AN INVESTIGATION INTO THE PROVISION OF SUPPORT WITHIN TRANSITION TO PRACTICE PROGRAMS FOR NEW GRADUATE NURSES IN RURAL HEALTH SETTINGS

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ABSTRACT

In Australia, very few new graduate nurses enter the rural nursing workforce, and those who do go to large regional area health services. Little is known about the role transition process experienced by the small number of graduates working in rural health services and even less is known about their support needs during the transition process. The new graduate nurse who enters the rural health workforce enters a professional practice very different from metropolitan nursing practice and also from what they have experienced in their preparation for professional nursing practice. In the rural practice environment many nursing graduates will be expected by employers to have high levels of independence, well-developed problem solving abilities and assume management and leadership responsibilities early in their graduate year. The diversity and complexity of rural nursing practice, coupled with the present staffing ratios and skill mixes within rural health services, often prevents the new graduate from having time to make an effective transition into the nursing workforce and also significantly impacts on the educational and support services that can be offered to new graduate nurses in transition programs in rural health services. This study sought to investigate the nature and timing of support required for the safe transition to the rural nursing workforce.

Using a qualitative, exploratory, descriptive longitudinal case study design, this study was conducted in rural health services within one area health service of northern New South Wales, Australia. Data collection for this study occurred in two phases. First, a questionnaire of rural nurses responsible for Transition to Practice Programs within rural health services was conducted in Phase One of the Study. In Phase Two, individual interviews with new graduate nurses occurred at three points in time at intervals consistent with Duchscher’s Stages of Transition Theory (2008, p. 443), which was utilised as the theoretical framework for this study. Also in Phase Two, individual interviews were conducted with experienced rural nurses who, at the time of the study, worked with the new graduate nurses.
The data were analysed using content analysis in Phase One and thematic analysis in Phase Two and the findings from Phase Two have been presented as four major themes.

This study found that the new graduate nurse making the transition to professional rural nursing practice moves along the transition continuum described by Duchscher (2008) and that there are particular and unique aspects of the rural nurses role and responsibilities for which new graduate nurses require learning support during their transition to rural nursing practice. This study also found that there is minimal understanding at the individual clinical unit level, local health service level, and at the Area health service level, of the support needs of the new graduate nurse who is making the transition to rural nursing practice.

This study has implications for practice and policy in relation to the support offered within rural Transition to Practice Programs and for the recruitment and retention of graduate nurses to the rural nursing workforce. Recommendations for addressing the nature and timing of support to provide for a safe, supported transition to the rural nursing workforce are made. A proposed framework that would support a Transition to Practice Program in the rural context is presented and discussed. The framework consists of five principles and each principle provides strategies on which to base structural decisions when designing and developing a rural Transition to Practice Program.

Further investigation regarding the provision of support during the transition from student to professional practicing rural nurse is required. As this case study was conducted in only one area health service of northern New South Wales it is recommended that this study be replicated and extended to all rural areas of New South Wales to determine and compare similarities and differences in the level of support offered by other rural Area health services.
CHAPTER ONE

Introduction

1 Introduction

Chapter One introduces the research project and explores the reasons for undertaking this study to investigate the transition of new graduate nurses into rural nursing practice within a Transition to Practice Program. The purpose of the research and the research questions are presented, followed by a discussion of the significance of the study. An introduction to the methodology is provided, definitions adopted by the researcher for the thesis are presented and the limitations of the research are identified. Finally, an outline of the thesis is presented and described.

1.1 Background to the Study

This study emerged from my desire to understand the support needs of new graduate nurses making the role transition from student to registered nurse within rural practice settings. My interest in new graduate nurses and their journey of integration into the rural nursing workforce stems primarily from my work over twelve years as a Clinical Coordinator in a pre-registration nursing program within a regional university of New South Wales. The study also arises from my own interest in rural nursing following my experiences as a practising rural nurse for many years.

In my role as Clinical Coordinator I have been required to visit and meet with students and staff of rural health services to support and monitor the progress of student nurses during their clinical experience as well as to support and liaise with health service staff during the clinical placement period. Over the past twelve years I have been concerned for new graduates within rural health services for several reasons. First, when I visited health services it was not uncommon for new graduate nurses to recognise me as being ‘someone from a university’ and
they would initiate conversations with me regarding their experiences. From my own observations and personal communications with these new graduates, I came to realise that their experience in rural practice is vastly different from what their initial expectations of beginning practice were, especially when compared to the experience of their peers in metropolitan centres.

Second, in the role of Clinical Coordinator I have become increasingly aware of the difficulties rural health service staff encounter, in supporting new learners in the rural workplace. Operational barriers within rural health services such as heavy workloads, skill mix and staff ratios are impacting on the ability of the rural Registered Nurse (RN) to support nursing students for clinical experience. There are often insufficient numbers of RNs available to offer preceptorship or mentorship to pre-registration nursing students which makes it difficult to sustain these models of support and there is a subsequent reluctance by registered nursing staff to accept nursing students for clinical placement. In addition, nursing students, anecdotally and according to evaluation results of their clinical placements, identify the insufficient number of RNs within rural health services is impacting on their experiences of clinical learning. Thus, as a researcher I became aware that operational barriers within rural health services that impacted and influenced the experiences of clinical and learning support for pre-registration nursing students might also be impacting and affecting the provision of support for new graduate nurses who were making the role transition within rural health services.

Third, in my role as Clinical Coordinator, I was responsible for delivering workshops to experienced registered nurses on how to meet the learning support needs of pre-registration nursing students during clinical placement experience. Throughout the delivery of these workshops rural health staff were constantly seeking assistance and advice from me regarding how best to support new graduate nurses in the rural workplace given the operational barriers that were present within the rural practice environment. Thus, the difficulties rural nurses were experiencing in providing support for new graduate nurses during their transition to rural nursing practice was becoming an increasing concern for me.

Finally, I have developed a small body of research and scholarship that centres around the transitional experiences of new graduate nurses, the clinical learning support needs of new learners in the health workplace and the recruitment and retention of graduate nurses to the
rural nursing workforce that has also served to further my interest and concern for the new graduate nurse making the transition to rural nursing practice.

In 2003 I conducted an initial research project that investigated the lived experience of new graduate nurses in rural practice settings (Lea & Cruickshank, 2007). This study found that new graduate nurses had expectations of graduate nurse programs that were not met because of operational barriers such as inadequate staffing ratios and skill mixes present within the rural health services. Furthermore, these operational barriers had negatively impacted on the new graduate nurses experience of their transition to rural nursing practice. From this research a recommendation was made that a further study be conducted to evaluate the effectiveness of the structure and content of graduate programs. It was hoped the findings from such a study could identify the structural barriers and functional elements of rural Transition to Practice Programs. Also, this initial study recommended further research into the new graduate experience of rural nursing practice, specifically to investigate the perceptions of experienced rural nurses regarding the performance of graduate nurses in rural health services during their transition to professional practice.

Following from this study, I conducted a small study in 2005 to identify barriers to the first year of practice for newly graduated nurses in rural practice settings from the perspective of experienced rural Registered Nurses. The findings from this unpublished study validated the results from the Lea and Cruickshank study (2007) which had showed the workload and responsibility as well as the effectiveness of support systems available during the transition to rural practice were identified as areas of concern for the new graduate nurse making the transition to rural nursing practice.

A further study was conducted in 2007 to identify the factors that influenced the recruitment of final year nursing students to rural nursing practice (Lea, Cruickshank, Paliadelis, Parmenter, Sanderson & Thornberry, 2008). A major finding from this study was that final year nursing students were reluctant to pursue rural transitional programs upon graduation because of a perception of a lack of support within rural health services for new graduate nurses making the transition to rural nursing practice.

In 2011 I undertook a collaborative research project with a private healthcare organisation to investigate the experience of new graduate nurses making the role transition within a private
health service (Lea, Thornberry & Kiely, 2011). This study explored the effectiveness of a Transition to Practice Program offered by the largest private health care provider in Australia. The study identified that tailoring the transitional program to the clinical context positively influenced a successful transition. Furthermore a structured and consistent approach within the transitional program resulted in consistently high new graduate nurse retention within the transitional program and at the completion of the program.

Throughout these investigations I was mindful of a gap in the literature surrounding the phenomenon of support during the transition to rural nursing practice. Specifically, there was a gap surrounding the nature and timing of support required by new graduates who were making the transition to rural practice. Furthermore, I was cognisant of the difficulties and challenges that the provision of effective and timely support during the role transition to rural nursing practice presented to both the new graduate nurse and rural registered nurses.

Alongside these research projects that centred on new graduate nurse transition I was also involved in scholarly activities that focused on the provision of clinical learning support by health professionals to new learners in the health workplace, in particular the rural and regional health workplace. Initially these activities commenced as workshops for registered nurses regarding the provision of effective clinical support for nursing students during clinical placement experience. However because many large rural and regional health services were unable to support nursing students within preceptor or mentor models of clinical support, the workshops evolved to include the preparation of university employed Clinical Facilitators/Clinical Educators for their role in supporting nursing students during clinical placement periods. As a result of the difficulties that registered nurses identified they had with supporting new graduate nurses, further workshops were developed and delivered to include content on how to provide learning support for new graduate nurses during the transition to professional practice. From these activities arose a funded research project that investigated the support experiences of rural pre-registration nursing students within a clinical facilitator model of support in the rural practice context (Sanderson & Lea, 2012). Also, the researcher was invited by rural health service staff to provide consultation and collaboration in developing, preparing and implementing a formal structured model of support for new learners within a large rural health service (Miller, Lea & Targett, 2011). In addition, as part of a project funded by The Health Education and Training Institute (New South Wales Ministry of Health), I was involved in the preparation and delivery of inter-professional
clinical teaching workshops to prepare rural health professionals for their clinical support roles of health students (Paliadelis, Stupans, Puxty, Fagan & Lea, 2012). As a result of my scholarship in this area, I became aware that there are specific and unique aspects of rural nursing practice that influence the nature and timing of support for new graduate nurses that have not been explored or acknowledged as influencing the new graduate nurses’ experience of transition.

It is well documented in the literature that the transition process from a student nurse to a registered nurse is a stressful experience that is both physically and emotionally demanding (Dufault, 1990; Green, 1988; Madjar, 1997). The transition process into the nursing workforce is fraught with numerous complexities and transition-based issues have been well documented (Kramer, 1974; Moorehouse, 1992; Kelly, 1996, 1998; Boyle, Popkess–Vawter & Taunton, 1996; Madjar, 1997; Winter–Collins & McDaniel, 2000; Chang & Daly, 2001; De Bellis, Longson, Glover & Hutton, 2001; Goh & Watt, 2003).

According to the literature, (Winter-Collins & McDaniel, 2000; Chang & Hancock, 2003; McKenna & Green, 2004; Maben, Latter & Clark, 2006; Duchscher, 2008; Young, Stuenkel & Bawel-Brinkley, 2008; Zinsmeister & Schafer, 2009) the successful assimilation of the new graduate nurse into the nursing workforce is largely dependent on the amount and quality of support that the new graduate receives during the transition period. This is especially true within the first three months of employment when a rapid and major transformation occurs, both professionally and personally, in the new graduate (Madjar, 1997; Greenwood, 2000; Goh & Watt, 2003; Lea & Cruickshank, 2007; Johnstone & Kanitsakai, 2008). Problems associated with the transition process are universal for beginning practitioners. To some extent they encounter similar problems to those experienced by any newcomer into any workforce. However, in nursing the process is complicated because of the unpredictability of daily practice and the high level of responsibility that is often placed on new practitioners (Kelly, 1996; Madjar, 1997; Mosel Williams, 2000; De Bellis, Longson, Glover & Hutton, 2001; Oermann & Garvin, 2002; Casey, Fink, Krugman & Propst, 2004; Maben, Latter & Clark, 2006; Duchscher, 2008).

For the new graduate in rural practice the role transition is further complicated by the unique role of the rural nurse. Rural nursing has been referred to as a unique specialty, and is described as a specialist-generalist role (Hegney, 1996). For example, rural nurses work in
areas where there are limited health services, health care facilities, and medical practitioners (Bennett, Barlow, Brown & Jones, 2012; Seright, 2011). Thus the role of the rural nurse requires a multidimensional approach accompanied by a broad range of skills. Rural nurses work in professional and social isolation (Bennett, Barlow, Brown & Jones 2011), and frequently do not have ancillary and medical support. This often results in them being the primary care giver and jack of all trades, meaning that they work in all areas and sometimes, because of a lack of available resources, they may work beyond their legal boundaries (Hegney, 1996; Bridgewater, 1998; Lea & Cruickshank, 2007).

Therefore, it is not surprising to find that very few new graduate nurses enter the rural workforce and those who do go to large regional health services (Blue, 1993; Handley, 1998; Hegney, 1996; Lea & Cruickshank, 2005). As previously mentioned, beginning nurses enter rural practice which is very different from urban practice and concern has been expressed in the literature for the employment of new graduate nurses into rural practice because some authors believe it is not possible to prepare undergraduate students for the advanced nature of rural nursing practice (Huntley, 1995; Madjar, 1997; Hegney et al. 1997, cited by Kenny & Duckett, 2003, p. 615).

Thus, this study emerged from my concerns for new graduates within rural health services and also for the rural nursing workforce. I believed that by conducting this study I would be able to further identify the specific issues encountered by new graduate nurses with regard to their requirements relating to the nature and timing of support during the transition process to rural nursing practice. Specifically, this study sought to investigate the phenomenon of support for new graduate nurses enrolled in a rural Transition to Practice Program. I wanted to ascertain if new graduate nurses employed within a formal Transition to Practice Program experienced the stressors and processes identified in each of the three stages of transition identified in Duchsher’s (2008) Stages of Transition Theory. I believed that the findings of this study could be used to more effectively equip nursing students for the experience of transition into rural practice by identifying and exploring the three distinct stages of the transition year that Duchscher (2008) has proposed. Specifically, the study would inform new graduates of what they could experience and encounter at each stage of transition. As well, the study could also assist rural health services and transitional program planners to structure transitional programs and incorporate supportive strategies for each of the distinct stages of transition. Finally, the study findings would inform the content of rural transitional programs.
enabling program planners to ensure that the content of the rural transitional program is congruent with the challenges and skills required of the new graduate nurse within the rural clinical context.

1.2 Purpose of the Study

The purpose of this study was to investigate new graduate nurses’ transition into rural nursing practice within a Transition to Practice Program. To address the research problem, information was required from new graduate nurses employed as registered nurses within a Transition to Practice Program in a rural health service at the time of the study. Also, information was required from the experienced rural nurses who work with new graduate nurses in the rural health services. Using a qualitative case study framework the major aims of the study were to:

- Explore the new graduate nurses’ perception and experience of the nature and timing of support throughout their Transition to Practice Program in a rural setting
- Investigate the experienced rural nurses’ beliefs, perceptions and experience of providing support to new graduates during a Transition to Practice Program in a rural health setting and;
- Identify the functional elements of rural graduate nurse transition programs and develop guidelines that will assist in the design of Transition to Practice Programs that match with the rural context and capacity.

In exploring the phenomenon of support for new graduate nurses within a Transition to Practice Program, this study specifically aimed to investigate and describe the nature and timing of support required during the transition to rural nursing practice that is specific for the rural context and capacity. For the purpose of this study, definitions of the terms that pertain to the characteristics of support that is nature and timing will be clarified. Nature refers to the type of support and where the support comes from. Timing refers to when support is provided within a Transition to Practice Program.
1.2.1 Research Question

In order to explore the nature and timing of support required by new graduate nurses during the transition from student nurse to registered nurse in the rural workforce the following question was developed.

What is the nature and timing of the support required by new graduate nurses throughout a Transition to Practice Program during the transition from student nurse to registered nurse in rural practice settings?

The following research questions were also formulated to assist in exploring the support required for graduate nurses and to identify issues related specifically to the provision of support.

- What are the new graduate nurses’ perceptions and experiences of support throughout a rural Transition to Practice Program?
- What are the experienced rural nurse’s beliefs, perceptions and experiences of the nature and timing of support provided to new graduates during a Transition to Practice Program that would provide for a ‘safe’ and supportive transition in a rural health setting?
- What are the functional elements of a rural Transition to Practice Program?

