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TESI DI LAUREA

NURSES' EXPERIENCE OF TRANSITION TO A NEW SUB-INTENSIVE CARE UNIT FOR RESPIRATORY PATIENTS: A QUALITATIVE STUDY.

Relatore: Dott. Danielis Matteo

Correlatore: Dott.ssa Bottega Michela

Laureanda: Marangon Francesca

Matricola: 2090100

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ABSTRACT

INTRODUZIONE: Le transizioni di ruolo rappresentano una sfida importante per gli infermieri, spesso caratterizzate da stress e sconvolgimenti emotivi legati allo sviluppo di nuove identità, valori e competenze. Sebbene molta attenzione sia oggi dedicata al supporto degli infermieri novizi in transizione nella pratica clinica, i processi che gli infermieri esperti affrontano durante la transizione tra specialità cliniche, come il passaggio da un setting di reparto a un setting di area critica, come la terapia sub-intensiva, risultano ancora poco approfonditi in letteratura. Comprendere queste dinamiche è fondamentale per favorire transizioni efficaci, ridurre il turnover e promuovere il benessere dei professionisti, nel contesto di modelli assistenziali in continua evoluzione.

OBIETTIVI: L'obiettivo di questo studio è esplorare le esperienze degli infermieri esperti all'inizio della loro transizione lavorativa dal *setting* di reparto a quello di terapia sub-intensiva respiratoria. L'obiettivo secondario è identificare le barriere ed i fattori facilitanti che influenzano questo processo, al fine di fornire indicazioni utili per supportare le transizioni.

DISEGNO DELLO STUDIO: È stato condotto uno studio qualitativo utilizzando la metodologia dell'*interpretive description*.

MATERIALI E METODI: Utilizzando un campionamento propositivo di 14 infermiere esperte provenienti da un reparto di pneumologia, sono stati condotti due focus group semi-strutturati, trascritti integralmente e analizzati tramite analisi tematica.

RISULTATI: I risultati evidenziano due temi interconnessi che rappresentano dimensioni complementari dell'esperienza di transizione: (a) vivere l'introspezione dell'attesa; (b) incontrare facilitatori e ostacoli al cambiamento organizzativo.

CONCLUSIONI: I risultati evidenziano la complessità della transizione di ruolo per gli infermieri esperti e la necessità di interventi mirati ed *evidence-based*. Formazione strutturata, affiancamento personalizzato e pratiche organizzative inclusive sono essenziali per favorire l'adattamento, migliorare la resilienza e garantire la continuità del servizio, assicurando al contempo un'assistenza sanitaria di alta qualità.

Parole chiave: critical care; management; nurses' experiences; qualitative research; transition

ABSTRACT (ENGLISH)

BACKGROUND: Role transitions in nursing represent a significant challenge for both novice and experienced nurses, often characterized by stress and emotional upheaval associated with the development of new identities, values, and competencies. While substantial attention is devoted to supporting new graduate nurses, the processes that experienced nurses undergo when transitioning between clinical specialties, such as moving from ward settings to critical care environments, like sub-intensive care units, are underexplored in the literature. Understanding these dynamics is essential to foster effective transitions, mitigate turnover, and promote well-being amidst evolving models of care delivery.

OBJECTIVES: The aim of this study was to explore the experiences of experienced nurses transitioning from a clinical ward environment to a subacute care setting. The secondary objective was to identify the barriers and facilitators influencing this process to provide insights for supporting transitions.

DESIGN: We conducted a qualitative study using interpretive description methodology.

METHODS: Using a purposeful sample of 14 experienced nurses from an adult respiratory ward unit, two semi-structured focus group interviews were conducted, transcribed verbatim and analysed via thematic analysis.

RESULTS: Our findings indicate two interconnected themes that reflect two complementary dimensions of the transition experience: (a) experiencing the introspection of waiting; (b) encountering facilitators and barriers to organizational change.

CONCLUSIONS: The findings highlight the complexity of role transitions for experienced nurses and the need for targeted, evidence-based interventions. Structured training, tailored mentorship and inclusive organizational practices are essential to foster adaptation, enhance resilience, and support workforce sustainability while maintaining high-quality care.

Key Words: critical care; management; nurses' experiences; qualitative research; transition

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What is already known

- Transitions to new clinical settings are complex and nonlinear processes that significantly challenge experienced nurses, requiring them to adapt their skills and confidence while navigating new environments.
- Existing research predominantly focuses on novice nurses transitioning into practice.
- Little is known about the experiences of experienced nurses transitioning into specialistic units, such as sub-intensive care units, including their specific support needs and challenges requirements.

What this study adds

- This study increases the evidence about the transitions of nurses in different settings, highlighting the complex nature of this process for experienced nurses as they prepare themselves to move into a new sub-intensive care unit.
- It highlights the need for structured, evidence-based training programs tailored to the specific needs of experienced nurses transitioning to sub-intensive care settings.
- It identifies critical barriers, such as perceived undervaluation, marginal involvement in planning, and systemic issues like medical staffing shortages and turnover.

1. Background

Healthcare systems worldwide are facing unprecedented challenges in maintaining adequate human resources to ensure resilience and meet rising healthcare demands, especially in the context of the aging population (OECD, 2023). The COVID-19 (acronym for coronavirus disease of 2019) pandemic has intensified the "great resignation" phenomenon, drawing attention to severe workforce shortages across healthcare professions, including nurses (Poindexter, 2022; Poon et al., 2022; AACN, 2022). This shortage could negatively impact quality and safety indicators, such as mortality and infection rates (Blegen et al., 2011). Ensuring appropriate staffing levels, along with recruiting and retaining skilled nurses, remains a critical goal for healthcare organizations worldwide (WHO, 2020).

In this context, role transitions in the workforce require special attention. This phenomenon often presents challenges, including emotional upheaval as individuals strive to redefine themselves and adapt to the new situations (Gill & Shanta, 2020). Ineffective transitions have been linked to negative organizational outcomes like absenteeism, a decrease in cooperation, greater resignation and turnover rates, which can compromise healthcare quality and safety (Kiel, 2012; Chicca & Bindon, 2019). Instead of this, successful transitions are characterized by indicators such as a sense of well-being, the acquisition of new skills and the development of stable interpersonal relationships (Schumacher & Meleis, 1994). Meanings, expectations, level of knowledge, skills and planning, environment and emotional and physical well-being are all important factors that can influence the quality and consequences of the transition experience (Schumacher & Meleis, 1994).

The concept of transition in literature is generally defined as any passage or movement from one state to another (Schumacher & Meleis, 1994; Meleis, 2010), triggered by a change (Meleis, 2010; Arrowsmith et al., 2016), and characterized by unfolding phases over time (Arrowsmith et al., 2016). While some authors view transitions as linear others describe them as complex and non-linear processes. This complexity is evident in the concept of “new-to-setting” nurse transitions, where an experienced nurse moves laterally to a new clinical area as explored by Chicca & Bindon (2020). These transitions are influenced by multiple factors and involve fluctuations in skills, confidence, and emotions, such as accomplishment and frustration. They are dynamic, evolving as the nurse adapts to the new clinical setting (Chicca & Bindon, 2020).

