The novel nature of this finding was linked to participants' beliefs and values of person-centred practice.

In the present study, the newly graduated nurses talked about how the care context influenced their relationships with patients and how they integrated patients' physical, psychosocial and relational needs in their care delivery. This attests to the fact that newly graduated nurses, when discussing direct care, emphasized the complexity of care by addressing the nurse–patient relationship, integrating patients' needs into care actions and considering the context of care. This tripartite approach is in alignment with the dimensions of the Fundamentals of Care framework (Feo et al., 2017). The fact that newly graduated nurses emphasized the complexity of care was an unexpected finding as recent reviews have found that newly graduated nurses had communicative knowledge deficits (Elias & Day, 2020) and felt inadequate to assess patient information/knowledge (Kaldal et al., 2022).

This study found that newly graduated nurses often worked alone and were not asked reflective questions by their colleagues. However, when prompted by the researcher (i.e. during the participant observation or under the interview), they were able to demonstrate their ability to recognize the disconnect between their theoretical training and their practice. Despite being offered a local nursing development program, the newly graduated nurses experienced insufficient transition support, and their needs were not adequately met. The reason for this could be attributed to the absence of accreditation programs for practice transitions that establish a consistent national standard for development programs that facilitate the transition of registered nurses into clinical practice, which are available in other countries. (American Nurses Credentialing Center, 2020; Australian Nursing and Midwifery Accreditation Council, 2019). Unmet need of support has been addressed by other studies that highlight that hospital settings do not readily support newly graduated nurses' critical reflection (Voldbjerg et al., 2017; Willman et al., 2020). Additionally, nurses in this study showed a reluctance towards asking for support and guidance themselves. This has also been reported elsewhere (Voldbjerg et al., 2017). A study by Shin et al. (2022) reported that developing critical reflection competency promoted nurses' professionalism and individual growth, whilst Kuennen (2015) argued that it is an effective tool to develop and understand clinical practice. Furthermore, nurses' ability to critically reflect has a positive effect on patient care outcomes (Pangh et al., 2019). Newly graduated nurses should critically reflect with nurse colleagues, mentors and nurse leaders so that they (the newly graduated nurses) can develop clinical judgement and ultimately make better clinical decisions. Newly graduated nurses' translation of professional beliefs and nursing values into practice are contingent on a supportive environment and culture to facilitate the conscious process of critical reflections.

In this study, newly graduated nurses focused on task-oriented care. A study by Sharp et al. (2018) highlighted that task-focused ways of working are dominant in workplace cultures where the emphasis is on efficiency. The nurses in our study discussed how their practice could function differently, potentially improving the patient experience. However, they expressed a sense of resignation, acknowledging that the context of care, including policy and system-level factors, influenced their practice. They reported that inadequate support was hindering them and their ability to deliver care and that newly graduated nurses support needs were not being adequately addressed. Our study found that the number of interruptions in direct care encounters was more frequent when there was an overload of patients and therefore was related to the efficient use of the unit's available resources. Moreover, newly graduated nurses worried about adopting cultural behaviours that accepted the postponement of patients' care needs. This left them with feelings of uncertainty and confusion, as their ideals of nursing care did not fit into the clinical context. This indicated a distinctive need for ways of handling emotional distress. Critical reflection is also important for helping nurses cope with negative emotions (Pangh et al., 2019). The nurses in this study often experienced emotional distress. Thus, there is untapped potential in providing support that combines coping strategies for emotional distress with critical reflection.

This study confirms that, when their professional beliefs and nursing values conflicted with clinical practice, newly graduated nurses experience a lack of competency in transforming choices in relation to care delivery into care actions. This has become a vicious cycle; organizational constraints blur nurses' commitment to care, leading to missed nursing care and a disregard for professional beliefs and nursing values. Supported critical reflections are a possible

way out of the spiral that constitutes the paradox of being committed to care whilst providing compromised care among newly graduated nurses.