In this study a Transition to Practice Program is defined as structured support and assistance provided for graduate nurses in the transition from student to registered nurse throughout the first year of professional nursing practice.

1.3 Significance of the Study

This thesis will make both a practical and theoretical contribution. As previously mentioned, a review of the literature indicates that very few new graduate nurses enter the rural workforce, and those who do go to large regional area health services (Blue, 1993; Hegney, 1996; Handley, 1998; Lea & Cruickshank, 2005). However, little is known about the role transition process experienced by the small number of graduates working in these regional area health services. Even less is known about the support needs during the transition process for the minority group of graduates who enter small rural health services. Thus, this study attempts to
address this gap in the research literature regarding the provision of support during the transition process, particularly in the rural nursing literature.

Factors that impact on the provision of support during the transition process for graduates working in rural health settings will be identified using the Stages of Transition Theory and its associated concepts of Transition Shock as developed by Duchscher (2008, 2009). As this theory will underpin this study it will also be utilised throughout the thesis as the theoretical framework. This substantive theory of role transition to professional nursing practice for newly graduated nurses incorporates elements of Transition Theory and Role Theory.

Identification of these factors will have a twofold effect. First, the research findings will contribute to nursing in the tertiary education sector by providing an understanding of the specific issues faced by new graduate nurses who make the transition into rural practice. The research findings will provide further understanding of the process of transition to rural nursing practice. They will be utilised to prepare nursing students for the barriers and hurdles that they will encounter at each of the three stages of transition, enabling them to be better placed to deal with the challenges if they arise. Second, the research findings will identify for rural nurse practitioners whether rural Transition to Practice Programs have a desirable impact on the graduates’ transition. This practical contribution has the potential to assist rural nurses with the development and implementation of supportive graduate nurse programs specific to the rural environment. Finally, this study will assist the researcher to highlight to the nursing profession the current problems faced by rural health services in Australia when employing new graduate nurses in rural practice. More specifically, it will present the recruitment and retention concerns of new graduate nurses in the rural workforce which need to be addressed if rural nursing practice is to survive as a viable, rewarding nursing specialisation.

1.4 Methodology

The aim of this study was to explore and provide an understanding of the support needs of new graduate nurses making the transition to rural nursing practice settings within a Transition to Practice Program. By exploring the experiences of new graduate nurses and the experienced rural nurses with whom they worked at the time of the study, I also sought to identify aspects of the role transition that are unique to rural practice settings. The researcher chose a qualitative case study approach for several reasons. First, many authors have indicated in the literature that quantitative research methods are not appropriate to study
experiences that have meaning for people (Hallett, 1995; Annells, 1999; Van der Zalm & Bergum, 2000; Schneider, Whitehead, LoBiondo-Wood & Haber, 2013). Second, a case study research method is best suited to answer how and why questions regarding a set of events over which the investigator has little or no control. Third, this type of research design is suitable for describing, exploring and understanding complex phenomenon in its real life context (Stake, 1995; Yin, 2009) when the researcher is interested in both the phenomenon and the context in which it occurs (Salminen, Harra & Lautamo, 2006). Fourth, a case study design is appropriate when the field of inquiry is under-researched and if there is minimal or limited foundational research in the area (Fitzgerald, 1999, p. 75). There is very little literature that explores the support experiences of graduate nurses in rural practice, as well as the perceptions and experiences of experienced rural nurses who work with them in the rural practice setting so a case study research design was deemed to be the most appropriate to address the research problem and achieve the study aims. In this study, the case is defined as the rural Transition to Practice Program.

In this study, evidence was collected and triangulated from a survey, individual in-depth interviews and the researcher’s journal. The survey of fourteen small and large rural health services established a picture of the structure of the transitional program within rural health services in New South Wales. The journal forms part of the ‘chain of evidence’ (Yin, 2009, p. 120) for this case study and was used to record handwritten case study notes regarding all aspects of the research process.

The views of new graduates and experienced rural nurses were viewed as crucial in discovering in-depth, rich data that would address the aims of this study. Therefore, individual in-depth interviews were conducted with fifteen new graduate nurses who, at the time of this study, were making the role transition within rural practice settings. In addition individual in-depth interviews were conducted with fifteen experienced rural nurses who were employed in rural health agencies where the new graduate nurses were employed. I considered this to be an appropriate data collection method because I wanted to explore new graduates’ experiences in order to understand their feelings/emotions as well as explore the perceptions and experiences of the experienced rural nurses.

This study used the Stages of Transition Theory (Duchscher, 2008, 2009) as the theoretical framework. The Stages of Transition Theory is influenced by concepts central to Role
Theory, Reality Shock Theory (Kramer, 1974) and Transition Theory (Meleis, Sawyer, Im, Hilfinger Messias & Schumacher, 2000). The Stages of Transition Theory posed by Duchscher (2008), arises from Transition Theory (Schumacher & Meleis, 1994) and subsumes elements of professional role socialisation as identified by Kramer (1974). These elements have been identified in the literature as important underpinning elements of new graduates’ experience. Therefore, this researcher believed the Stages of Transition Theory (Duchscher, 2008) would provide an appropriate framework from which to view the provision of support during the transition process from student nurse to registered practising nurse within rural practice settings.

1.5 Limitations and Key Assumptions

This study was conducted in fourteen rural towns of northern NSW and is therefore not representative of the new graduate nurse population in all rural areas of this State. However, the researcher was not interested in making statistical inferences or generalising the findings to the wider population. Rather, the purpose was to obtain rich and insightful data that would shed light on the barriers as well as the positive factors that impacted on the experiences of a sample of graduate nurses who made the role transition in rural practice settings.

There are two major assumptions on which this study was based. The first is that I had an expectation, based on personal experience, findings from my own research studies and anecdotal evidence, that new graduate nurses working in rural health settings do encounter specific problems during their transition process. The second assumption, also based on personal experience and findings from previous research studies, is that the new graduate nurse making the transition to professional nursing practice requires support for a period of twelve months.

1.6 Definition of Terms

The following terms have been identified for this research study to avoid confusion and to enhance clarity and consistency. A number of these definitions have been drawn from various sources and will be identified as such. Those without a reference are the researcher’s understanding of the term.
Table 1.1 Definition of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Clinical Nurse Educator (CNE)</td>
<td>A Registered Nurse ‘appointed to a position classified as such and who holds relevant clinical or education post- registration qualifications or such education and clinical experience deemed appropriate by the employer’ (NSW Public Health System Nurses’ and Midwives (State) Award 2011, p. 5).</td>
</tr>
<tr>
<td>Clinical Nurse Manager Grade 1 (CNM)</td>
<td>A Registered Nurse/Midwife who is allocated to a Nurse Manager position and ‘who participates in the management of nursing services as the Deputy Nurse Manager in a small rural health facility and is responsible to an onsite manager’ (NSW Public Health System Nurses’ and Midwives (State) Award 2011, p. 5).</td>
</tr>
<tr>
<td>Clinical Nurse Specialist Grade 2</td>
<td>A Registered Nurse/Midwife appointed to a position classified as such with relevant post-registration qualification and at least 3 years experience. Role characteristics include: a high level of clinical nursing knowledge, experience and skills in providing complex nursing/midwifery care directed towards specialist clinical practice across a small or medium sized health facility…(NSW Public Health System Nurses’ and Midwives (State) Award 2011, p. 6).</td>
</tr>
<tr>
<td>Enrolled Nurse (EN)</td>
<td>A person licensed under an Australian State or Territory Nurses Act to provide nursing care under the supervision of a Registered Nurse (Levett-Jones &amp; Bourgeois 2007:243).</td>
</tr>
<tr>
<td>Endorsed Enrolled Nurse (EEN)</td>
<td>A person licensed under an Australian State or Territory Nurses Act to provide nursing care under the supervision of a Registered Nurse (Levett-Jones &amp; Bourgeois 2007:243) who holds a medication administration qualification.</td>
</tr>
<tr>
<td>Health Service Educator (HSE)</td>
<td>Classified as a Nurse Educator Grade 2 this position refers to a Registered Nurse/Midwife with post registration clinical and or educational qualifications who is responsible for ‘a nursing/midwifery education portfolio across a public hospital or….’ (NSW Public Health System Nurses’ and Midwives (State) Award, 2011, p. 8). However, in rural health services this position is required to provide professional education and support for all staff within the health service.</td>
</tr>
<tr>
<td>Health Service Manager Grade 6 (HSM)</td>
<td>Classified as a Grade 6 Nurse Manager this position is ‘the on-site Executive Officer in addition to responsibility for the management of nursing services in a facility or hospital generally greater than 10 adjusted daily average of occupied beds [ADA] and generally not exceeding 30 ADA (NSW Public Health System Nurses’ and Midwives (State) Award, 2011, p. 94).</td>
</tr>
<tr>
<td>Large Rural Health Service (LRHS)</td>
<td>Located in outer regional areas in a rural town whose population base is 25,000 or more and whose health service has a bed capacity that ranges between 100 and 150 and as such would be classified according to the number of admissions per year as ‘medium acute hospitals in regional areas’ (Commonwealth Department of Health and Ageing, 2010, p. 49).</td>
</tr>
<tr>
<td>Mentor</td>
<td>A term used interchangeably in Australia, with the term preceptoring, to describe the supportive, educative role of the Registered Nurse (Levett-Jones &amp; Bourgeois, 2007).</td>
</tr>
<tr>
<td>Multi Purpose Service (MPS)</td>
<td>Located in outer regional areas in rural towns generally in populations less than 10,000. The bed capacity of these health services usually ranges between 30 and 50. They are classified by the Australian Department of Health and Ageing as ‘small non-acute hospitals’ with ‘patient throughput of less than 2000 admissions per year with 40% non acute…’(2010, p. 48).</td>
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New Graduate Nurse (NGN)  
‘a Registered Nurse with less than one year’s clinical experience in the area of nursing practice in which they are currently working’ (Williams 1989 cited in Roberts & Farrell, 2003, p. 13).

Nurse Manager (NM)  
Classified as a Grade 3 Nurse Manager, this position is ‘responsible for the management of nursing services in a small health facility or hospital’ (NSW Public Health System Nurses’ and Midwives (State) Award, 2011, p. 93).

Nurse Unit Manager (NUM)  
A Registered Nurse/Midwife in charge of a ward or unit in a public hospital or health service. Responsibilities of this position include coordination of patient services, unit management and nursing staff management (NSW Public Health System Nurses’ and Midwives (State) Award, 2011, p. 9).

Preceptor  
A term used interchangeably in Australia, with the term mentoring, to describe the supportive, educative role of the Registered Nurse (Levett-Jones & Bourgeois, 2007).

Registered Nurse (RN)  
A person licensed to practise nursing under an Australian State or Territory Nurses Act (Levett-Jones & Bourgeois, 2007, p. 245).

Rural town  
For the purpose of this study rural towns are classified to be outer regional according to the Commonwealth Department of Health and Ageing (2010) and/or those towns whose population base is classified as rural, according to The Australian Bureau of Statistics, Australian Standard Geographical Classification Remoteness Areas Classification (ABS 2001, accessed 22 April, 2010). This system classifies areas depending on their distance from different sized urban areas where the population size of the urban centre is considered to govern the range and type of services available.

Small Rural Health Service (SRHS)  
Located in outer regional areas in rural towns with a population base of 10,000–24,000 whose health care facility has a bed capacity of between 30 and 60 and would be classified as ‘small regional acute hospital (mainly small country town hospitals)’ because of their admissions per year and treating fewer than 2,000 patients per year (Australian Department of Health and Ageing, 2010, p. 48).

Transition to Practice Program (TPP)  
A twelve month structured program provided by health services, that aims to assist the transition from undergraduate student to registered nurse by providing extensive clinical orientation and structured support. This may include rotations through clinical areas, plus a range of educational and supportive strategies, for example preceptorship, mentoring, and study days that will assist the new graduates to consolidate skills and gain experience (Jackson, Mannix & Brown, 2001; Kluge, 2001).

1.7 Organisation of the Thesis

This thesis is presented in five chapters. In Chapter One the research topic is introduced. A background to the problem is provided, followed by the purpose of the study and the research questions. The significance of the study is discussed and it is identified that the research findings will make both a practical and theoretical contribution. The methodology and theoretical framework utilised in this study are identified. This chapter also identifies the limitations and the key assumption related to this study and, a list of definitions is provided to classify terms used throughout the thesis.
Chapter Two of this thesis presents an overview of rural nursing practice in Australia and a critical analysis of the research-based literature related to the role transition for new graduate nurses’ in metropolitan and rural practice settings. Additionally, the theoretical framework which utilised the Stages of Transition Theory and associated concepts are presented and discussed.

In Chapter Three the justification for the research design and methodological approach chosen for this study is presented. This chapter provides detailed descriptions of the recruitment and selection of participants, the sampling strategy, the method of data collection, the use of a researcher’s journal and the data analysis techniques as well as a discussion of rigour and trustworthiness required for a qualitative case study. Finally, the ethical considerations and methodological limitations relevant to this research study are identified and discussed.

In Chapter Four the results of this study are presented in four major themes and eleven subthemes and a detailed account of the justification for the data analysis procedures is provided. The profiles of participants are also described. Themes One, Two and Three map the milestones of transition for the rural graduate nurse participants. Theme One ‘Getting Started at the 3-4 Month Milestone’ contains three subthemes: ‘Influences on Support whilst Stepping into the Rural RN Role’, ‘The Rural Transition to Practice Program’ and ‘Support Experiences versus Support Needs’. Theme Two ‘Settling In at the 6-7 Month Milestone’ has three subthemes: ‘Influences on Support Whilst Settling in to the Rural RN Role’, ‘The Rural Transition to Practice Program’ and ‘Support Experiences versus Support Needs’. Theme Three ‘Just another nurse at the 11-12 Month Milestone’ also has three subthemes: ‘Influences on Support whilst Immersed in the Rural RN Role’, ‘The Rural Transition to Practice Program’ and ‘Support Experiences versus Support Needs’. Theme Four ‘The Rural RNs Experience with Newly Graduated Nurses in Rural Practice’ represents the experiences and perceptions of participants who are experienced rural nurses and is informed also by the following three subthemes: ‘Rural RNs Engagement and Experience of the Rural Transition to Practice Program’, ‘Providing Support to Newly Graduated Nurses’ and ‘Rural RNs Recommendations for Rural Transition to Practice Programs’. For each theme extracts from the data are presented as narratives that enrich the findings and accurately portray the true picture that emerges from the themes.
The thesis concludes with Chapter Five, which presents the researcher’s interpretations of the findings and major conclusions. The themes and subthemes are linked to the Theoretical Framework with interpretation and analysis from the theory and the research literature described in Chapter Three. Chapter Five also provides a discussion of the conclusions and implications of the study and a proposed framework that would support a Transition to Practice Program in the rural context is then presented and discussed. The implications for practice and policy are addressed and recommendations are made for education, practice, policy and further research into this field of study.

1.8 Conclusion

In summary, this chapter has laid the foundations for the thesis. The chapter has introduced the research topic and presented a background to the study. Following this the purpose, research questions and significance of the research have been described. The theoretical framework which guided the current study, and the methodology employed by the researcher, have been introduced. Research limitations and assumptions have been identified and a definition of terms has been provided. Finally, each chapter of the thesis has been outlined. The following chapter will present a review of the literature in relation to the research topic.
CHAPTER TWO

Literature Review

2 Introduction

This chapter discusses the literature that pertains to the provision of support during the role transition for new graduate nurses in metropolitan and rural practice settings within Australia. The aim of this chapter is to provide an overall review of the issues surrounding the role transition and the provision of support during the transition from student to registered nurse followed by an examination of these issues as they specifically apply to the new graduate making the role transition in rural health care facilities.

In section one, an overview of rural nursing practice in Australia is presented. This section specifically examines the role of the rural nurse and the current issues affecting the rural nursing workforce, in particular the issues for new graduates in rural nursing practice. In section two, the theory of the new graduate nurse transition The Stages of Transition Theory and its associated concepts of Transition Shock as developed by Duchscher (2008, 2009) will be presented as the theoretical framework for this study because of its direct relevance to the concerns of the study. This substantive theory of role transition to professional nursing practice for newly graduated nurses incorporates elements of transition theory and role theory. This section first provides an overview of the development of transition theory as a middle-range, discipline-specific theory for nursing. The major focus is on situational nursing transitions and related concepts such as role stress and role strain will be discussed, and the impact of these concepts on new graduate nurses in rural areas is also explored.

