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Research Paper

Newly qualified intensive care nurses' lived experiences of being a shift leader in a private healthcare institution in Gauteng, South Africa

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ABSTRACT

Objective: Newly qualified intensive care nurses (NQICNs) are expected to execute the shift-leading role immediately after graduation. Critical reasoning, problem-solving, decision-making, and evidence-based clinical judgment are thus essential skills for intensive care nursing graduates. This study aimed to explore and describe NQICNs' lived experiences of being shift leaders.

Methods: This descriptive qualitative study was based on the data collected through semi-structured individual interviews. Five NQICNs in five hospitals from one region in Gauteng, South Africa, were interviewed between September and December 2019. NQICNs working as shift leaders for 10 to 12 months after intensive care training were eligible for inclusion in the study. Data were analyzed using the four steps suggested by Giorgi.

Results: The results revealed three themes and seven sub-themes. NQICNs suffered greatly intrapersonally (NQICNs reported intrapersonal suffering, manifesting as pre-shift anxiety, severe work stress, and post-shift exhaustion; NQICNs employed coping mechanisms and either fought, fled, or froze during conflict or crises; NQICNs lack of shift-leading experience did not match their heavy load of responsibilities and accountability); the NQICNs interpersonally matured and empowered themselves (NQICNs experienced support and challenges on an interpersonal level; NQICNs improved their interpersonal relationships and felt proud of and empowered by their professional growth); NQICNs highlighted various requirements to help them manage the high demands of leading shifts (others should fulfill certain needs to enable NQICNs to handle the shift-leading role; self-awareness as a need to enable NQICNs to embrace the shift-leading role).

Conclusion: A greater understanding of NQICNs and their unmet needs will enable nurse managers, educators, and nurses to better support NQICNs' evolution from novice to competent shift leaders.

What is known?

- Newly qualified intensive care nurses (NQICNs) need to be adequately prepared to immediately execute the shift-leading role after qualifying.

What is new?

- The study affirms that NQICNs need more time to be ready to execute shift-leading roles.
- The NQICNs identified various needs that should be addressed to ease their transition to shift-leading roles.

1. Introduction

Critical care is a multidisciplinary and inter-professional speciality dedicated to comprehensively managing patients with or at risk of developing acute organ dysfunction [1]. The diverse, highly skilled multidisciplinary team needs to work in synergy to ensure quality patient outcomes [2], and qualified intensive care nurses take turns leading shifts.

Different terms are used globally in referring to the nurse team leader (shift leader) in the intensive care unit (ICU) for a specific shift. However, the role characteristics and primary responsibilities share major similarities; it is a redundant role that provides

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supervision and leadership for a particular shift. The intensive care nurse team leader in South Africa is called a 'shift leader.' In the United Kingdom and other countries, these individuals are called 'clinical coordinators,' 'charge nurses,' and 'clinical leaders' [3–5].

The shift leader's primary responsibilities entail providing clinical nursing leadership, supervision, and support to teams to optimise safe standards of patient care during each shift; coordinating and supervising nurse staffing; ensuring continuity of patient care; and communicating with the multidisciplinary team to ensure effective and safe patient care is delivered promptly [3]. Ultimately, the shift leader's failure to perform their responsibilities results in poor quality at the point of care. Interpersonal skills, critical reasoning, problem-solving, decision-making, and evidence-based clinical judgment are some professional attributes essential for shift-leading effectiveness [6]. Therefore, a shift leader should ideally be a registered nurse with substantial experience and a post-basic qualification in intensive care nursing. Moreover, shift leaders are outside the organization's management hierarchical structure but provide leadership through collegial relationships, focusing on quality clinical practice [7]. Formal training or preparation needs to be provided for the shift-leading role in South African nursing.

Globally, undergraduate nursing curricula need to cover the knowledge and abilities required for intensive care nurses [6]. Thus, professional nurses need post-basic training to acquire clinical specialist skills in fields like intensive care [7]. During intensive care training, professional nurses are prepared to become intensive care nurse specialists whose primary function is clinical patient care. However, their professional role largely entails leading and managing shifts [8]. The World Health Organization (WHO) consequently recommends that all nursing programs (basic and post-basic) incorporate leadership modules [9]. Unfortunately, these curricula often focus on learning what leadership is rather than how leadership capacity can be developed [10]. Therefore, professional nurses assume the charge-nurse role (shift-leading) with limited leadership training and role clarification [4].

Upon graduation, newly qualified intensive care nurses' (NQICNs) leadership and management skills still need to be established. However, these individuals have delegated roles of significant responsibility as shift leaders at an early stage of their careers, and they have yet to have the opportunity to consolidate their new clinical knowledge with practice [11]. Scholars argue that newly qualified nurses need an opportunity to develop and refine their clinical skills; once they are competent in clinical skills, they are open to developing more complex (leadership) competencies [5,12]. It is also reported that leadership skills are acquired based on advanced education and extensive work experience [12].

There needs to be more literature exploring clinical leadership experience within ICU teams [13]. Current literature on leadership focuses on formal titled leadership, leaving a gap in our understanding of individuals' experiences in informal clinical leadership roles (shift-leading) when they provide leadership directly at the point of care [14]. Ultimately, the shortage of skilled intensive care nurse specialists is a global concern [15], resulting in the premature delegation of NQICNs to lead shifts without mentoring.

