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**A mixed method study on  
Nursing graduate support programs  
in rural and remote areas of Western Australia**

This thesis is presented for the degree of  
**Doctor of Philosophy**

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School of Nursing and Midwifery  
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2020



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## Declaration

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## Abstract

**Aim:** To determine if the current rural graduate programs in Western Australia adequately support new graduate nurses transitioning into rural and remote practice.

**Background:** Graduate nurse transition to employment is a time of significant change and challenges often results in periods of transition shock. These challenges are magnified in rural areas when graduates have limited rural nursing experience and move to commence their career. Supportive graduate nursing programs are essential for enabling nursing transition to practice and assist in reducing attrition rates. Graduate programs were developed to smooth the transition for university trained bachelor's degree registered nurses into the workforce.

**Design:** A parallel convergent mixed method design which was informed by Duchscher's Stages of Transition Theory, the conceptual framework chosen to guide the study.

**Method:** Through a purposive sample of graduate and senior nurse participants were invited from rural and remote Western Australia during 2015 to mid-2016. The quantitative tool was applied three times to new graduate registered nurses of which a total of 34 completed the survey. The survey was applied once to senior nurses, 40 of whom completed the survey. Semi structured interviews were conducted for both cohorts at three separate time intervals. Ten new graduate registered nurses and 15 senior nurses were interviewed throughout the 12-month timeframe. Braun and Clarke thematic analysis was applied to analyse the qualitative data. Descriptive statistics and content analysis were used to analyse the surveys.

**Results:** In the first three months new graduates cycled through both transition shock and honeymoon periods resulting in a high level of satisfaction overall, however less satisfaction with the preceptorship. The level of satisfaction dropped significantly at seven months resulting in transition crisis before the adjustment period began. The transition occurred in a linear manner over three distinct timeframes. Limited resources were highlighted as an obstacle to providing adequate support in the rural graduate programs.

**Conclusion:** Graduate programs need to be structured but flexible to allow for individual differences in graduates and clinical situations. The honeymoon stage co-existed with transition shock which may hide the need for adequate support to continue. Inadequate and/or a lack of preceptorship was evident throughout the Western Australian rural graduate programs.

**Relevance to clinical practice:** Graduate programs need to be structured but flexible to allow for individual differences in graduates and clinical situations. New graduate nurses would benefit from a break midway through their transition year to assist and overcome the transition crisis stage. Development of the preceptor role through education is required to deliver adequate support to graduate nurses and decrease transition shock. Emphasis on the transition journey is required in undergraduate final semesters to help better prepare new graduates to manage the change from students to registered nurse.

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## Abbreviations

<b>CN</b>	Clinical Nurse
<b>CNM</b>	Clinical Nurse Manager
<b>DON</b>	Director of Nursing
<b>ED</b>	Emergency Department
<b>GNC</b>	Graduate Nurse Coordinator
<b>HR</b>	Human Resources
<b>MMAT</b>	Mixed Method Appraisal Tool
<b>NGRN</b>	New Graduate Registered Nurse
<b>RN</b>	Registered Nurse
<b>SDN</b>	Staff Development Nurse
<b>SN</b>	Senior Nurse
<b>WA</b>	Western Australia
<b>WACHS</b>	Western Australia Country Health Service
<b>WHO</b>	World Health Organization

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## Definitions

### **Graduate nurse coordinator (GNC)**

A graduate nurse coordinator relates to the senior nurse who oversees the graduate program within the hospital. Within the rural setting, the graduate nurse coordinator may hold a different name such as clinical educator or staff development nurse, and often hold more than one portfolio.

### **Supernumerary**

A supernumerary is when a nurse works alongside another nurse and does not take a patient load therefore they don't have direct responsibility and spend time learning the system in a new environment (Rush, Adamack, Gordon, Lilly, & Janke, 2013).

### **Preceptor**

A preceptor is a ward registered nurse allocated to a graduate, who aims to instil confidence, develop clinical knowledge, time management skills and encourage resolution for a selected period of time (Fedoruk & Hofmeyer, 2012).

### **Support**

Support involves a number of attributes that works towards enhancing clinical competency, increasing confidence, critical thinking and professional development of graduate nurses (Duchscher, 2008). It involves attributes such as access to nurse educators, preceptors, study days and structured programs.

### **Performance management**

Performance management is the evaluation of each graduates' level of competency by a senior nurse. Usually undertaken at the beginning of a rotation to develop learning objectives and at the end of each rotation to provide feedback on how well the graduate met the objectives.

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## List of Publications

### Appendix A:

Fowler, A. C., Twigg, D., Jacob, E., & Nattabi, B. (2018). An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates. *Journal of Clinical Nursing*, 27(5-6), e753-e766.

### Appendix C:

Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B. (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models. *Journal of Clinical Nursing*, 00(1-11).

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## Statement of Contributors

This thesis contains published work, all of which has been co-authored. The bibliographical details of the work, a description of the work, and an estimated percentage of contribution (%) of each author are listed below:

**Article 1:** Fowler, A. C. (70%), Twigg, D. (10%), Jacob, E. (10%), & Nattabi, B. (10%)

**Title:** (2018). An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates. *Journal of Clinical Nursing*, 27(5-6), e753-e766.


Amanda Fowler (*maiden name*) – Abstract, integrated review, data extraction, interpretation of the data, discussion and draft. All other authors contributed to the abstract, review of papers for inclusion, critical review and final edit of the article.

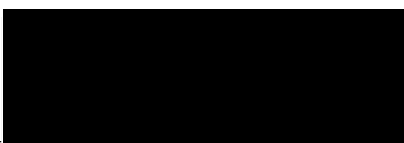
**Article 2:** Graf, A. C. (70%), Jacob, E. (10%), Twigg, D. (10%) & Nattabi, B. (10%)

**Title:** (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models. *Journal of Clinical Nursing*, 00(1-11).

Amanda Graf – Abstract, critical review of each framework, discussion recommendations and draft. All other authors contributed to the abstract, design, method, critical review and final edit of the article.

We confirm permission has been obtained from all authors to include the articles in this PhD thesis.

Signed  Date 14/05/2020  
Professor Diane Twigg, co-authored both articles

Signed  Date 12/05/2020  
Associate Professor Elisabeth Jacob, co-authored both articles

Signed  Date 12/05/2020  
Dr Barbara Nattabi, co-authored both articles

Signed  Date 12/05/2020  
Amanda Graf, PhD Candidate



---

## Acknowledgements

I first started this research journey back in 2013 believing that I was not smart enough to gain a doctorate degree. However, my principle supervisor believed in me right from the start, and although my question changed and I talked in circles a lot (this really frustrated Di) whilst learning the art of research, Professor Di Twigg supported me with her expert advice, each step of the way. Being intelligent is not the only trait needed to complete a PhD, as persistence and stubbornness also helps which I definitely possess. With this in mind, I invited two more esteem academics to join my supervisory team, Dr Barbara Nattabi and after candidature, Associate Professor Elisabeth Jacob. Thank you, Barbara, for your sound advice and for trying to teach me the art of academic writing. Beth, I argued with you the most as your expertise was with both research method and overarching question – thank you for your valuable insight and difference of opinion along the way. I was privileged to have three very different mind sets provide guidance and support as each chapter and publication was developed within this thesis. Thank you all for providing support and guidance over the past seven years.

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## Quotation

“Like beauty theory is in the eye of the beholder”

(Saldaña, 2016, pp. 278)

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# **CHAPTER 1: Introduction**

## **Introduction**

Expectations of new graduate rural nurses differ to what is expected of metropolitan graduate nurses as rural nursing is different to nursing in the metropolitan areas. Literature suggest there is greater autonomy, a sense of community and often varied clinical skills required in rural areas (Lea & Cruickshank 2007; Lea & Cruickshank, 2014). The diversity of patients and level of responsibility differ in the rural hospital which can be attributed to lower staff ratio, and patients with varied illness or medical complaints. The clinical knowledge required for rural nursing is broad as opposed to specific (Lea & Cruickshank, 2017), moving between nursing paediatric, adults to older adults and emergency cases. Bennett, Barlow, Brown, & Jones (2012) claim that attrition rates for new graduates are as high as 86% in some rural and remote areas in Australia. Within rural Western Australia (WA) in 2015, there are 17 hospitals throughout the seven regions offering graduate programs to support the transition to rural registered nursing. Transition programs are vital in rural areas to reduce the effects of transition shock and decrease attrition rates.

This chapter presents the rationale for this study and explains why this particular area of nursing was chosen for investigation. It provides an overview of the support available for graduate nurses and the broad healthcare setting within rural and remote Western Australia. In addition, this chapter will outline the purpose and significance of the study and conclude with an overview of the thesis structure.

## **Rationale for this study**

During my clinical career, I worked across three different regions within rural Western Australia. While in a senior position I was approached by junior nurses who required support and education as part of their graduate program. I found the experience of assisting junior nurses with complex procedures unsettling. I felt unprepared as I did not feel I had the skills to teach advanced clinical procedures. At the time, no formal training programs were offered to senior nurses in the hospital prior to taking on preceptor roles. I later discovered that there were no structured programs available to the junior nurses in the rural area. This was due to the fact that the nurse educator

overseeing the 12-month graduate program in the hospital, was also the only clinical nurse manager with many other hospital responsibilities.

My lack of preceptorship training, absence of formalised training programs for graduate nurses in the rural environment and dearth of literature in this area, therefore kindled my interest in this field of research. I developed an interest in determining what were the facilitators and barriers to effective graduate nursing programs and what sort of rural training programs adequately supported nurses in their transition from university to rural clinical practice.

## **Graduate nurse programs**

In Australia throughout the 1980s, nursing education moved from a hospital-based training model to the university sector (El Haddad, Moxham, & Broadbent, 2013). Prior to 1980, nursing education in Australia consisted of an apprenticeship-style training where the majority of clinical skills were learnt within the hospital environment (Cowin & Duchscher, 2008). Student nurses were employed by hospitals and conducted their apprenticeship within one facility. It was during this time that nurses learnt the culture of the clinical environment and became an integral part of the hospital setting (El Haddad, et al., 2013). However, since the shift of nursing training to the university sector, practical experience during a nursing students' education is now attained at a variety of facilities. This, coupled with advances in the technology and complexity of patient care, have led to increasing demands for accountability from both universities and hospitals to train nurses for the future workforce (El Haddad, et al., 2013).

Transition programs for graduate registered nurses were introduced into most hospitals in Australia following the move of nurse education into the university setting. The introduction of these graduate programs was premised upon the understanding that new graduates require time to adequately develop particular skill sets. Research also found that the high attrition rate of newly trained graduates was often due to lack of confidence and support within the first few months (Goode, Lynn, Krsek & Bednash, 2009). Reducing the notably high attrition rates both nationally and internationally during the graduate programs, are important factors to consider especially considering the estimated worldwide future nursing shortage (Rush, Adamack, Gordon, Lilly, & Janke, 2013). Graduate training programs are currently offered throughout Australia in

the first year of practice, to bridge the gap, with the theory taught at university compared to the practice expected in a clinical setting (de Swardt, du Toit & Botha, 2012). The graduate programs also help reduce the initial culture shock, which is often experienced when a graduate is new to an environment and has limited experience considering that it takes time to adjust to a new clinical environment (Kramer, Brewer & Maguire, 2013). The graduate program has become an essential part of the new graduates' transition year. The requirements for graduates have changed significantly since the move of registered nurse (RN) education into the universities and the decreased clinical exposure during training (Reeves, 2007). Rush et al., (2013) suggest that structured graduate programs need to focus on implementation of clinical skills, mentorship training and peer collaboration, all areas which are difficult to teach in university nursing programs.

While it is acknowledged that research has been conducted into graduate nurse programs across Australia and internationally, the uniqueness of Western Australia, including the remoteness and limited resources available in areas outside metropolitan Perth, had not yet been researched nor had literature published. For this reason, the research presented in this thesis explored the nature of support available to new graduate registered nurses (NGRN) undertaking graduate programs, throughout all the seven regions of rural and remote Western Australia.

## **Rural and remote workforce**

Western Australia has a surface area of 2.5 million square kilometres, with a significant area considered rural, remote and very remote (WACHS, 2018). The way remoteness and rurality are defined and understood is important. Defined remoteness or rurality is used to assess health and workforce needs, and the resources allocated to meet these needs, include staff and physical resourcing, and other funding.

Several different classification systems have been developed to define remoteness and rurality in Australia. These tend to be defined in terms of the size of a community, distance from population centres, and access to services. In Australia, the three systems most commonly used to categorise remoteness include:

- The Rural Remote and Metropolitan Areas classification uses population size and direct distance from the nearest service centre to determine seven

categories: capital cities, other metropolitan centres, large rural centres, small rural centres, other rural areas, remote centres and other remote areas.

- Accessibility/Remoteness Index of Australia uses a geographical information system to define road distance to service centres to produce a sliding scale of remoteness. Accessibility/Remoteness Index of Australia includes five categories: highly accessible, accessible, moderately accessible, remote, and very remote.
- The Australian Standard Geographical Classification defines remoteness by Census Collection Districts on the basis on the average Accessibility/Remoteness Index of Australia score within the district. The remoteness of local areas is then assessed and classified by the Accessibility/Remoteness Index of Australia categories: major cities, inner regional, outer regional, remote and very remote.

(AIHW, 2004)

Rural and remote areas employ a smaller percentage of nurses compared to metropolitan areas. According to the World Health Organization (WHO), 50% of the world's population lives rurally, however only 38% of nurses worldwide, work within rural areas (WHO, 2009). According to Mills, Francis, and Bonner (2005) the rural nursing population within Australia accounts for approximately 26% of the total nursing workforce. Life in the rural sector is often likened to living in a goldfish bowl (Germov, 2009). Health care professionals have the sense of being known in a community, lacking privacy and often being consulted in shopping centres for medical advice (Germov, 2009). Socialisation can be difficult and isolating, living and working in a rural setting creates an extra dilemma for new graduates to navigate (Lea & Cruikshank, 2007). Rural areas of Western Australia encompass one third of Australia's surface area, and similar to national figures, 25% of the Western Australian nursing population are located in rural areas (WACHS, 2010). Western Australia Country Health Service provides over 29 direct patient services including acute, chronic, and palliative care services to over 531,934 people (ABS 2016 cited in WACHS 2018; WACHS, 2012).

Rural Western Australia is divided into seven regions for the purpose of delivering health care and the majority of these regions are located north of Perth. The

northern regions include the Kimberley, Pilbara, Midwest, Wheatbelt, and Goldfields. The South West and Great Southern regions are located south of Perth (see Figure 4:2). According to WACHS (2010) the further north a healthcare centre is situated the more population density decreases. For example, the Kimberley region has an estimated population of 36,000 in a land area of 421,450 square kilometres (0.09 people per square kilometre), whereas the South West has a population of 167,000 with a land area of only 24,000 square kilometres (7 people per square kilometre).

Based on distance from essential services, the Kimberley region is more remote than the South West. The Goldfields, on the other hand, has a land mass of 770,488 square kilometres, the largest of the seven regions of rural Western Australia, and is home to approximately 61,500 people (0.08 people per square kilometre). The Kimberley, South West and Goldfield regions areas are all classified as rural; however, the majority of the Kimberley region is further classified as remote and very remote. The Goldfields are further classified as very remote, remote and outer regional, in comparison to the South West region, which is classified inner regional, outer regional and remote (Wood, Newton, Bineham, & Lockwood, 2012a, 2012b, 2012c). The classification of the three rural areas highlights the diversity in the country regions and is reflected within the health care system of Western Australia.

## **Health profile of rural and remote population of Western Australia**

The demographics and demands on Western Australian hospital and healthcare services vary and are dependent on remoteness and population density. For example, in the Kimberly region, 46% of the residents are of Aboriginal descent, compared to only 3% in the South West (Wood et al., 2012a, 2012b, 2012c). Within the Pilbara region, about half of the population are fly in fly out (FIFO) or drive in and drive out (DIDO) employees (WACHS, 2010). Fly in fly out and drive in and drive out employees in Western Australia mainly consist of employees of mining and resource development companies who work on a roster system. They fly or drive to remote areas and work on site for a selected period of time before returning home for a period (Storey, 2010).

Given the substantial differences in population demographics across the state, each of the regions has different healthcare needs and demands. According to Wood et al., (2012a, 2012b, 2012c) the predominant reason people attend emergency



departments (ED) across rural Western Australia is due to injury, poisoning and toxic drug effects, with the exception being in the Kimberly region. The high percentage of injury presentations can be attributed to the types of employment in rural areas, which includes agriculture, mining, forestry and fishing jobs (Germov, 2014). These work categories are considered some of the highest risk jobs in Australia (Germov, 2014).

In contrast to other regions, the Kimberley region demonstrates different emergency department presentations, although high risk jobs are prominent within the region. Health profile statistics revealed that skin, subcutaneous tissue and breast related conditions were the main reasons people presented to the emergency department in 2013/14 (Serafino & Anderson, 2015). Norwegian scabies, which is highly contagious, (Holt, McCarthy & Carapetis, 2010) is often seen in emergency departments as opposed to a general practice largely due to the cost and lack of general practitioner clinics in some areas (Serafino & Anderson, 2015). Category three presentations, the classification assigned to patients who are unwell but not critical and need to be seen in less than 30 minutes, were also high in the Kimberley region (Wood et al., 2012a, 2012b, 2012c). It should be noted that the Kimberley region has a higher percentage of Aboriginal people, who live in crowded conditions and have a high prevalence of chronic diseases. For example, renal failure is 10 times more common and cardiovascular presentations are four times higher than the non-Aboriginal population. Because of the higher prevalence of chronic diseases, Aboriginal people have a lower life expectancy (Germov, 2014).

In all seven regions there are large proportions of non-emergency, general practice presentations. The frequency of diseases of the ear, nose and throat, respiratory disorders, muscular skeletal conditions and digestive disorders varies between regions (Wood et al., 2012a, 2012b, 2012c). The variance could be attributed to access to healthcare centres, socioeconomic factors, transport issues, education and age (Serafino, Anderson & Waenerberg, 2015). This indicates that healthcare services in Western Australia would benefit from improved primary health care facilities across all regions (Wood et al., 2012a, 2012b, 2012c). Whilst these statistics do not take into account the very remote nursing posts or health care facilities, that due to their location do not have an emergency department, they provide an overview of the healthcare needs of rural and remote Western Australia. According to Phillips (2009), health outcomes in rural

settings are worse than health outcomes in metropolitan areas and tend to worsen the more remote a region is.

Differences in severity or types of presentation between rural and remote Western Australia can present challenges for graduate nurses, particularly those trained in metropolitan centres who have not had rural and remote hospital placements during their university education. Patients can present with poor social conditions and prevalent health complaints which increases the challenge. These are known factors which impact on graduate nurses. What is unknown is how well graduate nurse programs in these rural and remote locations supports the graduate nurse during their transition phase.

## **Purpose of this research**

The purpose of this research project was to determine if the rural graduate programs in Western Australia adequately support new graduate nurses transitioning into rural and remote practice. This study explored the experiences of new graduate registered nurses and senior registered nurses (SNs) to determine if current graduate programs were effective in supporting new graduates to build the confidence and skills necessary for rural and remote practice. This study explored the facilitators and barriers to effective nursing graduate programs in rural and remote Western Australia. The research also considered if a sustainable, structured and universal graduate nurse programs for rural and remote areas within the seven regions of Western Australia was desirable and practical.

## **Research questions**

1. What are the experiences of nursing graduates in rural and remote Western Australia?
2. Are the rural nursing graduate programs effective in supporting new graduates in building confidence for rural and remote practice?
3. What are the facilitators and barriers to effective nursing graduate programs in rural and remote areas?
4. How satisfied are graduate nurses with the nursing graduate programs in rural and remote Western Australia?

## Objectives

- To explore and describe the experiences of nursing graduates in rural and remote Western Australia.
- To determine the effectiveness of rural transition programs in building the confidence of new graduate nurses over a 12-month period.
- To determine the effectiveness of rural and remote transition programs in providing adequate support for nursing graduates to enable consolidation of knowledge.
- To identify the facilitators and barriers to effective nursing graduate transition programs.

## Significance of the study

The transition phase for graduate nurses has been subject of numerous reviews (Rush, et al., 2013). However very few studies have investigated the supportive measures for rural and remote graduate nurses (Lea & Cruickshank, 2015; Mills, Birks & Hegney, 2010; Mills et al., 2005; Ostini & Bonner, 2012; Sivamalai, 2008; Trépanier et al., 2013). To date there is no literature on the graduate nursing programs in rural and remote Western Australia. This research therefore provides both a practical and theoretical contribution to the health sector workforce in Western Australia.

In the past, attrition rates within the first year of nursing have been recorded at unacceptable rates due to inadequate nursing transition graduate programs (Rush, et al., 2013). Bennett, Brown, Barlow, & Jones (2010) found that attrition rates within the first year of nursing practice were between 20-50% and have been noted in some rural and remote areas to be as high as 86% in Australia. Internationally, the implementation of structured graduate programs has been associated with a decrease in attrition from 34% to 6% (Bennett, et al., 2010; El Haddad, et al., 2013; Rush et al., 2013).

Although there are structured programs within rural and remote Western Australia, every region has a different program with different support systems available to graduate nurses. This research explored whether the current programs provided the support required, for both new graduate registered nurses and senior nurses working with graduates in rural and remote areas. This study reviewed the level of support and

intention of graduates to continue working in rural areas after completion of the graduate year.

## **Method**

A parallel convergent mixed method approach was chosen for the study. Creswell (2014), along with Teddlie and Tashakkori (2009), stipulate that applying mixed methods to research values both statistical and narrative views. Qualitative data from interviews and quantitative data from questionnaires were collected simultaneously at 3-4 monthly intervals over a 12-month period. Graduate nurses and senior nurses' precepting graduates were included within the study. The experiences of both senior and graduate nurses were considered vital to this research as both are integral parts of the graduate program.

Duchscher's theoretical framework, also known as the Stages of Transition, was selected as the framework for this research. Duchscher's (2007) framework has a strong theoretical influence from two seminal frameworks, Kramer Reality Shock framework (Kramer 1974) and Benner's Novice to Expert framework (Benner 1984), (Duchscher, 2008). The framework provided a structured approach to the collection of both qualitative and quantitative data, with the underlying concepts used to develop the questionnaire and the semi-structured questions. The framework also guided the analysis of both qualitative and quantitative data.

## **Organisation of the thesis**

This thesis includes 11 chapters, commencing with this introductory chapter which has outlined the rationale for this study. This chapter includes a background to the study providing a very brief history of nursing graduate programs and an outline of the issues experienced with rural and remote health services. Also included is the purpose and significance of the study, an outline of the research questions and aims, method, and a brief introduction to the theoretical framework.

Chapter 2 consists of an integrated review of the literature on graduate nurse programs, drawing on international and national research. Emphasis is placed on the facilitators and barriers of graduate programs in both rural and metropolitan settings.

The integrated review elucidates the lack of research regarding rural and remote nurse graduate programs in Western Australia.

Chapter 3 provides a description of the theoretical framework underpinning this study, the Duchscher Stages of Transition Theory, focusing on the doing, being and knowing stages. This model encompasses socialisation, reality shock and the clinical progression of a graduate nurse's transition to practice.

Chapter 4 describes the research paradigm, the study design and the research methods used in this study highlighting why a mixed method approach was chosen. The settings for the research and how the participants were selected are outlined along with ethical considerations, development of the questionnaire, data collection, and the data analysis methods.

Chapters 5 and 6 present the qualitative findings on the facilitators and barriers experienced by both new graduate registered nurses and senior nurses throughout the 12 months' transition into rural and remote practice. Chapters 7 and 8 present the quantitative findings from the nursing graduates and senior nurses, respectively.

Chapter 9 presents both the qualitative and quantitative findings together. Chapter 10 brings together all the findings and reflects on the graduates' transition experiences provides an idea of a new model evolving from the Duchscher framework. This chapter also interprets recent literature to support or challenge the findings from this study. The final chapter, Chapter 11, presents a summation of the findings and proposes opportunities for future research.

## CHAPTER 2: Integrated Review

Chapter 2 of this thesis has been published by Wiley as the following article:

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(Published under Amanda Graf's former name A. C. Fowler)

The green open access version of this paper will be available at:

<https://ro.ecu.edu.au/ecuworkspost2013/3799/>

## REVIEW

# An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates

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**Aims and objectives:** To examine international studies that specifically focus on transition to practice for graduate registered nurses in rural and remote areas.

**Background:** Supportive graduate nursing programmes are essential for enabling nursing graduates' transition to practice and reducing attrition rates. Literature examining support measures for nursing graduates within metropolitan areas is abundant. However, there is a paucity of evidence on effective graduate programmes for rural and remote-based nursing graduates.

**Design:** A systematic approach was used to identify robust research within appropriate electronic databases.

**Method:** Eligible articles were critically reviewed using the Mixed Method Appraisal Tool critical appraisal tool. Eligible articles were thematically analysed using the Braun and Clark approach.

**Results:** Eight articles met the selection criteria for inclusion. Findings revealed that while most graduate nurses survived the transition process, they often felt overwhelmed and abandoned with intense feelings of frustration. Many suffered transition shock and did not feel ready for the role. Socialisation of graduates to the clinical environment was lacking. Support offered in many graduate programmes was ad hoc and unstructured. Senior staff were inadequately supported in their roles as preceptors to assist with the transition. Critical support measures recommended included both debrief sessions and regular one-on-one support.

**Conclusions:** Graduate programmes need to be structured yet flexible to accommodate the needs of rural and remote nurse graduates. Graduates need to be transitioned into practice with decremental support processes for both workloads and education. Preceptors require education on how to mentor before they can provide the appropriate support for graduates. Without these measures in place, a decrease in transition shock may not be possible.

**Relevance to clinical practice:** Graduate programmes need to be structured yet flexible, including assistance with both clinical skills and socialisation. Senior staff require education before they can adequately support new graduates.

**KEYWORDS**

graduate programmes, new graduate nurses, preceptorship, rural and remote, socialisation

## 1 | INTRODUCTION

New graduate programmes following completion of degree programmes are currently offered in many countries for registered nurses. As registered nurse education is predominately conducted in universities, new graduate programmes have become essential to bridge the gap between theory and practice and to help reduce the initial transition shock for graduate nurses. A new graduate's experience during transition into the workforce is directly related to attrition rates (Phillips, Kenny, Esterman, & Smith, 2013). Frequent restructuring of rural healthcare facilities can lead to staff shortages. As a result of these shortages, graduate nurses are being expected to work without support, beyond their present abilities, creating less than desirable graduate experiences (Lea & Cruickshank, 2007). In rural Australia, nurse graduate attrition rates have been reported to be as high as 86% (Bennett, Brown, Barlow, & Jones, 2010). Reducing the notably high attrition rates both nationally and internationally during new graduate programmes is crucial, especially with the projected future nursing shortages (Rush, Adamack, Gordon, Lilly, & Janke, 2013). The needs of the novice nurses are dynamic and have changed significantly since the transfer of registered nurse education from health services to the university system (Reeves, 2007). Rush et al. (2013) suggest that structured new graduate programmes should focus on clinical skills, mentorship training and peer collaboration. The purpose of this review was to examine studies worldwide that are specifically focused on the support new graduate registered nurses in rural and remote areas receive and their experiences of their new graduate programmes during their transition to practice.

### 1.1 | Graduate transition

Workforce planners are experiencing challenges due to the significant number of experienced nurses reaching the age of retirement (Hoare, Mills, & Francis, 2013). A shortage of 85,000 nurses by 2025 is predicted by Health Workforce Australia (Health Workforce Australia, 2014) as the number of nurses retiring is greater than those entering the workforce. This workforce shift has placed a strain on health facilities both in primary healthcare and in acute healthcare settings (El Haddad, Moxham, & Broadbent, 2012).

Increasing the number of new graduate nurses is one strategy to manage the predicted shortage (El Haddad et al., 2012; Gregg, Shigematsu, Hayashi, Kono, & Yoshida, 2011; Koh, 2013; Kowalski & Cross, 2010; Wu, Fox, Stokes, & Adam, 2012). However, there is evidence that an increasing number of new graduate nurses are leaving the profession within the first year of employment (Parker, Giles, Lantry, & McMillan, 2012). Reasons behind rising attrition rates include bullying, poor training, insufficient socialisation, ineffective support, unrealistic workloads and transition shock (Phillips et al., 2013). Widespread research indicates that transition shock is common among new graduate nurses, both in rural and in urban areas in Australia (Fielden, 2012; Gregg et al., 2011; Kowalski & Cross, 2010; Lea & Cruickshank, 2007; Phillips et al., 2013). "Transition shock" is a term that incorporates four

#### What does this paper contribute to the wider global community?

- Rural and remote preceptors are required to provide both social and clinical support and need to be educated on how to best undertake this.
- Graduates programmes need to be structured but flexible to allow for individual differences in graduates and clinical situations.
- Further research is required to understand the needs of the rural and remote graduate nurse.

distinct elements relevant to the graduate's experience: emotional, physical, sociocultural and intellectual (Duchscher, 2007). Transition shock may occur when a new graduate is placed in an environment that is new or foreign and is characterised by emotions including stress, frustration, discouragement and disillusionment (Duchscher, 2009). Within the first 4 months of employment, the emotional challenges of the transition vary depending on the supportive nature of the environment (Duchscher, 2007). New graduates who are less supported are more likely to feel overwhelmed, scared, have self-doubt and be fearful, which may result in the resignation of a graduate nurse. Consequently, a new graduate's experience during the transition into the workforce directly influences attrition rates (Phillips et al., 2013). In Australia, the estimated cost to replace a new graduate is approximately AU\$100,000 (El Haddad et al., 2012).

Australian research has found that heavy workloads, inadequate levels of support and undesirable organisational cultures are associated with negative experiences within the first year of a nurse's career, resulting in some 50% of new graduates leaving during this period (Parker et al., 2012). Unclear or unrealistic expectations of a new graduate nurse may add to their frustration and ultimately result in negative experiences (Fielden, 2012; Koh, 2013; Lea & Cruickshank, 2007; Ostini & Bonner, 2012). Similarly, research in Sweden demonstrates that lack of confidence, feelings of frustration and inadequacy and not feeling ready to take on a full patient load are some of the main complaints of new graduate nurses when they first enter the workforce (Andersson & Edberg, 2010). Similarly, studies from Saudi Arabia and Singapore have found that new graduates are often overwhelmed at the beginning of their transition (Fielden, 2012; Koh, 2013; Lea & Cruickshank, 2007). The responsibility of preparing new graduates for the transition lies with universities, according to Lea and Cruickshank (2007), who suggest that universities need to prepare undergraduates so they know how to manage expected social and clinical challenges in the work place.

Nursing education in Australia moved to the university sectors during the 1980s, and subsequently, both universities and hospitals jointly assumed accountability for the quality of nurses entering the workforce. Despite this joint accountability, El Haddad et al. (2012) argue that preregistration education is the domain of universities, while postregistration training is exclusively the responsibility of



healthcare facilities. As new graduate nurses have completed preregistration education, this places a burden on healthcare facilities to adequately support the increasing number of nursing new graduates and to effectively decrease the rate of attrition. Healthcare facilities must be aware that, no matter what university education was attained, new graduate nurses may not be necessarily work ready and able to undertake a full workload (Keahey, 2008). A gap may exist between what was taught in theory and how to implement the knowledge into practice, making a new graduate programme an essential part of a transition year (El Haddad et al., 2012; Koh, 2013; Wolff, Pesut, & Regan, 2010). Structured new graduate programmes need to focus on clinical skills, mentorship training and peer collaboration (Rush et al., 2013).

## 1.2 | The rural context

Experiences for new graduate nurses in rural areas differ from urban graduates; rural nurses are often expected to work in several departments, become specialised in more than one area, show confidence in their skills and be able to work independently (Keahey, 2008). Consequently, nurses in rural areas are more generalised the more remotely they work (Mills, Birks, & Hegney, 2010). Rural nurse managers have been found to expect new graduates to be independent workers, critical thinkers and demonstrate competence in generalist nursing skills on commencement of their graduate year (Bennett, Barlow, Brown, & Jones, 2012; Nayda & Cheri, 2008). Lea and Cruickshank (2007) argue this is an unrealistic expectation, as the generalist skill set required for rural nursing often takes years to acquire. Over the last decade, new graduate programmes have been ad hoc and fall short of what is required for rural new graduates (Bennett et al., 2010). Parker et al. (2012) suggested that transition to practice in rural and remote areas could be improved with access to education, organisational support and enhanced communication along with the availability of resources specifically relevant to rural areas.

In addition to clinical orientation, new graduate nurses relocating to a rural hospital need to transition socially (McKenna & Newton, 2008). Rural nurses tend to reside in the communities where they work, often finding that they have to maintain both professional and social relationships with coworkers and patients. When something negative happens in a nurse's private life, it is difficult to keep it private from the rest of the community (Mills et al., 2010). Equally daunting is nursing a client belonging to the same social group within the community. This substantially increases the general pressures in developing the required skill set of a registered nurse and is why support and guidance is critical to the successful transition of new graduate nurses in rural areas (Keahey, 2008).

There is a plethora of information discussing the new graduate nurse experience, transition and the importance of strong support during the transition period in metropolitan areas (El Haddad et al., 2012; Koh, 2013; Rush et al., 2013; Wolff et al., 2010). However, there is limited literature available on the support available for new graduate nurses within the rural context and how best to ensure their retention in the health workforce.

## 2 | AIMS

The purpose of this integrative review was to examine studies worldwide that specifically focused on support processes for new graduate registered nurses in rural and remote areas and their experiences of their new graduate programmes and transition to practice. The aim of this analysis was to identify the qualitative, quantitative and mixed-method studies that explore the experiences of rural and remote new graduate registered nurses who participated in new graduate programmes.

### 2.1 | Research questions

1. What support structures are available to assist the transition of new graduate registered nurses in rural and remote areas?
2. What are the experiences of rural nursing graduates enrolled in new graduate programmes?

## 3 | METHODS

The following PICoS statement was used for the search strategy for all research study designs:

### 3.1 | Protocol

P (population)	graduate nurses
I (phenomenon of interest)	new graduate programmes
Co (context)	remote and rural hospitals
S (study design)	mixed/integrative methodology, qualitative and quantitative

The Joanna Briggs Institute (2014) literature review method was followed. This process involved the development of objectives, inclusion and exclusion criteria, a comprehensive search, critical appraisal, data analysis and final presentation. However, the Mixed Method Appraisal Tool (MMAT) was applied to critically appraise the literature. The Mixed Method Appraisal Tool (MMAT) consists of four main criteria for each study design. The presence or absence of a criterion attracts a quality score of 25% or 0%, respectively. The lowest score for either the qualitative or quantitative segment in a mixed-method study is recorded because the quality of the article cannot exceed the weakest component (Pluye, Gagnon, Griffiths, & Johnson-Lafleur, 2009). The databases searched included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, ERIC, Informit, Web of Science and Scopus. There were three major groups of search terms: "graduate nurses," "graduate programmes" and "rural and remote settings," were used for the search of each database as listed in Table 1. Boolean terms "OR" and "AND" were applied where appropriate.

**TABLE 1** An example of the search terms used in CINAHL database Logic Grid with Keywords and Index Terms or Subject Headings (CINAHL)

Population	Interest	Context	Study design
Graduate Nurses	Graduate programmes	Remote/Rural Hospitals	Mixed/Integrative
New nurse(s)	Transitional programme(s)	Remote hospitals	Qualitative studies
New graduate nurse(s)	Learning environment(s)	Remote practice	Quantitative
Novice nurses	Training support	Rural practice	
MH new graduate nurses—education	Clinical competence	Rural	Mixed
MH new graduate nurses	Clinical supervision	Rural health	
MH new graduate nurses—psychosocial factors	Professional development	MH hospitals, rural	
MH novice nurses	MH clinical supervision	MH rural health services	
MH novice nurses—education	MH transitional programmes	MH rural health nursing?	
MH novice nurses—psychosocial factors	MH learning environment	MH rural health	
	MH learning environment—clinical	MH rural health centres	
	MH support, psychosocial	Regional hospitals	
	MH support, psychosocial, education	Regional practice	
	MH clinical competence		
	MH professional development		
	MH preceptorship		
	Preceptorship		

### 3.2 | Screening

The literature search followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart guidelines (Moher, Liberati, Tetzlaff, & Altman, 2010). The Mixed Method Appraisal Tool (MMAT) was applied to critically appraise the selected articles (Pluye & Hong, 2014). Inclusion criteria included papers in the English language, and peer-reviewed research articles. Papers were included from 1988 onwards, as this was when the transition from hospital-based training to tertiary education commenced in many countries (El Haddad et al., 2012). Inclusion criteria also included rural and remote context and new graduate programmes offered in hospital settings. Exclusion criteria included any studies that focused on programme evaluation and discussion papers only, undergraduate nursing programmes or community new graduate programmes.

### 3.3 | Data extraction and quality appraisal

Figure 1 presents the search strategy: the initial search generated 787 articles. When limiters such as dates, English language and peer review were applied following the PICoS, 448 articles were excluded. This decreased the number of articles to 339. Forty-one articles were then excluded as they focused on undergraduate programmes. Of the 298 identified articles, both titles and abstracts were screened by two reviewers (AF and EJ), and 18 articles remained. Two independent reviewers (AF and EJ or AF and DT) reviewed the articles using the MMAT critical appraisal tool, and 10 articles were excluded because they were discussion articles or evaluations and did not explore new graduate nurses' experiences. The majority of

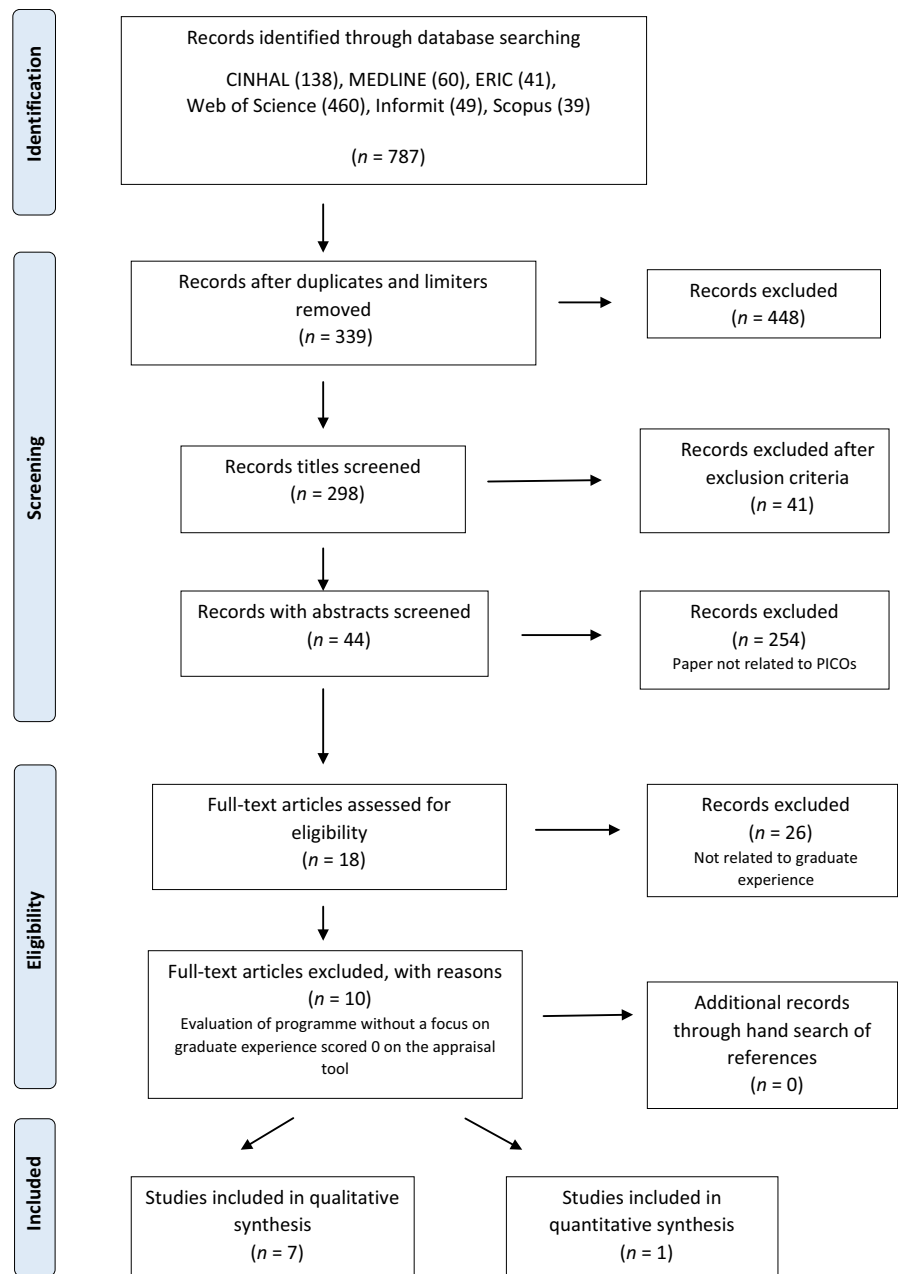
the eight remaining papers were qualitative studies and one was a quantitative study. The studies listed in Table 2 were mainly conducted in Australia and one was based in the USA. Most of the papers scored 75 or above on the MMAT appraisal tool and only one scored 50.

Once the studies were selected, data were extracted, and synthesis of the data followed a thematic analysis approach following Braun and Clarke (2006) step-by-step approach. There are six steps within this thematic approach; first, one becomes familiar with the data, then creates codes, identifies themes, uses a concept map to review the themes, describes and names the themes and finally provides a report (Braun & Clarke, 2006). The findings from the quantitative study were included in the analysis results to support the initial themes evident from the qualitative papers.

## 4 | RESULTS

### 4.1 | Setting

Eight studies were included in the review, seven based in Australia and one in the United States of America (USA). The Australian studies were based in the states of New South Wales (NSW) (5), Victoria (1) and South Australia (SA) (1). The five papers from NSW reported on three separate studies. One study explored the perceptions of 16 senior nurses from one hospital (Lea & Cruickshank, 2015), while another focused on the experience of 15 new graduates from 14 different rural towns (Lea & Cruickshank, 2014). Two papers examined the perspectives of 10 new graduate nurses (Lea & Cruickshank, 2005, 2007). The qualitative study based in South



**FIGURE 1** Integrative review PRISMA flow chart

Australia consisted of 21 participants from 14 rural hospitals (Mellor & Greenhill, 2014), and another study in NSW included a small cohort of five participants all from the same hospital (Ostini & Bonner, 2012). Six studies explored the experiences of new graduate nurses in rural and remote hospital settings. Most new graduate nurses were working in public hospitals, although one study also interviewed new graduate nurses from private health facilities. The USA-based study based in the state of Milwaukee interviewed 382 new graduate nurses from urban areas and 86 rural-based new graduate nurses.

## 4.2 | Experiences of the nursing graduates

On conducting thematic analysis of the papers, two main themes were identified around the experience of new

graduate nurses: “transition shock” and “a sense of belonging” (Table 3).

### 4.2.1 | Transition shock

Transition shock may occur when a new graduate is placed in an environment that is new or foreign and is characterised by unrealistic expectations (Lea & Cruickshank, 2014). New graduates who are less supported are more likely to experience transition shock and feel overwhelmed, scared, have self-doubt and be fearful (Lea & Cruickshank, 2014). Transition shock can be caused by role ambiguity and often leads to internal conflict (Lea & Cruickshank, 2014). Many of the new graduate nurses who participated in the reviewed studies experienced transition shock; this theme is subdivided into three subthemes, “overwhelmed with change,” “abandonment” and “fractured reality.”

**TABLE 2** Summary of the literature reviewed

Data extraction						
Author and title	Country	Research Aims	MMAT score	Participants	Method/Methodology	Key findings/themes
Mellor and Greenhill (2014). A patient safety focused registered nurse transition to practice program	Australia South Australia (S.A)	To determine the nature of professional support given to new graduate registered nurses in rural areas?	75	n = 21 new graduate registered nurses' (NGRN's) participants from 14 rural hospitals	Qualitative Grounded theory Focus groups Thematic analysis End of transition year	Underprepared for practice—graduates identified the gap between theory and practice and found the role of RN was very different from that of a student Overwhelmed and abandoned—graduates were expected to be fully work ready, preceptors were not prepared for the role, little feedback was provided to students, and systems were not in place to facilitate the preceptor role. Need for clinical supervision—new graduates expressed the need to learn about quality and safety in clinical practice
Ostini and Bonner (2012). Australian new graduate experiences during their transition program in a rural/regional acute care setting	Australia New South Wales (NSW)	To explore the experiences of new graduates in their transition to the RN role in a rural context	75	n = 5 NGRNs From one regional facility	Qualitative Interpretative paradigm Content analysis Semistructured interviews	Being supported—this included orientation, supernumerary time, assistance with time management, debriefs and availability of clinical educator Being challenged—learning not to panic, doing things themselves, difference between being a student and an RN Reflections on being a new graduate—looking at things that could be improved in a programme. Reflections on a rural new graduate programme—highlights the differences and advantages of a rural new graduate programme in a large regional facility

(Continues)

TABLE 2 (Continued)

Data extraction						
Author and title	Country	Research Aims	MMAT score	Participants	Method/Methodology	Key findings/themes
Lea and Cruickshank (2005). Factors that influence the recruitment and retention of graduate nurses in rural health care facilities	Australia NSW	1. To find out about the recruitment and retention of new graduates 2. To explore the journey of transition for new graduates employed in graduate nurse transition programmes in northern New South Wales (NSW)	50	n = 10 NGRN's participants 8 different hospitals	Qualitative hermeneutic–phenomenological approach Semistructured interviews	Having rural connection—the main consideration for participants when making decisions to go rural was the people they knew, being a country person was often the main influence Have regrets—participants enjoyed the diversity of rural nursing practice and did not have any regrets with their choice of entering rural practice. They were, however, dissatisfied with several aspects of the rural graduate programme
Lea and Cruickshank (2015). Supporting new graduate nurses making the transition to rural practice: views from experienced rural nurses	Australia NSW	To present the findings from experienced rural nurse participants of a larger study that explored the transitional experiences of newly graduated nurses making the role transition in rural healthcare facilities in Australia	75	n = 16 senior RNs 1 × hospital	Qualitative Case study Thematic analysis Semistructured interviews	Providing support to newly graduated nurses—provision of timely support for graduates on the ward is affected by skill mix and staff allocation within the rural environment. Senior staff were lacking awareness on how to meet a graduate's support needs.
Lea and Cruickshank (2007). The experience of new graduate nurses in rural practice in New South Wales	Australia NSW	To explore the role transition for new graduate nurses in rural practice in New South Wales (NSW)	75	n = 10 NGRNs 8 different hospitals	Qualitative hermeneutic–phenomenological approach Thematic analysis 60- to 90-min in-depth interviews	Socialising to registered nursing in rural practice—Organisational culture and level of responsibility were highlighted as concerns for the graduates and influenced their retention within the rural nursing workforce.

(Continues)

**TABLE 2** (Continued)

Data extraction						
Author and title	Country	Research Aims	MMAT score	Participants	Method/Methodology	Key findings/themes
Lea and Cruickshank (2014). The support needs of new graduate nurses making the transition to rural practice in Australia	Australia NSW	1. To explore the transitional experiences of newly graduated nurses making the role transition in rural healthcare facilities in Australia 2. Identify the functional elements of rural graduate nurse transition programmes and develop guidelines that will assist in the design of transition to practice programmes that match the rural context and capacity	75	n = 15 NGRNs 14 different rural towns	Qualitative Case study Thematic analysis Semistructured interviews at 3, 6 and 10 months	Rural new graduate nurses have unique experiences and learning needs within their transition year There were three times of importance with themes: 3 months—just getting started 6 months—settling in 10 months—feeling part of the team
McKenna and Newton (2008). After the graduate year: a phenomenological exploration of how new nurses develop their knowledge and skill over the first 18 months following graduation	Australia Victoria	To explore how new nurses develop their knowledge and skill over the first 18 months following graduation, as well as factors promoting or inhibiting their development.	100	n = 21 participants including 8 participants from large regional hospitals, 13 from public metropolitan hospitals and 4 from private outer metropolitan areas	Qualitative phenomenological approach Thematic analysis Focus groups Data collected at 6 monthly intervals Last focus group only 9 participants	Sense of Belonging, Independence and Moving on were the three themes identified. It was only after the completion of a graduate year that new nurses gain a sense of belonging and were able to complete their socialisation into the clinical workplace
Bratt et al. (2014). Are rural and urban newly licensed nurses different? A longitudinal study of a nurse residency programme	USA Milwaukee	To compare rural and urban nurse residency programme participants' personal and job characteristics and perceptions of decision-making, job satisfaction, job stress, nursing performance and organisational commitment over time	75	n = 382 urban and n = 86 rural newly licensed hospital nurses	Quantitative Longitudinal design Data collected at the start, middle and end of programme	Rural nurses had significantly higher job satisfaction and lower job stress compared with urban nurses. Perceptions of their organisational commitment and competency to make decisions and perform role elements were similar

NGRN, new graduate registered nurses; NSW, New South Wales; RN, registered nurse; SA, South Australia; USA, United States of America; Vic, Victoria.

**TABLE 3** Thematic analysis

Themes	Categories	Codes
Transition shock	Overwhelmed with change	Not ready for a full patient load Expected to hit the ground running Level of responsibility
	Abandonment	Ad hoc support and education Self-support (no assigned preceptor) No formal feedback No time for formal education
	Fractured reality	Requirement to undertake leadership roles No time to reflect Lack of allocated debrief sessions Lack of clarity of preceptor roles
Sense of belonging	Horizontal violence	Allocation of heavy workload to make or break the graduate Sink or swim mentality Belittling when questions were asked
	Social support	Living in a goldfish bowl Having to socialise with work colleagues

#### 4.2.2 | Overwhelmed with change

Being overwhelmed is an emotion that occurs when a person is faced with too much of anything; a prolonged experience of being overwhelmed increases the duration of transition shock. Lea and Cruickshank (2007, 2014) and Mellor and Greenhill (2014) revealed that new graduate nurses felt overwhelmed and unprepared and less supported in comparison with metropolitan-based nurses. Initially, new graduates did not realise that the role would be significantly different from that of a student nurse and consequently experienced a degree of transition shock within the first few weeks of commencing their programmes (Lea & Cruickshank, 2014).

To further exacerbate this intense period, it appeared that the senior nurses had unrealistic expectations of the new graduates. New graduates in the rural sector were expected to “hit the ground running,” accept full responsibility for patients and to be accountable for a full patient load as soon as possible, with little support when left as the only registered nurse on the ward (Lea & Cruickshank, 2007, 2014, 2015). The responsibility of the new graduate nurse extended to supervising nursing students early in their graduate programme which only served to prolong their feelings of transition shock (Lea & Cruickshank, 2014).

#### 4.2.3 | Abandonment

Mellor and Greenhill (2014) reported that new graduates were left without supervision early on in their transition and as a result felt abandoned by senior nurses. Lea and Cruickshank (2005, 2014) and Mellor and Greenhill (2014) found that little to no structured clinical support was offered to the new graduates. Due to the shortage of staff in rural areas and inadequate skill mix, orientation was not often delivered and one-on-one support was absent at the ward level (Lea & Cruickshank, 2005, 2014; Mellor & Greenhill, 2014).

New graduates found that clinical support was ad hoc or that they had to search for support (Lea & Cruickshank, 2007, 2014, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012) what Johnstone, Kanitsaki and Currie (as cited in Lea & Cruickshank, 2015) refer to as “self-support.” Studies from NSW revealed that when the new graduates asked for support, they were met with friendly and helpful staff; however, self-support was only successful if the new graduates knew when they needed clinical support and if they were confident enough to ask (Lea & Cruickshank, 2007, 2014, 2015). The success of self-support also varied depending on senior staff working on a shift with the new graduates and not all staff were approachable (Lea & Cruickshank, 2007, 2014, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012).

Lea and Cruickshank (2015) identified that there was a lack of formal support and little feedback for new graduates. There was no time for ad hoc or on the ward educational support, and any attempt made by senior nurses to address this was problematic in the rural environment due to the lack of resources (Lea & Cruickshank, 2015). Lea and Cruickshank (2005, 2014) and Mellor and Greenhill (2014) found that new graduates were disappointed with the lack of formal feedback on their clinical practice, and they often had no idea if expected objectives were being met. In contrast, Bratt, Baernholdt, and Pruszyński (2014) reported that 92% of 86 new graduates in rural areas felt that they had met their objectives.

#### 4.2.4 | Fractured reality

Fractured reality is defined as the gap between the expectations and experiences and within this context is when a new graduate's expectations are different from what they experienced when they enrol for their programme. Transition shock occurs when the reality is far from one's expectations. Lea and Cruickshank (2015), Mellor and Greenhill (2014) and Ostini and Bonner (2012) identified factors that could work well within the supportive structured new graduate programme; however, these attributes were not often present in the rural studies and were therefore expressed as needs by both the new graduates and senior nurses. New nursing graduates soon discovered that their expectations were different to the expectations from senior staff, and time needed to ensure a safe transition was not offered (Lea & Cruickshank, 2014). In this context, fractured reality resulted.

Lea and Cruickshank (2014) found that the new graduates within the first 3 months were task-orientated and often felt stressed if they were not able to accomplish their set tasks. Similarly, Mellor and Greenhill (2014) identified that new graduates struggled to prioritise, but could cope with individual tasks if given an optimal patient load. At ward level, the new graduates said that they needed time allocated to master time management, including time to learn how to prioritise, time with a one-on-one preceptor and time to learn how to communicate with multidisciplinary staff (Lea & Cruickshank, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). Lea and Cruickshank (2015) also proposed that not being rostered on night shift, or allocated critically ill patients, allowed time for new



graduates to adjust and learn. Ostini and Bonner (2012) suggested that access to the clinical educators was also a vital component for the first 3 months of a structured programme. Clinical educators were found to offer nonjudgemental support with difficult shifts, location of equipment, psychosocial factors and policy and procedural questions (Ostini & Bonner, 2012). Discussion of patient management after the handover process was considered important and role reversal was one of the strategies suggested where the new graduate becomes the preceptor, and the preceptor becomes the new graduate, to allow time for new graduates to increase confidence and improve clinical abilities (Lea & Cruickshank, 2015).

The model of care for patients used in health services has also changed, to include a team nursing approach, resulting in new graduates being assigned team leadership roles within their first year of practice (Lea & Cruickshank, 2014, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). Educational support following implementation of this new model appeared to be lacking for new rural graduates, increasing transition shock; though, the nurses' experience depended on the level of support provided. New nursing graduates believed that to transition successfully, they would benefit from an incremental educational support process to allow time to transition from being a student to registered nurse before having to delegate and learn other leadership roles (Lea & Cruickshank, 2014, 2015; Mellor & Greenhill, 2014). Without this support, new graduates felt a level of role ambiguity in regard to delegation of duties and team leader roles, which resulted in feelings of heightened stress and anxiety (Ostini & Bonner, 2012). Intense clinical support within the first 3 months, regular debrief sessions for both good and bad experiences and time allocated to discuss learning objectives were all viewed as critical supportive measures (Lea & Cruickshank, 2014). Overall, rural new graduate nurses felt that they needed more time with their preceptors in order to adjust to their new circumstances and learn.

It is important to realise that not all senior nurses responsible for supporting the new graduates fully understood the responsibilities of being a preceptor, the importance of debrief sessions or the support new graduates needed. Senior ward staff reported having little understanding of the formal support mechanisms offered within the new graduate programme (Lea & Cruickshank, 2015). Senior nurses indicated that education was needed to acquire a more in-depth understanding of the new graduates' needs and insight when a new graduate was not coping with a workload, and time allocated to provide formal feedback (Lea & Cruickshank, 2015). Not coping with workloads may stem from a lack of time to master the clinical skills or it might be related to poor socialisation to the current ward environment.

#### 4.2.5 | A sense of belonging

A sense of belonging refers to the process of becoming enculturated within a new environment. This sense of belonging is important for all new graduates, but especially for rural nurses because in rural environments people often socialise with the same people they work

with (Lea & Cruickshank, 2007). Throughout the new graduate programme, social support can be facilitated through a consistent preceptor or mentor who promotes learning and development as well as introduces the new graduate to the department's culture, routines and practices. Lea and Cruickshank (2007) and McKenna and Newton (2008) suggest that new graduate programmes are not always successful in meeting the socialisation needs of new graduates. New graduates felt that they did not belong as long as they were viewed as being different and held the label of "new graduate"; it was not until the label was removed that a sense of belonging occurred (McKenna & Newton, 2008). The sense of belonging theme was further subdivided into two subthemes, "social support" and "horizontal violence."

#### 4.2.6 | Social support

New graduates need to assimilate and learn to communicate with the multidisciplinary team to understand the integrative process of managing critically ill patients (Mellor & Greenhill, 2014). McKenna and Newton (2008) indicate that it was not until the new graduates completed their 12-month transition programme, with a heightened level of independence and knowledge, that they felt they belonged on a ward and had the confidence to communicate effectively with the multidisciplinary team. When the transition programmes were complete, new graduates in one study were advised to seek employment in metropolitan hospitals to gain experience before settling down in the rural communities (Lea & Cruickshank, 2005; Ostini & Bonner, 2012). This resulted in new graduates losing or not attaining a sense of belonging within the rural community.

A study conducted in Victoria found that clinically short rotations added variety to a new graduate programme but decreased the opportunities for socialisation and new graduates who were not included in social events often felt that they did not belong (McKenna & Newton, 2008). Some new nursing graduates assimilated quickly into the community, particularly those originally from rural areas (Lea & Cruickshank, 2007) and other new graduates moved to be with family and thus had a support network around them (Lea & Cruickshank, 2005). Regardless, new graduates needed time to adjust to socialising with people they worked with and this could be difficult if the ward had negative dynamics (Lea & Cruickshank, 2007). Bratt et al. (2014) highlighted that nurse managers have an important role ensuring that new graduates in a rural setting are socialised appropriately to both clinical and community environments. This importance has been acknowledged by some universities in the USA where a socialisation unit is now offered within the undergraduate course (Bratt et al., 2014).

#### 4.2.7 | Horizontal violence

Lea and Cruickshank (2007) found that graduates were faced with aggressive and unprofessional behaviour from senior ward staff. A "sink and swim" mentality was also evident, with new graduates required to prove themselves before they were accepted as part of



the team (Lea & Cruickshank, 2007). Lea and Cruickshank (2007) and Ostini and Bonner (2012) identified that it took 3 weeks for new nursing graduates to settle into the ward environment although it was between 3–6 months before the new graduates felt part of a team. This depended on the attitudes of the ward staff, and if there were any negative attitudes, new graduates left the ward without ever feeling that they belonged (Lea & Cruickshank, 2007; Ostini & Bonner, 2012).

## 5 | DISCUSSION

This integrative review was focused on both support processes available and the experiences of rural and remote new graduate nurses. The themes and subthemes explored are interconnected and embedded in the professional and social needs of the new graduates. Nationally, the lack of role models is seen as a barrier to retention rates in rural settings, and the “sink or swim” mentality is considered a form of horizontal violence (Mills et al., 2010). Expecting new graduates to “hit the ground running” or observing if they can manage with little support and portray confidence enough to ask for support when needed is not in keeping with best practice evidence for new graduate programmes. Horizontal violence may be averted if new graduates have access to information, assistance such as preceptorship, resources and staff development along with choices in shifts and clinical placements (Parker et al., 2012). Future new graduate programmes would have greater success in decreasing transition shock if greater flexibility and support was provided.

Ostini and Bonner (2012) suggest that nurses tend to “eat their young” (horizontal violence), and subsequently, both a supportive organisational culture and social interactions are important. Ward culture had a significant effect on the socialisation experience of new graduates within the rural climate due to the complex nature of living within small social communities (Lea & Cruickshank, 2007; Sedgwick & Pijl-Zieber, 2015). Despite these drawbacks, there are many reasons why new graduate nurses choose to work in rural settings, including familiarity with the rural community, proximity to family members and the work environment itself (Trépanier et al., 2013).

Universities may need to prepare the new graduates to deal with challenging ward cultures (Lea & Cruickshank, 2007). An example is in the USA where universities included a socialisation unit in the undergraduate course (Bratt et al., 2014). El Haddad et al. (2012) argue that postregistration training or socialisation is exclusively the responsibility of healthcare facilities. However, no matter what university education was attained, new graduate nurses may not necessarily be ready to work as independent practitioners taking leadership responsibilities (Keahey, 2008). Duchscher (2008) suggests that it can take up to 18 months before a new graduate progresses from a novice to an advanced beginner. Therefore, preceptors and new graduate programme coordinators should allow for time to transition, both socially and clinically. Appropriate training of preceptors and senior nurses may not only decrease horizontal violence but also reduce extreme transition shock.

Transition shock is often experienced and prolonged when there is no preceptor or one-on-one support being provided (Lea & Cruickshank, 2007, 2014, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). Indeed, as Keahey (2008) states “a caring preceptor adds a powerful dimension to the [new] graduate program by serving as a role model, promoting socialisation, and giving immediate constructive feedback” (p. E19). Not all assigned preceptors knew the role of the mentor and were often unaware of the new graduate's needs (Lea & Cruickshank, 2015). This combined with preceptors being poorly prepared for the leadership role, heavy workloads, no recognition for the extra responsibility and lack of team work significantly affects the preceptorship role (Henderson & Eaton, 2013).

The importance of appropriate supervision and governance of the new graduate programme with formal training before preceptors accept the role has been demonstrated in the UK (Harrison-White & Simons, 2013). Formalised training programmes are needed and may result in highlighting the stress and extra duties required of preceptors or mentors. This may potentially lead to supervision roles being appropriately awarded (Harrison-White & Simons, 2013). If preceptors are allocated adequate time and provided with appropriate recognition, the role may become more attractive. In addition, support from both clinical nurses and nurse managers would assist the even distribution of workload, decision-making and leadership qualities that accompany these roles (Johnstone, Kanitsaki, & Currie, 2008). This was reinforced by new graduates reporting that if they were in contact with nurse leaders and nurse educators, they felt less isolated and more supported (Dyess & Sherman, 2009; Keahey, 2008; Ostini & Bonner, 2012). Mellor and Greenhill (2014) further suggest that new graduates who do not receive direct clinical supervision were vulnerable and often expected to make clinical decisions beyond their scope.

In the rural environment, nurses must develop exceptional clinical judgement and discover and partake in many learning opportunities that will lead to the development of masterful generalist skills (Dowdle-Simmons, 2012). In comparison with urban nurses, rural and remote nurses require generalist skills in order to cope with the diversity of health-related illnesses with which they are likely to be confronted (Trépanier et al., 2013). New graduates experience transition shock in rural areas as much as in urban health facilities. However, in rural and remote settings, these challenges faced are combined with limited health services, limited resources, generalist skills and the reduced privacy of living and working in a small community (Bennett et al., 2012; Ostini & Bonner, 2012). This makes the rural new graduates' experience considerably different from their urban counterparts (Bennett et al., 2012; Ostini & Bonner, 2012).

While support is provided through the structured new graduate programmes, Keahey (2008) found that the programmes do not always match the needs of the new graduates within the rural context. New graduate programmes require more structured processes to address the needs of today's new graduate nurse (Bennett et al., 2010). However, a “one-programme-fits-all,” particularly in the rural environment, is no longer considered appropriate (Keahey, 2008). The timing and type of support required for each new graduate

nurse is very much an individual matter (Murray, Havener, Davis, Jastremski, & Twichell, 2011). Access to education, effective communication, both clinical and social organisational support and increased resource relevant to rural areas are needed to improve the transition process (Parker et al., 2012). Ostini and Bonner (2012) suggested that the first 3–4 months in a hospital environment is the most stressful for new graduates in rural Australia. Johnstone et al. (2008) propose that the first 4 weeks and the beginning of each new clinical rotation are significant times to provide support for new graduates in order to transition into the workforce smoothly.

Our review has several limitations. Only eight articles were included in the analysis, with the majority of studies conducted in Australia. Of these, four articles related to two studies and three articles involved separate studies so the integrative review only reported on five Australian research studies and one international study, that is, six independent studies in total. Therefore, the findings are not representative of all new graduate nurses or new graduate nursing programmes, internationally. All studies had small numbers, limiting our ability to generalise the findings. Also, it is known that experiences of nurses change over time and most studies only collected cross-sectional data. Only three of the studies collected data at separate intervals, which limits the ability of this review to determine the support provided through the entirety of a new graduate programme and the changes new nurses experience over time.

## 6 | CONCLUSION

This review identified many of the challenges faced by rural new graduate nurses, some of which are the same as metropolitan-based graduates. Our findings reveal that new graduate nurses often felt overwhelmed and abandoned with intense feelings of frustration. Many suffered transition shock and did not feel ready for the role. Most support offered in the new graduate programmes was ad hoc, and senior staff were inadequately supported in their roles as preceptors. However, there were additional issues, for example, the lack of resources for preceptorship and the heightened importance of socialisation in the rural and remote context. New graduate programmes need to be structured; however, the findings suggest that flexibility may be required to sufficiently accommodate the needs of new rural and remote nurse graduates. Transitioning slowly, by providing education and increasing the workload incrementally, is an important supportive measure, and the time needed for a new graduate to adjust varies depending on individual needs.

Providing a preceptor is viewed as an important supportive measure in helping support new graduates' transition into clinical practice. Preceptors need to be aware of a new graduate's needs and adequately supervise the new graduate nurses within the transition period. Both university undergraduate programmes and nurse managers need to take responsibility for socialising new graduates. If the transition period is supportive and tailored to the individual needs of

a new graduate, it is likely that transition shock will decrease and retention rates will increase within the rural environment.