Section three identifies and presents the research-based evidence that pertains specifically to the beginning registered nurses’ transition to professional practice. In addition, the concepts of professional socialisation and reality shock that can occur for new graduate nurses as they
enter the nursing workforce are examined. Associated concepts including undergraduate nursing preparation, the gap between nursing education and nursing service, enculturation of new graduate nurses and horizontal violence are also discussed. Finally, the effectiveness of structured support mechanisms implemented to assist in easing the role transition for the new graduate nurses is reviewed.

For the literature survey, electronic and manual searches of the relevant literature were undertaken to determine the full extent of the published research regarding this topic. A review of the national and international literature was conducted combining the bibliographic database, library catalogues and electronic databases. The primary sources of relevant journal articles include electronic databases and published literature reviews. Therefore an electronic search of research and literature on graduate nurses and graduate nurse programs published in peer reviewed journals of nursing and nursing education from 2000 to the present and limited to English language journals was employed to access relevant literature. Electronic search engines such as Google, Google Scholar, Summon, Informit Online, AltaVista, Wiley InterScience and New South Wales Health’s Clinical Information Access Portal (CIAP) were used to aid the search. Electronic databases searched were ProQuest, MEDLINE (MEDical Literature Analysis and Retrieval System online), CINAHL (Cumulative Index of Nursing and Allied Health Literature), Emerald, Gale (Infotrac), Ovid, SAGE Journals and Scopus. Key words and search terms employed to help define the focus of the search and to locate a broad range of research literature relevant to the topic included: new graduate nurses, transition, graduate nurse programs, transitional programs, rural nursing, rural graduate nurses. These terms were used alone or in combination in both simple and advanced searches. Whilst searching for peer-reviewed literature a focused strategy of following citation trials within individual highly cited papers relevant to the topic area was also implemented. As well, Internet searches were employed that focused on websites of organisations relevant to the field of study, such as professional organisations, government departments and health services. Finally, ‘grey literature’ in the form of recent government reports, plans and strategy documents were examined for relevance to nursing workforce and rural health workforce recruitment and retention.
2.1 Section One

2.1.1 Rural Nursing Practice in Australia

Since the late 1980s, there has been a growing body of knowledge that recognises rural nursing as a separate and unique identity from both remote and metropolitan-based nursing and there is an established body of literature related to rural nursing in Australia. The literature concentrates on defining rural nursing, investigating the scope of rural nursing practice, identifying the educational and research needs of rural nurses, the issues surrounding the recruitment and retention of the rural nursing workforce as well as providing discussions as to the preparedness of new graduate nurses for the diversity of rural nursing practice (Blue, 1993; Hegney, 1996; Bridgewater, 1998; Handley, 1998; Kenny & Duckett, 2003; Lea et al., 2008; Mills, Birks & Hegney, 2010).

Rural nursing in Australia has been referred to as a unique specialty, described as a specialist-generalist role (Hegney, 1996; Kenny & Duckett, 2003). For example, rural nurses work in areas where there are limited health services and facilities and limited numbers of medical practitioners, and frequently they work in in professional and social isolation (Bennett et al., 2012). As a result, the role of the rural nurse is multidimensional and unique, and requires a broad range of skills. Mills, Birks and Hegney (2010, p. 31) note that the role is a generalist-specialist one that is performed along a continuum dependant on and influenced by the context of practice. Mills et al. (2010) state that the distance from a tertiary referral centre, the size and composition of the health team, the prevailing work conditions and the size and composition of the community influences the context of practice for rural nurses.

Authors such as Blue (1993), Hegney (1996), Keyzer (1998) Hegney and McCarthy (2000) and Francis, Bowman and Redgrave (2002) have highlighted common elements of rural nursing practice. For example, rural nurses are often the primary care givers, often referred to as jack of all trades (Hegney, 1996; Bridgewater, 1998), who work in areas which may be without ancillary or medical support. As a result, this sometimes necessitates them working beyond their legal boundaries and often making decisions in the absence of other health professionals (Hegney, 1996; Bridgewater, 1998; Hegney & McCarthy, 2000; Kenny & Duckett, 2003; Lea & Cruickshank, 2007). Additionally, rural nurses have a high community profile, which often results in a blurring of roles and a lack of anonymity for the rural nurse,
as they often have to care for and work closely with people they know professionally, personally and socially.

Several authors (Taheri-Kennedy, 1997; Barber, 2007; Mills, Francis & Bonner 2007; McCoy, 2009; Hunsberger, Bauman, Blythe and Crea, 2009; Mills, Birks & Hegney, 2010) identify the role diffuseness that occurs for rural nurses because of the mixing of personal and professional roles in rural practice which Taheri-Kennedy (1997) terms the rural culture. The role diffuseness for health care providers in rural areas is much greater than their urban counterparts (McCoy, 2009, p. 129). According to Taheri-Kennedy (1997) this diffusion of personal and professional roles is an expectation that rural cultures have of rural nurses. Furthermore, Taheri-Kennedy (1997) states that rural people are different from urban people in geographical, occupational and cultural ways that affect health perceptions, behaviours and pathology risks. Therefore, the experience of nursing in rural communities is seen as unique, and nursing care must be appropriate for the rural culture. Interactions such as grocery shopping are usually thought to be social circumstances but in rural communities they can involve a professional role. It is not unusual for a nurse to go shopping and be recognised by people as the nurse who has recently cared for them or their relative, or for the nurse to be consulted in the street regarding a person’s health problems. As well, professional roles can involve a personal role if the patient is a friend, neighbour or acquaintance. This can also influence work relationships as work colleagues maybe neighbours, friends, relatives or perhaps acquaintances met through sporting, school or social networks. Role diffuseness results in a lack of anonymity for rural nurses and Hegney (1996) suggests that the lack of anonymity experienced by rural nurses is difficult for them, especially for those nurses who have grown up in the rural area. Being highly visible in the community, feeling as though they are under surveillance and not having their workday contained in working hours can be a struggle for rural nurses. In contrast, Mills et al. (2010) acknowledge that rural nurses have interconnectedness with the community that is generally considered a positive outcome by rural nurses that assists toward building social capital through the sharing of knowledge and resources.

The critical health workforce shortages within Australian rural health services and in particular the nursing workforce problems which face rural areas are prominent themes in the current literature pertaining to rural nursing. Issues surrounding the difficulty in recruiting and retaining experienced rural nurses have been identified by Hegney, McCarthy, Rogers–Clark
and Gorman, (2002a) who found that management practices, emotional demands of work, and lack of recognition were some of the influences on the retention of experienced rural nurses. In addition, Kenny and Duckett (2003) identified a lack of consideration given to the rural nursing workforce in terms of support and access to education, which compounds the rural nurses’ professional isolation. The problems of a lack of systemic support and professional isolation have also been recognised by the Australian Government Department of Health and Ageing (2008) as important factors that need attention in addressing the rural nursing workforce shortage.

2.1.2 The New Graduate Nurse in Rural Practice

As mentioned previously, the retention and recruitment of health professionals to rural areas has been acknowledged as a major problem in Australia (Hegney, 1996; Bell, Daly & Chang, 1997; Courtney, Edwards, Smith and Finlayson, 2002; Kenny & Duckett, 2003; Mills, Francis & Bonner, 2006; Mills et al., 2010; Bennett et al., 2012), which has been a long-standing concern. Lack of access to adequate support, education and training are identified as common themes that influence the retention of the rural nursing workforce (Hegney, 1996; Bell et al., 1997; Kenny & Duckett, 2003; Mills et al., 2006, 2010; Australian Government Department of Health and Ageing, 2008).

There is a low turnover of nursing staff in rural health care facilities compared to metropolitan and remote areas (Hegney, 1996; Kenny & Duckett, 2003), and this is due to the stability of rural lifestyles and also to the fact that many partners of rural nurses are employed within rural communities, for example, the police force, teaching and farming (Hegney, 1996; Lea & Cruickshank, 2005). However, the rural nursing workforce is an ageing one, and numerous reports focus on the recruitment and retention of new graduate nurses as an important issue for rural health care facilities (Hegney, 1996; Bridgewater, 1998; Mosel Williams, 2000; Cowin, 2002; Hegney, McCarthy, Rogers-Clark & Gorman, 2002b; Lea & Cruickshank, 2005; Gum, 2007; Government Department of Health and Ageing, 2008; Mills et al., 2010; Bennett et al., 2012). However, the diversity and complexity of rural nursing practice means the rural nurse must have a strong theoretical and practical knowledge base, and there has been concern in the literature for the employment of new graduate nurses into rural practice because some authors believe it is not possible to prepare undergraduate students for the advanced nature of rural nursing practice (Huntley, 1995; Hegney et al., 1997 cited by Kenny & Duckett, 2003, p. 615). Further, Kenny and Duckett (2003) state that while there is an
emphasis on postgraduate education to prepare registered nurses for rural practice, the
majority of experienced rural nurses do not have postgraduate qualifications. Rather the
majority of rural nurses have trained under an apprenticeship model and have no university
education (Kenny & Duckett, 2003, p. 616). Rural nurses can face extreme difficulties
pursuing postgraduate studies, with cost, family commitments as well as difficulties being
released to attend education being cited as difficulties and barriers to pursuing post graduate
education (Kenny & Duckett, 2003). Kenny and Duckett (2003, p. 615) state that the reality is
that the future rural nursing workforce in many rural health settings is recruited from
undergraduate courses delivered by regional universities. Thus, it has been advocated that
education providers need to provide specific theoretical and operational preparation in the
pre-registration nursing course for this area of practice (Kenny & Duckett, 2003, p. 613).

New graduate nurses who enter the rural workforce enter a professional practice very different
from metropolitan practice and also from what they have experienced as an undergraduate
nursing student. The literature identifies unique characteristics of rural practice, including the
unique clinical experiences associated with rural practice, greater autonomy enjoyed by rural
health professionals, and the rewards of living in a small community (Wolfenden, Blanchard
& Probst, 1996; Mills et al., 2006; Lea et al., 2008). However, issues of concern for new
graduates who enter the rural workforce are employer expectations, support and workloads
(Kenny & Duckett, 2003; Lea & Cruickshank, 2007; Lea, 2007; Lea et al., 2008; Nayda
Cheri, 2008). In the past twelve years the diminishing infrastructure of rural towns and the
subsequent restructuring of rural health services have significantly impacted on the staffing
ratios and skill mixes within rural health care facilities. This has influenced the educational
and support services that can be offered to staff (Kenny & Duckett, 2003; Lea & Cruickshank,
2007; Parker, Giles, Lantry & McMillan, 2009; Bennett et al., 2012) in particular, to new
graduates in transition programs in rural areas.

Hegney (1996) and Bridgewater (1998) believe that the difference between rural and
metropolitan nursing practice may be attributed partly to the scope and diversity of rural
nursing practice whereby the level of responsibility and skills differs from that of their
metropolitan peers. Thus, it is likely that new graduate nurses in rural practice settings will
have to assume workload responsibilities that are vastly different from their metropolitan or
regional peers. For example, staff ratios in rural areas can mean that the new graduate may be
required to relocate to different clinical areas on a daily basis to provide assistance when, for
example, other areas within the hospital are short-staffed, when staff are experiencing emergency situations, or when meal relief for other staff members is required. Thus, new graduates in rural practice may be required to move between clinical units fairly constantly throughout one shift. To further highlight this point, it is not uncommon in rural health care facilities for the Accident and Emergency area to be attached to a general ward area. Staff rostered to that ward are expected to also attend to the Accident and Emergency area should the need arise during the course of the shift (Lea & Cruickshank, 2007). Also, it is not uncommon for paediatrics, maternity, and acute surgical care clinical areas to be a component of the general ward in rural agencies. In addition, many small rural hospitals have long term residential care facilities because of the lack of residential aged care facilities in the rural area (Hegney, 2007). Thus, the context of rural practice means that rural nurses must be able to switch clinical focus quickly, in addition to possessing a broad range of assessment and clinical skills (Lea et al., 2008) and a broad understanding of referral services (Kenny & Duckett, 2003; Seright, 2011).

In many clinical areas of rural hospitals there are only one or two registered nurses on duty at any one time and in some smaller rural hospitals there might be only one or two nurses on duty for the entire hospital. Having lower registered staff to patient ratios than their urban peers means that the rural new graduate’s expectations of a supportive transitional experience are generally not met because many rural graduate nurses will be required to take on workload responsibilities, with limited supervision or guidance, that allows no time for familiarising or settling into the work environment (Lea & Cruickshank, 2007; Lea, 2007; Seright, 2011). In addition, many graduates will be expected by employers to have high levels of independence, have well developed problem solving abilities and be able to assume management and leadership responsibilities, such as being in charge and delegating, as well as directing and coordinating roles very early on in their graduate year (Kenny & Duckett, 2003; Lea & Cruickshank, 2007; Lea, 2007; Lea et al., 2008; Bennett et al., 2012).

The most recent published data on new graduate nurse employment destination in New South Wales indicates that for the year 2008, 77% of the new graduate nurse positions available within New South Wales Health were within the metropolitan context, with only 33% located within rural health services (New South Wales Health, Hunter New England Area Health Service New Graduate Forum, 2010). Graduate nurse positions are limited in rural areas because of the reasons previously mentioned and also because of the size of individual health
services and the populations they serve, as well as the availability of financial resources to recruit new staff. Rural health agencies vary in the number of graduate nurse positions they have available. Generally, large rural health care facilities can accommodate between four to six graduate nurses whilst smaller rural health care facilities can accommodate only one to two graduate nurses per year. A unique aspect of graduate nurse programs in rural health care facilities is that graduate nurses may be required to rotate for periods of up to three months to smaller satellite health facilities within the region during their graduate program.

Blue (1993), Handley (1998), Hegney (1996), and Lea and Cruickshank (2005) have indicated that very few new graduate nurses enter the rural workforce, and those who do go to large regional health services. Very few rural health care facilities directly employ staff members, as most come under the umbrella of a larger area health service that recruits for their smaller rural health facilities. This means that new graduates might be offered a position within any of the area health services rural sites within New South Wales, as part of their employment choices through the New South Wales New Graduate Nurse Employment Consortium.

Employment intentions of final year nursing students and new graduate nurses have been found to be influenced by their rural connections and their intentions to return to rural communities following completion of undergraduate preparation (Lea & Cruickshank, 2005; Lea et al., 2008). However, for the small group of new graduate nurses who have often relocated to the rural town to enter rural nursing practice (Bennett et al., 2012), there is often no guarantee of a permanent position once the graduate year is completed (Lea & Cruickshank, 2007). This is because of the low turnover of staff in rural health facilities, as previously mentioned. The introduction of second year graduate nurse programs in some larger rural health agencies is aimed at retaining graduate nurses, however graduates in smaller rural health agencies will leave the rural area upon completion of their 12-month graduate nurse program to seek more permanent employment in metropolitan or larger regional centres, thus the new graduate is lost to rural practice.
2.2 Section Two

2.2.1 Theoretical Framework

In this study, the Stages of Transition Theory recently described and suggested by Duchscher (2008) provides a substantive theory and model that explicates the stages through which new nursing graduates advance during the first twelve months of transition into acute care settings (Duchscher, 2008). It provides the most accurate representation to date of this situation-specific transition and is therefore an appropriate framework from which to examine support of new graduate nurses in rural practice settings during the transition experience. Historically, explanations for and of the process of transition from student nurse to professional practising nurse have been consumed by descriptions of the adjustment to new roles and socialisation to the role of practising nurse, influenced by concepts central to Role Theory, Reality Shock Theory (Kramer, 1974) and Transitions Theory (Meleis et al., 2000). The Stages of Transition Theory arises from Transitions Theory (Schumacher & Meleis, 1994) and subsumes elements of professional role socialisation as identified by Kramer (1974). Thus the following section will provide an overview of the concepts of Transitions Theory, a discipline specific theory for nursing which has its origins in role theory, and it will then examine Duchscher’s (2008) Stages of Transition Theory, which provides the theoretical framework for this study.