Inherent extreme stressful situations and ethical dilemmas are part of the distinctive ICU environment that the shift leader must deal with almost daily [16]. Experienced intensive care nurse specialists view the shift-leading role as demanding since they must make prompt and sound decisions in a chaotic environment [5]. Moreover, the shift leader can ultimately advance the intensive care team's cohesion or have the opposite effect. When the shift leader is unsure of their decision-making, the entire nursing team becomes uncertain, threatening patients' safety and quality of care [17]. While on duty, the shift leader is held accountable and responsible for their actions and those of their team. This can be overwhelming for the NQICN, who still needs mentoring to adjust to their new role of authority and great responsibility. Hence, this study aimed to understand NQICNs' experiences as shift leaders in a Gauteng private healthcare institution. The researcher thus posed the question: What are NQICNs' experiences of the shift-leading role?

2. Methods

2.1. Study design and participants

A descriptive qualitative study was conducted to gain insight into NQICNs' experiences as shift leaders. This study was reported following the Consolidated Criteria for Reporting Qualitative Studies (COREQ). A private healthcare institution consisting of 15 hospitals in one region was approached for data collection; five hospitals permitted data collection for the study. The selected healthcare institution is among the triad of major private conglomerates in South Africa, providing quality healthcare services to consumers with medical aid coverage and those who can afford to pay for services. These units under study admit patients of various disciplines, including cardiac, cardio thorax, neuro, surgical, trauma, and medical. Thus, the study was conducted in a natural, unmanipulated setting.

This study was conducted during a significant era in nursing education, marked by a transition from the R212 curriculum for post-basic critical care nursing to the R635 curriculum for a post-graduate diploma in critical care. The transition resulted in a discernible reduction in the number of NQICNs, with a corresponding impact on the overall pool of eligible study participants. Purposive sampling was thus used to deliberately select informative participants about the research phenomenon. NQICNs working as shift leaders for 10 to 12 months after intensive care training were eligible for inclusion in the study. Within the five hospitals that agreed to be part of the study, eight nurses qualified as intensive care nurses in December 2018, and they met the inclusion criteria to be part of the study. When data collection commenced in September 2019, three of the nurses had already resigned. Thus, five newly qualified nurses met the principal researcher's inclusion criteria.

2.2. Recruitment and enrolment

The author initiated recruitment by emailing invitation letters to prospective participants with a thorough explanation of the study's purpose. In collaboration with a senior intensive care registered nurse with a master's degree who worked at the data collection site, a meeting was arranged with interested participants. The first participant met the author on the interview day and received a verbal explanation of the study's goal and the data collection procedure. Subsequent participants met with the author days before their interview and were informed of the purpose of the study and the procedure.

2.3. Ethical consideration

Permission for the study was obtained from the Academics Ethics Committee (REC-01-101-2018), the Higher Degrees Committee (HDC-01-69-2018), and the private institution in Gauteng where the study was conducted (UNIV-2018-0051). The researcher adhered to the following ethical principles throughout the study: respect for autonomy, beneficence, non-maleficence, and justice. Participants received information letters that emphasized the study's aims, objectives, and potential risks. Furthermore,

participants exercised their self-determination and autonomy, gave voluntary written consent before data collection, and agreed to be audio recorded. Once the interviews commenced, participants were assured their participation was voluntary and they had a right to withdraw at any time.

2.4. Data collection

Data were primarily collected through individual phenomenological interviews using a broad, open-ended question: "How is it for you to be a shift leader?" This question initiated a dialogue that incited NQICNs to narrate, in their own words, how they experienced the shift-leading role. All interview questions were open-ended and non-leading to allow participants to express their experiences freely after establishing rapport. All interviews were recorded using an audio recorder to preserve each participant's responses. Participants felt comfortable talking about their experiences, and each interview session lasted approximately 45 min.

A research specialist with a doctorate and the principal researcher's co-supervisor were present during the first interview. The interview was regarded as a pilot interview to determine the central question's effectiveness in producing the required data to answer the research question. After conducting the pilot interview, it was determined that the research question was effective, and no changes were necessary. Data from the pilot interview were valuable and formed part of the data analyzed for the main study. Participant recruitment and interviews thus continued; by the fourth unstructured individual phenomenological interview, no new themes emerged, and data saturation was reached, as agreed with the supervisors and independent coder. The researcher conducted a fifth interview to confirm no additional themes would emerge. The independent coder also confirmed data saturation with the fifth interview. Data were collected from September 2019 to December 2019, which allowed the researcher prolonged engagement in the field.

2.5. Data analysis

The researcher followed Giorgi's [18] data analysis stages in this study. Transcribed interviews and field notes were analyzed as the research data. Consequently, following each interview, the researcher listened to the audio recordings and transcribed the data word-for-word. The researcher's immersion in the data was achieved by spending a significant amount of time reading and contemplating the data and repeatedly analyzing transcripts and field notes to extract meaning from the data. Three columns were used to tabulate the transcripts. On the left was a column indicating whether the data came from the researcher or the participant; the middle column included participant data and the column on the right contained codes. In the middle column, the information was color-coded: direct quotes from participant interviews were in black, the researcher's field observations were in green, and the researcher's sentiments and opinions were in yellow. To gain a comprehensive understanding, the researcher read the transcripts multiple times (an average of three). The raw participant data (written in the right-hand column) were categorized to detect noteworthy trends throughout all interviews and derive meaning. Negative experience codes were grouped and named, positive experience codes were grouped and named, and relationships and development needs codes were also grouped and named. In April 2020, a consensus discussion was held with the independent coder, where only linguistic and phrase issues existed in the analyzed data, and agreement was obtained on the findings.