As evident from the only and most recent mixed-methods systematic review by Arrowsmith et al. (2016) on the subject, studies on nurses’ transitions primarily focus on novice nurses

(students and new graduates transitioning to clinical practice) and less in experienced nurses, undergoing role changes or advancing to specialist roles. Other studies, not included in the review, examine transitions to educational, managerial, or research roles (Manning & Neville, 2009; Pilat et al., 2019; Lönn et al., 2022). Both novice and experienced nurses face stress, anxiety, and depression during transitions, especially in the initial stages (Arrowsmith et al., 2016; Li et al., 2023; Aldosari et al., 2021; Melissant et al., 2024).

Experienced nurses, despite their resilience from prior skills, may feel vulnerable and uncertain, and sometime reluctant to admit knowledge gaps, which can increase their stress. Without adequate support, they may report an intention to leave their job or leave the nursing professional altogether (Gill & Shanta, 2020; Windey & McGuire, 2020). However, support resources are typically focused on new graduates, as about 25% leave their positions within the first year (Chicca & Bindon, 2019; NCSBN, 2024), often overlooking the unique needs of experienced nurses undergoing lateral transitions (Chicca & Bindon, 2019).

In critical care, “new-to-setting” transitions are particularly challenging, given the expertise required to navigate high-tech environments with intensive patient care demands (Gohery & Meaney, 2013). Support interventions, such as a preceptorship programme with a fixed period of preceptorship and named preceptors for new staff, training programs focused on clinical area skills, staff rotation and structured orientation programs have shown effectiveness in facilitating such transitions (Gohery & Meaney, 2013; Jarvi & Uusitalo, 2004; Mohan & Gomathi, 2015).

In this context, Intermediate Care Units (IMCUs) have gained significant importance, especially during the COVID-19 pandemic, when the demand for Intensive Care Unit (ICU) beds surged globally (López-Jardón et al., 2024). IMCUs are designed for patients with failure of one or more organs, with care and monitoring needs more intensive than what can be guaranteed on the medical or surgical general wards, but do not require the human and technical resources of typical ICU patients (Hampton et.al, 2023). The term "Intermediate Care Unit" can be understood as an umbrella term encompassing various labels used in the literature, such as: "intermediate care units", "highly dependent units", "step-down units", “telemetry unit", "post-interventional unit", "intermediate coronary care unit", etc. (Stacy, 2011; Renda et al., 2021). The various types of IMCUs share the level of care intensity provided (Stacy, 2011; Bulbul et al., 2023). These units can help optimize hospital productivity by reducing ICU occupancy, the required staffing, and lowering in-hospital mortality rates (Bulbul et al., 2023). However, despite having fewer staff than ICUs, IMCUs still demand similarly high levels of training (Waydhas et al., 2018). The Respiratory

Intermediate Care Unit (RICU) is a specific type of IMCU for managing patients with severe respiratory failure without another severe organ dysfunction (Renda et al., 2021).

In February 2020, the Italian government responded to healthcare facility shortages by directing regional health authorities to increase ICU capacity by 50% and double beds for respiratory patients, leading to 3,500 ICU and 4,225 RICU beds (Decreto-legge n. 34, 2020 [Decree-Law No. 34, 2020]; Renda et al., 2021). However, concerns about appropriateness and sustainability of this increase prompted the Superior Health Council to propose a new critical care model integrating ICUs and IMCUs into a structure with three care levels (1=low, 2=medium, 3=high), where Levels 1 and 2 (RICUs) serve as links between ICUs and standard care units (Ministero della salute, 2023). This model aligns with the emerging intensity of care model, where three levels of intensity are proposed: low, medium, and high. Unlike the traditional "disease-centred" model, which organizes hospitals into specialized wards by main disease, the intensity of care model adopts a "patient-centred" approach, grouping patients with similar care needs (Liguori et al., 2018; Nardi et al., 2012). The growing need to optimize economical and human resources and to promote a global approach to the patient has led to the implementation of the intensity of care model, currently being tested in the hospital organization in several Italian regions (Liguori et al., 2018; Nardi et al., 2012).

During the COVID-19 pandemic, studies explored nurses' experiences when urgently transferred to new units like sub-intensive care unit. They initially faced negative emotions such as fear, information overload, skill gaps, and an unfamiliar environment (Danielis et al., 2021; Fagerdahl et al., 2022). Someone felt abandoned by the organization (Fagerdahl et al., 2022). While a lower nurse-to-patient ratio allowed more personalized care, the crisis caused care disruptions, increased moral distress, but also strengthened skills and professional identity (Danielis et al., 2021; Fagerdahl et al., 2022).

However, it seems that no well-designed study, have investigated the post-emergency experience of experienced nurses transitioning into new RICU environments. Understanding their perspectives is critical to preparing them for these roles, considering emerging intensity of care organizational models, the time required for skill development, and minimizing risks of burnout and job turnover. This study aims to explore the onset experiences of experienced nurses transitioning from a ward setting to a new sub-intensive care unit for respiratory patients, providing insights that could help nursing leaders and nursing professional development practitioners and offer targeted support to optimize transitions, promote resilience, and improve healthcare quality and safety.

2. Methods

2.1 Study design

A qualitative study was conducted using Interpretive Description methodology, with a noncategorical approach for qualitative health research, developed by Thorne and colleagues (Thorne et al., 1997).

This methodology focuses on describing and interpreting a phenomenon, exploring the meaning of related behaviours and formulating a valuable clinical response. The product of Interpretive Description is a new understanding of a complex phenomenon, with a focus on its practical implications (Thorne et al., 2004; Hunt, 2009).

Interpretive Description was developed in response to a need within nursing science for a flexible method that overcomes the limitations of traditional qualitative approaches. It aims to address the specific questions of applied disciplines like nursing and to generate practical, clinically relevant knowledge. This approach moves qualitative inquiry beyond basic description to a more abstract and analytical level (Beck, 2013; Thorne et al., 2004).

Interpretive description is aligned to a constructivist and naturalistic orientation to inquiry (Hunt, 2009).

Moreover, the interpretive description approach acknowledges the theoretical and practical knowledge about the phenomenon under study that researchers bring to the study (Hunt, 2009). In the beginning stages of the analysis the researcher is encouraged to focus on broad questions to apprehend the overall picture, rather than analysis that focuses on the minutiae of the data with detailed line-by-line coding (Hunt, 2009; Thorne et al., 2004).

The practical nature of the research questions and the aim of the study align with the philosophical underpinnings and methodological design of Interpretive Description. Researchers are interested in generating disciplinary knowledge that informs practice within the field of human resource development with the aim of providing leadership with detailed insights into processes, thereby fostering a focused understanding and strategic alignment.

The Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014) were followed.