2.2.2 Role Theory Informing Transition Theory

Transition Theory as described and suggested by Schumacher and Meleis (2000) is a middle range nursing theory specific to the discipline of nursing that provides a framework through which nursing phenomena related to transitions and the facilitation of transitions can be examined (Im, 2011). Transition Theory provides a lens to examine situation-specific transitions and aspects of transitions. For example, in the present study it provides a framework to examine the provision of support for newly graduated nurses during the role transition from the educational setting to the workplace (Meleis, 2010).

The development of transitions theory and the associated concept of transitions has evolved from the social sciences and health disciplines, most recently from the discipline of nursing, specifically for understanding the transition process as it relates to health and illness. Kralick, Visentin and van Loon (2006, p. 321) write that transitions theory has a history with other disciplines such as anthropology where the work of Van Gennep and others highlights the ‘rites of passage’ throughout stages of human life. This theory describes three distinct phases
of transition as people move through life: rites of separation, rites of transition and rites of incorporation (Kralick, Visentin & van Loon (2006, p. 323). As well, Im (2011, p. 280), states that transitions theory was originally ‘borrowed’ from symbolic interactionism and role theories that also have origins in the behavioural and social sciences arising from authors such as Biddle and Thomas (1966), Hardy and Conway (1978) and Biddle (1979). Frequently adopted to provide a theoretical perspective that can be applied to propositions for nursing care and to the acquisition of the professional role of nursing (Meleis, 2010, p. 13), role theory, specifically Meleis’s Role Insufficiency Theory, provided the foundations for the development of The Transitions Theory—a situation-specific theory for nursing (Im, 2011). A discussion of Role Theory is provided to demonstrate the theoretical basis for Transitions Theory.

Role theory contends that roles are assigned to individuals in society and each role has recognisable patterns of behaviours and expected behaviours that go with it (Kilstoff & Rochester, 2001, p. 79). Additionally, expected patterns of behaviour are also assigned to the individuals with whom the role occupant interacts (Hein & Nicholson, 1994, p. 308). Socialisation for roles begins in infancy where role modelling and the reinforcement of socially relevant behaviours are learned through the influence of family. It continues through to adulthood where individuals develop new behaviours and values associated with adult professional roles.

In the symbolic-interaction perspective the role is seen as reciprocal because it is dependent on other individuals who are involved in the interaction. For example, it may involve role modification, where an individual adopts the attitudes or behaviours of others that are involved in an interaction. Or, the interaction with others is structured in such a way as to modify and make explicit certain aspects of the role (Hardy & Conway, 1978, p. 24). Specifically, these characteristics are known as role taking and role making, terms that are used to describe the process that takes place when role modification is consciously entered into. By observing the behaviour of individuals within a certain occupational role, another individual who wishes to be in that role can change or model their behaviour to conform to the expectations that others have of the behaviours that go with that specific role.

The symbolic-interaction perspective of Role Theory helps to explain the professional role and the professional socialisation of new graduate nurses who will learn by role taking or role
making, by observing, understanding and responding to the meaning of actions of other nurses (Creasia & Parker, 2001, p. 75). The nurse’s own role expectations and the expectations of other individuals with whom the nurse interacts will also influence behaviour patterns that are specific to the nurse’s professional role. Individuals with whom the nurse interacts, for example, doctors, other nurses and healthcare workers, patients and their families, will all have expectations of the nurse’s behaviours and will interact to condemn or support the behaviour within the nursing role. Barter, McLaughin and Thomas (1997, p. 31) state that nurses need to know the function they fulfil, as well as the associated behaviours and expectations concerning the roles of other individuals within the health care organisation so that they can respond accordingly.

Within a defined role there can be multiple associated roles that can be assumed within the same context. For example, the role of the nurse involves that of a caregiver, as well as an education and administrative role and these main roles can have sub-roles that have a similar focus yet differing dimensions. For example, the nurse’s educational role is one that can have numerous sub-roles. Sub-roles form complex patterns of overlapping social positions and roles, each demanding certain behaviours and relationships, which are unique (Creasia & Parker, 2001, p. 77). Thus, the education of patients and their families, clinical education of student nurses and providing in-service education for peers and colleagues, are different dimensions of the nurses’ educational role.

However, multiple and sub-roles that an individual assumes can lead to conditions that make fulfilment of roles difficult or which can adversely affect the role occupant, leading to a phenomenon known as role stress (Hardy & Conway, 1978, p. 74). According to Hardy and Conway (1978, p. 73) role stress occurs when ‘a social structure creates very difficult, conflicting, or impossible demands for occupants of positions within the structure’. Role obligations might be irritating, unrealistic or vague and can lead to role strain where the individuals experience feelings of frustration, anxiety, irritability or distress because they cannot meet the role obligations (Creasia & Parker, 2001, p. 78). An inability to meet role obligations can result in conditions associated with role stress, which are categorised as: role conflict; role ambiguity; role incongruity; and role overload, all of which commonly occur within nursing.
Role stress and role strain are prevalent in nursing because of the multiple roles and sub-roles within the professional nursing role. Also, role stress and role strain are generated in nursing because of the changes in the organisation and delivery of health care, the formation of new nursing roles, as well as technological advances and prevailing economic conditions (Hardy & Conway, 1988 cited in Creasia & Parker, 2001, p. 78).

Conditions associated with role stress and role strain are role conflict, role ambiguity, role incongruity, and role discrepancy and they are encountered in the role transition for the new graduate nurse. They have been identified in the literature as common elements of the new graduate nurse's experience of transition to professional practice (Horsburgh, 1989; Moorehouse, 1992; Kelly, 1996; Winter-Collins & McDaniel, 2000; Kilstoff & Rochester, 2001; Oermann & Garvin, 2002; Goh & Watt, 2003; Young, Stuenkel & Bawel-Brinkley, 2008).

In addition, a change in role relationships, expectations or abilities, denotes a role transition, which will require individuals to incorporate new knowledge and alter behaviour, which in turn will change the definition of themselves in their social context (Meleis, 2010, p. 15). In earlier work, Meleis and colleagues identified role insufficiency where difficulty is experienced in performance, cognizance or behaviour of a role, as the result of unhealthy role transition (Im, 2011, p. 280). Im (2011) states that Meleis et al. (2000) contend that unhealthy role transitions occur because individuals may not be properly prepared for a transitional experience. Role insufficiency is demonstrated by behaviour that results from a disparity in fulfilling role obligations or expectations, or the perception of inadequate role performance by self or significant others. For example, an individual may display behaviour such as anxiety, depression, apathy, frustration, grief, unhappiness and aggression or hostility, which will impede their progress towards health, well-being and role adaptation (Meleis, 2010, p. 17). Further, Meleis (2010, p. 17) states that role insufficiency may be voluntary or involuntary and can result from poor role definition, from the dynamics of role relationships or from lack of knowledge of role behaviours, sentiments and goals (Meleis, 2010, p. 7).

Meleis’s development of role supplementation as a nursing therapeutic (Im, 2011, p. 282) was initially aimed at preventative or therapeutic interventions to ameliorate or prevent role insufficiency in a health-illness situation (Meleis, 2010, p. 17). Schumacher and Meleis (1994) identified that transition and the facilitation of transitions was central to nursing work
because nurses, through their work, encounter many situations for role change such as the transition from wellness to illness, birth and death. These authors also believe that nurses are in the best position to assess clients’ needs during the role transition and provide interventions based upon the need created by the role transition (Meleis, 2010). Further, they state that human beings, environment and health are central concepts to the discipline of nursing and nurses deal with environments that support or hinder personal, communal, familial or population transitions (Meleis, 2010, p. 11) hence the conception of transitions theory and its application to nursing practice, research and education.

This early work surrounding role insufficiency and defining goals for healthy transitions (Im, 2011, p. 282), plus the development of role supplementation formed the basis for the Transitions Theory proposed by Meleis (2010, p. 11) which Kralik et al. (2006, p. 323) states ‘provided both a perspective and framework for creating meaning of the concept of transition’.

2.2.3 Transition Theory

There are many different ways to define transitions, often transitional definitions will change according to the disciplinary focus, the precise meaning varying with the context in which the term is being used (Kralik et al., 2006, p. 320). However, Kralik et al. (2006, p. 323) quote Chick and Meleis’s (1986) definition of transitions as the one most commonly used for nursing:

A passage from one life phase, condition, or status to another… transition refers to both process and the outcome of complex person-environment interactions. It may involve more than one person and is embedded in the context and the situation. Defining characteristics of transition include process, disconnectedness perception and patterns and response (1986, pp. 239-240).

Transition is the movement and adaption to change (Kralik et al., 2006, p. 326). That is, the psychological processes involved in adapting to a change event or disruption in order to incorporate the change event into people’s lives. Changes in identity, roles, relationships, abilities and patterns of behaviour are all commonalities to transitions (Chick & Meleis, 1986 cited in Kelly & Mathews, 2001, p. 156). According to Kelly and Matthews (2001, p. 156), patterns of behaviour may include disorientation, distress, depression and anxiety. As well,
feelings of disconnectedness, a sense of insecurity and disequilibrium are characteristic of a transition (Kelly & Mathews, 2001, p. 156).

Meleis et al. (2000), describe six components of the transitions framework that include types of transitions, universal properties of transition experiences, transition conditions that facilitate and inhibit healthy transitions, indicators of healthy transitions including outcome indicators, and nursing therapeutics.

In describing types and patterns of transitions that could be used to explain nursing phenomena, Meleis et al. (2000) cited in Meleis (2010, p. 56) state that transitions exhibit patterns of multiplicity and complexity, they are not discreet or mutually exclusive and individuals may experience single or multiple transitions. Types of transitions include developmental, health-illness, situational and organisational (Schumacher & Meleis, 1994 cited in Meleis, 2010, p. 39). Developmental refers to changes in the life cycle and health-illness refers to the response by individuals and families to illness contexts. Organisational refers to those changes that occur in social, political or economic contexts and situational transitions are conceptualised as a change in educational and professional roles. For example, the transition in clinical practice roles that occurs throughout a nursing career or, transition from clinician to administrator and, relevant to this study, the transition to professional practising nurse from a student nurse (Schumacher & Meleis, 1994 cited in Meleis, 2010, p. 39).

Factors that influence any type of transition are referred to as universal or essential properties that are not discrete but complex and interrelated. Awareness, engagement, change and difference, time span, and critical points and events (Meleis et al., 2010, p. 14) are considered to be the essential properties of transitions. To be in transition a person must have awareness of the changes occurring. Awareness of the change is followed by and influences engagement where the person is immersed in the transition, seeking out information, modifying activities and making sense of the circumstances (Meleis et al., 2000, p. 14; Kralik et al., 2006, p. 323). Kralik et al. (2006, p. 323) cite Bridges (2004) stating that before a transition process can begin individuals need to acknowledge that a change is taking place, that is, acknowledge that a prior way of living has ended or current reality is under threat. When awareness occurs the individual can make sense of what is happening and reorganise a way to live or respond to the change (Kralik et al., 2006, p. 323). Change and difference are essential properties of
transitions that involve noticing what has changed and how things are different. Meleis et al. (2000, p. 15) and Kralik et al. (2006, p. 323) state that dimensions of change include the nature of change, how long it may take, an individual’s perception of the importance or severity of the change, and the impact of change on personal, familial and societal norms and expectations.

Time is an essential element of transitions as transitions are characterised by flow and movement of phases over time (Meleis et al., 2000, p. 15). Transitions have an *initial phase* or *entry* phase that is the anticipation or perception of change, a *midpoint* or *liminal period* characterised by a period of instability, confusion and distress (Meleis et al., 2000, p. 15; Kralik et al., 2006, p. 325). The *reincorporating* period or the *ending* signifies a new beginning or period of stability (Meleis et al., 2000, p. 15). Essential to the transition is the resultant reconstruction of self-identity (Kralik et al., 2006, p. 320).

Fedoruck and Hofmeyer (2012, p. 4) citing Kralik et al. (2006) state that the transition process of becoming a registered nurse has four identifiable phases. The first phase involves the predictable structured *familiar* life of a student that provides security, a recognised identity, plus a range of acquaintances where the student is socio-culturally accepted. An *ending* to being a student that is characterised by disruption, ambiguity and loss of identity, insecurity, and marginalisation indicates the second phase. The third phase called the *limbo* phase is where becoming a registered nurse may be disorientating and disempowering and may involve feelings of confusion, powerlessness, isolation and insecurity. The final phase identified by Kralick et al. (2006) is characterised by the graduate nurse becoming *ordinary* in a new role and identity, with experiences related to renewal, transformation, familiarity and reconnection with colleagues.

Meleis et al. (2000, p. 15) state that it is not possible to set boundaries on time taken to move through the phases, as transitions do not always follow the same trajectory. Rather there is variability over time. As well, phases of transition, as suggested by Kralick et al. (2006, p. 326), are non linear, can be cyclical and recurring in nature as new issues that arise can halt progress and ongoing changes will need to be incorporated into new ways of living. Some transitions are associated with critical points and events that increase awareness of change or difference, can trigger more active engagement in dealing with the transition, or can provide a sense of stabilisation (Meleis et al., 2000, p. 15). Thus, people can move back and forward
through transition phases depending on what is occurring in their lives (Fedoruk & Hofmeyer, 2012, p. 5).

The experience of transitions is influenced by conditions that can facilitate, hinder or constrain the progress towards a healthy transition (Meleis et al., 2000, p. 16). This author (2010, p. 44) states that it is important to understand the transition from the perspective of those experiencing it and this involves understanding what constitutes important influencing factors. For example, personal conditions such as meanings, expectations, cultural beliefs and attitudes, socioeconomic status, preparation and knowledge, emotional and physical well-being and capacity to plan for change all influence the conditions under which healthy transitions occur. In addition, environmental factors as well as community and societal conditions can impact on transition experiences.


Meleis (1975 cited in Meleis, 2010, p. 18) identifies that nursing therapeutics or interventions are aimed at promoting, restoring and creating conditions conducive to healthy transitions and identifies measures used to assess readiness for transition. Measures advocated by this author include education for preparation for transition, the use of role supplementation strategies aimed at achieving role mastery, communication and social interactions to clarify roles and to assist with role learning.

The transitions framework provides an understanding of the transition process and the properties inherent in transitional processes. Meleis et al. (2000, p. 18) states that transition
experiences are characterised by ‘their own uniqueness, complexities and multiple dimensions’ and more diverse transition experience and patterns need to be explored. Thus, this theory does not specifically address the phenomenon of role transition from student to registered nurse. However, much research into this phenomenon has been driven by this middle range theory. Duchscher’s (2008) Stages of Transition Theory builds on transition theory and theories related to professional socialisation in nursing and provides ‘in-depth understanding of the levels and nature of vulnerability at different points in time’ (Meleis et al., 2000, p. 18) during the role transition experience from student to registered nursing practice. The Stages of Transition Theory will now be examined.

This description and understanding of the phases and stages of transition for newly graduated nurses as posed by Kramer (1974), focuses on the new graduates’ responses during the initial stages of role transition as being primarily about the gap between the education and practice environments (Duchscher, 2009, p. 1110). Kramer’s work suggested that new graduates experience a reality shock with the discovery that educational values concerning nursing practice instilled during undergraduate preparation conflict with work-world values (Duchscher & Cowin, 2006). Since then, many authors (Goh & Watt, 2003; Roberts & Farrell, 2003; Casey, Fink, Krugman & Propst, 2004; McKenna & Green, 2004; Maben, Latter & Clark, 2006; Newton & McKenna, 2007; Zinsmeister & Schafer, 2009), have identified concerns or issues for the new graduates at specific points in time that have peripherally enhanced understanding of transitional stages and processes, however, none have ‘distilled out the nuances of the transition experience at various stages or have clarified the relationship of the stages of growth and change in the newly graduated nurse to the passage of time’ (Duchscher, 2008, p. 443).