2.6. Trustworthiness

The researcher coded and analyzed data while the research supervisors inspected the procedure. Additionally, an independent coder participated in data analysis and consensus talks to facilitate member checking. During interviews, the researcher paraphrased, clarified and summarised to validate what participants heard and observed. Multiple data sources were used, including in-depth, phenomenological, individual interviews, and field notes, resulting in data triangulation. Phenomenological reduction and bracketing were adhered to by the researcher, keeping a reflexive journal to bracket his feelings and opinions throughout the study. Rich descriptive data about the research methods, the study's setting, the sampling approach, and participant demographics contributed to the findings' transferability.

3. Results

During data collection, the study's sample comprised five female NQICNs aged between 34 and 49. Participants' intensive care experience before acquiring a post-basic critical care qualification ranged from two to five years. Participants had less than a year's experience working as a shift leader in a private health institution's ICU at the time of data collection. The participants' average experience as a shift leader was 10.6 months (see Table 1).

NQICNs suffered deeply at an intrapersonal level when they were prematurely forced to shoulder heavy responsibilities and take accountability for all staff and patients with complex needs. At an interpersonal level, they experienced professional growth and development through heuristic learning while facing multifaceted challenges with other role players in the unit. They identified various needs that should be addressed to cope with the high demands placed on them when they are expected to lead shifts.

3.1. NQICNs suffered greatly intrapersonally

NQICNs endured intense intrapersonal suffering due to multifaceted factors, including undefined shift-leading responsibilities and unpreparedness for the role. NQICNs reported overwhelming anxiety, work stress, and exhaustion before, during, and after the shift.

3.1.1. NQICNs reported intrapersonal suffering, manifesting as pre-shift anxiety, severe work stress, and post-shift exhaustion

Pre-shift anxiety arose when NQICNs recognized they were the only ICU-trained individuals on shift, coupled with unhelpful staff. Participant 4 asked, *"… how do they expect us to work in this kind of situation … ?"* referring to poor staffing norms and no mentoring. Reflecting on leading a resuscitation, Participant 2 shared: "… *once you are done with the situation, you sit down, then anxiety comes back again, then you start trembling, and you start sweating."* After leading a shift and facing a lack of teamwork, Participant 5 said: *"… as you get home, the first thing you want is to bath and crawl into bed."*

3.1.2. NQICNs employed coping mechanisms and either fought, fled, or froze during conflict or crises

NQICNs shared that they resorted to various coping mechanisms to get through the working day, especially when confronted with challenges that exceeded their adaptive abilities. A description follows of the coping mechanisms NQICNs adopted in situations they encountered in their transition to the shift-leading role.

NQICNs offered a variety of responses to share their coping mechanisms. In full-capacity units, bed negotiation disputes typically culminated with physicians swearing at shift leaders. Participant 2 responded, *"I swear back*." When overseeing nurses who

Table 1
Summary of participants' demographic data.

Participant	Gender	Age (years)	Nursing qualifications & year obtained	Experience as a shift leader (months)
Participant 1	Female	49	• Diploma in Medical & Surgical Critical Care Nursing – Adult (General) (2018) • Elementary Critical Care Nursing in-service certificate (2016) • Diploma in General, Psychiatric and Community Nursing & Midwifery (2003)	10
Participant 2	Female	34	• Diploma in Medical & Surgical Critical Care Nursing – Adult (General) (2018) • Elementary Critical Care Nursing in-service certificate (2016) • Diploma in General, Psychiatric and Community Nursing & Midwifery (2011)	10
Participant 3	Female	36	• Diploma in Medical & Surgical Critical Care Nursing – Adult (General) (2018) • Elementary Critical Care Nursing in-service certificate (2016) • Diploma in General Nursing (2013)	11
Participant 4	Female	37	• Diploma in Medical & Surgical Critical Care Nursing – Adult (General) (2018) • Diploma in General Nursing (2013) • Elementary Critical Care Nursing in-service certificate (2010)	11
Participant 5	Female	49	• Diploma in Medical & Surgical Critical Care Nursing – Adult (General) (2018) • Elementary Critical Care Nursing in-service certificate (2016) • Diploma in General Nursing (2010)	11

resist NQICNs' delegation as shift leaders, NQICNs often resort to avoidance: *"I get away and do the task myself."* (Participant 3). NQICNs also experienced turmoil when they were required to telephonically report a deteriorating patient to a rude surgeon. Participant 5 mentioned: "… *he's just something else because before you even call him, you have to go to the phone and turn around, and say, okay, God can't I phone somebody else instead of him*."

3.1.3. NQICNs' lack of shift-leading experience did not match their heavy load of responsibilities and accountability

NQICNs undertook shift-leading roles immediately after completing their critical care training. They discovered that the responsibility and accountability of the shift-leading role are heavy, particularly if one has no solid basic leadership experience. Participants also realized that the accountability of caring for one patient differs immensely from the responsibility and accountability of leading a shift.