## 7 | RELEVANCE TO CLINICAL PRACTICE

The findings in the review can be implemented by rural facilities when constructing new graduate programmes for newly graduated rural and remote nurses. Supportive measures, education and time allocated to allow for the transition to occur are important for all new graduates. Implementing appropriate supernumerary time and well-informed preceptors is important for all new graduates; however, the time required may change with each graduate and the needs for each rural site. Therefore, new graduate programmes need to be structured but flexible to allow for individual differences in new graduates and clinical situations. Education and time is required for new preceptors and senior nursing staff to adequately support new graduate nurses. This would require adequate skill mix and extra staff to be rostered to allow appropriate time for effective preceptorship and education to occur. It was evident throughout the integrated review that the social aspect of rural nursing is important to achieve a sense of belonging. Rural and remote preceptors are required to provide both social and clinical support.

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## CONFLICT OF INTEREST STATEMENT

No conflict of interest declared.

## CONTRIBUTIONS

The literature search, quality appraisal, data extraction and analysis of the included articles: AF; screening of literature and quality appraisal: DT, EJ; manuscript preparation: AF, DT, EJ, BN.

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## CHAPTER 3: Theoretical Framework


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# Contemporary nursing graduates' transition to practice: A critical review of transition models

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## Abstract

**Aim and objective:** To critically review contemporary transition theories to determine how they apply to the newly qualified graduate registered nurse programmes.

**Background:** Graduate nurse transition to employment is the time of significant change which has resulted in high attrition rates. Graduates are often challenged by their expectation of nursing practice and the reality of the role. The transition from hospital-based training to university-based training has resulted in the need for primary employment to commence with graduate/orientation/internship programmes to help support new graduates transition into clinical practice. One transition model, Duchscher's stages of transition theory, utilised three former theories to develop a final model.

**Design:** A narrative critical literature review.

**Method:** The theories selected for the review were Kramer's reality shock theory, Benner's novice to expert theory, Bridges transition theory and Duchscher's stages of transition theory.

**Conclusion:** Duchscher's stages of transition theory reflects the experiences of registered nursing transition into the workforce directly from university. The application of the theory is effective to guide understanding of the current challenges that new graduate nurse's experience today. There is a need for new graduates to complete their university degree as advanced beginners in order to decrease the experience of transition shock and keep pace with rapidly changing demands of the clinical environment. This may be achieved by increasing ward-based simulation in university education. A theoretical framework can provide a deep understanding of the various stages and processes of transition and enable development of successful programmes.

**Relevance to clinical practice:** Both universities and hospitals need to adapt their current practice to align with the needs of new graduates due to large student numbers and ongoing systematic advancements to decrease the attrition rate.

## KEYWORDS

Benner's novice to expert theory, Bridges transition theory, culture shock, Duchscher's stages of transition theory, graduate nurses, Kramer's reality shock, transition

## 1 | AIM

This paper provides a narrative critical literature review of four main theories that attempt to explain newly qualified graduate nurses' transition to practice. The aim of the review was to provide a critical analysis of the current state of knowledge regarding nursing transition to practice frameworks. The discourse will include Kramer's reality shock theory, Benner's novice to expert theory, Bridges transition theory and Duchscher's stages of transition theory.

### 1.1 | Background

Internationally, nursing education has rapidly evolved since the 1980s. In many developed countries, there has been a transition from hospital-based training to university-based training (Wardrop, Coyne, & Needham, 2019). However, this has resulted in reduced clinical instruction and exposure, reduced workplace readiness and a lack of confidence among newly graduated nurses (Jamieson, Sims, Basu, & Pugh, 2019). Nursing students are expected to develop the skills required to practice as a registered nurse (RN) during their undergraduate degree, with knowledge and skills in the practice of nursing science and theory (Jacob, McKenna, & D'Amore, 2014). High patient acuity and high staff turnover rates add to the challenges new graduate's experience in their first year of practice (Kavanagh & Szveda, 2017). Graduates may struggle to adapt to the role of a registered nurse as they feel unprepared for working as a part of the clinical team (Hezaveh, Rafii, & Seyedfatemi, 2014). Graduates are required to learn or consolidate both psychomotor and critical thinking skills quickly (Theisen & Sandau, 2013). The longer-term impact of this includes high attrition rates of up to 60% in the first year (Odland, Sneltvedt, & Sorlie, 2014) for which a range of support programmes have been developed to counteract this, including orientation-, supernumerary time-, preceptorship- and theory-based training lasting anywhere from six weeks to 12 months (Rush, Adamack, Gordon, Lily, & Janke, 2013).

Graduate programmes for newly qualified graduate registered nurses were introduced into most hospitals following the transition of nurse education into the university setting in order to help graduate nurses assimilate into the clinical environment (El Haddad, Moxham, & Broadbent, 2017). Worldwide, newly qualified nurses are offered a number of different programmes, all aimed to support their transition to practice. For example, transition programmes may be termed graduate programme, transition to practice programme, residency programme, internship or an extended orientation programme (Edwards, Hawker, Carrier, & Rees, 2015). The aim of transition programmes is to provide support to graduate nurses to ease their transition into the role of the registered nurse in order to decrease the attrition rate of new graduates. The high attrition rate of new graduates is thought to be due to lack of confidence and limited available support within the first few months of practice (Edwards, Hawker, Carrier, & Rees, 2015). The introduction of graduate programmes was based on the understanding that new graduates

### What does this paper contribute to the wider global community?

- It is important for all transition programmes to be based on a theoretical framework.
- Graduate nurses need to commence clinical practice as advanced beginners, to keep pace with changes, ward-based simulation is a tool that could help achieve this.
- Both universities and industry need to work in partnership to help reduce the transition shock still experienced by today's new graduates.

require time to develop clinical skills, build confidence and feel like they are effective team members within the new environment and aim to reduce the initial shock often experienced when a graduate is new to an environment and has limited experience (Kramer, Brewer, & Maguire, 2013).

Reducing the notably high attrition rates both nationally and internationally during the graduate programmes is an important consideration especially in view of the cost of training nurses and the estimated worldwide future nursing shortage (Walton, Lindsay, Hales, & Rook, 2018). Graduate programmes consist of a range of models which may include preceptorship, supernumerary time, face-to-face study days, formal assessments, online course work, self-directed learning packages and performance appraisals (Spector, Ulrich, & Barnsteiner, 2017). The nursing graduate programme has become an essential part of the new graduates' transition year.

Multiple theories have been developed to help gain an understanding of the experience of graduate nurses within their first year of transition to a clinical environment. Less is known about which transition theory is applied when developing the most effective transition to practice programme. Transition programmes are vital to reduce the effects of transition shock and decrease attrition rates.

## 2 | DESIGN

Considering the range of graduate programmes across the world, the high levels of attrition of newly qualified nurses, the challenges of transition to practice and various levels of support provided to newly qualified nurses, we set out to provide a narrative critical literature review of a number of theories related to transition to practice applicable for contemporary new graduate nurses.

## 3 | METHOD

The aim of the review was to provide a critical analysis of the current state of knowledge regarding nursing transition to practice frameworks. A narrative literature review selects to review published articles that describe and discuss the current state of a specific topic



from both a theoretical and contextual view point (Rother, 2007). Four main theories were chosen for the review as they were the main theories cited in literature as the basis for nursing graduate programmes as they provide perspectives on the experiences of today's graduate nurses' transition to clinical practice. The theories selected for the narrative critical review were Kramer's reality shock theory, Benner's novice to expert theory, Bridges transition theory and Duchscher's stages of transition theory. The four theories were selected because they provide perspectives on the experiences of a graduate nurses' transition to clinical practice. A clear theoretical framework can provide a comprehensive understanding of the various stages and processes of transition and enable development of successful programmes to aid in the transition of nursing graduates.

## 4 | RESULTS

### 4.1 | Kramer's reality shock theory

Kramer's reality shock theory (1974) was one of the first theories developed to describe a nurse's transition to practice. Included in this theory is the concept of "culture shock," first described by Oberg (1960), an American anthropologist. Culture shock is defined as a set of confused or uncertain emotions experienced by an individual in an unfamiliar environment (Lina & Setiawan, 2017). Culture shock is thought to occur in four different stages: the honeymoon phase, shock and rejection phase, adjustment phase and recovery phase (Eckermann et al., 2010).

Kramer's (1974) work in graduate nurse transitions argues that similar to Oberg's culture shock, graduate nurses undergo a reality shock cycle on commencement in the workforce. Kramer describes "reality shock" as the emotions a graduate nurse experiences when starting work in a new environment and proposes that when socio-cultural norms are different to what is expected, reality shock occurs (Kramer, 1974). Shock is seen to consist of sociocultural, physical and emotional response an individual exhibits when experiencing unexpected or negative events whilst in an unfamiliar environment (Kramer, 1974). Kramer argues that reality shock, similar to Oberg's culture shock, progress through four phases; the honeymoon, rejection/regression, recovery and resolution phase.

Kramer's "reality shock" theory recognises that graduates experience sociocultural, physical and emotional responses to the new experience of practice as a registered nurse (Wakefield, 2018). This theory commences with a honeymoon phase, full of enthusiasm and excitement which graduates experience for a brief period. Not all new graduated registered nurses are expected to experience a honeymoon phase. Instead, some skip the first stage and commence with the rejection or shock phase (Al Awaisi, Cooke, & Prymachuk, 2015).

The rejection phase occurs as graduates feel unprepared for the realities of clinical practice. Graduates, lacking confidence and experience, often feel a sense of rejection within the clinical setting (Freeling & Parker, 2015). Immature conflict resolution often

emerges, reflected through feelings of anger and frustration towards the new culture. During the rejection phase, an individual may experience periods of heightened self-doubt and conflicting values as they reject the reality of the role they are required to fulfil. Not all graduates enter this stage; however, those who do feel some form of rejection due to conflict with their previous belief system (Kramer, 1974). The rejection phase is often accompanied with ethnocentrism, where a person idolises where they have come from, for example, their former student life. Kramer (1974) suggests that not all graduates reminisce fondly of their student days and some graduates may actually blame the education system for feeling underprepared for the role of a registered nurse.

The recovery phase is the third step within the reality shock cycle, when the new graduate develops to feel a sense of belonging within the new environment and an acceptance of their role. The final phase is referred to as the resolution phase (Wakefield, 2018). During this phase, graduates determine their future pathway regarding nursing. The new graduate's resolution phase can consist of the nurses staying within the profession, moving hospitals or areas or leaving the nursing profession altogether (Martin & Wilson, 2011). This resolution may happen earlier in the process with the graduate leaving the nursing profession without finishing their graduate programme. Kramer's reality shock theory is seen to be a cyclic process with graduates moving from resolution back to shock as new experiences are encountered. For example, a graduate nurse may experience the "shock" phase and move through to the resolution, only to find that when something new is presented they return to the shock phase and the cycle starts again.

Differences between Oberg's culture shock and Kramer's reality shock occur in the length of time during which the shock occurs, the expectations of people experiencing the new environment and belief in what is the optimal environment. In contrast to the sudden onset of culture shock, reality shock experienced by graduate nurses is thought to be a more gradual and prolonged process. Where culture shock is expected to improve with time as people assimilate with the culture after a short duration of time, in nursing the experienced situation may not improve (Kramer, 1974). The expected competence level of the person also differs between the two models. Kramer suggests that with reality shock new graduate nurses are expected to begin at a competent level, whereas when moving to a new country, expectations are far less with regards to being competent in understanding the culture and even the language. The third difference is the beliefs to what the optimal environment consists of. A person experiencing culture shock will often believe or feel that home is better, whereas new graduates do not always hold the belief that their expectations developed through nursing education were better than being in a clinical environment (Kramer, 1974). These notable differences may intensify the rejection or "shock" phase.

Following the transition of nurse education into the higher education sector, there has been a plethora of research reflecting the rejection phase highlighted within Kramer's reality shock theory with regards to new graduate nurses (El Haddad, Moxham, & Broadbent, 2012; Jamieson et al., 2019; Kramer, 1974; Lea & Cruickshank, 2007; Martin &



Wilson, 2011). Negative experiences were consistently reported within the first few months of a new graduate's transition (Rush et al., 2013). An understanding of reality shock was seen as important, as when graduates are in a state of "shock" they are unable to perform efficiently (Meleis, Sawyer, Im, Messias, & Schumacher, 2000). This work laid the foundation for the development of graduate programmes that reflected the different stages of reality shock during the graduate year.

## 4.2 | Benner's novice to expert theory

The second main transition theory explored was Benner's novice to expert theory. Benner's novice to expert theory explored the stages of development from nurses beginning as a student to becoming an expert. The principles of this theory were modelled from Dreyfus (1980) who developed a skill acquisition model following research involving chess players and pilots (Chang & Daly, 2012). The Dreyfus model was applied by Benner to a study that examined the knowledge and performance of nurses (Benner, 2001). Benner used the model to elicit knowledge concerning practical understanding and expert capabilities of nurses working at different levels within a clinical unit (Benner, 2004). The original Dreyfus skills acquisition model consisted of five progressive stages ranging from novice to mastery. Similar to the Dreyfus model, the Benner's novice to expert theory describes the progression of a novice nurse to a nurse expert through 5 stages. Differences in the models include the names and expectations of the first two stages (Figure 1: Benner's novice to expert theory) (Benner, 2001; Duchscher, 2009). The initial stage in Benner's model, "the novice," refers to nursing students, and a new graduate nurse was considered to enter the workforce at stage two, as an advanced beginner (Benner, 2001).

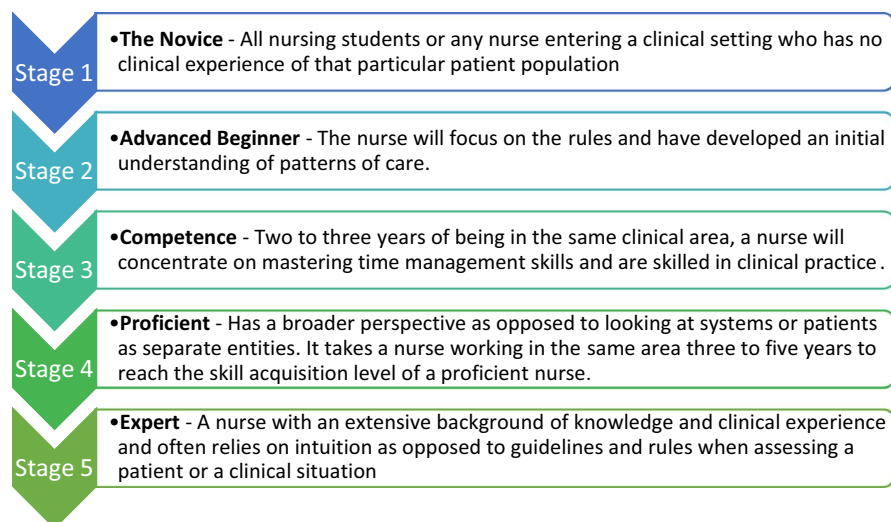
The novice to expert theory aligns closely with experiential learning, recognising that an individual develops by spending time in a situation to enable them to adjust to social situations and adapt skills before they can progress to the next stage (Benner, 2004). The theory focuses on a nurse's progression in both professional

socialisation and clinical skills level. Wardrop et al. (2019) suggests Benner's novice to expert theory is neither "linear nor predictable" (p1). However, the theory provides a platform for nurse managers to measure a graduate's progression within a transition programme as they achieve confidence and competence. This transition theory assisted with recognising the different levels of nurses and the need for graduate nurses to consolidate skills before being expected to practice at a competent level. This is pertinent to graduate programmes as it explains why graduates require time to develop their level of competence before they are able to master the skills and expectations of a registered nurse.

## 4.3 | Bridges transition theory

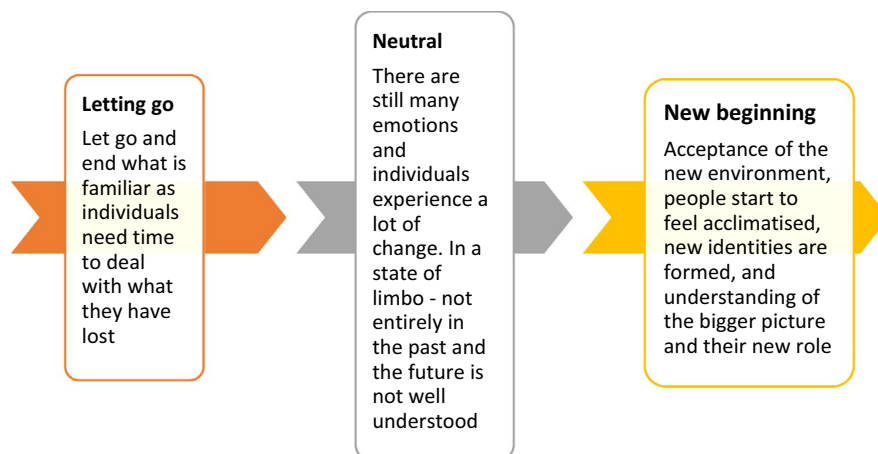
Similar to other transition theories, Bridges transition theory describes different stages involved in transition, suggesting there were three stages of transition: "letting go," "neutral," and "new beginnings" (Figure 2: Bridges transition theory; Bridges, 2009). Bridges transition theory, progression between stages is linear, as opposed to cyclic, in that a person must complete one stage before being able to move to the next stage (Arrowsmith, Lau-Walker, Norman, & Maben, 2016). Bridges believes that transition needs to have a beginning and an end point and that it is important for an individual to recognise the need to change to be able to make sense of the process (Bridges, 2009).

Bridges (2009) suggests that many people focus on the change that is taking place rather than thinking about the first step of transition and letting go of the familiar to accept changes, which sets the process of transition up for failure. Taking the time to physically, emotionally and mentally let go of what once was, is an important first step in transition, according to Bridges (2009), and is similar to grieving any loss. This involves recognising the loss of what was and respecting the past (Bridges, 2009). Some people will transition more effectively if they take a piece of the past with them (Bridges, 2009). This enables a person to become creative and look for new opportunities (Ulrich, 2016). Bridges stipulates throughout this theory that



**FIGURE 1** Benner's novice to expert theory (Benner, 2001) [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

**FIGURE 2** Bridges transition theory (Bridges, 2009) [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]



"transition starts with an ending and ends with new beginnings" (2009, p. 5) and that if individuals are not supported through the three transition stages even the best programmes may fail. Bridges transition theory influenced the structure of graduate programmes, recognising that transition should be viewed in different stages and each stage needs to be completed before new graduates can move onto further stages. This enabled programmes to be developed which assisted graduates to "let go" and grieve familiar processes to enable them to move forward in their development as nurses.

#### 4.4 | Duchscher's theoretical framework

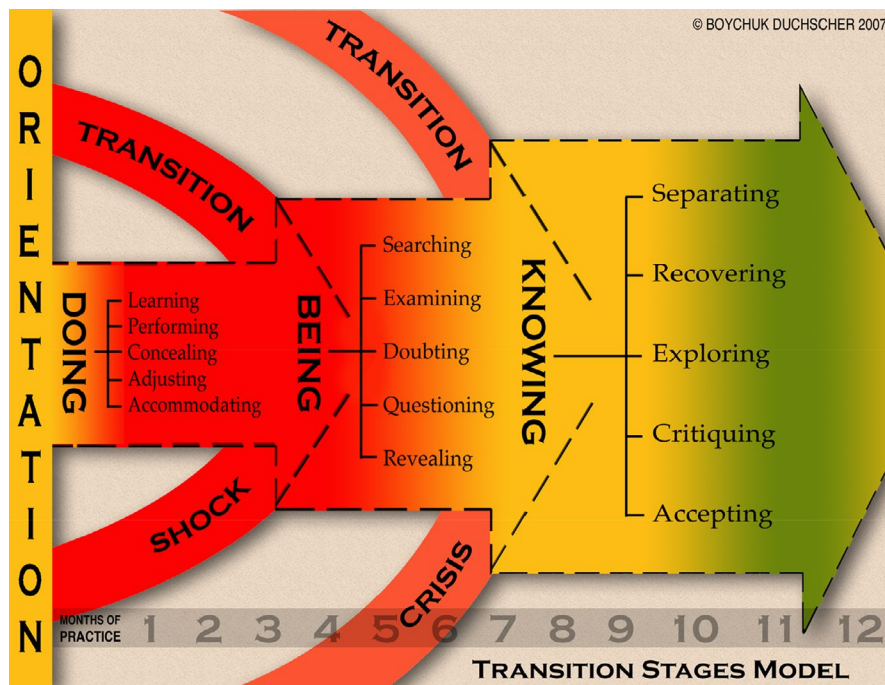
Duchscher's stage of transition theory evolved from Bridges transition theory and was influenced by both Kramer's reality shock theory and Benner's novice to expert theory. There are multiple components included within Duchscher's theoretical framework. The first component referred to as the transition stages model (Figure 3: transition stages model) is a three-step linear progression, termed the "doing," "being" and "knowing" phases. The three phases reflect the process of change within a graduate's year. The first phase of the transition stage model generally takes three to four months of the graduate year and is known as the "doing" phase. During the "doing" phase, the graduate nurse learns how to do everything (task/rule focused) and is often not able to look beyond this skill set (Duchscher, 2008). This process can leave the graduates thinking their current nursing ability is lacking resulting to a lack of confidence and self-doubt (Lea & Cruickshank, 2014). This was also the period in which a new graduate experienced culture or transition shock and is often the most vulnerable time within the graduate's first year (Duchscher, 2008).

The second phase of the transition stages model is the "being" phase, which occurs within the fourth to eighth month of the new graduate's transition year. At the beginning of this stage, the graduate remains disenchanted with their current role, despite becoming familiar with the environment and letting go of the past. The graduate gradually begins to complete tasks with confidence and begins to accept responsibility for clinical decisions. In completing this stage, the graduate is more confident within the work environment, more engaged within their own sociocultural groups and moving away from the crisis stage (Duchscher, 2008).

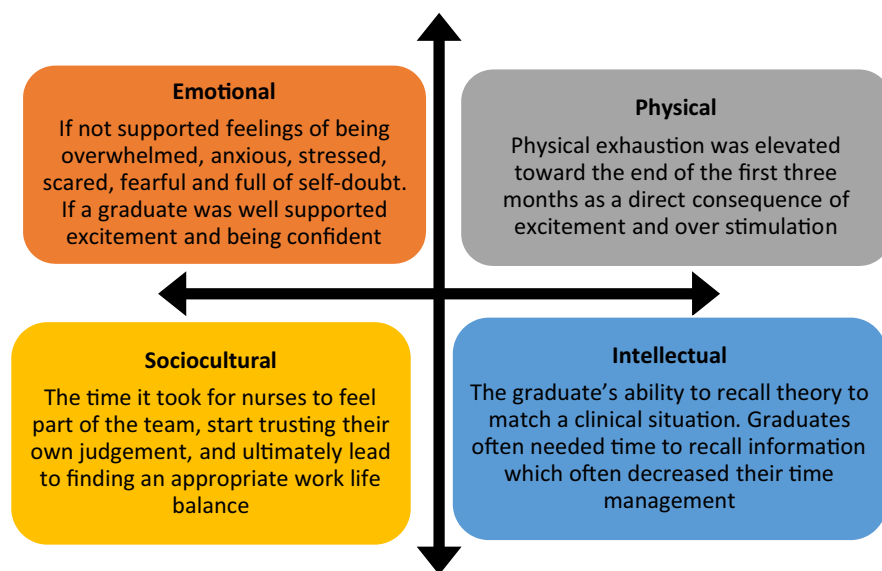
It is during the second stage that new graduates develop the confidence to speak up for themselves. They may no longer require a preceptor; however, feel leadership roles are more advanced than graduates are ready to embrace. In this phase, graduates are now able to understand what is happening around them, gaining confidence in their own ability to judge, predict and plan appropriate clinical practice (Lea & Cruickshank, 2014). It is at this stage when new graduates start to have time to focus on personal issues, spend time with family and loved ones, as clinical events that happened at work no longer consume their life (Duchscher, 2008). Feeling independent and comfortable enough to ask questions, the graduate moves into the final stage of the transition model, the "knowing phase" (Duchscher, 2007).

The "knowing" stage is when the graduate's concerns revolve around political aspects of nursing such as shift hours being decreased, lack of staff and having to care for more patients or being called into work on rostered days off (Duchscher, 2007). This is the time graduates start articulating a dislike for shift work, not being able to book recognised holidays such as Christmas off and often being the last staff member to be considered or asked when advice was being sought (Duchscher, 2007). During this stage, graduates may be assigned student nurses and they begin to realise how far they have progressed since commencing their graduate programme (Duchscher, 2007). Within this stage, the graduates are no longer considered new to the area. Compared with newly qualified graduate nurses, the graduate nurse in this final stage feels confident (Lea & Cruickshank, 2014) and this marks the end of the process of "becoming." In this final stage of transition, the nurse no longer feels inadequate and has a better understanding of the work environment.

Another component, of the stages of transition theory is the transition shock model, which is initially perceived throughout the "doing" stage and followed by transition crisis. Transition crisis develops when the new graduate's fears are replaced with frustrations of having little influence to change operational systems (Duchscher, 2008). Transition shock is a reflection of the stress graduates' experience as they transitioned from being student to a registered nurse (Duchscher, 2008). Duchscher describes the graduate's experience of transition shock through four distinct elements: emotional, physical, sociocultural and intellectual elements (Figure 4: The four psychosocial elements).



**FIGURE 3** Transition stages model (reprinted with permission) [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]



**FIGURE 4** The four psychosocial elements (Duchscher, 2009) [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

Within the first four months, the emotional aspects of the transition stage vary depending on the supportive nature of the environment (Lea & Cruickshank, 2014).

Graduates who are less supported are more likely to feel overwhelmed, scared, self-doubt and be fearful. Fear of being viewed as clinically inadequate and failing to provide appropriate care or failing to accept responsibility as a registered nurse (RN) were amplified within the first four months of the transition period (Wakefield, 2018).

Duchscher's research indicates that physical exhaustion was elevated towards the end of the first three months as a direct consequence of excitement and over stimulation. A number of participants stated that the constant doubting of their own clinical judgement or ability to perform clinical skills led to diminished rest, resulting in physical exhaustion (Duchscher, 2007).

Emphasis was placed on the sociocultural aspects of a new graduate's journey within the first few months. During this time-frame, graduates were often task orientated, concentrating on paperwork, medication rounds and administrative duties as opposed to patient care (Duchscher, 2007). This led to new graduates feeling that they had not fulfilled their role as patient advocate due to time constraints and ultimately left them feeling confused between what they thought their role was and what it actually entailed.

New graduates often appeared to be coping but felt anxious, uncertain and stressed particularly when graduates found themselves caring for critically ill patients. They felt overwhelmed and out of their depth. Duchscher (2007) established that whilst the graduates seem to have the intellect to ask to be assigned to a less critical patient, this did not happen frequently. Intellectual support can be measured

within a graduate programme by reviewing the orientation process, how many supernumerary days were allocated, how many study days are assigned to the graduate programme and how supportive the programme is towards theoretical knowledge (Chang & Daly, 2012).

If new graduates did not feel settled within the new environment, transition shock was prolonged. The rejection phase of transition shock was also prolonged in less supportive environments. Supportive measures influenced a graduate's experience when they transitioned from partial responsibility (during orientation) to full responsibility (full workload) within the first few weeks of the graduate programme (Duchscher, 2008). The work of Duchscher assisted in preparing graduate programmes that were aligned to the level of the nurse, prepared for the different stages a nursing graduate would experience and allowed for completion of each stage of the transition.

Whilst reviewing Benner's novice to expert theory, Duchscher suggested the "doing" stage coincided with Benner's novice stage, which describes nurses with no experience with a patient population or area they have entered (Benner, 2001). The "being" stage aligns with Benner's "advanced beginners" stage of skills acquisition. The advanced beginner stage suggests that whilst graduate nurses have marginal capabilities and need support, they do have experience within the context they are now employed (Benner, 2001). Duchscher argued the first four months of a new graduate's journey were that of a novice nurse and indicated that graduates do not enter the advanced beginner's stage until five to seven months into their graduate year (Duchscher, 2009).

## 5 | DISCUSSION

Decreased clinical practice in undergraduate programmes and an increased number of nursing students in the clinical areas have affected a new graduate's workplace readiness (Bvumbwe & Mtshali, 2018). Murray, Sundin, and Cope (2018) found that new graduates do not feel ready for practice when they start their graduate programme. Clinical placement hours have generally decreased in undergraduates degrees; however, the impact of this change is often minimised by increasing time in one clinical setting. Graduates still need a minimum of 800 hr and therefore experience a depth of knowledge with a focus in fewer areas. If the graduate gained employment in the same clinical area, it could be argued the graduate is clinical ready. Brown (2017) suggests the new graduates are only advanced beginners if they had acquired many different clinical experiences as students. Perhaps it is not about many different experiences, instead a comprehensive experience is more effective in building attributes of an advanced beginner. Changes in the educational experience of a nursing student, since Benner's novice to expert theory was developed, may require a change to the description of a graduate nurse at that stage. These changes include decreased face-to-face teaching time at universities and the expectation of students to learn independently (Chen, Fei, Huang, Xu, & Wu, 2019).

Changes also include higher patient acuity and decreased clinical placement time, exposure to a variety of wards for short periods when on placement and high student numbers in the clinical area, limiting

learning opportunities (Kavanagh & Szveda, 2017). These challenges with clinical placement, along with concerns for patient safety, increase a student's anxiety, decreasing their ability to gain experience and learn effectively in today's clinical area (Jenson & Forsyth, 2012). Changes in health services, such as decreased length of hospital stay resulting in a rapid pace of change, and advanced technology, result in decreased time for teaching of students whilst on placement, leading to nurses graduating with a decreased ability for clinical judgement and a lack of confidence (Kavanagh & Szveda, 2017). Simulation is an education technique that can assist student nurses to learn technology, gain confidence and improve clinical judgement skills. This suggests a greater importance in supporting nurses to develop as they move through the different stages (Benner, 2004).

Whilst Benner's novice to expert theory provides an overview of suggested stages of development, it has been criticised for failing to discuss ways in which nurses acquired knowledge or how knowledge provision was facilitated to enable them to move between stages (Izumi, 2011). Kennedy, Kenny, and O'Meara (2015) argued that "implied" knowledge is not tacit but shared through critical debriefs and storytelling during social interactions and hence professional socialisation is critical to enable nurses to gain knowledge through experience, with clinical and socialisation skills shared between novice and senior staff (2015). Cook suggested that efficient education support from mentors or preceptors facilitate shared knowledge (2016). Similar to Benner's novice to expert theory, Duchscher's stages of transition theory did not focus on the facilitation of knowledge itself but the progression of graduates transitioning from a novice, requiring extra support, being task orientated to the role of an advanced beginner, gaining confidence and the development of clinical judgement (Boyer, Mann-Salinas, & Valdez-Delgado, 2018). The provision of support and knowledge adequately shared throughout a graduate's transition journey is crucial for a graduate programme to be considered successful.

Bridges transition theory is similar to previous theories on organisational change. The terms "change" and "transition" are not interchangeable; a transition is the process individuals go through for change to occur (Kralik, Visentin, & Loon, 2006). If individuals are not supported through the three transition stages even the best programmes may fail. If this is extrapolated into the context of nurse transition from university to the clinical setting, the provision of support throughout a graduate's transition journey is crucial for a graduate programme to be considered successful.

Duchscher's stages of transition theory, three-step process "the doing," "being" and "knowing" aligns with Bridges transition step; "doing" is letting go, and transition shock is often evident. Bridges neutral stage aligns with Duchscher's second step of being and the effects of transition crisis prevail. The graduates' experience during the neutral stage or "no-man's land" may be prolonged if the graduate is less prepared both emotional and intellectually to cope with the rapidly changing clinical setting. The final stage "new beginnings" aligns with "knowing." Transition is progressive regardless of a graduate being portrayed as a novice or advanced beginner. Duchscher suggests the stages of transition is nonlinear; however, a graduates' transition journey has a beginning, middle and end point therefore linear in

progression. The majority of graduates' transition into the workforce progress in a developing pattern similar to the skills acquisition model.

Duchscher builds upon and expands the work of both Kramer and Benner to develop a transition to practice theory. Through Duchscher's research, the term "transition shock" was developed and incorporated deeper elements than reality shock (2007). The four elements were identified and acknowledged to affect a graduate transition "shock" experience. The elements include emotional, physical, sociocultural and intellectual elements; three of these elements were explored throughout "Kramer's reality shock theory" in 1974 (see Table 1). These elements are heightened when graduates enter a phase of transition shock. Seminal work by Kramer (1974) identified the importance of recognising and managing the negative emotions experienced by novice nurses during the new graduate year. Duchscher suggested there is more than one phase of "reality shock" graduates experience within their graduate programme (Wakefield, 2018). Wakefield (2018) proposed that transition crisis is a second phase of culture shock. It could be further argued this phase is an additional step and differs from culture shock. This is reflective of the new graduate's transition in modern nursing, changes to undergraduate training and increased student numbers has resulted in graduates being in turmoil for nine months. Transition crisis, according to Duchscher's stages of transition theory, occurs when graduates are no longer new to the hospital environment; however, they are still learning sociocultural aspects and start to question clinical practice (Duchscher, 2009).

## 5.1 | Suggested components of a structured transition programme

### 5.1.1 | Recommendations for Education

Hayter (2017) suggests that to better prepare new graduates and decrease transition shock, undergraduate education should include

a realistic view of daily stressors experienced in a clinical setting. Time and experience in appropriate clinical placements or simulated environments are required for nursing students to acquire clinical skills, develop critical thinking abilities to enable them to gain the confidence to practise at an advanced beginner level (Hayter, 2017). Recent studies on the use of extended, immersive simulation may assist in reducing transition shock, as simulation provides a realistic ward environment in which students are able to develop skills in communication, team work, decision-making and time management prior to graduation (Rodgers, McConnell, de Rooy, Ellem, & Lombard, 2014). Nursing graduates are entering the workforce as novices as opposed to advanced beginners. Duchscher's solution was to introduce a prolonged orientation programme from 12 to 24 weeks consisting of equivalent time spent between classroom theory and clinical practice to prepare the new graduate for the role of an advanced beginner (Duchscher, 2009). A reduction in transition shock requires new graduate to commence their transition programme as advanced beginners. Due to the complexities of clinical areas and fast moving information and technology systems, the only way new graduates are going to begin their career as advanced beginners is to be introduced to ward-based simulation training programmes throughout their nursing degree (Brown, 2017; Kavangh & Szveda, 2017). Universities can adapt their current practice to align with the needs of new graduates to help better prepare and lessen the effects of transition shock.

### 5.1.2 | Recommendations for Policy

Graduates equipped with the right support mechanisms can successfully navigate their way through the rejection phase (Sparacino, 2016). Support measures such as transition programmes have been shown to lessen the degree of reality shock experienced by graduate nurses (Rush et al., 2013). Programmes that include adequate supernumerary time and preceptorship support have been shown to

**TABLE 1** Summary of transition theories

	Theories	Main elements	Key points
Duchscher's Theoretical Framework (2007) Stages of Transition Theory • Transition shock model; Consists of sociocultural, emotional and physical and intellectual elements. • Transition stage model; Doing, being and knowing stages. • Nonlinear	Kramer's reality shock (1974)	Culture shock (1960) 4 stages within the cycle Honeymoon, rejection/regression, adjustment and recovery phase Honeymoon—rejection/regression phase— Recovery and resolution phase	Cyclic process  Social, emotional and physical responses. Cyclic process
	Benner's Novice to expert (1984)	Dreyfus skills acquisition model (1980)  5 stages Novice—advanced beginner—competent—proficient—expert	5 stages Progression is linear  5 stages Progression is linear
	Bridges transition theory (1991)	3-step process Letting go—Neutral—New beginnings. Taking time to adjust to change is important	3-step progression Linear progression



decrease the negative effects of reality shock and time spent within the rejection phase (Gerrish, 2000).

Current literature suggests there is a lack of nationally recognised transition programmes (Wardrop et al., 2019). Many programmes are formulated and run by the facility and may lack uniform structure (Calleja, Adonteng-Kissi, & Romero, 2019). The use of a structured, theoretical framework is considered essential to develop graduate programmes that meet the needs of nursing graduates and decrease the attrition rate in the first year of practice. The American Nurses Credentialing Centre (ANCC) launched the practice transition accreditation programme reviewing nearly 40 evidenced based components offered within a graduate programme (Church, Cosme, & O'Brien, 2019). Ensuring both the use of a theoretical framework followed by an accreditation process for all graduate nurse programmes would guarantee standardisation and strengthen the support offered within all graduate programmes.

### 5.1.3 | Recommendations for Practice

Duchscher proposed that transition programmes should have a set of components in order to successfully assist graduate nurses with transition (2007). The first component includes education, consisting of theory and role play. Graduate nurses need education on effective communication, workload delegation and management, along with discussions centring on conflict resolution and understanding current lifestyle adjustment (Duchscher, 2009). Duchscher highlighted the inclusion of unit-specific skills, professional roles and responsibilities, and supernumerary time as important components of an effective transition programme. Effective preceptorship within the first three months, delivered by experienced nurses, would help to guide new graduates from task orientated duties to holistic nursing care (Duchscher, 2007). It is essential for senior nurses to be able to identify and understand the effects of transition shock to enable them to effectively identify problems and assist graduates with the transition.

## 6 | CONCLUSION

This narrative critical review highlights four distinct theories that have been used to create a contemporary theoretical framework applicable for today's graduate nurses. Kramer's theory was developed in 1974 and provides a basic understanding of the transition process; however, the role of the new graduate has significantly changed. Benner's novice to expert and Bridges transition theory are concepts that also remain relevant although they are both limited by the changing level of graduating nurse, from advanced beginner, to novice level. Duchscher's conceptual framework aligned the three valid theories with the challenges contemporary registered graduates' experience.

New graduate nurses currently transition into the workforce with limited clinical hours, and decreasing face-to-face education which

often leads to an increased gap between theory and practice. This heightens the possibility and duration of transition shock. Support through graduate transition programmes is vital to decrease attrition rates through managing the transition shock which will occur. A clear theoretical framework can provide a deep understanding of the various stages and processes of transition and enable development of successful programmes.

New graduates commencing as novices may be reflective of the changes in undergraduate degrees. Extended ward simulation appropriately resourced helps to advance the skills acquisition and bridge the theory practice gap present in some undergraduate degrees. Graduates need to complete their university degrees as advanced beginners, to decrease their current experience of transition shock. Duchscher's transition shock model provides a platform for researchers to base the understanding of a new graduates transition into the workforce.

## 7 | RELEVANCE TO CLINICAL PRACTICE

Universities and clinical facilities need to work together and incorporate effective simulation activities to help bridge the gap between theory and practice and enable students to graduate at a higher functioning level. Current literature is calling for increased skills acquisition to be conducted in undergraduate degrees and for simulation activities to continue to evolve to increase critical thinking skills and produce advanced beginners not novice nurses. This may aid to easing the transition process for newly graduates nurses entering the workforce.

The rapid changes within the clinical environment and evolving education system are important issues to consider and with less clinical hours available in undergraduate courses leaves nursing graduates feeling unprepared for clinical practice. Nurse managers and senior nurses supporting new graduates need to understand the new graduates needs. Understanding the needs of new graduates start with being aware of transition shock and graduates needing to let go before being able to move forward.

Duchscher's theoretical framework, the stages of transition theory, adapted from Bridges three step linear process aligns with the current 12-month graduate programme utilised in many countries (Rush et al., 2013). This coupled with the integration of the four elements affecting transition shock relevant to a graduate nurse's 12-month programme strengthens the efficacy of this framework. Following a theoretical framework when developing a graduate programme proved to be beneficial for both the graduate nurse and team facilitating the programme.

### CONFLICT OF INTEREST

No conflict of interest declared.

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## **CHAPTER 4: Methodology**

### **Introduction**

Chapter 3 presented the Duchscher's Stages of Transition Theory, the conceptual model selected to underpin this research. This chapter presents the mixed method research approach used for this study. The aims and objectives of the study are presented in this chapter and the research design discussed in detail. An explanation of the setting, sample size, target population and recruitment methods are also presented. The theoretical framework and how it guided the timeframe for the data collection periods are also outlined. This chapter will include a discussion of the data collection procedures, the analysis, and a discussion of the ethical considerations relating to this research.

### **Justification for a mixed method approach**

This study was informed by a pragmatic philosophical approach which is a relatively new research paradigm (Teddle & Tashakkori, 2009). The concept of 'pragmatism' itself is not new. As a philosophical view, it dates to the 1870s, originating from the USA through the writings of Peirce, James and Dewey (Hookway, 2015). This philosophical view was not considered important during the 20<sup>th</sup> century and did not resurface until the 1970s (Hookway, 2015). However, the way this philosophy is applied to contemporary research is a comparatively new concept.

A 'pragmatist' focuses on the research question and uses all methods available to address the research question, including using multiple or mixed methods. Pragmatism is not committed to one reality, however, examines a question from several perspectives to reveal the most appropriate answer or truth for the given time (Creswell, 2014). Employing a mixed method approach exposes more than one worldview and uses different ways of gathering information in order to explore the research question holistically.

In order to understand why the pragmatic approach was chosen, it is important to discuss the limitations of choosing a qualitative or a quantitative method when researching a particular, small and finely dispersed population group. Qualitative

research investigates why people think the way they do or describes a phenomenon not previously identified. This approach is subjective and often accomplished through in-depth interviews, observation and/or focus groups (Richardson-Tench, et al., 2014). In contrast, quantitative research is focused on testing a hypothesis to see if a program has achieved what it set out to do or testing the validity of the survey. These tests are often completed using a survey or data collection tool, utilise statistical analysis processes and are considered a scientific approach, therefore they are considered a less subjective form of research (Richardson-Tench, Taylor, Kermode & Roberts, 2014).

In considering the approach for this research, adopting a qualitative method alone was thought to provide a limitation in that it may have resulted in a diminished ontological view due primarily to small participant numbers, as one opinion is not necessarily the reality viewed by all the members of the study. In contrast if this study had adopted a quantitative approach only, the study would not have elucidated a deep understanding of the personal experiences of the graduate nurses. Understanding the population group before determining a research method is important, particularly when accepting the limitations of targeting a small specific cohort dispersed across the diverse Western Australian rural landscape. Using one approach only would provide insufficient data to address the question or aims sufficiently (Creswell & Plano Clark, 2011).

It is not however, just the population who need to be understood before the appropriate method can be chosen, the question or hypothesis is equally, if not more, important. This study focused on building an understanding of the support available to graduate registered nurses for each region in Western Australia Country Health Service. Whilst a quantitative method would be able to compare the regions and types of support available in each area in terms of budget, number of support personnel per graduate, employing a qualitative approach would yield a far more descriptive and intimate view of the support the graduates receive. Creswell (2014), along with Teddlie and Tashakkori (2009), contend that applying a combination of methods to research values both statistical and narrative views. For this reason, pragmatists use both qualitative and quantitative methods to fully examine their research questions (Creswell, 2014). Applying a mixed method approach was more appropriate for this research to construct

a deeper level of understanding and validation of the answers provided in response to the research question (Creswell & Plano Clark, 2011).

Employing the mixed methods approach also enables triangulation to be used to strengthen the findings. Triangulation occurs when combination of data sets, methods, investigators and analysis procedures are linked to provide a more trustworthy result (Richardson-Tench, et al., 2014). Triangulation was applied with participants, who completed the interview and surveys at the three different collection times. This small data set was analysed from both a longitudinal and horizontal focus. This was followed by comparing and contrasting results collected simultaneously through both methods which corroborates the data, increasing the validity of the study (Creswell & Plano Clark, 2011). By also comparing these results to data collected at multiple different times, the ambiguity of the information gathered is greatly reduced if the two methods of data collection used produces the same result (Teddlie & Tashakkori, 2009).

Prior to this research being conducted, there was little published information regarding the delivery of graduate programs in rural Western Australia. This resulted in the decision to use the qualitative descriptive method to explore the delivery of the graduate programs in the rural environment across the seven regions of Western Australia. Interviews with graduates participating in the study were conducted three times during the twelve-month graduate period. In order to increase the validity of the research, the quantitative method was also used in the form of a survey that was delivered concurrently to collect data from senior nurses who work with graduates, and graduate nurses participating in the graduate program.

## **Research design**

This study followed a longitudinal convergent mixed method parallel design in which both qualitative and quantitative methods were applied concurrently. The convergent design is a popular mixed method design and is also referred to as a triangulation design, drawing on two methods and merging the results to explore one question (Creswell & Plano Clark, 2011). Consideration of workload and the narrow timeframe for data collection was considered when choosing this design. Subsequently the data from both methods were analysed individually over a much longer timeframe. Following analyses, the results from both the qualitative and quantitative data was

triangulated and then compared and contrasted which was presented throughout the discussion. Recommendations were encapsulated and presented within the final report.

Strengths of the convergent mixed method design consists of it being efficient, collecting both qualitative and quantitative data at the same time, will allow for the same view point to be obtained using both methods and as previously mentioned both data sets can be collected and analysed separately (Creswell & Plano Clark, 2011). There are many challenges with this method of research such as differences in sample size, difficulties with merging two very different data sets in a significant way and finally, implications of findings that dispute one another (Teddlie & Tashakkori, 2009). Creswell and Plano Clark (2011) suggests the strength of the parallel design allows for analyses of the data sets independently, then comparing the results before merging the information throughout the discussion.

The research design also incorporated the time elements from the theoretical framework of Duchscher (2005). Duchscher's theory divided the graduate year into three stages throughout the graduate year. This required a longitudinal approach to the data to demonstrate changes to graduate nurse perceptions of the support provided throughout the graduate year. The stages determined by Duchscher were used in this study to determine when to undertake the data analysis.

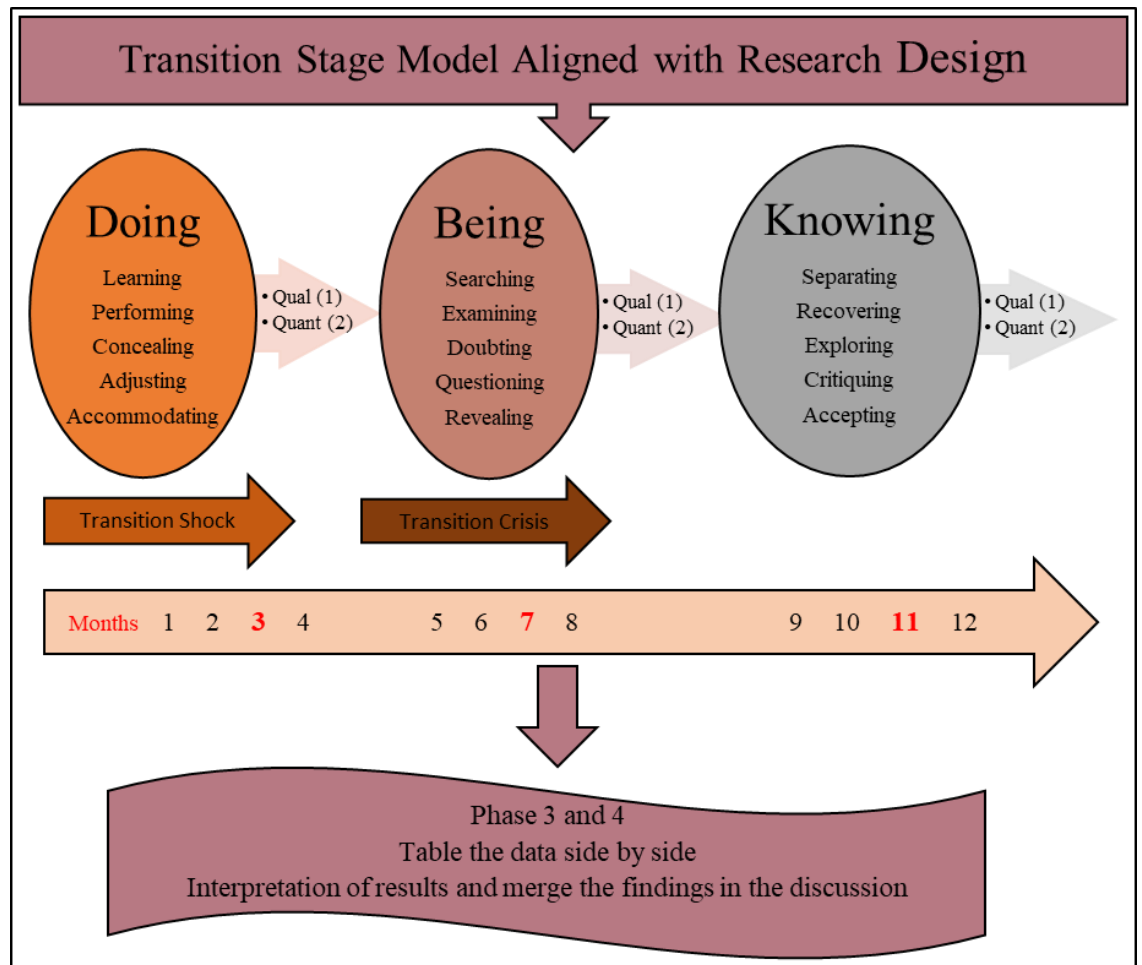
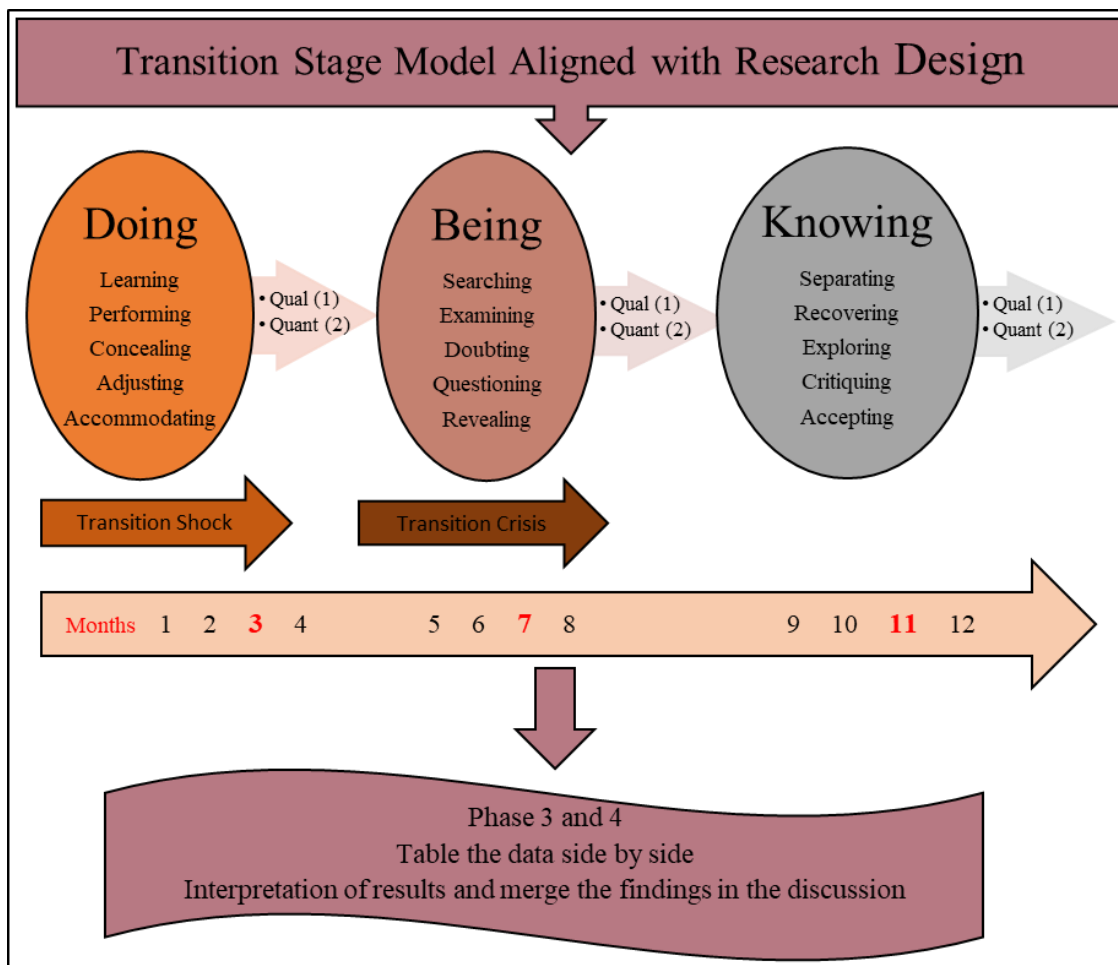


Figure 4:1 illustrates how the longitudinal convergent mixed method parallel research design, the data collection methods and specific data collection timeframes were incorporated within the theoretical framework.



**Figure 4:1** *The research design integrated with the theoretical framework*

Note: Qualitative data = 1

Quantitative data = 2

Months highlighted: the three phases of data collection at 3, 7 and 11 timeframes

Phase one was conducted during the ‘doing’ phase of the Transition Stage Model. The first set of data was collected concurrently within the third month. This included both qualitative and quantitative data. Phase two of data collection occurred four months later towards the end of the ‘being’ stage of the Transition Stage Model. This was followed by phase three of data collection at eleven months during the ‘knowing’ stage, which marked the end of the graduate program. The research design contained three steps within the data collection period before moving into phase four where the data was analysed, triangulated and merged within the discussion. It is within the discussion the findings are integrated back to the Stages of Transition Theory.

## Setting

Western Australia's Country Health Service (WACHS) is the biggest country health service in Australia and also one of the largest in the world (WACHS, 2010). The state of Western Australia has a surface area of 2.5 million square kilometres, with 70 rural and remote hospitals spread throughout the state. Western Australia Country Health Service provides over 29 types of direct patient services which comprise of acute, chronic and palliative care facilities to over 700,000 people (ABS, 2011; WACHS, 2012). Services provided at a health facility depend on its size and may include inpatient and outpatient care, radiology services, theatre, dialysis, mental health, maternity and emergency services. In 2014-2015 there were 2,913 nurses working in the rural and remote sector in Western Australia (WACHS, 2015).

This study was conducted in health facilities across all seven country regions of Western Australia, namely: the Kimberley, Pilbara, and Midwest, Goldfields, Wheatbelt, South West and Great Southern regions. Target health facilities for this research were non-tertiary public hospitals that held the capacity of between 18 beds in rural facilities, up to a maximum of 110 beds in regional healthcare facilities. Figure 4:2 displays the size and location of each of the regions.

Figure 4:2 is not available in this version of the thesis

### ***Figure 4:2 Western Australian Country Health Service health regions***

Table 4:1 lists the seven regions with the numbers of hospitals offering graduate positions in each region, the number of graduate positions in each region and bed

numbers. The increased split in the Midwest region reflects the recruitment of graduates every three months for 2015. The South West region was the largest employer of graduates during the study.

**Table 4:1** *Regions, bed numbers and number of graduates employed across 17 rural and regional hospitals*

Regions	Number of hospitals offering graduate positions	Hospital bed numbers	Graduate positions Feb intake	August intake
Kimberley	3	57 32 31	7	0
Pilbara	2	55 31	6	0
Midwest	1	65	3 2	2 1
Goldfields	1	90	4	4
Wheatbelt	2	44 40	4 2	2
South West	6	98 42 25 24 22 18	19	0
Great Southern	2	109 36	9	0

## Rural and remote classification in Western Australia

The Western Australia Country Health Service uses the Accessibility/Remoteness Index of Australia classification when categorising each country region within the state (Wood, et al., 2012a, 2012b, 2012c). The Accessibility/Remoteness Index of Australia classification system provides a measure of remoteness for all places in Australia and classifies regions into five groups:

1. Highly accessible regions – unrestricted accessibility to goods and services and opportunities for social interaction;
2. Accessible – some restrictions to some goods;
3. Moderately accessible – significant restriction to goods and services;
4. Remote – very restricted accessibility to goods and services; and



5. Very remote – very little accessibility to goods and services and opportunities for social interaction.

The Pilbara is categorised as very remote, the Wheatbelt is moderately accessible, the Great Southern is classified as having parts that are accessible and yet others which are moderately accessible. The Midwest is classified as being accessible, yet very remote (AIHW, 2004). The Kimberly region is classed as both remote and very remote, the Goldfields region has areas classed as very remote, remote and outer regional, in comparison to the South West region, which is inner regional, outer regional and remote (Wood et al., 2012a, 2012b, 2012c). Some of the regions have multiple classification as it depends on how close a town is to goods and services based on road distance (AIHW, 2004). The classification of the rural areas highlights the diversity in the country regions and is reflected within the health care system of Western Australia.

### **Clinical service framework classification**

In Western Australia, the clinical service framework classification is used to classify the different levels of health service provision. Table 4:2 outlines the number of graduates employed in each of the three categories: The Regional Resource Centre, the Integrated District Health Service and Small Hospitals/Primary Health Care Centres.

The Regional Resource Centre is the largest of the three services and provides diagnostic services, emergency and outpatient facilities, outreach specialist services, secondary-level acute care and procedural (surgical) services (WA Health Clinical Services Framework, 2014-2024). The Integrated District Health Service provides diagnostic, emergency, acute inpatient and minor procedural services, low-risk obstetrics and aged care services, coordination for acute, primary and mental health services (WA Health Clinical Services Framework, 2014-2024, p.37). The Small Hospitals/Primary Health Care Centres provide emergency care, aged care and limited medical and surgical services.

**Table 4:2      *Region, district and small hospital (number of graduates employed).***

<b>Classification</b>	<b>Clinical service framework classification</b>	<b>Bed numbers</b>	<b>Facilities</b>	<b>Graduate no's</b>
Large hospital	Regional Resource Centres	51-110	6 Hospitals	41
Medium size	Integrated District Health Services	30-50	7 hospitals	19
Small hospital	Small Hospitals/Primary Health Care Centres	< 30	4 hospitals	5

Note: number of graduates covers both cohorts

Of the 17 hospitals who facilitated graduate programs there were six Regional Resource Centres: Broome, Port Hedland, Geraldton, Kalgoorlie, Bunbury and Albany. The ten integrated district health services hospitals were Derby, Kununurra, Karratha, Narrogin, Northam, Busselton, Katanning, Margaret River, Collie and Warren (Manjimup) leaving Bridgetown as the one small hospital/primary healthcare centre (WA Health Clinical Services Framework, 2014-2024). The Wheatbelt is the one region that does not have a Regional Resource Centre due to its proximity to the metropolitan area, relying on visiting specialists and the use of Telehealth. The hospitals in the Wheatbelt are all classified as integrated district health services. Each of these clinical services offer a unique graduate program experience.

## **Graduate programs in Western Australia**

The Western Australia Country Health Service offers over 60 nursing graduate places each year. Many of the graduate programs within the Western Australian metropolitan areas are conducted over periods of 12-18 or 24 months. These programs consist of study days, self-directed learning packages, workbooks, and preceptorship. A preceptor is a ward nurse allocated to a graduate, who aims to instil confidence, develop clinical knowledge, time management skills and manage conflict resolution for a selected period of time (Fedoruk & Hofmeyer, 2012). With each rotation a graduate nurse is allocated a new preceptor. In contrast, the rural and remote graduate nurse programs consist of study sessions, professional development days, supernumerary days, and preceptorship over a 12-18 month period with the opportunity to rotate through various areas dependent upon the health care facility (WACHS, n.d). The Western Australian Health Department information pamphlet provides information about the rural and remote graduate programs, outlining a structured program that

entails clinical skill development specific to rural and remote areas. The program also includes a supportive environment and opportunity for professional growth (WACHS, n.d).

Differences exist between the rural graduate programs, depending on the area. The graduates in the Kimberley, Midwest and Wheatbelt regions rotate through several smaller health service sites during the 12-month graduate training program, however in the Pilbara, Goldfields, South West and Great Southern regions, graduate nurses stay within the one hospital and rotate throughout the various hospital departments. Although in the majority of regions there is one dedicated graduate program coordinator, within the smaller sites support for this role is often delegated to the senior nursing staff as an additional role. The slight changes in graduate programs for each site was taken into consideration when the methods for the research was formulated.

## **Research objectives**

The overall aim for this mixed method research study was to determine if there was adequate support for graduate nurses in the rural and remote hospitals within Western Australia, therefore, the research questions were developed to align with the requirements for both qualitative and quantitative styles of research.

Four research questions were developed to explore the support available to graduate nurses and their experience undertaking these programs:

1. What are the experiences of nursing graduates working in rural and remote WA?
2. Are the rural nursing graduate programs effective in supporting new graduates in building confidence for rural and remote practice?
3. What are the facilitators and barriers to effective nursing graduate programs in rural and remote areas?
4. How satisfied are graduate nurses with the nursing graduate program in rural and remote Western Australia?

Gathering data to answer the four questions was achieved using both interview and survey questions within a structured timeframe. A pragmatic paradigm coordinated this research technique.

## **Methods**

The data collection strategies for this study consisted of in-depth interviews, and two structured questionnaires. The qualitative data was collected through a series of longitudinal interviews across the three phases in order to gain a rich, in-depth understanding of the graduates' experiences throughout the year and the senior nurses' insights into the graduate nursing program (Sandelowski, 2000) (see Appendix O). Both the qualitative and quantitative data sets were collected at three separate intervals over a single (usually 12 month) graduate program, at the beginning, in the middle and near completion of the graduates' program to align with Duchscher's theoretical framework. In order to gain a larger sample size for the quantitative study, two cohorts of graduates commencing at the beginning and end of the calendar year were approached to participate in the study. Data collection occurred over a period of 18 months.

### **Qualitative data**

Open-ended interviews which enabled deeper exploration of the topic area (Patton, 2002) were undertaken with graduate and senior nurses during each of the three phases of the project. Conducting one-on-one interviews facilitated direct questioning and probing, which enabled sharing of comprehensive information (Teddlie & Tashakkori, 2009). The interviews followed a semi-structured format where a small number of questions were asked of each participant which led on to an open discussion. Thoughts and feelings of the researcher were documented before conducting each interview to maintain an awareness of any preconceptions the researcher may have had (Streubert & Carpenter, 2011). The interview process reflected in an interactive personal context of the lived experience of each graduate or senior nurse.

Semi-structured interviews were the primary mode of data collection for the qualitative phase of the research. During each stage, structured interview questions were tailored to align with the framework and the interviews elicited information covering both social and clinical supportive measures.

The initial interview was conducted within the first four months of the graduate program, aligning with the first stage of the Transition Stages Model. The Transition Stages Model initial stage generally takes 3-4 months of the graduate year and is known as the “doing” stage (Duchscher, 2008). The second set of interviews were conducted within the seven month timeframe, thus corresponding to the second stage of Duchscher’s transition model, the ‘being’ stage, which occurs within the 5-8 month period of the new graduate’s transition year (Duchscher, 2008). The ‘knowing’ stage corresponds to a graduate’s final stage within a graduate program, and therefore the final set of interviews were conducted during the eleventh month of the graduate program (Duchscher, 2008).

### ***The interview for the senior nursing staff***

Interviews were conducted with senior nurses from each rural and remote region. These nurses were responsible for overseeing the graduate nurses. The interview process for senior nurses was scheduled the same as the graduates and hence was repeated at each of the three intervals previously highlighted to identify difference in support provided and needed at each of the different stages in the framework. The interviews with the senior nurses enabled the data gathered to align with, or build on, the graduate nurses’ experience of progression through Duchscher’s Transition Stages Model.

### **Quantitative data collection instrument**

The second method used to gather data for the study were two questionnaires. One questionnaire was designed for graduate nurses and the other for senior staff members. Both questionnaires were developed from a study that focused on whether graduate nurses were satisfied with graduate nurse programs in Victoria, Australia (Reeves, 2007). The questionnaires had previously been tested for reliability and validity (Reeves, 2007). Permission was gained from the author to use this tool to collect the quantitative data (see Appendix J). The questionnaires were modified to make the questionnaires suitable for Western Australian programs (see Appendices P and Q). The Rosenberg’s self-esteem scale was added to the graduate’s questionnaire which allowed for a deeper insight into the responses for each graduate nurse participant as to how their self-esteem changed throughout the graduate year. This tool also has been

extensively tested for both validity and reliability (Rosenberg, 1965). This tool was able to be used without explicit permission as long as the family was notified (Appendix L).

### ***Pilot testing two questionnaires***

Following ethics approval, five senior nurses and four graduate nurses from a small public metropolitan healthcare facility piloted the questionnaire for face and content validity. The surveys were tested by each participant at the same time to ensure the questions were clear and concise, contained no ambiguity and related to the attributes of a structured graduate program. Meeting everyone together saved time and allowed for easy discussion about the questions in the survey which may have been missing, misleading or unclear (Portney & Watkins, 2000). One question in the survey was changed following the meeting regarding the number of rotations to clarify the question.

### ***Questionnaires distribution***

Questionnaires were distributed via email to all graduate and senior nurses working in rural and remote Western Australia. An email was prepared for both cohorts and sent to the Western Australian Country Health Service liaison, who distributed the information to the Graduate Nurse Coordinators in each region who further disseminated the information to all possible participants. At the time of the research there were 65 graduate nurses undertaking a rural or remote graduate program and approximately 200 senior nurses involved in supporting the graduate nurses. Electronic links to both questionnaires were sent out to participants by an independent correspondence person from the Western Australia Country Health Service to maintain privacy of potential participants. Links (emails) were sent out at the three intervals as described previously and a follow up reminder was sent out the following week. The questionnaires were set up in the Qualtrics data management system so the surveys could be completed electronically.

The questionnaires were structured with pre-coded non-forced choice questions. The pre-coding of questions made it easier for entry and data analysis. The questionnaire for the senior rural registered nurses was divided into 11 sections. The questionnaire for the graduate nurses was divided up into 12 sections. Both surveys

were followed by two or three open-ended questions. The questionnaires were divided into the following sections:

1. Demographic data, university attendance, size of hospital;
2. The clinical rotations;
3. Preceptorship;
4. Supernumerary time;
5. Graduate nurse coordinator / Staff development nurse / Clinical educator;
6. Support given to the graduates;
7. Being part of the team;
8. Theoretical component of the program;
9. Performance management;
10. Evaluation;
11. Overall satisfaction with the program; and
12. The self-esteem section (for the graduate nurses only).