In the Stages of Transition Theory, as outlined by Duchscher (2008), aspects of the new graduate nurses’ transition experience have been matured to provide an overall representation of the journey of transition. Using a qualitative interpretive inquiry approach Duchscher (2008) explored the process of transition for fourteen graduates employed in metropolitan hospitals in Canada. Using face to face interviews at intervals over 18 months plus focus group discussions and process revealing exercises such as journal writing, letter writing and collage construction, Duchscher (2008, p. 442) identified and provided descriptions of the stages of transition, and the processes inherent in the transition experience, that occur in the first 12 months specifically for the new graduate nurse in acute care settings. Included and
embedded in this situation specific theory is the identification of concepts that informed Transition Shock Theory and its associated conceptual framework (Duchscher, 2009).

Duchscher’s model of The Stages of Transition is provided below as Figure 2.1. This figure depicts the staged experience of transition to professional nursing practice that has emerged from her body of work and identifies the processes inherent in each stage of the transition process. Embedded within the initial stage of transition Duchscher (2009) identifies the concepts that informed the theory of Transition Shock, which is identified as the most immediate, acute and dramatic stage in the transition process (Duchscher, 2009, p. 1111).

**Figure 2. 1 Stages of Transition Theory**


**2.2.4 Stages of Transition Theory**

Duchscher (2008, p. 444) describes the initial 12 months of the transition to professional practice as ‘a process of becoming’ that is both a personal and professional journey for the
new graduate nurse. Through studies conducted over 10 years with new graduate nurses, Duchscher’s theory demonstrates that new graduates, during the first 12 months of professional practice, will evolve through a continuum of three stages; doing, being and knowing. Encompassed in this journey are ordered processes of anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. The stages, Duchscher states, are not linear, prescriptive or progressive, are ultimately transformative and might be influenced by critical events such as practice situations or contexts and new events, that may cause transient regressions along the continuum (Duchscher, 2008, p. 444).

2.2.4.1 Stage One: Doing

The first three to four months of professional role transition is represented by the Doing stage. This stage is characterised by ‘tremendous intensity, range and fluctuations of emotions’ (Duchscher, 2009, p. 1105). Transition Shock, Duchscher (2009, p. 1105) states, is embedded in this first stage as new graduates, who require prescriptive directives for clinical care in particular clinical situations, work through processes of learning, performing, concealing, adjusting and accommodating.

Transition Shock Theory encompasses and subsumes elements of transition theory, reality shock, cultural and acculturation shock as well as role theory and professional role adaption (Duchscher, 2009, p. 1104). It is described by Duchscher (2009, p. 1104) as the period of ‘inbetween-ness’ when moving from the known role of the student to the less familiar role of professional practitioner. The contrast between relationships, roles, responsibilities, knowledge and performance expectations required in the professional practice setting will, Duchscher (2008) states, mediate the intensity and the duration of the transition experience and will ‘qualify’ the early stage of the new graduate nurse’s professional role transition. Duchscher’s (2009) conceptual framework for Transition Shock (Figure 2.) illustrates that this first stage is motivated and mediated by changing roles, responsibilities, relationships and levels of knowledge in both the personal and professional lives of graduates and is characterised by feelings of disorientation, loss, doubt and confusion. Furthermore, the adjustments for the new graduate in the first 1-4 months are not just the result of the gap between what was taught in the education setting and what they experience in the work setting, but is also the result of emotional, physical, intellectual and sociocultural changes.
The emotional adjustments are associated with feelings of overwhelming stress and anxiety that often correlate with insufficient functional and emotional support, lack of practice experience and confidence, plus insecurities in communicating and relating to colleagues. In addition, loss of control and lack of support for professional practice values and anticipated roles, as well as unrealistic performance expectations by the institution, colleagues and themselves contribute to a ‘traumatic adjustment’ (Duchscher, 2009, p. 1106). New graduates at this time experience fear of rejection by their peers, and go to great lengths to disguise feelings of inadequacy. Duchscher (2009, p. 1107) states fears are related to being exposed or thought of as clinically incompetent, failing to provide safe care to their patients, and not being able to cope with designated roles and responsibilities. Also potentiating self-doubt and isolation for the new graduate is the loss of previous support systems from the educational setting and guilt about not maintaining practice standards and intentions they had been taught as part of their professional role (Duchscher, 2009, p. 1106).

Physical adjustments are influenced by the energy consumed in trying to perform in a new role at the level expected, without revealing any difficulties. The expectation of making advanced clinical judgements and clinical decisions, unclear practice expectations by managers and colleagues, assumptions of a successful transition, unanticipated role-relationship struggles and the physical demands of adjusting to shift work, coupled with changes to living arrangements and personal relationships contribute to new graduates physical exhaustion (Duchscher, 2009, p. 1106). The evolution of a more mature, professional sense of self in this phase is the result of the sociocultural and developmental adjustments. This adjustment is about the new graduate trusting their professional selves, distinguishing themselves from others, being accepted into the nursing culture, balancing personal and professional work life as well as seeing and doing in the real world as opposed to what was learned in the education setting (Duchscher, 2009, p. 1108). In addition, Duchscher identifies that in the first 1-4 months, new graduates function in a hypersensitive and self critical state, they expect feedback from senior colleagues and in the absence of feedback will use other indicators to ensure their own safety, competence and progression. In addition, considerable stress is experienced in supervising, delegating and providing direction to other personnel and in relating to other professionals, for example communicating with physicians and more senior staff.
Intellectual adjustments in the initial transition are influenced by theory practice gap and incongruities that signify reality shock, a lack of preparation for transition experiences as well as a lack of awareness of graduate roles and responsibilities by senior nurses once the orientation period is over (Duchscher, 2009, p. 1109). In addition, Duchscher (2009, p. 1109) identifies deterrents for seeking assistance and support in this stage as feelings of burdening already overworked colleagues, and being thought of as ignorant or inexperienced. Stress for the new graduate at this time is manifested by a perceived lack of collegial and/or mentorship support by the perception of being placed in clinical situations beyond their cognitive or experiential comfort level and by a lack of predictability and recognition for the graduates beginning status in workload assignments (Duchscher, 2009, p. 1109).

2.2.4.2 Stage Two: Being

According to Duchscher (2008, p. 445) in the next few months a ‘consistent and rapid advancement in thinking, knowledge level and skill competency’ symbolises the second stage of transition the Being stage, between the fourth and eighth month period is characterised by searching, examining, doubting, questioning and revealing. Recovering from the initial Transition Shock, this stage commences with a doubt in their abilities, and peaks with a crisis of confidence because of insecurities regarding competence and a fear of failing patients, colleagues and themselves (Duchscher, 2009, p. 446). During this time the new graduate experiences an increased awareness that something is different, awareness of themselves professionally and the role of the nurse in relation to other health professionals. In addition, the new graduate will start to withdraw from their surroundings as they search for balance in their personal and professional lives. In this stage the new graduates’ sense of self trust evolves as they begin to seek validation and clarification for their own clinical judgements and actions rather than requiring prescriptive directions (Duchscher, 2009, p. 446). In the later part of this stage less emotional energy is required, graduates relax into ‘a more comfortable space’ and experience a ‘reawakening’, which allows them to be in new and unfamiliar practice situations and plan long-term career goals (Duchscher, 2009, p. 447).

2.2.4.3 Stage Three: Knowing

The final stage is focused on separating, recovering, exploring, critiquing and accepting (Duchscher, 2009, p. 443) and occurs between the eight to twelve month time period. New graduates in the Knowing stage are at the end of recovery and are moving out of the learner
role into a role they perceive as having more expectations. They begin to explore and critique their ‘new professional landscape’ (Duchscher, 2009, p. 443). Factors contributing to new graduate stress at this time are the frustration in dealing with ‘the system’ as opposed to earlier stress related to capacity to cope with roles and responsibilities. Signs of progress include being able to answer questions, assist others with workload and the advancement of organisational and prioritization skills. In addition, the graduate experiences a shift in personal relationships from family and friends to co-workers and nursing colleagues.

In this study, the Stages of Transition Theory and associated Transition Shock Theory, as proposed by Duchscher (2008, 2009), will provide an appropriate lens through which to view the phenomenon of support throughout the rural Transition To Practice Programs because in this study a stated aim is to determine the specific support needs over time that would assist with a safe transition to the rural workforce. In addition, this situation specific theory provides a framework from which to compare and contrast the transitional experiences of newly graduated nurses making the role transition in rural health care facilities with the experiences of the graduates from Duchscher’s (2008) study who made the role transition in metropolitan health settings and it is hoped that this will contribute to the advancement of the theory of new graduate nurse transition.

2.3 Section 3
2.3.1 The Transition to Professional Practice for the New Graduate Nurse

The transition process into the nursing workforce is fraught with numerous complexities, and transition-based issues have been well documented (Moorehouse, 1992; Kelly, 1996, 1998; Boyle, Popkess-Vawter & Taunton, 1996; Winter-Collins & McDaniel, 2000; Chang & Daly, 2008; De Bellis et al., 2001; Roberts & Farrell, 2003; McKenna & Green, 2004; Maben, Latter & Clarke, 2006; Lea & Cruickshank, 2007; Duchscher, 2008; Young, Stuenkel & Bawel-Brinkley, 2008; Parker et al., 2009; Zinsmeister & Schafer, 2009). The literature from Australia and overseas identifies and explores various aspects of the transition process in nursing and the difficulties encountered by beginning registered nurses as they enter the nursing workforce. For example, professional socialisation, the theory practice gap, the new graduates’ preparedness for practice and the lack of effective support during the change in role, as well as the oppressive workplace culture into which the new graduate transitions have all been researched in the literature. These issues are central to this research study and will be
addressed in this section. Furthermore, in reviewing the global and national literature regarding new graduates making the transition to professional nursing practice, the researcher also wished to explore whether the experiences encountered at each of the individual stages of transition outlined in the Stages of Transition Theory (Duchscher, 2008) were also experienced within a formal Transition to Practice Program.

2.3.2 Professional Socialisation

The process of role transition from student to graduate nurse is identified by Chang and Daly (2008, p. 5) as an intense period of socialisation into the workplace culture of the clinical world where beginning registered nurses learn what is expected of them in their new role as a registered nurse. It is a process of making a significant adjustment to changing personal and professional roles at the start of one’s nursing career and generally thought to encompass the first 12 months as a graduate (Duchscher, 2008, p. 442).

Professional socialisation is a process whereby an individual adult learns the roles and values of a profession with the aim of developing a professional identity. In nursing, professional socialisation is ‘a process where a student or nurse acquires the knowledge and skills needed for practice’ and also where they ‘internalise the norms and values of the nursing profession into their behaviour’ (Oermann, 1997, p. 10). This socialisation process allows an individual to develop a self-concept associated with a role and then to acquire the role behaviours and expectations needed for carrying out the role in practice. For each new role that is acquired a re-socialisation process or role transition will occur. In nursing, re-socialisation or role transition often occurs with a change in focus of a role. Moving to a nursing management role or moving from community nursing to a more acute setting are two examples. However, of importance to this study is the role transition or re-socialisation that occurs for new graduate nurses entering professional practice where they need to adapt to the workplace nursing role learned in the educational setting. New graduate nurses will also experience frequent re-socialisation because graduate nurse programs in Australia generally require them to rotate to different clinical areas every three months. Thus, the graduate nurse will experience re-socialisation as they learn to adapt to different clinical areas, management styles, patient care practices and staff personalities. This will be explored in this study.

For the student nurse, professional socialisation and subsequent role acquisition occur initially in the educational setting and begin with recognition of the attributes that make the ideal
professional nurse. That is, knowledge of the formal role of nurses and all its dimensions is acquired. This is followed in the practice setting where an awareness of the nursing role, which is only shaped by experience, is developed and the student then attempts to model professional behaviours and attitudes.

Oermann (1997) discusses several models, which have been developed to describe this process of professional socialisation within nursing. For example, Cohen’s (1981) model, describes professional socialisation in nursing in terms of cognitive development of the student. Cohen believes that the nursing role develops as a result of professional socialisation, which could not be provided by nursing education (Cohen, 1981 cited in Green, 1988). A model by Hinshaw (1986) describes the socialisation process as the transition of anticipatory role expectations to actual role expectations of the professional, setting the standard for an individual entering the profession.

Kramer (1974) provides one of the best-known models of re-socialisation and the transition into nursing which describes the reality shock experienced with the transition from the educational setting to the workplace for new graduate nurses. The model describes fears and difficulties new graduate nurses experience in adapting to the work setting. In particular, it identifies the discrepancy between educational preparation and work place expectations, where new graduates in assuming and developing their new roles experience role stress, in particular role ambiguity, role conflict and role overload (Clayton, Broome & Ellis, 1989, p. 72; Oermann, 1997, p. 13; Chang & Hancock, 2003; Chang & Daly, 2008, p. 5). Winter-Collins and McDaniel (2000, p. 106) discuss four phases of reality shock that are experienced sequentially by newly graduated nurses and which are identified by Kramer’s 1974 model. The first stage is the honeymoon phase, which is characterised by nurses’ excitement and euphoria when obtaining their first nursing job. The shock phase constitutes the second stage where graduates discover that their goals may not be able to be met because of their inexperience or because of the organisational nature of the environment. This shock phase is often characterised by feelings of depression, outrage and fatigue. However it is followed by a recovery phase where graduates gain a perspective of their job. The final and fourth phase is the resolution phase where the graduate gains a nursing self-identity.

In 2007, Newton and McKenna, as a result of their qualitative study with 25 new graduates undertaking a graduate nurse program, acknowledged that reality shock still prevails some 40
years on from Kramer’s initial reality shock theory. Focus group discussions conducted at two points in time, four-six months and eleven-twelve months over the graduate year, aimed to describe graduates’ knowledge and skill acquisition. The participants identified unpreparedness for practice because of ‘gliding through’ undergraduate studies, not taking in what was being studied and so when they commenced their graduate programs did not feel prepared. Also, in the initial stages of their program participants identified a focus on themselves, where they were ‘surviving’ the realities of practice, trying to manage their time and get tasks done, as well as learning the social hierarchy that prevails. Toward the six-month stage the graduates were ‘beginning to understand’ where they fit in, their place in the organisational and nursing culture. They described gaining confidence but needing the graduate program as a shelter in times of uncertainty and insecurity. In the eleven-twelve month stage graduates had progressed to ‘knowing how to’ manage clinical situations as they had been taught during their educational preparation. Finally at the end of their program participants acknowledged their transformation as a nurse but also that they still had a lot to learn. Newton and McKenna (2007) concluded that these feelings of being unprepared to enter practice and face the responsibilities and challenges of being a registered nurse indicate that preparation of undergraduate students still appears unable to reduce reality shock and ease the role transition for graduates.

Concepts of reality shock continue to serve as the construct for understandings of the initial transition to professional practice (Duchscher, 2009, p. 1111). However, more recently Duchscher (2009, p. 1111) has proposed a model for Transition Shock that occurs when new graduates move from the protected academic environment to the unfamiliar and ‘expectant’ context of professional practice contributing to the role strain and role stress in the new graduate. Duchscher’s research shows that Transition Shock moves beyond Kramer’s understanding of the graduates’ responses being primarily about a gap in what they were taught and what they come to know in the real world of professional practice. As discussed in detail in Section Two of this chapter, Duchscher’s model of Transition Shock is the most acute and dramatic stage of professional role adaption in the first three to four months and demonstrates the physical, emotional, socio-developmental, cultural and intellectual challenges within the role transition with which the new graduate is confronted (Duchscher, 2009).
Inadequate socialisation and mismanagement of new nurses’ early professional experience can lead to job stress for new graduate nurses. Job stress is acknowledged as the strongest predictor of job satisfaction for new graduate nurses (Kramer, 1974 cited in Boyle et al., 1996; Chang & Hancock, 2003; Parker et al., 2009; Duchscher, 2009) and often results in the new graduate nurse experiencing low motivation, unnecessary conflict, and demoralisation that decreases quality of patient care. This is directly related to the turnover and attrition rates of new graduate nurses in the workforce (Boyle et al., 1996; Cowin, 2002; Duchscher, 2008; Stuenkel & Bawel-Brinkley, 2008). To overcome job stress and to assist in the successful socialisation to the nursing role Kramer (1974), Boyle, Popkess–Vawter and Taunton (1996), Winter-Collins and McDaniel (2000), Chang and Hancock (2003), McKenna and Green (2004), Maben, Latter and Clark (2006); Duchscher (2008), Young, Stuenkel and Bawel-Brinkley (2008), Zinsmeister and Schafer (2009) have advocated measures to promote a supportive, nurturing environment for new graduates to reduce role stress and role discrepancy as they enter the nursing workforce. These measures include: the provision of positive preceptor and/or mentoring experiences that promote quality co-worker interactions, clearly defined workload responsibilities to reduce role conflict and role ambiguity and structured support systems such as continuing education and staff development. They argue that these strategies are important to enable the new graduate to develop a sense of belonging, which can assist with a successful socialisation to the registered nursing role.