NQICNs acknowledged lacking experience in critical care shift-leading, saying: *"I might be older, but my critical care hasn't been for long"* (Participant 1), suggesting not feeling prepared and ready for the role. NQICNs mentioned that they accepted the shift-leading role as a gesture of solidarity in light of the shortage of qualified nurses available to lead shifts: "*… but you eventually get forced into doing it because you now qualified.*" (Participant 1). However, being liable for the entire team was a stressor for NQICNs: "… *you are accountable for somebody's responsibility.*" (Participant 3).

3.2. The NQICNs interpersonally matured and empowered themselves

Participants explained challenging moments and often being left alone, with limited supportive encounters. However, the participants also acknowledged the professional growth and development they attained by commencing the shift-leading role. The credit for their growth primarily goes to the participants, who obtained it through heuristic techniques and adapting when thrown into the deep end. Furthermore, key role players in the intensive care team and nursing management were credited for the participants' professional growth and development.

3.2.1. NQICNs experienced support and challenges on an interpersonal level

Support: At the start of each interview, participants indicated they had complete support from all key role players in their ICU team. Participant 4 shared, *"You always got a senior, you can always run to, even with doctors you can grab even if it's not their patients; you do get* support." Participant 2 reiterated: *"What helps is the kind of doctors that we work with; these never a stupid question, anytime it's a learning time*." Moreover, immediate unit managers were applauded for being supportive: "… *she is supportive."* (Participant 5).

Non-support and challenges: However, as the interviews progressed and participants became comfortable relating their experiences, they verbalized a lack of support from key ICU team members and interpersonal challenges. Thus, the interpersonal relationship between NQICNs and ICU team role players can be described as a double-edged sword of negative and positive experiences.

The following participants' quotes illustrate non-support and interpersonal challenges: *"Doctors are disrespectful and intimidate nurses."* (Participant 1). *"Some doctors, the moment you phone them, they start screaming … what the (and utter the F word) … sorry," (loudly imitating the doctor displaying angry facial gestures)* (Participant 3). Participants also described interpersonal relations among the nursing team as non-caring, illustrated as follows: "… *if you have not got compassion for your colleague, how can you have compassion for the patient?*" *(sounds shocked and surprised)* (Participant 1). Participant 5 also reiterated: "… *they just don't care. It's frustrating."* Moreover, NQICNs perceived the nursing staff as lacking professional cohesion: "… *there are very few people that get on with one another.*" (Participant 1).

Furthermore, interpersonal relationships with senior nursing and general hospital management were non-existent: *"… they always like on a shady area, the only time you will see them should there be a crisis, should there be a complaint, you would know that there are people called management."* (Participant 2). NQICNs related loneliness while being overwhelmed by their workload and needing support. Participant 1 stated, *"… we are being thrown in the deep."*

3.2.2. NQICNs improved their interpersonal relationships and felt proud of and empowered by their professional growth

NQICNs felt they had grown personally and professionally, becoming stronger and more confident. Overcoming problems during shifts, such as interpersonal conflicts and staffing crises, boosted their confidence. Participant 2 stated: *"… overcome crisis … it builds your confidence."* Participant 3 attested: *"I think I developed that confidence; I have grown … I have survived this place. I think I can survive anywhere."* Participant 4 also said: *"I can talk to the doctor without doubting myself."*

3.3. NQICNs highlighted various requirements to help them manage the high demands of leading shifts

During the interviews, NQICNs identified and described the

challenges they faced as they transcended to the shift-leading role. The key challenge participants identified reflected their support needs to ease the negative transitions they endured. The descriptions provided by participants also illuminate the support needs reflected in existing literature, which recommends transition support for graduates assuming leadership roles. The key role players in the ICU multidisciplinary team and management are outside sources of support. The NQICNs' intrinsic motivation is also paramount in acquiring the skills associated with the shift-leading role.

3.3.1. Others should fulfill certain needs to enable NQICNs to handle the shift-leading role

Participants agreed they depend on support from the multidisciplinary team and nursing or hospital management to execute the shift-leading role effectively. Some of the participants of the need identified for each key multidisciplinary team member in the ICU to facilitate participants' smooth transition to the shift-leading role follow:

Nursing and general management: Human resource management must clearly define NQICNs' shift-leading duties since they require an explicit understanding of their expectations as they assume the role. Participant 3 explained: "*When you know what is expected of us, it will lessen the burden because you know I'm supposed to do this ABCD these clearly defined*." NQICNs require visibility from management, encouragement, and recognition for the work they are doing, as expressed by Participant 2: "*… even if they are fooling you but the fact that they are coming in acknowledging and appreciating the things that you did*."

Doctors: The NQICNs require that doctors address them professionally, using appropriate language and refraining from insults. This view was highlighted by Participant 2, stating: "*… to show that I don't like you swearing, talk to me like I am a person.*" Doctors should avoid pressuring NQICNs because this leads to a toxic workplace atmosphere, and the nurses feel they have to prove themselves to earn doctors' acceptance as they assume shift-leading rather than being supported.