2.2 Setting and sample

The study was conducted in a 1,000-bed hospital located in north-east Italy. During the pandemic emergency, the respiratory ward underwent a comprehensive requalification of its available beds (20 in total) into RICU beds dedicated to COVID-19 patients. The level of

care intensity was low-medium. Currently, there are a maximum of two dedicated RICU beds exclusively for COVID-19 patients. In compliance with regional decrees, this ward was recently relocated to a newly created setting within the same hospital, with a total of 33 beds: 26 for stable respiratory patients and seven dedicated to the new Respiratory Intermediate Care Unit. Although the relocation is complete, the new sub-intensive care unit is not yet operational. The unit will be organized in a single open-space room, offering a medium level of care intensity with continuous, face-to-face patient monitoring, and the possibility of invasive monitoring, such as repeated blood gas checks via radial artery access, when necessary, which was previously not possible because the patients were not in direct view. The staff in the new unit will be the same as that in the respiratory ward unit, which includes registered nurses (RNs), medical doctors (MDs), nurse assistants (NAs), physical therapists (PTs) and respiratory therapists (RTs). The nurse-to-patients ratio will be 1:4.

The study was conducted prior to the relocation to the new hospital area.

A purposeful sampling method aimed at selecting the most informative participants (Polit & Beck, 2018) was used. The inclusion criteria were as follows: 1) experienced nurses, defined as Registered Nurses (RNs) with at least one year of experience in the clinical practice area (Schmitt & Schiffman, 2019; Lartey et al., 2014; Chicca & Bindon, 2019); 2) transitioning from an adult respiratory ward to a new sub-intensive care unit dedicated to respiratory patients; 3) at any level of education; 4) willing to participate in the study.

A total of 20 RNs were eligible. Preliminary contact with potential participants was initiated through an email sent by the Principal Investigator (PI) (FM), one month in advance, providing a brief explanation of the study's objectives and extending an invitation to participate. Subsequently, the PI personally met with colleagues to collect confirmations of participation and address any concerns raised. Each eligible participant was left free to participate or not in the study.

A total of six nurses declined to participate due to time constraints related to: family responsibilities (four nurses), work-related responsibilities (one nurse), and educational commitments (one nurse).

Fourteen RNs were recruited until data saturation was reached (i.e., replication of previously collected data).

Table 1 provides a description of the study participants by gender, age, education, and professional experience.

Table 1
Participants' characteristics.

	Registered Nurses N = 14
Gender, n (%)	
Female	14 (100)
Age, years, mean (SD)	40.8 (8.5)
Education, n (%)	
Nursing diploma	3 (21.4)
Bachelor's degree	6 (42.9)
Advanced education[a]	5 (35.7)
Working experience, years, mean (SD)	15.8 (8.0)
Working experience in Adult Respiratory Ward, years, mean (SD)	7.8 (5.5)

SD, Standard deviation
[a] for example: master's degree

2.3 Data collection

Focus groups were employed as a method of data collection (Krueger et al., 2014; Tracy, 2019; Doyle et al., 2020). The Focus Group brings together individuals with similar characteristics in a relaxed and permissive environment where they share thoughts and experiences. Participants not only express their own views but also listen, reflect, and interact with others in the group. This synergistic process refines individual viewpoints, generating data and insights that would not be accessible without the interaction found in a group (Krueger et al., 2014; Doyle et al., 2020).

We conducted a total of two focus group interviews in June 2024.

Focus groups were conducted by three researchers [FM (female), MB (female) and MD (male) / SA (female)] who were respectively: a) FM, a student in Master of Science in Nursing, who had been working as an RN for three years in the same ward as the participants; b) MB, a Nurse Manager in the hospital approached, with a PhD and expert in research; c) MD, an Assistant Professor in Nursing, with a PhD and expert in research; d) SA, a Nurse Educator with a Master of Science in Nursing.

Researchers: FM and MB/MD/SA acted as interviewer and moderators, respectively. In the first focus group there were: FM, MB, and MD. In the second focus group, instead: FM, MB, and SA.

Seven RNs, were, on average, involved for each focus group. The focus group were ended when data saturation was reached as judged by three researchers independently.

An interview guide containing open ended questions, probing questions, and prompts, was developed based on six main dimensions reflecting the research questions, specifically the

important factors influencing transition process according to the model of Meleis and Schumacher (1994): meanings, expectations, level of knowledge/skill, environment, level of planning and emotional and physical well-being. The interview guide served to support discussion (supplementary material - document 1). The interview questions were not provided to the participants in advance.

Each focus group started with a stimulus image depicting a seven-bed sub-intensive care unit (supplementary material - document 2).

The interview questions focused on the following aspects: frontline nurses' experiences, perceptions, and feelings regarding the transition from the clinical ward environment to the subacute care environment, including preliminary training and education, as well as factors that might facilitate or hinder the transition.

The focus groups were audio-recorded and verbatim-transcribed, after participants completed forms for informed consent.

A short data collection form was designed with the following sociodemographic information: gender (female, male), age (years), level of education (Nursing Diploma, BSN (Bachelor of Science in Nursing), Advanced education), working experience (years) and working experience in Adult Respiratory Unit (years).

This form was filled out by the participants before the start of each focus group, after researchers presented the study aims.

Each focus group was held at a time suitable to participants and in a quiet, illuminated, and private meeting room in the hospital to ensure confidentiality and facilitate the comfort of participants. The chairs were arranged in a circle to enable everyone to make eye contact and facilitate horizontal communication.

The audio-taped focus group interviews lasted approximately 60 minutes.

In the second focus group, a nurse left the discussion 15 minutes early for a personal commitment.

In each focus group, answers and interactions among participants were encouraged by researchers. A non-judgmental approach was adopted. Nothing was assumed, and all opinions were respected. Participants were encouraged to speak freely at any time.

At the end of each focus group, participants were offered a small buffet, allowing participants to ask questions or voice any concerns or dissatisfaction they may have (Polit & Beck, 2018) and were given a small gift as a token of appreciation for their decision to participate.

After participants left the room, the research team conducted a 15-minute debriefing to compare notes, share highlights, and consider what others on the team had observed or heard (Krueger et al., 2014).

Taped interviews were transcribed verbatim by the PI (FM). To ensure the respect of anonymity, quotes were indexed as being from one of the focus groups (e.g., FG1), and each experienced RN was sequentially numbered (e.g., RN1). FM, MB, MD read through each transcript to allow emerging insights to be incorporated into the ongoing data collection (Hunt, 2009; Thorne et al., 2004).

2.4 Data analysis

Analyses were informed by authors' research interests and experience.

A thematic analysis approach was used, following the phases described by Braun and Clarke (Braun and Clarke, 2006). As thematic analysis is very flexible and facilitates distinguishing, identifying and interpreting themes, i.e., significant patterns in the data, we considered it appropriate for use with interpretive descriptive methodology.

Overall, the thematic analysis was guided by one analytic question:

(a) How do experienced nurses perceive and experience the transition from the clinical ward environment to the subacute care environment?

After reading and re-reading the transcripts (familiarization with the data), the initial coding phase started with the three researchers (FM, MD, MB) reading the transcripts separately and coding for patterns and themes, labeling paragraphs that contained information regarding points discussed. In the next phase, the three analyzed the initial codes together, sorted them into potential themes and discussed their meanings and emerging patterns with the aim of reaching a shared understanding/agreement. For the next step, all relevant coded data extracts were collated within the identified themes, through an iterative systematic process until the final themes emerge and mind-maps used to meaningfully organize any emerging themes. The three authors reviewed the identified themes for internal homogeneity (i.e., meaningful cohesion of codes) and external heterogeneity (i.e., clear distinctions between themes), re-coding the data extracts as necessary. They further refined and defined the themes by identifying their individual and collective essence (Braun and Clarke, 2006). Conceptual themes were derived inductively from analysis within and between individual focus group interviews (Hunt, 2009; Thorne et al., 2004). Finally, findings were developed from themes by condensing and rewording them into sentences or short phrases that clearly answered the research questions (Vanover et al., 2022).