The senior nurse questionnaire was designed to gather information about the graduate program and gain an understanding if the senior nurses were satisfied with all aspects of the current program (Reeves, 2007). (Appendix Q).

The questionnaires employed throughout this study were coded and consisted of 35-45 questions, generally taking no longer than 20 minutes to complete. For this research the graduates completed the same survey at each interval so changes in responses across the different time periods could be assessed.

## **Validity and reliability**

Measurement of validity and reliability of a scale determines if a chosen data survey captures what it was intended to capture and accurately reflects the full extent of the concept being explored (Teddle & Tashakkori, 2009). This survey was used previously on two occasions and the data collected were consistent, strengthening the reliability of the instrument (Reeves, 2007). The questionnaire was shown to represent all documented components of a graduate nurse program in another state of Australia, (Victoria), and was developed following an extensive literature review (Reeves, 2007). The survey was piloted before being used in Western Australia and reviewed for translational validity by the pilot group, assessing both face and content validity within

the Western Australian context. The survey was closely examined by the researcher and pilot study group highlighting if each question reflected the supportive measures needed within a structured graduate program, strengthening the survey's capacity to address the research question. This strengthened the survey although, the response was limited to participants from two graduate nurse program cohorts only.

## **External validity**

This study captured the current perspective of the nursing staff involved with rural graduate programs in Western Australia. The study was not extended to rural and remote nursing staff who had completed a graduate program in previous years. Accordingly, the findings are not able to be extrapolated to all rural areas within Australia, however, combining the mixed method results increased the validity, and along with regular delivery of the questionnaire, over 50% of graduates in rural Western Australia responded which increased the prospect of generalisation of the findings to all graduates enrolled in programs in rural and remote Western Australia.

## **Participants**

### **Sample selection**

For this study, graduate nurses and senior rural and remote nurses were purposively sampled from each region. Purposive sampling involves participants who are specifically invited to be part of the study because they are experienced in the subject area (Burns & Grove, 2009). This method captured the knowledge and perceptions of members from the target group. As this study was focused on identifying the support available for rural graduate nurses, both the nursing graduates and the senior nurses who facilitated the graduate program were invited to participate (Speziale & Carpenter, 2007). This homogenous form of sampling allowed for exploration of the graduate nurse program from two perspectives (Teddlie & Tashakkori, 2009).

### ***Participant recruitment***

All the graduate nurses, and senior rural and remote nurses involved in graduate programs located in hospitals that facilitated graduate nurses, were invited to participate in the quantitative survey via email. Before the email was distributed, a video conference presentation was conducted for senior nurses and information was relayed



by video conference and in person. The presentation was conducted on two separate occasions at the beginning of the research project. All senior staff members involved in the coordination of the graduate nurse program from each region were invited to the first presentation, where the study was presented, and any questions answered. The second presentation was for senior staff members in the Pilbara region only. All graduates were recruited through presentations delivered on site at various intervals throughout the first 12 months. A nominated contact person situated at the Western Australia Country Health Service's main office, organised the first presentation to senior nurses and also played a part in distributing the information to all the senior staff members, who in turn emailed all the graduates at each of the data collection intervals throughout the 18 months.

Senior registered nurses at five different hospitals were contacted by email at each of the data collection periods with the aim to capture all possible participants and decrease the workload of senior members. Towards the end of the data collection period the survey was resent out to all 17 sites in order to increase response rates.

### ***Qualitative data collection***

The in-depth semi-structured interviews were conducted face-to-face for a majority of the senior nursing staff during the first data collection period. Teleconferencing was used for senior nurse interviews when required. The interviews for all graduates were conducted with the use of technology, including teleconference facilities available throughout the clinical settings and the University campus. The interviews ranged from 20 minutes up to 70 minutes in duration and all were recorded using digital recorders. A short notation was completed in the researcher's journal prior to the interviews which was a useful source of complementary data because it highlighted the researcher's thoughts and bias before the interviews began (Rudestam & Newton, 2014).

### ***Quantitative data collection***

The senior registered nurses received the quantitative survey via email. Nurses were included if they held an education portfolio, preceptored graduates or were involved in supporting graduate nurses. All graduate nurses employed by the Western Australia Country Health Service were invited to take part in the graduate questionnaire.

The survey was available by email link to Qualtrics or paper-based copies of the survey were distributed which were subsequently entered into Qualtrics by the researcher.

## **Data analysis**

### **Qualitative**

Thematic analysis is a foundational analytical method. Thematic analysis enables the researcher to organise data into patterns or themes and presents a deeper rich detailed account of the research topic (Braun & Clarke, 2006). Braun and Clarke's step by step thematic approach was used to analyse the qualitative data (Braun & Clarke, 2006). According to Braun and Clarke (2006) thematic analyses consist of two different styles of approach: inductive and deductive. The inductive approach is often used when there is no previous knowledge on the subject matter or the knowledge which is available is fragmented (Elo & Kyngäs, 2008). When coding data using an inductive style, the codes are derived directly from the data. A deductive approach is often used when testing a theory or comparing categories or themes at different times (Vaismoradi, Turunen, & Bondas, 2013). Latent thematic analysis was also considered and is reflected when choosing the level at which to identify the themes or a theme. This is when the next step is taken, and themes are interpreted with more than a semantic approach. Latent thematic analysis is not just descriptive but interpretative examining of the underlying ideations (Braun & Clarke, 2006).

Considering there is limited literature on rural and remote graduate programs in Western Australia, it was decided to adopt a descriptive approach following both an inductive and deductive style of thematic analysis for this research. The first set of data collected followed the inductive process, which allowed the general patterns in the data to be discerned. The subsequent data collected was analysed using a deductive process, comparing patterns in responses to those from previous stages. When any new categories emerged, the inductive process was used following the approach outlined by both Elo and Kyngäs (2008) and Hsieh and Shannon (2005).

The inductive content data analysis approach used in this research followed a systematic six step approach to organising the data (Braun & Clarke, 2006). Firstly, the researcher was immersed in the data by reading and re-reading the unit of analysis as a whole. Only then did the researcher move onto looking at the data word by word and

capturing ideas (Braun & Clarke, 2006). While doing this, the researcher often returned back to the beginning of the text and wrote notes in the margins to document first impressions. This was followed by the second step, the creation of codes which were noted throughout and more than one key thought was developed. Although coding is the second step, it is an ongoing process throughout the thematic data analysis approach. Coding was done manually with the use of butcher's paper and 'post-it' notes which allowed for transparency and patterns to occur. Themes were developed during the third stage from the codes creating 'significant clustered groups'. A thematic map was developed to help organise levels of significance from the main themes and sub-themes (Braun & Clarke, 2006). The fourth stage when the themes form a set of data were reviewed. Some themes were expanded, and others collapsed, and new themes developed, with final overall patterns strengthened. The themes were then reviewed by two researchers, taking into account the entire data collection to ensure the themes worked and code any additional data (Braun & Clarke, 2006). Throughout stage five, names and definitions were developed for each theme, identifying why they were important constructs within the data set. The final stage of the integrated steps was to finalise the findings and the story the data portrayed. This process was followed for all of the data collected from the interviews conducted within the first four months of the graduate program. The interviews conducted from the next two intervals (8 and 12 months) were analysed using both a deductive and inductive process.

The deductive content analysis approach is often used to prove or add to an existing theory (Elo & Kyngäs, 2008). In the case of this study, the second and third set of qualitative data enhanced the first and further validated the theoretical framework that underpinned the study. The deductive process used was the same as the inductive throughout the preparation stage – sampling and data collection, selecting of unit of analysis (the entire transcribed interview), followed by reading and re-reading of the interview transcripts until immersion occurred (Elo & Kyngäs, 2008). The themes developed throughout the inductive phase became the main focus for coding throughout the deductive phase. The information gathered that did not fit within the pre-conceived themes were then analysed using the inductive principles (Elo & Kyngäs, 2008).

## ***Credibility and dependability***

The credibility and dependability of this qualitative research is strengthened using several strategies, which included member checks, personal meetings and reflexive diaries (Teddle & Tashakkori, 2009). Member checks helped substantiate the researcher's view of the interpreted data to ensure the data captured was a true account of the participant's perspective (Streubert & Carpenter, 2011). All interview transcripts were sent to the participants for checking. One graduate nurse sent their interview back with a few minor corrections and three senior nurses made corrections. At the beginning of the second and third interviews, the researcher reviewed the previous interviews, which provided a connection and allowed for probing or further clarification. Personal meetings enhanced mutual trust, allowing for rich data to be collected throughout the interview process (Minichiello, Axford, Sullivan, & Greenwood, 2004). A reflexive diary was used to document the method of data collection and collect information about how the researcher felt at the time of the interview. This process enhanced credibility of the data collected (Streubert & Carpenter, 2011). A short notation of the researcher's understanding of graduate programs before the commencement of data analysis was recorded and highlighted the embedded knowledge the nurse researcher sustained (Neergaard, Olesen, Anderson, & Sondergaard, 2009).

An independent researcher compared categories from both deductive and inductive thematic analysis ensuring the same trends and patterns are found, adding to the validity of the data (Elo & Kyngäs, 2008). Another strategy employed was ensuring that the participants felt comfortable to speak freely, and only participated if they wanted to be a part of the study, again strengthening the rigor of the qualitative descriptive data. This choice to participate allowed for rich information to be shared and appropriately represented through the analysis (Neergaard, et al., 2009).

These multiple techniques were aimed to provide an accurate representation of the graduate programs from the perspectives of both the graduates and the senior nurses. The overall strategies adopted increased the credibility of the findings between regional areas.

## **Quantitative data analysis**

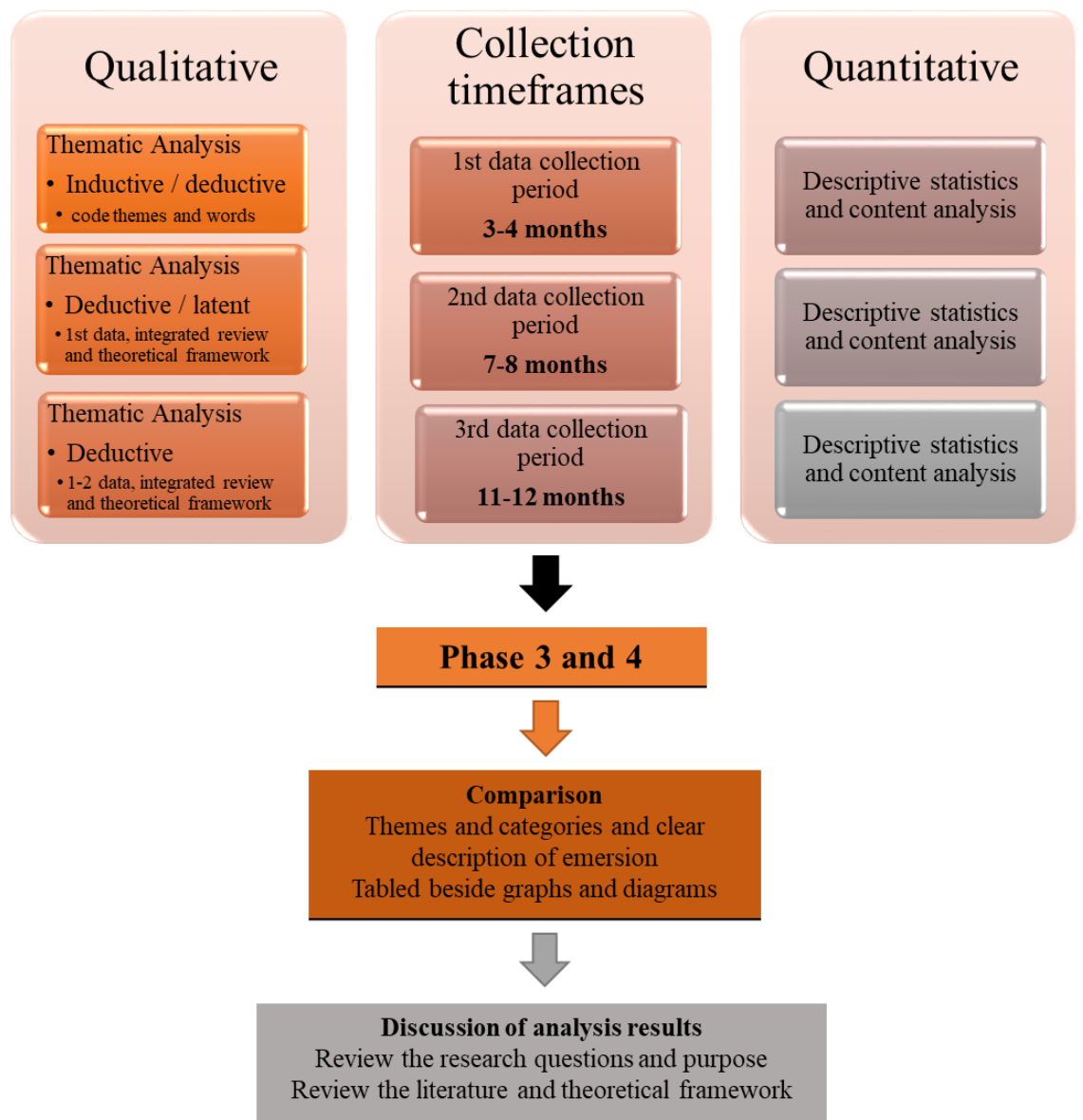
The information collected from the quantitative data via Qualtrics was transformed to Excel format and then to SPSS Version 22 software for analysis. The quantitative data was cleaned, and the final number of surveys were grouped into three separate timeframes for one set of analysis. Descriptive statistics were used to summarise the quantitative data due to the small sample group. Percentages were used to summarise both the continuous variables e.g. age, and the categorical variables e.g. gender. Percentages were also applied to the remaining questions which were analysed using a 5-point Likert scale. The three different Likert measurements consisted of agreement, valuable and satisfaction level each variable included a not applicable segment. The various stages of analysis are illustrated in Figure 4:3. Questionnaires were reviewed by timeframe then longitudinally to analyse changes over time for the graduate nurses.

### ***Rosenberg self-esteem tool***

Self-esteem was measured using a ten item Likert scale with items answered on a 5-point scale – from 1=strongly agree to 5=strongly disagree. Five questions were from a positive perspective for example: on the whole, I am satisfied with myself and five questions were written from a negative perspective e.g. at times, I think I am no good at all. This was to account for respondents strongly agreeing to all questions (Rosenberg, 1965) see Appendix L. The first scale grouped questions 39, 43, and 45 together with two or more positive responses resulting in a positive grade. Scale 2 placed 40 and 41 together with one or more positive responses providing a positive outcome. Scale 3, 4 and 5 related to question 46, 37 and 44 independently. The last scale grouped questions 38 and 42 where one or more positive responses would result in a positive outcome. There are six categories involved in the Guttman scale measured from 0-6. The Guttman scale was used to measure Rosenberg's self-esteem scale. A grade between 0-2 indicated a low self-esteem, a grade of 3-4 indicated a moderate self-esteem and participants who received a grade of 5 or 6 were considered to have high levels of self-esteem (Rosenberg, 1965). The use of the Guttman scale increases the strength of the tool and is easy to analyse. The Guttman scale allows the cumulative score to indicate the level of self-esteem or response because the scale is determinist (Forrester, 2009).

## ***Content analysis***

The online surveys contained three open-ended questions which were analysed using the content analysis approach outlined by both Jacob, McKenna and D'Amore (2014) and Chambers and Chiang (2012). QCAmap was a tool used to code, group and abstract the data from the three questions (Mayring, 2014). For this study the codes were not predetermined but evolved from the detailed descriptions. A set of rules applied before coding commenced to enable replication of the analysis (Neuendorf, 2016). Content analysis involves coding written words into categories. The number of times the same words were repeated were highlighted. Some responses contained more than one code. The coded information informed the key points (Jacob et al., 2014). The key points were grouped together to form categories and subsequent themes. Code frequency with similar values were tallied and divided by number of participants who submitted written responses. This was reflected in the results with a percentage. The content analysis resulted in systematically obtaining measurable descriptive information, therefore strengthening the validity of the inferences (Elo & Kyngäs, 2008). The broader steps taken for data analysis are evident within the following diagram.



**Figure 4:3** *Data analysis – Qualitative and Quantitative*

## **Merging the data**

Throughout integrating, triangulating and/or making sense of the combined data sets, a simple process was followed. This allowed for the independent researcher to come in and follow the process resulting in the same findings. This step by step process began by highlighting one of the research aims each time the data was reviewed (Teddlie & Tashakkori, 2009). As the analysed data was revised reflexive diaries were taken into consideration along with the notes made in columns and notes taken throughout the separate analytical process during phase one and two. Interpretations were made of the data to align with all or part of the research question (Teddlie & Tashakkori, 2009). Once this process was completed for each research question the interpretations were once again tabled side by side and either compared, combined and/or contrasted. If the information did not match, reasons were sought through current literature, field notes and raw data for possible explanations (Teddlie & Tashakkori, 2009).

In contrast to the aforementioned side by side comparison of data, an alternative transformation method was also employed with a select number of variables. The chosen variables related to, or directly answered, the research question as open-ended questions from the surveys. This process requires one data method to be transformed into the other. Within this study, the qualitative data from the surveys was coded and transformed into quantitative data (Creswell & Plano Clark, 2011). This was conducted by highlighting the frequency of themes that were coded via thematic analysis.

Discussion of the findings, the final phase of this research design, led to further explanations of the themes and the possibility of generalising the meta-inferences for all of rural and remote Western Australia (Creswell & Plano Clark, 2011). Throughout this phase the primary focus was to discover differences and similarities between the two data sets. When the segments or variables did not reflect the same information and the findings failed to align with the literature or theoretical framework, further exploration was performed (Creswell & Plano Clark, 2011).

Within this research design, triangulation of data was evident through a number of phases. Triangulation of the data was applied when the two interpreted data sets were compared, transformed and findings were merged. This enabled the interpretation of the



combined results and further evaluated how the findings addressed the research question.

## **Rigor for mixed methods**

There are a number of potential threats when it comes to the validity of a mixed method study, however within this study a number of steps were considered throughout the final stages to ensure these concerns were kept to a minimum (Creswell & Plano Clark, 2011). Data being collected from purposefully selected participants, due to their expertise, all of who needed to be a graduate nurse in rural remote Western Australia, or a senior nurse involved in the graduate program, strengthening the validity (Creswell & Plano Clark, 2011). Both graduate and senior nurse data questions were set up to address the same topic which potentially decreased threats which could arise when the data was merged and/or combined throughout the final phases of the research design.

Results were displayed in a table format in order to interpret configuration for ease of duplication if needed, reducing threats and legitimising the findings (Onwuegbuzie & Johnson, 2006). As previously suggested the transformation of data was carried out following a systematic process allowing for the independent review by a second researcher. In addition, quotes from the deep enriched data were used to support the qualitative findings (Creswell & Plano Clark, 2011). The merging of data sets allowed for each research question to be addressed. The two data sets were of equal importance leading to a reduction of possible threats to the validity of the study, although if the numbers differed, the rich qualitative data was balanced due to the intensity of information (Onwuegbuzie, & Johnson, 2006). Data was interpreted several different ways (e.g. as a continuum) reviewing the three stages from each individual participant and information gathered from each stage was interpreted in its entirety. This allowed for inferences to be made from all separate stages and as a whole which strengthened the validity of the results (Creswell & Plano Clark, 2011).

Adding to the quality or ability for the mixed data sets to validate findings or legitimise results, Teddlie and Tashakkori (2009) developed a framework to follow. This was used in this study and further enhances the quality and rigor of the analysed data and findings. Table 4:3 outlines the quality for the research undertaken.

***Table 4:3      Integrative framework for inference quality***

Table 4:3 is not available in this version of the thesis

(Teddle & Tashakkori, 2009, p 301)

## **Ethical considerations**

### ***Informed consent and confidentiality***

Ethical approval to undertake the research was obtained from the Human Research Ethics Committee (HREC) at both Edith Cowan University and the Western Australia Country Health Service (Appendices G and H). Participation was voluntary and participants were informed they were under no obligation to take part in the study. All rural and remote staff members contacted via email, from the appointed WACHS liaison, received information about the research and its purpose. Each candidate received a letter asking for their informed consent to participate (Appendix N). As the request to participate email included a copy of the information statement and a link to the survey, completion of the survey was considered to be informed consent. The participants were advised of the confidentiality of the study and they could withdraw at any time without penalty or effect on their work life prior to publication of the results.

Potential risks for participants such as anxiety regarding their employment could occur if any identifiable disclosure arose for an individual participant or a location site. In this project, to negate this risk, informed consent was obtained, and confidentiality and anonymity of each participant and the location of sites were protected (protecting the identity of participants and locations). Study sites will not be named but will be referred to as small designated hospital and region A, B, C, for example. Participants were advised of counselling services such as Beyond Blue if they wished to speak with a counsellor following an interview. Confidentiality was upheld when the data was analysed by linking all participants to a specific data code. A different code was allocated for each region (as mentioned) and a second code was given to graduates nurses and senior staff members, thus ensuring the participants were not identifiable by name. Only the researcher and supervisory team had access to these codes. This project will contribute to knowledge about supportive measures available for rural and remote graduate programs in Western Australia. The final report will be disseminated throughout the seven regions via virtual electronic systems and personal presentations. This will help inform future consideration for senior nurses and management involved in a new graduate's transition to practice.

The data was kept on a password protected computer in the researcher's locked office and will remain there for a period of seven years in accordance with ethical

practice guidelines and the Western Australia Country Health Service ethical requirements (NHMRC, 2007). A copy of a report of the study was provided in person to the Western Australia Country Health Service before any papers were published regarding the results (Creswell, 2014). Funds to complete the research were sought and granted by the Western Australian Nurses Memorial Charitable Trust. No conflict of interest was identified, as neither the researcher, the Western Australia Country Health Service nor the Western Australian Nurses Memorial Charitable Trust stood to profit from this research project.

## **Summary of chapter**

This chapter provided an explanation as why a mixed method design was chosen to address the research aims. This was followed by an in-depth description of the setting. The research design and how each step aligned with the chosen conceptual framework was then presented. The processes involved in the qualitative and quantitative data collection and analysis were discussed. Finally, this chapter discussed the quality and rigor of the data and briefly discussed the ethical considerations. The next chapter will discuss the first of the findings from the study.

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## **CHAPTER 5: Experiences of Nursing Graduates in Rural and Remote Western Australia: Qualitative Findings**

### **Introduction**

Chapter 4 outlined the methodology and design for this study. The findings for this study are presented in the next four chapters: the qualitative findings from the new graduate registered nurses and senior nurses interviews are presented in chapters 5 and 6. Chapters 7 and 8 present the results from the new graduate registered nurses and senior nurses surveys, respectively. This chapter presents the findings from the in-depth interviews conducted with 10 newly graduated registered nurses and the findings are presented in the form of themes drawn from their interviews. Chapter 6 will then present the qualitative findings from interviews held with 15 senior nurses.

### **Participants**

#### **New graduate registered nurses**

Ten nursing graduates participated in the interviews for the study. The new graduate registered nurses were undertaking graduate programs at district and regional facilities. Participants were aged between their 20s and mid-50s and were of both genders. Twenty-two in-depth interviews were undertaken with 10 new graduate registered nurses over the three phases of the study. Eight new graduate registered nurses participated in the first stage of interviews. Six new graduate registered nurses participated in the second stage of interviews and eight new graduate registered nurses participated in the third interview. Of the 10 participants, five new graduate registered nurses participated in all three interviews, two new graduate registered nurses participated in two interviews, and three new graduate registered nurses were interviewed once. At least one new graduate registered nurse from each of the seven regions participated in the interviews. The findings of the three time-framed interviews follows.

## **Phase one**

### **Findings**

Thematic analysis of the interviews with new graduate registered nurses identified four themes that ran across the graduate year. These themes were ‘Professional beginnings’, ‘Fractured reality’, and ‘A sense of belonging and Transference of knowledge’. The theme ‘Professional beginnings’ described the new graduate registered nurses’ perceptions of the challenges they faced acclimatising to the nursing role for each rotation throughout the program. ‘Fractured reality’ explored the difference between a new graduate registered nurse’ expectations and their actual experiences of undertaking the graduate program and working as a registered nurse. The theme ‘A sense of belonging’ portrayed the psychosocial aspects of the new graduate registered nurses’ experience, highlighting the importance of friendship and community ties. The ‘Transference of knowledge’ identified that clinical education was gained through both structured and ad hoc educational opportunities and described how the knowledge was utilised by the new graduate registered nurses. These themes will be discussed individually while providing the evidence for the results. Table 5.1 outlines the overarching themes and their sub-themes identified throughout the research and how the themes relate to the different stages the new graduate registered nurses experience during their graduate year.

**Table 5:1**      *New graduate registered nurses' transition to rural nursing*

<b>Themes/ Timeframe</b>	<b>Professional Beginnings</b>	<b>Fractured Reality</b>	<b>Sense of Belonging</b>	<b>Transference of Knowledge</b>	
3 months	<b>Thrown in the deep end</b> <i>overwhelmed belongingness</i>	<b>We're not ready</b> <i>support online-guidance communication</i>	<b>Settling In</b> <i>social peers clinical</i>	<b>Tell me what I need to know to survive</b> <i>Structured study days E-learning ad hoc education</i>	<b>Sub- Themes and Categories</b>
7 months	<b>Treading water</b> <i>Hesitant belongingness</i>	<b>We're working on it</b> <i>support online-guidance communication &amp; feedback</i>	<b>No-man's land</b> <i>social peers clinical</i>	<b>I still need to know more</b> <i>Structured study days E-learning ad hoc education</i>	
11 months	<b>Swimming without 'floaties'</b> <i>confidence belongingness</i>	<b>We're ready now</b> <i>support guidance communication, debrief &amp; feedback</i>	<b>Feeling Settled</b> <i>social peers clinical</i>	<b>Ok got it, now what?</b> <i>Structured study days E-learning ad hoc education</i>	

Note: italic, right alignment = categories for each of the subthemes

## **Theme 1.0: Professional beginnings**

The theme 'Professional beginnings' refers to the challenges new graduate registered nurses felt in undertaking the professional role of a registered nurse. Education that provides the insight to be able to navigate complex and at times unknown tasks, describes the training nursing professionals require to operate independently (Chang & Daly, 2016). The term "professionals" defined by Chang and Daly (2016) was in the context of a beginning registered nurse. Throughout the conversations with the new graduate registered nurses, it was clear many felt they needed to perform specific skills, with both confidence and competence before they felt valued as part of the clinical team in each of the different clinical areas (rotations).

The rural and remote graduate program required that all of the new graduate registered nurses rotated through different clinical environments with the majority rotating every four months. Each time the graduates rotated to a new clinical area, marked the beginning of a new professional experience for each new graduate registered

nurse. The experiences of starting each new rotation differed for each of the new graduates.

Three subthemes highlighted these challenges: a swimming analogy was used to describe the sentiment by several participants in describing their experience and depicts the new graduate registered nurse's learning the role of a registered nurse similar to the way in which a child learns to swim, hence the swimming analogy has been used for this theme. New graduate registered nurses progressed throughout their graduate year as they developed the skill and confidence to practice as a registered nurse, from feeling like they were 'drowning' at the beginning of the first rotation, to feeling like they could finally 'swim' for the final rotational change. The subthemes reflect the swimming analogy and were identified were: 1.1 Thrown in the deep end; 1.2 Treading water; and 1.3 Swimming without 'floaties'.

### ***1.1 Thrown in the deep end***

This sub-theme described by the new graduates refers to the new graduate registered nurse feeling unprepared for the responsibilities of a registered nurse and feeling like a 'stranger' in the clinical world. Within the first three months, some of the new graduate registered nurses described feeling like they were thrown in the deep end of a swimming pool and were drowning because of the situation in which they found themselves. This feeling was evident in periods when support was not available, and self-esteem was lacking. Many new graduate registered nurses felt there was a lack of support and sensed they had '*no safety net*' (GN7-3). From this subtheme two categories were identified – feeling overwhelmed and belongingness.

#### **1.1.1 Overwhelmed**

At the commencement of their graduate year, many new graduate registered nurses reported feeling overwhelmed by how much they had to learn despite their undergraduate training. Being 'overwhelmed' was an emotion expressed when the new graduate registered nurses felt they needed to practice in the full role of a registered nurse despite not feeling ready for this role. This was exacerbated by an expectation of new graduate registered nurses to 'hit the floor running', to be able to perform basic clinical skills and manage a full patient workload. One of the new graduate registered nurses believed that their university had prepared them well, and being a high achiever,



they assumed they would be able to cope. When this did not happen, emotions of self-doubt and being overwhelmed ensued:

*Completely overwhelming. Unfortunately, I felt very I did not have a lot of confidence in myself, so it was very difficult the first few shifts... And there were times where I felt like dropping in the towel and you know there were tears and I think the expectations that I had on myself were very high because I had done well academically. I thought that I needed to excel as soon as I stepped onto the floor (GN7-3)*

The extent of feeling overwhelmed was different for each new graduate registered nurse and depended on their personality, life experience or level of maturity, personal expectations, the time taken to adjust to the new role, and the support provided. Other new graduate registered nurses spoke of being overwhelmed with the workload until they had learned how to manage their time appropriately. Many of the new graduate registered nurses felt the first three months were not smooth and many felt isolated, stressed and had feelings of inadequateness as they transitioned into the role of a registered nurse. The new graduate registered nurses expressed a lack of knowing of what to do and felt unable to fully work as an effective team member. As one new graduate registered nurse said, *“initially it was sort of a new environment that I was uncertain, was probably feeling that I wasn’t pulling my weight. Not knowing what I was doing”* (GN6-3). One of the new graduate registered nurses stated, *“It was a steep learning curve”* (GN3-3). Even when one graduate nurse had attended the same clinical environment as a student nurse in their final year, she still found it *“stressful. I did not expect to be put in the deep end”* (GN6-3).

The new graduates indicated they felt unprepared for the difference with the level of support provided as a student nurse to the support provided as a new graduate registered nurse, which exacerbated their feelings of being overwhelmed. This was emphasised by one of the graduates who had come from a metropolitan area where they had experienced ongoing support. *“Just the fact that I didn’t have a preceptor, so you didn’t have anyone. I was a partnership student at [hospital name withheld] so we always had a staff development nurse [for support]”* (GN2-3). The new graduate registered nurse felt isolated within the district hospital and felt she had been *“let loose on proper patients without any back up”* (GN2-3). The graduates’ experience of supportive measures and time needed to adjust to the workplace was different to what

they expected. *“In the regional/remote areas I knew there would not be the support you have in the cities but did not realise that there would be so little”* (GN1-3). The perceived lack of support contributed to the feelings of being overwhelmed. Even graduates who received one-on-one support through preceptorship still felt they were *“thrown in”* and *“treading quicksand for a while”* (GN3-3), however, some of the new graduate registered nurses believed this was *“one way of learning”* (GN1-3). The majority of the new graduate registered nurses experienced a sense of unease and were challenged by the role of a registered nurse whilst learning within the clinical area.

### **1.1.2 Belongingness**

While the new graduate registered nurses felt overwhelmed, many also indicated they felt as though they belonged on the ward after some time had passed.

Belongingness correlates to the clinical setting and does not encompass the social setting. Belongingness within this context related to the new graduate registered nurses feeling they were part of the clinical team. The graduates indicated that it took at least four weeks to ‘fit in’ the clinical area. Time management seemed to be crucial before the new graduate registered nurses felt a sense of belongingness:

*Um, I guess actually realising that it is not as scary as what I thought it might be and actually getting a handle on things. Sort of by the end of the first four weeks, I guess, it was like, okay yes, I can do this. I am not giving out morning medication until 12 midday, and getting to do actually nursing work as such, rather than just giving medication, is quite a high point for me. Basically, the basics. (GN1-3)*

This comment demonstrated the task-orientated focus of many new graduate registered nurses on commencement of a rotation. Their focus was on being able to administer medication on time. Not all of the new graduate registered nurses felt that sense of belonging within the first four weeks. A small number of new graduate registered nurses felt they had to prove their skills, when working with some staff members, and lost confidence in their own abilities. This group of new graduate registered nurses did not feel part of the team within the first four weeks. The following new graduate registered nurses experience suggested that not all staff were approachable:

*Yeah, I am still finding my way around it all. There is [are] definitely staff that are there that, you know, you feel hesitant or nervous about*

*doing particular things, like particular skill or what not, you know, because you have that sense of judgment or disgust looking down on you. Sort of that still occurs. (GN6-3)*

One of the new graduate registered nurses tried to share knowledge gained at university and was advised to use different practice methods. *“I have spoken out about something, and they have said well actually we are in [hospital name withheld] and there is kind of an [hospital name withheld] way, and there is kind of the other way things are done”* (GN 1-3). This highlights differing nursing culture, and the challenges new graduate registered nurses faced with learning how to fit in with different practice expectations. Graduates who challenged current practice described feelings of isolation as opposed to belongingness.

The subtheme of ‘thrown in the deep end’ provided insight to the experience of graduates’ professional beginnings and feelings of being overwhelmed and the time required to feel part of the team within the first three months of the graduate program. After being thrown in the deep end and not drowning, the new graduates learnt how to survive in the clinical environment. Participants in this study referred to this phenomenon as ‘learning to tread water’.

## **1.2 Treading water**

This subtheme was identified by new graduate registered nurses on the second interview at seven months and describes how moving to a new ward resulted in new graduate registered nurses again feeling overwhelmed at the beginning, but it did not last as long as the initial rotation. The new graduate registered nurses had moved to their second rotation by either changing wards or moving to a new hospital. The new graduate registered nurses felt disorientated when they moved to a new clinical area and were once again ‘treading water’ or ‘taking time’ to find their place in the nursing team. One of the new graduate registered nurses described their experience, *“I left general ward feeling that I was an actual nurse and then [moved wards] you come back feeling like you are a student again but it’s only for the first couple weeks”* (GN4-7). The graduates no longer felt like they were ‘*thrown in the deep end*’, however they still felt like they were in deep waters and just able to keep their head above the water in the unfamiliar territory. This feeling did not last as long as the initial experience.

By the middle of the graduate year, the new graduate registered nurses' focus had changed from articulating concerns with individual skills such as time management to focusing on reorienting with staff and clinical areas. The participants concentrated on learning the dynamics of the new environment and advancing their clinical skills. The interviews identified changes in the emotional state of new graduate registered nurses. While the initial feeling of being overwhelmed had past, new graduates expressed feeling exhausted as they were emotionally drained and struggled to navigate work-life balance. Many of the new graduate registered nurses experienced depleted energy levels as they navigated these challenges:

*Today I just was like 'oh my gosh', just hit a wall...I think that sort of thing as well. I'm just struggling a bit with the whole work/life balance thing and the fact that I am just exhausted when I finish work and just can't like do as much as I used to and I have to force myself to rest and it's just learning to like manage that. (GN9-7)*

And

*I really struggled with that [being tired] and ... [it] happened while I was in ED as well and I guess the whole realisation that I'd actually been up here for the six months as well and hadn't actually had a break or anything. (GN1-7)*

The graduates believed their experience of exhaustion was magnified because they had not taken a break and were physically tired. The impact of a new home, new job, ongoing learning were not considered as factors, until asked to reflect.

The impact of low staffing levels and poor rostering practices were viewed by the new graduate registered nurses as factors that increased their feelings of tiredness. One new graduate registered nurse discussed being rostered between two wards for seven days. This was thought to exacerbate the tiredness of the new graduates:

*I had done a seven-day week, I spent, I'd finished on the ward on the Sunday night and did five days of trying to learn new things with dialysis, and then I got a call ... back into general ward on a Saturday night, so I ended up doing seven days straight... I had a bit of burnout that following week. (GN 4-7)*

Being rostered continually for seven days was not an isolated incident and similar rostering patterns resulted in graduates stating they were exhausted or unwell.

### 1.2.1 Hesitant

Navigating through the new environment was not easy for the new graduate registered nurses and if not adequately supported, they often took longer to feel at ease. Many graduates shared their feelings of being overwhelmed at the beginning of the new rotation. The new graduate registered nurses suggested the challenges were similar to what they felt within the first few weeks of the graduate program. One of the graduates shared their experience with learning advanced skills, *“It was massive high learning curve... You get to learn lots, and things and I think after I actually had, like because to start with I felt very, very overwhelmed because it’s only a 7 bed ED [emergency]”* (GN1-7). However, these emotions would *“only last for the first couple weeks”* (GN4-7):

*I think there’s probably just one or two days or times in the last couple of weeks in ED where I’ve sort of just felt completely overwhelmed. Like when, if it just changes so quickly and I feel like I don’t know enough and I’m sort of like ‘ah’ what are we doing, like I don’t know what to do. (GN8-7)*

The graduate suggested the nurses were all very senior and happy to help in the specialised areas, which indicated that more support was available for the new graduate. The new graduate registered nurses indicated feelings of self-doubt diminished over a reduced timeframe.

### 1.2.2 Belongingness

The level of one-on-one support, such as preceptorship, influenced the new graduate registered nurses’ sense of belonging from the beginning of their second rotation. The common theme among the participating new graduates highlighted a lack of support, leaving them feeling that they did not belong.

When preceptors were not allocated to the new graduate registered nurses, the graduates resorted to choosing their own preceptors or gravitating towards approachable nurses on shift. One of the new graduates identified this type of self-support to be effective, however they did not comment on whether or not they felt like they were part of the team. New graduate registered nurses who were allocated preceptors indicated this role was not taken seriously, as the rosters often did not synchronise, or the

preceptor only completed the minimal paperwork required. New graduates were all left to seek help and advice from other staff members. ‘Unprepared’ preceptors or self-support did not align with the graduates’ needs. This resulted in the new graduate registered nurses feeling inadequate or feeling unwelcome and like they do not belong. In direct contrast, one of the new graduates was provided with support and felt a sense of belonging within the clinical area:

*One, I've had one main one and then I've got another two that I spend a bit of time with as well..... And I do the whole lot, I cannulate them, do all the care and just go to the preceptors if and when I need to ask a question. They just come back and check, make sure, because we double check all machines and stuff here anyway with two nurses. So they just do that with me and if I get stuck or if I'm not happy with something I'll go and get them and they'll come over and they go through alarms with me and they, yeah, they're very good. (GN4-7)*

The new graduate registered nurses no longer felt as they were drowning all the time and although there were still episodes of feeling overwhelmed, the majority coped with the prevailing circumstances and learnt new skills.

### **1.3    *Swimming without ‘floaties’***

By the final interviews at the end of the graduate year, the new graduate registered nurses were able to work as independent professionals with minimal support. Their experiences during the graduate year lead to an increase in confidence and they no longer felt overwhelmed with changes in environment. The graduates no longer felt that extra support or ‘a floatation device’ was required to help keep their heads above water. Although graduates still faced obstacles, change was less disruptive as new graduate registered nurses were familiar with the organisation, the expectation of staff, and of patients. The experiences shared at eleven months indicated the new graduate registered nurses were successful in developing self-confidence and the majority had gained a sense of belonging.

The new graduate registered nurses progressed through the year and many had moved for a third time to a new ward. Despite the rotation change, graduates did not talk of being tired or overwhelmed. When the graduates spoke, confidence and pride in themselves was evident in their voices as they shared their insight of how the past year

had progressed. The new graduate registered nurses were excited about how much they had learned:

*It was such a big culture shock when I started working. I think I am standing above some of my friends that I did tertiary graduate programmes a little bit. Like my friend came and stayed and she was doing hers at [metropolitan hospital name withheld] and I was telling her that I've been to these resusses [sic] and I'm cannulating and I'm doing ABGs [arterial blood gases] and all these stuff and I feel like it's such great exposure. Even though there was not much support it is just such great exposure and I've learnt, and I've seen so much, and it's all been for the best. (GN10-11)*

The new graduate registered nurses agreed the experience had been “*fantastic, a real eye opener*” (GN1-11). All felt they had developed their skills and received a ‘*broad range*’ of knowledge to progress as a registered nurse in a rural or metropolitan clinical area with confidence. Daily challenges no longer seemed to be large obstacles as many new graduate registered nurses had learnt where to find help if required.

### **1.3.1 Confidence**

During the third phase of interviews, it was clear that through experience and time the new graduate registered nurses had built a degree of confidence. Although advanced skills remained challenging, the graduates were eager to learn. The new graduate registered nurses shared experiences of coping, managing workloads and feeling more confident and were happy to share their knowledge:

*So, I got to actually take someone through that and show them and train them and so from doing that I was like, ah, I feel much more confident now yeah. So little things like that actually, yeah make you feel like you're real' (GN3-11).*

One of the graduates stated they still had periods of feeling stressed, however it did not last the entire shift. The majority of new graduate registered nurses had learnt how to manage the challenges despite the rotational shift work:

*I don't know whether the workload is different or whether we're just, I'm getting better at my time management skills ..... I would say a lot of that is to do with experience as well.... And then as the year sort of progresses, you sort of get more confident with your own ability (GN1-11).*

The new graduate registered nurses stationed in both smaller district hospitals and regional centres expressed they were a lot more confident in their clinical skills. All the new graduate registered nurses felt their knowledge levels had increased. Despite a lack of variety of patient presentation and skills required working in the district hospitals, graduates suggested they would be confident with the skills they had acquired when working in a larger facility.

The new graduate registered nurses indicated that coordinating a shift was out of their capabilities. As the year progressed, graduates were encouraged to take on more complex workloads when partnered with a senior nurse which helped develop both their confidence and skill level:

*I think I didn't feel like a nurse until I went to paediatric ward actually, yeah. Just like, yeah I felt a bit like a fraud as you do I guess .....he {my preceptor} would give me like the harder patients to, ... if anything starts going haywire then sure he'll jump in but he allowed me to manage them and supervise me doing it so I actually got to notice changes and do the whole respiratory regime and all that sort of stuff. So those sorts of things of building my confidence and actually being allowed to do that was really good. (GN3-11)*

Having a preceptor who knew how to teach and trusted the new graduate registered nurse's ability to handle a complex patient load or would ask if they had any queries, increased the graduate's confidence. The new graduate registered nurses believed they were ready for the challenge. Being trusted with complex patients by a respected staff member enabled the new graduate to feel capable and gave her a sense of belonging.

### **1.3.2 Belongingness**

Belonging within this context continued to be about feeling part of the team. Confidence, knowledge and experience helped the new graduate registered nurses reach this comfort zone. During the final rotation graduates felt they were “*a lot more confident and I know a lot more and I feel, you know, I am good on the ward and part of the team, yes, definitely*” (GN5-11). The graduates now felt a lot more at ease.

The graduates were allocated students to supervise within their final rotation of the program. The majority of new graduate registered nurses felt a sense of belonging



when they were trusted with students. Some enjoyed having students and felt that it helped to increase their own learning. A few of the new graduate registered nurses understood that education was a part of the role within their profession, however there was a lack of consistency for when graduates were allocated students. One new graduate registered nurse had students in the first rotation and final rotation. Being allocated students appeared to depend on the ward and nurse unit manager as well as the graduate's abilities. Instead of finding the task daunting, she embraced the experience:

*I quite like students. Yeah, I like finding out where their knowledge is at and stuff like that and teaching people. I really enjoy that side of nursing and I guess sharing knowledge and stuff like that. So, I quite often had students in [hospital name withheld] (GN1-11).*

Other new graduate registered nurses not officially assigned students said the students still followed them around. The new graduate registered nurses implied this was due to the ward having a team approach to supportive measures as opposed to allocating one nurse. One of the new graduate registered nurses shared her experience as a student and conveyed she felt more comfortable with the preceptor being a new graduate than a senior staff members “*because they [graduates] remember exactly what it's like [to be a student]*” (GN 9-11).

## **Summary**

The challenges new graduate registered nurses faced with professional beginnings within the rural and remote regions of Western Australia were not isolated to supportive measures such as preceptorship. Being part of the team and building confidence was important as the graduates learnt the role of an independent registered nurse. New graduate registered nurses identified a gap between what they experienced and what they expected from the management team involved within the graduate program. The next theme, fractured reality, highlights the difference between expectations and experience from new graduate registered nurses' viewpoint.

## **Theme 2.0: Fractured reality**

New graduate registered nurses perceived a very real difference in their expectations of a graduate program to what was actually experienced. All new graduate registered nurses encountered a difference between what they expected from the management team in support measures and what happened in practice. This gap can be

defined as a ‘fracture’ within the new graduate registered nurse’s perception of reality. ‘Fractured reality’ within in this context was when graduates’ expectations were different from what they experienced.

The new graduate registered nurses all indicated their understanding of the graduate nurse coordinator being the manager of the graduate program, with one graduate nurse coordinator employed for each region. The graduates believed that guidance and support for them as being registered nurses would be provided by the graduate nurse coordinator. Throughout the year, they shared their expectations and experiences directly relating to this support, which differed for all the participants. The majority of new graduates felt the support was not at the level they needed. Additionally, they all indicated that nursing management expected an unrealistic level of autonomy once their orientation was complete. Their level of independence grew throughout the program and by the final interview, new graduate registered nurses felt prepared to practice independently as registered nurses. Three sub themes were identified within the fractured reality theme: 2.1 We are not ready; 2.2 We are working on it; and 2.3 We are ready now (are we ready?).

## **2.1 *We are not ready***

The subtheme ‘we are not ready’ reflects the new graduates’ belief that they did not feel ready to work on their own without supervision. This theme considers the interviews conducted when graduates had been working as a graduate for three months. Within the first three months, the new graduate registered nurses’ conversations included detailed descriptions of their orientation to the graduate program, the lack of expected support and the feelings they were not prepared for the role expected of them. The three categories identified within this subtheme are: 2.1.1 Support; 2.1.2 Online guidance; and 2.1.3 Communication.

### **2.1.1 Support**

New graduate registered nurses found the support provided by their graduate nurse coordinator very different to the support provided during their undergraduate training and different to what they had expected. The one-on-one support provided during undergraduate training was not available to new graduate registered nurses who were expected to work independently after their orientation. The following graduate

expected more from the clinical educators especially when the staffing levels were inadequate:

*The staffing level was quite low at that particular time...the workload wouldn't have been as heavy and I guess just yeah, it's I guess just having a little bit more support... We haven't had much support at all from the clinical development nurse. I don't think she has come onto the ward once (G1-3).*

Graduates had expected to have support from their graduate nurse coordinator similar to that of a clinical facilitator during their undergraduate program. This would enable on-call help to be available to them as needed. The new graduate registered nurses commenced on the wards post orientation where they received supernumerary time with senior nurses. The new graduate registered nurses were allocated at least two supernumerary days. The graduates felt the allocated supernumerary time of between 2-10 days was beneficial but being on their own so soon was not expected and an unrealistic expectation. One of the new graduate registered nurses received two weeks of supernumerary time “*but after the first two weeks no not a specific preceptor*” (GN8-3). This graduate suggested they would have benefitted from having a preceptor as well as supernumerary time.

Lack of preceptor support was common for about 50% of the participating graduates throughout all seven regions. This type of support was available only during the supernumerary period. Some of the new graduates were allocated preceptors however, their rosters did not align after the first two weeks of supernumerary time. Preceptors were often allocated but were sporadically available to the new graduate registered nurse due to roster issues. Regardless of being employed in a district or regional hospital, all the new graduates shared similar experiences. A new graduate registered nurse employed in a district hospital discussed her surprise of how different it was from when they were students:

*Just the fact that I didn't have a preceptor, so you didn't have anyone.....The staff were all happy to help and answers questions, but it's not the same as having a resource available or staff development nurse available or a preceptor available. (GN2-3)*

Although there was support available, it was very different to the graduates' expectations. The new graduate registered nurses completed a period of orientation. The

majority expected a greater level of support than they received following this orientation.

The new graduate registered nurses discussed their frustration with the support received from the graduate nurse coordinator within the first three months of their clinical rotation. Following initial orientation, the support provided to new graduate registered nurses changed considerably, and half of the participating graduates mentioned the graduate nurse coordinator was not as helpful as they had been during the orientation process. One graduate shared their experience when seeking help, “*only contact her regarding the orientation day and the June study days that's it that's all the support we have from her*” (GN6-3). Another graduate spoke of being intimidated by the graduate nurse coordinator’s suggestion to “*find someone*” (GN8-3) to monitor and help complete the medication competency requirements. This graduate had expected to have a preceptor assigned instead of being told to find their own assistance.

Some new graduate registered nurses had a more structured experience where support was arranged by the graduate nurse coordinator or nurse managers. However, their experience was not positive:

*There wasn't a lot of one-on-one support. It was, or you go to them if you need to be told what to do with X or what to do with Y or you know where a form is... But yeah getting back to preceptors, I didn't really feel that I got a lot of benefit from them in the beginning. (GN7-3)*

The role of the preceptor was unclear to most new graduate registered nurses who were unsure of when they could ask for assistance. It was unclear if the needs of the new graduates had been articulated by the graduate nurse coordinator to the assigned preceptors, or whether they had any education on the preceptor role and responsibilities prior to undertaking a preceptor role. Many of the new graduate registered nurses had presumed their preceptor, would have a similar role to the preceptor buddy they worked with when they were student nurses, although this was not what was experienced. In this context, fractured reality resulted.

### 2.1.2 Online guidance - Access to evidence-based practice

Online guidance within the first three months refers to the need for new graduate registered nurses to access online policies and procedures specific for each ward to enable them to implement evidence-based care. The new graduates all understood the policy and procedures were located online.

During the stage one interviews, many new graduate registered nurses expressed their concerns with the limited availability of the policy and procedures in the rural and remote hospitals. One graduate said they were “*quite lost in terms of access to protocols and nursing practice guidelines purely because the system that we operate on in WACHS is very cluttered and it is very difficult to find*” (GN2-3). Another graduate discussed a time of realisation, when they realised the medication policy was located on the back door of the medication room. This graduate indicated a lot of information was provided within the first few months that she had not noticed the policy. The challenge to absorb all the knowledge shared during orientation was similar for all graduates:

*There are some {policy and procedures} they don't have a lot for [hospital name withheld] [WACHS] ... So, I believe, so we use a lot of [hospital name withheld] [metropolitan hospital] policy and procedures yeah, they are not straight forward, but there is very few apparently. I was talking to our development nurse clinical development nurse, and she said basically that they were really quite hard to find and there is not very many of them. (GN1-3)*

In direct contrast, a new graduate registered nurse from a regional hospital discussed the ease of locating several policies once shown how to search for them online. This graduate also mentioned how their group received print outs of some of the more common policies from the graduate nurse coordinator because the Western Australia Country Health Service was updating this system. The majority of graduates felt they were lacking the appropriate guidance from senior nurses about the online system.

### 2.1.3 Communication

The level of communication was different for each of the regions. Many of the new graduates perceived they had not received appropriate communication during orientation about the senior nurses' roles being different in the rural areas. When

expectations were not communicated by the senior nurses and the experiences were different to what graduates expected, confusion and disappointment resulted. The following new graduate registered nurse shared her experience of a breakdown in communication between hospitals:

*Originally, we knew we weren't going to do paediatrics. That was quite upsetting because we have had all this supernumerary time that was in the paediatric section, and we were told that we weren't actually going to be there in our first rotation. (GN1-3)*

The graduate nurse coordinator advised the graduates they would not be expected to work on the paediatrics ward in the district area. Although the experience was different to what was expected, this graduate was thankful for the supernumerary time as she spent a lot of time working on the paediatrics ward in her first rotation.

The new graduate registered nurses discussed a breakdown in communication in relation to differences between metropolitan and rural hospitals access to staff development nurses (SDNs). The graduates from district areas stated there was not always a staff development nurse available in the hospital. If there was a staff member appointed to the staff development nurse role, they were often not there to support the new graduates instead busy “with getting the regular staff through education” (GN1-3). This was explained during orientation for one of the graduates. Some of the graduates felt let down when they learnt the staff development nurse was not available specifically for new graduate registered nurse support. In addition, not everything communicated came to fruition:

*We were told in orientation that we would have two supernumerary days but that the SDNs and the GNC would be on the floor with us especially through that first week so that we could get our medication competency and things like that, but I actually didn't see anyone. (GN7-3)*

Some new graduate registered nurses had positive experiences with the level of support suggesting the staff development nurses in the hospital were “telepathic” (GN3-3) and were on the ward regularly and appeared when they were needed the most. The role of a staff development nurse was inconsistent between regional and district hospitals, therefore the channel for effective communication changed from one hospital to the next. Within the regional hospitals, an individual person was appointed to either

in full or part-time capacity, whereas it was a much smaller education portfolio within the district hospitals. This education role will be further explored in the fourth theme.

## **2.2 *We are working on it***

This subtheme reflects the new graduate registered nurses' experiences in developing confidence and independence as they progressed through the graduate year. By the seventh month, the graduates had learnt the basic hospital and ward routines and were beginning to feel more comfortable with working independently. Despite the development of confidence throughout the graduate program, there was still a gap between expectations and the graduates' experience with the management team for the graduate program. This subtheme had similar categories including: 2.2.1 Support; 2.2.2 Online guidance; and 2.2.3 Communication and feedback.

### **2.2.1 Support**

The type of support required by graduates changed throughout the year. At the time of the seven-month interviews, new graduates still required support to build confidence and undertake their role, but the place they looked for support had changed. The graduates relied on the senior nurses involved in the graduate program less for support and moved to relying on fellow registered nurses for help. This may have been due to the lack of accessibility of the graduate nurse coordinator or due to changes in relationships with the senior staff. This was demonstrated in comments such as:

*I barely see [name withheld] [GNC] but like the senior staff are great ... I've had sort of had a few shifts where I've looked after a student which has been really good. I'm a bit like, oh I don't know, you know. I feel like I'm still too new to have a student. But once you've actually have a student you realise how much you have learnt in the past seven, or you know, six or seven months, and you're like wow, like I, I feel different when I started, like it's great. .... I remember when I first started this grad programme and I was you know, terrified. (GN8-7)*

The change in required support may also have been in part due to the growing self-confidence of graduates. One graduate discussed having the skills to carry out assessment and being able to recognise a patient's needs. *"I guess things that I'm realising I do know more than I think I do"* (GN2-7).

The new graduate registered nurses managed to develop their skills and confidence through other self-supporting methods and develop an understanding of the magnitude of these roles. “*She’s [preceptor] got so many hats and very limited time for me so and that’s the big issue in the smaller hospitals I think*” (GN2-7). Although, the self-support process intimidated one of the graduates because they felt like they were “*at the bottom of the food chain it’s really scary*” (GN9-7) when expected to speak up.

Another way new graduate registered nurses were able to elicit support was to approach the management team:

*Yeah, the SDN is acting in the role and ...doesn’t want that job. ... After I had a meeting with the SDN, the clinical nurse coordinator, the manager and [person’s name withheld] [GNC], once I had a meeting with all [of] them, things kind of changed a bit because they realised there wasn’t that much support there. (GN1-7)*

Not all areas had a graduate nurse coordinator responsible for graduates. The smaller district hospitals received directives from the graduate nurse coordinator from regional areas. A participating new graduate registered nurse from one of these district hospitals felt there had been no actual support from the graduate nurse coordinator within her region:

*There’s been no follow up support from [name withheld] ...So to be honest I don’t think I actually got anything from the programme, nothing that I wouldn’t have got with them apart from the fact that I’ve actually got a job which is great. (GN2-7)*

The same graduate was quick to reflect she had received adequate support from the staff nurses in the hospital.

### **2.2.2 Online guidance - Access to evidence-based practice**

Graduates’ concern about the limited access to policies and procedures remained an issue in the midyear interviews. Many of the new graduate registered nurses relied on more experienced nurses for direction. This became problematic when the practice did not match the theory covered in the undergraduate degree. One graduate was quick to share her frustrations with the cultural ‘norm’ in their clinical area, which she believed was not using evidence-based practice:



*There is, there is the gap there... People do things in the way that they've always done things because it's the way that they've always done it, and they've been 50 years... So yeah but some things you can implement, and people go 'Oh that's a good idea, I'll do that'. But yeah, it's, we've got a lot of nurses that have been there for a long time. (GN2-7)*

A graduate from another region was also frustrated when they tried to make sure their practice reflected evidenced based practice. This graduate had worked with staff in a specialised area and each staff member demonstrated the same skill differently:

*As a grad you're trying to work out what the best way is to do things and you kind of want policies and procedures and stuff like that rather than just going off what everyone else says. ... I think part of it is because they just don't have the policies and procedures for WACHS, like even on the wards and stuff there's not as many policies and procedures. (GN1-7)*

This demonstrates that graduates want clear instructions on how to undertake skills, which are not always available. While the graduates were learning, they were eager to learn best practice and not what everyone has always done. Although this was a dominant theme within the first three months, less than half of the participating graduates voiced their frustrations with the limited use of the policy and procedures by the seventh month.

### **2.2.3 Communication and feedback**

Graduate nurses discussed the need for clear communication to enable them to develop as registered nurses. The new graduate registered nurses shared different views relating to miscommunication, clear communication and limited communication. The graduate who had approached the management team was pleased that effective communication made a difference:

*I guess it's just all about communication ... They actually put, the clinical nurse manager please support [person's name withheld] [the graduate] in the roster... just so that they knew then that they needed to be a clearer with information. (GN1-7)*

One staff development nurse advised the graduates that she came to visit but they were absent each time. This comment resulted in frustration through the lack of communication. The new graduate registered nurses felt that if management had spoken

to them and booked a time, it would have been a more effective supportive measure. In direct contrast, another graduate was relieved when the graduate nurse coordinator advocated for increased supernumerary time within a specialised area. The new graduate felt in this instance communication was an effective supportive mechanism.

The new graduate registered nurses were asked if they had received any formal feedback from the appropriate staff member. The majority of new graduates indicated they had received feedback but little that was tangible, meaning there was no written evidence. The other main concern was the preceptors who had completed the required clinical forms at the beginning of the rotation were often not the same nurses who completed the forms at the end of the rotation. One of the new graduate registered nurses elected to wait until their preceptor had met with them during a shift change, but were not able to go through the comments together:

*Yeah, well the people who were my preceptors and buddies were actually away so I couldn't actually, I had to wait 'til one of them got back... So, I basically had to give it to her because I was on night shifts and get her to do it because we weren't on the same shifts.  
(GN3-7)*

Over half of the participating graduates indicated the nature of shift work and rosters not aligning with preceptors all affected the feedback requirements within the graduate program. The new graduate registered nurses all said that the way the feedback was provided was in a different format to what they envisioned following their orientation. Again, this indicates miscommunication was present within the graduate program and fractured reality continued.

### **2.3    *We are ready now (are we ready?)***

Throughout the final set of interviews, the new graduate registered nurses' conversations were full of confidence, knowledge and excitement. The graduates voiced their insights with respect to their support and guidance needs and the majority indicated their needs were being met. There was still a level of fractured reality in terms of expectation and experience, however the new graduate registered nurses were comfortable with working independently by the end of the graduate program. Overall, the majority of graduates felt they were equipped with the knowledge and confidence to

seek assistance when required. The three categories identified within this subtheme were 2.3.1 Support; 2.3.2 Guidance; and 2.3.3 Communication, debrief and feedback.

### **2.3.1 Support**

New graduate registered nurses did not feel the need for extra support at the end of the program. Many of the graduates felt supported whilst working with or without a preceptor during their final rotation:

*They were quite happy with what I had done in that week to take me off supernumerary... I would presume I would [have a preceptor], but no, not really... I am just treated like another one of the staff members' now. (GN4-11)*

Another graduate received one day only as supernumerary before being deemed competent. The staff were like “you know what you are doing and then, they were like, if you are need to know anything, just ask questions, and I am like, oh okay” (GN5-11). This graduate was comfortable with this happening on her third and final rotation and not the first two rotations. The expectation was to receive a lot more supernumerary time to support the graduates as they transitioned into a new clinical area. A few of the new graduates were drawn towards the staff members who were helpful and indicated they were supported during the final rotation. The difference being, graduates were now comfortable with choosing their own preceptor and were quick to identify and locate knowledgeable staff. Some of the graduates suggested that it was moving to a more cohesive ward environment that made all the difference:

*People are happy and willing to help you out here. Like I remember in [hospital name withheld] and stuff, and there was quite a number of different personalities that did their own thing and would make themselves scarce and you wouldn't see them. Whereas here they're all very happy to help and willing to help and stuff like that, so I think that makes a huge difference. (GN1-11)*

The nursing staff were portrayed as being supportive, and happy to help. The clinical team worked well together. “They’re really happy to teach and they’re really good at teaching and yeah they support you quite a lot which is a lovely change” (GN3-11).

### 2.3.2 Guidance

By the end of the graduate program, interviews with graduates no longer felt the need to discuss issues with policy and procedures, but instead shared experiences regarding guidance received from senior staff during their final rotation. One of the graduates gave very positive feedback and stated *“the clinical nurse on ED has an open door policy...I have still got the uh...the coordinators of the program, um, I still use them as well, all the staff... yes, they’re all, all quite good”* (GN4-11). Another graduate suggested they felt supported *“when I was having that really bad day with [name withheld] and saying that she, all those horrible things, they [GNC] really backed me up and I felt really supported”* (GN5-11). The experience from one new graduate registered nurse was not positive when she felt excluded due to being in the small rural community and found it difficult when clinical staff failed to separate their personal life from their work life. *“I think because it’s a smaller community and she’s friends with them as well. It’s the line of manager to staff is not, it’s quite blurred”* (GN3-11). This graduate’s reflection of their experience indicated there was a lack of leaderships skills from the management team.

### 2.3.3 Communication, debrief and feedback

#### 2.3.3.1 Debrief

In the final set of interviews graduates focused on their need to debrief after critical incidents. New graduate registered nurses shared their experience with being involved in a medical emergency team call, a death of a patient in palliative care and a resuscitation on arrival in the emergency department. The first graduate called a medical emergency team call after their patient had suffered a cerebral event and subsequently died. The new graduate remembered the day as being hectic and struggled with the workload, and expressed how helpful it would have been to have a supportive discussion following the incident:

*I think after that I didn’t really want to go back... I actually seek to go talk to my grad coordinator about it...But it would have been really nice with, to kind of have someone that day to recognise that yeah it was quite awful. (GN10-11)*

Another graduate reflected on the support she received following the death of a patient receiving palliative care treatment. The new graduate said they had *“no idea*

*what's happening here, it was freaking me out"* (GN5-11) and was unsure what to say to family members when the patient died. The new graduate made staff aware that it was the first time she had been involved with a death. The clinical nurse manager (CNM) from the ward debriefed the new graduate the following day.

The third graduate shared their experience of a resuscitation in the emergency department. They did not see the event as significant while at work and it was not until she got home that she felt the impact of the incident:

*Reality hit me, I was, yes, was very upset...So I rang the nurses the next day, went in and had a debrief... with the clinical nurse manager who was also part of that resus [sic]...Um, and also with the other, a couple of the other staff there were all there, we just had a bit of a chat about it as well, so...So that worked, and it was really, it was a really good and, a good learning experience and they are a supportive group of people... So, they are quite happy to talk through and you know, give me plenty of feedback on how well I handled it and that sort of stuff, so, that I was doing everything that I should have been doing. (GN4-11)*

Each of the graduates needed to talk to someone after the death of a patient and each had to initiate the debrief themselves. All spoke with their graduate nurse coordinator and discussed the incidence with their colleagues who were also involved. The first graduate's experience with the debrief session did not meet their expectations as they expected to debrief with the staff involved on the day. The importance of following up after major events was apparent especially for the new graduates.

### **2.3.3.2 Feedback**

Feedback was part of the preceptorship role within the graduate program. Some new graduate registered nurses were happy with the feedback they received. Others noted that it was difficult to get formal feedback. One graduate did not feel comfortable with their preceptor completing the formal feedback because they had been on holidays for six weeks and had not really worked alongside them. This graduate chose to approach their staff development nurse from the area who was happy to provide the required feedback. Another graduate was frustrated with their experience when trying to complete the formal feedback:

*Oh, that was just ridiculous because you're supposed to sit down and talk to your preceptor and stuff about these things...I finished on night shift, so I didn't actually get to do that with her... I left my paperwork there for her and she had a whole week to do it and then she didn't and then she went on holidays so then it took a bit longer for it to be done so it's not really representative I don't think. (GN3-11)*

The majority of new graduates were disappointed with the formal feedback received at the end of each clinical rotation although many indicated they were happy with the informal feedback received along the way.

## **Summary**

Throughout the graduate program, the majority of participants discussed a gap between their expectations and experiences. Many felt they were expected to work independently earlier in the graduate program. Despite the fractured reality and perceived poor management of their expectations, the new graduates progressed and by the end of the graduate program were able to work autonomously as registered nurses. The next theme describes the new graduates' ability to cope when expectations were not met.

## **Theme 3.0: A sense of belonging**

The theme 'A sense of belonging' focuses on the graduates feeling like they belong whether it was on the ward or within the community. The majority of new graduate registered nurses felt a sense of belonging whilst working on the ward however, a small number of graduates also experienced episodes of feeling like an outsider. Four of the six participating new graduate registered nurses discussed a positive relationship with community members whilst others relied on family or partners for support. The conversations about belonging did not centre entirely on family supports. Graduates discussed both peer and clinical supports that emerged for personal emotional needs. The psychosocial belongingness theme ascertained new graduate registered nurses found support from three primary sources: social, peer and clinical support. There were three sub themes identified under a sense of belonging theme: 3.1 Settling in a rural community; 3.2 No-man's land; and 3.3 Feeling settled.

### **3.1 Settling in a rural community**

The majority of new graduate registered nurses needed time to settle in with the community, their family and clinical areas. The information gathered from the new graduate registered nurse's interviews at three months indicated many senior staff members were supportive. The graduates often felt a sense of belonging when consideration was given for their personal wellbeing. The three categories aligned with the primary sources of emotional support: 3.1.1 Social; 3.1.2 Peer; and 3.1.3 Clinical.