5.1 | Study limitations

This focused ethnography was confined to 5 units in a Danish university hospital and might therefore not be generalizable; however, the findings were contextualized and mainly consistent with other international studies. This study reported on how factors emerging in the clinical context influenced newly graduated nurses' delivery of care. Participants in this study were volunteers therefore not necessarily mirroring the experiences of all newly graduated nurses. However, the median age was representative of graduates in Denmark. Access to the field and participants was negotiated in advance. Recruitment was facilitated by the clinical nurse managers in the unit, and the degree of volunteer participation might have been influenced by a desire to fulfil obligations and the power structure between a leader and employee. However, voluntariness was essential to ensure good ethical practice and fundamental to gaining trust and 'getting the foot in the door' (Higginbottom et al., 2013). The first author's background in nursing as a clinician and educator provided insight into the field. However, it is possible that the researcher's known background as a nurse educator might have facilitated participant answers consistent with the undergraduate Bachelor of Nursing program curriculum such as a focus on person-centred care. To address the potential limitation of participants answering in ways consistent with the nursing curriculum, data source triangulation was used to obtain multiple perspectives and validate the data (Bazeley, 2020). No pilot test was performed before field observations and interviews, but the in-field analysis ensured the observations and interviews informed each other and allowed the researcher to increase her focus during the data collection process.

6 | CONCLUSION

Understanding what factors influence newly graduated nurses' direct care delivery is important for supporting newly graduated nurses' transition to practice and ultimately the delivery of patient care. This study found that newly graduated nurses are committed to care whilst experiencing that they provide compromised care. The paradox between a commitment to care and compromised care delivery was borne out of tensions between newly graduated nurses' professional beliefs and nursing values, a desire to integrate patients' needs and preferences, and organizational constraints on everyday practices where newly graduated nurses often worked alone. The findings demonstrate that newly graduated nurses intended to provide safe nursing care for their patients but the barriers that organizations place on newly graduated nurses' behaviours redirected their behaviours away from their ideal. These findings point to that newly graduated nurses not being work ready as they had a hard time translating beliefs to practice but also add nuances in the current discourse in nursing practice, about newly graduated nurses' lack of work readiness by highlighting an outstanding commitment to care and distinctive values—a virtuous principle to promote direct care delivery. An awareness of the contrasts between the actions and intentions of direct patient care can support newly graduated nurses to approach their direct patient care more consciously and critically. An expanded way of thinking about newly graduated nurses' direct care delivery should include improving the support they receive in critical reflection of their everyday practice. By establishing a culture where critical reflection is embedded and asking questions is a welcomed part of care delivery, the context of care delivery might change from being unsupportive to supportive.

7 | RELEVANCE TO CLINICAL PRACTICE

The findings from this study were generated from the everyday practice of newly graduated nurses and illuminated a range of interrelated factors that impact their care delivery. The findings suggest that there are key actions to be taken in relation to supporting newly graduated nurses' direct care delivery. Newly graduated nurses seem to possess adequate knowledge of the nature and ethics of the nursing profession upon graduation. However, they report delivering compromised patient care, indicating a lack of competency in independently ensuring quality nursing care. It is a shared responsibility between clinical practice and education to further develop meaningful ways to support newly graduated nurses' transition into clinical practice and minimize experiences of a theory-practice gap when delivering direct patient care. Direct care delivery might be promoted through a focus on continuous and supported critical reflections to illustrate potential risks of delayed or missed nursing care. Similarly, establishing onboarding programs and other support activities for newly graduated nurses to address contrasts between intentions and care actions and organizational constraints are essential. Policy decision makers in Denmark should consider the need for developing a national accredited transition program to ensure equal support for newly graduated nurses regardless of their place of employment. Nurse managers, mentors and experienced colleagues might consider how newly graduated nurses' critical reflection competency is supported to address value inconsistencies, emotional distress and interprofessional conflicts to ensure high-quality patient care.

CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

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

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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