The analytical processes were regularly reviewed, and the final list of themes and related significant quotes were collaboratively agreed upon.

During coding, researchers collected memo writings which are informal analytic notes about the data and their connections. Memoing is an ongoing activity in which researchers deposit their ideas, reflections and intuitive contemplations and document them through interaction with the data, building an audit trail of the data analysis process (Birks et al., 2008). Memos and discussions were utilized within the research team to scrutinize and acknowledge the preconceptions and knowledge brought into the study, stemming from both professional perspectives and personal experiences.

Data analysis was conducted using the qualitative data analysis program ATLAS® software. Finally, this process led to the development of the two interconnected themes presented below.

2.5 Rigor

Methodological rigour was ensured by following the concept of trustworthiness and related criteria proposed by Lincoln and Guba (Nowell et al., 2017):

1. Credibility was pursued by a) involving RNs transitioning from a ward to a new sub-intensive care unit devoted to respiratory patients, describing the number of participants, non-participants, and dropouts, along with the reasons for their decisions, b) engaging researchers with adequate knowledge and research skills, c) making complexities visible through the analytic process, d) striving to make visible and accessible throughout the report the researchers' interpretive perspective. Consistent with Thorne et al. (2004), member checking was not employed in this study, as it is considered potentially misleading in interpretive research. Specifically, interpretive description aims to extend beyond the perspective of any single individual to identify commonalities across a range of experiences within a phenomenon. As Thorne et al. (2004) explain, techniques such as having research participants “validate” findings may undermine this objective by limiting the analysis to individual perceptions, which could detract from the broader interpretive insights that the methodology seeks to achieve.
2. Transferability was ensured through data saturation and comprehensive field notes on the main points that were shared during focus group interviews.

3. Dependability was ensured by a) using the same interview guide across all focus groups and b) providing an in-depth description of the study procedures and analysis to allow for replication.
4. Confirmability was ensured by a) creating a clear audit trail, documenting the direct quotes along with a detailed description of their sources (e.g., RN1) and the coding tree, b) conducting multiple meetings to discuss emerging codes, categories, and themes until a consensus was reached, and c) explaining reasons for methodological and analytical choices throughout the entire study so that others could understand how and why decisions were made.

2.6 Ethics

The regional ethical committee of the Northern Veneto Area approved the research project described here (Prot.0009164/24 [supplementary material - document 3]); the study was conducted in accordance with the Declaration of Helsinki (World Medical Association, 2013). Our practices concerning data collection, processing, and storage were guided by GDPR's core principles of legality, fairness, transparency, purpose limitation, data minimization, accuracy, storage limitation, integrity, and confidentiality. We were committed to ensuring compliance with General Data Protection Regulation regulations (GDPR Regulation [EU] 2016/679) and respecting the rights of individuals regarding their personal data. Participant privacy was strictly maintained, and all data provided by them were kept confidential. Additionally, measures were taken to ensure that participants remained anonymous throughout the study. We presented all results anonymously and limited data access exclusively to the research team.

3. Results

The study sample comprised 14 registered nurses, all female, with a mean age of 40.8 years. As reported in Table 1, the highest level of education among participants varied: 42.9% (n = 6) held a bachelor's degree, 35.7% (n = 5) had advanced education (e.g., a master's degree), and 21.4% (n = 3) held a nursing diploma. On average, participants reported 15.8 years of professional nursing experience and 7.8 years of work experience in the respiratory ward.

The onset experience of experienced nurses moving from a respiratory ward to a new sub-intensive care unit for respiratory patients is expressed by two interconnected themes: (a) experiencing the introspection of waiting; (b) encountering facilitators and barriers to organizational change (Table 2). Together, these themes reflect complementary dimensions of the transition process, encompassing both the personal and organizational aspects of the experience.

3.1 Experiencing the introspection of waiting

The initial phase of the transition process, examined in this study, goes through the moment the change is communicated to the nurses' team to the staff's relocation. During this period of waiting, experienced nurses reflected on the future that lay ahead and, on their ability, to face it. The anticipation of change resulted in an inner conflict as they navigated between excitement and concerns. This theme outlines the introspective and personal dimensions of the transition experience, as represented by the related categories in the paragraphs below.

3.1.1 Being torn between different facets of change

Experienced nurses in the early stages of the transition process reported feeling torn between different facets of change: on one hand, positive expectations and on the other, concerns related to the logistical, technical, and organizational dimensions of the transition.

Initially, some nurses perceived the change as a stimulating opportunity for professional growth and development, drawing on their prior experience in managing sub-intensive care patients during the COVID-19 pandemic. This enthusiasm even prompted one nurse to leave her previous organization to join the new unit described in the study, motivated by its opening. However, over time, this initial enthusiasm diminished, influenced by delays and the perceived lack of "cornerstones," understood as essential elements needed to face the forthcoming transition: *"However, as time went on, I thought about it more and realized that perhaps some fundamental elements are missing. So, yes, the enthusiasm has faded a bit, but ideally, I think it could be a good thing…"* (FG1RN1).

The prolonged waiting period and lack of clear communication fostered a sense of suspension and uncertainty, described by one nurse as being in a "limbo," which made it difficult to envision and prepare for the change: *"And so, we are still waiting for this relocation. I mean, we're living in a sort of limbo. In the meantime, yes, we see it developing, but... I don't know, it still feels like something... [sentence left incomplete]"* (FG2RN3).

Nurses also expressed doubts about the patient case mix they would be required to manage in the new setting, citing a lack of sufficient information, along with concerns about their ability to care for patients with unfamiliar or atypical conditions unrelated to pulmonary diseases, particularly in critical situations outside their usual area of expertise: *"If patients with other diseases come in, that's when I start questioning myself a bit, especially in critical situations…"* (FG1RN3).

The physical layout and limited space of the new sub-intensive care unit raised concerns about its functionality and capacity to support the required workflows: *"The sub-intensive care unit, if you look at it, might seem adequate, but then add the patients, the monitors, the infusion stands... it all seems very, very small"* (FG2RN7). Some nurses also worried about "being isolated" from their colleagues due to the facility's design, which separated the respiratory ward from the sub-intensive care unit. Furthermore, others voiced concerns about the ward's distance from the intensive care unit and diagnostic radiology, anticipating time-sensitive challenges in transporting critically ill patients.

3.1.2 Perceiving unpreparedness

Nurses reported feeling unprepared to face the challenges of the new reality, as exemplified by one participant's statement: *"We're not trained, at least speaking for myself, I'm not trained for a sub-intensive care unit, and I don't think the doctors are either"* (FG2RN5). This sense of unpreparedness was compounded by the possibility of making mistakes or failures, perceived as inevitable without sufficient preparation, which emerged as a significant source of anxiety. These concerns were further aggravated by legal and moral implications, as expressed by one participant: *"Putting aside all the legal aspects, which I don't even want to think about, but just on a moral level, I can't risk doing something I don't know how to do and therefore making a mistake... I just want to be prepared"* (FG1RN1).