Thus, the effectiveness and adequacy of formal transitional support programs provided to new graduates in easing their role stress and assisting with their professional socialisation to the rural registered nurses role is an important issue in the transition process. It is this issue which this researcher will explore in this study.

2.3.3 Theory Practice Gap

The transition process from student nurse to registered practising nurse has been identified by new graduates as an extremely stressful experience that is physically and emotionally demanding (Dufault, 1990; Green, 1988; Madjar, 1997; Kelly & Mathews, 2001; Chang & Hancock, 2003; Goh & Watt, 2003; Maben, Latter & Clark, 2006; Duchscher, 2008, 2009). Whilst it is appreciated that new graduate nurses face similar problems to those encountered by any new individuals to the workforce, the role transition in nursing is complicated by the unpredictability of daily practice and the level of responsibility and accountability in every day practice (Madjar, 1997, p. 3).
There is debate in the literature as to the actual cause of difficulties encountered during the transition process for new graduate nurses, and recommendations made for easing the role transition for graduates depend on the explanation given for the transition problems. As previously stated, the successful role transition for new graduate nurses appears dependent on the level of support they receive in assisting them to socialise to the professional role of nursing. Earlier studies (Madjar, 1997; Kluge, 2001; Pigott, 2001; Ramritu & Barnard, 2001; Oermann & Garvin, 2002; Goh & Watt, 2003) suggest that inadequate undergraduate nursing preparation can also contribute to problems for the new graduate, especially with regard to a lack of time management skills, an inability to critically and analytically think about appropriate nursing care, and an inability to cope with the workload.

As early as 1994, the National Review of Nursing Education identified that the link between nursing education and the demands of the workforce was a focus for concern. This report highlighted the differing expectations between universities, hospital settings and new graduates as they enter the nursing workforce. The report also indicated that the level of competence of new graduates, the adequacy of undergraduate clinical preparation and the need for employers to provide support during the transition period all required attention (Commonwealth of Australia, 1994). Transition-based problems encountered by new graduate nurses continue to be linked to a claimed gap between the theory and practice of nursing. That is, the ‘academic/hospital’ dichotomy is seen to constitute a gap between what is taught in the classroom and what actually happens in the day-to-day practice of nursing (Heslop, McIntyre & Ives, 2001; Duke, Forbes & Strother, 2001; Maben, Latter & Clarke, 2006; McKenna & Green, 2004; Duchscher, 2008; McKenna & Newton, 2009). It has also been suggested that the service industry places too high an expectation on the beginning nurses as they enter the nursing workforce (Oermann & Garvin, 2002).

Pigott (2001, p. 24), states that criticism exists towards tertiary nurse education for failing to adequately prepare nursing students with the clinical skills required to cope with the ‘real’ world of practice. The author also acknowledges that this is further complicated because there are differences between experienced nurses, new graduates themselves and the service industry in the performance expectations of new graduates (Pigott, 2001, p. 24).

Kluge (2001) concurs with Pigott (2001) and also suggests that tertiary programs may be failing to adequately prepare nursing students for the reality of practice. Kluge (2001) states
that repeated observations and anecdotal evidence from experienced staff within the health service industry have highlighted the difficulties new graduates have in transferring and integrating theoretical knowledge to the clinical field. Kluge’s (2001) qualitative study of new graduates’ use of reflective practice during their transitional support program recommended that nurse education needs to utilise reflective practice to bridge the gap between theory and practice.

Amos (2001) suggests that the level of responsibility placed on new graduates is a major issue that causes them extreme stress and nervousness in their graduate year. It has been shown that new graduates also feel that their educational preparation fails to prepare them adequately for the workload and the level of responsibility that they must assume upon entering the nursing workforce as evidenced by a study conducted in North America by Duchscher (2001). A phenomenological study of the process of professional socialisation for six graduate nurses in acute care settings highlighted the overwhelming sense of responsibility new graduates feel upon entering the workforce and their perceived lack of preparation for the level of responsibility which was expected of them. The graduates were concerned that they had never, as undergraduate nursing students, had to assume the total responsibility for patient care and they felt that there was ‘disparity in the lack of preparation by their nursing education’ (Duchscher, 2001, p. 429). However, the graduates also identified a lack of support and guidance from their nursing peers in the workforce, which resulted in low self-confidence. Furthermore, they focused on being accepted by their peers, which influenced their clinical judgment and decision-making because they felt validated or invalidated by the responses to their decisions and clinical judgments from more senior nurses. To ease the transition Duchscher made several recommendations that included not rotating new graduates to other clinical units until they have at least a minimum of one year’s clinical experience. This recommendation was made because the author found that the rotation of graduates to different clinical units did not serve to adequately orientate new graduates nor did it contribute to new graduates clinical decision-making abilities or self esteem. In addition, the author recommended the introduction of programs that provide supernumerary employment for graduates to allow for integration into the professional role, where formal and informal preceptorship programs can serve to support the new nurse. A final recommendation was for incentives for senior staff for the expanded role and commitment that is required to provide positive preceptoring and a nurturing environment for new graduate nurses.
In the United Kingdom, Maben, Latter and Clark (2006) undertook a qualitative longitudinal study to investigate the extent to which individual newly graduated nurses adopt the ideals and values of a pre-registration nursing course. Conducted over three years their study used surveys of final year nursing students, plus individual interviews at four–six months and eleven–fifteen months post graduation. The findings of this study confirmed a continued existence of a theory practice gap in nursing. The authors found that the high practice ideals that the new graduate commences with were consistently thwarted in practice. They asserted that there is conflict between professional practice and the bureaucratic structure within which it operates as well as conflicts within professional practice itself. The findings of individual interviews at time intervals of up to fifteen months post graduation showed that participants identified professional and organizational factors that worked to sabotage the new graduate’s ideals and values during the socialization process. For example, time constraints because of poor staff levels, skill mix and workload were identified as organizational factors that influenced professional sabotage by more senior colleagues who exhibited sets of covert rules and poor behaviour that failed to support or demonstrate to the new graduates how to implement their ideas and values into practice. Thus the new graduates in this study had no support and few positive role models to help them navigate the gap or disparity between nursing as taught and as nursing as practiced. A limitation of this study is that data were collected between 1999 and 2000 and curricula and educational preparation may have changed since this time. However evidence from authors such as Lea and Cruickshank (2007), Johnstone, Kanitsaki and Currie (2008), Duchscher (2008), Bennett et al. (2012); Ostini and Bonner (2012) indicate that workload, skill mix and organizational pressures are still of concern for new graduates and the nursing profession within both the Australian and global contexts.

Ramritu and Barnard (2001) believe that within Australia undergraduate nurse preparation needs to be further evaluated and there needs to be ‘congruence between entry-level competency standards and the actual understanding and experience of beginning-level new nurse graduates’ (2001, p. 54). Ramritu and Barnard (2001) used a phenomographic approach to explore the conceptions of competence that six graduate nurses have within paediatric settings. New graduates in this study conceptualised and understood competence as management of time and workload, the performance of clinical skills, possessing adequate knowledge, the ability to utilise resources, having an awareness of and application of ethical principles within their practice, and also recognising that their competence would evolve.
Findings from this study demonstrated that graduates acknowledged difficulties in organising and prioritising their workload, because they lacked the appropriate knowledge and skills required for provision of care. Graduates also believed the learning of skills in the educational environment was different from learning in the clinical setting and that it was not possible to learn all the necessary skills during the undergraduate program. Whilst these findings have merit and application, participants may not have had a lot of exposure to specialty paediatric areas during their undergraduate clinical preparation. A major recommendation from this study was that undergraduate clinical skills should be taught utilising the clinical settings. Furthermore, this study also recommended that new graduates require ongoing workplace support in provision of care as well as ongoing educational support in time management, clinical procedures and interactions with other health professionals, patients and their families. Ramritu and Barnard (2001) further assert that health agencies need to factor the teaching role of more experienced nurses into staffing requirements so that effective support can be delivered to assist the new graduate in the provision of care. The identification and description of ongoing effective workplace and educational support required by the new graduate nurse within a rural setting is a major aim of the current study.

McKenna and Newton (2008) and Newton and McKenna (2009) employed a qualitative approach to collect data between 2003 and 2004 from 25 participants recruited from four different hospitals in Victoria, at intervals over 18 months. Using a series of focus groups and participant anecdotes their study examined how graduates develop knowledge during their graduate programs. From participants’ written anecdotes these researchers identified four ways of knowing: ethical knowing, knowing self, empirical knowing, and personal knowing. These researchers also found that these ways of knowing demonstrated the professional maturity of the graduates as nurses. However, McKenna and Newton identified that due to their limited clinical experience and because of the pressures of socialisation and time management, the interpretive, contextual, intuitive and subjective knowledge, that is aesthetic knowing, was not evident in the participant’s anecdotes. They contend that current pedagogical approaches employed in the academic setting do not always prepare the students for their professional role. In agreeing with Maben et al. (2006), Newton and McKenna identify that graduates ‘struggle with the tensions of ideals and values they brought into nursing with the reality of professional practice’ (Newton & McKenna, 2009, p. 160). Further they state that there needs to be a shift away from educational models and trends that are driven by a scientific-technological paradigm and a move towards models that promote the
caring and emotional learning that is necessary for nursing practice. For example, engaging students in more reflective practice can promote different ways of knowing, and may better prepare students for the challenges of being a graduate where socialisation and organisational barriers prevent the development of this aesthetic way of knowing in nursing (Newton and McKenna, 2009, p. 161). The effectiveness of support to enhance clinical learning during a rural Transition to Practice Program is an important consideration for the current study, as the nature, timing and length of support may significantly impact on the development of clinical knowledge in new nursing graduates.

Since the early 1990s, authors such as Dufault (1990) and Del Bueno (1994) have expressed concern for the health service industry expectation of new graduates where staff mix and staff reductions have meant that new graduates are expected to be accountable, responsible and competent as quickly as possible upon becoming registered nurses.

In a study of the processes by which new graduates learn to fulfil the role of a registered nurse, Moorehouse (1992) refers to the dichotomy between anticipated role and actual job descriptions that creates confusion for new graduates. White (1996) also highlighted the dichotomy between the actual and anticipated role in a phenomenological study that investigated the feelings graduate nurses have about clinical practice. Pressure experienced by newly graduated nurses was a major theme that emerged from the data. The beginning nurses in this study felt that there just wasn’t enough time to deliver care the way they would like and indeed the way they had been taught. This resulted in a dichotomy between the educational preparation and the reality of the workplace. However, it could be argued that the ideals of the educational institution are merely best practice standards that perhaps are being compromised by the workplace setting. As early as 1996, Hewison and Wildman commented that as a learner nurse there is an expectation to treat patients as individuals, implement nursing theory and advance their own learning. However, the environment that nurses are expected to practice in is not conducive to this expectation as it is one that is, ‘orientated to throughput, numerical targets and financial constraints’ (1996, p. 754).

Authors such as Kelly (1996), Mosel Williams (2000), De Bellis et al. (2001), Oermann and Garvin (2002), Casey, Fink, Krugman and Propst (2004), Maben, Latter and Clark (2006) and Duchscher (2008), have also highlighted the reality of the practice setting and the level at which beginning registered nurses are expected to function, because of the current climate of
the health service industry. Staff mixes and staff reduction have meant that new graduates are expected to be accountable, responsible and competent as quickly as possible and the health service industry work expectations are that new graduates need to *hit the decks running*.

Studies by Madjar (1997), De Bellis et al. (2001) Maben, Latter and Clark (2006) also found that the present economic rationalisation of health settings is responsible for the difficulties new graduates experience. However, they also suggest that there is a failure of health care staff to recognise the inexperience of beginning registered nurses, so the provision of adequate support for new graduates is not addressed.

Madjar’s 1997 study of new graduates within NSW examined the nature of transition to practice, specifically focusing on the expectations that new graduate nurses had of their skill and competence as they entered the workforce. The expectations of these were compared and contrasted with the expectations of more experienced registered nurses. This descriptive-correlation study included well over half of the new graduate nurse population within NSW who began employment in the first three months of 1997. The study sample also included 752 experienced registered nurses alongside whom the new graduates had worked. There were numerous key findings from this study that related to the expectations of competence of new graduates. The study found that most new graduates and experienced Registered Nurses felt that three months after beginning employment the new graduate had acquired and developed adequate knowledge, skills and expected competence to perform safely and adequately in a medical/surgical area within a metropolitan setting (Madjar, 1997, p. vii–ix).

In addition, Madjar’s (1997) study found that discrepancies existed between clinicians regarding their expectations of beginning registered nurses. The experienced clinicians also believed that the duration of clinical placements for student nurses was not sufficient for them to develop the required competencies and skills for entering the workforce. These findings refute the findings from an earlier study by Battersby and Hemmings (1991) who explored the competence and clinical preparation of new graduate nurses. Battersby and Hemmings (1991) used a self-report survey on a sample of new graduates and nursing unit managers to assess perceived clinical performance of graduates during their first year. The results from this study showed that the amount of pre-registration clinical experience was not as significant in influencing the perception of competence by new graduates and their experienced registered
nurse colleagues as was the quality of the experience and the guidance received during the clinical experience.

However, whilst the new graduates from Madjar’s study felt they had acquired the necessary clinical and professional competencies to enter the nursing workforce they also believed there was a lack of effective support during their transition to the registered nursing role. The graduates in this study felt poorly treated by colleagues, which resulted in the transition experience being an extremely stressful, draining and challenging one. Furthermore, the graduates perceived that more experienced colleagues were ‘more intent on asserting their own place within the hierarchy than developing professional relationships’ (Madjar, 1997, p. ix). In addition, experienced registered nurses lacked sensitivity, as well as professional courtesy, and this did not facilitate a supportive learning environment.

It needs to be noted that participants from this study were drawn mostly from one metropolitan health service, with the majority of the participants having completed their undergraduate preparation within metropolitan universities. Caution needs to be taken before generalising these findings to all new graduates within NSW, as the study findings are not representative of new graduates who undertake a graduate nurse program outside metropolitan areas. Whilst the findings provide insight into transition issues which affect new graduates, there are significant differences in workload responsibilities of nurses in rural areas compared to their metropolitan counterparts.

A South Australian study by De Bellis et al. (2001) highlighted the unrealistic work expectation by the service industry of new graduates upon their initial entry in the workforce. Using interviews and focus group discussions with 44 new graduate nurses, the authors identified issues and difficulties experienced by new graduates. Findings from this study indicate that health care organisations and more experienced registered nurses expect new graduates to function as registered nurses with a full patient load within a very short period of time. This study also identified an environment of ‘doing without thinking’ (De Bellis et al., 2001, p. 8) where, because of the new graduates’ inexperience with the heavy workload and the unpredictability of the work, there was no time for thought, they were just expected to get the work done. The authors of this study argue that rationalisation of the health setting has impacted on the level and type of support that can be offered to the new graduate and this rather than undergraduate preparation is responsible for problems associated with graduate
nurses. The writer also believes that a major problem may be an inadequate application of clinical knowledge into the clinical setting rather than inadequate undergraduate preparation.

Oerman and Garvin (2002) surveyed new graduates in the first three months of their initial clinical practice in hospitals in North America, to describe stress and challenges for new graduates. Using a Clinical Stress Questionnaire they surveyed 46 new graduates from three health settings. Stresses identified were common to issues previously identified to new graduates during this initial transition phase, that is, confidence, competence, inconsistent preceptors, staffing and skill mix. However, their findings indicate that experienced nurses providing support and working with new graduates may set too high a standard of care and that they need to be realistic about the clinical knowledge, critical thinking, decision making and technical skills they expect of new graduates. Further, they identified that the predominant stress reported by the participants was the fear of making mistakes attributed to increased workload and responsibilities, as well as the stress associated with working with ‘difficult nurses’ who did not facilitate their learning or confidence through open communication. The new graduate nurses perception and experience of the provision of support to reduce the stress during the transition to professional rural nursing practice is a major aim of this study.