#### **3.1.1 Social support**

Family support was a key theme in the interviews conducted with the new graduate registered nurses within the first three months. All new graduates described times when they experienced emotional struggles as they settled into their new environment, irrespective of whether family support was close or not. Half of the participating new graduate registered nurses moved to rural hospitals to be with or close to family. One of the graduates moved to be with their partner midway through their degree and established a lifestyle in the rural area before graduating. This graduate believed they were *"lucky to be awarded a graduate program"* (GN6-3), close to family. Three new graduate registered nurses moved to be with family. Another graduate indicated her parents were elderly, and it was great they were able to spend time with their grandchildren. One new graduate registered nurse moved interstate with her children and experienced some 'teething' problems not related to the graduate program. *"I have a had a few personal issues in the first three months nothing to do with work my work itself, [family] but they [staff] were really good with that sort of support"* (GN4-3). This graduate discussed how the family adventures exploring the new country helped her family transition to the rural area.

In direct contrast, four new graduate registered nurses left their families when they moved to start their graduate programs. One graduate described feelings of isolation. *"Coming to a town on your own it's not the easiest thing...especially in the beginning you are analysing everything you have done all day"* (GN7-3). This graduate had travelled extensively however had never *lived* in a rural area before. Another participant from this group spoke of originally being from regional areas and described her experience of social support:

*I lived here for over three and half years in the early 2000's so I have a few people, my old neighbour is still here so um yeah, so I know I have support if I need it and a couple of other friends. (GN 3-3)*

The new graduate registered nurses shared their experiences of finding support or the long-term support with family as they began to settle into the rural area. Though the majority of graduates had support from family and friends, they also sought local support, thinking it might be helpful when trying to integrate as a member of the community.

### **3.1.2 Peer support**

Peer support was discussed in relation to making friends with staff and fellow graduates in the first three months. A number of new graduate registered nurses spoke about their experience of peer support while settling in and highlighted that fellow graduates and newly qualified nurses provided reassurance:

*It's probably having the other grads as well and the other young nurses I find that they're really supportive... There's a couple of other nurses that are only one or two years out as well and you sort of bounce off them and they can share their experiences with you... It's like you will be alright...once you have done this a few times it'll be easy, so that's always good as well. (GN8-3)*

Another graduate also agreed that fellow graduates were a great source of emotional support. Instead of seeking reassurance in the clinical area, the graduate suggested that it was through debriefing sessions set up by the graduate nurse coordinator that their peers could “*speak away from the work environment*” (GN6-3). This provided a safe outlet for new graduate registered nurses who “*don't feel comfortable speaking to their mentors or clinical managers*” (GN 6-3) to share similar experiences from the clinical area.

The following two graduates had different experiences. One graduate felt comforted by their fellow graduate and highlighted that she had made friends with a staff nurse:

*The other grad... she is a great support person... there is another nurse [a peer] that I get on quite well with, so she has been a bit of a social support for me as well outside of work. (GN1-3)*



The second graduate indicated that it was difficult to find peer support:

*I just found the staff they are friendly at work but that's as far as it goes for socialising so I mean that's fine you know everyone's got their own little clique and life outside of work, but it doesn't really worry me... I'm quite independent, yeah but on the other hand, it would be nice to be a bit more befriended. (GN7-3)*

Throughout the discussions, the new graduate registered nurses indicated they felt less isolated when they bonded with fellow nursing graduates who shared similar experiences and episodes of self-doubt. Organised debriefing sessions helped each participant begin to settle into his or her new environment.

### **3.1.3 Clinical support from colleagues**

Clinical support from senior nursing staff was the third type of support that emerged from the interviews. Two main themes arose from this category. Clinical support was provided directly when needed and indirectly via enabling flexible rostering to meet graduates' emotional needs.

Support was provided by senior nursing staff when conflict arose, or expectations were not met. One of the graduates who had moved away from family received support from senior staff that assisted with decreasing her stress:

*After I had my little breakdown after [a] month in...I was taken aside and yeah had a good talk to both my clinical nurse manager and my grad coordinator. It relieved a lot of the stress. (GN7-3)*

Another graduate dealt with conflict that arose with the clinical nurse manager and did not feel the need to further discuss the incident with the graduate nurse coordinator. "I was going to go and talk to her [GNC] about what happened with my preceptor but because I spoke to my manager about it, I felt like I had already dealt with it" (GN5-3). This new graduate registered nurse felt that the support she received on the ward enabled her to resolve the conflict to settle into the graduate role.

The use of a flexible rostering system was also seen by graduates as a way in which the nurse managers tried to provide emotional support. Nurse Managers were seen to try to accommodate new graduate registered nurses' psychosocial emotional needs by approving the roster requests to allowing graduates to have extended time for

trips home. This was more apparent for the new graduate registered nurses without family close by. One of the graduates was eager to celebrate a milestone birthday with her family and another graduate had several family commitments planned:

*I went back probably once a month, I went back in March for my graduation, and I went back in April for my partner's mums wedding... I am going to try and get back in June. I've just got to pop over and that will be in my next rotation, so I have to go and see the manager over there to see about getting time back over there but the CNM has been pretty good. (GN3-3)*

New graduate registered nurses were appreciative of this supportive measure and felt treated as valued staff members, however not all roster requests met with approval, especially when traditional holidays were requested. One of the new graduate registered nurses put in leave for the Christmas period, which was “*knocked back because ... other people have already put in for it*” (GN7-3). Approval for Christmas and New Year was difficult for all staff not just the new graduate registered nurses. GN7-3 indicated they understood the demands although remained disappointed by the rejection and felt graduates’ holiday requests were not taken into consideration.

### **3.2 *No-man’s land***

*To belong or not belong: That is the question*

This subtheme indicates the new graduate registered nurses did not know what to expect each day. Some days they talked about feeling part of the team and other days they suggested they felt like outsiders. Graduates having to prove themselves worthy to be part of the team was a common theme throughout the second rotation. A sense of belonging was not always evident within the transcripts from the participating new graduate registered nurses. This subtheme had the same three categories as the previous section: 3.2.1 Social; 3.2.2 Peer; and 3.2.3 Clinical.

#### **3.2.1 Social support**

Social support in this context encompasses both community and family supportive measures the graduates experienced. The majority of graduates discussed at least one of these social supports and two new graduate registered nurses specified they received support from both family and community members. One graduate had moved towns

without family and shared her experience of being “*pretty home sick the first month*” (GN3-7), however this graduate managed to leave town and catch up with family and friends a few times within the first seven months:

*I was here just missing my family and friends and stuff there... I was down in Perth just on the weekend just gone.... So, I met my partner there just because I was catching up with my cousin who is in a band that was playing there. So, saw him play and caught up with some other friends and then I was probably back in [name withheld] [country - home] 2-3 weeks before that, I think. (GN3-7)*

This new graduate registered nurse had not yet settled in and was in-between the comforts of home and the new town with limited emotional support. In direct contrast, another graduate had moved without family support and integrated themselves within the community by having a base in the nursing quarters and house sitting:

*I'm back in the quarters now and .... we've got two new nurses who are doing the travel programme and they're lovely and they live in the quarters so, it's been really good to move back in here and sort of live with them. Oh, the footy's been happening, we won both A and B league grand finals on the weekend so that was really exciting. Yeah no, it's been really good, yeah there's just so many nice people, yeah. (GN8-7)*

A few new graduate registered nurses moved with their family and shared their experience of enjoying the sporting activities prominent within the rural townships. One of the graduates “*really liked [name of town withheld] in terms of like the lifestyle and what you can do, you know like surfing and just being outside*” (GN9-7). Social support with family and/or community members increased the new graduates' sense of belonging within the rural environment. The majority of new graduate registered nurses enjoyed their experiences with rural and remote social supports. This did not always flow over into the workplace.

### **3.2.2 Peer support**

The category ‘peers’ within this context refers to the general nursing staff, as opposed to senior nursing staff, the new graduate registered nurses were working with during their second rotation. During the second set of interviews, the majority of new graduate registered nurses did not mention creating close bonds or forming friendships with their peers. A graduate suggested this was because of the multiple rotations they

had experienced in the three-month period. A common theme emerged during the interviews that not all staff were supportive. Several new graduate registered nurses shared their concerns about feeling like they had to constantly prove themselves within the clinical setting. The graduates believed to gain the respect from their peers they had to ‘*prove their worth*’. One of the new graduate registered nurses shared her experience of feeling like an outsider when she was called into the manager’s office to discuss an incident form that was conducted incorrectly a month previously. This new graduate registered nurse indicated she did not realise they had done anything wrong until they were called in:

*...for my learning it would have been fine to put a datex [incident form] in but come and tell me you’re doing it so then I don’t make the same mistake while I’m waiting to get feedback...I think it was crap...Yeah probably very demoralising and whatnot because you, yeah you felt, it didn’t make you feel really good and it’s like it’s my second rotation so I’m not a student. I’m not, not that I’m awesome you know like it’s just like, it was a lot of mistrust and it’s like yeah, I have been on surgical ward, so I do know how to give medication. It was just that yeah just...I found it a little bit narky, quite rude and not productive and not supportive and yeah...it made me go well I’ve got to watch my back here and that’s not a good team environment and it’s fair enough you have to prove yourself, I can understand that but you can still be nice to someone while they are showing you their worth. (GN3-7)*

A few new graduate registered nurses shared their experiences of being challenged by their peers when they rotated from a slow-paced ward to a fast-paced ward or specialised area. Some of the graduates felt ridiculed when they took longer than expected to complete an advanced skill. One new graduate registered nurse suggested that having a good shift depended on who was rostered on:

*They just don’t help, and they just don’t notice that you’re struggling. Other ones are really aware of it and just really help and because you don’t want to just be all the time ‘oh I’m not coping’, like ‘I’m really struggling’ ...I don’t want to be like that ...Like it depends, actually your shift really depends on who’s coordinating...Like some of them just aren’t supportive at all. (GN9-7)*

In direct contrast, the following graduate felt emotionally supported and said she was advised she was doing well. The staff were “*like stop being so hard on yourself, you know just keep doing what you’re doing*” (GN8-7). This graduate was still settling

into the new environment and still unsure of herself. Another graduate said she felt very lucky to have a supportive team who were happy to teach and support her learning.

During the second rotation, there were times the graduates did not feel part of the clinical team and few were able to bond with their peers. The new graduate registered nurses felt they had to prove themselves before the behaviours and comments from the ward nurses indicated they were trusted to perform as a competent independent registered nurse.

### **3.2.3 Clinical support from colleagues**

The experiences of the new graduate registered nurses in regards to the clinical support received from the senior nursing staff such as the clinical nurse manager and graduate nurse coordinators was different to what they had experienced with their peers. Although, one graduate, did say she was not welcomed onto the ward and “*felt I was like okay no acknowledgement [by the CNM] that’s fine*” (GN9-7). This graduate also indicated the staff development nurse was supportive at the beginning of the second rotation. The mixed messages from the senior staff resulted in the graduate being unsure if they were welcome on the ward. Several new graduate registered nurses shared positive experiences:

*...if I ever need anything I, when I had my bit of a burnout...she (graduate coordinator) was fantastic...She let me just sit and chatted to me and she’s helped me out a couple of times when it comes to just things to do with my daughter. (GN4-7)*

The majority of the participating graduates shared their experience of feeling ‘*part of the team*’, or a sense of belonging when the clinical coordinators were ‘*just checking in*’, and ready to lend a hand or debrief if need be. Some of the graduates appreciated the bond between the graduate nurse coordinator and themselves:

*Yeah and it’s just been like and I actually, I actually went and had a chat with the old grad supervisor because she’s just finished her masters and I’ve been considering doing a graduate certificate next year...My old grad support person [person’s name withheld] had contacted the manager there to just ask you know what the best certificate is. (GN3-7)*

This graduate felt accepted sufficiently by the senior nurse enough to ask for advice and discuss future employment opportunities. While there were times when the new graduate registered nurses did not feel a sense of belonging, the majority of graduates indicated there was at least one senior staff member with whom they could work through the emotional challenges that surfaced throughout the second rotation.

### **3.3 *Feeling settled***

During the final interviews, the conversations changed. The new graduate registered nurses now spoke of their peers as part of their social circle. New graduate registered nurses shared their experience of being accepted within the clinical team, although they said that not all nurses were effective role models. Feeling more settled within the environment, the graduates had developed sufficient awareness to know who to approach when, or if, they required emotional support. This subtheme had the same three categories: 3.3.1 Social; 3.3.2 Peer; and 3.3.3 Clinical.

#### **3.3.1 Social support**

During the last set of interviews, the new graduate registered nurses discussed their relationship with family members both distant and close by, and spoke of friendships that had developed with community members and colleagues from the hospitals. One of the graduates shared their insights with making friends during the final rotation and indicated that relationships had changed with peers as they become part of their social circle outside of work. They indicated staff were friendly and often “*said oh we’re going here do you want to come and stuff like that, so that’s really good*” (GN1-11). The challenges for this new graduate registered nurse was that she knew she would not be staying at the hospital:

*I guess one of the down sides is you just don’t really get involved that much with the community unless you sort of really seek it out. I guess if you’re a little bit shy then generally you don’t seek it out and you don’t really want to get involved in too much in the community because you know that you’re going to be moving on. (GN1-11)*

Over half of the new graduate registered nurses were planning to stay on after their graduate program had a different outlook when making friends. One of the graduates had made many friends within the hospital and reconnected with community people. “*I just caught up with him, went there for dinner the other night so that was*

*really great. It was just like old times so yeah*” (GN3-11). Another graduate indicated she had made many friends who were clinical which helped to debrief after a busy shift, and another remained close with their fellow graduate nurses.

The friendships could not replace the comfort this graduate felt when speaking with a family member:

*Mum was there for a month, mum's a nurse practitioner so she was very supportive of some of the challenges I was having. She could debrief with me ... so it was really good to have her, mum and dad there and all that. So definitely found it easier because that way I could go home and eat with them and not have to try and move like away completely. (GN10-11)*

Within both the community areas and hospital settings, the majority of new graduate registered nurses felt comfortable and their social network increased over the graduate year. Throughout the interviews there was a sense of belonging within the social lives of all the new graduates.

### **3.3.2 Peer support**

Peer support discussed during the final set of interviews was not focused on friendships, instead it was all about feeling accepted. Some of the graduates felt a sense of belonging when staff appraised their work favourably and other new graduate registered nurses relied on their fellow graduates for support stating they believed their peers were the only ones who “*know exactly what you're going through*” (GN9-11). This was similar to the experiences shared by some of the participants in the first three months. Few new graduate registered nurses shared their experience of being accepted by fellow nursing staff. One graduate said that the majority of nursing staff were supportive and welcoming to both new graduates and nursing students.

Another graduate felt accepted within the team especially when one of her colleagues encouraged her to apply for further studies so she could continue working in the specialised area. “*I would really recommend it [theatre course]. You know I loved you in there and it would look really good on your resume...so yeah I'm very excited*” (GN8-11). Another new graduate registered nurse shared their experience of when they started to feel like ‘one of the team’ and had progressed from being ‘just another graduate’:

*Like on the ward I was a grad because I had a different uniform to others but in ED I wear the same uniform and sometimes some doctors might forget but people always say yeah you know let [person's name withheld] [me] jump in there, she'll be right and it's amazing exposure and also amazing support. (GN10-11)*

This new graduate believed they were accepted and valued as a new junior staff member. The majority of new graduate registered nurses felt accepted by their peers. There was no indication of any participants who did not feel accepted. All the new graduate registered nurses appeared to be settled by the end of their graduate program.

### **3.3.3 Clinical support from colleagues**

This category included new graduate registered nurses' experience with the support provided by prominent senior nursing staff and nursing management. A common theme presented during the interviews focused on the new graduate registered nurses finding the right person with the appropriate clinical knowledge to trust and learn from:

*I guess because you're sort of rotating so quickly you don't know who you can talk to and who you can't sort of talk to, and who talks to who and who stays with who outside of work and stuff like that and in such a close, small community. It's really hard to know where that is and where it's not. (GN1-11)*

Another new graduate registered nurse suggested that “*some of the nursing staff were restrictive, they don't know you and they don't know how you work and things like that*” (GN4-11). The graduate often felt the staff did not trust them and would take over patient care. A few other new graduate registered nurses did not trust the answers given or found that staff were not approachable or willing to help. The majority of new graduate registered nurses took time to work out who was helpful. “*I've just figured out people who I find are really helpful and that I can trust and are really supportive when I need them*” (GN9-11). Graduates settled into the role as registered nurses and were able to decipher how to work best with the colleagues who shared the same roster.

The clinical support provided through direction from nurse managers often impacted on the new graduate registered nurse's sense of belonging within the clinical setting:



*... [the coordinators] quite difficult...she's nice as a person out of work but as the coordinator she's really...she just sits on her butt the whole time and just doesn't care...it's really hard to have a good shift when she's coordinating. (GN9-11)*

The attitudes of the senior staff affected the experience of the graduates. One of the graduates spoke of her concerns over the effects on fellow graduates working on a ward she felt had a 'toxic' culture, specifically the "cliquey [group], we call it the purple circle" (GN3-11):

*So in regards to the manager of whatever else she does really well, which she's very organised and that sort of stuff, in terms of staff attitude management I think because it's a smaller community and she's friends with them as well as the line of manager to staff, it's quite blurred... I know one of the other graduates who started her rotation on there from the midyear intake was nearly ready to quit because of the attitude there. (GN3-11)*

Another new graduate registered nurse reflected how she felt by comparing her actions to other nursing staff:

*I feel like, um, I am appreciated by most of the team, um, because I kind of put an effort in, help everybody else, rather than some of the nurses we have got that just do their workload. (GN2-11)*

Feeling settled did not mean the new graduates always felt they belonged however, many did feel accepted and gravitated towards the staff who were knowledgeable and approachable.

## **Summary**

The new graduate registered nurses became more settled within the community and with family life as the year progressed. Peer support changed from bonding within the clinical workplace to becoming part of the social group. Not all peers became friends and the graduates did not trust that all staff members' knowledge base aligned with best practice. The majority of new graduate registered nurses shared positive experiences with the nurse managers and were appreciative of the support they received. Perceptions altered to focus on clinical coordinators and feelings that a 'good shift' was reliant on staff the graduates were working with. A sense of belonging was vital for new graduates to master the art of working effectively with fellow staff members.

## **Theme 4.0: Transference of knowledge**

The transference of knowledge is the fourth theme, which emerged from the data collected throughout interviews with the graduate nurses' during their transition year. This theme reflects the value new graduate registered nurses put on the development of their clinical and nursing knowledge during the graduate year.

Several formats were used for the transference of knowledge during the graduate year. These included formal and informal study days, online modules, and assessments and discussions with preceptors. Differences were found by the new graduate registered nurses in what they needed in educational support during the transition year as they developed confidence and experience in the role of a registered nurse. The new graduate registered nurses felt that the first three months on the ward was a "*huge learning curve*" (GN7-3) and many graduates wanted to just complete the basic education requirements. It was seven months into the program when learning advanced skills became the focus. By the end of the year, the new graduate registered nurses were discussing their futures and looking into enrolling for postgraduate studies. The three subthemes identified for this theme: 4.1 Tell me what we need to know to survive; 4.2 I need to know more; and 4.3 Okay got it, now what?

### ***4.1 Tell me what I need to know to survive***

Transference of knowledge within the first three months was extensive as new graduate registered nurses learned what was needed to work as a registered nurse. This sub theme 'tell me what I need to know to survive' refers to the amount of learning that new graduates were expected to undertake in the first couple of months to understand the health service, policies and procedures and expectations of each ward. New graduate registered nurses indicated they had a lot to learn within the first three months in understanding their new role and due to being overloaded with this new learning, they were not able to make use of additional education sessions. New graduates were expected to undertake education support during this time in the form of structured study days, online learning and/or ad hoc education sessions and undertake mandatory competency sessions. The formal transference of knowledge was conducted in three separate formats, resulting in three categories for each sub-theme: 4.1.1 Structured study days; 4.1.2 E-learning; and 4.1.3 Ad hoc education.

#### 4.1.1 Structured study days

The word ‘structured’ means that there was an order to how the study days were planned. This subtheme describes the new graduate registered nurse’s perceptions and experiences with the education delivered during the structured study days. Structured education was an essential component for all the graduate programs. Participating graduates had mixed perceptions about the study days. One of the new graduate registered nurses believed there was not “*enough detail, and I think there is too much general topics crammed into the one day. It's just like a glance over things*” (GN2-3). In contrast, another graduate enjoyed the variety of topics presented by a number of guest speakers. Graduates also shared their experiences, indicating that the delivery of knowledge was interactive. Some of the new graduate registered nurses talked about short presentations they had to do and guest speakers who were invited to share knowledge. The same group of graduates said they really liked the interaction in these sessions and found it more favourable than didactic learning. Travel to a metropolitan area was necessary for a different group of new graduate registered nurses:

*[it was] really interesting. Actually it was quite broad but the topics like they had AF [Atrial Fibrillation], COPD [chronic obstructive pulmonary disease] Asthma, CCF [congestive cardiac failure] and all the sort of comorbidities that our patients have here so it was really good to learn it was really relevant. (GN8-3)*

A graduate from a regional facility identified her structured study days had some flexible content and the graduates were able to indicate what education would be relevant for their ward and the Learning and Development team would include the topic in planned study days:

*I mean there is stuff that they want to do in it but there is also, say if we wanted um them to give us more information on ECG's, which is one of the ones we recently did. They would get a package together and present that as well. There is things that they have to do throughout their graduate study days but there is always room to have your extra I have found. (GN4-3)*

The structured study days were delivered at different times throughout the year. The new graduate registered nurses appeared to prefer having input into the content delivered in the structured education sessions.

### 4.1.2 E-Learning

E-learning refers to education that is supported by electronic resources and technologies. The Western Australia Country Health Service has multiple online self-directed learning packages. The new graduate registered nurses had mixed experiences with the E-learning component and expectations within the first three months. The E-learning packages dominated the orientation period, consisted of mandatory training for example, basic life support, manual handling, cultural awareness, fire and safety, and infection control principles. The online training was required of all registered nurses commencing in the hospital, some packages were new, and others built on acquired theory. All mandatory skills were considered important for a graduate to fulfil the Work Health Safety requirements, once they started their clinical practice. One new graduate registered nurse shared her thoughts, “*so the first week we didn't really even go on the ward it was all computer based learning and essential skills*” (GN8-3). Another graduate outlined that there was one full day dedicated to the packages:

*Had a day off just in L and D [Learning and Development] going through a lot of the online programs that we have to do competencies... We spent a whole day in L and D doing them, and by the end, eyes were hanging out of heads. ...So, we did all the ones we needed to get through. (GN3-3)*

Following the original orientation packages, new graduate registered nurses were also expected to undertake further E-learning packages while undertaking rotations. E-learning opportunities were only available on the Western Australia Country Health Service computers, and if the ward was busy, the graduates were unable to find the time to access the Western Australia Country Health Service e-learning resources database. The majority of new graduate registered nurses discussed the difficulty with finding time to complete the online self-directed learning packages:

*We are connected to what is called capabilities.... We kind of have to have some of them done but a lot of that is done in our own time. Because there's just there is really not a great deal of opportunities on the ward. Sometimes on the weekends you might get half an hour but that's not, you can't really get into anything substantial. (GN1-3)*

The new graduate registered nurses suggested that it would have been better if they were able to access the E-learning packages at home so they could keep up with the mandatory requirements.

Differences were identified in the number of learning packages that graduates were expected to complete. One of the graduates said that they were given a list of the mandatory learning packages that were pertinent to the hospital. The graduate was also given a few extra learning packages that were ward specific and would help the graduate gain confidence in the clinical area. In contrast, other new graduate registered nurses were not encouraged to complete non-mandatory learning packages within the first three months and were instead advised “*to get yourself sorted first*” (GN7-3). There was a strong sense of belief that new graduate registered nurses needed to take time to orientate to their clinical environment before completing non-mandatory education packages.

There was an abundance of educational opportunities on the wards and many new graduate registered nurses were “*not looking for a great deal of more education*” (GN1-3). Learning how to manage on the ward as a registered nurse seemed to be the focus and many completed only the mandatory education packages. One new graduate registered nurse indicated they “*haven’t done a lot*” or “*haven’t actually looked*” (GN5-3) for any extra education. Another graduate suggested she was still coming to terms with working as a registered nurse and had not completed many self-directed learning packages. In contrast, a small number of graduates did complete non-mandatory self-directed online courses within the first three months of the graduate program. Generally, the new graduate registered nurses worked through the online learning opportunities at their own pace.

#### **4.1.3 Ad hoc education**

Ad hoc education within this context is education that is normally unplanned as part of the graduate program. This included ward in-services developed for all nursing staff and informal education provided by educators or other staff as the opportunity arose. The ad hoc education usually focused on mandatory requirements or learning opportunities specific to the clinical area. A small number of new graduate registered nurses discussed the ad hoc education sessions that occurred within their hospital

environment. One of the graduates indicated that the staff development nurse conducted an ad hoc session for safe blood transfusion:

*Staff development nurse, she came with all of them to do a blood safe interactive in-service on the floor where they had a fake scenario of how you give bloods and what the process is... That was a good learning package actually because I had never given bloods before and it was the next week that I had a patient that required bloods. (GN7-3)*

Another graduate was not so fortunate and taught himself how to complete the skills using the policy and procedural manual. “If I’m not sure I have to pretty much self-direct myself and look it up so the first time” (GN6-3). A few new graduate registered nurses discussed the use of video conference in place of face-to-face ad hoc education. One of the graduates would have liked more in-service or ad hoc education:

*It would be good to have more study days like or just little even just little in-service. We have had a couple of in-services on the ward but I think yeah you are not always there for them and you don't have a lot of time so when you do go to them your always in the back of your mind that I've got to get back to my patients sort of thing. (GN3-3)*

Many of the new graduate registered nurses discussed the limited ad hoc education delivered in the rural and remote areas compared to more frequent ad hoc education received as an undergraduate.

## **4.2 I need to know more**

This sub theme reflects that the graduates at seven months wanted to learn more, now that they felt familiar with the role of a registered nurse. The new graduate registered nurses were becoming more vocal about the content and delivery methods of the graduate study days. There was a renewed desire for knowledge, as at seven months the new graduate registered nurses were ready to engage in the non-mandatory self-directed learning packages. The same three categories were identified at the seven-month interviews as in the three-month interviews; however the focus of the discussion had changed. The categories were: 4.2.1 Structured study days; 4.2.2 E-learning; and 4.2.3 Ad hoc education.

#### 4.2.1 Structured study days

This category refers to the importance of structured study days meeting the needs of the graduates. By the seventh month interviews, new graduate registered nurses were at a stage in their development where they were able to use the study days to their full advantage, incorporating the information they learnt into their daily practice. The structured study days delivered at various intervals continued to include a variety of delivery methods. All the participating new graduate registered nurses discussed the content and usefulness of the education sessions provided. A number of graduates suggested that some of the structured education was not relevant or was not well retained. Many, who were keen to learn more, gravitated towards staff happy to share knowledge.

Delivery of structured study days seemed to differ between each health service. One of the new graduate registered nurses revealed the information provided in the structured study days was crammed, and all delivered in the first half of the year:

*I think our study days finished in June, so I haven't had any since then... I can't remember [what was included] to be honest... There are so many things that they cram into the study days. (GN2-7)*

The majority of participants talked about structured study days continuing past June. Another graduate also believed there was a lot of information and had mixed feelings about the content:

*They give you a big headache like by the end of the day you're just like 'oh my gosh'... Yeah like, we just get exhausted like all this information. I feel like some of its really useful and some of it's just not... (GN 9-7)*

Content of the study days also appeared to vary between health services. Although the new graduate registered nurses were ready to engage in more education, the structured study days appeared to contain a little bit of everything and did not give the graduate time to assimilate the combined knowledge. Some of the graduates indicated that the information shared during the study days was not relevant at the time of delivery and would have been beneficial later in the year. One new graduate registered nurse suggested that a whole section within the study day was not applicable to them, as it did not align with their allocated rotations. Within this region, the paediatric study day

included a five-minute presentation delivered by each graduate. This graduate was able to benefit regardless of not being given a paediatric rotation and reflected by “*saying that, I picked something that I would see in ED too, so mine [presentation] was dehydration*” (GN4-7). The new graduate registered nurses spoke about the study days being beneficial when experts in the field delivered the sessions and involved relevant topics to their current wards, such as palliative care and cardiac care.

The majority of new graduate registered nurses discussed the relevance of their structured graduate assessments that needed to be completed as part of the graduate program. A graduate indicated they had just completed their presentation during the last study day and was thankful it was finished. Another new graduate registered nurse believed that the assessments were not effective in advancing their knowledge or skills:

*The assignments that we're set to do, one of them I can't see the point of, they don't even actually follow up to see whether you have done it and they don't give you a mark. So, to me that is completely pointless.*  
(GN2-7)

Although the graduates were ready to learn more, transference of knowledge through structured assessments was not considered helpful for the majority of new graduate registered nurses at the seven months interviews.

#### **4.2.2 E-learning**

By seven months, new graduate registered nurses were keen to learn more but were frustrated by the lack of time for study. Some of the graduates continued to talk about the difficulties with E-learning and despite wanting to learn, completing the packages often depended on complexities of the ward:

*...And we're supposed to be doing it [online packages] like in ward time which on rehab I managed to find the time because you have quiet moments but on surgical like there's no frigging way you can do any of it like.* (GN9-7)

Many of the new graduate registered nurses were now concentrating on achieving the advanced skills. This often required a senior nurse to validate practice once the online component had been completed. One graduate shared their experience of gaining skills with the support of the staff development nurse:



*They were always on the ward and always willing to help you and stuff like that if you had any questions and stuff.... I did, I did my IV package while I was there.... So, cannulation and taking bloods.*  
(GN1-7)

Another new graduate registered nurse shared her delight when the clinical nurse manager organised a day in theatre so she could gain validation and complete their cannulation competency in one day. One of the graduates from a regional facility was given an orientation book to learn about specialised machines for example dialysis and watched You-tube videos “on how to cannulate” (GN4-7) before the direct supervision or the validation process began. An additional new graduate registered nurse working in a district hospital suggested there were limited senior nurses who could validate skills. If the skill was a mandatory requirement, and current staff needed validation often the staff in the emergency department would be prioritised over graduates. Despite the obstacles, the majority of the participating new graduate registered nurses discussed the need or desire to obtain advanced clinical skills in preparation for their final rotation.

#### **4.2.3 Ad hoc education**

Ad hoc education continued to be seen as important for the development of new graduate registered nurses. The majority of graduates indicated they had attended at least one ad hoc education session within the last four months. The new graduate registered nurses’ desire to know more had been reflected in the increased number of ad hoc education sessions discussed. The ad hoc education sessions appeared to be ward dependent. The following graduate shared her experience once she rotated to the surgical ward and received education from the staff development nurse who was allocated to support the new graduates:

*They’re (SDN’s) pretty good to be, like this week they’ve been awesome, like they’ve been on the ward like pretty much every day apart from Friday and they just kind of come and see us [grads], like because they’ve changed it [the format] so they’re specific to like surgical. So, like surgical has like a staff development nurse to look after us [grads].* (GN9-7)

Other new graduate registered nurses spoke of ad hoc education being conducted by senior nurses on wards and in the emergency department. A graduate spoke about

one of the senior nurses being very passionate about education and eager to share knowledge with the new graduate registered nurses:

*it's not so much on a regular, ...But because she knows that I'm in there as a grad and learning and stuff she'll quite often pull me aside and talk about the patient that we've had and you know go through some of the ECG's or lab results and so that's really good. (GN8-7)*

New graduate registered nurses continued to make use of the video conferences that were available if there was a topic relevant to their rotation, “*I did go and watch a VC [videoconference] on the effects of ICE [methamphetamines] and on management of ice... Being that I'm going into ED next*” (GN4-7). Another new graduate registered nurse attended a short education session on her rostered day off, “*there was ...a talk given by a palliative care doctor on pain management and that sort of stuff, which was really interesting*” (GN3-7). This graduate had indicated that it was impossible to attend an education session while on duty because there was no staff to handover patient care to while they attended unplanned education sessions. The new graduate registered nurses appeared frustrated with the inability to attend education sessions and increase their knowledge.

### **4.3 Okay got it, now what?**

The sub theme ‘ok got it, now what?’ refers to how the graduates by 11 months had gained the required knowledge to work successfully as junior registered nurses and now needed to secure future employment. The education experiences discussed during the final interviews were directed towards further job prospects. All of the participating new graduate registered nurses agreed they had learnt so much since the start of the program but not all graduates appreciated the way knowledge was transferred. There were the same three categories identified as in the previous time periods, but again, a different focus was seen for each category. The categories were: 4.3.1 Structured study days; 4.3.2 E-learning; and 4.3.3 Ad hoc education.

#### **4.3.1 Structured study days**

The structured study days for the final part of the graduate year had mixed reviews and included more than just the graduate study days. Some of the regions had delivered all the structured days within the first half of the year, the regions which

continued to deliver the study days toward the end of the graduate program focused on future employment. One of the new graduate registered nurses had not attended any study days in the last four months. Another graduate indicated that the study days were tailored to help gain future employment. *“We just had one that was all about like CVs, [curriculum vitae] and actually like, which was probably the most useful one that year”* (GN 9-11). The following new graduate registered nurse enjoyed the flexibility of the study days:

*Yeah, they were amazing. So, our grad coordinator actually asked us what we would want them [study days] to be on... At the time... there was a lot of sepsis, so we got drilled with sepsis which was great... We had a palliative nurse come through and talk about drugs and looking after palliative [patients] because that was something that all we grads struggled with, looking after palliative patients and obviously not much resources being around. (GN10-11)*

A few graduates discussed the benefit of a full day workshop being organised and delivered by medical staff:

*The paediatric doctors have put on a couple of workshops, a neonatal one and a paediatric one... I got to go down and see a couple of the scenarios during the double staffing time. But then I got to do the paediatric workshop which went all day which, so they go over just assessing a paediatric patient and then they run scenarios and stuff in the afternoon which is good and put you all in groups. So yeah, the paediatric medical team's really good. They're really good with training and answering questions. (GN3-11)*

Participating new graduate registered nurses did discuss a few challenges that related to the structured learning. One graduate suggested that *“trying to work out how much more sort of formal learning you actually need to do as a grad and like not overloading graduates”* (GN1-11) was challenging. The new graduate registered nurses were focused on employment prospects and wanted to learn enough to practice independently but not spend time learning skills that would not be beneficial in other areas.

Several graduates discussed their disappointment with assessments, which were allocated throughout the year. *“There's all this stuff [assessments] that's supposed to be technically done, but um, there's been no follow up on any sort of stuff like that”* (GN5-11). The graduates indicated the assessments for example, written case studies, similar

to university assessments, were not beneficial to their learning because often no feedback was received. The graduates believed due to the lack of follow up or feedback, the written assessments were completely irrelevant to the program (GN2-11).

#### 4.3.2 E-learning

This category is reflective of the new graduate registered nurses being able to time manage efficiently now which enabled them to have more time to focus on self-paced learning opportunities. The graduates indicated they were encouraged to complete the packages at their own pace and were aware that although confident in their current clinical area, extending their professional development would increase their chance for ongoing employment. One graduate wanting to work in the emergency department completed “*a lot more self-based learning packages, so I started the triage, I have looked on ECG... the IV cannulation and the um, catheterisation*” (GN2-11). Few graduates discussed completing a number of online packages, “*I do them all the time, yes, especially on night shift*” (GN5-11). This graduate spoke of a list containing relevant online learning packages for the ward, which was a helpful guide. One of the new graduate registered nurses had completed many relevant packages, including the preceptorship package.

Other new graduate registered nurses shared their enthusiasm and excitement about enrolling into both short courses and postgraduate studies offered online, showing they felt ready to gain further knowledge and skills to further their career:

*I did clinical upskilling in the bush [remote area] which was 12 modules and included ECG interpretation, ABG results, non-invasive ventilation, arrhythmias ... So that's just, that was just for a bit of extra because I think I was getting a bit bored and burnt out, so I thought I'd do a bit of extra study while I was up there. And then I've just enrolled in my paediatric emergency course. (GN10-11)*

And

*I'm just enrolled, just last week actually in graduate certificate in child and family health which will get me to work in community health and yeah, my placements will be in the population health centre here. And then the lady there, there's actually a job going there at the moment. I just don't feel I've got enough experience yet to do that role. But not only do I have limited nursing experience, I don't, and*

*paediatric experience I don't have any community health experience although I've been told they are really helpful and they train you and all that sort of stuff I don't, I tend to like a little bit of background and foundation and because I'm enjoying paediatrics so much as well and I've had my contract extended there. I'd actually really like to get more clinical experience in that area anyway just for my own future endeavours and stuff. If I move somewhere else, I can then still pick up clinical stuff in the hospital. (GN3-11)*

This graduate indicated a clear vision of where her nursing journey headed and realised her current limitations with the experience gained throughout the graduate program.

#### **4.3.3 Ad hoc education**

Throughout the twelve-month graduate program, the majority of the new graduate registered nurses believed there should have been more ad hoc education, even though they felt confident with their clinical skills. The graduates discussed that the ad hoc education sessions were lacking in the graduate program in comparison to the session they attended as student nurses. Some of the new graduate registered nurses indicated a lack of resources limited the ability for this format of education in the rural and remote areas:

*It's just having access and the opportunity and the space to, to learn and explore and ask questions and practice skills and that's, that's the main thing I guess, particularly like I said, we don't have those areas where we have validators and you can't practice things because there's no equipment or there's just no resourcing for it. (GN2-11)*

The new graduate registered nurses shared how they valued their experience with knowledge being shared from senior nursing staff who provided ad hoc education. One graduate shared her excitement of a new experience when she helped with the delivery of a baby and both the midwife and staff development nurse:

*We had the midwife, the SDN who works nights and myself and so we actually, I said look I hadn't, there was this woman in labour and stuff, and I said I haven't actually done any births or anything like that. So we actually went up and looked at the neonatal resuss and the cot ... and looked at everything that needed to be done there and yeah what we needed to do and stuff like that, and then yeah as the time got closer than the midwife called just before this lady birthed and then we went from there, and yeah it was really good. (GN1-11)*

Another graduate had rotated to a smaller remote area and learnt about pathology skills, which were skills not required from nurses in larger facilities:

*You got to centrifuge your own blood and then you put them in freezer box and security picks it up and take it to Perth, and they do X-rays there and in the ED department some people do the X-rays. Just things that you don't think about when you're in a smaller site you just learn. (GN8-11)*

## **Summary**

The new graduate registered nurses were overwhelmed with the amount of new knowledge they faced within the first few months of their graduate program. Once settled with the routine of being a registered nurse, all new graduate registered nurses expressed a desire to learn more. An increase in education was delivered through multiple on-line self-directed learning packages and being able to direct the structured study days. The new graduate registered nurses were confident in their knowledge and practice by the end of the graduate year and felt they had a good knowledge base. Many had started investigating postgraduate studies or increased learning packages to prepare for future employment. Knowledge was transferred in a variety of formats to suit the graduates' needs.

## **Summary of chapter**

This chapter discussed four themes that evolved from the interviews with the newly graduated registered nurses: professional beginnings, fractured reality, a sense of belonging and transference of knowledge. The themes highlighted the facilitators and barriers graduates experienced within their 12-month transition. The importance of clear guidance, feeling welcome and continuous education opportunities were evident throughout the findings. The next chapter will present the qualitative data analysis from the senior nurse's interviews.

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## **CHAPTER 6: Experiences of Senior Nurses Supporting New Graduate Nurses in Rural and Remote Western Australia: Qualitative Findings**

### **Introduction**

The previous chapter provided a detailed account of the themes identified in new graduate registered nurses' interviews. This chapter will present the themes that evolved from the senior nurses' interviews. The findings for the senior nurses will be presented as one timeframe as interview responses were similar across the different timeframes as the senior nurses supported the graduates throughout the 12-month period.

### **Participants**

#### **Senior registered nurses**

Fifteen senior nurses participated in the qualitative phase of the study: nine were graduate nurse coordinators, three held the position of nurse unit manager or clinical nurse manager, two participants were staff development nurse (also known as nurse educators) and one was a clinical nurse (a senior registered nurse). These senior nurses were from both district and regional facilities, aged between 20 and 60 years of age. The participants were of both genders, 13 female (86%) and two males (14%). Participants were from all seven regions. Six senior nurses participated in the first stage of interviews. Nine senior nurses participated in both the second and third stages of interviews. Three of the graduate nurse coordinators were interviewed at all three intervals, three senior nurses participated twice, and nine senior nurses were interviewed once, resulting in 24 in-depth interviews. The interviews for the senior nurses were undertaken at the same time intervals as the new graduate registered nurses, allowing for triangulation of data and to ascertain any correlation between the information gathered at the same intervals.

### **Findings**

Four themes were identified from the thematic analysis of senior nurse interview transcripts. These were: 'Professional challenges', Leadership and management', 'A sense of belonging' and Transference of knowledge'. The theme 'Professional challenges' examines the challenges senior nurses experienced as the graduates'

transition from student to clinician in the ward environment. The ‘Leadership and management’ theme emphasised the need for senior nurses to exhibit good communication with graduates, limitations due to fiscal matters and finding the right person for the job. The third theme, ‘A sense of belonging’, highlighted how important it was for new graduate registered nurses to be able to feel like a valued team member. ‘Transference of knowledge’ referred to how fluid the design and structure of the graduate programs were throughout the regions. Table 6.1 outlines the themes and their relating sub-themes. Each theme will be explained separately.

**Table 6:1**      *Senior nurses supporting graduates*

Themes	Professional Challenges	Leadership and Management	A Sense of Belonging	Transference of Knowledge
Sub-Themes	A team approach to supportive measures	Setting the Scene	The Art of Settling In	There is more than one way
	Staff supportive needs	The Three R’s (Recruitment, Retention and Right person for the job)	Time Matters	Making the most of what you have
	Recognition of supportive staff	Communication is the key	Work-life balance	The minimum requirement

## **Theme 1.0: Professional challenges**

The first theme refers to the challenges and barriers senior nurses experienced when providing support for new graduates. In this theme, senior nurses identified the challenges encountered as they implemented supportive measures for new graduate registered nurses throughout the graduate program. Three sub-themes emerged from the data: 1.1 A team approach to supportive measures; 1.2 Staff supportive needs; and 1.3 Recognition of supportive staff.

### **1.1    *A team approach to supportive measures***

Senior nurses felt strongly that support for rural graduate nurses required a team approach to providing both preceptorship and supernumerary time. This was evidenced in comments such as, “*I’ve finally got the team that I want and I’ve got them in the spots that I need them to be for the grads*” (SN8), and “*It tends to be more a team approach than just a one-on-one*” (SN12). Senior nurses who were unable to provide



the team approach to providing graduate support, felt it limited their ability to successfully fulfil the role. This was expressed by one senior nurse as, *“given the mobility of the workforce, given the flexibility of the workforce [swapping shifts] and the unpredictability of the workforce, it’s not a great system to have someone who is your go to person all the time”* (SN12). Another senior nurse said, *“support wise on the ward with the graduates, it’s very limited at the moment because of the staffing in this department”* (SN2).

Senior nurses reported a variety of supportive mechanisms provided for rural graduates. Supernumerary time at the commencement of a rotation varied depending on the type of clinical area *“1-2 weeks supernumerary”* (SN2) or *“two days supernumerary”* (SN6). Preceptorship was also provided *“The whole grad program they have a preceptor that they can go to”* (SN3) and spend time with nurse educators on new graduate registered nurses regular study days. *“There’s a lot of lesson to take in but it’s nice to spend the week getting to know me and [name withheld] and the staff development team and managers”* (SN4). The senior nurses believed it was a professional challenge to provide this type of focused support.

Professional challenges identified in coordinating focused support were often due to limited resources and staff. *“I just feel that they’re not supported at the moment but it’s more due to other factors. It’s more due to them not being supported because of recruitment issues, HR issues”* (SN1). Senior nurses found it difficult to provide support to new graduate registered nurses due to the small numbers of senior staff available. Differences were found in the number of senior staff available to support new graduate registered nurses and the size of the health service:

*Being a small site you know there’s a midwife on every shift and then there’s an RN and then there’s an ED person... We have such a mixed cohort of patients and we only have a staff development nurse who’s got a portfolio and she has two days a fortnight. (SN14)*

The size of the hospital had a direct impact on support available to new graduate registered nurses. The regional centres had graduate nurse coordinators on site, nurse unit managers, and staff development nurses, *“In a big hospital there’s lots of people that have staff development fulltime and they follow them up”* (SN14). Larger hospitals also had senior ward nurses who take on the role of preceptor. The smaller district areas

have less access to graduate nurse coordinators and staff development nurses and fewer senior nurses employed in the health services, limiting the availability of senior staff members to support new graduate registered nurses, “*They [new graduate registered nurses] may not feel supported like there’s not a staff development nurse to run to every time they need something, but they’ve got their senior nurses [clinical nurses]*” (SN3). The district areas had fewer graduates, although the support requirements are the same. Due to the decreased availability of senior staff, the responsibility of supporting new graduate registered nurses often becomes part of the role of all senior nurses, such as the nurse unit managers and senior nurses, in the smaller district hospitals.

One of the key points throughout the conversations with the senior nurses included the ability to roster each graduate with a preceptor. Rostering senior registered nurses to preceptor new graduate registered nurses was a professional challenge because of limited senior nurses available to undertake preceptorship and staff were often employed part-time. Allocating one preceptor to a fulltime new graduate was challenging and often not possible. The senior nurses who were interviewed discussed the need to implement a teamwork approach to address this challenge. The use of a precepting team, with several allocated preceptors, enabled the new graduate registered nurses to be supported by a team and not rely on the availability of a single preceptor:

*Part of the program is that they’re allocated with a preceptor or preceptor team. Some are obviously, some of the locations they’ll run a team of preceptors because they have a really part-time workforce and it’s easier to have, like, maybe two or three preceptors and a lead. (SN6)*

And

*We’ve got an abundance of part-time workers and so we have a lot of people who work two or three shifts. A lot of people work one or two shifts, we’ve got a lot of people that have very set shifts that they will do. So it’s really, really hard to get the consistency of a preceptor working alongside them. So what they’ll do is really share it between a few. (SN8)*

In the scenario of team precepting, the team leader of the group supporting a graduate was often the ward coordinator of each shift. With this hierarchical approach, the ward coordinator was responsible for aligning the supportive needs of the new graduate registered nurses with the available supportive measures. The program’s

success relied on the senior nurses stepping into the role of preceptor and support the new graduate registered nurses as required. Ward coordination changed with each shift rotation.

Even with this team approach, nurse managers identified the difficulties with coordinating the rosters and providing appropriate skill mix to support new graduates and the changing acuity of patient care. Roster allocation influenced the support available for new graduate registered nurses:

*Country health is changing and the acuity's changing. We are managing a lot more acuity. Means that we should be having more experienced nurses, but our casual staff tends to be a lot of junior staff. So you're putting graduate nurses who've got, you've just got to manage that. (SN12).*

And

*I guess in terms of acuity, like you want them to have acuity but I would never give high acuity unless we had senior staff support that could support them through that patient. (SN13)*

Patient acuity and staffing numbers influenced the support available for new graduate registered nurses with each shift. Teamwork was viewed as an effective tool to support new graduate registered nurses where skill mix was limited, and patient acuity was high. One senior nurse indicated the “importance of allocating a lighter load for the graduate” (SN8) when the graduate nurse was new to the clinical area. This was believed to allow the new graduate registered nurses time to adjust and become competent within the new environment. The difficulty with allocating a lighter load in smaller sites related to staff numbers, “the other sites [smaller], they [graduates] tend to get more patients because honestly, there's less staff on” (SN6). One of the senior nurses further suggested that an allocation of stable patients for new graduate registered nurses was thought to be supportive however “often they [stable patients] have the quickest turnaround time” (SN4), which resulted work consisting heavily of paperwork as opposed to becoming familiar with clinical skills. Alternatively, some senior nurses suggested coordinators should provide the new graduate registered nurses with a full patient load and allow time, with a preceptor, to support the graduate in providing for patients. “I believe that they work as a full FTE when they start. I don't agree with anyone who says that they don't. They are registered nurses and they can function, they

*just have a few more questions and you have to be patient with them”* (SN4). Despite trying to provide supportive measures and implementing a number of different methods, due to smaller staffing numbers focused support remained challenging.

The senior nurses who coordinated the graduate programs at the district centres had little influence in rostering preceptors with the graduates however they were aware of rostering issues, *“I’ve had feedback where you know they’re on with an enrolled nurse. You know – not acceptable sort of practice”* (SN5).

Many of the senior nurses discussed heightened levels of frustrations when preceptor support was not reflected in the rostering system from a management level:

*I don’t think they’ve been allocated a preceptor...that kind of attitude... they know about preceptorship. It is just people are time poor. They roster them quickly and without thought that they needed to have that preceptor. (SN5)*

Despite the allocation of preceptors, at times this did not occur. *“The grads were really unlikely to work with their preceptor”* (SN4). One of the senior nurses tried to address this by allocating more than one preceptor for each new graduate registered nurse however, this had minimal success in solving the problems because of the limited availability of suitably qualified and experienced nurses for rostering:

*I’ve found it very difficult to get the manager to roster – It is difficult here – I understand it can’t be every shift, but I probably would have preferred or would have really liked would be a little bit more support from their specific preceptors. (SN1)*

Rostering graduates on night duty provided an additional challenge for rural and remote areas. This was due to appropriate skill mix, staffing numbers, and adequate support delivered through preceptorship was difficult on night duty, in rural and remote Western Australia. The challenge of providing support on night rotations depended on staff numbers which altered between regional and district hospitals. Graduates were believed to be *“overwhelmed anyway with it [work] and [with] limited resources on night duty”* (SN5) which would often increase transition shock. The senior nurses felt that due to the lack of support available, new graduate registered nurses should not be allocated on night rosters. A senior nurse from one district hospital did intervene with a manager’s roster when *“there was one [a grad] that was rostered to night duty on one*

*of the wards. She was taken [off] night duty” (SN3), and another stated, “don’t put them [new grads] on night shift” (SN12).*

It is important for teamwork to be reflected at all levels within nursing to be able to conduct successful supportive measures for the new graduate registered nurses. A small number of senior nurses indicated they allocated night duty for new graduate registered nurses during the first clinical rotation, but only when the new graduates had accomplished a number of online training resources, and if they felt the new graduate registered nurse would manage with the decreased support available. Another senior nurse from the regional facility discussed their frustration with one of the nurse managers who appeared to disregard the supportive needs of new graduate registered nurses early in their transition year. *“We still have one manager ...who will put them on night duty two weeks after they start... why does she do that? It doesn’t make any sense” (SN8).* Many senior nurses voiced their frustrations with the lack of support provided for the new graduate registered nurses in the clinical wards. Support provided for the new graduate registered nurses was believed to be ward dependent.

The conversations throughout the interviews portrayed a number of different opinions about which support measures new graduate registered nurses required which included rostering, appropriate skill mix and preceptorship. All were universally identified as professional challenges as was the importance of working as a team when providing support throughout the graduate program in rural and remote sectors.

## ***1.2 Staff supportive needs (educational needs)***

The subtheme ‘staff supportive needs’ refers to how senior nurses believed that nursing staff who provide support to new graduate registered nurses also need to be supported in their role. Senior nurses felt it was important for any nurse who would be working with new graduate registered nurses to be educated about the needs and supportive measures available for new graduate registered nurses in their area:

*We send out an email and basically try and you know, offer the preceptors support if they require it as well. Given them some information about, you know, preceptoring in that role. (SN2)*

As new senior nurses were appointed, it was unclear, if they had previously acquired preceptor training or worked as preceptors in their previous roles. *“Not all of*

*the preceptors have done ... formal training*” (SN2). Support measures for preceptorship therefore varied throughout the regions. *“We are going to look at preceptorships ... and how they [SNs] become you know the leaders for the next grad”* (SN8). It was believed that staff members new to managerial roles or new to the rural areas would benefit from education about specific rural new graduate registered nurses support needs. *“We [ran supervision training] at the end of last year’s supervision course and that was really good” ... “People [who] attended gravitate toward the education portfolio”* (SN1). This was not a compulsory measure, currently *“the training [isn’t] a requirement”* (SN6) within the senior staff inductions.

Education of preceptors was to provide them with an understanding of the role and graduates expectations. The senior nurses understood some of the ward staff expected the new graduate registered nurses to *‘hit the floor running.’* (SN8) One senior nurse believed this to be an unrealistic expectation and provided education in short segments to all clinical staff:

*They [clinical staff] expect them [new graduate registered nurses] to be fully formed as they come out of Uni and so what I’ve [GNC] had to do is do a lot of education on the wards ...I have presented a bit of research on graduates and talk about the lived experiences and what they are likely to need in terms of support. (SN8)*

The conversations with senior nurses around this educational need, indicated the potential for it to become a cyclic process in rural areas due to the high staff turnover. *“It is difficult up here because they have such a high turnover of life agency and transient staff”* (SN2).

The challenge consisted of providing support for the preceptors new to the role and gain the skills required to preceptor new graduate registered nurses. Other senior nurses suggested appropriate education for the role of preceptorship may help increase the level of support available. One senior nurse spoke of an online education package, which could help with preceptorship and clinical supervision, however this was a lengthy process and not considered compulsory:

*Online programs, as well through our LMS system, that nursing staff can do. In saying that, they are quite time consuming and they, I think if you do the whole lot, it's about ten hours, so really the uptake of*

*that you know, a lot of staff, nursing staff may start it, but I don't imagine many would finish the whole program. (SN1)*

Senior nurses were presumed to have the attributes to supervise graduates regardless of their education background. “Really it’s just an expectation that they’ll do those roles. It says in the clinical nurses’ job description that they will educate, support and preceptor” (SN4). It is assumed the supportive role was part of the senior nurses’ role despite the level of previous experience. “I don’t know if all of them have had previous experience, but they’re the senior nurses from the department” (SN15). Preceptorship was considered part of the job description without any structured education process:

*In Melbourne you’d actually do a full day of, like being a preceptor and what it entails and learning stuff and how to work with people and what your role is, versus up here like, are you happy to take a student [or grad], great here you go. Which I guess you know is fine and you get on and do it, but it is just getting the right things in play, being as prepared as you can be and knowing that all the supports are in place. (SN13)*

The need for specific education was also made evident as another of the senior nurses suggested “*more preceptoring type training*” (SN8-11) was required for the team, issues with appropriate feedback had been identified, they were looking to include “*how to do proper feedback*” (SN8-11) in the training module. There was no clear job description or structure identified for educational support within the preceptorship model.

Several senior nurses shared their experience with long-term senior staff who would not accept the role of a preceptor. One of the suggested barriers for being reluctant to take on the position was the senior nurses who had worked for an extended period in the same environment was these nurses “*don’t feel confident and that sort of thing [preceptorship]*” (SN14). There were conversations about the coordinating staff being too busy to take on the preceptor role. This was seen to be a conundrum “*because clinical nurses ... are specialised and they’re experienced and so forth*” (SN5). The senior nurses interviewed suggest, not all senior nurses assume preceptorship is the responsibility of all senior nurses within the hospital and there was an opportunity for stronger clarification, preceptor education and role recognition.

However, one senior nurse provided a suggestion to help combat the challenges faced with effective preceptors within the rural and remote areas:

*Preceptoring should be part of the clinical skills [competency], because we get a lot of students here and we get, I mean we've got grads programme so maybe, really as a nurse's role, preceptoring should be part of it. (SN14)*

Many of the senior nurses suggested new graduate registered nurses required emotional support within the first six months of the graduate program and this needed to be part of the preceptorship skill set. The senior nurses spoke about several new graduate registered nurses who were involved in emotional dilemmas due to the social impact of living rurally:

*Mainly around um like more around debriefing, support. So um several issues and tears. We've had several of the grads come in have had or encountered some stressful new events.... It's that reality that they do know of people in the community [who they might nurse] and it's quite a close link in there too. (SN2)*

The senior nurses provided emotional support and were able to show empathy when the graduates were not coping with having to nurse people known to them from the community. Some of the senior nurses communicated they had an open-door policy for all staff needs, including a 'shoulder to cry on'. "*Obviously if there is any issues or things they come to us or we go to them and organise things that way*" (SN2). The open-door policy with senior nurses appeared to work well for the new graduate registered nurses in the latter part of the transition program. However, the senior nurses indicated new graduate registered nurses were often too shy to approach senior nurses within the first few months. "*They were really reluctant to call me*" (SN1). Psychosocial and emotional elements were identified by all senior nurses as important factors within the preceptor role.

### ***1.3 Recognition of supportive staff***

The sub-theme of recognition for supportive staff refers to how the role of a preceptor was often taken for granted and staff were not rewarded or recognised for the additional workload involved in supporting new graduate registered nurses. The conversations about recognition of supportive staff were similar in all regions. Some senior nurses from regional facilities indicated preceptorship was the responsibility of



senior nurses, referred to in Western Australia as clinical nurses (CN), “*which I think is difficult for the CN’s because they get tired and overwhelmed*” (SN4). Another senior nurse stated registered nurses who expected to one day become senior nurses should learn the preceptor role, incentivising them for future promotion. The team approach to preceptorship, helped combat rostering issues and often included registered nurses, and one or more senior nurses, but with no acknowledgement or remuneration.

There was no recognition for the senior nurses other than reiterating that it was part of their job description. “*There’s definitely no monetary [value] I think it’s something that you could probably add to your CV*” (SN13). The lack of recognition was reiterated by a senior nurse from a district hospital, “*there’s nothing, like no professional recognition to say that they’ve done X amount of hours with graduates or students*” (SN9). The lack of incentive plus the increase in workload was a professional challenge identified by all senior nurses interviewed. One suggestion was to obtain photos and place them on the hospital notice board so all staff would know who the preceptors were “*and getting pins for them to wear and a few other ideas as well just to get them a bit more out there and more recognised*” (SN1). Without formal recognition and the professional challenges of staff retention, effective preceptorship was often limited.

## ***Summary***

The professional challenges experienced by the senior nurses within the rural and remote regions of Western Australia were not isolated to support measures alone. The following theme of leadership and management will discuss limited resources in the rural and remote setting and importance of finding the right people for the job. This theme will also provide a description of the graduate nurse coordinator role throughout rural and remote Western Australia.

## **Theme 2.0: Leadership and management**

Leadership and management skills were identified as essential attributes for all senior nurses involved in supporting a new graduate’s transition. This theme refers to challenges identified by senior nurses in managing the support provided by senior nurses to new graduate registered nurses throughout the graduate program. The leadership and management support noted throughout the interviews consisted of

communication, clear directives, financial stewardship, recruitment and retention of nursing staff and team work. There were three sub-themes identified: 2.1 Setting the scene; 2.2 the three R's (Recruitment, Retention and the Right person for the job); and 2.3 Communication is the key.

## **2.1 *Setting the scene***

Setting the scene represents understanding the role of all staff who were involved in the graduate program. Specifically, it is important here to understand the role of the graduate nurse coordinator. This sub-theme identified the multiple roles the coordinators had and the gap between managing and influencing the clinical support available at the ward level. Senior nurses felt it was important to understand the diversity of the graduate nurse coordinator role in order to appreciate the challenges involved in facilitating support measures for new graduate registered nurses in rural and remote settings. When the senior nurses were asked to describe their role, the conversations consisted of phrases including time constraints, multiple roles, communication gap, financial constraints, lack of resources and staff.

Frustrations with being time poor were common complaints among those interviewed, *"because I've got other requirements as well, so demand on my time. I can't, you know, hold their hands so to speak"* (SN5). The limited number of senior staff in small district hospitals results in senior nurses holding more than one portfolio. One senior nurse's involvement with graduate nurses consisted of *"33 and a third [percent] .... I no longer have a real clinical focus on the wards"* (SN3). This limited the amount of time available to support graduates.

Multiplicity of roles of the graduate nurse coordinator was another factor limiting the amount of support available to graduates. The role of supporting new graduates was only one component of the senior nurses' role within the rural and remote areas. The multiplicity in their coordination role extended to supporting undergraduate student placements. *"Most graduate support nurses within WACHS allocate student places as well"* (SN4). Another senior nurse, new to the role, identified the multiplicity of roles made the job stressful, *"I love the grads, but the other roles around it stresses me out quite a lot and sometimes you feel like if I was just in grad support, it would be much, much easier"* (SN10). This senior nurse suggested the role entailed more than just

looking after both graduates and student nurses. The additional components of the senior nurse roles were not implicit in the job description:

*It's got a managerial aspect to it and it's a bit of a dog's breakfast, but we haven't had a staff development nurse – I've been it. I'm it. I've been staff development nurse and student program organiser and program person and learning and development. (SN3)*

The constraints with multiple roles was further reiterated when a senior nurse stated she did not see the graduates often as “my role is generally a regional role and coordinating role..., I am not on the floor with them” (SN1). The senior nurses discussed their capacity to support new graduate registered nurses were restricted by competing components of the role.

Despite the constraints or limitations, few senior nurses discussed ways to provide support for new graduates:

*So support is a big question and from my point of view I am giving them support as a coordinator. Not specifically clinical support, so yeah, there is a few ways of looking at it. So from my point of view and my job, well how I facilitate coordinating the program, I think there is a lot of sort of what's the word paperwork type. ...So I try and get the grads to get to know the coordinators 'cos they have to, and then find one that you gel [get along] with that you can go to with problems. (SN7)*

Senior nurses suggested the support measures varied from ward to ward and the allocation of preceptorship was left to the senior nurses or managers from each ward. One of the methods used by a facility to help combat the lack of funding for specific graduate support nurses and provide the expected support new graduate registered nurses need, was for the staff development nurses to front load their time to provide extra support at the beginning of the graduate program and decrease the support towards the end of the program. “They're [SDNs] 0.5 FTE but they try to stack their shifts up when the graduate is first starting” (SN6). This was a creative way to limit the financial shortfall associated with some regional and remote positions, finding ways to make limited funding work demonstrates both leadership and managerial characteristics.

The management of clinical skills attainment for new graduates was considered difficult in some regions because the clinical support was facilitated by the ward nurses and not under the management of the senior nurse education teams in the regional areas:

*A lot of stuff clinically on the floor is taken out of the education team's hands, so the preceptors that they get, who are they rostered with, um, the level of skill with the staff they are working with in the departments and in the [region's name withheld] we have such a junior work force. I do feel that sometimes the grads aren't supported clinically. We can offer as much, you know, as we can, but we do rely heavily on the staff on the floor obviously, to you know... assist with the education and support. And I just feel that that doesn't happen. (SN1)*

Staffing was problematic in at least three of the seven regions within rural and remote Western Australia. "It's reasonably difficult here at the moment because a lot of the most senior staff aren't that senior, particularly in the general ward" (SN2). This was often due to the transient workforce.

Limited staff and financial constraints were noted barriers to managing the new graduate registered nurses' transition year. One of the main problems with the sporadic support appeared to be financial:

*I would love to see that they actually have support, but look, it's, you know, I think that the idea of a staff development nurse or an actual clinical supervisor is beyond.... don't have the money for that. And, because staff development nurses are always traditionally just pulled back into the roster....so it's just a myth, really, staff development nurses. (SN3)*

This barrier was reiterated by a senior nurse in a district area suggesting that graduate programs were important but integral to the success of such programs was adequate funding, "they need to be supported and they need to be, like financially supported... I think we have a responsibility and I think that it's essential that we do it and continue to do it" (SN14). Limited funds were further suggested by another senior nurse who saved money by not replacing educators when they took annual leave:

*We found that we needed to ramp up that kind of support so in this kind of resource challenged environment, we don't cover our leave. We use that extra money that we would usually use to backfill [our] leave (SN8).*

Although this may have been beneficial when everyone was on board it would result in limited supportive staff (staff development nurses) during times of annual and sick leave. Therefore, managing the appropriate times for leave would be considered important.

## **2.2    *The three R's***

The second sub-theme 'The three R's: recruitment, retention and the right person for the job, describes the importance of being able to recruit and retain the right people in the role to provide the support for the new graduate registered nurses. Recruitment of senior nurses and retention opportunities for new graduates appeared particularly difficult in the rural areas. The senior nurses indicated that staff had resigned due to the fluctuation in Western Australia's mining industry. This resulted in junior nursing staff dominating the wards. The complexity of rostering, lack of experienced staff and skill mix and the current job freeze were a constant concern highlighted throughout the interviews.

One of the senior nurses shared her experience with recruitment and suggested the lack of successful applicants ultimately affected the support available for new graduates:

*We couldn't – recruit – people weren't applying, staff weren't applying and HR issues as well. ...I've advertised that position three times and there's been one applicant.... It is frustrating and disappointing ... It's more due to them not being supported because of recruitment issues, HR issues... but that's difficult, we're in an isolated area. (SN1)*

Further discussions included the issues with the amount of paperwork involved with human resources affecting timely recruitment. *"It takes so long to get all the documents through HR. By the time you – yeah, there's just a lot of – and then people pull out"* (SN1). One senior nurse spoke of having two applicants apply for a staff development role, however *"deemed that they were not suitable"* (SN3). The senior nurse was concerned with finding a person for the position who had both management and leadership qualities. In some regions, senior nursing role positions were left unfilled, and little effort was made to fill the gap:

*No-one's been sitting in jobs and you know, – when you don't sit in it a lot of people don't take responsibility for it and ...And staff that are here aren't really engaged in the organisation. So, they come, they do their work, they go. They're not really interested in kind of going that extra step ...I think putting the right staff into the right roles is somewhere to start. (SN1)*

This 'gap' was alleviated in some regions, with nurses 'acting up' which means filling in until the role was filled, however senior nurses suggested this often failed to improve staff morale, because the nurses did not take ownership of the role.