Nurses described a sense of inadequacy regarding their technical skills across several areas. One key concern was arterial cannulation, a skill they recognized as essential but noted they had either never practiced or not revisited in years. They also expressed apprehension about using and operating certain medical devices, such as specific ventilators, syringe pumps, and

other essential equipment, which they anticipated encountering more frequently in the sub-intensive care setting but reported having limited or no prior experience with. Another critical area was interpreting and responding to critical patient data, with one participant highlighting the importance of clear guidelines or checklists to support decision-making in high-pressure situations: "*So, having and being trained on a checklist to keep in mind for knowing what to monitor in the patient"* (FG2RN7). The anticipated pharmacological demands of sub-intensive care patients were also described as a challenge.

Participants further noted that insufficient training was not limited to nurses but also extended to physicians, raising concerns about the team's overall readiness to meet the demands of the new sub-intensive care unit.

As reported in Table 2, nurses also feared that the transition would occur without proper planning, with last-minute decisions further complicating the process. A verb frequently used by Italian-speaking nurses to express this perception was *"essere buttati,"* denoting a sense of being hastily or carelessly relocated to the new ward without adequate preparation.

3.2 Encountering facilitators and barriers to organizational change

In the transition experiences of experienced nurses, organizational factors played a significant role, influencing their adaptation and approach to the change. These factors included both facilitators and barriers. This second theme focuses on the external and organizational factors perceived to shape and influence the process.

3.2.1 Experiencing facilitators

Participants identified several factors that could support a smoother transition to the new sub-intensive care unit.

Nurses emphasized the importance of teamwork and collaboration across all professional roles, suggesting that a collective approach would foster a more cohesive and effective work environment: *"We need to be united; we all need to go in the same direction… Teamwork is key"* (FG1RN2). They also highlighted the perception of working within a cohesive and collaborative team as a significant advantage.

Additionally, participants stressed the critical need for well-structured training programs to build confidence and ensure readiness for the new unit: *"In a context where everything is planned, you also need to provide training, and not training that is quick and unstructured…it needs to be something done properly"* (FG2RN2). Nurses advocated for a comprehensive training approach that included specific courses, both theoretical and practical elements, time dedicated to familiarizing themselves with the new environment and

mentoring with experts. However, opinions on mentoring varied. One nurse for example, highlighted the benefits of structured mentoring, noting the difference between the support typically provided in ICU settings and the lack of comparable preparation for the new sub-intensive care unit: *"Because, if you start in an ICU, you typically have six months of mentoring…And here?"* (FG1RN7). In contrast, some nurses raised concerns about mentoring. For example, one participant expressed apprehension about being paired with a colleague whose teaching style might not align with their learning preferences, potentially leading to misunderstandings or misinterpretation of critical information: *"I mean, I could have one approach with that colleague, and that colleague might interact differently with someone else. The way information is received could be...distorted"* (FG2RN7). Another participant feared being judged by colleagues: *"They would make fun of you because you go there and ask a question"* (FG1RN5).

Given these challenges with mentoring, nurses highly valued experiential learning opportunities, particularly in familiar environments. Shadowing shifts with experts in the new ward was regarded as an effective way to enhance comfort and practical understanding: *"In my opinion, a person feels more comfortable and learns better in their own work environment"* (FG2RN2).

3.2.2 Experiencing barriers

While some facilitators were identified, participants also reported significant obstacles to a smooth transition. Concerns about both shortages and the expertise of medical staff emerged as a recurring theme, with some nurses questioning the team's capacity to effectively manage the sub-intensive care unit: *"We don't have doctors, and we also don't have doctors who are capable of managing a sub-intensive care unit"* (FG1RN7). These concerns were closely tied to high physician turnover. Nurses reported the recruitment of inexperienced physicians, such as residents, alongside the resignation of experienced senior doctors. Participants described challenges in adapting to new staff and highlighted inefficiencies, such as repeated tasks and unnecessary tests, which they felt increased their workload.

Nurses expressed fears that these difficulties would intensify in the new setting. They anticipated challenges in managing patients, including fragmented care caused by staffing shortages, and raised concerns about insufficient collaboration with medical staff. These issues, they believed, could further undermine teamwork and hinder their ability to adapt effectively to the transition.

Additionally, participants highlighted that negative, hesitant, and uncooperative attitude from medical staff, combined with logistical challenges, significantly impacted the overall work climate. Nurses described a widespread reluctance among some physicians: *"More than one doctor has told me, 'No, I don't want to go there in these conditions, knowing I'd have to cover countless shifts because there isn't enough medical staff'"* (FG1RN3). This perceived negativity was viewed as undermining morale and teamwork. Nurses emphasized the importance of fostering a more optimistic and collaborative environment, built on trust and enthusiasm across all professional roles, to establish a supportive and effective work atmosphere: *"Because we can't be the ones who stay positive while the doctors are hesitant"* (FG1RN3).

Nurses also expressed dissatisfaction with their limited involvement in the planning and decision-making processes for the new unit: *"I didn't feel involved because they never presented us with a project… There's a lack of sharing the initial project"* (FG2RN3). They described feeling marginalized in organizational and decision-making processes, particularly regarding the design and allocation of workspaces. Some participants perceived that other professional, such as nursing assistants, had been more involved in these decisions: *"Perhaps the involvement was more focused on nursing assistants, particularly regarding the organization of storage and waste disposal areas"* (FG2RN4). Moreover, the lack of information sharing about the project created significant uncertainties regarding key organizational and operational aspects, including staffing levels, logistics, total bed capacity, workspace configurations, and the target patient population.

Finally, the limited investment in training and preparation for the transition left some nurses feeling undervalued in their role within the new unit: *"Why isn't there any investment in this? They say, 'Anyway, you already know how to manage a ward.' That may be true, but there's very little investment in us, and that upsets me because, in the end, we're the ones who do the work"* (FG1RN3). Participants pointed to a lack of focus on their professional development, particularly in equipping them to meet the challenges of the new sub-intensive care unit. They called for greater investment through structured training programs and financial incentives. Frustration was also expressed over the perceived prioritization of infrastructure and equipment over initiatives that could directly enhance staff readiness and growth.

Table 2
Coding tree: themes, categories and codes identified from focus groups.