Nursing team: NQICNs need their staff to participate in decision-making, as reflected in Participant 1 quote: "*… so I said to her we make decisions together; we want you to participate as well.*" Participant 2 similarly emphasized the need to rely on their staff: "*… best thing one can do is to have a good* support *structure from the team.*" NQICNs need staff to be proactive and critically think for themselves, and not only be dependent on the shift leader, as the needs and nature of critical care require prompt actions to save lives. In support, the senior intensive care staff should support NQICNs as they commence the shift-leading role. Participant 3 stated: *"Senior staff should be there to help."*

3.3.2. Self-awareness as a need to enable NQICNs to embrace the shift-leading role

Towards self*:* NQICNs were aware of the need to work on intrinsic self-motivation to be effective in executing the shift-leading role, as reflected in Participant 1 verbatim quote: *"I feel that you need a lot of courage, strength, and motivation to take the role."* Also, NQICNs acknowledged that commencing the shift-leading role is more beneficial than waiting to be perfect. Participant 3 said: "*… when you are waiting to be perfect, you will never get there. You must start and learn … I realized that when I started, I learned more than when I was just nursing.* "

The NQICNs recommended being given at least a year to consolidate their theoretical knowledge with practice and, during this period, to be joined up with a skilled shift leader before undertaking the shift-leading role independently. Participant 4 said: "*… it came early. It was prematurely for me at least a year nursing the patient, then after a year, I can run the shift because I got exposure.* "

Moreover, unconditional care among nurses is crucial in creating positive practice environments. According to Participant 1: "*… one can see compassion and care in the eyes of the nurse. It would make such a big difference if every nurse is like that; we need to work together, and shift leaders need to set an example.* "

4. Discussion

NQICNs endured intrapersonal suffering, hindering their intrapersonal skills of independence, adaptability, assertiveness, responsibility and trustworthiness, courage, problem-solving, critical analytic thinking, decision-making, crisis management, innovative thinking, and improvisation [19]. These intrapersonal skills guide nurses' rational thought and decision-making [19,20]. Therefore, intrapersonal suffering from overwhelming stress can impair NQICNs' cognitive functioning, posing risks to the quality of care and patient safety. Overwhelming stress during shifts is cited as a hindrance to professional effectiveness as it impairs attention and concentration, consequently impeding the development of interpersonal relationships among multidisciplinary team members, with detrimental effects for both NQICNs and patients [21].

Leadership competency gaps are suspected to result from knowledge and skill deficits or an inability to apply what was taught because nursing curricula (theoretically) have leadership modules [23]. However, the standard for educating and preparing nurses is insufficient in preparing new graduates for essential leadership roles [23]. Real day-to-day contextual and work challenges require all levels of nurses to be prepared and equipped with clinical leadership skills at the point of care [24]. NQICNs felt overwhelmed and inadequately prepared to take the team-leader role. Moreover, a lack of explicit role expectations caused confusion and ambiguity among nurses assuming clinical leadership roles [23]. Postgraduate critical care students identified ambiguous role expectations as a cause of overwhelming stress and anxiety in various clinical learning environments [25].

Coping is accepted as a vital part of survival, particularly in the fast-paced healthcare environment. Coping mechanisms denote specific behavioral and psychological efforts people employ to master, tolerate, reduce, or minimize stressful events [22]. The coping mechanisms applied can either be effective or ineffective [26]. Effective coping mechanisms (adaptive) yield positive outcomes, such as professional growth and development [22]. However, ineffective coping mechanisms (maladaptive) yield negative outcomes, hindering professional growth and development [22]. Newly qualified nurses frequently use avoidance as a conflict resolution or coping mechanism [27], with positive or negative consequences. Avoidance can be beneficial when the situation requires cooling off, but it can lead to unresolved fights, brewing worse conflicts [22,27]. Avoidance and an inability to confront others' substandard performance and negligence (opting to compensate by correcting others' negligence) threaten quality care and reveal ineffective leadership competency.

Participants' lack exposure to complex clinical situations during training resulted in increased self-doubt and a lack of confidence post-graduation [28]. New graduate nurses articulated their inexperience in clinical specialist skills and confidence to deal with new responsibilities like team leadership [29]. Further, stress was exacerbated as new graduates realized the responsibilities for the role were far more complex and with greater consequences than they understood [29]. Recognizing that strong clinical skills do not equate to strong leadership skills, the lack of training and orientation for leadership roles increased stress, frustration, failure, and, ultimately, burnout [30].

NQICNs' transition from sole direct patient care to supervisory

and leadership roles comes with heightened responsibilities [31]. ICU shift leaders are responsible for coordinating, planning, and assessing the unit's daily activities, and they typically make these managerial and leadership decisions [30,32]. The ICU shift leader's decision-making is complex and overlapping, as it entails organizational issues like patient assignments, the availability, and capacity of the nurses, timing treatments, and ensuring continuity of care from shift to shift [2,30].

Moreover, physician impoliteness may hinder interpersonal relationships between nurses and doctors, and collaboration is essential to ensure patients' needs are met [33]. Negative behaviors, such as ignoring, yelling, and sarcasm, are disruptive [34]. In addition, doctors' negative attitudes form a barrier and promote continued negative attitudes, such as nurses' ambivalence towards the doctor, making nurses hesitant to seek assistance in the future, thereby delaying the continuity of care. Therefore, poor nurse-doctor relationships lead to a loss of professional dignity, increased nurse turnover, and poor-quality care [17]. Shouting and swearing are common forms of verbal abuse used by doctors, especially when high tension levels, resulting in lower self-esteem and psychological disturbance for victims [35].