There were conversations of senior nurses finding the right person for the job. A lot of time and effort was put into recruiting senior staff who “*would make great preceptors but again that's been an issue, so to find fulltime staff to act as specific preceptors is just really hard*” (SN7). Some of the senior nurses were disheartened to witness new vibrant staff being employed with great ideas and watching their “*bubbles burst a little bit because staff just don't care. And so, they don't care*” (SN1).

Finding the right person for the job was central to both recruitment and retention in rural and remote areas. The senior nurses shared their frustrations of working with nurses who had lost their passion for nursing and failed to support the junior staff. These reflections involved long-term senior staff employed in the workforce. Long-term senior nurses were often given positions that had not been filled despite recruitment drives, resulting in staff lacking one or both leadership and managerial qualities. Staff were failing to take responsibility for the senior roles they had been allocated. Some staff “*take the [senior role] title and don't really do much with it*” (SN9-11). One of the senior nurses shared her reflection of the challenges she encountered when working with senior nurses who lacked motivation:

*What I'm thinking is you have got to get the right people for in the job, it's not that she's underperforming but she's just not motivated enough to do the job the way we want to see it done and even though I have given her the research it's very unlikely she would have read it. So when we have day meetings, it's like very passive/aggressive type of behaviour. (SN8)*

This created barriers when trying to implement supportive measures such as preceptorship and educational opportunities. Recruitment and finding the right person

for the senior nurse role was therefore, problematic, which had a cascade effect on the supportive measures available for the new graduates:

*You know, we do actually make an importance when we do actually talk about all the different roles and the transient nature of the [regions name withheld] – you're telling one person and they leave and then it can break down like that. (SN5)*

The transient clinical workforce made it difficult to provide consistent coordination throughout the graduate program. One of the senior nurses addressed this complication when she assigned the education portfolio holder to more than one staff member, “*Just because of the transience*” (SN2). This alleviated the pressure of one senior nurse being solely responsible for all the education support for both graduates and clinical staff in the area.

In contrast to the recruitment concerns, towards the end of the graduate program, senior nurses were increasingly concerned with the lack of opportunities available for new graduate registered nurses following the graduate program:

*They finish their grad year and they haven't had much experience in ED, you know – Same for say, theatre or dialysis, or wherever they'd like to work. There's nothing available when they finish. They're out in the big wide world and they've got to apply for jobs with competition from registered nurses that could be 1.9 [a nurse with 9 or more years' experience]. So what do they do? So they leave. (SN1)*

The issues with retention rates surfaced in all interviews with senior nurses because the government had announced a recruitment freeze during the period of this research. The senior nurses were worried for the new graduate registered nurses' future employment prospects. One of the senior nurses worked tirelessly to ensure the graduates were offered extensions on their current contracts:

*The graduates that are out there um suddenly had the carpet taken out from underneath them. And we spend um a whole study day in November um preparing them for their interview for the next phase of their career then suddenly there's no jobs in the whole of WA. So what we've ended um managing to do it to extend their 6 term contracts for another 6 months which is effectively giving them 18 month graduate program. (SN8)*

Other senior nurses were disheartened. “We know we need staff but once again... keep going on about it but budget constraints, none of them have been able to get any form of employment from the grad program which is really disappointing” (SN15). Senior nurses indicated the graduates were not offered any fulltime or permanent contracts, yet were encouraged to apply for casual or short-term contracts whilst the recruitment freeze was active.

The issues of recruitment and retention are considered managerial, however finding the right person for the job appears to be centred on finding senior nurses with a passion for nursing. The senior nurses believed that assigning the responsibility for supporting the new graduate registered nurses to one senior registered nurse may not benefit either party if a lack of time or a lack of passion was evident. Finding the right person for the role was difficult when there was low morale or nurses lacking leadership skills were the only applicants during the recruitment drives. Finding the right person for the job and recruiting staff to fill the roles to help support new graduates was considered an important step to be able to retain new graduate nurses.

### **2.3    *Communication is the key***

The third sub-theme ‘Communication is the key’ refers to the importance of effective communication skills required within the clinical environment. It is important that graduates are provided with the information on what to expect from the graduate program and what support is available. It is vital that a clear understanding of responsibility in undertaking the senior nurse role is reflected. The senior nurses all stated clear and concise communication would help reduce limitations or barriers when supporting a new graduate’s transition. The interviews indicated periods of frustration when clear direction was not forthcoming for the supportive roles. The challenge of effective communication was evident throughout the Western Australia Country Health Service hierarchy top down approach to new graduates, and not solely the actions of the graduate nurse coordinators.

Episodes of clear communication were shared. When planning study days, the senior nurses understood that “*constant communication*” (SN5) between the graduate nurse coordinators, senior nurses, and graduates was an effective method to manage and plan flexible study days, with a focus on the graduates clinical needs “*as opposed to*



*[education not being significance in] their clinical practice” (SN5). This experience however, differed throughout each region. During orientation, in a smaller hospital, one of the senior nurses explained the support that would be available during the orientation days, and offered suggestions for other support options:*

*I always let the grads know that we do not have a staff development nurse. There is a lot of support on the wards and a lot of supernumerary time ... You can go out and get study days and that makes up for the lack of staff development by having your preceptors that you follow. (SN3)*

This senior nurse had a very clear and concise idea about communicating expectations for both senior nurses and new graduate registered nurses with regards to supportive measures.

Senior nurses suggested they were often frustrated with not being provided with expected progression of the new graduate registered nurses by the area coordinators. Providing information such as “*by week six this is what you [new graduate registered nurse] should be able to do*” (SN14) would have been helpful. Clear instructions from the program leaders (graduate nurse coordinators) to clinical workforce nurses was identified as being needed to assist all senior nurses to help new graduate registered nurses progress toward expected goals and skills acquisition. This clarity in expectations included being aware of the instructions about the assessment pieces. “*I got an email saying that he [the grad] hadn’t done a couple of assignments and I thought oh I didn’t know*” (SN14). The flow of necessary communication appeared to be missing from a top down approach. The senior nurses also identified a set of clear guidelines outlining the programs goals and current expectations for each graduate, would have been beneficial before allocating appropriate preceptors:

*Where the grads are going to be rotating and what they’re aiming to achieve and then obviously personalise it when you actually meet your grad and what they specifically want to go through...I do think it would be good, even if it was just in email format, ....maybe an email saying look these are our grads that are going through, this is what's expected of them, this is when they're going to be doing their reviews, you’ve been allocated you know at this time of year this grad and maybe just a basic outline of the programme. I mean you sort of work out the programme, piecing it together from what you see, rather than what you’ve been pre-told. (SN13)*

Communication was considered an important skill, especially with the casual employment and transient nature of the rural and remote nursing workforce. Senior nurses from one region revealed that communicating the expected goals for new graduates was often a cyclical process:

*It can be difficult. As I said, a lot of it's the transient nature. [Hospitals name withheld] and [hospitals name withheld] have lost their – both their staff development nurses [SNs] that we liaise with. So it becomes that process again ...So communication can be quite difficult. (SN5)*

These limitations or barriers with effective communication, resulted in some of the senior nurses responsible for graduate nurses in smaller sites having limited knowledge about the structure of the graduate program.

This was further supported by a senior nurse who suggested that future education about preceptorship should involve the importance of handing over information on the graduate's individual needs. *"Staff handing over ...where the grad needs support and encouragement"* (SN2). Efficient management of new graduates requires communication between all staff involved in support of new graduate registered nurses at all times not just when graduates are rotating wards/hospitals.

Senior nurses from the regional hospitals discussed a variety of effective communication methods used between them and the new graduate registered nurse. One senior nurse suggested that the best way to keep in contact with the new graduate registered nurses was via their personal emails due to limited opportunity on the wards to access work emails and work emails not being accessible at home. This senior nurse believed using personal emails helped her feel *"like I can be more approachable for them"* (SN7) always keeping the communication channels open. Another senior nurse indicated she did not use direct contact with the new graduate registered nurse but relied on other staff, *"the managers always feedback to me"* if there is no feedback, *"then I know that everything is okay"* (SN3). Other senior nurses used a combination of direct contact with new graduate registered nurses and eliciting feedback from ward managers depending on the need of the new graduate registered nurse:

*Somebody's there but it depends on which ward they are working in. I don't know, there's different cultures from ward to ward. Yeah and some grad RNs they adjust well in those wards but some find it*

*difficult. So it's a matter of just, I don't know, try and try just to be there ...My presence [helps]. I just have to be there all the time, the majority of the time, speak to the managers as well if it's any issues that we can resolve ....So yeah it's just a matter of communication, communication, communication, but sometimes it doesn't change.*  
(SN10)

The senior nurse suggested that graduates' support structures varied depending on the ward, however constant communication was the only effective measure to help keep support consistent between each ward.

### ***Summary***

Senior staff within the rural and remote hospitals often held more than one portfolio, increasing their workload and limiting the time they had available to provide support to new graduate registered nurses. Both limited staff and financial stewardship were considered barriers to managing the new graduate registered nurses' transition year. Leadership skills were thought to be beneficial to providing clinical support to new graduate registered nurses, however, employing a person who is lacking in both leadership and clinical skills for a senior supportive role seemed to have a negative effect on a graduate's transition. Managing the graduate nurse program requires constant clear and concise communication between all parties involved in the process. Both leadership and management skills are essential for all senior nurses when supporting the new graduate registered nurses' transition to practice in rural areas.

### **Theme 3.0: A sense of belonging**

The theme 'sense of belonging', describes the senior nurses' thoughts and beliefs of what support new graduate registered nurses required to feel like as an effective team member within the rural and remote environment. The senior nurses spoke of the importance of adequate emotional support and being welcomed into the rural environment. This theme includes three sub-themes: 3.1 The art of settling in; 3.2 Time matters; and 3.3 Work-life balance.

#### ***3.1 The art of settling in***

The art of settling in or feeling settled refers to the process by which the new graduate registered nurses were accepted as part of the clinical team. All the senior nurses interviewed, discussed the importance of the new graduate registered nurse

feeling a sense of belonging to the clinical environment and expressed how the transition year involved providing both clinical and emotional support to nursing graduates to enable them to develop a sense of belonging. *“I don’t feel safe here ...no one’s supporting me, no one’s helping me. If you’re not here, I can’t call anyone, what do I do”* (SN1). The graduate was concerned and needed both clinical and emotional support. However, from a slightly different perspective one senior nurse believed that any efforts would reap rewards at the end of the program:

*The grads go through loops to get on a program and you know they have to travel, they have to do this, they have to do that, so you want to give them the support, they deserve that and then they are going to become ...a really competent staff member in the future. (SN7)*

Different ways were used by senior nurses to facilitate this belonging. At the beginning of the graduate program, two of the senior nurses facilitated informal meetings:

*We have afternoon tea with all the grads... and what we do is we welcome them and we talk about the program... you know, and we say how is it going? But we also have other grads from other years come and they do a reflection. (SN6)*

The senior nurse discussed the importance of conducting an informal meeting within the first four weeks of the graduate program to find out how the new graduate registered nurse was progressing and help alleviate the initial stress many of the new graduate registered nurses experience. This welcoming gesture was thought to improve the graduate’s sense of belonging within the new environment.

Referral to counselling services was another way in which senior nurses supported new graduate registered nurses. This may be required at any time during the graduate year. One of the senior nurses discussed how she was required to provide emotional support due to new graduate registered nurses feeling under pressure midway through the graduate program:

*So the person in question was not coping through different various reasons, personal and professional... I’ve had another one for personal reasons needed to have leave because she felt she wasn’t doing her job correctly through [personal] circumstances ...We directed both those grads to the, our [VIAC] program, so that’s the counselling service that we offer. (SN5)*

Some of the emotional turmoil new graduate registered nurses experienced was thought, by the senior nurses, to be caused by the need for new graduate registered nurses to move away from family and friends, adding pressure to the busy year of learning new skills and frequent clinical rotations. For some graduates, this move was seen as being *“too much for them”* (SN11), as they no longer had the same access to personal emotional support from family. The emotional maturity of new graduate registered nurses was seen as influencing whether or not they were able to manage the move to live in a new community and settle into each clinical environment. For example, *“we have one graduate down there who clinically is safe but interpersonally has not been able to develop any meaningful relationships with her colleagues”* (SN4).

The graduate’s contact person was often the graduate nurse coordinator, however for many, the graduate nurse coordinator was not working at the same facility. One senior nurse proposed that the graduates should be provided with a senior nurse working in the same facility, to assist with the emotional wellbeing of the graduates, in addition to their preceptors, whilst working in the rural areas. Someone who could *“touch base with the graduates, I still think it’s still quite daunting, they’re living away from home, it’s a whole new experience”* (SN13). One of the senior nurses indicated that enjoying being in the community and becoming social, was an important indicator of feeling a sense of belonging. They felt retention of graduates was linked to their ability to integrate with the community, if the graduates or nurses new to the area did not enjoy the lifestyle and had difficulty when trying to *“sort of settle here then people move”* (SN2).

Senior nurses from regional facilities indicated that there was a difference between supporting metropolitan graduates than those who had originated from rural areas or had completed education in rural-based universities. The senior nurse indicated that the new graduate registered nurses originating from urban areas required a lot more support:

*A lot of them haven’t had that experience at all and even some of them living away from home their metro girls come down and they need completely different but quite separate emotional and social supports, because they’re most of the time they have no idea what it’s like living in a small, rural setting. It is a real shock and particularly for ones*

*that have a very close family, about that week they start to get quite teary. So it is something that we go all okay. (SN8)*

The variety of patients that would be under the care of a nursing graduate in rural hospitals was also seen to cause increased stress for students who were not familiar with nursing in rural areas. Senior nurses said that graduates from metropolitan universities needed to adjust to living in rural areas as well as adapt to the variety of clinical events that presented in the rural and remote hospitals. The senior nurses indicated if the new graduates had attended a rural placement as an undergraduate, it was advantageous because the graduate knew what to expect:

*We know we've seen these people and they've actually wanted to come out. We know that if they're asking for a rural placement, then they have an interest in it, so they'd probably be more likely to survive psychologically. (SN3)*

If the graduate had progressed and enjoyed the rural lifestyle, chances are they had the emotional maturity to settle in despite the move:

*With the metro girls we are getting down here, we are having to put significant amount of hours into them to get them into working across all of the different, for example in surgical ward, it's just not one kind of surgery it's 20 different kinds of surgery. So there is a fair bit of support for the metros whereas the local ones that have come through [University name withheld] have already done their placements in those areas and they get it so they are nowhere near as difficult to orientate. (SN8)*

And

*We recognise that there are real issues coming to a country programs and not having that close shoulder to shoulder staff development and support, and that the... the grad needs to be a certain kind of person to be able to cope. (SN3)*

Over time, new graduate registered nurses were seen to develop rapport with ward nurses and become one of the team. The use of first names was perceived to indicate a sense of belonging by the ward staff for the graduate. When a new graduate registered nurse was accepted as part of the team by ward nurses, they were referred to by their name, rather than as 'the grad':

*The girl on medical ward, she functions as a member of the team. She's not identified as a graduate. You know, often grads are*

*identified as 'the grad' or 'a grad', she's referred to by her name. She functions as a member of the team, she is given more acute patients because they feel that she has the capacity to manage them. The grad on surgical ward has worked in between surgical and day ward, she has been moved to both areas and she does also function at the same level as the staff in the surgical ward. (SN4)*

The new graduate registered nurses' sense of belonging was seen by senior nurses to be reflected in their enthusiasm to advance their clinical skills. Whilst most new graduate registered nurses were keen to develop their skills, a couple of graduates were missing study days and not seeking out new experiences. This was thought by senior nurses to be because the graduates did not feel they belonged within their current environment. *"I would have thought very carefully about offering her a position. Um because of the skill and their attitude"* (SN8). Some of the senior nurses ascertained a graduate's sense of belonging was reflected in a graduate's level of clinical skills. However, one senior nurse believed that regardless of the high level of support, sometimes graduates lacked the initiative to progress their clinical skills. *"Different motivation levels and desire to advance their skills and stuff so, some I would say have had to require a little bit of prompting"* (SN15). Another senior nurse indicated a graduate in her region did not have the same sense of belonging as the rest of their colleagues and *"has actually [had] quite [an] extended sick leave"* (SN2). This graduate did not appear to be motivated to stay working within the current environment.

Alternatively, one of the senior nurses talked about the graduates in their final rotation, needing less support, and noticed that they appeared to have settled into the ward routine *"quite quickly"* (SN13). The graduates had learnt how to manage and felt like they belonged in the team and were comfortable in their clinical role. The new graduate registered nurses were more familiar with dispensing medications and had mastered the art of time management and admissions by *"six months [they] really started getting [their] head around that"* (SN14). For many senior nurses, a sense of belonging was linked to the progression of a graduate being able to perform a set of clinical skills at a junior level. Other senior nurses suggested some of the new graduate registered nurses were working at as an independent registered nurse (level 1.2) midway through the graduate program and *"a couple that are, that are working above that level"* (SN8). Despite the different rates of advancement, the senior nurses accepted that the graduates were able to practice independently as a newly qualified nurse by the end of

the graduate program with the projection they could effectively work in a rural and remote setting.

### 3.2 *Time matters*

This sub-theme refers to the length of clinical rotations and how long it takes for new graduate registered nurses to develop relationships and feel like they belong on a ward. The length of clinical rotations was seen by senior nurses to influence a graduate's sense of belonging. Senior nurses believed that the length of the clinical rotation influenced the new graduate registered nurse's ability to feel like a valid member in the clinical team. At the time of the interview, most new graduate registered nurse's clinical rotations lasted 12 weeks. However, several senior nurses believed that the new graduate registered nurses required more than 12 weeks per rotation to feel a sense of belonging on the clinical wards and consolidate their clinical skills. The change to a six-month rotation will *"sort of just gives them a bit more time to cut their teeth in one spot without just getting settled and then getting displaced again"* (SN9). The common concerns raised due to short placements was that when the new graduate registered nurses progressed to a level where they could function within the clinical environment with limited support, it was time for the new graduate registered nurses to rotate to another speciality. *"We had some feedback from the grads that they felt like they were just getting settled and then they had to move on. So, we tried the six month program and they really, really enjoyed that"* (SN6). Rotations required the new graduate registered nurse to move to a different ward or hospital and start the process of developing relationships and building trust again. Staying in one place for a longer duration was thought to increase the opportunity for the graduates to feel like they belonged. One senior nurse believed the new graduate registered nurses missed out on learning in-depth about the clinical area with shorter rotations, decreasing their chance of feeling like a valued team member. *"It makes such a difference being in this place for six months. I finally feel comfortable, the last three months have been really good and I feel much more part of the team"* (SN7). Another senior nurse shared her view on how short rotations affected the graduate's ability to 'fit in':

*When I took over the role I had them rotating every 12 weeks and I just went 'oh my God that is going to destroy them' and it was, it was horrible. They were just totally, like their social network, and because*



*it is so conservative down here, you have to win the trust of the staff.  
So that really short rotation thing could never, ever, ever work. (SN8)*

Another senior nurse shared her experience of a graduate remaining in the same clinical area for two rotations and stated the graduate “*was really quite grateful because she felt like she was just starting to settle in*” (SN12). However, increasing time in one clinical area did not appear successful in providing a sense of belonging for all graduates. The senior nurses discussed (the same graduate) “*one grad who has struggled*” (SN2) “*we didn’t have them rotate*” (SN1), with the hope to improve the new graduate registered nurses’ clinical capabilities and sense of belonging:

*She stayed on the general ward and she has actually, certainly improved with, her clinical practice and her knowledge base and her time management things, so I think we definitely made the right decision. (SN1)*

However, the graduate did not want to stay on and one senior nurse suggested that “*she needs to try and find someone to give her references for ongoing jobs*” (SN2).

One of the senior nurses suggested that she had asked the graduates within their region for feedback about the lengths of rotations and most graduates preferred longer rotations, “*[I asked] do you think two six-month rotations would be good, and they said yes*” (SN1).

Another senior nurse indicated that they thought the graduates would like to have six-month rotations, “*they kind of run the risk of, I guess, not getting the specialty*” (SN1), however accepted that graduate programs with three rotations allowed for the experience in specialised areas. One of the senior nurses involved in supporting graduates rotating to different hospitals as opposed to rotating to different wards, spoke of the feedback she received from both new graduate registered nurses and the nurse managers from the district hospitals. This senior nurse indicated the rotations were hard for both senior staff and new graduates:

*Every rotation is so unique, it’s a real big life change for them and to be changing every three months, it’s just too much. And mainly it came from nurse managers saying their just feeling comfortable. They’re becoming a really valuable staff member and then they’re moving and the next one we get is green and we have to give them this time and so they’re not getting, not use out of them. (SN7)*

There were plans to change the rotations to 12 months and/or two six-month rotations, and not rotating graduates to different hospitals. *“The biggest battle was to accept the six months and my next big battle will get them to keep them for a year and not rotate them at all”* (SN8). This would help facilities when they ‘*get those grads that specifically cannot leave [hospitals name withheld], you know mature aged grads with kids*’ (SN7). The senior nurses thought the proposed changes would benefit both graduates and clinical staff and increase the likelihood of retention of graduates:

*We are trialling this 12-month program this year .... hopefully we can provide a local with a job because they’re all saying your grads come through [hospitals name withheld] but they never stay, so we’re hoping that might give them what they need, what they want, you know that’s what I am trying to keep everyone happy. (SN7)*

### **3.3 Work-life balance**

This sub theme reflects the differing opinions about the fulltime equivalent (FTE) contracted time allocated for individual graduates throughout the seven regions and how it affected the work-life balance of new graduate registered nurses.

Senior nurses reported that most new graduate registered nurses were working on a fulltime basis and believed this was the only way to achieve a successful graduate year. *“There is one thing that I would never do again though. [Name withheld] is doing a part-time graduate program, I will never offer that again”* (SN3). Many new graduate registered nurses were thought to not want to work fulltime anymore as it affected their life work balance:

*I have noticed in the last two years is that people don’t want to work a full FTE, they want to work at least a 0.6 to 0.8 as a grad and we have never had the luxury of being able to offer that. So I have managed to wrangle a deal out of the ward manager that next year they will work 0.9 so that’s some compromise, because they get very tired. (SN8)*

The senior nurses changed the fulltime equivalent in a number of regions to accommodate an increased number of graduates in rural Western Australia. The new graduate registered nurses’ contracts for the graduate program varied from 0.6 fulltime equivalent to 1.0 fulltime equivalent. A senior nurse from another region indicated that they had always had a 0.7 fulltime equivalent as a minimum entry for new graduate registered nurses especially for nurses with children and, *“they have to make a choice if*

*they can't meet those hours then, they usually leave"* (SN6). The senior nurse further discussed times when all the graduates were fulltime and halfway through the program would drop their hours. *"So we'd have a vacancy of like two FTE, which is really not good... because we can't fill them"* (SN6). One of the senior nurses was concerned with a new graduate registered nurse in their region who wanted to be 0.6 fulltime equivalent throughout the graduate year because she could not commit to fulltime hours. The senior nurse indicated that part-time employment as a graduate was available, *"but my feeling is that you need a fulltime program to actually, you know, consolidate everything"* (SN3). There were also suggestions the new graduate registered nurses who were offered 0.8 fulltime equivalent always had the option to work more hours if they wanted:

*But a lot of them say it's great, because you know – they've got so much in their head that, that 0.8's really good. Then they can see the region as well, you know a lot of them want to you know travel and camp and explore the [regions name withheld] region. (SN5)*

Some rural regions continued to require 1.0 fulltime equivalent employment for new graduate registered nurses. The importance of work-life balance was noted by senior nurses to becoming part of the standard within the rural sector increasing the percentage of part-time and casual employment for both junior and senior nurses to help with retention.

## ***Summary***

The senior nurses discussed the importance of welcoming the new graduate registered nurses onto the ward and being able to provide emotional support throughout the graduate year, to help each graduate feel a sense of belonging. Each graduate progressed within the clinical environment however, senior nurses believed that the graduates who failed to show any clinical progression did not gain a sense of belonging. Shorter rotations also appeared to affect a new graduate registered nurses' ability to obtain a sense of belonging within a clinical area.

## **Theme 4.0: Transference of knowledge**

Transference of knowledge is the fourth theme to emerge from the senior nurses' interviews. According to the senior nurses, understanding how knowledge was shared transferred and assimilated was important. The senior nurses discussed the availability

and structure of the education sessions which varied throughout the regions and between regional and districts hospitals. The graduate nurse coordinators were tasked with organising the 5-6 structured study days, and many discussed the need for graduates to travel to regional facilities to complete this training. Completion of the graduate program education assessments were considered a strong indication of how well a new graduate registered nurse had progressed. The district hospitals and one regional hospital did not have dedicated staff development nurses so many discussed the role of the education portfolio holder. A senior nurse with the education portfolio was responsible for the ongoing professional development in their smaller district areas. The education opportunities discussed within these areas varied and often depended on the proactive nature of the nursing staff. The three sub-themes identified for this theme: 4.1 There is more than one way; 4.2 Making the best of what you have; and 4.3 Minimum education requirements.

#### **4.1 *There is more than one way***

The sub-theme ‘there is more than one way’ relates to senior nurses understanding the benefits to graduates, if different learning methods were applied to the transference of the knowledge needed to practice as a registered nurse. The graduate nurse program was delivered through structured study days with the support of ad hoc education and self-directed on-line learning opportunities. Formats for the study days varied and generally involved a didactic style of presentation. Simulation equipment was also utilised when available and guest speakers were invited to conduct workshops. The senior nurses indicated the new graduate registered nurses really enjoyed the education session if the information shared was relevant to their current clinical practice or a case study, “*they were personally involved in, so it was a really great learning opportunity for them to actually reflect back*” (SN2). The variety of teaching methods, with a mixture of simulation, workshops and didactic presentations, appeared to be well received. One of the senior nurses said, “*we try to get as much as we can in when we’ve got them in person*” (SN6). This comment suggests face-to-face education remained highly valued despite the increased discussions of E-learning expectations in the rural and remote areas.

Education opportunities were scheduled at different times throughout the regions. There was no strict routine or uniform structure. Each senior nurse chose the style and

time they thought best suited the environment. The way structured study days were delivered differed between the graduate programs. Several programs completed all their study days in the first six months so the new graduate registered nurses “*could ... apply the [newly learnt] principles*” (SN3) throughout the year. This concept was repeated on more than one occasion:

*We [used to] spread them across the years, but a couple of years ago we did a big study on that and decided that we will run them in the first three months. Because whoever got the last study day, people are saying oh well we'd really, really have liked to have known that earlier. (SN6)*

Other senior nurses stated they spread the study days over the full 12 months to align with the times the new graduate registered nurses rotated to a new ward or new hospital. The reason for this was to create less disruption on the ward and provide every opportunity for the graduates to attend the allocated study days. “*There's two days, three days at the start, and then we have four days over the year so they're set study days that we run*” (SN1).

A senior nurse who coordinated the study days to align with the shift in rotations, would organise guest speakers, debrief with the graduates, and would “*also ask them what topics they [the graduates] would like in the study day*” (SN7). Several senior nurses said they were happy to tailor the educational content to the topics that the graduates perceived as useful. The majority of senior nurses were happy to keep the study days flexible to accommodate both graduate needs and target topics current within the clinical environment. One of the senior nurses was approached towards the end of the graduate year and asked by some new graduate registered nurses to provide master classes:

*I have gone yeah okay because ...I get that if you are asking I will do it. So they asked me for a night duty survival lecture and shift coordination so I actually get them on some supernumerary shift coordinating at 10-12 months. And the reason I do that is because, not to learn how to shift coordinate because down here they [the grads] would never be allowed to do that. Because they [managers] are very conservative about that, but because they need to know the timing and the way to speak to the shift coordinator... we haven't done it before, so that's a little bit of a trial to see how we go. (SN8)*

The senior nurses believed the new graduate registered nurses felt empowered when they were able to have a say in future education topics.

The method used to deliver the education was considered important. One of the senior nurses talked about a simulation exercise, which mimicked a clinical scenario a small group of graduates had experienced. The lesson was early recognition of a deteriorating patient, “*we run it as a simulation first to see how they would respond*” (SN2). Documentation was a part of the exercise following a debrief session. The graduates would then conduct the scenario again and “*they nail it*” (SN2). The majority of senior nurses spoke of simulation as a great method to transfer the required knowledge:

*So, we use as much simulation equipment as I possibly can with our current resources. They’ll increase when we get our new department building. And it’s based on knowledge I don’t spend half a day covering what they do at Uni – [we] recognised prior learning. (SN4)*

The senior nurses were vocal about inviting guest speakers who specialised in their field and were happy to impart knowledge. One of the senior nurses shared her experience of workshops being conducted as part of the structured study day, which included wound care. “*They do a theoretical component and then they have a break and then they will get pictures of wounds and they are required to write out like a wound care plan*” (SN4). In one of the regional facilities, “*there’s no shortage of people that want to come and give information to the graduates*” (SN9).

Feedback about education content was also discussed by the staff development nurses. A senior nurse who had recently taken over the graduate program shared her view about one of the study days being pitched at too simple a level for graduate registered nurses:

*Some of the topics – it’s a bit undergrad, and I think they’re looking for a little bit more and we should easily be able to offer that. ...So, they’re actually ok – it’s more the content of the last two days, I’ve found, they haven’t really enjoyed. Yeah, which I’m not happy about. (SN1)*

If the feedback was critical, and content was not relevant for the graduates or poorly received, the nurses giving the education “*changed [the content and method] based on the feedback that they provided*” (SN4). The senior nurses responded to the

feedback and changed the way they delivered the education session to suit the graduates' needs. This resulted in positive feedback the next time the education was delivered to the new graduate registered nurses. It was when the educators delivered content in a didactic format "*the feedback is that they prefer the hands-on stuff, as opposed to the lectures*" (SN2) or the majority of content was online, less positive feedback was noted.

Despite the positive feedback with using different styles of education, several senior nurses discussed the attendance at various planned education sessions had been dropping off towards the end of the year. The debriefing session conducted every fortnight in one region was poorly attended throughout the 12-month graduate program. The senior nurses suggested the main reason for this was rostering difficulties, "*they're struggling a bit with um in services education [via videoconference due to remoteness] because of their staffing issues*" (SN9) with not enough staff to cover patient care so a graduate could leave the ward to attend. The senior nurses indicated when education sessions were not compulsory then "*people used to not sort of come – for whatever reason*" (SN6). Graduates within each region consisted of small numbers, and it was often hard to plan an education session for the group as it was difficult to gather them all together at the same time. One suggestion was to try and align the rosters with the education and debriefing times:

*It's been really difficult to capture them, so that's certainly something we're currently developing a programme for next year and improving the study days, and we're working on that at the moment. So that'll be something that we'll set up from the outset of the programme, those catch up fortnightly session, and have it as a programme at the start, so they know so they can actually roster them such to ensure they attend. Whereas at the moment it's very difficult to capture them.*  
(SN1)

The nursing staff including new graduate registered nurses often did not make it to the planned education sessions because they believed their patients were a priority as opposed to making "*educational opportunities a priority*" (SN4). The graduates were often encouraged to attend educational sessions outside of the study days. Attendance and the importance of transferring knowledge was problematic regardless of whether the course was compulsory or not.

## 4.2 *Making the best of what you have*

This subtheme is about making the best of the resources available for assisting with the education of new graduate registered nurses. The senior nurses throughout the regions discussed the lack of educational resources, which involved both staff and equipment. However, many discussions focused on support and guidance provided as education or information was transferred despite the lack of resources.

Senior nurses employed by the health services also assisted with new graduate registered nurse education, although it was not their specific role. The staff development nurses in these areas were busy with their other educational requirements but assisted new graduate registered nurses when they were able:

*So now I do 0.6 of staff development and 0.4 on the ward as paediatrics CN [SN].... So, I always said that I could not do anything with students and grads and what have you because officially I was the staff development nurse for the whole of the [regions name withheld]. So, I had still said I don't, even though I have increased my hours in staff development I don't have time to spend doing stuff with grad nurses. I'm happy to help them when they need it if I'm on the ward or going to see them, but I don't specifically do stuff with them per se for the grad programme. ....but if I'm doing education or they need to know something or they want to do a self-directed learning pack then so then I'm obviously able to help them to do those sort of things and I sit down with them and go through things with them. But really, I'm not actually spending official time with them. (SN11)*

One of the senior nurses indicated that the staff development nurse in her facility was only employed for 0.2 fulltime equivalent and although very passionate about education, this small amount of time did not allow much time for supporting the new graduate registered nurses. “*She loves passing on her knowledge and she comes up with amazing power points so I try and use her as much as I can but 0.2 is pretty hard to find her*” (SN7). This staff development nurse did manage to conduct an education session when rostering and time permitted.

New graduate registered nurses who travelled to attend structured study days were often in contact with the staff development nurse from the regional centres, however the education received was not always relevant in the district areas they travelled from. A senior nurse from a district facility did not think there was “*enough education specific for this site*” (SN15). A method utilised by some senior nurses to combat this



conundrum was to organise and conduct regular ad hoc education sessions specific to the smaller, district hospitals. One staff development nurse proudly spoke about the simulation workshops she offered twice a week. The senior nurses always encouraged the new graduate registered nurses to attend any workshop or in-service run by the ward staff and staff development nurses from their clinical area.

Experienced staff on the wards also relied on the senior nurse to assist new graduate registered nurses gain clinical skills and confidence:

*Some people are more approachable than others and I think we're lucky at the moment that there's quite a few people that would be good to work with and are willing to like take the time to and share skills. But I do also think that that's also, I mean like everybody's got their strengths, I do think some people are probably better taking it slower and going through things and teaching things than others. (SN13)*

A senior nurse from a regional facility reiterated that not all staff were approachable and spoke of the need to change people from working “*in their own silo*” (SN1). The senior nurses believed all registered nurses and health professionals needed to be encouraged to provide education and work closely to support the new graduate registered nurses. For example, “*Our paediatricians will educate on the entire morning ward round. So there's no issues with grads in paediatrics but in ED as I said to you lately there's been a lot of support required [with education needs]*” (SN4). The staff who offered the most education opportunities and who gravitated towards junior nurses to offer support were often approached to become education portfolio holders. “*The grads end up gravitating towards the staff that provide the most support and are the most approachable.*” (SN7)

Experienced registered nurses who embraced the role of educator were sometimes, especially in the district areas, articulated as having an education portfolio. The use of education portfolio holders was a different method to help provide education for all staff on a ward and limit the effects of the lack of resources, such as staff development nurses, in the rural areas. The education portfolio holder registered nurses would sometimes try and focus on site-specific education for all clinical staff:

*They're [education portfolio holders] encouraged to actually provide evidence to their ward about what they have been able to provide, not individually but what they have organised for their wards to have*

*access to, so just recently [for example] we've had general ward have organised the diabetic educators to come and do a couple of sessions around insulin. (SN2)*

The discussions about an education portfolio holder role consisted of helping to ensure all staff were up to date with mandatory requirements. The education portfolio holder was also often the support person for the new graduate registered nurses within the district areas, helping assist graduates attain appropriate clinical skills.

Other educational methods consisted of video conference (VC) and telehealth opportunities. This relatively new technology had started to roll out into the rural and remote areas in 2015. The senior nurses who supported graduates in district and regional facilities would run “two weekly tutorials in the afternoon where they [the graduates] can all VC in” (SN9). This was utilised for study days to save time previously spent travelling from one hospital to another. Telehealth was also used for education of new graduate registered nurses and ward staff. The telehealth facility was used to record or link up in real time to a planned education or in-services held in metropolitan hospitals and telecasted all around the state, “they get recorded if possible and put onto health tube” (SN11). There were several television monitors being placed on all clinical wards. The extra monitors were thought to help reduce the problem of losing nursing staff halfway through a shift to attend or link into an education session, they could remain on the wards in close proximity to patients in case of emergencies:

*[Education is] mainly it's in the form of video conferencing, so we've just managed to get a video conference unit put into the staff room on the general ward, cos that often was a big issue. We've also got one put in into the handover room on the paediatric ward through Scopia and we're doing the same with maternity and the same for theatre. And that's so staff can access like VC's and education like in their own ward areas, the problem is trying to get big numbers off the ward at the one time. So at least even though ideally you don't want them to be interrupted if something happens on the ward the staff are still there, so they can be pulled out if they need to be (SN2).*

The education portfolio holders would alert staff to the educational opportunities especially if the information was relevant to the current clinical events within the hospital. Despite the highlighted limitations in rural areas, there were a number of ways to provide education for all nursing staff.

### 4.3 Minimum education requirements

This sub theme ‘is there a minimum education requirement’, incorporates the educational pathway for new graduate registered nurses to transition to independent registered nurses. The senior nurses spoke about the core competencies that need completing annually by all nursing staff including the graduates, and other skills, which may require validating before graduate nurses being deemed competent to practice independently.

The senior nurses discussed a list of educational achievements expected of all nursing staff. Within the first few months of starting a graduate program, the senior nurses would provide new graduate registered nurses with a list of core competencies and relevant learning packages they were expected to complete. One of the senior nurses shared her experience with using the assessment documents from the toolbox:

*So, it's the toolbox that's online and you can utilise the documents from that. I don't think we require enough of the grads at the moment. So, at the present they need to do one physical assessment, which actually isn't that in-depth. It's like a couple of tick boxes. It doesn't actually demonstrate their knowledge or awareness or ability to do a head-to-toe assessment. (SN1)*

During orientation, the majority of senior nurses spoke of the need to ensure core competencies required by the health service were undertaken. One senior nurse suggested we “go through all the online training, LMS, infection control, all HR stuff, emails and how to do SIMs reports and audits” (SN1). In addition to the mandatory competency assessments, several senior nurses highlighted the additional assessments and expectations incorporated in the new graduate registered nurses’ education program. When describing the assessments, the senior nurses discussed a previous program which required the completion of a graduate certificate in clinical nursing:

*WACHS used to participate in the grad's certificate in clinical nursing through [WA University's name withheld] in a partnership. We have not done that for the last two years... We still maintain that level of program. (SN6)*

The graduate certificate consisted of a number of assignments, both written and observed including written reflections, presentations and a list of core competencies the graduates were expected to attain. Following termination of the graduate certificate

course, the curriculum was kept and incorporated in the Western Australia Country Health Service toolbox, which is an electronic file system accessible to all rural and remote health services. Differences were found in the assessments used by the different health regions as senior nurses could incorporate different parts of the assessments in their graduate programs, “*you can use whatever you like. I think if you looked at it we probably used a little bit more than most*” (SN4).

Senior nurses had different views about how to achieve the assessments provided from the toolbox. More than half of the senior nurses expected the new graduate registered nurses to prepare and complete an oral presentation. The requirements for the presentations varied, one of the senior nurses instructed their group of graduates to complete a five-minute anatomy and physiology presentation in front of fellow graduates. In contrast, other senior nurses expected a little more:

*We ask them at that time to present a safety and quality audit and we sort of support them to do that and they present that to a fairly senior meeting which is usually to the collective DONs and nurse managers from the regional sites, they're the people that would be looking for employees next year. We don't make it easy ...it is just about giving them an opportunity to do a very quick and finite project on their own. So that's about looking at the need to be independent and to do something ... It's at that point where they really want to be independent and do something and complete something and be recognised for something ... So that's like the little pat on the back they get, or the warm fuzzies from it. The managers will look at those projects and ... they will often ask them to present them at ward meetings and they will put them up on the notice board so they will get a bit of really positive feedback from it. (SN8)*

One of the senior nurses who utilised the presentations and physical assessments said that both assessment pieces were lacking in detail, “*They're assessed, and they're graded but it's more just a tick that they've done it*” (SN1). Therefore, the benefits of completing the assessments depended on the senior nurse who coordinated the graduate program. The one requirement all senior nurses agreed with, was the essential skills, or mandatory competencies, otherwise the expectations of how many skills or assessments varied within each region.

The current educational program for the graduates appeared to be in a state of change. Whilst the graduate certificate was a structured process, the funding was no

longer available. The senior nurses who were familiar with and approved the assessments continued to follow the guidelines set within the graduate certificate. The senior nurses who were not familiar with the postgraduate qualification did not see any benefit for the graduates:

*It's not a robust system if there's not a grad certificate [post graduate qualification] offered to the graduates. So we ask them to complete different and various things as part of WACHS health essential training. We sometimes get them to get, to do that graduate diagnostic testing online [part of the grad cert assessment] ...is under review at the moment so I'm not going to get them to do it. So I guess their clinical assessment tool is one of the assessment, they have to do, a summative, a formative and a summative CAT [Continuous assessment tool] assessment. (SN5)*

Graduates were expected to undertake the mandatory training but had additional requirements. Most of these core requirement sessions were undertaken as online competency packages which could only be undertaken while at the health services. This caused difficulties between senior nurses and new graduate registered nurses when working in busy clinical wards as time was not allocated for online training. As one senior nurse stated, “*I would have preferred her to be in theatre doing scrubs/scout kind of stuff than sitting down and doing online training. It's important [online training], but she only gets 10 weeks in theatre*” (SN1). The graduates were not able to complete the online learning activities at home in their own time because the Western Australia Country Health Service toolbox was only available through the workplace-based computers.

The senior nurses discussed a range of clinical skills and competencies they encouraged the new graduate registered nurses to complete within the 12-month graduate program:

*They're obviously encouraged to work, you know concentrate consolidating their clinical skills in their first year, but it is [more or] less up to them ... So, yes, they're encouraged to do those things but not honestly not pressured either. We just want them to obviously get their grounding around the basic nursing care first. (SN2)*

Clinical skill requirements differed between the different programs and sites depending on the need and complexity of each ward requirements. There were few discussions about the clinical skills expected to be completed which included:

medication competency, advanced life support, IV cannulations, and venepuncture. There were a number of different learning packages that the senior nurses said which were related to the appropriate clinical area. A senior nurse would “*give them [the graduates] links to be able to do it or if they’re in a paediatric rotation, I give them a paediatric education package*” (SN5).

Midway through the graduate year, the senior nurses discussed the implementation of a new clinical competency framework, which will be implemented to standardise graduate programs across the Western Australia Country Health Service. It is expected that this framework will replace the current assessment structure and provide a uniform structure to the education delivered across graduate programs in rural and remote Western Australia:

*The idea behind this [clinical competency framework] is its specific for each clinical area, let me find it. Okay it’s the clinical competency framework. ... It’s a document that links policy and education or resources um that are specific to an area and there’s three documents for area. We expect them [graduates] to only complete the first one because that is like the beginning level document. Then their knowledge of that area is based on a level, so we use Benner’s novice to expert. WACHS uses Benners’ levels to determine where the graduates sit. ... From my perspective it’s kind of like balancing, having them balance their requirements of the program their learning needs. ... I think the framework minimises stress associated with identification learning needs because they kind of being, we are kind of hitting every bump along the way already with this new document.*  
(SN4)

The framework is divided into three documents outlining the different levels of development. The first document is mandatory for all nursing staff and records the frequency of clinical competencies achieved and attendance of structured education sessions (SN2). The new graduate is expected to complete all of the required number of competencies indicated in the first document (the beginner’s stage) by the end of the transition year. The second and third documents comprise advanced skills and are often ward specific and may assist with future employment or future promotion:

*So it will provide evidence of learning in a certain clinical area, so if they, if one of them you know, they’re on a speciality rotation or they’re in medical surgical and that’s where they want to go, it will help them kind of identify what they have done cause its structured*

*formalised all titles are the same everywhere across WACHS and if the more of these frameworks are complete in the area um, the higher you know, the managers would see that they would be highly sought after employees. (SN4)*

The new document clearly states what the minimum requirements are for all graduate nurses would be completing the first clinical competency requirements, no matter which region they attended the graduate program.

### ***Summary***

Transference of knowledge is a vital part of the graduate program. Educators were flexible and used a variety of approaches for teaching to cater for health service requirements and graduate learning needs. The new clinical framework was viewed as a positive guideline that would assist in providing consistency across the different clinical sites.

### **Summary of chapter**

This chapter provided the results for the finding from the interviews conducted with senior nurses. The four themes discussed included professional challenges, leadership and management, a sense of belonging and transference of knowledge. The next two chapters, 7 and 8, present the quantitative findings from the new graduate registered nurses and senior nurses' surveys.

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## **CHAPTER 7: New Graduate Registered Nurses View of Graduate Programs in Rural and Remote Western Australia: Quantitative Results**

### **Phase one – New graduate registered nurses**

#### **Introduction**

Chapter 5 and 6 outlined the qualitative findings from interviews with both the new graduate registered nurses and senior nurses. Chapters 7 and 8 present the quantitative findings of the study. This chapter reports the findings from the new graduate registered nurses' survey and is divided into three parts. Part A outlines the new graduate registered nurses' demographics, supportive mechanisms, education, performance management and satisfaction with the graduate program. Part B presents findings related to the new graduate registered nurses' level of self-esteem. Finally, Part C consists of the results of the three opened ended questions from the survey. The following chapter, chapter 8, then presents the quantitative findings from the senior nurses' survey.

#### **Survey completion**

Sixty-eight surveys were completed by new graduate registered nurses, 21 surveys at three months, 28 surveys at seven months and 19 surveys at 11 months (Table 7:1). Of the 56 new graduate registered nurses employed at the beginning of 2015 within the rural and remote regions of Western Australia, 34 (60%) completed at least one round of the survey. Of these, 19 (56%) completed the survey at one time point, nine (26%) new graduate registered nurses completed the survey at two time periods and six (18%) new graduate registered nurses completed the survey at all three time periods. Nine new graduate registered nurses were employed in the midyear intake of which six graduates completed the survey at one time point. The six new graduate registered nurses (66%) were incorporated within the first cohort data set.

The initial data collection resulted in a 32% response rate, 19 graduates from the possible 56 cohort. The highest response rate, 43%, was collected at seven months and the lowest number of participants, 29%, completed in the final data collection.



## PART A

### Demographics

There were a total number of 40 participants: four males (10%) and 36 females (90%) (Table 7:1). The participants were from all the seven regions of Western Australia as described in chapter 1 and had graduated from the four universities in Western Australia offering Nursing bachelor's degrees and universities outside of the state. To ensure confidentiality, the source regions and universities attended by individual nurses have been de-identified with the universities are labelled A-E and regions are listed 1-7.

The majority of respondents came from region 6 (27%), followed by region 1 (17%) and region 4 (17%). In the first three months survey, 28% of new graduate registered nurse participants were from region 4. There were no participants from two of the seven regions during this first data collection period. The majority of participants were from region 6 for the subsequent timeframes. Forty eight percent of the nurses were aged between 20 – 29 years with the minority (2%) being aged between 50 – 59 years of age. The highest number of participants attended university A.

**Table 7:1**      *Demographic characteristics of the participants*

Time period survey conducted	3 months	7 months	11 months	Completed the survey once
<b>Total number</b>	n=21*	n=28*	n=19*	n=40**
<b>Gender</b>				
Male	2 (9%)	2 (7%)	1 (6%)	4 (10%)
Female	19 (91%)	26 (93%)	18 (94%)	36 (90%)
<b>Region</b>				
1	5 (24%)	4 (14%)	2 (10%)	7 (17%)
2	4 (19%)	4 (14%)	3 (16%)	5 (12%)
3	0	2 (7%)	1 (5%)	2 (5%)
4	6 (28%)	3 (10%)	3 (16%)	7 (17%)
5	2 (17%)	4 (14%)	2 (10%)	5 (12%)
6	4 (19%)	7 (25%)	4 (21%)	11 (27%)
7	0	3 (10%)	2 (10%)	3 (7%)
<b>Age Range (years)</b>				
Age group 20 – 29	9 (42%)	13 (46%)	11 (57%)	19 (48%)
Age group 30 – 39	7 (33%)	9 (32%)	5 (26%)	12 (30%)

<b>Time period survey conducted</b>	<b>3 months</b>	<b>7 months</b>	<b>11 months</b>	<b>Completed the survey once</b>
Age group 40 – 49	4 (19%)	6 (21%)	3 (15%)	8 (20%)
Age group 50 – 59	1 (5%)	0	0	1 (2%)
<b><i>University</i></b>				
A	9 (43%)	12 (46%)	7 (39%)	17 (43%)
B	3 (14%)	2 (4%)	4 (22%)	7 (17%)
C	2 (9%)	6 (23%)	3 (17%)	6 (15%)
D	1 (5%)	1 (4%)	1 (6%)	1 (2%)
E	6 (28%)	7 (23%)	4 (17%)	9 (23%)

\* Percentages are as a proportion of the respondents who completed the survey at that time period

\*\* Percentages are as a proportion of the total number of participants

## Choice of hospital

New graduates were asked to indicate why they had chosen the particular hospital for the graduate year from a selection of options listed. New graduates selected multiple reasons why they chose the hospital at which they were completing their graduate program. At three months, the majority of nurses selected their hospital because of the types of rotations offered (86%), for personal reasons (81%), and the hospitals reputation (76%) (Table 7:2). The indicated reason for the choice of hospital was similar at both seven and eleven months.

**Table 7:2**      *Reasons for hospital choice*

Choice of program	3 months (n=21)			7 months (n=28)			11 months (n=19)		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree	Agree	Neutral	Disagree
The hospital has a good reputation	16    76%	4    19%	1    5%	15    54%	10    36%	3    10%	11    58%	8    42%	0    0
The rotations offered were what I wanted	18    86%	3    14%	0    0	21    75%	7    25%	0    0	13    68%	6    32%	0    0
Supportive measures offered to graduate nurses	13    62%	8    38%	0    0	12    43%	9    32%	7    25%	12    63%	3    16%	4    21%
Large regional hospital	11    52%	5    24%	5    24%	20    72%	6    21%	2    7%	12    63%	4    21%	2    10%
Personal reasons	17    81%	3    14%	1    5%	23    83%	2    7%	3    10%	17    94%	2    6%	0    0
Availability of graduate program	14    67%	1    5%	6    28%	21    75%	3    10%	4    15%	11    55%	8    45%	0    0

## **Clinical rotations**

The new graduates rated the value and satisfaction of different rotations provided during their programs. Table 7:3 presents data related to both the perceived value of the different rotations offered and the overall satisfaction of the new graduate registered nurses with the rotations allocated throughout the 12-month program. Not all new graduates undertook every rotation so the number of respondents for each rotation varied. For the first three months, the general medical/surgical ward, emergency department, and paediatric ward were rated as the most valuable rotations. The following Table 7:3, indicates how the value placed on a clinical rotation compared with the satisfaction new graduate registered nurses had with the rotation. The majority of placements were seen as valuable and new graduate registered nurses indicated they were satisfied with the clinical placements regardless of where they occurred throughout the graduate year. The highest rated placement was the medical/surgical ward and the lowest rated placement was other. Other clinical placements areas included mental health, dialysis or maternity clinical rotations.

**Table 7:3**      *Graduates level of satisfaction and perception of the value for all rotations*

EMERGENCY												
Level of satisfaction	Not valuable			Neutral			Valuable			Total		
Months	3	7	11	3	7	11	3	7	11	3	7	11
Not Satisfied	0	0	0	0	0	0	0	1	1	0	1 (7%)	1 (9%)
Neutral	0	0	0	0	1	0	2	2	2	2 (17%)	3 (22%)	2 (18%)
Satisfied	1	0	1	0	2	0	9	8	7	10 (83%)	10 (71%)	8 (73%)
TOTAL	1 (8%)	0	1 (9%)	0	3 (22%)	0	11 (92%)	11 (78%)	10 (91%)	12 (100%)	14 (100%)	11 (100%)

PAEDIATRICS												
Level of satisfaction	Not valuable			Neutral			Valuable			Total		
Months	3	7	11	3	7	11	3	7	11	3	7	11
Not Satisfied	1	0	0	0	2	0	0	0	0	1 (8%)	2 (15%)	0
Neutral	0	1	0	0	1	1	2	2	1	2 (17%)	4 (30%)	2 (18%)
Satisfied	0	0	0	3	2	0	6	7	9	9 (75%)	7 (53%)	9 (82%)
TOTAL	1 (8%)	1 (8%)	0	3 (25%)	3 (23%)	1 (9%)	8 (67%)	9 (69%)	10 (91%)	12 (100%)	13 (100%)	11 (100%)

GENERAL MED/SURGICAL												
Level of satisfaction	Not valuable			Neutral			Valuable			Total		
Months	3	7	11	3	7	11	3	7	11	3	7	11
Not Satisfied	0	1	1	0	0	0	1	1	1	1 (5%)	2 (8%)	2 (11%)
Neutral	0	0	0	0	1	0	2	5	2	2 (11%)	6 (23%)	2 (11%)
Satisfied	0	0	0	0	0	0	16	18	14	16 (84%)	18 (69%)	14 (78%)
TOTAL	0	1 (4%)	1 (6%)	0	1 (4%)	0	19 (100%)	24 (92%)	17 (94%)	19 (100%)	26 (100%)	18 (100%)

THEATRE															
Level of satisfaction	Not valuable			Somewhat valuable			Neutral			Valuable			Total		
Months	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11
Not Satisfied	0	0	0	0	0	0	0	2	0	0	0	0	0	2 (20%)	0
Neutral	2	0	0	0	1	0	0	0	1	0	1	1	2 (25%)	2 (20%)	2 (29%)
Satisfied	0	1	1	0	0	2	1	1	0	5	4	2	6 (75%)	6 (60%)	5 (71%)
TOTAL	2 (25%)	1 (10%)	1 (14%)	0	1 (10%)	2 (28%)	1 (12%)	3 (30%)	1 (14%)	5 (63%)	5 (50%)	3 (44%)	8 (100%)	10 (100%)	7 (100%)

COMMUNITY												
Level of satisfaction	Not valuable			Somewhat valuable			Neutral			Valuable		
<i>Months</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>
Not Satisfied	0	0	0	0	1	0	0	1	0	0	0	0
Neutral	1	0	0	0	1	0	0	2	2	1	0	0
Satisfied	1	1	1	0	0	1	2	1	2	3	3	1
<b>TOTAL</b>	<b>2</b> (25%)	<b>1</b> (10%)	<b>1</b> (14%)	<b>0</b>	<b>2</b> (20%)	<b>1</b> (14%)	<b>2</b> (25%)	<b>4</b> (40%)	<b>4</b> (58%)	<b>4</b> (50%)	<b>3</b> (30%)	<b>1</b> (14%)

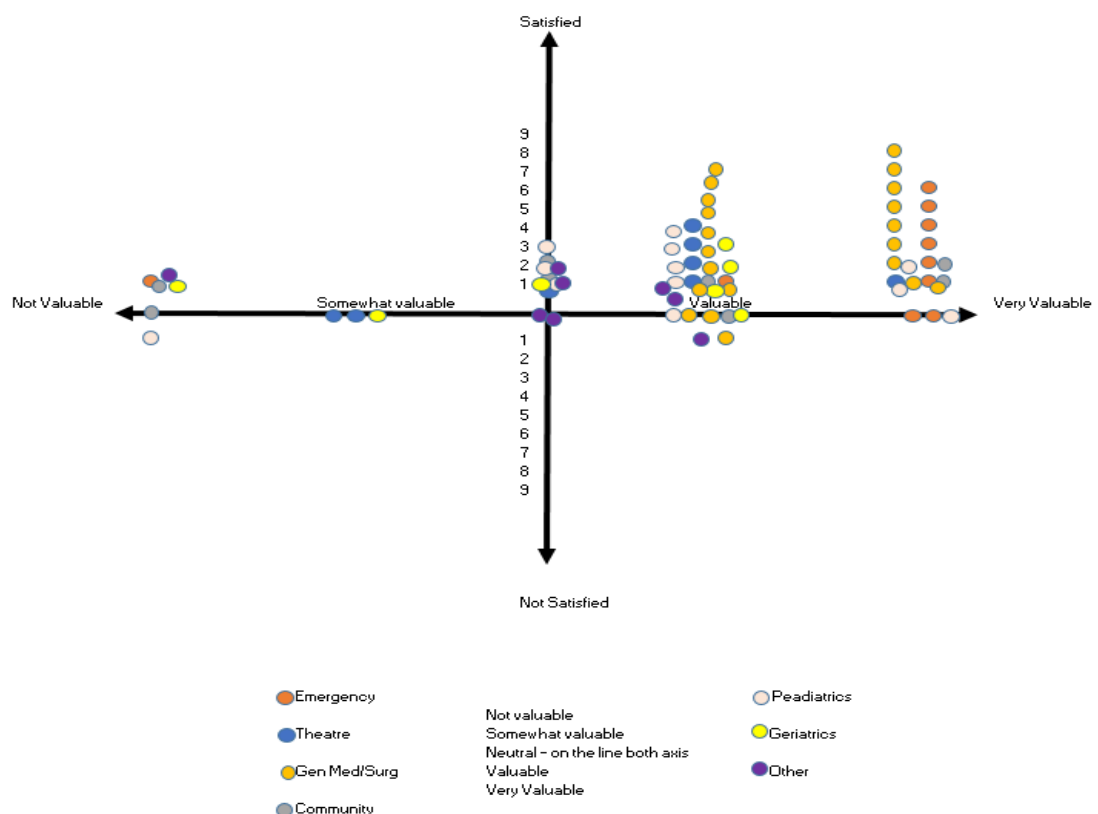
GERIATRICS												
Level of satisfaction	Not valuable			Somewhat valuable			Neutral			Valuable		
<i>Months</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>	<i>3</i>	<i>7</i>	<i>11</i>
Not Satisfied	0	0	0	0	1	0	0	1	0	0	0	0
Neutral	0	0	0	1	0	0	0	2	1	1	2	1
Satisfied	1	2	1	0	0	1	1	2	3	3	3	0
<b>TOTAL</b>	<b>1</b> (13%)	<b>2</b> (16%)	<b>1</b> (14%)	<b>1</b> (13%)	<b>1</b> (8%)	<b>1</b> (14%)	<b>1</b> (14%)	<b>5</b> (38%)	<b>4</b> (58%)	<b>4</b> (60%)	<b>5</b> (38%)	<b>1</b> (14%)

OTHER															
Level of satisfaction	Not valuable			Somewhat valuable			Neutral			Valuable			Total		
Months	3	7	11	3	7	11	3	7	11	3	7	11	3	7	11
Not Satisfied	0	1	0	0	0	0	0	1	0	1	0	1	1 (13%)	2 (18%)	1 (12%)
Neutral	0	1	0	0	0	0	2	3	1	0	0	1	2 (25%)	4 (36%)	2 (25%)
Satisfied	1	1	1	0	0	2	2	1	0	2	3	2	5 (62%)	5 (46%)	5 (63%)
TOTAL	1 (13%)	3 (27%)	1 (12%)	0	0	2 (25%)	4 (50%)	5 (46%)	1 (12%)	3 (37%)	3 (27%)	4 (50%)	8 (100%)	11 (100%)	8 (100%)

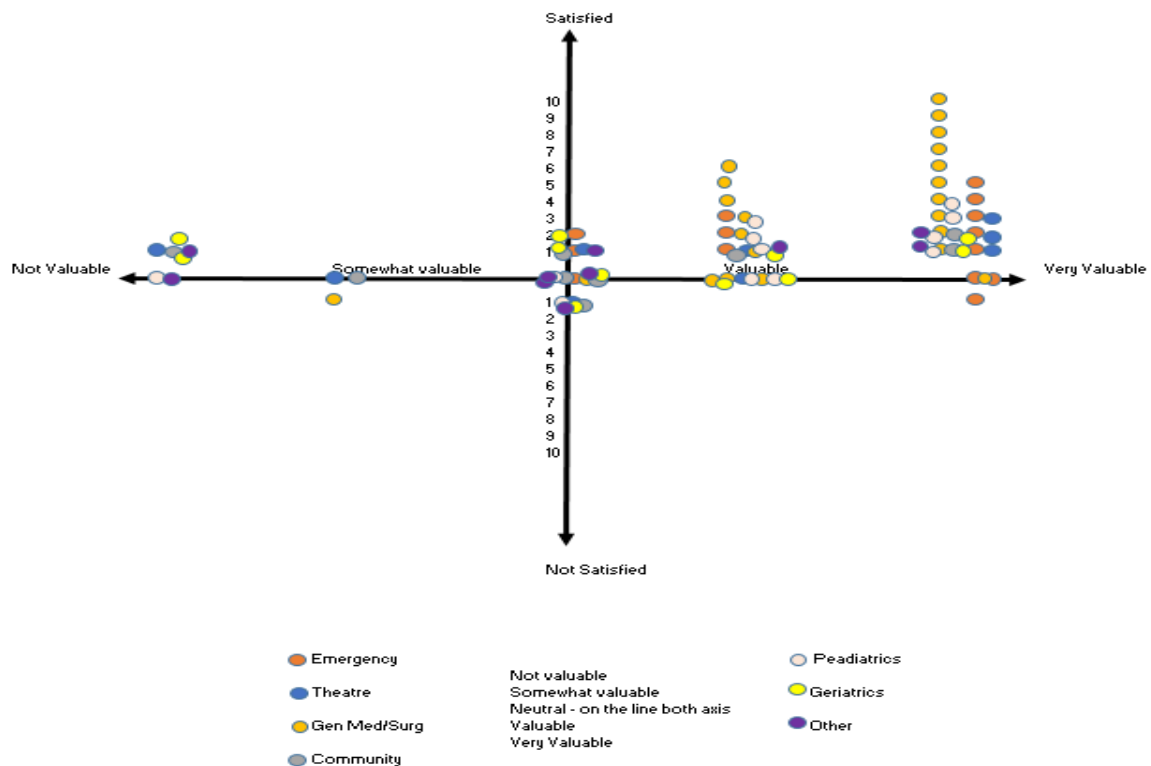


## Value placed on each clinical rotation and new graduate registered nurses' level of satisfaction

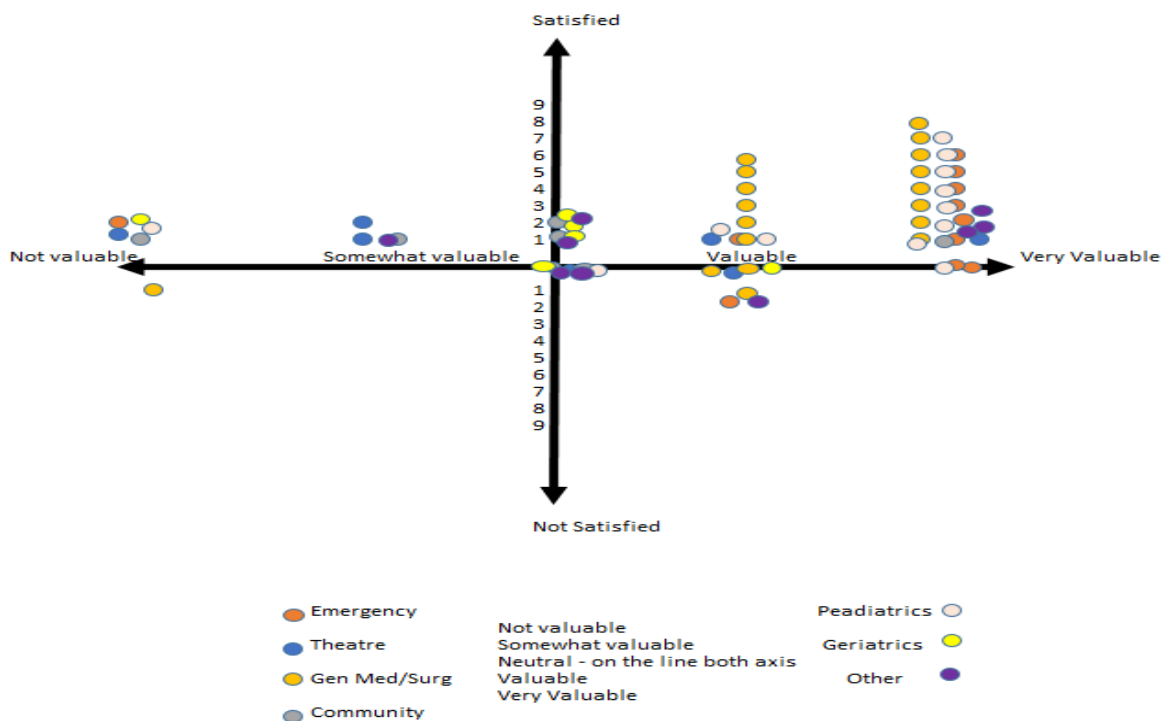
Cartesian graphs were developed to demonstrate the relationship between new graduate registered nurses' satisfaction with a clinical rotation and how valuable they felt the placement was for them as developing nurses in their graduate year. As Figure 7:1 demonstrates, at three months, the majority of participating new graduate registered nurses were satisfied with their clinical rotations and found them valuable or very valuable. At each of the three time frames the majority of graduates rated the general/medical ward as valuable and were satisfied with the rotation. At three and 11 months the emergency department was considered valuable, however the focus was less significant for this department at seven months. At 11 months the paediatrics rotation was considered valuable.



**Figure 7:1** Value of clinical rotations and level of satisfaction with the rotations: Three months



**Figure 7:2** Value of clinical rotations and level of satisfaction with the rotations:  
Seven months



**Figure 7:3** Value of clinical rotations and level of satisfaction with the rotations:  
11 months

## **Supportive mechanisms**

Participants were asked about the supportive mechanisms that were in place to assist with their transition to working as a registered nurse. These supportive mechanisms included regular study days, supernumerary time, time with nurse educators, and time with preceptors. Each element was measured by the new graduate registered nurses for level of satisfaction.

## **Supernumerary time**

The majority of participants received four or more supernumerary shifts for their first clinical placement Table 7:4. The greater number of supernumerary shifts provided, the greater the satisfaction rating. In contrast, one graduate who was not offered supernumerary time also indicated their overall satisfaction with the supernumerary time. Due to the low numbers, statistical analysis of the relationship between the number of supernumerary shifts and new graduate registered nurse satisfaction was unable to be undertaken.