Themes and categories	Codes	Quotes	Participants
1. Experiencing the introspection of waiting			
1.1 Being torn between different facets of change	Feeling enthusiastic about the new professional challenge	*"...When I first found out, I was enthusiastic because, after all, in our ward we have already managed sub-intensive patients. It seemed stimulating…However, as time went on, I thought about it more and realized that perhaps some fundamental elements are missing. So, yes, the enthusiasm has faded a bit, but ideally, I think it could be a good thing…".* (FG1RN1)	FG1RN1, FG1RN2, FG1RN3, FG2RN3, FG2RN4, FG2RN6
	Experiencing a state of limbo	"*And so, we are still waiting for this relocation... I mean, we're living in a sort of limbo... In the meantime, yes, we see it developing, but...I don't know, it still feels like something... [sentence left incomplete]".* (FG2RN3)	FG1RN2, FG1RN3, FG1RN5, FG1RN6, FG2RN2, FG2RN3, FG2RN4, FG2RN5
	Worrying about patient case mix	"*Yes, because there's this aspect: if all the patients are pulmonology cases, there's experience in that area. However, if patients with other diseases come in, that's when I start questioning myself a bit, especially in critical situations…".* (FG1RN3)	FG1RN1, FG1RN2, FG1RN3, FG1RN5, FG2RN1, FG2RN3, FG2RN2, FG2RN4, FG2RN5
	Worrying about the layout of the new ward	"*The sub-intensive care unit, if you look at it, you might think it seems adequate, but then add the patients, add the monitors, add the infusion stands, the cabinets for the medications, and everything...To me, it all seems very, very small".* (FG2RN7)	FG1RN2, FG1RN3, FG2RN1, FG2RN4, FG2RN6, FG2RN7
1.2 Perceiving unpreparedness	Feeling inadequate on technical skills	"*Also, we're not trained, at least speaking for myself, I'm not trained for a sub-intensive care unit, and I don't think the doctors are either".* (FG2RN5)	FG1RN1, FG1RN2, FG1RN3, FG1RN5, FG1RN7, FG2RN2, FG2RN3, FG2RN4, FG2RN5, FG2RN6, FG2RN7
	Fearing mistakes and failures	*"Putting aside all the legal aspects, which I don't even want to think about, but just on a moral level, I can't risk doing something I don't know how to do and therefore making a mistake...I just want to be prepared".* (FG1RN1)	FG1RN1, FG1RN3, FG1RN4, FG1RN5, FG1RN7, FG2RN1, FG2RN5
	Expecting a sudden and disorganized transition	"*Yes, but it will be: 'Tomorrow you'll do the relocation'"* (FG1RN2) "*And then: 'The sub-intensive care unit opens the day after tomorrow'".* (FG1RN1)	FG1RN1, FG1RN2, FG1RN5, FG1RN6, FG1RN7, FG2RN1, FG2RN3
2. Encountering facilitators and barriers to organizational change			
2.1 Experiencing facilitators	Advocating for a collective approach	*"But I don't think anyone would step back, some might do it with a bit more fear, others with more enthusiasm...Of course, teamwork is key. We can't think of ourselves as nursing assistants-nursing assistants, nurses-nurses, doctors-doctors, physiotherapists-physiotherapists...We need to be united; we all need to go in the same direction…".* (FG1RN2)	FG1RN2, FG1RN3, FG1RN5, FG2RN3, FG2RN4, FG2RN5, FG2RN6

	Recognizing the need for structured preparation	*"However, in a context where everything is planned, you also need to provide training, and not training that is quick and unstructured, it needs to be something done properly".* (FG2RN2)	FG1RN1, FG1RN2, FG1RN3, FG1RN4, FG1RN5, FG1RN7, FG2RN1, FG2RN2, FG2RN3, FG2RN4, FG2RN6, FG2RN7
	Favoring experiential training	*"Well, about training in our workplace, I'm speaking from the heart here because, when the idea of starting to do shifts in other units was first mentioned… In my opinion, a person feels more comfortable and learns better in their own work environment".* (FG2RN2)	FG1RN3, FG1RN5, FG1RN6, FG1RN7, FG2RN1, FG2RN2, FG2RN3, FG2RN4, FG2RN5
2.2 Experiencing barriers	Worrying about physician turnover	*"Honestly, it gave me anxiety, but because, in my opinion, we don't have doctors who are capable of…We don't have doctors, and we also don't have doctors who are capable of managing a sub-intensive care unit".* (FG1RN7)	FG1RN1, FG1RN2, FG1RN3, FG1RN4, FG1RN5, FG1RN7, FG2RN3, FG2RN4, FG2RN5
	Experiencing negative influence of medical staff attitudes	"*Because we can't be the ones who are positive, and then the doctors, who are hesitant, along with logistical problems, I mean, everything contributes to ruining the work climate, in a way".* (FG1RN3)	FG1RN1, FG1RN3, FG1RN7, FG2RN3
	Feeling marginally involved	*"It's true, I didn't feel involved because they never presented us with a project…I mean, there's a lack of sharing the initial project".* (FG2RN3)	FG1RN1, FG1RN2, FG1RN3, FG1RN4, FG1RN6, FG2RN2, FG2RN3, FG2RN4, FG2RN5, FG2RN6, FG2RN7
	Being undervalued	*"All our doubts, the lack of preparation, and the fact that we're going to face something new… Why isn't there any investment in this? They say, 'Anyway, you already know how to manage a ward.' That may be true, but there's very little investment in us, and that upsets me because, in the end, we're the ones who do the work.".* (FG1RN3)	FG1RN3, FG1RN5, FG2RN2

FG1RN1, focus group n.1 registered nurse n.1.

4. Discussion

The study aimed to explore how experienced nurses experience the phenomenon of transition into a new sub-intensive care unit. The participating nurses expressed two interconnected themes: (a) experiencing the introspection of waiting; (b) encountering facilitators and barriers to organizational change. These themes illustrate the multifaceted nature of role transition, encompassing both personal and organizational dimensions.

The first theme, '*experiencing the introspection of waiting',* captures the emotional and cognitive processes that nurses suffer during the initial stages of transition. From the moment the change is communicated, nurses enter in a personal introspection phase, forming expectations about the future and reflecting on their ability to manage the transition.

As illustrated in the graphical representation (supplementary material - document 5), this phase is characterized by an interior conflict. Nurses reported a tension between positive emotions, such as enthusiasm for professional growth, and negative expectations, including concerns and uncertainties about the demands of the new role.

This emotional ambivalence aligns with the nonlinear and dynamic nature of role transitions experienced by experienced nurses, as described by Chicca and Bindon (2019) and reflects findings from prior research on transition processes (Arrowsmith et al., 2016). It is also consistent with two theoretical frameworks available in the literature. Dellasega's (2009) model outlines three stages of transition for experienced nurses: assessing expectations, performing realistic appraisals, and adjusting. Chicca's (2021) framework, *"Weathering the Storm of Uncertainty,"* describes a process in which experienced nurses detach, encounter uncertainty, and establish practice and place as they transition to new specialties. However, unlike Chicca's framework, which positions uncertainty as emerging after new-to-setting nurses begin their roles, our findings, similarly to Clarke and Malinen (2024), reveal that uncertainty is already evident during the initial detachment phase. This uncertainty stems from the anticipation of change and the lack of clear and shared information, emphasizing the need for improved communication and organizational transparency to reduce feelings of "limbo" and foster preparedness.