Furthermore, nurses experienced being overlooked and excluded by doctors, and negative body language was one of the most harmful forms of non-verbal abuse [36]. Some doctors abuse their power and authority when they do not agree with nurses as they advocate for patients. Also, reporting such incidences generally results in management siding with the doctor.

The value of support from a qualified nurse preceptor and experienced nurses is vital for successful transitions to the shift-leading role [37]. In many South African ICUs, supervision and support are lacking due to the shortage of intensive care qualified nurses [16]. Research has found that NQICNs were deprived of supervision and mentorship for their new professional role [25]. Orientation and mentorship for this role (ICU-qualified) are either too short or not offered to new graduates entering the fast-paced environment. The NQICNs also endured uncaring interprofessional relations, belittled, humiliated, and isolated by some senior staff members [25]. Despite evidence that peer-to-peer interpersonal relations among ICU nurses are imperative for good workplace relationships as they impact nurses' central purpose of delivering quality patient care [38]. Competent ICU nurses are ultimately not created in silos without support, and good team, collaboration, and socialization in the ICU nursing team are vital in nurses' transition [28].

The presence and guidance of effective nurse preceptors reduce new graduate nurses' anxiety in clinical practice [39]. Caring and supportive relationships, where ICU nurses feel safe and cared for by nurse managers and nursing colleagues, accelerate professional development [13]. Leadership support is thus essential for nurses' evolution from novice ICU nurses to competent practitioners [13], yet some nursing service managers are unapproachable and unsupportive. ICU nurses appreciate nursing management's visibility and presence in clinical settings as it assures them of management's commitment and support for the team's efforts [38].

Newly qualified nurses often cross-examine their practice through critical thinking and reflection. They observe trends and patterns by anticipating appropriate actions for a situation [40]. Subsequently, they start trusting their instincts, and their confidence grows in advocating for patients and practice. Therefore, confidence cannot be taught but is built in real-life situations. Practice environments, characterized by healthy professional interpersonal relationships, support from clinical supervisors and constructive feedback, transform new graduates' self-doubt, and they become confident critical care nurses.

In the Australian critical care context, NQICNs are only sometimes expected to perform leadership roles, such as team leader or resource person; they gain knowledge in performing these roles under supervision since they are in the early novice to expert continuum [41]. Respect and integrity underpin the professional nature of desired interpersonal relationships among ICU nurses, their management, and practice doctors. An awareness of and understanding of newly qualified nurses' experiences and their unmet needs will thus enable nurse managers, educators, and nurses to support this population better [14,15,41]. Ultimately, self-care remains a fundamental need for those who care for others.

5. Implication for clinical practice

The lack of support for NQICNs significantly impacts their ability to transition into clinical leadership roles. Clinical leadership abilities often take longer to develop than they should because nurses lack the mentoring and coaching they need to become effective leaders. Lowered levels of work satisfaction are associated with increased rates of burnout and staff turnover among NQICNs who report feeling unsupported or devalued in their positions. Substandard quality care ensues due to nurses' lack of experience in making important clinical leadership decisions. Miscommunication between healthcare team members, for example, is one medical mistake that may occur when there is a lack of clinical leadership to coordinate care. Patient safety might be jeopardized, and the likelihood of adverse events can increase due to these mistakes. In conclusion, work satisfaction, quality of care, and patient safety may suffer when newly qualified critical care nurses lack guidance when entering clinical leadership positions. Therefore, it is crucial to provide new graduate nurses with advice and support when they assume clinical leadership positions so they can fulfill their responsibilities and continue to deliver excellent care to their patients.

6. Implication for nursing research

The empirical data support that mentorship, which involves guidance and support by experienced, qualified nurses, can significantly enhance clinical leadership competencies among newly qualified nurses. This, in turn, can lead to improved patient outcomes and increased job satisfaction. The study's findings suggest that NQICNs who assume the role of shift leaders undergo considerable internal turmoil, compounded by a lack of support and care among nurses. Therefore, an exploration of the fundamental factors contributing to inadequate readiness for clinical leadership roles following post-basic nursing education was warranted. Moreover, it was required to explore the fundamental determinants that give rise to the phenomenon of a lack of care and compassion among nurses in the ICU toward their peers. In the South African context, it is imperative to establish and execute meticulously designed support initiatives for NQICNs. Additionally, researchers should explore nurse managers' role in advancing mentoring and cultivating leadership development programs within the ICU context. Finally, researchers must devise effective strategies to expedite the development of shift-leading skills among NQICNs after formal studies, as leadership abilities are typically honed gradually over time.

7. Limitations

This study's sample only consisted of female participants, thus not representing all genders and limiting the researcher's ability to conclude how newly qualified male ICU nurses experience the shift-leading role. There is also limited literature exploring informal leadership roles in acute care settings. Further research should select large sample to guarantee a better representation.

8. Conclusion

The study revealed NQICNs are not ready to assume shift-leading roles immediately post-graduation. Therefore, support in the form of mentorship (for 10 to 12 months after graduation) will give NQICNs time to gain self-confidence for the role. A better understanding of NQICNs' experiences and unmet needs will enable nurse managers, educators, and nurses to better support NQICNs' evolution from novice to competent shift leaders, thus maintaining quality nursing service management and care.

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Data availability statement

The datasets generated during and/or analyzed during the current study are available from the corresponding author upon reasonable request.