**Table 7:4**     *New graduate registered nurses' level of satisfaction with supernumerary time*

Time	3 months (n=21)						7 months (n=28)						11 months (n=19)					
	Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied	
0 shifts	1	5%	0	0	0	0	0	0	1	4%	0	0	0	0	0	0	0	0
1 shift	2	10%	0	0	1	5%	0	0	0	0	2	8%	1	5%	0	0	1	5%
2 shifts	5	24%	1	5%	0	0	10	36%	1	4%	1	4%	5	28%	0	0	1	5%
3 shifts	0	0	1	5%	0	0	1	4%	1	4%	1	4%	1	5%	1	5%	0	0
4 or more shifts	7	33%	2	10%	1	5%	6	21%	3	11%	0	0	3	16%	2	10%	0	0
<b>TOTAL</b>	<b>15</b>	<b>71%</b>	<b>4</b>	<b>19%</b>	<b>2</b>	<b>10%</b>	<b>17</b>	<b>61%</b>	<b>6</b>	<b>23%</b>	<b>4</b>	<b>16%</b>	<b>10</b>	<b>54%</b>	<b>3</b>	<b>15%</b>	<b>2</b>	<b>10%</b>

## Graduates experience of preceptorship

Preceptorship is a supportive measure involving one-on-one support. New graduate registered nurses who received preceptorship ranged in satisfaction from very unsatisfied to very satisfied, with the majority of participants appearing satisfied (Table 7.5). However, not all new graduate registered nurses received preceptorship as part of their graduate program. Similarly, those new graduate registered nurses who did not receive preceptorship ranged from being very dissatisfied to very satisfied, indicating that support for the new graduate registered nurse may have been available from other methods.

**Table 7:5** *New graduate registered nurses availability of preceptorship and level of satisfaction*

Graduates satisfaction level of preceptorship and number of graduates who received preceptorship					
Preceptorship offered	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<b>3 months</b>					
yes	1 (5%)	3 (15%)	2 (10%)	6 (30%)	5 (25%)
no	1	0	2	0	0
<b>7 months</b>					
yes	0	5 (18%)	3 (10%)	4 (14%)	2 (7%)
no	1	5	6	1	1
<b>11 months</b>					
yes	0	2 (10.5%)	3 (16%)	6 (31.5%)	1 (5%)
no	1	3	3	0	0

Preceptorship ranged from one week to over eight weeks depending on the placement (Table 7:6). Surprisingly, graduates who received eight weeks of preceptorship appeared less satisfied with the placement than graduates who received shorter preceptorship periods.

The number of shifts per week offered to new graduates for preceptorship appeared to influence the new graduate registered nurses' level of satisfaction (Table 7:7). New graduates offered low numbers of shifts to work with preceptors expressed more dissatisfaction with preceptorship than students with higher numbers of shifts to work with preceptors, with more dissatisfaction expressed by students at the 7 and 11-month data collection periods.

**Table 7:6**      *Level of satisfaction with number of weeks' new graduate registered nurses were offered preceptorship*

Time	3 months (n=17)			7 months (n=17)			11 months (n=15)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
<1-2 weeks	7    41%	2    12%	2    12%	3    18%	3    18%	4    24%	3    21%	2    13%	4    26%
> 2-4 weeks	1    6%	0    0	0    0	3    18%	0    0	0    0	0    0	2    13%	0    0
> 4-6 weeks	2    12%	0    0	0    0	0    0	0    0	0    0	1    7%	0    0	0    0
>6-8 weeks	0    0	0    0	0    0	2    12%	0    0	0    00	1    7%	0    0	0    0
>8 weeks	1    6%	0    0	2    12%	0    0	0    0	2    12%	2    13%	0    0	0    0
<b>TOTAL</b>	<b>11   64%</b>	<b>2    12%</b>	<b>4    24%</b>	<b>8    47%</b>	<b>3    18%</b>	<b>6    35%</b>	<b>7    48%</b>	<b>4    26%</b>	<b>4    26%</b>

**Table 7:7**      *Level of satisfaction with number of shifts new graduate registered nurses were offered preceptorship*

Time	3 months (n=18)			7 months (n=19)			11 months (n=15)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
<1-2 shifts	2    11%	1    6%	1    6%	0    0	2    10%	7    37%	0    0	1    7%	2    13%
>2-4 shift	1    6%	0    0	1    6%	1    5%	1    5%	0    0	1    7%	2    13%	2    13%
>4-6 shifts	3    15%	1    6%	0    0	4    20%	0    0	1    5%	4    27%	1    7%	0    0
>6-8 shifts	2    11%	1    6%	1    6%	1    5%	0    0	0    0	0    0	0    0	0    0
> 8 shifts	3    15%	0    0	1    6%	2    10%	0    0	0    0	2    13%	0    0	0    0
<b>TOTAL</b>	<b>11   58%</b>	<b>3    18%</b>	<b>4    24%</b>	<b>8    42%</b>	<b>3    16%</b>	<b>8    42%</b>	<b>7    47%</b>	<b>4    27%</b>	<b>3    26%</b>

### **A graduate's involvement with the graduate nurse program coordinator**

The number of hours new graduates were able to spend with the graduate nurse coordinator also appears to influence satisfaction. New graduate registered nurses who spent less time with the graduate nurse coordinator rated their satisfaction lower than new graduates who were able to spend more time with the graduate nurse coordinator. Dissatisfaction with the smaller number of hours the graduate nurse coordinator was able to spend with new graduate registered nurses appeared to increase with the seven and 11 survey periods (Table 7:8).

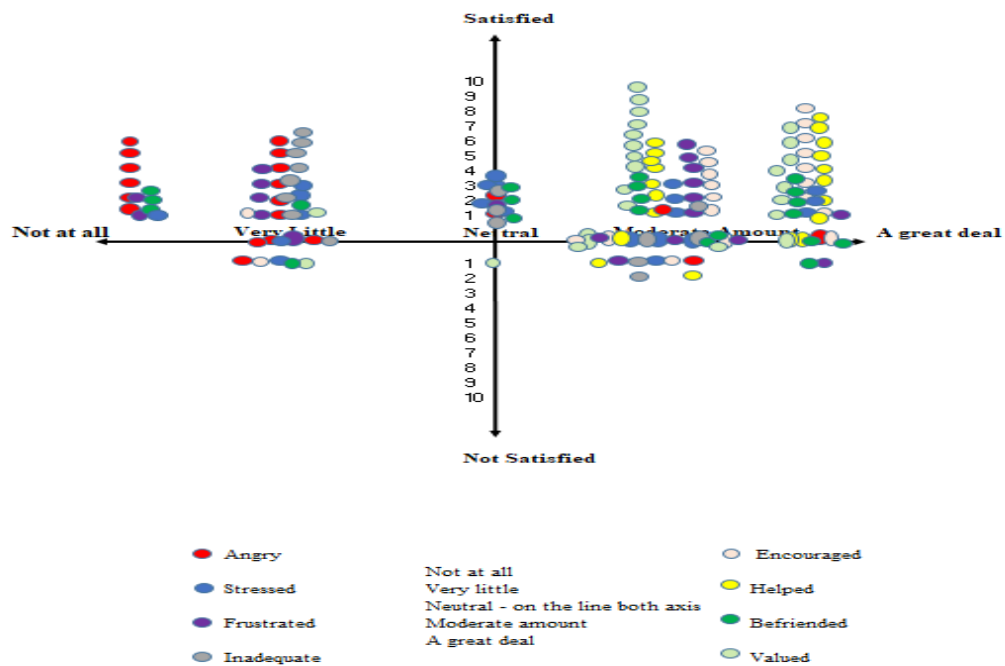
**Table 7:8**      *The level of satisfaction with time spent with the graduate nurse coordinator*

Time	3 months (n=18)			7 months (n=27)			11 months (n=18)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
> 0-1 hour/week	5    28%	3    17%	3    17%	5    18%	5    18%	10   37%	5    27%	1    6%	8    44%
> 1-2 hours/week	6    33%	0    0	0    0	3    11%	1    4%	2    8%	2    11%	0    0	1    6%
> 3-4 hours/week	1    5%	0    0	0    0	0    0	0    0	0    0	0    0	1    6%	0    0
> 5-6 hours/week	0    0	0    0	0    0	0    0	0    0	0    0	0    0	0    0	0    0
> 7 hours/week	2    10%	0    0	0    0	1    4%	0    0	0    0	0    0	0    0	0    0
<b>TOTAL</b>	<b>14   66%</b>	<b>3    17%</b>	<b>3    17%</b>	<b>9    33%</b>	<b>6    22%</b>	<b>12   45%</b>	<b>7    38%</b>	<b>2    12%</b>	<b>9    50%</b>



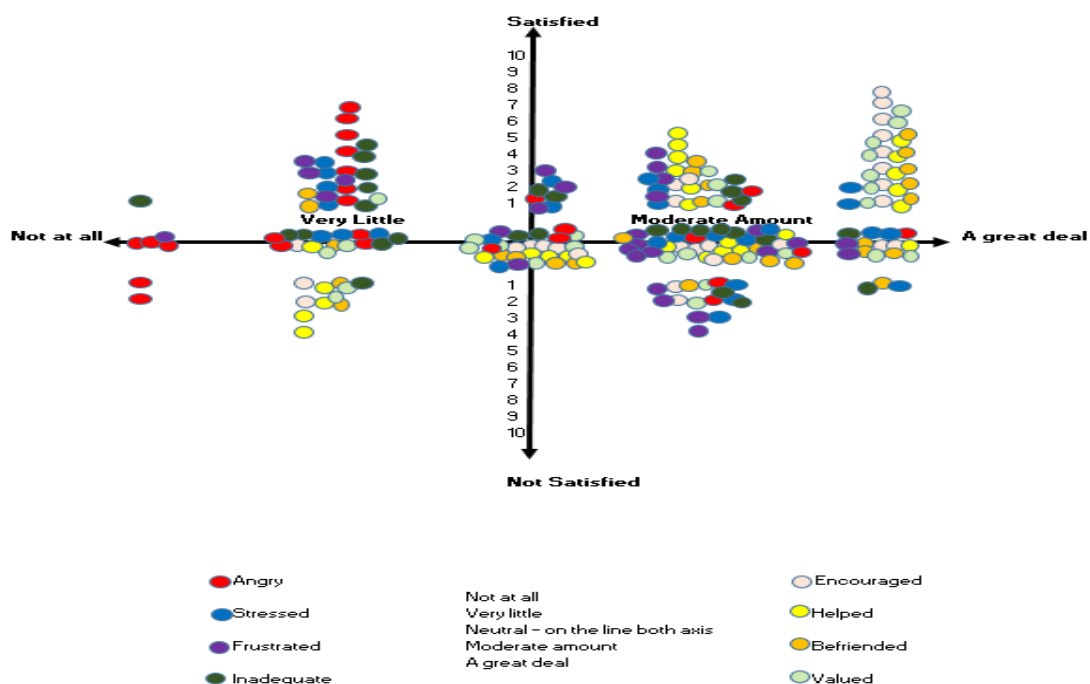
## Support – Range of emotions

New graduates displayed a range of emotions at the three month survey, but regardless of whether the emotion was positive (valued, helped, encouraged, and befriended) or negative (angry, frustrated, stressed, and inadequate) 72% of new graduate registered nurses felt satisfied with the support received during the program (Figure 7:4).



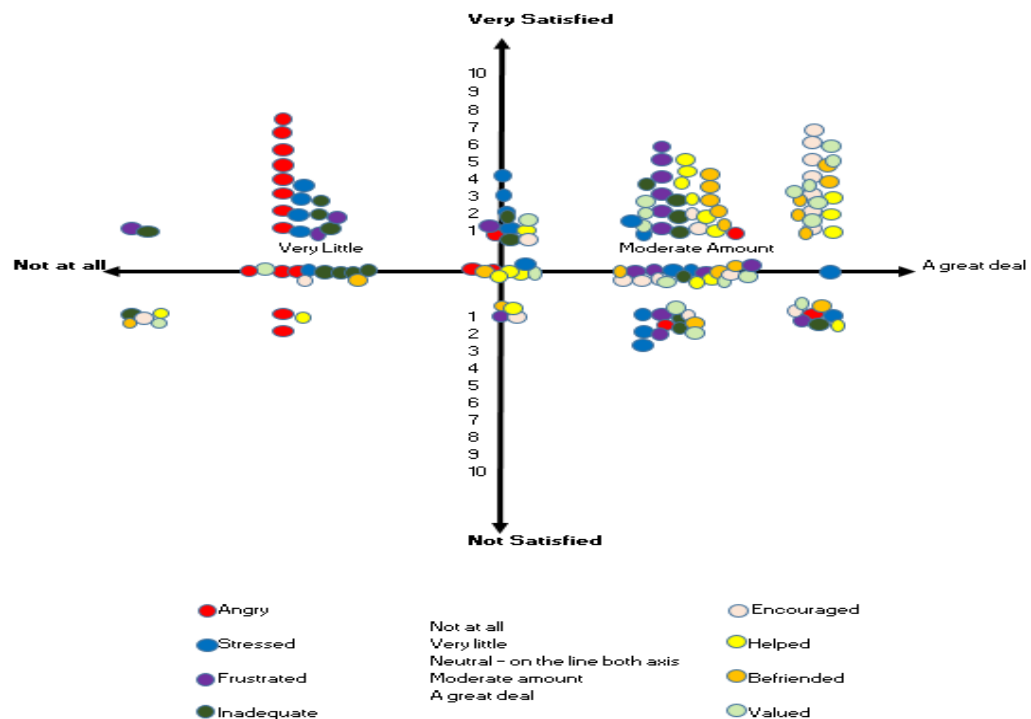
**Figure 7:4** *How often emotions were felt by the new graduate registered nurses in relation to overall satisfaction with the support received within the graduate program at three months*

At seven months the mood of new graduate registered nurse participants appeared to shift with (n=46%) graduates neither satisfied nor dissatisfied with the support received and indicated a mix of both negative and positive emotions. Graduates who were satisfied with the support received (n=39%) displayed positive emotions a lot more often than negative emotions such as anger and feeling inadequate. Graduate nurses who were dissatisfied (n=15%) with the support indicated negative emotions more often than positive (Figure 7:5).



**Figure 7:5** *How often feelings was felt by the new graduate registered nurses in relation to overall satisfaction with the support received within the graduate program at seven months*

At 11 months the graduates again indicated a greater level of satisfaction with the support provided. Anger was an emotion rarely experienced and the greater the positive emotions, the greater the satisfaction with the support received. There was a moderate amount (68%) of frustration felt by the new graduates despite them being satisfied with the support received (Figure 7:6).



**Figure 7:6** *How often feelings were felt by the new graduate registered nurses in relation to overall satisfaction with the support received within the new graduate registered nurse program at 11 months*

Overall, throughout the 12-month graduate program the majority of graduates did experience a range of positive emotions. Whilst emotions initially were mainly positive, there were less positive emotions during the second data collection period. New graduate registered nurses reported experiencing mostly positive emotions at the end of the graduate year. The new graduate registered nurses were more likely to be frustrated and less likely to be angry throughout the 12-month program.

### Approachability of staff

In association with the support received the graduates were asked how often they felt nursing staff were approachable. The approachability of staff appeared to decrease slightly during the year and new graduate registered nurses reported less satisfaction with the support received at 7 and 11 months (Table 7:9).

**Table 7:9**      *How often new graduate registered nurses felt that staff were approachable in relation to the level of satisfaction with the support received*

Frequency	3 months (n=21)						7 months (n=27)						11 months (n=19)					
	Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied	
Not at all	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Very little	0	0	0	0	0	0	0	0	0	0	2	7%	0	0	0	0	0	0
Neutral	0	0	0	0	0	0	0	0	3	11%	1	4%	0	0	3	11%	2	11%
Moderate amount	10	48%	2	9%	1	5%	5	18%	7	26%	1	4%	6	33%	3	17%	0	0
A great deal	5	24%	2	9%	1	5%	6	22%	2	7%	0	0	4	22%	0	0	1	6%
<b>TOTAL</b>	<b>15</b>	<b>71%</b>	<b>4</b>	<b>19%</b>	<b>2</b>	<b>10%</b>	<b>11</b>	<b>42%</b>	<b>10</b>	<b>37%</b>	<b>4</b>	<b>15%</b>	<b>10</b>	<b>55%</b>	<b>5</b>	<b>28%</b>	<b>3</b>	<b>17%</b>

### **Length of time taken to be part of the team**

New graduate registered nurses were asked to indicate, given a choice of timeframes, how long it took for them to feel as if they were part of the team, indicating they felt comfortable and/or useful within their environment. At three months the majority of graduates suggested that it took 4-6 weeks for them to feel part of the team. This timeframe decreased at seven months with new graduate registered nurses reporting that it took 2-4 weeks to feel like they belonged in the team. Surprisingly, at 11 months the majority of new graduate registered nurses indicated it took longer than previously, between 6-8 weeks to feel part of the team. The graduate's satisfaction level with the support received to feel part of the team decreased over time, with greater dissatisfaction expressed at 11 months (Table 7:10).

### **Satisfaction with theoretical modules within the graduate program**

The new graduate registered nurses were asked how much theory they were provided with during the program, and if they were satisfied with the time allocated to the theory component within the graduate program. The time allocated for delivery of theoretical content remained consistent at each of the three intervals. However, the theory may be in service and ad hoc sessions as opposed to being focused on structured study days within the program. Satisfaction with the theory component was relatively similar at both three and seven months, although the level of satisfaction decreased at 11 months (Table 7:11).

**Table 7:10** *Graduates satisfaction level of support received in relation to the time taken to feel part of the team*

Time	3 months (n=21)						7 months (n=27)						11 months (n=19)					
	Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied	
<1-2 weeks	3	14%	0	0	0	0	4	15%	2	7%	1	4%	1	5%	0	0	0	0
> 2-4 weeks	5	24%	2	9%	0	0	3	11%	5	19%	0	0	3	15%	0	0	0	0
> 4-6 weeks	4	19%	1	5%	1	5%	3	11%	0	0	1	4%	1	5%	3	15%	1	5%
>6-8 weeks	2	9%	1	5%	0	0	2	7%	0	0	0	0	5	25%	0	0	2	10%
>8 weeks	1	5%	0	0	1	5%	3	11%	2	7%	1	4%	0	0	2	10%	1	5%
<b>TOTAL</b>	<b>15</b>	<b>71%</b>	<b>4</b>	<b>19%</b>	<b>2</b>	<b>10%</b>	<b>15</b>	<b>55%</b>	<b>9</b>	<b>33%</b>	<b>3</b>	<b>12%</b>	<b>10</b>	<b>55%</b>	<b>5</b>	<b>25%</b>	<b>4</b>	<b>20%</b>

**Table 7:11** *Graduates satisfaction level in relation to the amount of time theory was provided*

Time	3 months (n=18)						7 months (n=28)						11 months (n=16)					
	Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied	
< 8 hours	1	5%	1	5%	0	0	1	4%	1	4%	2	7%	0	0	0	0	2	7%
> 8-24 hours	3	17%	2	11%	0	0	2	7%	2	7%	0	0	3	18%	1	7%	0	0
> 24-40 hours	5	28%	1	5%	1	5%	8	28%	2	7%	0	0	3	18%	2	14%	2	14%
> 40-60 hours	3	17%	0	0	1	5%	6	21%	1	4%	0	0	2	14%	0	0	1	7%
More than 60 hours	0	0	0	0	0	0	3	11%	0	0	0	0	0	0	0	0	0	0
<b>TOTAL</b>	<b>12</b>	<b>67%</b>	<b>4</b>	<b>22%</b>	<b>2</b>	<b>11%</b>	<b>20</b>	<b>71%</b>	<b>6</b>	<b>22%</b>	<b>2</b>	<b>7%</b>	<b>8</b>	<b>50%</b>	<b>3</b>	<b>21%</b>	<b>5</b>	<b>28%</b>

## **Experience with performance management processes**

The graduates were asked when they had received performance management throughout the 12 months and how satisfied were, they with the process. The satisfaction level with the performance management appeared to decrease during the year (Table 7:12).

## **Overall satisfaction with the graduate program**

The new graduates' overall satisfaction with the graduate program was reviewed in conjunction with both the regions and universities the graduates attended. Both tables (7:13 and 7:14) reflect that the level of satisfaction was the highest at three months and lowest at seven months regardless of which university or region the new graduate registered nurses were from, indicating the transition experience was similar for all the new graduates. Students from universities outside of Western Australia expressed higher dissatisfaction at three months, with satisfaction decreasing over the graduate year higher for new graduates from one university.

**Table 7:12** *New graduate registered nurses' satisfaction with the performance management received*

Time	3 months (n=19)			7 months (n=27)			11 months (n=19)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
1-3 months	7 37%	1 5%	0 0	9 33%	7 26%	0 0	5 26%	1 5%	1 5%
4-6 months	7 37%	3 16%	1 5%	7 26%	0 0	2 7%	4 21%	3 16%	1 5%
7-9 months	0 0	0 0	0 0	1 4%	0 0	0 0	0 0	1 5%	1 5%
9-12 months	0 0	0 0	0 0	0 0	0 0	1 4%	1 5%	0 0	1 5%
<b>TOTAL</b>	<b>14 74%</b>	<b>4 21%</b>	<b>1 5%</b>	<b>17 63%</b>	<b>7 26%</b>	<b>3 11%</b>	<b>10 52%</b>	<b>5 26%</b>	<b>4 20%</b>

**Table 7:13** *Graduate level of satisfaction with the graduate program in each region*

Region	3 months (n=20)			7 months (n=28)			11 months (n=19)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
One	4 20%	0 0	1 5%	0 0	3 11%	1 3%	2 11%	0 0	0 0
Two	4 20%	0 0	0 0	4 14%	0 0	0 0	2 11%	0 0	1 5%
Three	0 0	0 0	0 0	1 3%	1 3%	0 0	1 5%	0 0	0 0
Four	5 25%	1 5%	0 0	3 11%	1 3%	0 0	4 22%	1 5%	0 0
Five	2 10%	0 0	0 0	2 7%	1 3%	1 3%	1 5%	0 0	1 5%
Six	2 10%	1 5%	0 0	4 14%	1 3%	2 7%	1 5%	2 11%	1 5%
Seven	0 0	0 0	0 0	1 3%	2 7%	0 0	1 5%	1 5%	0 0
<b>TOTAL</b>	<b>17 85%</b>	<b>2 10%</b>	<b>1 5%</b>	<b>15 53%</b>	<b>9 32%</b>	<b>4 14%</b>	<b>12 63%</b>	<b>4 21%</b>	<b>3 15%</b>

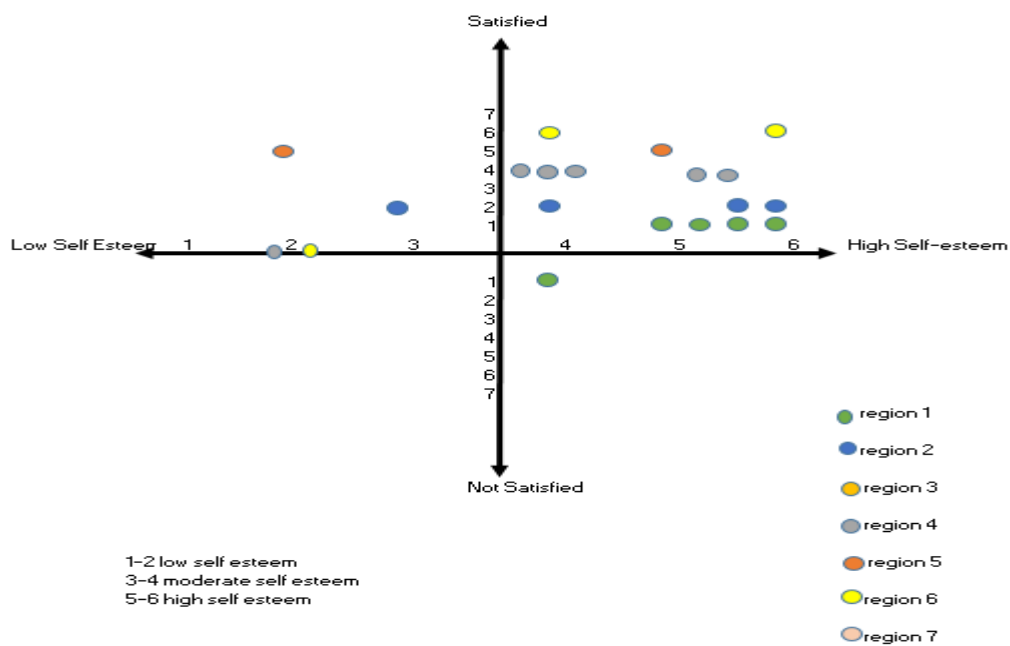


**Table 7:14 Graduate level of satisfaction with the graduate program from each university**

University	3 months (n=20)						7 months (n=28)						11 months (n=19)					
	Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied		Satisfied		Neutral		Dissatisfied	
A	6	30%	1	5%	0	0	8	29%	2	7%	2	7%	2	11%	3	15%	2	11%
B	3	15%	1	5%	0	0	1	4%	1	4%	0	0	3	15%	1	6%	0	0
C	2	10%	0	0	0	0	3	10%	3	10%	0	0	3	15%	0	0	0	0
D	1	5%	0	0	0	0	1	4%	0	0	0	0	1	6%	0	0	0	0
E	5	25%	0	0	1	5%	2	7%	3	10%	2	7%	3	15%	0	0	1	6%
<b>TOTAL</b>	<b>17</b>	<b>85%</b>	<b>2</b>	<b>10%</b>	<b>1</b>	<b>5%</b>	<b>15</b>	<b>54%</b>	<b>9</b>	<b>31%</b>	<b>4</b>	<b>14%</b>	<b>12</b>	<b>62%</b>	<b>4</b>	<b>21%</b>	<b>3</b>	<b>17%</b>

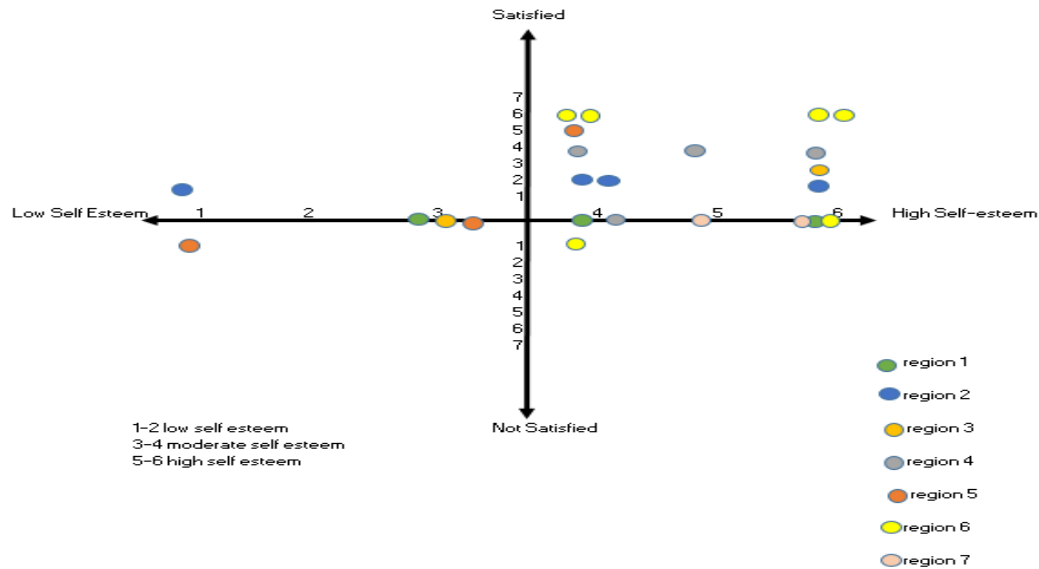
## PART B – Self-esteem and overall level of satisfaction with graduate program

The self-esteem scale was reviewed in relation to the new graduate registered nurse's overall satisfaction level of the graduate program. The level of self-esteem was compared to the satisfaction level of new graduate registered nurses. In the three-month survey, 10 (55%) participating graduates indicating they had high self-esteem and were satisfied with the graduate program (Figure 7:7).



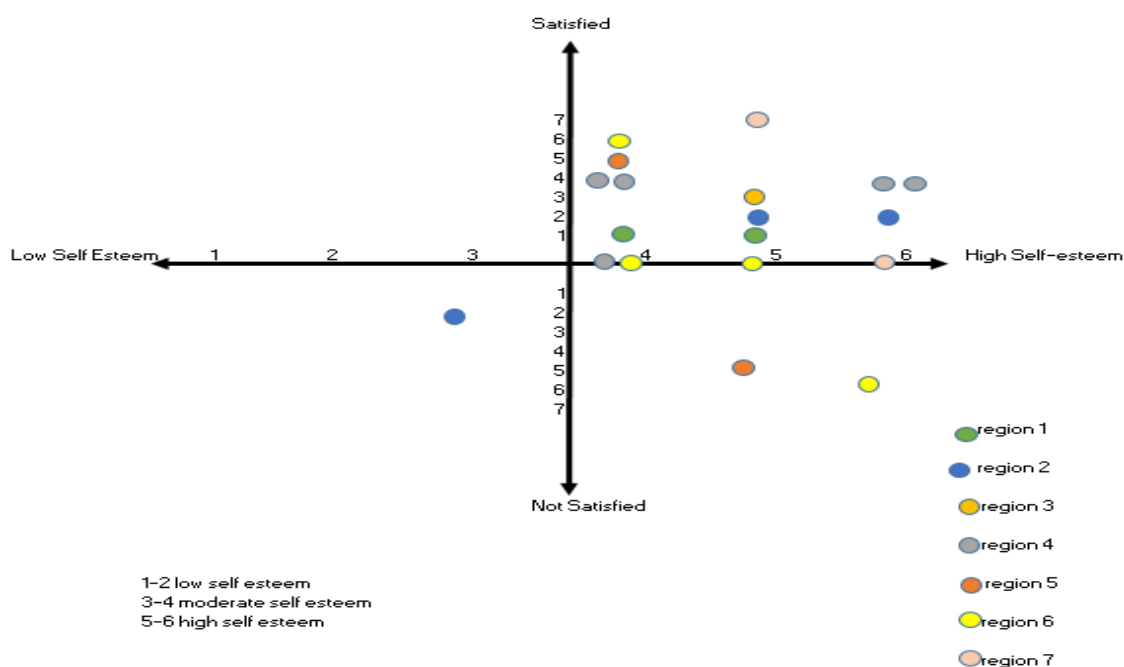
**Figure 7:7** *New graduate registered nurses' satisfaction level of the graduate program in relation to their level of self-esteem: Three months*

The remaining 24 graduates at seven months, self-esteem and level of satisfaction with the graduate program was plotted in (Figure 7:8). The number of graduates with high self-esteem had dropped at the seven-month period to 10 (41%) graduates and, six of these 10 were satisfied with the graduate program. The number of graduates reporting low self-esteem remained the same. The number of graduates reported moderate self-esteem increased by 8.3% (n=12). The level of satisfaction with the program of all graduates overall had decreased.



**Figure 7:8** *New graduate registered nurses' satisfaction level of the graduate program in relation to their level of self-esteem: Seven months*

The self-esteem of all new graduates appeared to have increased by 11 months, with 11 (57.8%) new graduate registered nurses rating themselves with a high self-esteem. Level of self-esteem did not appear to reflect upon the satisfaction with the graduate program, with seven (36.8%) new graduates with high self-esteem satisfied with the graduate program, two (10.5%) graduates with high self-esteem dissatisfied and two (10.5%) graduates were neither satisfied nor dissatisfied with the graduate program. The new graduate registered nurses' level of self-esteem appeared to have improve by the 11-month period with no new graduate reporting low self-esteem.



**Figure 7:9** *New graduate registered nurses' satisfaction level of the graduate program in relation to their level of self-esteem: 11 months*

## PART C – Content analysis of open-ended questions

The quantitative survey included two open-ended questions which were analysed for this research:

Question 1 – If you were given an opportunity to change anything about your graduate nurse program to improve it for future nurses, how would you like to see it change? and Question 2 – Where do you see yourself professionally in the next five years?

The responses to these questions provided information to further explore the responses from the survey. One of the questions was included to explore retention expectations of graduate registered nurses in the rural and remote sectors.

## Findings

The first open-ended question was completed by 18 participants at the first three-month period (85.71%), 22 participants (84.61%) at seven months and 17 (94.44%) participants at the 11-month period. Following data analysis, codes were generated from the comments. Twenty-eight codes were generated for the first three months data, 54

codes for the second data collection and 37 at the 11-month data collection (Table 7:15). Due to the similarity in content for the question across all three time periods, the data was reported as a whole. One theme, ‘Supportive Measures’ was identified from the data.

**Table 7:15** *Q1 – If you were given an opportunity to change anything about your graduate nurse program to improve it for future nurses, how would you like to see it change?*

Ranking	Category	Codes 3 months	%	Codes 7 months	%	Codes 11 months	%	Theme
1	Support	13	46.42%	25	46.29%	16	43.24%	Supportive Measures
2	Structure	8	28.57%	16	29.62%	12	32.43%	
3	Education	7	25%	13	24.07%	9	24.32%	

The theme ‘Supportive Measures’, related to the new graduate registered nurses’ need for emotional, intellectual, and sociocultural support from nurse educators, preceptors, nurse managers and graduate nurse coordinators during their transition to the work environment. This theme was found throughout the graduate program at all survey periods (3, 7 & 11 months). The theme included three categories of: support, education and structure. The categories identified for each collection period were the same, with the same ranking order.

The category ‘Support’ included both focused and informal support such as one-on-one preceptorship, supernumerary time and being welcomed by other staff. Support for graduates included all elements of the graduate program where focused and ad hoc support was provided. Graduates’ specified support could be improved in formal areas of allocation of one-on-one preceptorship, and informal ways such as being made to feel welcome during their supernumerary time. The majority of graduates indicated both sociocultural and emotional supportive measures provided through focused support because ‘*it can take time to settle into the workplace*’ therefore ‘*more support*’ could improve within the graduate programs offered throughout rural Western Australia.

The category of ‘Education’ referred to the graduates need for enhancing their clinical knowledge. This may involve structured and ad hoc education. Study days, ad hoc sessions and comments regarding the benefit of staff development nurses were highlighted as educational supportive measures. Graduates suggested providing

increased time to complete education learning packages and more focused support from senior nurses in preceptoring sessions would have proved beneficial throughout the program. Assessments were viewed poorly by graduates because there was ‘*no real accountability*’ as grading and formal feedback was rarely provided.

The category of ‘Structure’ incorporated the support provided by managers and coordinators involved in the program from an operational level. Clinical rotations, length of placements, and expectations were considered as structural supportive measures. Graduates commented on the need for longer rotations to consolidate skills and confidence and the importance for clear and concise direction throughout the graduate program.

In the second question, graduates were asked where they expected they would be in five years. This question was completed by 19 participants (90.47%) in the first three months, 23 participants (88.46%) at seven months and 16 participants (88.88%) at 11 months data collection periods. Thirty-five codes were generated during data analysis, 15 in the first three months, 12 codes for the second data collection and nine at 11 months (Table 7:16). Data analysis generated one theme, ‘Future Aspirations’.

**Table 7:16 Q2 – Where do you see yourself professionally in the next five years?**

Ranking	Category	Codes 3 months	%	Codes 7 months	%	Codes 11 months	%	Theme
1	Staying rural	8	53.33%	6	50%	5	55.55%	Future Aspirations
2	Further studies	7	46.66%	6	50%	4	44.44%	

The theme ‘Future Aspirations’ referred to the plans graduates had for progressing their future careers in nursing. This theme was divided into two categories which were the same over the different data collection periods: staying rural and further studies.

The category ‘Staying rural’ related to the graduates’ desire to remain working as a nurse in the rural and remote areas. Graduates expressed a desire to work in a specialty area of ‘*a general rural and/or regional hospital*’. Fifty percent of the graduates indicated they wanted to remain working rurally. The other 50% did not specify if they wished to stay or move to a metropolitan setting. One graduate was uncertain about her future in nursing and another indicated they would not continue in

nursing as their career, however there was no explanation as to why in the written survey.

‘Further studies’ related to the recognition by graduates that they required increased skill and knowledge to progress in their nursing career. Nearly half (44%) of respondents indicated they were interested in future education. This group of graduates indicated a number of different directions they wanted to work towards, for example, management, education and specialties within nursing.

## **Summary of chapter**

This chapter presented the quantitative results from the new graduate registered nurses survey. The survey provided the graduates level of satisfaction and insight to choice of hospital, clinical rotations undertaken, supportive measures provided, which included preceptorship and education support. The survey also provided the satisfaction level with the overall graduate program. These findings reflected the change in level of self-esteem over the 12 months and how it was influenced by the different supportive measures available. It also provided an indication of graduate’s intention to remain in rural and remote nursing practice. The following chapter will present the findings from the senior nurses’ survey.

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## **CHAPTER 8: Senior Nurses View of Graduate Programs in Rural and Remote Western Australia: Quantitative Results**

### **Phase two – Senior registered nurses**

#### **Introduction**

The previous chapter presented the new graduate registered nurses survey data results. This chapter will consist of the senior nurses' survey data results. The findings from the senior nurses survey is divided into two parts. Part A has five different segments and focuses on the senior nurses' demographics, supportive mechanisms, education, performance management and satisfaction with the graduate program. Part B presents the results from the two opened ended questions.

#### **Survey completion**

In total 40 surveys were completed throughout 18 months to align with the timeframe of both new graduate registered nurses cohorts. In consultation with the nurse managers and human resources manager in the department of the Western Australia Country Health Service, it was estimated that approximately 200 nurses throughout the seven regions were involved with supporting new graduate registered nurses transition to practice.

### **PART A**

#### **Demographic characteristics of the participants**

There was a total of 40 participants, four males (10%) and 36 females (90%) (Table 8:1) who completed the survey. The participants were from all seven regions and most had graduated from universities (n=28) 70% or were hospital trained (n=9) 23%. Several participants (n=3) 7% did not respond to this demographic question. The demographic data is provided in table and the regions are listed from 1-7.

The largest number of respondents came from both region 1 and region 6 (28%), followed by region 2 (17%). Thirty percent of the nurses were aged between 30 – 39 years with 5% (n=2) being aged between 60 – 69 years of age. The highest number of participants attended university E.



**Table 8:1      Demographic characteristics of the participants**

<b>Demographic</b>	<b>Number n=40</b>	<b>Percentage</b>
<b><i>Gender</i></b>		
Male	4	10%
Female	36	90%
<b><i>Region</i></b>		
1	11	28%
2	7	17%
3	2	5%
4	4	10%
5	3	7%
6	11	28%
7	2	5%
<b><i>Age Range (years)</i></b>		
Age group 20 - 29	5	13%
Age group 30 - 39	12	30%
Age group 40 - 49	7	17%
Age group 50 - 59	11	28%
Age group 60 - 69	2	5%
Age unknown	3	7%
<b><i>University</i></b>		
University trained	28	70%
Hospital trained	9	23%
Unknown	3	7%

Thirty (75%) participants completed the demographic question about post graduate studies. Thirty percent (n=12) of senior nurses held a graduate certificate followed by 25% (n=10) with a master's degree. The majority of participating senior nurses (n=19, 58%) had practice as graduate coordinators for less than three years with only five senior nurses working as graduate coordinators for greater than seven years (Table 8.2). The number of hours in which senior nurses worked as graduate coordinators varied from 0-1 hour per week (n=10, 33%) to more than seven hours per week (n=11, 37%). The amount of time allocated for coordinating the graduate program changed over the 12-month period of the study for (n=15, 35.7%) of graduate nurse coordinators. Six senior nurses reported the coordinating hours were not applicable to their role in supporting new graduate registered nurses.

**Table 8:2      *Demographic characteristics of the GNP and senior nurses' qualifications***

<b>Demographic</b>	<b>Number n=30-35</b>	<b>Percentage n=40</b>
<b><i>Senior nurses' qualifications</i></b>		
Graduate Certificate	12	30%
Graduate Diploma	8	20%
Masters	10	25%
<b><i>Length of time coordinating graduate program</i></b>		
0-1 Years	10	25%
>1-3 years	9	22.5%
>3-5 years	5	12.5%
>5-7 years	3	7.5%
More than 7 years	5	12.5%
<b><i>Hours employed to oversee the graduate program</i></b>		
0-1 hrs/week	10	25%
> 1-2 hrs/week	5	12.5%
>3-4 hrs/week	4	10%
>5-6 hrs/week	0	0
More than 7 hours per week	11	27.5%
<b><i>Does the amount of coordinating hours change over the year?</i></b>		
Yes	15	37.5%
No	14	35%
N/A*	6	15%

\*N/A – not applicable

## **Clinical rotations**

The majority of programs consisted of two or three clinical rotations throughout the 12-month graduate program. The majority of senior nurses (n=27, 69%) were satisfied with the number of clinical rotations offered (Table 8.3).

**Table 8:3      Number of rotations offered and level of satisfaction**

No of Rotations	Satisfied		Neutral		Dissatisfied	
	n=	%	n=	%	n=	%
1	1	2.56%	0	0	0	0
2	10	25.64%	4	10.25%	2	5.12%
3	12	30.76%	2	5.12%	1	2.56%
4	4	10.25%	1	2.56%	0	0
5	0	0	0	0	2	5.12%
<b>TOTAL</b>	<b>27</b>	<b>69.23%</b>	<b>7</b>	<b>17.94%</b>	<b>5</b>	<b>12.82%</b>

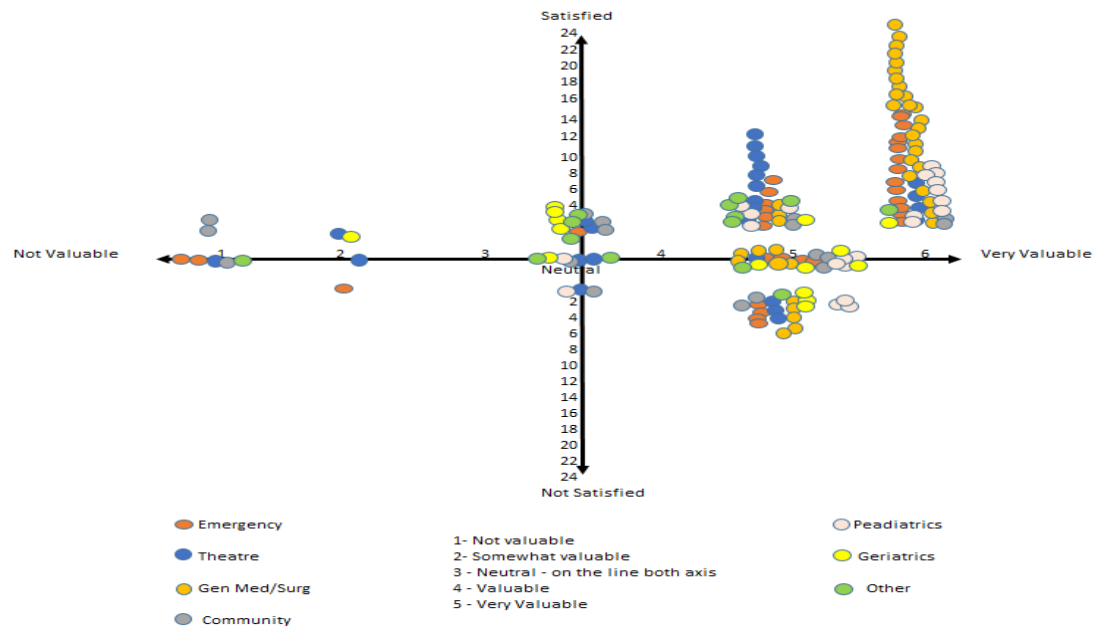
The following table (Table 8:4) presents data related to both the perceived value of the rotations and overall satisfaction with the rotations offered throughout the 12 month program by the senior nurses. The emergency and general medical/surgical rotations were considered valuable with high satisfaction from all senior nurses who rated the clinical rotations. There were varied responses for the value and satisfaction of the remaining clinical rotations, with other (mental health, dialysis or maternity) having the lowest value and satisfaction.

**Table 8:4      Value and the satisfaction of the clinical rotations offered**

<b>EMERGENCY (n=35)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	1 (2.8%)	0	4 (11.4%)	5 (14.28%)
Neutral	2 (5.7%)	0	0	4 (11.4%)	6 (17.14%)
Satisfied	0	0	1 (2.8%)	22 (62.85%)	29 (82.85%)
Total	2 (5.7%)	1 (2.8)	1 (2.8%)	30 (85.71%)	35 (100%)
<b>THEATRE (n=25)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	1 (4%)	3 (12%)	4 (16%)
Neutral	1 (4%)	1 (4%)	2 (8%)	1 (4%)	5 (20%)
Satisfied	0	1 (4%)	2 (8%)	13 (52%)	16 (64%)
Total	1 (4%)	2 (8%)	5 (20%)	17 (68%)	25 (100%)

<b>GENERAL MED/SURGICAL (n=39)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	0	5	5 (12.8%)
Neutral	0	0	0	6	6 (15.38%)
Satisfied	0	0	0	28	28 (71.79%)
Total	0	0	0	39 (100%)	39 (100%)
<b>COMMUNITY (n=17)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	1 (5.88%)	2 (11.76%)	3 (17.64%)
Neutral	1 (5.88%)	0	1 (5.88%)	3 (17.64%)	5 (29.41%)
Satisfied	2 (11.76%)	0	3 (17.64%)	4 (23.52%)	9 (52.94%)
Total	3 (17.64%)	0	5 (29.41%)	9 (52.94%)	17 (100%)
<b>PAEDIATRICS (n=22)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	1 (4.54%)	3 (13.63%)	4 (18.18%)
Neutral	0	0	1 (4.54%)	4 (18.18%)	5 (22.72%)
Satisfied	0	0	0	13 (59.09%)	13 (59.09%)
Total	0	0	2 (9.09%)	20 (90.9%)	22 (100%)
<b>GERIATRICS (n=15)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	0	3 (20%)	3 (20%)
Neutral	0	0	1 (6.66%)	4 (26.66%)	5 (33.33%)
Satisfied	0	1 (6.66%)	4 (26.66%)	2 (13.33%)	7 (46.66%)
Total	0	1 (6.66%)	5 (55.55%)	9 (60%)	15 (100%)
<b>OTHER (n=14)</b>					
<b>Level of satisfaction</b>	<b>Not valuable</b>	<b>Somewhat valuable</b>	<b>Neutral</b>	<b>Valuable</b>	<b>Total</b>
Not Satisfied	0	0	0	1 (7.14%)	1 (7.14%)
Neutral	1 (7.14%)	0	2 (14.28%)	1 (7.14%)	4 (28.57%)
Satisfied	0	0	3 (21.42%)	6 (42.85%)	9 (64.28%)
Total	1 (7.14%)	0	5 (35.71%)	8 (53.33%)	14 (100%)

The following Cartesian graph (Figure 8:1) illustrates how the majority of participating senior nurses were satisfied with the rotations offered and indicated the general surgical rotation to be the most valued learning environment for new graduates.



**Figure 8:1** Value and the satisfaction of the clinical rotations offered

## Supportive mechanisms

Supportive mechanisms implemented to assist new graduate registered nurses transition to practice included regular study days, supernumerary time, time with nurse educators, and time with preceptors. The senior nurses indicated whether they were satisfied or dissatisfied for each element offered within their clinical facility.

## Supernumerary time

Supernumerary time was usually allocated by the nurse manager at the beginning of each rotation for the graduates. At three months, the majority of senior nurses indicated the graduates received four or more supernumerary shifts (Table 8:5) and most senior nurses (70%) were satisfied with the number of supernumerary shifts offered to graduates. For the subsequent timeframes the majority of senior nurses were satisfied with two supernumerary shifts. Interesting to note, the senior nurses expressed greater dissatisfaction with their supernumerary time when longer supernumerary time was provided, although this may have been related to the type of placement. Dissatisfaction

also appeared to increase toward the end of the graduate year, with senior nurses expressing a high level of dissatisfaction at 11-months at which time the number of supernumerary shifts offered to new graduate registered nurses appears to have decreased.

### **Experience with preceptorship**

The majority of senior nurses indicated the graduates were offered preceptorship, although 30.5% reported there was no preceptorship available in their ward. This resulted in a mixed level of satisfaction with the preceptorship offered captured within in the survey (Table 8:6).

**Table 8:5**      *Senior nurses' level of satisfaction with supernumerary time*

Time	3 months (n=37)			7 months (n=38)			11 months (n=29)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
0 shifts	0    0	0    0	0    0	1    2.63%	0    0	1    2.63%	5    17.24%	0    0	2    6.89%
1 shift	0    0	0    0	0    0	2    5.26%	0    0	0    0	0    0	0    0	1    3.44%
2 shifts	6    16.21%	0    0	2    5.40%	11    28.94%	1    2.63%	3    7.89%	7    24.13%	1    3.44%	3    10.34%
3 shifts	4    10.81%	0    0	3    8.10%	6    15.78%	0    0	5    13.15%	4    13.79%	0    0	2    6.89%
>4 shifts	16    43.24%	2    5.40%	4    10.81%	6    15.78%	1    2.63%	1    2.63%	2    6.89%	1    3.44%	1    3.44%
<b>TOTAL</b>	<b>26    70.27%</b>	<b>2    5.40%</b>	<b>9    24.32%</b>	<b>26    68.42%</b>	<b>2    5.26%</b>	<b>10    26.31%</b>	<b>18    62.06%</b>	<b>2    6.89%</b>	<b>9    31.03%</b>

**Table 8:6**      *Senior nurses offer of preceptorship and level of satisfaction*

Preceptorship offered	Very dissatisfied	%	Dissatisfied	%	Neutral	%	Satisfied	%	Very Satisfied	%
Yes (n=)	0	0	7	18%	4	10.5%	16	41%	0	0
No (n=)	2	5%	3	7.5%	5	13%	2	5%	0	0

Senior nurses indicated they were more satisfied with the graduates receiving preceptorship for longer periods of time (Table 8:7). It appeared that preceptorship was not expected to be provided to graduates for the fulltime of the clinical rotations which averaged 16-24 weeks. Regardless of the allocated time, over half of the senior nurses were satisfied or neutral regarding the preceptorship offered.

**Table 8:7**      *Senior Nurses' satisfaction with preceptorship offered (no weeks)*

<b>Time</b>	<b>Satisfied</b>		<b>Neutral</b>		<b>Dissatisfied</b>	
0-1 weeks	4	10.00%	3	7.50%	4	10.00%
>2-3 weeks	4	10.00%	3	7.50%	4	10.00%
>3-5 weeks	1	2.50%	0	0	1	2.50%
>5-7 weeks	2	5.00%	1	2.50%	0	0
More than 7 weeks	8	20.00%	2	5.00%	3	7.50%
<b>TOTAL</b>	<b>19</b>	<b>47.50%</b>	<b>9</b>	<b>22.50%</b>	<b>12</b>	<b>30.00%</b>

### **Involvement of the graduate nurse coordinator**

The number of hours graduate nurse coordinators spent with graduates decreased over the 12 months (Table 8:8). The rate of satisfaction of senior nurses did not change between the three timeframes and the majority of senior nurses were satisfied with the time graduate nurse coordinators allocated for graduates.

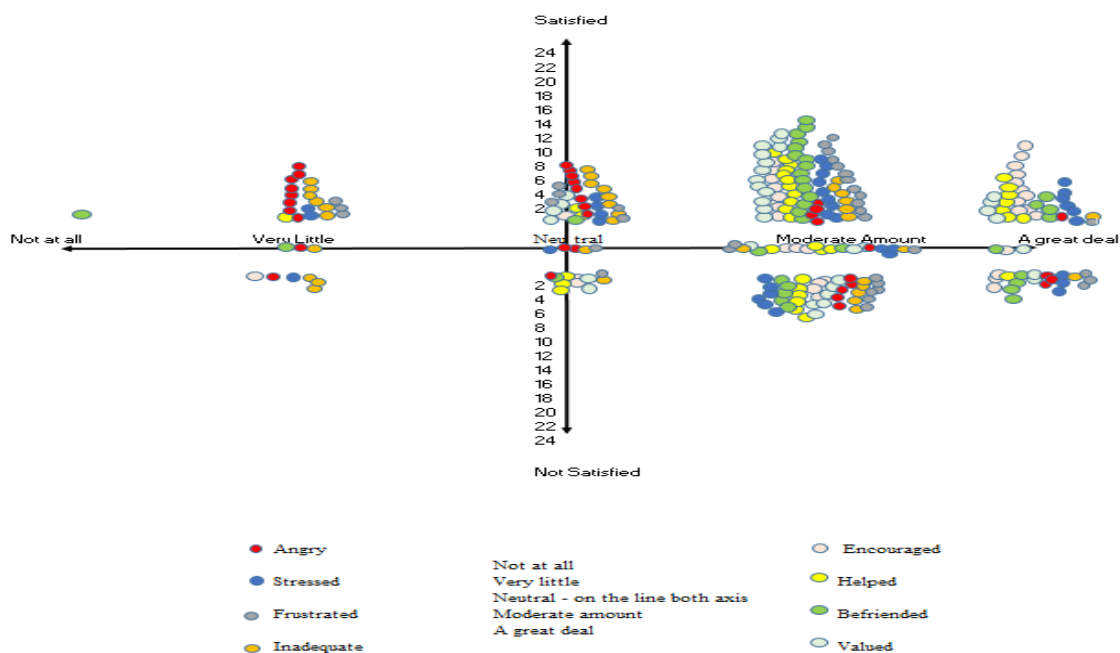


**Table 8:8**     *The senior nurses' level of satisfaction of the time graduate nurse coordinators spent with new graduate registered nurses*

Time	3 months (n=30)			7 months (n=29)			11 months (n=29)		
	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied	Satisfied	Neutral	Dissatisfied
> 0-1 hour/week	1    3.33%	1    3.33%	3    10.00%	5    17.24%	2    6.89%	3    10.34%	9    31.03%	4    13.79%	6    20.68%
> 1-2 hours/week	5    16.66%	4    13.33%	5    16.66%	7    24.13%	4    13.79%	4    13.79%	6    20.68%	2    6.89%	1    3.44%
> 3-4 hours/week	4    13.33%	1    3.33%	0    0	2    6.89%	0    0	0    0	0    0	0    0	0    0
> 5-6 hours/week	2    6.66%	0    0	0    0	1    3.44%	0    0	0    0	1    3.44%	0    0	0    0
> 7 hours/week	4    13.33%	0    0	0    0	1    3.44%	0    0	0    0	0    0	0    0	0    0
<b>TOTAL</b>	16   53.33%	6    20.00%	8    26.66%	16   55.17%	6    20.68%	7    24.13%	16   55.17%	6    20.68%	7    24.13%

**Support – Range of emotions**

The Cartesian graph below demonstrates the range of emotions which the senior nurses felt the new graduate registered nurses expressed during their graduate year. The majority of senior nurses indicated the graduates were valued, encouraged and befriended (Figure 8:2). The senior nurses believed the graduates were stressed and frustrated regardless of their level of satisfaction with the supportive measures.



**Figure 8:2**     *Senior nurses’ satisfaction level with the support graduates received in relation to a perceived range of emotions*

**Approachability of staff**

*The majority of senior nurses reported they perceived staff to be approachable and were satisfied with the support they provided to graduates (*

Table 8:9).

**Table 8:9**      *How often senior nurses believed staff were approachable and senior nurses level of satisfaction with support provided*

Frequency	Approachability (n=34)					
	Satisfied		Neutral		Dissatisfied	
Not at all	0	0	0	0	0	0
Very little	0	0	0	0	1	2.94%
Neutral	3	8.82%	0	0	4	11.76%
Moderate amount	14	41.17%	3	8.82%	2	5.88%
A great deal	3	8.82%	1	2.94%	3	8.82%
<b>TOTAL</b>	<b>20</b>	<b>58.82%</b>	<b>4</b>	<b>11.76%</b>	<b>10</b>	<b>29.41%</b>

### **The perceived length of time it took for graduates to feel part of the team**

Many senior nurses indicated that it took between 2-6 weeks for new graduates to look like they were part of the team. Regardless of the perceived time taken for graduates to feel part of the team the majority of senior nurses were satisfied with the graduate program offered (Table 8:10).

**Table 8:10**      *Perceived time taken to feel part of the team and senior nurses' level satisfaction with the graduate program*

Time	Satisfied		Neutral		Dissatisfied	
<1-2 weeks	2	5.71%	1	2.85%	1	2.85%
>2-4 weeks	5	14.58%	2	5.71%	3	8.57%
>4-6 weeks	8	22.85%	0	0	3	8.57%
>6-8 weeks	3	8.57%	0	0	2	5.71%
More than 8 weeks	3	8.57%	1	2.85%	1	2.85%
<b>TOTAL</b>	<b>21</b>	<b>60%</b>	<b>4</b>	<b>11.44%</b>	<b>10</b>	<b>28.57%</b>

### **Satisfaction with theoretical module throughout the graduate program**

The senior nurses indicated their satisfaction with the time allocated for the theory component offered throughout the graduate program. Over half of the senior nurses were satisfied with the level of theory provided within the graduate program. The majority of senior nurses (51%) suggested between 40-60 hours was allocated throughout the 12-month program for theoretical content to be delivered to graduates. The less time allocated to theory was directly related to the satisfaction level of the senior nurses with the theory provided.

**Table 8:11** *Level of satisfaction with the allotted time for theory*

Time	Satisfied		Neutral		Dissatisfied	
< 8 hours	0	0	2	6.45%	1	3.22%
> 8-24 hours	0	0	1	3.22%	2	6.45%
>24-40 hours	6	19.35%	1	3.22%	0	0
>40-60 hours	10	32.25%	0	0	2	6.45%
More than 60 hours	4	12.90%	0	0	2	6.45%
<b>TOTAL</b>	<b>20</b>	<b>64.51%</b>	<b>4</b>	<b>12.90%</b>	<b>7</b>	<b>22.58%</b>

## **Experiences with performance management processes**

Many senior nurses reported that the graduates received a performance management session within the first three months of their graduate program. Regardless of when the performance management was provided, most of the senior nurses were satisfied with the process.

**Table 8:12** *Level of satisfaction with the performance management*

Time	Satisfied		Neutral		Dissatisfied	
1-3 months	12	35.29%	5	14.70%	2	5.88%
4-6 months	6	17.64%	4	11.76%	0	0
7-9 months	2	5.88%	0	0	0	0
9-12 months	3	8.82%	0	0	0	0
<b>TOTAL</b>	<b>23</b>	<b>67.64%</b>	<b>9</b>	<b>26.47%</b>	<b>2</b>	<b>5.88%</b>

## **Overall satisfaction with the graduate program**

The senior nurses overall satisfaction with the graduate program was reviewed in conjunction with the regions the staff were employed. The majority of senior nurses were satisfied with the graduate program run within their region (Table 8:13).

**Table 8:13** *Level of satisfaction with the graduate program in each region*

Region	Satisfied		Neutral		Dissatisfied	
1	3	10.70%	3	10.70%	1	3.57%
2	2	7.16%	1	3.57%	0	0
3	2	7.16%	0	0	0	0
4	4	14.28%	0	0	0	0
5	2	7.16%	0	0	0	0
6	5	17.86%	3	10.70%	1	3.57%
7	1	3.57%	0	0	0	0
<b>TOTAL</b>	<b>19</b>	<b>67.85%</b>	<b>7</b>	<b>25.00%</b>	<b>2</b>	<b>7.14%</b>

## PART B – Content analysis of open-ended questions

The quantitative survey of senior nurses included two open-ended questions:

Question 1 – If you were given an opportunity to change anything about your graduate nurse program to improve it for future nurses, how would you like to see it change? and

Question 2 – Any further comments? The two questions were combined as the comments reflected areas for change and analysed.

### Findings

The first open-ended question was completed by 29 participants (72.5%) and 13 participants (32.5%) completed the second question. The two questions together generated 82 codes (Table 8:14) and generated two themes, an optimal graduate program and organisational challenges.

**Table 8:14** *Q1 – If you were given an opportunity to change anything about your graduate nurse program to improve it for future nurses, how would you like to see it change? and Q2 – Any further comments*

Ranking	Category	Codes	Percentage	Theme
1	Focused support	32	39%	An optimal graduate program
2	Education	20	24.39%	
3	Structure	13	15.85%	
4	Organisation challenges	12	14.63%	Organisational challenges
5	Guidance	6	7.31%	An optimal graduate program

Two themes evolved from the content analysis ‘An optimal graduate program’ and ‘Organisational challenges’. The first theme ‘An optimal graduate program’ refers to the senior nurses’ vision on what is required for a graduate program that provides the right amount of support for both graduates and preceptor nurses. The senior nurses indicated that emotional, intellectual, and sociocultural supportive measures were lacking in the current graduate programs. The supportive measures indicated for an optimal graduate program included focused support, educational support, and managerial support through guidance and structure. The theme remained consistent across the regions.

Focused support refers to both emotional and sociocultural support available for the individual graduate and preceptors and is reflective of one-on-one support provided through direct supervision. Focused support considered one-on-one preceptorship as a main focus with the ideal preceptorship including one experienced nurse for each new graduate registered nurse for the duration of the rotation to provide consistency for the new graduate registered nurse. Increase supernumerary time was also considered important to improve a new graduate registered nurse '*professional confidence*'. The current support for preceptors was considered as minimal and senior nurses believed that increased focused support for both preceptors and new graduate registered nurses in the form of time with staff development nurses to spend on building knowledge and sharing skills, would improve the graduate program for all involved.

Education referred to the need for new graduate registered nurses to be provided opportunities to improve theoretical knowledge and skills during a graduate year. Education was provided through shared knowledge between preceptors and new graduate registered nurses. Education support included both structured and ad hoc education for both graduates and preceptors. The senior nurses indicated a need for staff development nurses to be available for both new graduate registered nurses and preceptors to enhance educational experiences. Senior nurses highlighted a need for an increase in site specific education and time allocated to senior nurses to enable one-on-one support for graduates.

The structure of the graduate program refers to the breadth and depth of a graduate's experience. Structure and guidance consisted of formal and informal feedback, and length of rotations offered within a graduate program. The depth of knowledge a graduate could develop was seen to be limited when graduates were offered a variety of shorter rotations. The senior nurses indicated '*they have been rotated for weeks at a time and it is not long enough to see improvement*'. The senior nurses stated longer rotations were beneficial for both the hospital and new graduate registered nurse to consolidate clinical skills and knowledge.

Guidance as a category relates to communication skills and advice available to senior nurses to assist new graduate registered nurses. Senior nurses valued clear and concise communication from nurse educators to help tailor individualised support to guide the development of each of the new graduate registered nurses. Gaining insight of

the graduates needs before they commenced their rotation was considered a benefit however this was unavailable with the current graduate program structure. The clinical staff wanted clear *‘expectations of [the] graduate from the staff development [team]’*. Communication was also lacking with regards to structured education for example *‘when study days are on and what they are about’*.

The second theme ‘Organisational challenges’ referred to the obstacles managers encountered when trying to implement the support to provide an optimal graduate program. There was a belief that *‘politics and finance dictate successful outcomes’* and resulted in senior nurses feeling that *‘staffing and business of our main hospital always places a lot of pressure on our graduates’*. The constraints with staffing levels and funding was reiterated by all senior nurses who understood at the time support measures were suboptimal *‘management are aware and are trying various strategies to improve’*.

## **Summary of chapter**

This chapter presented the quantitative senior nurses’ results for this study. The senior nurses indicated their level of satisfaction with the supportive measures: preceptorship; and, feedback and education opportunities offered within the graduate program. The next chapter will present a summary of qualitative findings and quantitative findings and explore similarities and differences.



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## CHAPTER 9: Summary of Qualitative and Quantitative Findings

### Introduction

The previous chapter presented the findings for the senior nurse's quantitative data analysis. This chapter will present the summary of qualitative findings and quantitative findings. Similarities and differences between the new graduate registered nurses and senior nurses qualitative responses will be presented. This will be followed the new graduate registered nurses and senior nurses' quantitative findings tabled side by side.

### Qualitative findings

#### *Comparison of findings between new graduate registered nurses and senior nurses*

Both senior nurses and new graduate registered nurses identified a gap between expectations and experiences of new graduate registered nurses when discussing the support provided by the graduate nurse coordinator. Focused support through preceptorship and peer debriefing was difficult to maintain due to transitional staff and rostering issues however support through the rostering time off helped with the pressure of moving to work in a new environment.

Graduates spoke of not being involved with community members because they knew they would be moving again soon. This isolation was further exacerbated as each time a graduate moved to a new clinical area, they felt they had to prove their worth, aligning with the senior nurses measuring a graduate's ability to 'fit in' through skills acquisition. Both groups believed social and emotional support was required throughout the 12 months for all graduates (Table 9.1).

**Table 9:1**      *Similarities between nursing graduates and senior nurses*

<b>New Graduate Registered Nurses</b>	<b>Senior Nurses</b>
Lack of support	Difficult to provide focused support
Lack of senior nurses	Lack of senior nurses
Exhausted, finding it hard to cope with everything	Short rotations was detrimental and lack of support
Have to prove your worth before feeling a Sense of Belonging	Sense of Belonging was measured by progression of clinical skills
Education was ward dependent	Right person for the job (education portfolio holder) accountable on ward level
Clear communication and guidance is essential	Graduate nurse coordinator role not well understood
Social and emotional support	Social and emotional support needed
Homesick, not engaged with community	Increased pressure with move to location

### **Differences between the groups**

Whilst the study days organised by the graduate nurse coordinator were expected by the new graduate registered nurses, they were seen by some as being full of information which was hard to assimilate. Some graduates felt unsupported by the graduate nurse coordinator when the scheduled study days stopped at six months. In direct contrast, the senior nurses felt they needed to put as much information into the study days while they had everyone's attention and believed the information was warranted at the beginning of the program (Table 9.2).

The senior nurses discussed the importance of welcoming new graduates, and this was reiterated as a graduate shared her experience of not being welcomed by senior management. A sense of belonging was ward dependent for the graduates. The senior nurses highlighted the difference in needs, both emotional and social, between metropolitan and rural graduates.