A North American study by Casey, Fink, Krugman and Propst (2004) that utilised a quantitative descriptive survey design, was conducted at time periods of beginning, three, six and twelve months with new graduates in acute care settings. Participants described the difficulties with transition as lack of confidence in skill and deficits in critical thinking and clinical knowledge, as well as difficulties in relationships with peers and preceptors, struggles with dependence on others and wanting to be independent. Frustrations with work environments that were understaffed, had problematic nurse-to-patient ratios and had shortages and problems with retention of unit staff were also difficulties experienced during the transition as well as organising and prioritising skills and communication with physicians. These study findings highlight that although it is not uncommon for new graduates to feel inadequate when entering professional practice, new graduates do not have the confidence and competence to assume the level of responsibility for patient safety that is expected. Further, Casey, Fink, Krugman and Propst (2004) state that new graduates were viewed as immediate solutions to staffing shortages rather than a long-term strategy for professional development and retention, as indicated by curtailing of the length of the graduate orientation programs to
meet unit schedules and demands and a lack of incrementally staged responsibilities for the participants of this study. Thus this study aimed to explore the issues surrounding the provision of clinical and educational support within a Transition to Practice Program that would assist with the workload and responsibility expectations for graduate nurses within the rural practice setting.

More recently, Duchscher (2008) claims there is a discrepancy in ideology with regard to the approach to healthcare that contributes to the perception of a theory practice gap. That is, unrealistic expectations of the health industry are the result of a discrepancy between the educational focus where preparation for practice is based on holistic, primary healthcare frameworks and community based approaches to care (Duchscher, 2008, p. 196). This is in direct contrast to the illness focused, economically based and hierarchically driven medicalised approach to health care (Duchscher, 2008, p. 196). Parker et al. (2009, p. 8) note that ‘the challenges facing health care have escalated, putting increasing pressure on services and staff and their capacity to support and steward beginning nurses’ into their professional practice roles. More recently, El Haddad, Moxham and Broadbent (2012, p. 3) contend that the discourse that has previously centred on a theory practice gap or deficit, has switched to a debate centred on graduate practice readiness. El Haddad et al. (2012, p. 3), acknowledge that tensions still exist between health industry and tertiary education providers in Australia, because opinions between these sectors differ as to new graduate registered nurses practice readiness. That is, there is dissatisfaction with the level of preparation of new graduate nurses, and their ability to function as registered nurses upon graduation (Evans, Boxer & Sanber, 2008, p.20).

2.3.4 Enculturation of New Graduate Nurses

As previously stated, several studies have suggested that the difficulties encountered during the transition process may be directly related to the non-supportive environment and culture in which the new graduate is employed (Reddick, 1998; Mosel Williams, 2000; De Bellis et al., 2001; Thomka, 2001; Oermann & Garvin, 2002; Casey, Fink, Krugman & Propst, 2004; Lea & Cruickshank, 2007). New graduate nurses’ experiences of the ward enculturation process and how the ward culture affects new graduates upon entering the nursing workforce, has only been addressed in the literature as a cause for concern with respect to the recruitment and retention of new graduates into the workforce (Jackson, Clare & Mannix, 2002). There is a small body of literature that specifically explores how the workplace culture shapes their
experience when they enter the nursing workforce and an emerging body of literature that acknowledges the impact that the organisational culture, specifically horizontal violence, has upon the nursing workforce. In this current study how the workplace culture impacts and influences the nature and timing of support during a rural Transition to Practice Program is deemed by the researcher to be an important influence on the experience of new nursing graduates undergoing transition to rural nursing practice.

Numerous studies have identified that horizontal violence in the nursing workplace is a major factor that provokes anxiety and extreme work based stress for many nurses (Farrell, 1997, 1999, 2001; Taylor, White & Muncer, 1999; O’Connell, Young, Brooks, Hutchings & Lofthouse, 2000; Freshwater, 2000; Taylor, 2000; Jackson et al., 2002).

Horizontal violence refers to overt and covert non-physical hostility, and includes workplace conflicts, aggression and bullying. Farrell (1997) states that this type of violence can take many forms, the most common of which include gossiping, infighting, rudeness, criticism, scapegoating, and an unwillingness to speak up for others. These behaviours by nurses toward other nurses are attributed in the literature (Farrell, 1997; Paterson, McComish & Aitken, 1997; Taylor et al., 1999; Freshwater, 2000; O’Connell et al., 2000; Taylor, 2001) to power relations and oppressed group behaviour in nursing, where nurses direct their dissatisfaction inward towards each other. Jackson et al. (2002) report that hostile undercurrents, violence and hostility are part of the day-to-day lives of most nurses.

Kelly (1996) acknowledges that the social climate of the ward, which the new graduate enters, is of great significance to their experience, citing studies by Hipwell, Taylor and Wilson (1989) and Nelson and Fells (1989). These studies discuss interactions and interpersonal co-worker relations as being ranked as important elements in nurses’ work and acknowledge that horizontal violence or aggression in the nursing workplace is a significant problem that contributes to the level of job satisfaction, the current problems of recruitment and retention of nurses and, significant to the present study, the retention of new graduates in the nursing workforce.

In a qualitative study of graduate nurses’ recollections of their first year of practice, Kelly (1996) found that the rigid environment, unrealistic management expectations and conflict in attitudes, career aspirations and values makes the new graduates experiences traumatic.
Furthermore, part of the new graduates’ socialisation into health service is the pressure on new graduates by more experienced colleagues to conform to an ‘unquestioning conformity to social norms’ (Kelly, 1996, p. 1067).

Hinds and Harley’s (2001) ethnographic study of three new graduates specifically explored the power relations embedded in the new graduate nurses’ experience of practice and the socialisation of new graduates into the clinical ward culture. This study identified that the culture within a ward or unit may operate to shape the behaviours and mindset of new graduates and that power relations were pertinent aspects of the new graduates’ experience. It was found that senior nurses influence and shape newcomers’ conduct to fit the requirements for maintaining the social and cultural order of the ward environment. The respondents in this study identified characteristics which they thought were required to assist them to be accepted into the ward culture. For example, one characteristic was knowing that your practice was considered to be ‘safe’ by more experienced staff. To have senior nurses view your practice as ‘unsafe’ provided a very persuasive means of shaping behaviour, which influenced the new graduates behaviour because they would be ‘spoken about’ and be assigned outcast status by senior nurses if their practice was considered to be ‘unsafe’. These authors suggest, that whilst unsafe practice poses serious threats to the health of patients, the unsafe practice label assisted to determine who is an ‘insider’ and who is an ‘outsider’ in the culture of the ward. Hence new graduates held more importance on acceptance into the ward culture rather than maintaining values and beliefs learned through their undergraduate nursing education.

These findings are similar to the findings from Duchscher’s (2001) study of the process of socialisation of graduate nurses in acute care settings. Participants in this qualitative study believed that to blend into and be accepted in the unit they felt they had to uphold time-honoured traditions of the nursing unit and complete tasks on time so that they would not be exposed as new nurses or perhaps as less capable. These new graduates felt that not knowing something related to practice was a sign of weakness rather than an expected state of their beginning level and because of this they feared not being accepted by nursing staff within the unit.

According to Madjar (1997, p. 2), mastery of the registered nursing role, whereby the new graduate can act safely and competently, depends on several factors. These include the quality and the extent of their educational and clinical preparation, the personal qualities of each
beginning registered nurse, as well as the expectations and attitudes of experienced registered nurses with whom the new graduate works. The quality of orientation/transition programs and the exigencies of the clinical situation, with respect to staffing levels and other work demands placed on the beginning registered nurse, mean that it is usually the new graduate who must change and adapt to the ‘reality’ of the practice world.

Kelly (1998) also believes that it is the new graduate who has to adapt and change to the culture and social group in the real world of nursing. Kelly’s grounded theory study on how graduate nurses perceive their adaptation into the ‘real world’ of hospital nursing and what they perceived as influences on their moral values and ethical roles, found that many new graduates believe that they are entering a culture they know and understand. This misconception, Kelly states, is the first disillusionment new graduates experience. In addition, Kelly (1998) concluded that self-doubt and confusion for the new graduate is the result of intense stress and the desire to fit in to the particular culture on a hospital unit. This author believes that fitting into the culture of the unit is of vital importance in determining the new graduates’ experience of their role transition. Furthermore, Kelly believes that new graduates are unprepared to function as members of a team and they need to be better prepared for the social forces that will affect them as they enter the nursing workforce.

Many authors (Overman & Garvin, 2002; Clare & van Loon, 2003; Lea & Cruickshank, 2007; Duchscher & Cowin, 2006; Duchscher & Myrick, 2008; Evans et al., 2008; Parker et al., 2009) discuss the issues of acceptance into the workplace culture for new graduates as important as it impacts on the level and type of support offered to and sought by new graduate nurses.

Duchscher and Cowin (2006) believe the retention of graduates is directly related to a stressful, oppressive and traumatic environment into which the new graduate must make a transition. Duchscher and Cowin (2006, p. 156) state that new graduates are working in environments where their stress is derived from ‘anxiety laden relationships with seasoned nurses and medical staff’, for graduates it is antagonistic, unwelcoming, abusive, resistive to new ideas and fraught with negative attitudes about nursing and health care. In further commentary, Duchscher and Myrick (2008), discuss the oppressive culture in which hospital nursing continues, that contributes to a dissatisfying and disillusioning professional role transition for the new graduate nurse.
A phenomenological study of new graduates in rural practice conducted by Lea and Cruickshank (2007) found that the new graduate experience was influenced and shaped by the effects of the ward culture the graduate was trying to assimilate into. Further, social forces within the ward often resulted in negative ward dynamics and influenced the support the new graduate sought and received. For example, new graduates identified that the working climate was fraught with distrust, competitiveness and ‘bitchiness’. Senior registered nurses were identified as the main perpetrators and this influenced to whom new graduates turned for support, because they did not trust some colleagues. In addition, the manner and attitude of more senior nurses, particularly management staff were not always perceived as supportive. This major finding of this study concurs with earlier studies (Hinds & Harley, 2001; Duchscher, 2001) that the behaviour of other staff and the undercurrents in the ward operate to shape the behaviours of the new graduates to conform to the expectation of the registered nurse.

In 2008, Parker et al. were commissioned by New South Wales Health to examine the cohort of nursing graduates who entered the New South Wales nursing workforce in 2008 on transitional programs. The authors aimed to investigate positive and negative factors that influenced and impacted on transition to the workforce for new graduate nurses and midwives so that improvements can be made. The project employed a mixed method cross sectional design that collected quantitative data from an online survey and qualitative data from focus group interviews with 306 new graduate nurses. The nature of the workplace environment, the level and nature of support available to new graduates, along with their propensity to learn and adapt to workplace cultures were some of the key factors that their study identified as having a significant impact on the experience of transition for new graduates. Parker et al. (2009) found that the day-to-day interpersonal interactions and social dynamic impacted most on the graduates’ capacity to learn from and engage with the clinical context. New graduates in this study indicated that they expected a positive workplace culture as one that had a clear commitment to them as beginning practitioners, a fulfilment of the promises made to them in relation to support and learning opportunities, and where they would be treated with respect and courtesy. Instead, many new graduates in this study reported in the survey and the focus group interviews, of exposure throughout their graduate year to a lack of commitment, minimal support, unreasonable expectations and workload, and horizontal violence. The authors state that ‘in many instances, the violence was perceived as systematically directed at them as new graduates, others believed in the main it was a feature of individual attitudes and
poor morale’ (Parker et al., 2009, p. 39). In this study the majority of participants was employed in metropolitan areas and so the experience may differ for new graduates in more diverse clinical contexts. This is to be explored in this present rural study.

The issues of the workplace culture for new graduates has important implications for this present study because the review of the literature shows that unprofessional and un-supportive behaviours by more experienced registered nurses will impact on the level and type of support offered to and sought by new graduates nurses. This researcher believes that the culture of rural practices settings will be of significance in identifying who is best placed to provide support and in furnishing an understanding of the nature and timing of support the new graduate requires in rural health care facilities.

2.3.5 Transition Support Programs

The literature pertaining to the new graduate entering professional practice (Madjar, 1997; Kelly, 1998; Duchscher, 2001, 2008; Oermann & Garvin, 2002; Chang & Hancock, 2003; Bennett et al., 2012; Cubit & Ryan, 2011; Ostini & Bonner, 2012) maintains that the successful assimilation of the new graduate nurse into the nursing workforce is dependent largely on the amount and quality of support that the new graduate receives especially within the first three months of employment, as this is when a rapid and major transformation, both professionally and personally, occurs in the new graduate.

Graduate Nurse Programs (GNPs) or Transition to Practice Programs (TTPP), were developed in Australia in response to the problems associated with the reality shock of entering the nursing workforce. According to Glover, Clare, Longson and De Bellis (1998, p. 17), the main aim of the programs is to provide a ‘mediated’ entry to the workforce, providing structured support and assistance for graduate nurses in the transition from student to registered nurse. Levett-Jones and Fitzgerald (2005, p. 41) add that transition programs share three primary goals: to develop a competent and confident registered nurse, facilitate professional adjustment and develop a commitment to a career in nursing. Many authors support the use of structured support systems to provide a nurturing environment, professional role modelling and consolidation of skills to ease the culture shock and assist with the professional socialisation of the new graduate nurse (Boyle et al., 1996; Kelly, 1996; Winter-Collins & McDaniel, 2000; Duchscher, 2001; De Bellis et al., 2001; Oermann & Garvin, 2002; Chang & Hancock, 2003; Bennett et al., 2012; Cubit & Ryan, 2011: Ostini & Bonner,
It is also believed that structured support assists the new graduate with the application of knowledge, and the further development of clinical reasoning and decision-making (Clayton, Broome & Ellis, 1989; Nayak, 1990; Moorehouse, 1992; Jasper, 1996; De Bellis et al., 2001; Seright, 2011).

Structured transition programs vary in nature and duration within health services across Australia. The majority of health services in NSW have a 12-month transition program for new graduates, which includes rotations, each of three month duration, through medical and surgical areas. Towards the end of the graduate program graduates might be offered a clinical elective in one or two specialty areas of their choice. The specialty areas may include, Paediatrics, High Dependency nursing such as Coronary Care, Intensive Care, Operating Room and Recovery, as well as Emergency Department and Mental Health. Preceptoring and mentoring are terms used to describe the clinical support models that are generally used to support new graduates. The desirable qualities required of a preceptor or mentor include: acting as a role model, having clinical expertise, being able to assist with the application of theory to practice, and having a willingness to provide supervision and teaching (Hardyman & Hickey, 2001, p. 59).

There is very little research that specifically focuses on the factors that influence the undergraduate nurse’s decision of where to undertake their graduate year. However, studies have mentioned factors that influence the new graduate’s decision, as part of a broader study. For example, Heslop et al. (2001), in a study of undergraduate students’ expectations of their self-reported preparedness for the graduate role, obtained quantitative data regarding the main factors that influenced participants’ preference for specific graduate year programs. Respondents often cited more than one factor that influenced their decision. However, the majority of responses listed the following factors as influencing their decisions: locality, reputation of the health care facility, rotations offered to specialty areas and familiarity with the health care facility. This study also gathered data related to the clinical rotations favoured by students for their graduate year, the most common choices being Surgical, Paediatrics, Emergency Department, Medical, Critical and Coronary Care. There was little interest by participants in this study for aged care, community, oncology and palliative care. Whilst the data generated from this study originates from undergraduate students within a metropolitan university, the findings are transferable to undergraduates choosing rural graduate programs. There are no specific studies that focus on why graduate nurses have chosen a graduate year.
in a rural area, and the factors that influenced their choice for rural graduate nurse programs. However, Lea and Cruickshank (2005) identified as part of their study investigating the experience of transition for rural graduate nurses, factors that influenced the graduates’ decisions for a rural graduate program as related and influenced by the rural origins of the new graduate and the desire to return to a rural environment upon graduation.