Participants also expressed a profound sense of unpreparedness, citing specific skill deficits, such as arterial cannulation, as significant concerns. This sense of inadequacy, coupled with fears of making mistakes and their potential legal and moral implications, underscores the importance of structured training programs to alleviate anxiety, build confidence and ensure patient safety. These findings align with existing literature which highlights that even

experienced nurses may feel like novices in unfamiliar environments (Dellasega et al., 2009; Ashley et al., 2018; Chicca and Bindon, 2019; Chicca, 2021). Moreover, participants expressed an expectation of turbulent change, voicing discomfort with the idea of being abruptly placed into new and challenging settings without adequate preparation. This perspective aligns with existing literature, which emphasizes that poorly managed transitions can increase stress, reduce professional efficacy, and hinder adaptation into new roles (Dellasega et al., 2009; Ashley et al., 2018; Chicca and Bindon, 2019; Chicca, 2021). Similar discomfort related to turbulent change was also documented during the COVID-19 pandemic, when nurses faced sudden transfers to intensive and sub-intensive care units, resulting in high levels of stress (Danielis et al., 2021; Fagerdahl et al., 2022). These findings further underscore the importance of structured, evidence-based support programs to facilitate effective transitions.

The second theme, *encountering facilitators and barriers to* organizational *change,* reflects the external factors influencing nurses' adaptation to their new role. Facilitators identified included structured training programs, experiential learning opportunities and a collective team-based approach. However, significant barriers were also highlighted, including physician turnover, negativity among medical staff, marginal involvement in decision-making and perceived undervaluation by the organization.

Mentoring, a key component of experiential learning, was viewed positively by some participants but raised concerns for others. Mismatched teaching styles, potential judgment, and a preference for training within their own workspace emerged as challenges. These findings highlight the need for tailored and adaptive approaches, consistent with Dellasega et al. (2009) and Chicca and Bindon (2019). As Dellasega (2009) emphasized, “the ‘one size fits all’ approach does not work,” reinforcing the necessity of a customized strategy for supporting nurses during transitions.

Participants also reported frustration related to their limited involvement in planning the new sub-intensive care unit and the lack of initial project sharing by leadership. Research from other sectors supports this finding, indicating that marginal participation in planning processes is associated with increased dissatisfaction and resistance to change (Clarke and Malinen, 2024). This perception of marginal involvement amplified nurses' uncertainty and doubts, reinforcing the critical role of inclusive planning in fostering engagement and reducing resistance during organizational change.

Medical staff shortages and high turnover, a pressing challenge in healthcare systems, further exacerbated the difficulties of transition. While these issues directly affect physicians, their

impact extends to nurses, influencing their workload, sense of preparedness, and the overall work climate. These shortages also hinder change management processes by disrupting cohesion and collaboration, creating additional stress and uncertainty across the workforce. These external factors, along with emotional responses and expectations as internal factors, function as forces that either facilitate or hinder the transition into the new setting. This dynamic aligns with the theoretical framework developed by Chicca (2021) on the transition of experienced nurses into new settings and Meleis' Transitions Theory (Schumacher & Meleis, 1994). Moreover, there can be significant interactions between external and internal factors. For instance, negativity among medical staff, an external factor, can influence the internal climate by undermining teamwork and morale, thereby affecting nurses' emotional responses and sense of readiness for the transition.

These insights underscore the importance of addressing both internal and external dimensions simultaneously to optimize transitions. As highlighted by Ratnapalan et al. (2024), emotional responses and organizational factors must be considered together, as they are intricately connected and influence the overall success of the transition. Proactive management of emotional responses through leadership, communication, and education is critical for fostering engagement and reducing resistance during change. For instance, tailored training programs that address specific skill gaps can alleviate feelings of inadequacy and fear of mistakes, while involving nurses in planning and decision-making processes can enhance their sense of ownership and preparedness. Additionally, experiential learning opportunities within familiar work environments can further support confidence-building and adaptation, creating a more seamless and supportive transition experience.

Key facilitators for successful transitions identified in the literature include cohesive teamwork, structured training programs, mentorship and preceptor development initiatives (Chicca and Bindon, 2019), supportive leadership, psychologically safe work environments (Clarke and Malinen, 2024), comprehensive orientation programs, opportunities for team meetings, effective communication among nurses and with medical staff and opportunities for socialization (Ashley et al., 2018).

The findings of this study emphasize the importance of implementing targeted and evidence-based interventions to support nurses during transitions. Adequate training and increased support are essential to improving this process, ensuring that nurses are well-prepared to meet the challenges of their new role.

Effective strategies include structured orientation programs, personalized mentorship and inclusive organizational practices that foster trust and engagement through collaborative planning and transparent communication.

Addressing systemic challenges, such as staffing shortages and high turnover, is critical, as is promoting a positive work environment that values professional development and internal growth. Additionally, encouraging self-care and resilience through reflective practices can enhance nurses' ability to adapt and thrive in new settings (Chicca, 2021).

4.1 Implications for practice and research

This study examines the challenges faced by experienced nurses during the initial phase of their transition into a sub-intensive care unit, contributing to the growing body of knowledge on the transition processes of experienced nurses. Understanding the barriers and facilitators to organizational change serves as a starting point for improving the ongoing transition process for the nurses involved. Additionally, it can enhance the process for future recruitment and retention of nurses in this new ward. These findings can support nursing leaders, educators, and policymakers in designing tailored support programs that address the specific needs of experienced nurses adapting to this context.

4.2 Strenghts and limitations

This study addresses a gap in the literature by focusing on the role transition of experienced nurses moving into sub-intensive care settings, a subject often overlooked compared to the transitions of novice nurses. Using the Interpretive Description methodology, the findings are deeply rooted in participants' experiences, offering practical insights into the complexities of clinical transitions. The study employed focus groups to capture a wide range of perspectives, with thematic analysis conducted collaboratively to enhance both the credibility and depth of the findings. Additionally, the incorporation of direct quotes and real-world experiences enriches the narrative.

As the initial phase of an ongoing investigation, this study provides foundational insights into the early-stage challenges and needs faced by experienced nurses during their transition. It highlights how resource-constrained settings and extended project timelines exacerbate uncertainty, creating an urgent need for targeted interventions. The findings underscore actionable strategies, including structured training programs, shadowing opportunities within familiar work environments and the promotion of interprofessional teamwork.

Furthermore, the study emphasizes the importance of clear communication, strategic planning and proactive leadership in mitigating anxiety and fostering confidence during

transitions. These measures are not only critical for facilitating smoother transitions but also contribute to workforce sustainability and the maintenance of high-quality patient care.

Despite its strengths, this study has limitations that must be acknowledged.

The study focused exclusively on experienced nurses, representing only one segment of the multidisciplinary team. Future research should include other healthcare professionals, such as nursing assistants, physiotherapists, and medical doctors, to provide a comprehensive, 360-degree analysis of the transition experience. Additionally, gathering insights from a broader range of key stakeholders, such as nurse educators, managers, staff development professionals and preceptors or mentors, could further enrich the understanding of the challenges faced by new-to-setting nurses and inform strategies to better support their transition.

Furthermore, this study primarily focused on the initial phase of the transition process. Conducting longitudinal research across multiple time points, incorporating perspectives from both experienced nurses and other professionals involved in the transition, could yield deeper insights into the dynamics and progression of the transition process, thereby advancing the understanding of these complex phenomena.

5. Conclusions

The transition into a new sub-intensive care unit is a complex and nonlinear process influenced by personal and organizational factors. Addressing the emotional and practical challenges experienced by experienced nurses during this phase is essential for developing effective support systems. Evidence-based strategies, including structured training, mentorship and inclusive change management are key to enhancing resilience, facilitating adaptation and maintaining high-quality care in evolving clinical settings. By fostering resilience and addressing nurses' specific needs, leaders can strengthen the workforce and improve healthcare outcomes.