**Table 9:2 Differences between nursing graduates and senior nurses**

<b>New Graduate Registered Nurses</b>	<b>Senior Nurses</b>
Transition shock	Preceptorship needs to be effective
All graduates need support	Metro vs rural grads need support, needs are more complex
Study days stopped at six months Felt abandoned by program	Front loaded all education due to previous feedback
Study days crammed, not effective	Fit in as much as possible when you have everyone together
Looking to advance skills	Wanting to advance skills before being competent in basic skills
Debriefing was important	Debriefing was poorly attended
Not being welcomed	Being welcomed was important

## Quantitative findings

### *Similarities between the groups*

The level of satisfaction for the top three clinical placements consisted of medical/surgical, emergency and paediatrics during the second and final data collection. This aligned with the perception noted within the senior nurse's survey. Clinical rotations were rated relatively similar for both groups.

Both senior nurses and new graduate registered nurses indicated that more than four shifts of supernumerary time was satisfactory within the first rotation followed by two supernumerary shifts for subsequent rotations. Both groups also portrayed a lack of satisfaction with the preceptorship offered. However, the majority of both senior nurses and new graduate registered nurses were satisfied with the staff being supportive or approachable for a moderate amount of the time (Table: 9.3).

The response for performance management timeframe and level of satisfaction was also consistent in both groups, both indicating little feedback was received or given after seven months into the graduate program.

**Table 9:3 Comparison of new graduate registered nurses and senior nurses' quantitative results**

<b>Quantitative Survey</b>	<b>Graduate Nurses n=40</b>			<b>Senior Nurses n=40</b>		
<b>Level of Satisfaction</b>	<b>3</b>	<b>7</b>	<b>11</b>	<b>3</b>	<b>7</b>	<b>11</b>
<i>Demographics</i>	21	28	19			
Clinical rotations						
• Emergency Department	75% 2	57% 2	66% 3	62% 2		

Quantitative Survey Level of Satisfaction	Graduate Nurses n=40						Senior Nurses n=40		
	3	7	11				3	7	11
<ul style="list-style-type: none"> <li>• Paediatrics</li> <li>• Med/Surgical</li> <li>• Theatre</li> <li>• Community</li> <li>• Geriatrics</li> <li>• Other (MH, Dial, Mid)</li> </ul>	50% 4	53% 3	82% 1				59% 3		
	84% 1	69% 1	78% 2				71% 1		
	63% 3	40% 4	29% 4				52% 4		
	37% 6	30% 5	14% 6				23% 6		
	42% 5	23% 7	0 7				13% 7		
	25% 7	27% 6	25% 5				42% 5		
Supernumerary time									
<ul style="list-style-type: none"> <li>• 0 shifts</li> <li>• 1 shift</li> <li>• 2 shifts</li> <li>• 3 shifts</li> <li>• &gt; 4 shifts</li> </ul>	5%	0	0				0	2%	17%
	10%	0	5%				0	5%	0
	24%	36%	28%				16%	28%	24%
	0	4%	5%				10%	15%	13%
	33%	21%	16%				43%	15%	6%
<b>Preceptorship offered</b>	73%	50%	63%				67%		
Preceptor weeks									
<ul style="list-style-type: none"> <li>• &lt;1-2</li> <li>• 2-4</li> <li>• 4-6</li> <li>• 6-8</li> <li>• &gt;8</li> </ul>	41%	18%	21%				0-1 wk		10%
	6%	18%	0				2-3 wk		10%
	12%	0	7%				3-5 wk		2.5%
	0	12%	7%				5-7 wk		5%
	6%	0	13%				>7 wk		20%
Preceptor shifts	4-6 or >8	4-6	4-6						
Time with graduate nurse coordinator									
<ul style="list-style-type: none"> <li>• 0-1 hour/week</li> <li>• 1-2 hours/weeks</li> <li>• 3-4 hours/weeks</li> <li>• 5-6 hours/weeks</li> <li>• &gt;6-7 hours/weeks</li> </ul>	28%	18%	27%					3%	
	33%	11%	11%					16%	
	5%	0	0					13%	
	0	0	0					6%	
	10%	4%	0					13%	
<b>Support received (emotions felt)</b>									
Approachability of staff									
<ul style="list-style-type: none"> <li>• Not at all</li> <li>• Very little</li> <li>• Neutral</li> <li>• Moderate amount</li> <li>• A great deal</li> </ul>	0	0	0				0		
	0	0	0				0		
	0	0	0				8%		
	47%	18%	33%				41%		
	24%	22%	22%				8%		
Part of a team									
<ul style="list-style-type: none"> <li>• 1-2 weeks</li> <li>• 2-4 weeks</li> <li>• 4-6 weeks</li> <li>• 6-8 weeks</li> <li>• &gt;8 weeks</li> </ul>	14%	15%	5%				5%		
	24%	11%	15%				14%		
	19%	11%	5%				22%		
	9%	7%	25%				8%		
	5%	11%	0				8%		
Theory									
<ul style="list-style-type: none"> <li>• &lt;8 hours</li> <li>• 8-24 hours</li> <li>• 24-40 hours</li> <li>• 40-60 hours</li> <li>• &gt;60 hours</li> </ul>	5%	4%	0				0		
	17%	7%	18%				0		
	28%	28%	18%				19%		
	17%	21%	14%				32%		
	0	11%	0				12%		

Quantitative Survey Level of Satisfaction	Graduate Nurses n=40			Senior Nurses n=40		
	3	7	11	3	7	11
Performance management						
• 1-3 months	37%	33%	26%		35%	
• 4-6 months	37%	26%	21%		17%	
• 7-9 months	0	4%	0		5%	
• 9-12 months	0	0	5%		8%	
Graduate program						
• One	20%	0%	11%		10%	
• Two	20%	14%	11%		7%	
• Three	0	3%	5%		7%	
• Four	25%	11%	22%		14%	
• Five	10%	7%	5%		7%	
• Six	10%	14%	5%		17%	
• Seven	0	3%	5%		3%	
Overall satisfaction with program	85%	53%	63%		67%	

Note: Clinical rotations – Valuable and satisfied percentage %

Senior nurse time – level of satisfaction

Preceptor shifts – No of shifts that received highest satisfaction level

Graduate nurse coordinator – satisfaction level with the time spent with the graduate nurse coordinator

Approachability – combined with level of satisfaction with support

Part of the team – combined with level of satisfaction with the grad program

Graduate program – level of satisfaction in each region

Note: The percentage within the regions is the percentage of participating graduates from all regions not the percentage of graduates hired within the region

Note: The figures in green help to explain the similarities and differences across the three time frames and between the graduate cohort and senior nurse cohort

### ***Differences between the groups***

There was a discrepancy between the senior nurses and new graduate registered nurses' perception with the time a graduate nurse coordinator spent with new graduate registered nurses for the second and third rotation. The graduates believed the support received from the graduate nurse coordinator decreased over time. The senior nurses however, believed the support was consistent throughout the graduate program.

The level of theory also differed with the graduates considering they received 24-40 hours every four months, so not increased at the beginning or decreasing over time. The senior nurses on the other hand believed the graduate received 40-60 hours of structured study time.

Overall, the graduates were very satisfied with the graduate program within the first four months, however this level of satisfaction decreased when asked again at seven months and improved slightly by eleven months. The senior nurses considered the graduate program to be moderately satisfactory.

## **Summary of chapter**

This chapter provided a comparable summary of both new graduate registered nurses and senior nurses' qualitative findings. This chapter also provided a comparable summary of both new graduate registered nurses and senior nurses quantitative results. The next chapter will present a synthesis of both the qualitative and quantitative findings in alignment with the research questions and conceptual framework.

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## **CHAPTER 10: Discussion**

### **Introduction**

The previous four chapters consisted of both qualitative and quantitative research findings for new graduates and senior nurses. This chapter brings together all the findings and reflects on the graduates' transition experiences. Transition refers to a period of change from one stage to another, where one is expected to make adjustments to new conditions (Bridges, 2009). In this research, it refers to the period when a nurse commenced his/her graduate program, moving from what is known (university environment) to what is unknown (hospital environment).

The main aim of this research was to explore how well nursing graduates in rural and remote Western Australia were supported throughout their 12 months transition to practice. This study aimed to 1. Determine nursing graduates' experiences in rural and remote Western Australia; 2. Determine if the rural nursing graduate programs were effective in building their confidence for rural practice; 3 Determine the facilitators and barriers to effective nursing graduate programs; and 4. Determine levels of satisfaction with graduate programs

This chapter is divided in two parts: the first part presents findings on the nursing graduates' experiences and how effective the graduate program was in building the new graduates' confidence to work in rural and remote areas of Western Australia. The second part of this chapter presents the challenges and facilitators for developing a transition program that meets the needs of graduates, preceptors and health services in rural Western Australia. The fourth research question pertaining to whether the new graduates and senior nurses were satisfied with the support received and provided throughout the graduate program is addressed across both parts of the chapter.

### **Part One**

#### **Experiences of Western Australian rural and remote nursing graduates**

Graduate nurses in rural Western Australia were found to move through three distinct stages in a transformative progression during their graduate year. The Western Australian graduates' level of satisfaction with the graduate program reflected a V-

shaped pattern, with high scores at three months, a decline at seven months and an improvement at 11 months (see Figure 10:1). The three different stages have been labelled ‘Jumping in the deep end with a ‘floatie’; ‘Sink or swim’; and, ‘Swimming without ‘floaties’.

### ***Stage 1: Jumping in the deep end with a ‘floatie’***

The first stage ‘Jumping in the deep end with a floatie’ refers to the graduates commencing the graduate year experiencing a lack of confidence, a lack of support, fearing the unknown, and demonstrating transition shock, yet at the same time being excited about having the chance to undertake a graduate year and commence working as a registered nurse, experiencing the excitement of new experiences, moving to a rural area and being in a graduate program, representing a honeymoon stage. A floatie or floatation device is reflective of the support received whilst undertaking this turbulent period of their career.

On commencement of their graduate year, the new graduates experienced both feelings of excitement and stress and discussed emotions that included exhilaration and disappointment. The rural graduates felt valued, helped and encouraged and believed the staff to be approachable within the first three months (see Appendix R). The positive emotions, excitement, and high level of satisfaction or feeling of euphoria reflects the honeymoon stage as described by Cheng, Tsai, Chang & Liou (2014) lasting for the three months. The extended honeymoon period is congruent with Oberg’s culture shock theory which suggests when moving to a new environment the honeymoon stage may last from a few days to six months depending on the level of emotional support, friendliness of staff and excitement of being in a new town (Oberg, 1960). The graduates indicated satisfaction with emotional support, satisfaction with staff being approachable and overall level of satisfaction with the graduate program. The graduates felt a similar level of satisfaction during the supernumerary time which marks the orientation period both Kramer and Duchscher suggest aligns with the honeymoon period.

However, within the first three months the graduates also spoke of being ‘thrown in the deep end’, feeling ‘isolated’ and feared the unknown which is reflective of transition shock as described by Duchscher (2007). According to Cheng et al (2014)



reality shock or transition shock involves conflict, pressure and dissatisfaction. When the graduates discussed the main concepts of the graduate program (Graduate Nurse Coordinators, preceptorship and theory components) within the first three months, reality shock and transition shock became evident. Fifty percent of the new graduate nurses indicated there was a lack of support and spoke of a steep learning curve and feeling like they were thrown in the deep end without a safety net. The way in which graduates in this study moved between both positive and negative emotions suggests they vacillated between both honeymoon and transition shock for the first three months, depending on the prevailing circumstances.

### **Honeymoon and transition shock stages co-exist**

Differences for this study were found when comparing the rural graduate nurses' transition to Duchscher's transition shock model. This research has found a positive level of satisfaction indicative of the honeymoon stage occurring simultaneously with graduates experiencing negative emotions related to periods of transition shock. In contrast to Duchscher's research (2007) which found that once graduates felt transition shock that signified the end of the honeymoon period, when a graduate was responsible for their own patients, feelings of excitement were replaced by fear and anxiety resulting in transition shock (Kramer 1974; Duchscher, 2008 & 2009; Lea & Cruikshank, 2014). This would infer a longitudinal transition process, where graduates move from one stage into the next. In contrast, this research found that new graduate registered nurses experienced different stages concurrently, primarily based on the amount of support available at any particular time or during difficult situations. The findings from this study indicates that transition shock co-exists with the euphoric honeymoon stage and is dependent on the support received whilst in the initial transition stage.

While the majority of new graduates indicated they were satisfied with the Western Australian rural graduate program, they also reported negative emotions of feeling overwhelmed, under prepared and, at times, isolated at the beginning of their graduate year. Australian research has found that heavy workloads, inadequate levels of support and undesirable organisational cultures are associated with negative experiences within the first year of a nurse's career, resulting in some 50% of new graduates leaving during this period (Parker et al., 2012). However, there was no indication at three

months that the graduates from this study wanted to leave the profession. This was evidenced in this study by one graduate leaving in the first three months, due to health implications. Instead at three months the graduates spoke of being valued, helped, encouraged and befriended. The new graduates felt both excited and stressed, during their first three months of employment.

The differences with this group of graduates, in comparison to Duchscher's study conducted in 2005, may be considered a reflection of the changes within the nursing industry in Australia. The number of nurses graduating from bachelor nursing degrees has doubled (Schwartz, 2019). However, health services have not been able to double the graduate program placements to accommodate the larger number of graduating nurses (Schwartz, 2019). For example, in Queensland in 2014, 600 of the possible 2,500 new graduates were employed (Tuckett, et al., 2017, p106). This has resulted in applications for transition programs becoming a very competitive process. With only half of the Western Australian graduates getting jobs. GradConnect 2019 offered a total of 582 graduate RN positions across 44 graduate programs in WA and the number of applications received for graduate registered nurses' roles equals 1,657 (Department of Health WA, 2019).

The excitement of being offered a graduate program may be a reason for the prolonged euphoric effects of the honeymoon stage. This competitive process has influenced the experience of graduating nurses during their transition program. With fewer graduate program places available, the graduates interviewed in this study felt lucky to be offered a graduate program. This 'feeling lucky' may have contributed to the conflicting results from participants indicating that they were experiencing both positive emotions from a honeymoon stage at the same time as shock from taking a full workload as a novice nurse.

## **Rural context**

Similarities were also noted when comparing the rural graduate nurses' transition to Duchscher's Stages of Transition Theory (2007). Lack of experience to the patient population and limited exposure of clinical practice in the undergraduate degree supports positioning the new rural graduates commencing their transition program as novice nurses. While graduates in this study had previous experience attending clinical

placements as undergraduate nursing students in metropolitan hospitals, only few graduates had completed any placements in a rural setting before they commenced their transition program. This limited exposure to the type of placement in which they would work as graduates placed them in the novice category. A novice nurse is any nurse entering a clinical setting without having any clinical experience of the patient population and has traditionally been the term applied to student nurses (Benner, 2001). An advanced beginner progresses from the novice stage after gaining some experience with a particular patient group and is able to operate independently at a foundation level (Benner, 2001). According to Benner (2004) a new graduate is an advanced beginner. Both Duchscher and the findings from this research argue that new graduate nurses are commencing their transition program in rural areas with limited clinical experience as a novice.

The category of novice nurse for these graduates is also supported by the data from the senior nurses who suggested that graduates were commencing the graduate year with a lack of exposure to the multiple types of presentations and wards experienced by rural nurses. The limited exposure to different practice environments may be related to changes in education preparation in Australia, increasing the number of graduating nurses in response to a predicted nursing shortage in Australia (Al Awaisi et al., 2015; Health Workforce 2025, 2012). Recent OECD statistics show that Australia produce the 3<sup>rd</sup> highest number of nurses graduating (OECD, 2019). This finding is also supported by other researchers who found that educational changes increasing the number of nursing students, has resulted in a decreased range of placements and new graduates starting their career as novice nurses (Bvumbwe & Mtshali, 2018; Kavanagh & Szweda, 2017).

Further similarities to the conceptual framework were evident as the rural graduates were focused on completing tasks in a timely manner, within the first few months, as new skills took time to undertake and required supervision. Similar to Duchscher (2008) 'doing stage' this group of graduates, focused their supportive needs on clinical skills, highlighting a task orientated focus. Time management was a major focus of the graduates. The experience with learning how to manage time adequately was influenced by the level of support received. This was similar to Zerwekh and

Garneau's (2015) research who suggested the focus on time management was a priority, as it is an important skill to master and often the centre of a new graduate's efforts.

Feelings of satisfaction, improved self-esteem, and improved confidence enhanced the honeymoon stage as new graduates learnt to manage their time effectively. In contrast, when the graduates were unable to manage their time efficiently negative emotions occurred which heightened periods of transition shock. During this process the graduates fluctuated/vacillated between the honeymoon stage and transition shock dependent on the daily workload, access to senior nurses, preceptorship offered, feedback received and overall how well supported the graduates felt. When the graduates felt supported, they experienced excitement and confidence, when they felt unsupported, the graduates felt anxious and overwhelmed. Graduates could experience a variety of emotions on a daily basis and even on the same shift.

### **Theory provision**

New graduates reported that their clinical judgment and skills developed throughout the transition period as they were exposed to different patient conditions and situations. Graduates reported feeling greater satisfaction when they mastered their time management skills or identified deterioration in patient conditions, once again moving them into a honeymoon stage. In contrast, elements of transition shock, were evident when graduates were over stimulated with learning requirements, through structured study days, online learning packages and doubted their own clinical judgement. These findings are comparable to Calleja et al., (2019) research which indicates new graduates require education in three stages facilitating time to develop skills. For the first three months after commencing work as a graduate nurse, theory components should only include; guidance with new skills and procedures, time management, routines and patient care practices, medication management, and documentation (Calleja et al., 2019). Theory offered within the graduate program for each region consisted of orientation and structured study days within the first three months. It was felt that increased education sessions in the first few months decreased the time available to develop new skills and build the foundation of rural nursing practice.

## **Support**

As the graduates in this study entered their graduate programs as novice nurses, support during the initial months was vital to enable them to develop confidence in their ability to practice as registered nurses. Graduates who felt supported were able to feel safe to practice, ask questions and had a preceptor from which to bounce off ideas and opinions on patient care. When the graduates felt supported, they expressed feelings of excitement and heightened levels of confidence feeling empowered within the role of a registered nurse. This is reflective of the honeymoon stage. The support available varied from shift to shift, so the experience of the graduate also varied. When graduates felt unsupported during the initial stages, they often felt overwhelmed by the responsibilities that encompassed the role of the registered nurse. The concerns and uncertainty with being responsible for their own patient load was increased when less support was available. This finding is consistent with Phillips et al., (2014) study which found that graduates with limited support felt unsafe, insecure and severely inadequate for the tasks at hand. Graduates within this study described episodes of ‘transition shock’ with feelings of being overwhelmed, isolated and feeling unprepared. The new graduates expected there would be less support in rural areas, however they were not prepared for the true limitations and difficulty in accessing assistance.

## **Preceptorship**

The current study found that while graduates were satisfied with the initial supernumerary time on commencing in a ward, they were less satisfied with the preceptorship offered to provide ongoing support in the first three months. Support offered to the graduates through preceptorship was sporadic, often due to staff shortage, poor rostering, ill prepared preceptors and lack of communication. These findings are comparable with Bratt et al., (2014) who identified fewer preceptors were available to provide support within the rural areas. Calleja et al., (2019) study also found low levels of support available for new graduate registered nurses, highlighting that low resources are further exacerbated by poor communication, lower skill mix and unprepared preceptors in rural areas. Despite these findings, on days when new graduates had support available from appropriate preceptors the graduates in this study were able to thrive and feel confident and competent in their skills, moving back into the honeymoon stage.

To further exacerbate the lack of preceptor support available, new graduate registered nurses in the current study were often asked to find their own preceptor to help bridge the gap. Similar to this research, other researchers have found that at three months, self-selection of preceptors was found to be ineffective for graduates due to lack of confidence in selection of potential preceptors (Wardrop et al., 2019). This put further stress on graduates who were unfamiliar with which staff were trained in preceptorship or able to provide appropriate support and did not have the confidence to ask staff to preceptor them. Previous studies from rural NSW revealed that, self-support was only successful if the new graduates knew when they needed clinical support and if they were confident enough to ask (Lea & Cruickshank, 2007; 2014; 2015). The graduates in the rural area were not confident in asking for support at three months when needed from their main support person, the graduate nurse coordinator, many of whom had 'open door policies'.

The success of self-support also varied depending on senior staff working on a shift with the new graduates as not all staff were approachable (Lea & Cruickshank, 2007; 2014; 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). Although within this study both the senior nurses and graduates reported that the majority of clinical staff were approachable. This method of individually finding support has been used in other studies and reflects a lack of structured preceptorship (Lea & Cruickshank, 2007; 2014; 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). The structure of preceptorship was varied, and at times, limited or missing within the seven regions. Wardrop et al., (2019) found that the requirement for graduates to identify and ask a staff member to preceptor them resulted in the new graduate registered nurses not having a primary preceptor nurse from which to get support, leading to the graduates to rely on an assortment of nurses for help. Calleja et al., (2019) suggest that inconsistent and erratic support can lead to increased confusion and loss of confidence. This was similar to the experience this cohort of new graduates faced when support was inadequate, resulting in periods of transition shock.

### **Graduate nurse coordinator**

Not only did the graduates find it more difficult to transition to the role, failed expectations of a registered nurse when preceptorship was inadequate, but many felt a lack of support from the graduate nurse coordinator further exacerbated their difficulty

with the transition experience. The graduates in this study expected more mentorship from the graduate nurse coordinator, which reflected the different expectations between rural and metropolitan health care sectors. The graduates in this study expected the level of support to align with the support received from clinical facilitators as an undergraduate student which differed considerably to what they experienced when they started employment as a registered nurse in the rural areas. No fulltime graduate nurse coordinator was available to support graduates on any ward. This is similar to findings from Lea and Cruikshank (2017) who found that in rural areas, there is often no fulltime designated person responsible for the graduate program. Regardless of limited resources the graduates in this study did also indicate they received support from the graduate nurse coordinator when unable to address both personal and professional conflict, for example power imbalance or personality clash, on their own. The role of the graduate nurse coordinator and barriers to preceptorship will be further discussed in part two of the discussion chapter as it reflects both the facilitator and barriers to rural graduate program.

### **Role ambiguity**

New graduate nurses found one of the challenges of starting the new role was determining what the requirements of their role was. Graduates who had experienced preceptors were able to work through role responsibilities with them. This resulted in increased confidence and excitement in learning the role of a registered nurse resulting in the euphoric emotion evident within the honeymoon stages. If a graduate was paired with an inexperienced or busy preceptor, the responsibility for determining practice requirements was left fully up to the new graduates. This is not a new finding as research indicates transition shock is enhanced when unclear practice requirements were portrayed by senior nurses supporting new graduates (Duchscher, 2009).

Similarly, graduates indicated a need for easy access to policy and procedure manuals to enable them to find hospital guidelines to support decision making. Literature stipulates graduate nurse coordinators, nurse managers and effective preceptors are well placed to help new graduates who experience role ambiguity (Chang & Hancock, 2003). Access to guidelines increased the confidence of graduates, whilst when unable to find guidelines or when changes were being made and not communicated clearly to new graduates, their confidence and satisfaction decreased,

resulting in graduates feeling inadequate in the role of a registered nurse. These findings aligned with Phillips et al., (2014) study which identified unclear expectations resulted in role ambiguity. The graduates expressed the need for clearer guidance to help them develop a better understanding of their roles. Role ambiguity further exacerbated their transition shock experience.

### **Team member**

The graduate's transition journey included sociocultural aspects which centred on the feeling of belonging and developing professional boundaries. Within the first three months, the graduates were satisfied with the time it took to belong or feel part of the team, indicating they had expected it would take time to become familiar with the new environment. Similar to Lea & Cruikshank's (2007) findings, this study identified that a sense of belonging was significant for all new graduates, especially rural graduate nurses who often socialise with the same people they work with. Less than half of the graduates within this study moved to the rural area because of family connections, rather due to interest in a rural lifestyle and employment opportunities. Hence the new role required development of not only employment relationships, but new social and support networks. Research proposes that it is important for new graduates and colleagues to bond allowing for an increased sense of belonging, decreased sense of isolation, and ability to debrief if or when challenged (Cubit & Ryan, 2011; Rush et al., 2013). This need to develop new personal relationships in a small rural community led to some graduates from this study feeling isolated. For the rural graduates in Western Australia, isolation was lessened with increased peer support and/or frequent trips home. This cohort of graduates felt a sense of belonging, finding support from family, fellow graduates and/or staff members and were excited to be given the opportunity to work in rural areas. The excitement of starting new and/or moving to be with family, enabled the graduates to experience the positive emotions of the 'honeymoon stage' when provided with appropriate supportive measures.

### **Self-esteem**

In this study, the level of self-esteem of the graduates was seen to influence their transition shock. Most of the new graduates in this study reported a moderate to high level of self-esteem, which may contribute to high satisfaction level and prolonged



experiences of the honeymoon stage within the graduate program at three months. This is supported by research which suggests the level of self-esteem of a graduate influence the depth of transition shock experienced (Dames, 2019). There was an understanding by the Western Australian new graduates that it takes time to learn new routines and good and bad days are to be expected for all nurses. This understanding is thought to assist new graduates in their transition as they see that all nurses experience good and bad days, although less often than new graduates (Zerwekh & Garneau 2015).

### ***Stage 2: Sink or swim***

Graduates, at seven months sank when they were exhausted, disappointed, unsupported and/or feel disillusioned by the reality of nursing. The graduates swam when they were supported and realised, they were ready to learn more and felt confident in asking for help.

Following the initial stage of concurrent honeymoon and transition shock, graduates in this study experienced a period of transition crisis. Midway through the transition year graduates reported feeling exhausted and needed a holiday, and often felt like they were 'sinking', not coping. The initial transition shock had deepened to crisis level due to the loss of the feeling of excitement and euphoria experienced during the honeymoon stage, decrease in available support and realisation that the current role may be similar for the rest of their nursing career. Transition crisis was first identified by Duchscher (2007) as a time when graduate nurses begin to show disappointment or identify inconsistency within the health care environment.

Graduate nurses in Western Australia reported feeling less supported at the midway point in their graduate program and indicated being less satisfied with the decreased time available to spend with the graduate nurse coordinator and preceptors. Graduates reported a decrease in satisfaction with the amount of supernumerary time when changing rotations, frequency of feedback received, ability to become a team member and the overall satisfaction with the graduate program midway during the graduate year.

Within this study graduates felt like they needed increased support for longer durations and often felt they had to prove their capabilities with each senior nurse. There was also increased workload for some, and little tangible feedback received from

preceptors or the graduate nurse coordinators at seven months. These factors led to the graduates expressing feelings of dissatisfaction and exhaustion. The change in satisfaction and exhaustion indicated that a transition crisis was occurring and at times graduates felt like they were sinking. As the graduates progressed through the transition year, support measures were lessened as senior nurses believed that they had developed the required skills and knowledge to function independently. This is similar to other studies which suggests that by midway through programs, graduates are expected to have become familiar with the hospital environment and have developed a heightened level of confidence (Adams & Gillman, 2016; Fowler, Twigg, Jacob & Nattabi, 2018). This current study demonstrates that, with the loss of the honeymoon stage among nursing graduates in rural and remote Western Australia, transition shock actually deepens into a period of crisis and graduates felt they would either sink or swim depending on the support received (see Figure 10:1). This would indicate that supportive measures for graduates needs to continue past the midway period to decrease the effects of the transition crisis, particularly when changing to new clinical areas.

### **Exhaustion - sinking**

Work-life balance started to become a focus of new graduates around midway through their graduate program. Graduates worked fulltime and also took on extra work when requested, suggesting that this made them 'feel needed' and 'valued'. Rostering seemed to be a concern with graduates who reported being rostered seven days continuously with no breaks in between. This may have added to the graduates' struggle with the work-life balance and the exhaustion following the large amount of change they had experienced. This was comparable to Boamah and Laschinger's (2016) research, which showed that job stressors, such as extra shifts and workload can strongly affect a graduate's work-life balance. Further research also indicated emotional exhaustion is the main construct involved in burnout which can manifest as cynicism and affect interpersonal professional relationships (Boamah & Laschinger, 2016; Laschinger, Borgongni, Consiglio, & Read, 2015). This is similar to what emerged from this study and is reflective of the transition crisis experienced by the graduates (see Figure 10:1). Unlike research by Duchscher (2009) which suggests graduates are isolated and exhausted once the initial transition period ends at three months, the current

study found that exhaustion became evident midway through the transition program, around the seven-month period. This is a new finding from this study.

### **Swimming with help**

Midway through the program the graduates began to complete tasks with increasing level of confidence and begin to accept responsibility for clinical decision making. Graduates at seven months, now had an understanding about what was happening around them and had built confidence in their own ability to judge, predict and plan appropriate clinical nursing care. The graduates had moved from novice nurses to advanced beginners as defined by Benner (2004), as they have some experience in the rural environment and were able to operate independently at a foundation level. The graduates in this study were less occupied with their assigned tasks and were now able to focus their own personal development as a nurse, moving from the ‘doing’ stage to the ‘being’ stage role of an advanced beginner as described by Duchscher (2007). Duchscher (2007) described the ‘being’ stage as where graduates begin to question, examine and search for answers or explanations. As an advanced beginner, nurse graduates in this study demonstrated greater self-confidence, an eagerness to learn more to improve their nursing knowledge, but still felt the need for guidance so they could ‘swim’ better. The graduates had gained an understanding about the constraints with the support available. Lea and Cruickshank (2014) suggest that the implementation of a structured preceptorship may also help to build graduates’ level of confidence to move from the novice to advanced beginners’ stage in nursing. However structured preceptorship was limited in rural Western Australia.

### **Theory provision**

At seven months the graduates’ level of satisfaction with the theory increased significantly. Having mastered the basics of nursing care and ward structures, the Western Australian new graduates were ready to learn more and make use of the advanced skills or unstructured education available. This was similar to findings by Duchscher (2007) who suggested that once the graduates work through the emotional turmoil of commencing a new role, they are committed to work towards professional growth (Duchscher & Windey, 2018). As the many of the graduate programs had

decreased the amount of study days by seven months, graduates had to find other ways to increase their knowledge.

Ad hoc education was ward dependent and although graduates were exhausted midway through the program, they would attend extra study sessions on their rostered days off. The graduates were becoming more vocal about the content and delivery methods of the graduate study days. Studies have indicated that a degree of socialisation and assimilation is required before graduates are ready to embark on further education (Adams & Gillman, 2016; Feng & Tsai, 2012). This may account for the graduates in this study, renewed thirst for knowledge, and being ready, at seven months, to engage in the non-mandatory self-directed learning packages.

## **Support**

Learning how to manage challenging relationships was difficult for the Western Australian new graduates. At this stage the graduates, recognised power relations within the nursing hierarchy and were aware of how personality differences impacted on working relationships within the hospital setting. No longer influenced by the honeymoon stage, the graduates were able to recognise workplace incivility and started to identify the process of management within their environment. Negative workplace behaviour increases the depth of transition crisis and when management accept the behaviour as the 'norm', continues to be a problem for new graduates (Hawkins, Jeong, & Smith, 2019). Some graduates within this study reported not being welcomed by senior management when they initially commenced a new rotation. When graduates felt unwelcome and/or experienced negative attitudes and felt staff were unapproachable, this contributed to the graduate's feeling like they were drowning. This is supported by other research which found negative attitudes of staff can affect a graduate's experience (Lea & Cruikshank, 2014). Both new graduates and staff new to the clinical area adopting negative behaviours by senior nurses is described as a coping mechanism to try and fit in with other nurses (Hunter & Cook, 2018). Within this study there was an underlying reflection that if the graduates survived a less supportive environment, they would succeed in nursing anywhere. This aligns with reports that senior staff justify negative workplace behaviour as a way to improve a graduate's clinical abilities (Hawkins et al., 2019). The Western Australian rural graduate programs did not appear to assist in buffering negative attitudes of nurses towards especially new graduates. The

graduates believed they experienced workplace incivility when receiving critical feedback, feeling ridiculed and belittled. There were also reports of not being helped even when they asked and being left to believe they were inadequate in their role. These findings are comparable to research by Chachula, Myrick, and Yonge (2015) which described these challenging behaviours as horizontal violence which is often associated with a hierarchical organisational structure. The graduates within the current study managed incivility by gravitating towards approachable staff members for help so they could become better swimmers. This is comparable to Laschinger and Read's (2016) research, who suggest that using authentic leadership behaviour, approachability, direct guidance, and support, may help reduce workplace incivility. Few graduates managed to talk with the graduate nurse coordinator when they were unable to resolve matters on their own. By the middle of the graduate year, graduates had developed the confidence to speak up about negative experiences with senior nurses.

### **Team member**

The number of rotations in the graduate program influenced the ability of graduates to feel a sense of belonging in each clinical area. The shorter rotation between clinical areas resulted in the graduates expressing a reluctance to form strong friendships, as they knew they would not be staying long. The experience of feeling isolated enhanced the transition crisis at the seven-month period. Being accepted as part of the team was important to the emotional wellbeing of the graduates and influenced how they reported on their experience. Graduates in this study were rotated to new clinical areas within their transition program on average every four months. According to Missen, McKenna and Beauchamp's (2016) research, graduates starting new on a ward, having to re-socialise with ward culture, and meet new members of the staff, increased stress and job dissatisfaction. This is comparable to this study's findings with each new rotation, graduates felt they had to build new relationships, prove their clinical competency to the new staff and work through experience of horizontal violence. Although some graduates reported positive experiences when changing clinical areas, other graduates reported feeling ridiculed and belittled. This was in part, due to the need to develop new skills and competencies for each clinical area and the decreasing support offered to assist the new graduate to develop these competencies as the year progressed. This study identified that understanding the culture of the ward environment and

learning how to interact appropriately with both staff and patients, was just as important and often more challenging than becoming proficient in a variety of clinical skills. Similar to Feng and Tsai's (2012) findings, being part of the team is really important for graduates. For Western Australian new graduates, feeling a sense of belonging was sporadic, present one day gone the next, and dependent on the ward environment, skill mix, and workload. Creating a sense of belonging for the majority of graduates was also limited due to the length of each rotation in each of the clinical areas. The link between feeling part of the team and clinical rotations will be further discussed in part two.

Although the graduates suggested they were quicker to settle into their second ward, the graduates were less satisfied with being part of team and the support provided. The reduction in level of satisfaction was found to be directly related to the graduates increased understanding of ward management and decreased supportive measures. Findings differed between the ward areas where graduates were placed, suggesting that the level of satisfaction with the graduate program and a sense of belonging depended on both the culture of the ward and length of time spent in the clinical area. Therefore, being able to settle quickly (swim as opposed to sink) at the start of their second rotation might be more reflective of the graduates learning how to manage as opposed to feeling like they belong. This was comparable to Hunter and Cook (2018) who discussed the importance of professional socialisation and learning professionalism from experienced and approachable nursing role models. Level of satisfaction for both preceptorship and supportive measures was reduced at the seven-month period, in line with the reduction of support, however this type of focused support was still needed to help new graduates settle and understand the cultural nuances within a new environment.

### **Peer support**

Peer support became an important part of the coping mechanisms of most graduates by the middle of the graduate year. The excitement of being a registered nurse was no longer evident and the graduates were beginning to understand, at a deeper level, there was a difference between their idea of nursing and the reality of nursing. The graduates were disillusioned and the feeling of being homesick became evident for some graduates. It was at this point that peer support became important. Regular peer debriefing enabled a sense of belonging, feeling less alone and knowing that it is okay

to have a bad day. This aligns with research suggesting graduates, reaching this stage, were developing their professional identity, which is influenced by experience and ability to assimilate (Rasmussen, Henderson, Andrew, & Conroy, 2018). Regular debriefing was formally organised fortnightly by the graduate nurse coordinator and informally by graduates themselves in some regions, which helped the graduate's ability to assimilate and feel a part of the team. These findings are similar to the work of Lea & Cruickshank (2014) who identified that debriefing sessions are a valuable support for rural graduates. However, some new graduates in this study expressed reluctance to attend planned informal and formal debrief sessions held during work hours when it conflicted with patient care needs. This may have been reflective of the graduates not being confident within the current environment to delegate patient care to a team member, the high workload expected of all staff or the belief that to be a successful registered nurse, they needed to be able to provide all required patient care independently.

Graduates in this study expressed their desire for more one-on-one support during the middle of their graduate year. They had developed the confidence to speak up for themselves. The graduates advocated for themselves when there was a lack of support due to no allocated preceptor or heavy workloads. Once again, this suggests the need for supportive measures to continue for a longer period, opposed to being reduced as the graduate progressed.

### ***Stage 3: Swimming without 'floaties'***

The final stage 'swimming without floaties' reflected an adjustment stage. Increased satisfaction and confidence with their nursing role was evident and the graduates' discussions focused on future ambitions as a nurse. This study found that by the end of the graduate nursing program, all graduate nurses felt confident about practicing in rural and remote areas. The graduates were proud to reflect they felt equipped to work anywhere because of the clinical experiences gained in a rural sector even more so, when they compared themselves with colleagues from metropolitan areas. This finding differs to Bratt et al., (2014) study which identified increased autonomy resulted in increased job satisfaction.

The graduates had an increased level of confidence with caring for complex patients. The graduate's level of confidence was incremental and developed throughout the Western Australian rural graduate program. In contrast, McKenna and Newton's (2008) study identified new graduates did not feel confident in the role of a registered nurse until the end of the 12 months transition program. Despite the graduates projecting confidence in the final stages of the graduate program, they still indicated that support in the form of career advice and debriefing after critical events was needed.

### **Theory provision**

At the end of the graduate program the graduates' focus changed from surviving on the wards to determining how to secure future employment. This is reflective in the qualitative findings 'ok got it, now what?' theme. Graduates were looking for career advice and for future studies to enable them to work in their chosen areas. This is similar to the findings of Duchscher (2008) who found that during the final transition stage the 'knowing stage', the graduates were interested in advancing their career paths. Graduates receiving advice in planning towards future career goals was dependent on the individual graduate nurse coordinator and each graduate. Lea and Cruickshank (2014) also identified the need for education of graduates in the final stage to include interview skills to assist in gaining further employment. By the time the program had finished, some of the graduates had already commenced further studies and many had secured extended employment contracts. In some regions, graduates began to focus on developing leadership skills and the role of a shift coordinator.

### **Support**

Despite the graduates increased confidence and readiness to plan for the future, this group of graduates still felt the need for support. There was a need for formal debriefing sessions with senior nurses after clinical events. The events did not always revolve around a medical crisis, however due to the rural and remote environment, critical events such as caring for people they knew from the community added stress that may not have occurred in the undergraduate experiences or in a metropolitan region. Lack of anonymity and the increased importance of personal and professional boundaries, and confidentiality are often more apparent within small rural communities (Oosterbroek, Yonge, & Myrick, 2017). Combining personal and professional roles may



reflect a sense of belonging, however learning how to apply professional boundaries, balancing the conflicting expectations often takes time (Yonge et al., 2018). Supportive measures were required more for future direction and emotional support needed to continue to help develop an understanding of how to work professionally in the same community you live.

### **Team member**

A sense of belonging influenced the graduates' desire to further their educational opportunities and clinical skills. Graduates who felt a sense of belonging were often ready to precept students and learn advanced skills. Graduates who did not feel a sense of belonging failed to integrate further into the program and withdrew from the opportunities to advance their skills. This was comparable to Lea and Cruickshank's (2017) study who suggest graduates who received insufficient socialisation often resulted in low motivation for increasing clinical skills. For this study, the lack of motivation could also be attributed to limited future career opportunities available in rural areas. Providing one study day focused on graduates' current and future needs is a recommendation from this study. This recommendation was comparable to Duchscher's (2008) findings, which highlights future career and educational support is required in the final stages of the transition program.

The graduates had successfully transitioned from student to registered nurse. By this stage, the graduates had learnt who they could trust and rely on for positive and constructive guidance. This signified that the new graduates had learnt the skill of professional socialisation. These findings are comparable to Duchscher's (2008) research who identified that graduates at the 'knowing stage' were able to answer questions and assist others with their workload, having obtained a greater ability to cope. However professional socialisation is reflected in Lea and Cruickshank's (2014) research when the graduates at the 11-12 month timeframe felt accepted by the team and had made positive relationships.

## Graduates Level of Satisfaction over their Transition Journey

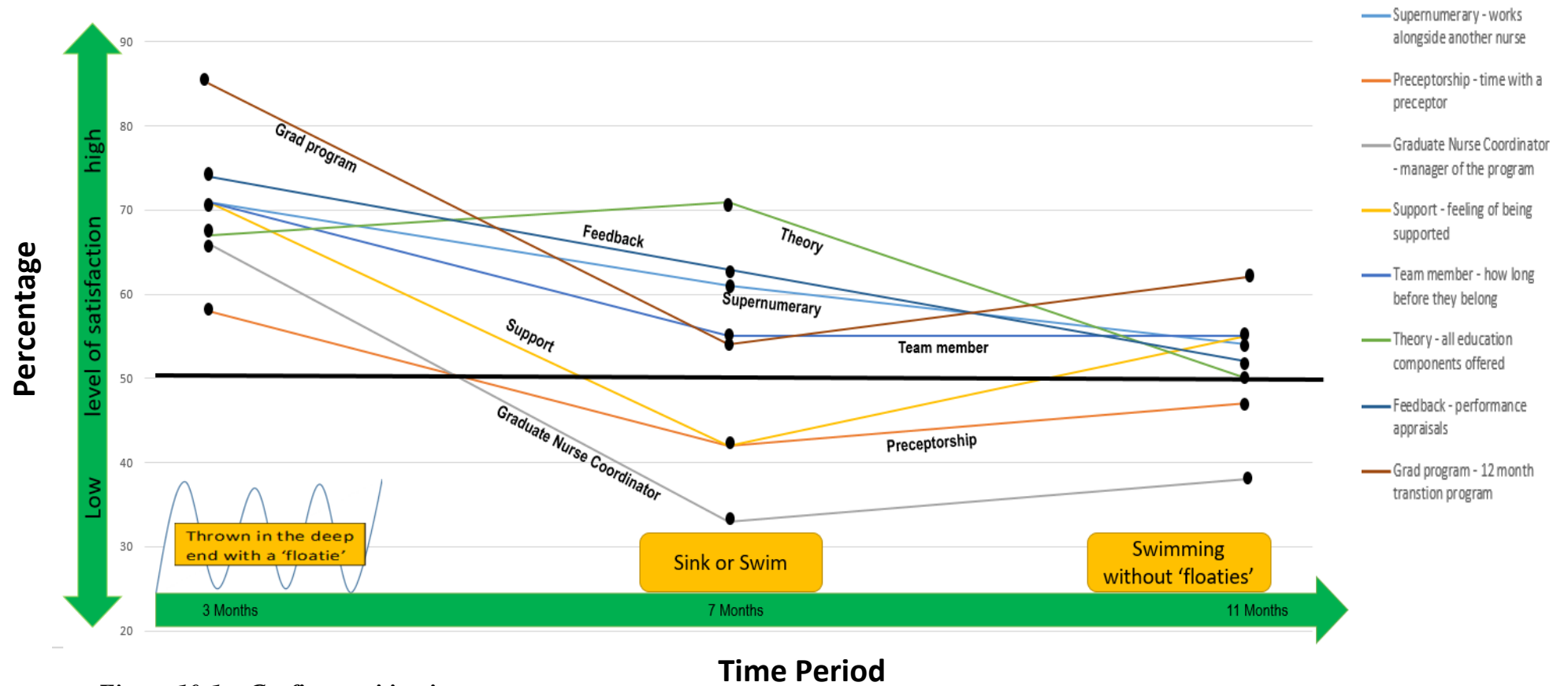


Figure 10:1 Graf's transition journey

A reason for new findings from this study could be attributed to the time of data collection accompanied by the mixed methods approach. Similar to this study, Ulrich et al., (2010) Goode et al., (2009) and Williams, Goode, Krsek, Bednash, and Lynn (2007) identified that new graduates started with high satisfaction rates, which decreased around six months before improving. Each of the studies data collection time points were at the beginning middle and end, as opposed to three, seven and 11 months. In contrast, Rush, Janke, Duchscher, Phillips, and Kaur (2019) identified studies that indicated a graduate's level of satisfaction did not change throughout the 12 months. Within a different study, the graduate's level of satisfaction was mixed dependent on which component was being measured e.g. workload, or support (Hussein, Everett, Ramjan, & Salamonson, 2017). The survey was applied at the beginning and end of the transition program.

Two studies have collected data at the three different time points, three, six and 12 months similar to this research, and measured level of satisfaction (Missen, McKenna, and Beauchamp, 2014). Both studies described by Missen et al., (2014) were descriptive comparative designs, the method used was quantitative only and found the graduate's level of satisfaction was high. Lampe (2014) identified the satisfaction level continued to decrease over the 12 months. In this study, the Western Australian rural and remote graduates started with a high to mid-level of satisfaction followed by a steep drop in satisfaction (except for theory) before improving slowly at 11 months.

## ***Summary***

Graduate programs continue to be needed to support the transition of new graduates from student to independent registered nurse. The decreased clinical hours offered in undergraduate degrees and increased number of graduating students each year, has changed the construct of a graduate to completing their degree at the novice level. Graduates go through different stages throughout their graduate year. The first stage, thrown in the deep end with a floatie, involved new graduates vacillating between transition shock and honeymoon periods resulting in a high level of satisfaction overall, however concurrently experiencing transition shock as they were faced with limited support and confusion regarding their nursing role. Towards the middle of the graduate year, graduates were exhausted from the physical and emotional changes, and their level of satisfaction dropped significantly resulting in a crisis point where graduates would

sink or swim depending on supportive measures. Although the graduates had started to question the application of the structured program, they soon became advocates for themselves. Questioning, advocating and being more settled signified the progression to the advanced beginner's stage by the middle of the year. The adjustment period began towards the end of the 12-month program and graduates were 'swimming without floaties' and the need for as much support and displayed confidence and competence in working towards their future careers. The transition occurred in a linear progression over three distinct stages. The graduates support needs differed at each time point however support was required for the full transition year.

## **Part Two**

### **Introduction**

Part two will focus on the facilitators and barriers to a successful transition for graduates identified throughout the transition journey. This will be broken into two main themes which surfaced, the first includes the provision of supportive measures. Focused support, close one-on-one support, was not consistent throughout the programs in all regions. The second highlighted, was the importance of a sense of belonging within the hospital and ward environment.

### ***Facilitators and barriers to effective rural nursing graduate programs***

Facilitators to effective nursing graduate programs in rural and remote Western Australia include adequate supernumerary time, trained preceptors and structured education sessions. Barriers to effective nursing graduate programs include short clinical rotations, ineffective preceptorship and limited resources. Support available for implementation of graduate programs in Western Australia's rural sector was limited, and both graduates and senior nurses struggled with the lack of resources. Similar findings were identified in other research into rural graduate programs in Australia (Calleja et al., 2019; Lea & Cruikshank, 2017; Lea & Cruikshank, 2014).

### ***Supportive measures***

#### **Role of the graduate nurse coordinator**

Graduate nurse coordinators within Western Australian rural and remote regions held multiple roles and were undertaking the graduate nurse coordinators role in a part-

time capacity. This meant that support from the graduate nurse coordinator was not always available to graduates. Graduate nurse coordinators were responsible for recruitment of new graduates, administration of the program, clinical rotations, facilitating the study days as well as being available for emotional and social needs (Missen et al., 2016). Comparable to Lea and Cruickshank's (2017) research, the rural graduate nurse coordinators in Western Australia were often restricted in providing focused support in rural areas due to multiplicity of roles and limited time allocated for graduate support.

Support from the graduate nurse coordinator decreased throughout the graduate year to coincide with graduates' increased confidence and skills acquisition. This is supported in research by Adams and Gillman (2016) which identified a decreased focused support was appropriate in the second rotation because the graduates were familiar with the clinical environment. However, within this study the level of satisfaction with the time spent with a graduate nurse coordinator decreased significantly midway through the program, suggesting the level of support may have been reduced too early. This is supported by other research, which suggests that a decrease in support over time should not automatically occur, but be tailored to graduate specific needs (Calleja et al., 2019). Several authors suggest a 2-3 tiered approach for the provision of support as occurred in the graduate program, with a preceptor, a clinical nurse manager and a graduate nurse coordinator providing appropriate support needs at different intervals for individual nurses within the transition program (Calleja et al., 2019; Rush et al., 2019; Lea & Cruickshank, 2014). Although the three tiered approach was implemented in rural Western Australia, the part-time allocation of the graduate nurse coordinator, difficulties in preceptor allocation and limited support time available due to multiple roles made this approach less effective. The lack of support available for graduates may limit their professional development as current research suggests it is important for graduates to be challenged and adequate support provided for professional development to occur effectively (Calleja et al., 2019). Within this study, a barrier to the transition of graduates was with the time available for graduate nurse coordinators to spend with each graduate to build confidence and develop skills.

The Western Australian new graduates continued to expect assistance from the graduate nurse coordinator in areas of social and emotional support, for example

conflict resolution, which was not always forthcoming. Similar to Lea and Cruickshank's (2017) findings, this research suggests that graduates' expectations of support from nurse management (both graduate nurse coordinator and clinical nurse manager) was left unmet. Missen, McKenna and Beauchamp (2015) suggest graduate nurse coordinators are expected to work closely with graduates and assist in identifying challenges and clinical strengths within a graduate's first year of practice, providing continuing intellectual analysis and providing educational needs specific to the wards. However, this current study found that a considerable number of graduates believed that this level of support was not available to them and was only experienced by a minority of graduates.

## **Feedback**

The graduates were satisfied at three months with the feedback they received which related to the performance appraisal and completed reviews from preceptors and/or clinical nurse managers before moving to the next rotation. According to Poikkeus, leino-kilpi, and Katajisto (2014), this was the perfect time, for senior nurses to nurture graduates, inspiring them to improve in areas of weakness and highlight areas of strength. This feedback helps to develop a graduate's self-awareness and focuses on the capacity for each graduate to evolve (Poikkeus et al., 2014). This transition facilitator is aligned within the first three months when graduates received increased support.

Formal feedback was provided within the first six months by managers and preceptors, not from graduate nurse coordinators. Within this study, formal feedback after six months was found to be limited from the preceptors and managers due to poor rostering and/or lack of knowledge on how to provide constructive feedback. This was similar to Lea and Cruickshank's (2017) research who identified that many graduates did not receive formal feedback instead often relied on causal conversations. This vital feedback could be improved if appropriate training was provided to all preceptors within the rural sector on the importance of providing feedback to the professional development of graduates.

The new graduates needed feedback support throughout the 12 months. During the latter half of the graduate program, both informal and formal feedback support was

sought from whomever would provide it, preceptors, senior nurses and managers, in this study, and less from graduate nurse coordinators. Some similarities with this research aligned with Calleja et al., (2019) findings, which suggests graduates often turned to managers and clinical educators for feedback, debriefing, emotional support, advocacy and encouragement within their clinical practice. This research ascertained that the graduates did not expect formal feedback from the graduate nurse coordinator. Within rural Western Australia, formalisation of a team approach would improve this supportive requirement drawing on managers, preceptors and graduate nurse coordinators to provide formal feedback.

### **Preceptorship support**

In the Western Australian rural areas, senior nurses understood that graduates were allocated preceptors for the duration of their clinical rotation however, in reality from a graduate's perspective it was less than 1-2 weeks. After the initial two weeks (supernumerary time) the rostering system resulted in challenges for the partnership to continue due to night duty, holidays and skill mix. Fewer senior nurses in some areas resulted in the graduate working opposite shifts. These issues with preceptorship in rural environments are similar to those identified by Calleja et al., (2019).

Both new graduates and senior nurses felt there was a lack of focused (one-on-one) support, such as preceptorship throughout the Western Australian rural graduate program and limited availability of senior nurses, this increased the challenges for the new graduates. Within the first three months a lot of the graduates felt abandoned due to the inadequate preceptorship. Graduate nurses reflected a lack of support through the negative emotions felt and experience of transition shock. The lack of preceptorship was apparent throughout the graduate year, however at seven months the graduates were able to identify issues with the health system, such as rostering and the part-time workforce, which led to some understanding about the lack of effective preceptorship.

Senior nurses discussed the need for a team approach to help address the lack of preceptorship being delivered. Within this study both individual preceptorship and team preceptorship was implemented depending on the region and available resources. Despite these efforts, overall there was a lack of satisfaction with the preceptorship offered. Calleja et al., (2019) suggested a variety of methods in addition to

preceptorship could be used to provide focused support, such as a one-on-one mentoring and group mentoring to overcome the limitations of preceptorship in rural environments. Having a mentor and a preceptor may have helped increase the level of support, however structured mentorship was not evident for the graduates within this study.

Graduates were often encouraged to find their own support when preceptorship was not provided, or to self-select their own preceptor. Senior nurses believed the self-select process was one method that would help address the limited resources barrier to providing adequate support. However, the success of self-support varied depending on senior staff working on a shift with the new graduates because not all graduates had the confidence to ask staff for preceptorship and not all staff appeared approachable to graduates (Lea & Cruickshank, 2007; 2014; 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012).

### **Training and recognition**

Senior nurses in this study highlighted the need for the training of preceptors. If the preceptor functioned as an educator, socialiser and validator for clinical skills, these attributes helped improve the confidence and competence of the graduates (Quek, Ho, Hassan, Uek, & Shorey, 2019). In direct contrast, when feedback was inadequate or avoided and the preceptor did not help validate clinical skills, the confidence and self-esteem of graduates within this study decreased. According to St-Martin, Harripaul, Antonacci, Laframboise, and Purden (2015), effective preceptorship is important to a graduate's transition as preceptors who were inexperienced, unprepared or unreceptive, hindered their development. Both graduates and senior nurses identified that there were not enough preceptors with appropriate experience or formal training in rural Western Australia to provide the appropriate level of support to graduate nurses. Research suggests that a supportive environment including affective preceptorship and an appropriate skill mix are vital to enable a supportive learning platform (Wardrop, et al., 2019). Graduates within Western Australia believed that if they needed focused (one-on-one) clinical support, they were required to rely on identifying staff from which to seek help themselves. If the graduate was successful, this may have provided a supportive person however less was known about their preceptor skills. Facilitators or requirements for preceptor training, according to Rush et al., (2019, p.153), involves



*“adult learning principles, learning styles, conflict resolution, interactive experiential approach and frameworks such as Benner’s novice to expert transition framework”.*

Inadequate preceptorship was a barrier within the rural areas and preceptorship training is needed in rural Western Australia to help address this gap. Successful preceptorship in specialised and in rural clinical areas increases retention rates (Oosterbroek et al., 2017) and may decrease transition shock for all rural new graduate nurses.

Preceptorship in rural Western Australia was considered effective if the graduate was paired with an experienced and supportive preceptor. This aligns with Rush et al., (2019) findings who also indicated that preceptorship was poorly received when graduates were matched with a less supportive or inexperienced nurse. Within this study it was identified that not all nurses have the desire or appropriate attributes such as patience, knowledge, ability and willingness to teach. Comparable with Calleja, et al., (2019) findings who further stipulate that many staff do not know what supportive needs graduates require to successfully transition.

From the findings of this research, it is apparent that preceptorship should be formally recognised in workloads and each preceptor should receive adequate training. ‘As Pasteur famously noted, experience alone is not sufficient to provide expertise’ (Schwartz, 2019 p.45). The senior nurses identified a lack of enthusiasm towards the role of preceptorship and suggested formal recognition and training as a possible solution. However, research suggests that adequate training might be affected by staffing limitations and workforce shortages which may result in lost opportunities to attend education sessions and enhance professional development (Twigg, Cramer, & Pugh, 2016). The education available for preceptors in rural Western Australia was limited and involved online learning packages. There was very little recognition and therefore no real incentive for senior nurses to take on the role of a preceptor. The preceptorship role was additional to the clinical role expected of senior nurses. It was often considered part of the role of a registered nurse, although workloads were never adjusted to acknowledge the extra work involved. The level of preceptorship needs to improve in rural Western Australia for support mechanisms to be effective.

## **Educational support**

Education is about the transference of knowledge. How knowledge was shared, transferred and learnt was important for all involved in the graduate program. Areas of educational support required within the graduate program included structure and flexible support and simulation.

### **Structured**

This research highlighted a need for education to be structured with direction as to what to complete for both mandatory and specific ward requirements. Five to six study days were allocated throughout the year, but most front loaded the days into the first six months of the program. This seemed to cause increased stress and overload for the graduates who just wanted to know enough about the health service and role requirements to survive their first placement. Decreasing the theoretical load at the beginning of the program was thought by graduates to help with time management and ability to access online resources more proficiently, enabling graduates to focus their energy on the important skill development areas. These findings align with studies that indicate organisational socialisation needs to happen before graduates can focus on structured education (Feng & Tsai, 2012; Malouf & West, 2011). The graduates' focus on time management during the first few weeks resulted in them having a limited ability to undertake and appreciate additional education opportunities. During the first three months, graduates' were constantly learning as they encountered new patient conditions and worked to consolidate skills. This resulted in the graduate feeling less satisfied with the educational component of the graduate program, as they were already feeling overwhelmed with individual learning opportunities. This is in contrast to the beliefs of senior nurses who felt they needed to provide all the information that graduates needed at the start of the graduate program. The graduates in Western Australia did not seek further education until midway through the transition year. These findings are comparable to McKenna and Newton's (2008) research who suggested that it takes up to six months before a graduate is settled. The graduates required a structured education program, consisting of only the necessary mandatory and ward specific knowledge to navigate the ward and patient care, especially within the first three months.

Rural and remote Western Australian graduates identified that their professional development was limited by a lack of staff development nurses, limited resources and they often missed education sessions due to time management concerns. These findings were similar to Hendrickx and Winters' (2017) research which highlighted that a lack of time, inadequate staffing, lack of technological resources, and lack of a dedicated clinical educator as barriers to providing education in rural areas. The graduate nurse coordinators in this rural study were focused on organisational directives, however many were also open to suggestions and when possible, allowed flexibility within the education schedule. This aligns with Missen et al., (2016) research who suggested the structured study days are dependent on financial and organisational directives.

### **Flexibility**

Increased flexibility in educational delivery was considered beneficial midway through the program by both graduates and senior nurses. Education needs of graduates began to focus on developing increased ward specific clinical skills rather than general skills, which were desirable to increase knowledge specific for each clinical environment. This is comparable to Missen et al., (2016) research which indicates graduates want education that is relevant to their everyday clinical practice. Midway through the program graduates felt they needed to know more and were ready to learn. More online learning packages were being utilised by graduates as they identified their own learning needs. Flexibility within the education supportive measures was warranted at this stage to enable graduates to access education as they felt ready.

At seven months both structured and flexible learning was appropriate, and within this research both were valued by the graduates and senior nurses. Graduates expressed a desire to have a voice in planning the content of education sessions by midway through the program. However, research by Missen et al., (2016) recommended a needs analysis before developing the graduates' study days. This could be done with graduates during the program to ensure that both required content from the health service and specific needs of graduates were being met. The structured study days for the majority of program were assigned throughout the year. Some senior nurses tailored the graduates' education sessions to what would be applicable for future and/or current clinical areas.

## **Simulation**

Face-to-face educational support from senior staff and other opportunities proved difficult in the rural areas. However, when structured study days and ad hoc sessions were scheduled, both senior nurses and new graduates discussed simulation as an affective educational method. Adams and Gillman's (2016) research identified that one of the main benefits of simulated education was that it was designed to encompass a multitude of learning objectives for example, problem solving, advanced skills acquisition, leadership skills and hence met the needs of multiple people with each simulation. The few rural graduates who undertook simulation-based training in Western Australia believed it was more effective than didactic or online learning activities. This is comparable to Adams and Gillman's (2016) study which considered simulation as an effective educational method within a transition program. Use of simulation, although not as common as didactic education sessions, was valued by graduates as an effective learning tool. Rush et al., (2019) also identified that simulation activities enhance confidence and competence for new graduate to function independently.

## ***A sense of belonging***

### **Rotation lengths**

All graduate programs within this study consisted of varied rotations, with different lengths of time and number of rotations in each region. Several graduates indicated that they had applied for rural graduate positions due to the rotations offered. Missen et al., (2016) research also identified that graduates wanted diversity within their graduate program. However, throughout the discussions, senior nurses felt depth of knowledge developed through longer experiences in one clinical area was more important. This was in direct contrast to the high percentage of senior nurses who were satisfied with the current clinical rotations. In order to explain this anomaly, further research would need to be conducted.

The shorter rotations was believed to limit the ability of graduates to be able to gain a sense of belonging whilst on the wards. When the graduate had developed the depth of knowledge and skills to become a valid team member they moved to a new location. The benefits of providing a depth of knowledge and socialisation to the ward

by staying in one clinical area within a transition year was seen by senior nurses to outweigh the benefits of providing a breadth of experience in multiple wards. Similar to Missen et al., (2016) findings which reflects graduates are just starting to feel a part of the team at three months, and often take longer to settle in their first rotation. Many graduate nurse coordinators throughout this study discussed changing the rotation lengths from three months to six months or even 12 months, due to both graduate and senior nurses' feedback. When asked directly, the majority of new graduates liked the idea of longer rotation and believed it would increase confidence and help provide an increased sense of belonging.

### **Four-month clinical rotations**

The senior nurses considered new graduates moving every four months and/or completing short rotations within a short time frame was detrimental to both the Western Australian rural graduates and the ward staff. This is comparable to Lea & Cruickshank's (2014) research who depicted new graduates enjoyed the rotational aspect but with each move, a loss of confidence would ensue. Adams and Gillman's (2016) research further identified that heightened anxiety levels was also attributed to clinical rotations. However, within this study a small number of senior nurses believed the four-month rotations were beneficial to new graduates despite the increased anxiety levels and loss of confidence. Similar to Missen et al., (2016) research who suggest this was attributed to if a graduate was unhappy, they were there for a short duration offsetting job dissatisfaction.

### **Team member**

Being considered a valid team member, was believed to be evident when graduates displayed the ability to accept responsibility and accountability for their workload, recognise their limitations, ask questions when appropriate, be able to display clinical judgement and escalate care if needed (van Rooyen, Jordan, ten Ham-Balyoi, & Caka, 2018). This took time and often the graduates within this study did not reach this level of competence until they had achieved the advanced beginners' stage and become comfortable working in a particular ward environment. Each time a graduate rotated to a new ward, they felt they were judged on their clinical competency before being accepted a valid team member. In contrast to these findings Lea and Cruickshank (2007)

suggest graduates were measured against their ability to cope with the workplace culture and workload, and not necessarily their ability to perform specific skills. However, Adams and Gillman (2016) suggest socialisation is the process through which graduates acquire knowledge and skills. This is comparable with this study, as some senior nurses understood there to be a direct correlation with fitting in and the level of competence in skills and knowledge. The drop in satisfaction level with being a team member of graduates following the first rotation supports the importance of longer placements in enabling graduates to develop the clinical skills and workplace culture to feel a part of the clinical team. This research reflects the importance of length of clinical rotation to develop the depth of knowledge in order to develop a sense of belonging and feeling like a valid team member.

## ***Summary***

The role of a graduate nurse coordinator in rural areas was complex and involved many portfolios, limiting their ability to provide support to graduate nurses. A team approach to coordination of graduate support may help balance the graduate nurse coordinators extensive role. Support provided by preceptors was ad hoc depending on rosters and other work requirements. This limited the support available to graduates and affected their ability to feel part of the team. Self-selection of preceptors was difficult for graduates who lacked confidence and did not know the ward staff. Training and experience of a preceptor influenced the graduate's journey, suggesting that there is a need to ensure preceptors complete appropriate training and are recognised within their clinical area. The number of clinical rotations allocated in a graduate program needs carefully consideration when developing the graduate program. The development of competence and confidence was linked to a sense of belonging, which improves with time in one clinical setting.

## **Summary of chapter**

This chapter addressed the four research questions. Similarities and differences were identified when the findings were compared to current literature and the conceptual framework. The co-existence of the honeymoon and transition shock stage was a new finding. Facilitators and barriers were found by both new graduates and senior nurses throughout the transition journey. The next chapter will consist of the recommendations, limitations and further research needs and conclude this thesis.

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## **CHAPTER 11: Conclusion**

### **Introduction**

The previous chapter addressed the research questions and mixed the findings from graduate and senior nurse interviews and survey. Both the differences and similarities with the current research and the conceptual framework were identified. This chapter will complete the research study and transition journey for the rural and remote Western Australian new graduate nurses who commenced their graduate program in 2015. The recommendations are reflective of the Western Australian graduates' perceived needs throughout the structured program. This chapter will provide a concise summation of the research questions and identify the limitations within the study. Further research recommendations will conclude the chapter and complete the thesis.

### **Graduate experience**

The graduate's level of satisfaction throughout the transition journey resembled a V-shaped pattern, high on commencement of the graduate program, dropping midway through the transition program before the level of satisfaction started to improve toward the end of the program. When mixing the two research methods, it was clear that the graduate experience of the honeymoon period melded with the transition shock stage for the first three months. Although exhausted midway through the year when transition shock was evident, there was minimal attrition in the program. The rural and remote graduates gained confidence by the end of the transition journey and believed they had the competence and confidence to practice as independent registered nurses.

### **Graduate programs**

Graduate programs continue to support the transition of new graduates. The decreased clinical hours offered in undergraduate's degrees and increased number of possible graduates each year has changed the construct of a graduate completing their degree at a novice level. This has resulted in the need for increased support measures to be in place for the length of the graduate program.

The findings from this study suggest that perhaps there is a need to structure a rural transition program differently. Due to limited resources, a team approach to the

graduate coordinator's role may be more effective in a rural setting. The team approach would include two groups, one group facilitating the tiered education throughout the program. The second group would facilitate the focused one-on-one preceptorship support. Creating a program that scaffolds learning to increase theoretical knowledge throughout the year would be beneficial to the learning needs of graduates. Combining the structure program with flexible content, online available self-directed learning packages and simulation was seen by participants to be the optimal method for delivering a rural graduate program.