CRediT authorship contribution statement

Lucky Mtsoeni: Methodology, Data curation, Investigation, Validation, Writing-original draft, Writing-review and editing, Conceptualisation. **Sidwell Matlala**: Conceptualisation, Methodology, Validation, Supervision, Writing-review and editing. **Charlené Downing**: Conceptualisation, Methodology, Validation, Supervision, Writing-review and editing.

Declaration of competing interest

The author declares no conflict of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijnss.2023.06.007.

References

[1] Marshall JC, Bosco L, Adhikari NK, Connolly B, Diaz JV, Dorman T, et al. What is an intensive care unit? A report of the World Federation of Societies of Intensive and Critical Care Medicine task force. https://doi.org/10.1016/j.jcrc.2016. 07.015. [Accessed 22 October 2022].
[2] Chamberlain D, Pollock W, Fulbrook P. ACCCN workforce standards for intensive care nursing: systematic and evidence review, development, and appraisal. Aust Crit Care 2018;31:292–302. https://doi.org/10.1016/j.aucc.2017.08.007.
[3] The Faculty of Intensive Care Medicine. Version 2.1 Guidelines for providing intensive care services Edition 2. https://www.rcslt.org/wp-content/uploads/media/docs/clinical-guidance/critical-care-gpics-v2.pdf. [Accessed 22 October 2022].
[4] Currey J, Eustace P, Oldland E, Glanville D, Story I. Developing professional attributes in critical care nurses using Team-Based Learning. Nurse Educ Pract 2015;15:232–8. https://doi.org/10.1016/j.nepr.2015.01.011.
[5] Giles M, Parker V, Conway J, Mitchell R. Knowing how to get things done: nurse consultants as clinical leaders. J Clin Nurs 2018;27:1981–93. https://doi.org/10.1111/jocn.14327.
[6] World Federation of Critical Care Nurses. Position statement provision of critical care nurse education. https://wfccn.org/wp-content/uploads/2020/07/WFCCN-Education-PS_secured.pdf. [Accessed 22 October 2022].
[7] Bruce JC, Baumann J, Schmollgruber S. Does improved postgraduate capacity shift the balance of power for nurse specialists in a low-income country: a mixed methods study. J Adv Nurs 2019;75:2969–79. https://doi.org/10.1111/jan.14109.
[8] Ekström L, Idvall E. Being a team leader: newly registered nurses relate their experiences. J Nurs Manag 2015;23:75–86. https://doi.org/10.1111/jonm.12085.
[9] WHO. Nursing and midwifery in the history of the world health organization 2017. https://www.who.int/publications/i/item/nursing-and-midwifery-in-the-history-of-the-world-health-organization-(1948%E2%80%932017. [Accessed 22 October 2022].
[10] Miles JM, Scott ES. A new leadership development model for nursing education. J Prof Nurs 2019;35:5–11. https://doi.org/10.1016/j.profnurs.2018.09.009.
[11] Holmgren C, Jussèn S, Hagiwara MA, Rådestad M. Charge nurses' perceived experience in managing daily work and major incidents in emergency departments: a qualitative study. Australas Emerg Care 2022;25:296–301. https://doi.org/10.1016/j.auec.2022.02.003.
[12] Baumann A, Hunsberger M, Crea-Arsenio M, Akhtar-Danesh N. Policy to practice: investment in transitioning new graduate nurses to the workplace. J Nurs Manag 2018;26:373–81. https://doi.org/10.1111/jonm.12540.
[13] Guibert-Lacasa C, Vázquez-Calatayud M. Nurses' clinical leadership in the hospital setting: a systematic review. J Nurs Manag 2022;30:913–25. https://doi.org/10.1111/jonm.13570.
[14] Schmollgruber S. Development of competency standards to inform intensive care nursing practice. 2015. https://wiredspace.wits.ac.za/server/api/core/bitstreams/1f8ea2d5-7c35-4727-9739-37eed05b6a13/content. [Accessed 22 October 2022].
[15] Brewster DJ, Butt WW, Gordon LJ, Rees CE. Leadership in intensive care: a review 2020. Anaesth Intensive Care 2020;48(4):266–76. https://doi.org/10.1177/0310057x20937319.
[16] Magro-Morillo A, Boulayoune-Zaagougui S, Cantón-Habas V, Molina-Luque R, Hernández-Ascanio J, Ventura-Puertos PE. Emotional universe of intensive care unit nurses from Spain and the United Kingdom: a hermeneutic approach. Intensive Crit Care Nurs 2020;59:102850. https://doi.org/10.1016/j.iccn.2020.102850.
[17] Ndou H, Ramathuba DU. Ethical conflicts experienced by intensive care unit health professionals in a regional hospital, Limpopo province, South Africa. Health SA 2020;25:1–9. https://doi.org/10.4102/hsag.v25i0.1183.
[18] Scholtz S, Nel EW, Poggenpoel M, Myburgh CPH. The culture of nurses in a critical care unit. Glob Qual Nurs Res 2016;3:2333393615625996. https://doi.org/10.1177/2333393615625996.
[19] Polit DF, Beck CT. Nursing research Generating and assessing evidence for nursing practice. eleventh ed. Philadelphia: Wolters Kluwer; 2021.
[20] Rabie GH, Rabie T, Dinkelmann M. Developing a competency profile for newly graduated registered nurses in South Africa. BMC Nurs 2020;19:68. https://doi.org/10.1186/s12912-020-00453-7.
[21] Guerrero JG, Banson A, Raguini M, de Sagun R. Interpersonal and intrapersonal intelligence skills of nursing students its relevance in the goal of patient care. Int J Med Res Health Sci 2019;8(4):30–8. https://www.researchgate.net/publication/352478625_Interpersonal_and_Intrapersonal_Intelligence_Skills_of_Nursing_Students_Its_Relevance_in_the_Goal_of_Patient_Care.
[22] Vinothkumar M, Arathi A, Joseph M, Nayana P, Jishma EJ, Sahana U. Coping, perceived stress, and job satisfaction among medical interns: the mediating effect of mindfulness. Ind Psychiatr J 2017;25:195–201. https://doi.org/10.4103/ipj.ipj_98_14.
[23] Mathumo-Githendu GW. Clinical leadership competency: newly qualified nurses' understanding and needs. 2018. https://hdl.handle.net/10539/25372. [Accessed 2 February 2021].
[24] Yaghobian M, Farhan R, Navipour H, Vanaki Z. Competencies of charge nurses: a systematic review and thematic synthesis. J Pakistan Med Assoc 2020;70:1225–31. https://doi.org/10.5455/JPMA.38686.
[25] Luger SJ, Ford DJ. A pilot quality improvement project facilitating leadership skills in rural new graduate nurses. Online J Rural Nurs Health Care 2019;19:136. https://doi.org/10.14574/ojrnhc.v19i1.544.
[26] Sanjuan P, Magallares A, Ávila M, Arranz H. Effective and ineffective coping strategies psychometric properties of the reduced version of brief-COPE for patients. The European Conference on Psychology & the Behavioral Sciences. Brighton, UK: The International Academic Forum; 2016. p. 1–10. 2016, www.iafor.org.
[27] White BAA, White HD, Bledsoe C, Hendricks R, Arroliga AC. Conflict management education in the intensive care unit. Am J Crit Care 2020;29:e135–8. https://doi.org/10.4037/ajcc2020886.
[28] DeGrande H, Liu F, Greene P, Stankus J-A. The experiences of new graduate nurses hired and retained in adult intensive care units. Intensive Crit Care Nurs 2018;49:72–8. https://doi.org/10.1016/j.iccn.2018.08.005.
[29] Woo MWJ, Newman SA. The experience of transition from nursing students to newly graduated registered nurses in Singapore. Int J Nurs Sci 2020;7:81–90. https://doi.org/10.1016/j.ijnss.2019.11.002.
[30] Zafke A. A charge nurse orientation. https://commons.und.edu/cgi/viewcontent.cgi?article=1283&context=nurs-capstones. [Accessed 22 October 2022].
[31] Kusi-Appiah E, Dahlke S, Stahlke S, Hunter KF. Acute care nursing team members' perceptions of roles: their own and each other's. J Nurs Manag 2019;27:1784–90. https://doi.org/10.1111/jonm.12877.
[32] Lundgrén-Laine H, Kontio E, Perttilä J, Korvenranta H, Forsström J, Salanterä S. Managing daily intensive care activities: an observational study concerning ad