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Supplementary documents

Document 1. Interview guide

- Introduction with clarification of the study objectives and general rules to follow during the focus group.
- Self-introduction of the researchers.
- Participants are informed about the audio recording of the focus group, the respect for privacy (anonymization of responses), the handling of personal data, and the possibility of leaving the discussion at any time.
- Reminder to respect the confidentiality of others' responses.
- Stimulus image as an icebreaker (image of a sub-intensive care unit).
- Questions:
    1. *What is the first thing that comes to your mind when you look at this image?*
    2. *Could you describe the emotions you felt when you were informed about the transfer to the new sub-intensive care unit?*
    3. *How do you feel about the idea of working in this new unit one day?*
    4. *How do you perceive your involvement in the opening of a new hospital department? How do you see your role in the creation of this new unit?*
    5. *What skills do you think should be developed before transferring to a sub-intensive care setting? In your opinion, what kind of training would be useful?*
    6. *What factors do you think could facilitate or hinder the transfer?*
    7. *Is there anything else you would like to add?*

- Conclusion of the discussion.
- Summary of the main topics covered and shared.
- Debriefing and thanking the participants.

Document 2. Stimulus image used in focus groups

Stimulus image

Document 3. Ethics approval statement

Prot. N. 0009164/24 del 30/04/2024

VERBALE RIUNIONE SEDUTA ORDINARIA

Comitato Etico Territoriale Area Nord Veneto

Data: 17 Aprile 2024	Dalle ore 14.30	Alle 17.30	Incontro n. 5/2024

Il Comitato Etico Territoriale CET Ara Nord Veneto, individuato con Decreto Ministeriale del 26/01/2023 "Individuazione di quaranta comitati etici territoriali", nominato con DGR n. 78 del 06/06/2023 giusta DGR n. 330 del 29 marzo 2023 dichiara di essere organizzato e di operare nel rispetto delle norme di buona pratica clinica (GCP-ICH) e degli adempimenti previsti nell'allegato al Decreto Ministeriale 1577/97: "Recepimento delle linee guida dell'Unione Europea di buona pratica clinica per l'esecuzione delle sperimentazioni cliniche dei medicinali"

- **Verifica del numero legale**

Presiede la seduta la Dott.ssa Giulia Cuman, la quale, riscontrata la presenza del numero legale (presenti 198 componenti effettivi su 20 totali) dichiara aperta la seduta, tenutasi per via telematica, e procede ad illustrare l'Ordine del Giorno.

Dr./Dr.ssa, Prof./Prof.ssa Nome_Cognome	**Ruolo Rappresentato**	**Presente/Assente**
Andrea Buda	Clinico	Presente
Pietro Minuz	Clinico	Presente
Piero Maria Stefani	Clinico	Presente
Vittorina Zagonel	Clinico	Presente
Massimo Sergi	Clinico esperto in procedure	Assente
Anna Rosa Marchetti	Medico di Medicina Generale	Presente
Enrico Opocher	Pediatra	Assente
Franco Noventa	Biostatistico	Presente
Gianluca Trifirò	Farmacologo	Presente

Roberta Joppi	Farmacista ospedaliero	Presente
Giulia Cuman	Esperto in materia giuridica	Presente
Valentina Veronica Caslini	Esperto in materia assicurativa	Presente
Antonio Quaranta	Medico Legale	Presente
Giuseppe Bon	Esperto in bioetica	Presente
Ilaria de Barbieri	Professioni sanitarie	Presente
Adriana Negrisolo	Rappresentante associazione dei pazienti o cittadini	Presente
Nicola Cataudella	Esperto in dispositivi medici	Presente
Davide Fasoli	Ingegnere clinico	Presente
Claudio Maffeis	Esperto in nutrizione	Presente
Franca Anglani	Esperto in genetica	Presente

I Componenti presenti si obbligano, come da regolamento, a non pronunciarsi ed astenersi dalla votazione nel caso di studi per i quali sia accertato un conflitto di interessi diretto ovvero indiretto.

Componenti Segreteria Tecnico-Scientifica del CET ANV:

Nome/Cognome	Ruolo rappresentato	Presente/Assente
Dott.ssa Marina Coppola	Responsabile USTS	Assente
Avv. Eleonora Martin	Personale Amministrativo	Presente
Dott.ssa Giorgia Zorzetto	Farmacista	Presente
Dott.ssa Silvia Giacomuzzo	Farmacista	Presente
Dott.ssa Fabiola Fatone	Psicologa	Presente

Comitato Etico Territoriale Area Nord Veneto

CET ANV

Alla Dott.ssa Francesca Marangon

UOC Pneumologia
Azienda ULSS 2- Marca Trevigiana

e.p.c Unità di Ricerca Clinica
Azienda ULSS 2

Oggetto: Presa d'atto – Nurses' experience of transition to a new sub-intensive care unit for respiratory patients: a qualitative study- Codice Protocollo: ETITSIR2024 (Codice Interno CET ANV 2024-28)

In data 25/03/2024, la Dott.ssa Francesca Marangon, in qualità di Principal Investigator dello studio in oggetto, ha chiesto la valutazione al CET ANV del protocollo dal titolo *"Nurses' experience of transition to a new sub-intensive care unit for respiratory patients: a qualitative study."*

Documenti sottomessi:

- Dichiarazione_studio_osservazionale_vers1_19.03.2024
- Protocollo_studio_vers1_18.03.2024
- Sinossi_protocollo_vers1_18.03.2024
- Scheda_raccolta_dati(CRF)_vers1_18.03.2024
- Dichiarazione_accertamento_natura_indip_studio_vers1_18.03.2024
- Lettera_trasmissione_studio_osservazionale_vers1_25.03.2024
- Traccia_focus_group_vers1_18.03.2024
- Curriculum_vitae_PI_vers1_14.03.2024
- Dichiarazione_conflitto_interesse_vers1_18.03.2024
- Foglio_informativo_modulo_consenso_vers1_19.03.2024
- Modulo_consenso_trattamento_dati_pers_vers1_19.03.2024
- Modulo_fattibilita_locale_vers1_19.03.2024
- Valutazione fattibilita URC_tesi qualitativa

Il Comitato Etico Territoriale ANV, presa visione della documentazione sopra riportata, **prende atto.**

Cordialmente,

Presidente Comitato Etico
Dott.ssa. Giulia Cuman

Giulia
Cuman
29.04.2024
10:54:22
GMT+01:00

Document 4. SRQR Checklist

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Title and abstract	**Page**
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	-
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	-
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	2
Purpose or research question - Purpose of the study and specific objectives or questions	4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7
Context - Setting/site and salient contextual factors; rationale**	5
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	6
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	11
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	7
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection, if/how the instrument(s) changed over the course of the study	7
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	6
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	9
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	9
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	10

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	12
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	12

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	19
Limitations - Trustworthiness and limitations of findings	22

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	-
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	-

*The authors created the SRQR by searching literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

Document 5. Graphical representation of internal and external factors (codes) influencing the transition process