Improving a sense of belonging for each graduate as they progressed through the three stages with clear and concise expectations was considered vital for all involved in the transition program. This could be addressed by reducing the number of clinical rotations offered within a graduate program and providing role descriptions and learning outcomes for each rotation. This would assist both the graduate and preceptors to understand the learning needs of the graduate and plan workloads and activities to assist in the personal development of each graduate. Pairing this with feedback from preceptors trained to deliver feedback in a constructive manner to build up the graduates' confidence level, would place the graduate in the best position to develop their professional competence and confidence.

## **Recommendations**

The findings from this study highlighted the multiple roles of the graduate nurse coordinator which included managing the education provisions and ensuring support was provided for each graduate. Preceptorship was lacking and the level of satisfaction with support decreased at seven months. Although, education was overwhelming to begin with, it was well received midway through the program and the graduates were generally satisfied with this component of the graduate program. A team approach to the graduate nurse coordinator role would be a recommendation from this study. For example, one group responsible for the education process within a graduate program and a second group responsible for the supportive needs such as preceptorship may reduce the level of both transition shock and transition crisis felt midway through the transition year.



As a result of the graduate's experience and input from senior nurses' recommendations from this study, a progressive approach to the structured education program would be beneficial. Beginning as a novice, a regimental approach to the exact education needs would benefit each graduate. This would be followed by a mix of flexibility and structure education. The structure and flexibility term relate primarily to the content of the planned study days. The final progressive stage would involve a flexible approach to structured education, tailoring the education to the needs of the graduates (see Table 11:1).

The recommendations for the senior nurse responsible for the supportive measures would include the need to continue increased support up to nine months for each graduate. Longer clinical rotations are advisable, with each rotation commencing with a structured hand over process from the previous preceptor of graduate nurse coordinators. This would lessen the need for graduates to prove themselves each time and aid the new preceptor in identifying learning needs and development opportunities for the graduate. One senior nurse in each of the smaller sites should take on the role of mentor for the graduates, ensuring they are allocated preceptors and are able to offer sociocultural support in lieu of the graduate nurse coordinator. It would also be advisable for all new graduates to be allocated a short break midyear and increased support during this period within the transition journey, to help lessen transition crisis.

Learning how to manage challenging relationships was also difficult for the new graduates within this study. A transition unit delivered in the third year of undergraduate nursing programs would be beneficial to help students learn how to manage difficult relationships without the support of their clinical supervisor. This unit could also cover the signs and effects of transition shock as providing a heightened awareness and understanding of this stage and ways to manage the changes may decrease the graduates' experience of transition shock and transition crisis through a graduate program.

**Table 11:1 Recommendations**

	<b>Identified Needs</b>	<b>Implementation</b>
<i>Support</i>	<p>Clarify graduate nurse coordinator responsibilities to provide focused (one-on-one) support only;</p> <p>Ensure each graduate has a two-week break midyear;</p> <p>Provide focused support for at least nine months;</p> <p>Allocate a senior nurse on each ward the responsibility for allocation of preceptorship and supernumerary time for graduates</p>	<p>Implement preceptorship education;</p> <p>Allocated supernumerary time;</p> <p>Reduce the number of clinical rotations to two per year;</p> <p>Coordinating senior nurse to handover graduate's progression from on rotation to the other;</p> <p>Appoint a coordinator (senior nurse) in each facility (clinical site)</p>
<i>Pre-registration education</i>	Transition to practice education	Implement unit which covers an understand of transition shock and transition crisis and ways to manage it
<i>Structured Education Support (graduate program)</i>	Education to be delivered by the staff development team in the region	– one team is responsible for education
	0-4 months – structured education	Orientation, specific learning packages, outline senior nurse roles and graduate expectations
	5 -8 months – mixed both structured and flexible education	Both structured study days and ward specific education – ask what the graduates want to learn about
	9-12 months – flexible education Career driven	Flexible education model- what the graduates want – leadership capabilities, interview skills apply for jobs working toward further studies.

## Future research

Further research is required to identify the possibility of a sustainable structured program for all seven regions. A pilot study of the recommended structured education graduate program would be beneficial in rural Western Australia reflective in two smaller regions to begin.

Future research should also include focusing on the graduates who predominately complete rural placements in their undergraduate studies and return to rural for a graduate program. The hypothesis would be if previous experience in rural settings produces advanced beginners or reduces the graduate's experience of transition shock in rural settings.

## **Limitations**

The main limitation throughout the quantitative segment of this study was the sample size. Over 50% of the newly graduated nurses participated in the study however numbers remained small due to the small population group. Although this study is transferable for all rural and remote Western Australian new graduates, due to the small numbers, this would limit the ability for this study to represent all rural and remote graduate nurses Australia wide. Not all senior nurses involved in the graduate's journey participated in the survey which limits the generalisability of the study to represent all senior nurses.

There were two limitations identified with the chosen quantitative tool. One limitation involved the segment that asked the question about theory, which was generic, limiting the ability to analyse the data in-depth. The question was not specific to the theory content or time offered for education. However, the qualitative interviews were able to cover the principles of education offered in the graduate program in-depth.

There was a second limitation with the survey which involved the scale for the feelings of support indicated by graduates. It was felt that this question would have been better as a 10-point Likert scale as opposed to a 5-point Likert scale. This would strengthen the ability to measure the findings.

With regard to the qualitative data analysis, there is one limitation which could be improved in future research. Gathering data at more frequent timeframes may provide further evidence of when the honeymoon stage and transition shock occurred concurrently and when changes in these occurred throughout the year.

## **Conclusion**

This chapter has provided a succinct answer to the research questions and highlighted the importance of transition frameworks to build supportive graduate programs. A sustainable structured education program which focuses on the different stages of the graduates' development would improve their ability to incorporate their professional development opportunities into their practice. Recommendations were presented from the findings of this study. However, there were a number of limitations

suggesting further research is strongly recommended to help further understand the transition phenomenon.

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"Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged".

## APPENDIX A: Article One

This following article is not available in this version of the thesis.

Appendix A has been published as:

Fowler, A. C., Twigg, D., Jacob, E., & Nattabi, B. (2018). An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates. *Journal of Clinical Nursing*, 27(5-6), e753-e766. DOI: [10.1111/jocn.14211](https://doi.org/10.1111/jocn.14211)

The green open access version of the paper will be available at:

<https://ro.ecu.edu.au/ecuworkspost2013/3799/>

## **APPENDIX B: John Wiley and Sons License for Paper One**

Appendix B is not available in this version of the thesis.

## APPENDIX C: Article Two

This following article is not available in this version of the thesis.

Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B. (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models. *Journal of Clinical Nursing*, 00(1-11). DOI: [10.1111/jocn.15234](https://doi.org/10.1111/jocn.15234)

The green open access version of the paper will be available at:  
<https://ro.ecu.edu.au/ecuworkspost2013/8301>

## **APPENDIX D: John Wiley and Sons License for Paper Two**

Appendix D is not available in this version of the thesis.

## APPENDIX E: Project Timeframe and Participants from WA Country Health Service Human Research Ethics Committee

### ☐ Project Timeframe and Participants

Expected Start Date	Actual Start Date	Expected Finish Date	Actual Finish Date	Expected Participant Numbers	Actual Participant Numbers	Expected Date of First Participant Recruitment	Recruitment Status
WA Country Health Service Human Research Ethics Committee (EC00292)							
14/03/2015	07/05/2015	01/12/2020	31/03/2018	75		04/05/2015	Recruiting
Goldfields Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
Great Southern Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
Kimberley Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
Midwest Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
Pilbara Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
South West Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting
Wheatbelt Regional Default - Office Use Only							
	07/05/2015		31/03/2018			04/05/2015	Recruiting



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## APPENDIX F: Ethics Approval from Joondalup Health Campus Human Research Ethics Committee

JOONDALUP  
HEALTH CAMPUS

19 March 2015

Ms A Fowler  
[REDACTED]

Joondalup Hospital Pty Ltd trading as  
Joondalup Health Campus  
ABN 61 106 723 193  
Cnr Grand Blvd & Shenton Ave  
Joondalup WA 6027  
PO Box 242  
Joondalup WA 6919  
Telephone: 08 9400 9400  
Facsimile: 08 9400 9054  
Web: www.ramsayhealth.com.au

Dear Ms Fowler

**RE: A mixed method study on nursing graduate support programs in rural  
and remote areas of Western Australia: A pilot study (ref 1504)**

The Human Research Ethics Committee of Joondalup Health Campus is pleased to notify you that your proposal to undertake research at Peel Health Campus has been approved, including endorsement from the Director of Clinical Services and Peel Health Campus Executive. As the Committee is bound by NHMRC Guidelines, the following conditions apply:

- That the Committee be notified immediately of any substantial changes in the design, methodology, time line or intended subjects of the project,
- That the Committee be notified immediately of any unforeseen complications of the project,
- That the Committee be notified if the project does not commence within six months of approval,
- That the Committee receive annual/final reports on the study (you will receive a pro forma from the Committee in twelve months), and
- That the Committee be informed of any other matters which arise during the course of the project which may have ethical implications.

Your approval is initially for four years; after this period you may be asked to re-apply. You are also required to notify the Committee promptly of any changes in your contact details.

Our best wishes for a successful implementation of your research project.

Yours sincerely

[REDACTED]  
Ann Y Hammer  
Executive Officer, JHC HREC

ec D Barr, DCS, and Dr M Sturdy, CEO, Peel Health Campus

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# APPENDIX G: Ethics Approval from WA Country Health Service Human Research Ethics Committee



Government of Western Australia  
WA Country Health Service

WACHS Research Ethics Committee  
189 Wellington Street  
PO Box 6680  
EAST PERTH BUSINESS CENTRE 6892  
Email: [Research.ethicscommittee@health.wa.gov.au](mailto:Research.ethicscommittee@health.wa.gov.au)

20 March 2015

Ms Amanda Fowler  
Lecturer  
Building 21 Room 424  
School of Nursing and Midwifery  
Edith Cowan University  
270 Joondalup Drive  
Joondalup WA

Email: [REDACTED]

Dear Ms Fowler

**Project Title:** A mixed method study on nursing graduate support programs in rural and remote areas of WA.

**WACHS HREC Reference:** 2015:03

The ethics application together with your response for further information and clarification for the project referenced above was reviewed by the WA Country Health Service Research Ethics Committee and I am pleased to have that the project has been approved. The following documents have been approved for use in this project.

Document
<ul style="list-style-type: none"><li>Revised 13 March 15 Participant Information Sheet, Interview Consent Form 1, Questionnaire Consent Form 2</li></ul>



Approval of this project from the WA Country Health Service Board Research Ethics Committee EC00261 is valid to 31 August 2016 (18 months) and on the basis of compliance with the 'Conditions of HREC Approval for a Research Project' (attached).

The nominated participating site in this project is:

- WACHS – Kimberley
- WACHS – Pilbara
- WACHS – Midwest
- WACHS – Wheatbelt
- WACHS – Goldfields
- WACHS – Great Southern
- WACHS – South West

[Note: If additional sites are recruited prior to the commencement of, or during the research project, the Coordinating Principal Investigator is required to notify the HREC. Notification of withdrawn sites should also be provided to the HREC in a timely fashion.

*Working together for a healthier country WA*

*Our Values: Community | Compassion | Quality | Integrity | Justice*



Government of Western Australia  
WA Country Health Service

A copy of this ethical approval letter must be submitted by all site Principal Investigators to the Research Governance Office or equivalent body or individual at each participating institution in a timely manner to enable the institution to authorise the commencement of the project at its site/s.

**This letter constitutes ethical approval only.** This project cannot proceed at any site until separate site authorisation has been obtained from the CE, or delegate, of the site under whose auspices the research will be conducted at that site.

The WA Country Health Service Board Research Ethics Committee is registered with the Australian Health Ethics Committee and operates according to the NHMRC National Statement on Ethical Conduct in Human Research and International Conference on Harmonisation – Good Clinical Practice.

Should you have any queries about the HREC's consideration of your project, please contact the Ethics Executive Officer of the WA Country Health Service Board Research Ethics Committee on [research.ethicscommittee@health.wa.gov.au](mailto:research.ethicscommittee@health.wa.gov.au) or mobile ph 0417 068 594.

The WA Health Research Governance Policy & Procedures 2012, Standard Operating Procedures and standard forms are available from the WACHS Research Ethics Committee Internet Page  
[www.wacountry.health.wa.gov.au/researchethicscommittee](http://www.wacountry.health.wa.gov.au/researchethicscommittee)  
or from the Ethics Executive Officer of the WA Country Health Service Board Research Ethics Committee.

Yours sincerely

**Samar Aoun**  
Chairperson  
WA Country Health Service Human Research Ethics Committee

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*Our Values: Community | Compassion | Quality | Integrity | Justice*

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## APPENDIX H: Ethics Approval from Edith Cowan University Human Research Ethics Committee

From: Research Ethics  
Sent: Monday, 23 March 2015 1:42 PM  
To: Amanda FOWLER [REDACTED]  
Cc: [REDACTED] Di TWIGG  
[REDACTED] Research  
Assessments <[REDACTED]>  
Subject: 12237 FOWLER ethics approval

Dear Amanda

Project Number: 12237 FOWLER  
Project Name: A mixed method study on Nursing graduate support programs in rural and remote areas of Western Australia

Student Number [REDACTED]

The ECU Human Research Ethics Committee (HREC) has reviewed your application and has granted ethics approval for your research project. In granting approval, the HREC has determined that the research project meets the requirements of the *National Statement on Ethical Conduct in Human Research*.

The approval period is from 23 March 2015 to 1 August 2019.

The Research Assessments Team has been informed and they will issue formal notification of approval. Please note that the submission and approval of your research proposal is a separate process to obtaining ethics approval and that no recruitment of participants and/or data collection can commence until formal notification of both ethics approval and approval of your research proposal has been received.

All research projects are approved subject to general conditions of approval. Please see the attached document for details of these conditions, which include monitoring requirements, changes to the project and extension of ethics approval.

Please feel free to contact me if you require any further information.

Regards

Kim

**Kim Gifkins, Research Ethics Officer**, Office of Research & Innovation, Edith Cowan University, 270 Joondalup Drive, Joondalup, WA 6027  
Email: [research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au) Tel: +61 08 6304 2170 | Fax: +61 08 6304 5044 | CRICOS IPC 002798

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This e-mail is confidential. If you are not the intended recipient you must not disclose or use the information contained within. If you have received it in error please return it to the sender via reply e-mail and delete any record of it from your system. The information contained within is not the opinion of Edith Cowan University in general and the University accepts no liability for the accuracy of the information provided.

CRICOS IPC 002798  
RTO PROVIDER 4756

## Conditions of approval

### 1. Monitoring of Approved Research Projects

Monitoring is the process of verifying that the conduct of research conforms to the approved ethics application. Compliance with monitoring requirements is a condition of approval.

The *National Statement on Ethical Conduct in Human Research* indicates that institutions are responsible for ensuring that research is reliably monitored. Monitoring of approved projects is to establish that a research project is being, or has been, conducted in the manner approved by the Ethics Committee. Researchers also have a significant responsibility in monitoring, as they are in the best position to observe any adverse events or unexpected outcomes. They should report such events or outcomes promptly to the Ethics Committee and take prompt steps to deal with any unexpected risks.

All projects approved by an ECU Ethics Committee are approved subject to the following conditions of approval:

- If the research project is discontinued before the expected date of completion, researchers should inform the Ethics Committee as soon as possible, giving reasons.
- An annual report (for projects that are longer than one year) and a final report at the completion of the research will be provided to the Ethics Committee. You will also be notified when a report is due. The ethics report form can be found on the ethics website [http://www.ecu.edu.au/GPPS/ethics/human\\_ethics\\_resources.html](http://www.ecu.edu.au/GPPS/ethics/human_ethics_resources.html)
- Researchers must also immediately report anything that might warrant review of the ethical approval of the protocol, including:
  - Any serious or unexpected adverse effects on participants
  - Any unforeseen events that might affect continued ethical acceptability of the project.

The Ethics Committee retains the right to require a more detailed and/or more frequent report if the research is deemed to be of high risk, and to recommend and/or adopt any additional appropriate mechanism for monitoring including random inspections of research sites, data and signed consent forms, and/or interview, with their prior consent, of research participants.

### 2. Changes and amendments

Compliance with the approved research protocol is a condition of approval, and any changes to the research design must be reported to the Ethics Committee. Amendments to the research design that may affect participants and/or that may have ethical implications must be reviewed and approved by the Ethics Committee before commencement.

Any changes to documents and other material used in recruiting potential research participants, including advertisements, letters of invitation, information sheets and consent forms, should be approved by the Ethics Committee.

In order to request approval for a change, please send an email to the Ethics Office outlining why the change is needed, describing the change (e.g. the new participants or new research procedures), and attach a copy of any amended documents.

### 3. Extension of ethics approval

All research projects are approved for a specified period of time – from the date of approval until the date of completion provided in the ethics application. If an extension of the approval period is required, a request must be submitted to the Ethics Committee. Please ensure that requests for extension of approval are submitted before the original approval expires.

In order to request an extension of ethics approval, please send an email to the Ethics Office providing a brief reason why the extension is needed and giving the new expected date of completion.



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## APPENDIX I: Ethics Extension Authorisation from Edith Cowan University Human Research Ethics Committee

**From:** Research Ethics <[research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au)>  
**Sent:** Monday, February 11, 2019 11:05:09 AM  
**To:** Amanda GRAF <[REDACTED]>  
**Subject:** Project 12237 FOWLER Research Ethics Extension Approved

Hi Amanda

**Project Number:** 12237  
**Project Name:** A mixed method study on Nursing graduate support programs in rural and remote areas of Western Australia

Thank you for your email.

Your request for an extension of ethics approval for this project has been granted until 1/12/2020

We also acknowledge receipt of your annual report. May we suggest with regards to the Security and Maintenance of data, particularly electronically that you contact Records Management (RAMS) regarding setting up a **Box Folder** in case your hard drive is "lost" or fails.

Kind regards

**Betty (Research Ethics)**  
R | 34.341  
P | 5818

# APPENDIX J: Change of Human Research Ethics Committee to Ramsay Health Care WA|SA HREC



18 December 2019

Ms Amanda Graf  
Edith Cowan University  
JOONDALUP WA 6027

**RE: A mixed method study on nursing graduate support programs in rural and remote areas of Western Australia (1504)**

I write to inform you that the Joondalup Health Campus Human Research Ethics Committee (JHC|HREC) (EC00267) will be closing shortly.

Under the *National Statement on Ethical Conduct in Human Research*, all research involving humans or their identifiable data, must be approved and monitored by a properly constituted HREC that has been registered with the NHMRC.

As part of transition arrangements, ethical oversight of this project has been accepted by the Ramsay Health Care (RHC) WA|SA HREC (EC00266), the details of which are as follows:

HREC Name	Ramsay Health Care WA SA HREC
HREC Code	EC00266
HREC Contact Officer	Joanna Brisbane
Position of HREC Contact Officer	Executive Officer
Contact Officer Phone	08 9400 9897
Contact Officer Email	RamsayHREC.WA-SA@ramsayhealth.com.au

Your project approval number is indicated above, please quote this number in all correspondence to the RHC WA|SA HREC.

Your ethical approval is initially for four years from date of initial approval; current approval for this project has been extended to 19/03/2021. After this date, you may be asked to apply for an extension or re-apply.

The RHC WA | SA HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research (2007, updated 2018). The Committee's continuing approval of this project is subject to the following conditions being met:

- The Coordinating Principal Investigator will immediately report anything that might warrant review of ethical approval of the project.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of any event, including new information from other published or unpublished studies which may have an impact on the continued ethical acceptability of the trial /evolving safety profile of the trial, or which may indicate the need for amendments to the trial protocol/documents and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the RHC research website\*.

Ramsay Health Care Australia Pty Ltd  
ABN 36 003 184 889  
Level 8, 154 Pacific Highway  
St Leonards NSW 2065 Australia  
Telephone: +61 2 9433 3444  
Facsimile: +61 2 9433 3460  
Email: enquiry@ramsayhealth.com.au  
ramsayhealth.com.au

- The Coordinating Principal Investigator will submit any necessary reports related to the safety of research participants in accordance with RHC WA|SA HREC policy and procedures. These instructions can be found on the RHC research website\*.
- The Coordinating Principal Investigator will report to the RHC WA|SA HREC annually in the specified format and notify the HREC when the project is completed at all sites.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC if the project is discontinued at a participating site before the expected completion date, with reasons provided.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of any plan to extend the duration of the project past the approval period listed above and will submit any associated required documentation. Instructions for obtaining an extension of approval can be found on the RHC research website\*.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC of his or her inability to continue as Coordinating Principal Investigator including the name of and contact information for a replacement.
- The Coordinating Principal Investigator will notify the RHC WA|SA HREC if the project does not commence within six months of approval.

You are also required to notify the Committee promptly of any changes in your contact details.

A copy of this ethical approval letter should be presented when required as official confirmation of the approval of the RHC WA|SA HREC.

Please note, existing research governance approval has been maintained. Your project is currently approved at the following Ramsay Health Care sites:

RHC Site	Date of Approval
Joondalup Health Campus	19/03/15

#### **What do I need to do?**

1. You will need to advise HRECs who have provided reciprocal ethical approval, funding agencies or other regulatory bodies of the change in ethical oversight.
2. Any participant documents will need to be updated (in the next print-run) with the following paragraph:

*The ethical aspects of this study have been approved by the Ramsay Health Care WA | SA Human Research Ethics Committee (RHC WA | SA HREC). If you have any complaints or reservations about any ethical aspect of your participation in a research project, please contact the Consumer Liaison Office at Joondalup Health Campus on (08) 9400-9404 who will direct your complaint to the most appropriate person. Any complaint you make will be investigated by an independent party, treated in confidence, and you will be informed of the outcome.*

The inclusion of this paragraph will not need to be reviewed by the full HREC but version numbers of amended documents will need to be noted by the Executive Officer, the contact details for whom are below.



Procedures relating to the submission of research amendments for existing projects, submission processes for ethical and research governance review of new projects and fees levied have also been modified. Please contact [RamsayHREC.WA-SA@ramsayhealth.com.au](mailto:RamsayHREC.WA-SA@ramsayhealth.com.au) for more information if required.

Our best wishes for the continued success of your research project.

Yours sincerely



A/Prof Paul Porter

Chairperson, Ramsay Health Care WA | SA HREC

Contact Details:

Joanna Brisbane, RHC WA | SA HREC

[RamsayHREC.WA-SA@ramsayhealth.com.au](mailto:RamsayHREC.WA-SA@ramsayhealth.com.au)

\*website: [www.ramsayhealth.com.au/Research/Research-Ethics](http://www.ramsayhealth.com.au/Research/Research-Ethics)

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## APPENDIX J: Permission to use Ms Julie Reeves' Collection Data Tool

**From:** Julie Reeves [REDACTED]  
**Sent:** Thursday, 7 November 2013 8:24 AM  
**To:** Amanda FOWLER  
**Subject:** RE: data collection tool developed in 2007

Hi Amanda

Thank you for your e-mail and request.

I am more than happy to give you permission to use the tool I developed. However I am just checking with ACU to ensure there isn't a issue at their end and I will let you know the outcome.

Thanks

Julie

Hi Amanda

I have heard from ACU and everyone agrees that you can use the tool I developed. Can you please ensure you acknowledge the authors and Australian Catholic University.

I wish you the best of luck with your professional doctorate.

Regards

Julie

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## **APPENDIX L: Permission to use the Rosenberg Self-Esteem Scale**

The Rosenberg Self-Esteem scale and permission to use it was received by mail August 2019.

The authorisation stated that the scale may be used without explicit permission. The author's family, asked to be kept informed of its use and they were updated in 2019.

The Morris Rosenberg Foundation  
c/o Department of Sociology  
University of Maryland  
2112 Art/Soc Building  
College Park, MD 20742-1315

### **Rosenberg Self-Esteem Scale** (Rosenberg, 1965)

The scale is a ten item Likert scale with items answered on a four point scale - from strongly agree to strongly disagree. The original sample for which the scale was developed consisted of 5,024 High School Juniors and Seniors from 10 randomly selected schools in New York State.

Instructions: Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.*	At times, I think I am no good at all.	SA	A	D	SD
3.	I feel that I have a number of good qualities.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.*	I feel I do not have much to be proud of.	SA	A	D	SD
6.*	I certainly feel useless at times.	SA	A	D	SD
7.	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.*	I wish I could have more respect for myself.	SA	A	D	SD
9.*	All in all, I am inclined to feel that I am a failure.	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items. The higher the score, the higher the self esteem.

The scale may be used without explicit permission. The author's family, however, would like to be kept informed of its use:

The Morris Rosenberg Foundation  
c/o Department of Sociology  
University of Maryland  
2112 Art/Soc Building  
College Park, MD 20742-1315

### **References**

References with further characteristics of the scale:

Crandal, R. (1973). The measurement of self-esteem and related constructs, Pp. 80-82 in J.P. Robinson & P.R. Shaver (Eds), **Measures of social psychological attitudes. Revised edition**. Ann Arbor: ISR.

Rosenberg, M. (1965). **Society and the adolescent self-image**. Princeton, NJ: Princeton University Press.

Wylie, R. C. (1974). **The self-concept. Revised edition**. Lincoln, Nebraska: University of Nebraska Press.

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## APPENDIX M: Permission to use Dr Judy Boychuk Duchscher's Framework

On 13 Feb 2014, at 6:09 pm, "Judy Duchscher" [REDACTED] wrote:

Amanda - did you receive my permission? I am giving it to you.

My life changed rather dramatically about 3 weeks ago - I am adjusting but it has been a roller coaster. Please forgive me for not getting in touch sooner. I am beginning to focus a bit more.

Please be in touch with whatever you need.

PS - are you aware of the WINN-NTF Conference - love to see you there. Go to <http://www.winn-ntf.com>

J

Dr. Judy Boychuk Duchscher, RN, BScN, MN, PhD

WINN-NTF Conference Chair ([www.winn-ntf.com/conference@winn-ntf.com](http://www.winn-ntf.com/conference@winn-ntf.com))

Executive Director - Nursing The Future ([newgraduates@nursingthefuture.ca](mailto:newgraduates@nursingthefuture.ca))

Assistant Professor - Faculty of Nursing

University of Calgary

Professional Faculties Building

Office #2230

2500 University Drive

Calgary, AB

T2N 1N4

Canada

403-210-7484 (UC Office)

403-220-6575 (Administrative Assistant Lisa Margulies)

Fax: 403-284-4830

IPHONE # (texts [REDACTED])

UC Email: [REDACTED]

Personal Email: [REDACTED] -

[REDACTED] [\[REDACTED\]](mailto:[REDACTED])

Professional Website: [www.letthelearningbegin.com](http://www.letthelearningbegin.com)

NTF Website: [www.nursingthefuture.ca](http://www.nursingthefuture.ca)

**From:** Judy Duchscher [REDACTED]

**Sent:** Thursday, 21 November 2013 9:20 AM

**To:** Amanda FOWLER [REDACTED]

**Cc:** [REDACTED]

**Subject:** Re: The stages of transition theory

Hello Amanda! I am so sorry I have delayed in responding to you - please know it is just because I am so swamped right now.

I will send you an audio message over the weekend with all the permissions.

J

Dr. Judy Boychuck Duchscher, RN, BScN, MN, PhD

WINN-NTF Conference Chair ([www.winn-ntf.com/conference@winn-ntf.com](http://www.winn-ntf.com/conference@winn-ntf.com))

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Calgary, AB  
T2N 1N4  
Canada  
403-210-7484 (UC Office)  
403-220-6575 (Administrative Assistant Lisa Marguiles)  
Fax: 403-284-4830  
IPHONE # (texts/cell) [REDACTED]  
UC Email: [REDACTED]  
UC Website: <http://nursing.ucalgary.ca/profiles/judy-boychuk-duchscher>



Let the learning begin. . .each of us the pupil of whichever one of us can best teach what each of us needs to learn (Maria Isabel Barreno)

On Nov 20, 2013, at 5:26 PM, Amanda FOWLER [REDACTED] wrote:

Hi Judy

I am at the beginning of my research journey whilst working as an academic at the School of Nursing and Midwifery at Edith Cowan University I am interested in graduate nurses and their experiences within the rural and remote areas in Western Australia  
I would like to use your theory as the conceptual framework throughout my research.  
I believe I need your permission before I can reproduce the diagram, so in essence I wondered if you would be kind enough to grant your permission for me to use the theory and diagram you developed.  
Thank-you for your time, I look forward to hearing from you soon.

Kind regards

*Amanda Fowler*

**Lecturer**

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## APPENDIX N: Information and Consent Letter



### A mixed method study on nursing graduate support programs in rural and remote areas of Western Australia (Ethics Protocol No. 12237)

#### Primary Investigator:

PhD candidate - Amanda Fowler, Edith Cowan University

Please take time to read the following information carefully. Feel free to ask me if anything is not clear to you or if you would like more information.

My name is Amanda Fowler. I am a Registered Nurse conducting this study as a requirement for the award of PhD through Edith Cowan University. Research predicts a nurse shortage in the future, a high attrition rate with graduate nurses in rural Australia is also a concern. Therefore I aim to evaluate the current graduate nurse programs within rural Western Australia to assess policy and practices and ultimately reduce the attrition rates of rural and remote nursing graduates.

#### Co Investigators:

Principle Supervisor – Professor Di Twigg, Head of School for School of Nursing and Midwifery at Edith Cowan University and Research Consultant for SCGH

Associate Supervisor – Dr. Elisabeth Jacob, School of Nursing and Midwifery, Edith Cowan University

Associate Supervisor – Associate Professor Barbara Nattabi, Rural and remote Health for Western Australian Centre for Rural Health (WACRH)

**Aim:** To evaluate the support given to graduate nurses in rural and remote clinical areas in Western Australia from the perspective of graduate nurses and rural nurses. This project will look at two consecutive graduate nurse cohorts, which will require both the interviews and survey to be conducted at four monthly intervals over an 18 month period.

#### Why is this project important?

The literature strongly suggests that there is a significant predicted shortage of nurses in the near future and this holds true as much for rural and remote areas as it does for metropolitan clinical facilities. This project hopes to address a gap in literature and gain an understanding of the effectiveness of current graduate programs. This will help identify the facilitators and barriers to effective nursing graduate programs and in effect plan for the future.

#### What is involved?

Graduate nurses and rural nurses who are involved with the graduate programs throughout the 17 WACHS clinical sites in the Western Australia regions will be asked to complete an on line survey, this survey will be sent out at four monthly intervals. The survey takes approximately 20-30 minutes to complete. If you decide you want to take part in the research project, you will be asked to give your consent at the start of the survey. The graduate nurses will be asked to complete the survey at each of the four monthly intervals however the senior nurses will need to complete the survey once only.

Both the graduate nurses and senior rural nurses overseeing the graduate program, from each region, will be invited to participate in a one hour interview three times throughout the 12 month graduate program. If you decide to take part in this in depth qualitative stage of the research, you will be asked to give your consent at the start of the interview.

**When will the project start?**

A link to the survey will be sent to your hospital email every 4 months over a 12 month timeframe, incorporating two cohorts:

April 2015; August 2015; January 2016 for the February intake and  
October, 2015; February 2016; June 2016 for the mid-year intake.

The interview will be conducted within similar timeframes.

**What about my privacy?**

All data will be kept confidential. Your personal identifying information will be removed from data files and replaced with a code once the sets of survey data are analysed. Only the researchers will have access to the data and information on participants. Data will be kept for 7 years in a locked file after publication and then transferred to the State Records Office for archiving. At this time, electronic and duplicate hard copy records held by ECU researchers will be securely disposed of.

The research findings may be published and/or presented in a variety of forums. Findings will be reported in a discussion and tabular format so that no individual participant will be identified in any report, publication or presentation.

Participation is voluntary, you are in no way obliged to participate and, if you do, you can withdraw at any time. Whatever your decision, it will not affect your relationship with your work environment, your employer, WACHS or Edith Cowan University.

If you find anything distressing about the interviews, or if the questions have inadvertently resulted in any anxiety. Please contact *beyondblue* on 1300 22 4636 or the Bush Support Line 1800 805 391 available 24 hours seven days a week. The department of health, via the employee assistance program also offers staff and family access to free confidential counselling for personal and work related matters.

**Who to contact with queries?**

Amanda Fowler RN, Lecturer and PhD candidate, School of Nursing and Midwifery, Edith Cowan University, can be contacted with queries related to this project. [redacted] mail:

[redacted] or if you prefer to contact my supervisors,

[Professor Di Twigg](#), [redacted]

[Associate Professor Barbara Nattab](#) [redacted]

If you have any complaints or concerns about any aspect of this research, which you cannot resolve with the researcher, you may contact the:

Research Ethics Officer, ECU, Tel +618 6404 2170, email: [research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au) (and quote ethics no. 12237)

The ethical aspects of this study have been approved by the Joondalup Health Campus Human Research Ethics Committee.

If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Executive Office – phone 9400 9404. Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.



**Title:** A mixed method study on Nursing graduate support programs in rural and remote areas of Western Australia

**Principal Investigator:** Amanda Fowler MEd RN School of Nursing and Midwifery (ECU) PhD candidate

**Co Investigators:**

Principle Supervisor – Professor Di Twigg, Head of School for School of Nursing and Midwifery at Edith Cowan University and Research Consultant for SCGH

Associate Supervisor – Dr. Elisabeth Jacob, School of Nursing and Midwifery, Edith Cowan University

Associate Supervisor – Associate Professor Barbara Nattabi, Rural and remote Health for Western Australian Centre for Rural Health (WACRH)

### Interview Consent Form 1

- ❖ I have read and understood the "Information to Participants".
- ❖ I have been given the opportunity to ask question and have had any questions answered to my satisfaction.
- ❖ I understand that I will participate in 3 individual interviews of approximately 1 hour duration which will be recorded.
- ❖ I will be asked open ended questions that explore issues raised in the literature related to support of graduate nurses in the rural areas.
- ❖ Project data and records will be retained for 7 years in a locked file after the date of publication at which time it will be securely disposed of.
- ❖ I agree that the research may be published knowing study sites will not be named in any publications and that no individual participant will be named.
- ❖ I agree to participate in this study, knowing that I may withdraw from further participation at any time, without explanation or penalty.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### For further information about this study

If you have any questions or require any further information about this research project, please contact: Amanda Fowler, Principal Investigator, on Ph: [REDACTED] Email: [REDACTED]

If you have any concerns or complaints about this project and wish to talk to an independent person, you may contact: the Research Officer at Edith Cowan University, Ph: (08) 6304 2170, Email: [research.ethics@ecu.edu.au](mailto:research.ethics@ecu.edu.au)

The ethical aspects of this study have been approved by the Joondalup Health Campus Human Research Ethics Committee.

If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Executive Office – phone 9400 9404. Any complaint you make will be treated in confidence and investigated, and you will be informed of the outcome.

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## **APPENDIX O: Example of Qualitative Questions for New Graduate Registered Nurses and Senior Nurses**

### **Qualitative Questions – samples for the new graduate registered nurses**

1. Describe your experiences as a graduate nurse?
2. Discuss the types of support have you received during this rotation?
3. What about social support? Is your family here; are you from a rural area, what has it been like adjusting to the rural setting?
4. How easy is it to obtain professional development leave?
5. Describe your study days - how are they delivered?
6. What do you think a graduate program should offer by way of support?
7. If you were able to change anything about the graduate program what would it be?

### **Qualitative Questions – samples for the senior nurses**

1. What are the essential components of a graduate program in rural and remote Western Australia? Please explain each component.
2. Discuss the action you take to help support the students during the graduate program?
3. How is your role with the graduate nurses recognised within the organisation?
4. What are your thoughts about the current graduate program and its capacity to support the new graduates?
5. Please discuss the attributes of the recent graduate nurses, having completed the graduate program.

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## APPENDIX P: New Registered Graduate Nurse Survey



Region:	Nurse Code:
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### Graduate Nurse Profile (please tick or cross your answers)

#### Demographics

1. At which hospital are you currently working during your graduate nurse program (Graduate Nurse Program)?
- Albany ☐
  - Geraldton ☐
  - Port Hedland ☐
  - Karratha ☐
  - Kalgoorlie ☐
  - Broome ☐
  - Derby ☐
  - Kununurra ☐
  - Busseton ☐
  - Bunbury ☐
  - Northam ☐
  - Narrogin ☐
  - Katanning ☐
  - Margaret River ☐
  - Collie ☐
  - Bridgetown ☐
  - Manjimup ☐
2. D.O.B: \_\_\_\_\_
3. What is your Gender:
- Male ☐
  - Female ☐
  - Other ☐
4. At which university did you complete your Bachelor degree?
- Edith Cowan University ☐
  - Murdoch ☐
  - University of Notre Dame ☐
  - Curtin ☐
  - University of Western Australia ☐
  - Outside of WA ☐
5. When did you begin your graduate program?
- Mid-year ☐
  - Beginning of the year ☐

6. When are you expected to finish your graduate program?

- <1 - 3 months ☐  
 >3 - 6 months ☐  
 >6 - 9 months ☐  
 >9 - 12 months ☐  
 >12 months ☐

7. How many beds are within this hospital setting?

- 10 - 25 ☐  
 26 - 50 ☐  
 51 - 75 ☐  
 75 - 100 ☐  
 > 100 ☐

8. Please rate the following statements

I chose to apply to the hospital where I started my graduate nurse program because:-

	Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
a) The hospital has a good reputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) The rotations offered were what I wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Supportive measures offered to graduate nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Large regional hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Personal reasons:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Availability of Graduate Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Rotations** (clinical rotation the time spent in one area over a length of 4 to 6 months within a graduate program)

9. Please identify your rotations throughout the Graduate Nurse Program and rate them by value.

Area	Not Valuable	Somewhat Valuable	Neutral	Valuable	Very Valuable
Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Med/Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Please indicate your level of overall satisfaction with the rotations of your graduate program

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Preceptorship** (A ward nurse allocated to a graduate, who aims to instill confidence, develop clinical knowledge, time management skills, and encourage conflict resolution for a selected period of time)

11. Did you participate in a preceptorship program during the Graduate Nurse program?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

12. During your first rotation what was the average length of time you were preceptored?

<1-2 weeks	<input type="checkbox"/>
>2-4 weeks	<input type="checkbox"/>
>4-6 weeks	<input type="checkbox"/>
>6-8 weeks	<input type="checkbox"/>
> 8 weeks	<input type="checkbox"/>

13. Approximately how many shifts did you work with your preceptor in the first 6 weeks?

<1-2 shifts	<input type="checkbox"/>
>2-4 shifts	<input type="checkbox"/>
>4-6 shifts	<input type="checkbox"/>
>6-8 shifts	<input type="checkbox"/>
>8 shifts	<input type="checkbox"/>

14. Please indicate your overall level of satisfaction with your experience of preceptorship

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Supernumerary Time** (when you work alongside another nurse and do not take a patient load therefore you don't have direct responsibility, you spend the time learning the system in the new environment)

15. On the first rotation of the graduate nurse program how many supernumerary shifts did you work?

0 shifts	<input type="checkbox"/>
1 shift	<input type="checkbox"/>
2 shifts	<input type="checkbox"/>
3 shifts	<input type="checkbox"/>
4 or more shifts	<input type="checkbox"/>

16. On the second rotation how many supernumerary shifts did you have?

- |                  |                          |
|------------------|--------------------------|
| 0 shifts         | <input type="checkbox"/> |
| 1 shift          | <input type="checkbox"/> |
| 2 shifts         | <input type="checkbox"/> |
| 3 shifts         | <input type="checkbox"/> |
| 4 or more shifts | <input type="checkbox"/> |

17. On the third rotation how many supernumerary shifts did you have?

- |                  |                          |
|------------------|--------------------------|
| 0 shifts         | <input type="checkbox"/> |
| 1 shift          | <input type="checkbox"/> |
| 2 shifts         | <input type="checkbox"/> |
| 3 shifts         | <input type="checkbox"/> |
| 4 or more shifts | <input type="checkbox"/> |

18. Please indicate your overall level of satisfaction with your experience of your supernumerary time.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Very Dissatisfied        | Dissatisfied             | Neutral                  | Satisfied                | Very Satisfied           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Graduate Nurse Program Coordinator / Clinical Educator / Staff Development Nurse (SDN)**

19. In the first three months of your graduate nurse program how many hours on average per week did you spend with your graduate nurse program coordinator / clinical educator/ SDN?

- |                     |                          |
|---------------------|--------------------------|
| >0-1 hour per week  | <input type="checkbox"/> |
| >1-2 hours per week | <input type="checkbox"/> |
| >3-4 hours per week | <input type="checkbox"/> |
| >5-6 hours per week | <input type="checkbox"/> |
| >7 hours per week   | <input type="checkbox"/> |

20. During the next 4-5 months of your graduate nurse program how many hours on average per week did you spend with your graduate nurse program coordinator / clinical educator/ SDN?

- |                     |                          |
|---------------------|--------------------------|
| >0-1 hour per week  | <input type="checkbox"/> |
| >1-2 hours per week | <input type="checkbox"/> |
| >3-4 hours per week | <input type="checkbox"/> |
| >5-6 hours per week | <input type="checkbox"/> |
| >7 hours per week   | <input type="checkbox"/> |

22. During the last 8-12 months of your graduate nurse program on average how many hours per week did you spend with your graduate nurse program coordinator / clinical educator/ SDN?

- >0-1 hour per week ☐  
 >1-3 hours per week ☐  
 >3-4 hours per week ☐  
 >4-6 hours per week ☐  
 > 7 hours per week ☐

23. Please indicate your overall satisfaction with the amount of time your graduate nurse program coordinator/ clinical educator / SDN spent with you

- Very Dissatisfied ☐    Dissatisfied ☐    Neutral ☐    Satisfied ☐    Very Satisfied ☐

**Support** (Involves nurse educators, preceptors, regular study days, evidence of a structured program that work towards enhancing clinical competency, increase confidence, critical thinking and professional development)

24. In your overall evaluation of your graduate program please indicate how often you experienced the feelings described below

	Not at all	Very little	Neutral	Moderate amount	A great deal
a) Encouraged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Inadequate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Befriended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Valued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Approachability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Stressed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Helped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Please indicate your overall level of satisfaction with the support you have received in your graduate nurse program.

- Very Dissatisfied ☐    Dissatisfied ☐    Neutral ☐    Satisfied ☐    Very Satisfied ☐

### Being Part of the Team

26. In your first rotation how long was it before you felt that you belonged to the area you were working within?

- <1-2 weeks ☐
- >2-4 weeks ☐
- >4-6 weeks ☐
- >6-8 weeks ☐
- More than 8 weeks ☐

### Theoretical component

27. What was the total number of hours you spent undertaking the theoretical component (structured study sessions) of the graduate nurse program?

- < 8 hours ☐
- >8-24 hours ☐
- >24- 40 hours ☐
- >40– 60 hours ☐
- More than 60 hours ☐

28. Please indicate your overall satisfaction with the theoretical component (structured study sessions) of the Graduate Nurse Program.

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Very Dissatisfied        | Dissatisfied             | Neutral                  | Satisfied                | Very Satisfied           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### Performance management via a clinical assessment tool

29. Please highlight when you received formal written appraisal/s during your graduate program.

- 1-3 months ☐
- 4-6 months ☐
- 7-9 months ☐
- 9-12 months ☐
- More than 12 months ☐

30. Did you complete any formal written self-appraisal with any of these formal appraisals?

- Yes ☐  
No ☐

31. Please indicate your overall satisfaction with the formal appraisals that you received

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Very Dissatisfied        | Dissatisfied             | Neutral                  | Satisfied                | Very Satisfied           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



### Evaluations

32. Did you undertake any formal evaluation of your Graduate Nurse Program?

Yes ☐

No ☐

33. Did the evaluations ask you to provide your overall satisfaction level with your Graduate Nurse Program?

Yes ☐

No ☐

### Overall Satisfaction

34. Please indicate your overall satisfaction level with your Graduate Nurse Program.

Very Dissatisfied  
☐

Dissatisfied  
☐

Neutral  
☐

Satisfied  
☐

Very Satisfied  
☐

**Self-Esteem** The next 10 questions is a list of statement dealing with your general feelings about yourself. If you strongly agree circle strongly agree and so on.

35. On the whole, I am satisfied with myself.

Strongly Disagree  
☐

Disagree  
☐

Neither Agree nor  
Disagree  
☐

Agree  
☐

Strongly Agree  
☐

36. At times, I think I am no good at all.

Strongly Disagree  
☐

Disagree  
☐

Neither Agree nor  
Disagree  
☐

Agree  
☐

Strongly Agree  
☐

37. I feel that I have a number of good qualities.

Strongly Disagree  
☐

Disagree  
☐

Agree  
☐

Strongly agree  
☐

N/A  
☐

39. I am able to do things as well as most other people.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. I feel I do not have much to be proud of.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. I certainly feel useless at times.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. I feel that I'm a person of worth, at least on an equal plane with others.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. I wish I could have more respect for myself.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. All in all, I am inclined to feel that I am a failure.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. I take a positive attitude toward myself.

Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. If you were given an opportunity to change anything about your Graduate Nurse Program to improve it for future nurses, how would you like to see it change?

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47. Where do you see yourself professionally in the next 5 years?

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48. Any further comments?

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*Thank you for taking the time to complete this questionnaire.*

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## APPENDIX Q: Senior Nurse Survey



Region:	Nurse Code:
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### Graduate Nurse Program Coordinator/Staff Development Nurse / Senior rural and remote nurse (Please tick or cross your answers)

#### Demographics

1. In which hospital/s do you coordinate the Graduate Nurses Program?

- Albany ☐
- Geraldton ☐
- Port Hedland ☐
- Karratha ☐
- Kalgoorlie ☐
- Broome ☐
- Derby ☐
- Kununurra ☐
- Busseton ☐
- Bunbury ☐
- Northam ☐
- Narrogin ☐
- Katanning ☐
- Margaret River ☐
- Collie ☐
- Bridgetown ☐
- Manjimup ☐

2. What is your age: \_\_\_\_\_

3. What is your gender:

- Male ☐
- Female ☐
- Other ☐

4. At which university/hospital did you complete your initial qualifications in nursing?

\_\_\_\_\_

5. Please state any post graduate studies that you have completed, Graduate Certificate, Diploma, Masters, PhD?

Honours	<input type="checkbox"/>
Graduate certificate	<input type="checkbox"/>
Graduate Diploma	<input type="checkbox"/>
Masters	<input type="checkbox"/>
PhD	<input type="checkbox"/>

6. How long have you been coordinating Graduate Nurse Programs?

0-1 years	<input type="checkbox"/>
>1-3 years	<input type="checkbox"/>
>3-5 years	<input type="checkbox"/>
>5-7 years	<input type="checkbox"/>
More than 7 years	<input type="checkbox"/>

7. How many hours each week are you employed to oversee the Graduate Nurse Program?

0-1 hour per week	<input type="checkbox"/>
>1-2 hours per week	<input type="checkbox"/>
>3-4 hours per week	<input type="checkbox"/>
>5-6 hours per week	<input type="checkbox"/>
More than 7 hours per week	<input type="checkbox"/>

8. Does the amount of coordinating hours change as the year progresses?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If you have answered 'yes', please describe how the coordinating hours change.

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**Rotations** (clinical rotation the time spent in one area over a length of 4 to 6 months within a graduate program)

9. How many rotations do graduate nurses undertake in their Graduate Nurse Program?

One	Two	Three	Four	Five
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Please state the clinical areas in which graduate nurses can rotate and rate them according to what you believe to be most valuable for the Graduate Nurses.

Area	Not Valuable	Somewhat Valuable	Neutral	Valuable	Very Valuable
Emergency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theatre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Med/Surgical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paediatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Please indicate your overall satisfaction with the rotations incorporated within the Graduate Nurse Program

Very Dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐ Very Satisfied ☐

**Preceptorship** (A ward nurse allocated to a graduate, who aims to instill confidence, develop clinical knowledge, time management skills, and encourage conflict resolution for a selected period of time)

12. Do all graduates participate in a preceptorship program during the Graduate Nurse program?

Yes ☐  
No ☐

13. What is the average length of time a new graduate is preceptored during the graduates' first rotation?

0-1 weeks ☐  
>2-3 weeks ☐  
>3-5 weeks ☐  
>5-7 weeks ☐  
More than 7 weeks ☐

14. On average in the first six weeks of a graduates first rotation how many shifts per week do they work with their preceptor?

1 shifts ☐  
2 shifts ☐  
3 shifts ☐  
4 shifts ☐  
5 shifts ☐

15. Please indicate your overall satisfaction level of the preceptorship program for graduates.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Supernumerary Time** (when you work alongside another nurse and do not take a patient load therefore you don't have direct responsibility, you spend the time learning the system in the new environment)

16. On the graduates first rotation how many supernumerary shifts does the graduate undertake?

0 shifts	<input type="checkbox"/>
1 shift	<input type="checkbox"/>
2 shifts	<input type="checkbox"/>
3 shifts	<input type="checkbox"/>
4 or more shifts	<input type="checkbox"/>

17. On the graduates second rotation how many supernumerary shifts does the graduate undertake?

0 shifts	<input type="checkbox"/>
1 shift	<input type="checkbox"/>
2 shifts	<input type="checkbox"/>
3 shifts	<input type="checkbox"/>
4 or more shifts	<input type="checkbox"/>

18. On the graduates third rotation how many supernumerary shifts does the graduate undertake?

0 shifts	<input type="checkbox"/>
1 shift	<input type="checkbox"/>
2 shifts	<input type="checkbox"/>
3 shifts	<input type="checkbox"/>
4 or more shifts	<input type="checkbox"/>

19. Please indicate your overall satisfaction of the amount of supernumerary time the graduates receive.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Graduate Nurse Program Coordinator / Clinical Educator / Staff Development Nurse**

20. In the first three months of the Graduate Nurse Program how many hours per week do graduates spend with the graduate nurse program coordinator /clinical educator/ SDN?

0-1 hour per week	<input type="checkbox"/>
>1-2 hours per week	<input type="checkbox"/>
>2-4 hours per week	<input type="checkbox"/>
>4-6 hours per weeks	<input type="checkbox"/>
More than 6 hours per week	<input type="checkbox"/>

21. In the following 4-5 months of the Graduate Nurse Program how many hours per week do graduates spend with the graduate nurse program coordinator / clinical educator/ SDN?

0-1 hour per week	<input type="checkbox"/>
>1-2 hours per week	<input type="checkbox"/>
>2-4 hours per week	<input type="checkbox"/>
>4-6 hours per weeks	<input type="checkbox"/>
More than 6 hours per week	<input type="checkbox"/>

22. During the last 8-12 months of your graduate nurse program how many hours per week do graduates spend with the graduate nurse program coordinator / clinical educator/ SDN?

0-1 hour per week	<input type="checkbox"/>
>1-2 hours per week	<input type="checkbox"/>
>2-4 hours per week	<input type="checkbox"/>
>4-6 hours per week s	<input type="checkbox"/>
More than 7 hours per week	<input type="checkbox"/>

23. Please indicate your overall satisfaction with the time Graduate Nurse Program Coordinator/ clinical educator / SDN spent with each graduate.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Support** (Involves nurse educators, preceptors, regular study days, evidence of a structured program that work towards enhancing clinical competency, increase confidence, critical thinking and professional development)

24. In your overall evaluation of the Graduate Nurse Program please indicate how often you believed your graduates would have experienced the feelings described

	Not at all	Very little	Moderate amount	A great deal	N/A
a) Encouraged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Inadequate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Frustrated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Befriended	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Valued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Approachability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Stressed:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Helped	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Please indicate your overall satisfaction level with the support graduates receive in their Graduate Nurse Program.

Very Dissatisfied ☐
 Dissatisfied ☐
 Neutral ☐
 Satisfied ☐
 Very Satisfied ☐

#### Being Part of the Team

26. On average in a graduate's first rotation how long does it take before a graduate feels they belong to the area they are working within?

<1-2 weeks ☐  
 >2-4 weeks ☐  
 >4-6 weeks ☐  
 >6-8 weeks ☐  
 More than 8 weeks ☐

#### Theoretical component

27. What is the total number of hours graduate nurses spend undertaking their theoretical component (structured study sessions) of the graduate nurse program?

< 8 hours ☐  
 >8-24 hours ☐  
 >24- 40 hours ☐  
 >40- 60 hours ☐  
 More than 60 hours ☐

28. Please indicate your overall satisfaction level with the theoretical component (structured study sessions) of the Graduate Nurse Program.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Performance management via a clinical assessment tool

29. Please highlight when graduates receive their formal written appraisal/s during their graduate program.

1-3 months	<input type="checkbox"/>
4-6 months	<input type="checkbox"/>
7-9 months	<input type="checkbox"/>
9-12 months	<input type="checkbox"/>
More than 12 months	<input type="checkbox"/>

30. Do graduates complete any formal written self-appraisal with any of these appraisals?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

31. Please indicate your overall satisfaction with the formal appraisals that graduates receive.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Evaluations

32. Do graduates undertake any formal evaluation of their Graduate Nurse Program?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

33. Did the evaluations ask graduates to provide their overall satisfaction level with the Graduate Nurse Program?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

### Overall Satisfaction

34. Please indicate your overall satisfaction level with the Graduate Nurse Program that you coordinated.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. If you were given an opportunity to change anything about the Graduate Nurse Program to improve it for future nurses, how would you like to see it change?

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36. Any further comments?

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*Thank you for taking the time to complete this questionnaire.*

## APPENDIX R: New Graduate Registered Nurses 3, 7 and 11 Month Cohort for Emotions and Satisfaction with Support

3 month cohort	Region	Encouraged	Helped	Befriended	Valued	Angry	Stressed	Frustrated	Inadequate	Satisfaction
	1	Moderate amount	Moderate amount	Very little	Very little	Very little	Very little	Moderate amount	Moderate amount	Dissatisfied
	1	Very little	Moderate amount	A great deal	Neutral	Moderate amount	Moderate amount	A great deal	Moderate amount	Dissatisfied
	2	A great deal	A great deal	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount		Neutral
	4	Moderate amount	A great deal	Moderate amount	Moderate amount	Very little	Moderate amount	Very little	Moderate amount	Neutral
	4	Moderate amount	Moderate amount	A great deal	Moderate amount	Very little	Very little	Moderate amount	Very little	Neutral
	6	Moderate amount	Moderate amount	A great deal	A great deal	Very little	Moderate amount	Moderate amount	Moderate amount	Neutral
	4	A great deal	A great deal	Neutral	Very little	Very little	A great deal	Moderate amount	Moderate amount	Satisfied
	4	Very little	A great deal	Not at all	Moderate amount	Very little	A great deal	Moderate amount	Very little	Satisfied
	4	Moderate amount	Moderate amount	Very little	Moderate amount	Moderate amount	A great deal	A great deal	Moderate amount	Satisfied
	4	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Not at all	Very little	Very little	Moderate amount	Satisfied
	6	Moderate amount	Moderate amount	Moderate amount	A great deal	Not At All	Neutral	Very little	Neutral	Satisfied
	6	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Not At All	Moderate amount	Very little	Neutral	Satisfied
	1	A great deal	Moderate amount	A great deal	A great deal	Neutral	Neutral	Moderate amount	Not At All	Satisfied
	1	Moderate amount	Moderate amount	Neutral	Moderate amount	Very little	Neutral	Moderate amount	Very little	Satisfied
	1	A great deal	A great deal	A great deal	A great deal	Very little	Moderate amount	Moderate amount	Neutral	Satisfied
	2	Moderate amount	A great deal	Neutral	Moderate amount	Neutral	Moderate amount	Neutral	Very little	Very Satisfied
	2	A great deal	A great deal	Moderate amount	A great deal	Not At All	Neutral	Very little	Very little	Very Satisfied
	5	A great deal	A great deal	A great deal	A great deal	Very little	Neutral	Neutral	Neutral	Very Satisfied
	5	A great deal	A great deal	A great deal	A great deal	Not At All	Very little	Not At All	Very little	Very Satisfied
	6	A great deal	Moderate amount	Not At All	Moderate amount	Very little	Very little	Very little	Very little	Very Satisfied
	2	A great deal	A great deal	Not At All	A great deal	Not At All	Very little	Not At All	Not At All	Very Satisfied

7 month cohort	Region	Angry	Stressed	Inadequate	Frustrated	Encouraged	Helped	Befriended	Valued	Satisfaction
	1	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	Very little	A great deal	Very little	Very Dissatisfied
	1	Not At All	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	Very little	Moderate amount	Dissatisfied
	6	Not At All	A great deal	A great deal	Moderate amount	Very little	Very little	Moderate amount	Very little	Dissatisfied
	3	Moderate amount	Moderate amount	Very little	Moderate amount	Moderate amount	Very little	Very little	Moderate amount	Dissatisfied
	1	Not At All	Moderate amount	Moderate amount	A great deal	Very little	Neutral	Neutral	Neutral	Neutral
	2	A great deal	A great deal	A great deal	A great deal	Neutral	Moderate amount	Very little	Very little	Neutral
	2	Not At All	Very little	Very little	Not At All	A great deal	A great deal	A great deal	A great deal	Neutral
	3	Neutral	Moderate amount	Moderate amount	Moderate amount	Neutral	Very little	Neutral	Very little	Neutral
	4	Very little	Neutral	Very little	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Neutral
	4	Very little	Very little	Moderate amount	Moderate amount	Moderate amount	Neutral	Neutral	Neutral	Neutral
	5	Neutral	Moderate amount	Moderate amount	Moderate amount	Neutral	Neutral	Neutral	Neutral	Neutral
	5	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Neutral	Neutral
	6	Moderate amount	Moderate amount	Neutral	Moderate amount	A great deal	Moderate amount	A great deal	A great deal	Neutral
	6	Not At All	Very little	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral
	7	Very little	A great deal	Very little	Moderate amount	Moderate amount	Moderate amount	A great deal	Moderate amount	Neutral
	7	Very little	Very little	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Neutral
	7	Neutral	Moderate amount	Very little	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Neutral
	2	Very little	A great deal	Very little	Neutral	A great deal	Moderate amount	Very little	Moderate amount	Satisfied
	1	Very little	Very little	Very little	Moderate amount	Moderate amount	Moderate amount	Moderate amount	A great deal	Satisfied
	4	Very little	Very little	Very little	Very little	A great deal	Moderate amount	A great deal	Moderate amount	Satisfied
	4	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	Very little	Satisfied
	5	Moderate amount	A great deal	Moderate amount	Moderate amount	A great deal	A great deal	A great deal	A great deal	Satisfied
	6	Neutral	Neutral	Neutral	Neutral	A great deal	A great deal	A great deal	A great deal	Satisfied
	6	Not At All	Moderate amount	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Satisfied
	6	Very little	Moderate amount	Neutral	Moderate amount	A great deal	Moderate amount	Moderate amount	Moderate amount	Satisfied
	6	Very little	Very little	Very little	Very little	A great deal	A great deal	A great deal	A great deal	Satisfied
	5	Very little	Very little	Very little	Very little	A great deal	A great deal	A great deal	A great deal	Very Satisfied
	2	Very little	Neutral	Not At All	Very little	A great deal	A great deal	A great deal	A great deal	Very Satisfied

11 month cohort	Region	Encouraged	Helped	Befriended	Valued	Angry	Stressed	Frustrated	Inadequate	Satisfaction
	2	Not At All	Not At All	Not At All	Not At All	A great deal	A great deal	A great deal	A great deal	Very Dissatisfied
	3	Moderate amount	Very little	Neutral	Moderate amount	Very little	Moderate amount	Neutral	Not At All	Dissatisfied
	5	Neutral	Neutral	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Dissatisfied
	6	A great deal	A great deal	A great deal	A great deal	Very little	Moderate amount	Moderate amount	Moderate amount	Dissatisfied
	4	Moderate amount	Neutral	Moderate amount	Moderate amount	Very little	Very little	Moderate amount	Very little	Neutral
	6	Very little	Neutral	Moderate amount	Very little	Neutral	A great deal	Moderate amount	Moderate amount	Neutral
	6	Moderate amount	Neutral	Moderate amount	Neutral	Very little	Moderate amount	Neutral	Very little	Neutral
	7	Moderate amount	Moderate amount	Very little	Moderate amount	Neutral	Moderate amount	Moderate amount	Very little	Neutral
	7	Moderate amount	Moderate amount	Neutral	Moderate amount	Very little	Very little	Moderate amount	Very little	Neutral
	1	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Satisfied
	1	A great deal	Moderate amount	Moderate amount	A great deal	Very little	Neutral	Not At All	Very little	Satisfied
	2	A great deal	Moderate amount	A great deal	A great deal	Very little	Very little	Moderate amount	Neutral	Satisfied
	4	A great deal	Moderate amount	Moderate amount	Moderate amount	Not at all	Very little	Very little	Very little	Satisfied
	4	Neutral	Moderate amount	Moderate amount	Neutral	Very little	A great deal	A great deal	Moderate amount	Satisfied
	4	A great deal	Moderate amount	A great deal	A great deal	Very little	Neutral	Moderate amount	Moderate amount	Satisfied
	6	Moderate amount	Neutral	Moderate amount	Moderate amount	Very little	Neutral	Moderate amount	Moderate amount	Satisfied
	2	A great deal	A great deal	A great deal	A great deal	Very little	Very little	Very little	Very little	Very Satisfied
	4	A great deal	A great deal	A great deal	A great deal	Very little	Very little	Moderate amount	Not At All	Very Satisfied
	5	A great deal	A great deal	A great deal	A great deal	Very little	Neutral	Neutral	Neutral	Very Satisfied

## APPENDIX S: Senior Nurses Cohort View with Emotions and Satisfaction with Support

Region	Encouraged	Helped	Befriended	Valued	Angry	Stressed	Inadequate	Frustrated	Satisfaction
5	Very little	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Moderate amount	A great deal	Very Dissatisfied
1	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Dissatisfied
6	Moderate amount	Moderate amount	A great deal	Moderate amount	Not At All	Moderate amount	Very little	Moderate amount	Dissatisfied
1	Neutral	Neutral	Moderate amount	Neutral	Neutral	Moderate amount	Neutral	Moderate amount	Dissatisfied
4	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	A great deal	Moderate amount	A great deal	Dissatisfied
5	A great deal	A great deal	A great deal	A great deal	Neutral	Moderate amount	Moderate amount	Moderate amount	Dissatisfied
?	A great deal	Moderate amount	A great deal	A great deal	Very little	Very little	Very little	Neutral	Dissatisfied
1	Neutral	Neutral	Neutral	Neutral	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Dissatisfied
1	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	A great deal	Very little	Moderate amount	Dissatisfied
?	A great deal	Moderate amount	A great deal	Moderate amount	Moderate amount	A great deal	A great deal	A great deal	Dissatisfied
6	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	Neutral	Very little	Neutral	Neutral
6	A great deal	Moderate amount	A great deal	A great deal	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Neutral
6	Moderate amount	Moderate amount	Very little	Moderate amount	Neutral	Moderate amount	Neutral	Moderate amount	Neutral
2	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Neutral
6	Moderate amount	Moderate amount	Moderate amount	Moderate amount	A great deal	A great deal		A great deal	Satisfied
6	A great deal	Moderate amount	Moderate amount	Moderate amount	Very little	Neutral	Neutral	Neutral	Satisfied
5	A great deal	A great deal	A great deal	A great deal	Very little	Moderate amount	Very little	Moderate amount	Satisfied
4	A great deal	Moderate amount	Moderate amount	Moderate amount	Neutral	A great deal	Neutral	Moderate amount	Satisfied
?	A great deal	A great deal	A great deal	A great deal	Very little	Moderate amount	Very little	Very little	Satisfied
3	Moderate amount	Neutral	Moderate amount	Neutral	Neutral	A great deal	Moderate amount	Moderate amount	Satisfied
6	A great deal	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Neutral	Neutral	Satisfied
7	Moderate amount	Moderate amount	A great deal	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Satisfied

Region	Encouraged	Helped	Befriended	Valued	Angry	Stressed	Inadequate	Frustrated	Satisfaction
4	Neutral	Neutral	Moderate amount	Moderate amount	Neutral	Neutral	Neutral	Moderate amount	Satisfied
1	A great deal	A great deal	Moderate amount	A great deal	Very little	Neutral	Neutral	Neutral	Satisfied
6	A great deal	A great deal	Moderate amount	Moderate amount	Moderate amount	A great deal	Moderate amount	Moderate amount	Satisfied
1	Moderate amount	Moderate amount	Moderate amount	Neutral	Neutral	A great deal	Moderate amount	Moderate amount	Satisfied
2	A great deal	Moderate amount	Moderate amount	Moderate amount	Neutral	Moderate amount	Very little	Moderate amount	Satisfied
4	A great deal	A great deal	Moderate amount	Neutral	Moderate amount	A great deal	Moderate amount	Moderate amount	Satisfied
1	Moderate amount	Moderate amount	Moderate amount	Moderate amount	Very little	Neutral	Very little	Very little	Satisfied
2	Moderate amount	Very little	Moderate amount	Neutral	Neutral	Moderate amount	Very little	Neutral	Satisfied
2	Moderate amount	Moderate amount	Neutral	Moderate amount	Neutral	Moderate amount	Moderate amount	Moderate amount	Satisfied
1	Moderate amount	Moderate amount	Not At All	Moderate amount	Very little	Very little	Neutral	Neutral	Satisfied
1	Moderate amount	Moderate amount	A great deal	Moderate amount	Very little	Moderate amount	Neutral	Moderate amount	Satisfied
6	A great deal	A great deal	Moderate amount	Moderate amount	Very little	Very little	Neutral	Very little	Very Satisfied
4	A great deal	A great deal	Moderate amount	A great deal	Moderate amount	Moderate amount	Very little	Moderate amount	Very Satisfied