hoc decision making of charge nurses and intensivists. Crit Care 2011;15: R188. https://doi.org/10.1186/cc10341.
[33] Layne DM, Anderson E, Henderson S. Examining the presence and sources of incivility within nursing. J Nurs Manag 2019;27:1505–11. https://doi.org/10.1111/jonm.12836.
[34] Higazee M. Types and levels of conflicts experienced by nurses in the hospital settings. Health Sci J 2015;9(1):1–6. https://www.researchgate.net/publication/289521762. [Accessed 22 October 2022].
[35] Ameen F. Nurse-Physician Conflict and power dynamic. JOJ Nurse Health Care 2017;5:1–5. https://doi.org/10.19080/JOJNHC.2017.05.555665.
[36] Labrague LJ, Santos JAA. Fear of COVID-19, psychological distress, work satisfaction and turnover intention among frontline nurses. J Nurs Manag 2021;29:395–403. https://doi.org/10.1111/jonm.13168.
[37] Molala W, Downing C. Experiences of newly qualified critical care nurses caring for post-cardiothoracic surgery paediatric patients in a private hospital in Gauteng. Int J Afr Nurs Sci 2020;13:100213. https://doi.org/10.1016/j.ijans.2020.100213.
[38] Ronnie L. Intensive care nurses in South Africa: expectations and experiences in a public sector hospital. J Nurs Manag 2019;27:1431–7. https://doi.org/10.1111/jonm.12826.
[39] Powers K, Herron E, Pagel J. Nurse preceptor role in new graduate Nurses' transition to practice. Dimens Crit Care Nurs 2019;38:131–6. https://doi.org/10.1097/DCC.0000000000000354.
[40] Elias CE, Day T. Experiences of newly qualified nurses in critical care: a qualitative systematic review. J Intensive Care Soc 2020;21:334–43. https://doi.org/10.1177/1751143720926794.
[41] Gullick J, Lin F, Massey D, Wilson L, Greenwood M, Skylas K, et al. Structures, processes and outcomes of specialist critical care nurse education: an integrative review. Aust Crit Care 2019;32:331–45. https://doi.org/10.1016/j.aucc.2018.09.007.