The effectiveness of graduate nurse transition programs is usually assessed within each health service at a local level and is more in line with a quality control measure. Anecdotal evidence from new graduates regarding their transitional programs identifies inconsistencies across health services and individual health care facilities regarding the quality and delivery of support within the programs. To this researcher’s knowledge only a small body of research into the new graduate nurses’ expectations and experience of graduate nurse transitional programs exists and this will now be discussed.

According to Heslop et al. (2001), findings from a descriptive survey of third year students about to join a graduate nurse program indicated that there is an expectation from graduating nurses that the GNPs will have a preceptor who will facilitate the transition process and will provide regular feedback on graduates’ performance. Students from this study expressed high expectations of preceptor support, however there were inconsistencies regarding the students’ expectations of the length of the preceptor support, with some undergraduate students expecting preceptor support to occur for four weeks and others expecting only two weeks of preceptor support. The authors recommended further research into new graduates’ expectations of their graduate year, their actual work experience, and whether their expectations were congruent with that of their workplace and the aims of this present study will address this recommendation.

A study by Hardyman and Hickey (2001) used a longitudinal survey to explore the expectations and experience of preceptorship from the views of a nationally representative sample (n=3476) of graduate nurses within the United Kingdom. Findings showed that there was an overwhelming demand by new graduates for a preceptorship model to ensure a smooth transition. At least half the respondents stated that they expected the preceptorship to continue for six months or more. Participants rated what they perceived as the most important aspects of preceptorship. For example, they received constructive feedback on their clinical skills,
they were taught new clinical skills, they had someone to help them settle into the clinical environment and they received emotional support.

An Australian study by De Bellis et al. (2001) identified issues surrounding the enculturation of nursing graduates, and problems encountered with the implementation of preceptorship in graduate nurse programs. These authors assert that graduate nurse programs are run by institutions who are ‘focused on outcomes and expenditure’ and do not provide an environment that is conducive to ongoing learning (De Bellis et al., 2001, p. 92). That is, the culture of the ward provides an environment that is contrary to the aims of graduate nurse programs and preceptorship. Participants in this study believed that the reality of the workplace and the lack of available experienced staff to act as preceptors, means that new graduates are expected to rapidly become productive members of the nursing team. The study also found that patient loads, inexperience with the workload and the unpredictability of the work meant that the new graduate, as has been previously mentioned in this chapter, was ‘doing without thinking’ (De Bellis et al., 2001, p. 91) to get the work done with very little support.

Additionally, participants identified a lack of orientation to the ward environment and a ‘Clayton’s preceptorship’, where graduates were often rostered on different shifts to their preceptor, or their preceptor’s workload precluded any time to contribute to the graduate and their learning (De Bellis et al., 2001, p. 87). There was also inappropriate preceptor allocation and inappropriate skill mix rostering which all affected the level of support the new graduate received. Graduates expected more support than they received and also expected the Graduate Support Coordinator attached to the agency to be available to them. However, the study found that due to work and other responsibility constraints within the agency there was very little support from the Graduate Support Coordinator.

A study by Moulinie (2000) explored the effectiveness of a graduate nurse program within a major metropolitan teaching hospital in New South Wales and produced similar findings to that of De Bellis et al. (2001), with respect to a ‘Claytons preceptorship’. However, new graduates of this study rated their transition as ‘smooth’, even though they also cited a lack of time provided by more experienced clinicians for teaching and support. Participants believed the benefits of their graduate program were; increased confidence, increased knowledge, and the development of technical and time management skills. However, it is not clear if the
‘smooth’ transition reported by these participants was the result of them gaining more experience rather than them being part of a graduate nurse program and this will be further explored in this present study.

Madjar (1997), in an earlier study, also found that the level and type of support provided to the new graduates was a major issue and new graduates differed in the level of support they thought they needed. In addition, graduate programs differed in the timing and delivery of that support. New graduates in this study felt that the level of support they received only served to highlight their inadequacies and could have been provided in a manner that was ‘looking out for’ and ‘acting with’, rather than just ‘telling’ and ‘supervising’.

In 2008, Evans et al. used a qualitative descriptive study to investigate the strengths and weaknesses of transition support programs for newly registered nurses within a metropolitan area of New South Wales, Australia. Nine newly graduated registered nurses who had completed a transition support program within the previous twelve-month period and thirteen experienced nurses participated in individual interviews. Reported strengths of the programs included support from preceptors when available or when provided, and the twelve-month structure of the program. However, being left to work alone without access to clinical support, unrealistically high expectations of the graduate nurses and rotational aspects of the program that served to decrease the new graduate’s confidence were seen as weaknesses of the programs.

Anecdotal evidence collected by the writer, as a Clinical Coordinator in a tertiary education institution, indicates that the expectations of graduate nurse programs by graduating nursing students about to enter the nursing workforce is not congruent with the actual graduate nurse program. New graduates report inconsistencies between health services and individual wards as to the content structure and delivery of the Programs. For example, they identify a low level of support and assistance. The project commissioned by NSW Health and Nursing and Midwifery Office (NaMO), and conducted by Parker et al. (2009, p. 11), supports this anecdotal evidence stating that the ‘proliferation of inconsistent programs within Australia and even within states and area health services’.

Whilst many studies and authors advocate support of the new graduate nurse, there is no operational definition of what constitutes support (Johnstone, Kanitsaki & Currie, 2008, p. 52)
or what constitutes best practice for supporting graduate nurses (Levett-Jones & Fitzgerald, 2005 cited in Cubit & Ryan, 2011). Recent studies suggest there is not a single model of graduate support that is more effective than another but recommends a variety of models of support to match context and capacity (Parker et al., 2009, p. 6). Furthermore, Johnstone, Kanitsaki and Currie (2008) acknowledge that the nature and implications of support in the context of the graduate nurse transition program has been under-researched. In this current study a major aim is to explore what constitutes effective support within a rural Transition to Practice Program and provide insight into best practice in the provision of support for new graduate nurses within the rural context.

McKenna and Green (2004) in a small qualitative study interviewed seven new graduate nurses at two points in time during their graduate nurse program within a group of hospitals in Victoria, Australia. Their findings indicated that there are developmental stages that the new graduate progresses through and that ongoing support is required at each stage to ease the transition. The findings for the first six months of practice support those of Duchscher (2001) and indicate that graduates are focused on survival, learning to develop routines and manage workloads. Learning is practice oriented and related to the repeated practice of skills thus learning is limited during this time. During the last six months of the program the study found that emphasis had ‘shifted to higher order thinking issues and self actualisation’ (McKenna & Green, 2004, p. 261). Graduates were able to focus on patients and holistic care and apply assessment skills. They were more aware of personal and professional growth and learning was primarily about the application of critical thinking. In the current study the aims are to identify the specific support requirements throughout each of the individual developmental stages of the transition to rural nursing practice.

Johnstone, Kanitsaki and Currie (2008) investigated the nature and implications of support in a graduate nurse transition program, using an exploratory-descriptive case study approach that utilised a qualitative and quantitative data collection and analysis. The study was conducted in a regional health service in Victoria and involved eleven new graduate nurses and thirty-four key stakeholders involved with the graduate nurse program within the health service. The findings identify that one of the most crucial times for the provision of support is the first four weeks and after the beginning of each rotation for the duration of the program. Additionally, the study highlights that informal teachers and graduates themselves, are those best suited to the provision of support. From this study, recommendations arose for further research into the
timelines and organisational strategies for the provision of support for those who are engaged in supporting new graduates at the ward level. This present study has as one of its aims to investigate the nature and timing of the support required at each stage of the transition to rural nursing practice.

Findings in the 2008 study commissioned by New South Wales Nursing and Midwifery Office (Parker et al., 2009) to examine the experience of new graduate nurses in the first twelve months of practice were similar to other studies that focused on the new graduate transition experiences cited earlier. This study found the nature and level of support to be one of the key factors that impacted on the 2008-2009 graduates’ experience and made several recommendations for the support offered to new graduates such as mentoring and other ward based processes. However, support programs were highlighted to be of questionable use to this cohort of new graduates. An unwillingness and a lack of capacity for ward based support for the new graduate was highlighted with educators identified as those who provided the essential support. This study recommended the development of supportive programs for new graduates within the rural context particularly because educators are noticeably lacking within the rural ward environment (Parker et al., 2009, p. 5). However, as previously stated, the sample for this study was broad and a limitation of the study was that it was not large enough to meaningfully examine the experiences of subgroups such as those from rural settings.

More recently Cubit and Ryan (2011) report the findings from an evaluation of a Graduate Nurse Program within an Australian metropolitan context. The existing Program underwent extensive redevelopment following poor evaluations from focus groups within previous cohorts of new graduate nurses. Problematic issues identified prior to the redevelopment were a lack of orientation, poor preceptor allocation, dissatisfaction with study day content, disorganised graduate meetings, redeployment of the graduate across the hospital, reliance on staff in education roles for support as well as issues around inadequate staffing and skill mix (Cubit & Ryan, 2011, p. 66). In redeveloping the program the researchers recognised the literature that focuses on the recruitment, retention and education needs of Generation Y learners and thus were cognisant of the needs of the Generation Y graduate nurse in the process of restructuring the existing program. For example, Cubit and Ryan (2011, p. 70) cite several authors Arhin and Cormier (2007), Hu et al. (2004) and Levett-Jones and Fitzgerald (2005) in identifying Generation Y learning needs that include engaging and learning more in environments that are meaningful and relevant to them; valuing feedback and recognition for
their work and being in supportive practice cultures. In evaluating the redeveloped program the researchers utilised online surveys administered four times during the twelve-month program as well as focus group discussions with sixteen registered nurses who had just completed the graduate program. Areas of excellence were identified as well as areas for improvement. In particular, their findings revealed graduate satisfaction with having a choice for clinical allocation and also for the timing and length of clinical rotations. In addition, the implementation of a tri level support system that made the graduates feel supported, encouraged and accepted as part of the team was rated to be the best aspect of the program. The tri level support system included frequent feedback from educators and senior nurses and face to face debriefing with peers; regular workshops, face-to-face ward-specific education delivered by education staff and hands on support from an allocated preceptor. While the limitations of this study were acknowledged as having a small sample size that was not a homogenous group of Gen Y learners and that it was only conducted in one hospital the findings of this study are important to assist with informing best practice principles for the development of context specific transitional programs for any generation of learner and will be further explored in this present study.

In 2012, Ostini and Bonner reported on a qualitative study that examined the experiences of nine new graduate nurses during a transition program in a rural/regional setting within Australia. The description for the setting of the study as a regional acute care hospital indicates that this study was not specifically a rural study but a study that is specific to a regional environment. Despite this limitation, however, the findings are relevant and useful for comparison with rural environments. Findings that specifically relate to the content and structure of the graduate program included identification of supportive aspects of the program. For example, having orientation to the facility and the clinical unit plus supernumerary time on the ward and at the start of each clinical rotation, were identified as supportive. However, in respect of formal ward based support structures new graduates in Ostini and Bonner’s (2012) study identified a lack of access and engagement with allocated mentors. In addition, the study identified elements that graduates perceived as contributing to the provision of a supportive learning environment such as the availability and attitudes of senior staff and debriefing with each other. The study also identified material support in the form of more study days, and increased access to educators as aspects to be improved within the new graduate programs (Ostini & Bonner, 2012, p. 249).
Lea, Thornberry and Kiely (2012) in a small qualitative study explored the effectiveness of support within a graduate nurse transition program offered by the largest private health care provider in Australia. This study utilised focus group discussion with 20 new graduate nurses employed on a transitional program during 2009 located in metropolitan, regional and rural areas of New South Wales. A major finding from this study was that tailoring and structuring the graduate nurse program to the specific clinical context, rather than an organisational wide program, positively influenced the new graduates’ perceptions and experience of support during their transitional journey. As well, the structured and consistent approach within the program, from employment interview through to Program completion, had positively influenced the retention of new graduates within the Program.

Given the findings of these most recent studies surrounding support for graduate nurses the present study aims to further explore and describe the nature, level and timing of support within the rural context of a rural Transition to Practice Program that will assist with the graduate nurses safe transition to the rural nursing workforce. As well, new graduates continue to report inconsistencies between health services and individual wards as to the content structure and delivery of the transitional program. For example, they identify a low level of support and assistance, and a lack of clinical rotations. Thus, new graduates’ perceptions of the provision of adequate and timely support and the effectiveness of graduate programs in rural areas in easing the transition experience will be a major focus that is further explored in this study.

2.3.6 The Transition Process for Graduate Nurses in the Rural Workforce

A search of the literature pertaining specifically to the transition process for new graduate nurses in the rural workforce revealed very little published literature. Authors such as Mosel Williams (2000) highlight the lack of evaluative studies, which focus on the new graduate in rural practice settings, or the experience of employing new graduates in rural health care facilities within Australia.

However, within the literature in Australia (Madjar, 1997; Kenny & Duckett, 2003) there is concern expressed for the new graduate who enters rural nursing practice, because of the belief that they are unprepared and are yet to acquire the broad range of skills that are required of rural nurses. There is a lack of support for the employment of new graduates in rural settings due to the perception that undergraduate nursing education does not provide sufficient
clinical practice in nursing programs to prepare students for rural nursing practice (Huntley, 1991 cited in Mosel Williams, 2000, p. 100). In addition, the workplace culture in rural areas is a significant issue for new graduates, and several authors including Bridgewater (1998), Reddick (1998), and Mosel Williams (2000), Lea and Cruickshank (2007) have identified common areas of concern that are unique to rural nursing practice.

For example, Reddick (1998) suggested that the clinical environment of rural agencies and the impact of work practices, stress levels and staffing issues have impacted on the support programs offered to rural graduate nurses and this has meant that the new graduate is often ‘plunged into a hostile environment’. Reddick (1998) also identified workplace barriers such as unprofessional behaviour by more experienced colleagues, competence measured by an ability to cope rather than application of knowledge and skills, and an under-estimation of the abilities of new graduates in rural practice. Furthermore, Reddick (1998) believed that new graduates have to prove themselves as valuable members of the team by being able to succeed with the workload without assistance. Because of the power relations still inherent within nursing, the new graduate must be mindful of communication with other registered nurses, as they might be labelled as too ‘cocky’ if they contribute to discussions, forgetting their place as ‘just a new grad’ (Reddick 1998, p. 4). The difficulties graduates in this study encountered perhaps may be attributable to the fact that some staff members have developed social cliques, into which the new graduate must try and assimilate.

Madjar (1997) found however, that experienced registered nurses who participated in her study felt that the new graduate was not adequately prepared to fulfil the registered nursing role within a rural setting. However, this finding must be treated with caution because only a small sample of rural nurses was included in the study. Furthermore, many new graduates in the study did not feel sure of their competence outside a metropolitan or large regional setting due to the perceived lack of exposure to rural placements during their pre-registration programs. Interestingly, graduates from regional universities, who were more likely to have experienced rural clinical education experiences, expressed less self-confidence in their readiness for rural practice than did graduates from metropolitan universities.

As previously discussed, however, Madjar’s study was centred on large metropolitan teaching hospitals, with the majority of the participants being drawn from one metropolitan health service. Although there was a small number of beginning registered nurses from rural areas in
the sample, the study does not specifically address the competencies of the beginning registered nurse within rural practice settings or the experience of new graduate nurses in rural practice settings. Perhaps the reported lack of self-confidence by graduates in this study can be attributed to the new graduates who are already in rural practice and have a better understanding of the realities of rural practice than their metropolitan counterparts.

Mosel Williams’ (2000) qualitative study of new graduates in rural practice in Queensland identified supportive factors and barriers, which existed for new nursing graduates in their first job. Using informal interviews with five new graduate nurses the study found that there are numerous environmental barriers that impact on the level of support, the level of responsibility, and the level of competence with which the new graduate is forced and expected to practise within rural practice settings. The study also found that competence is often perceived as an ability to cope with the workload rather than the application of knowledge and skills in practice. Barriers existed for the new graduates with respect to their socialisation into rural agencies. Mosel Williams (2000) likens the experiences of the new graduates in her study to moving through portals or doorways into effective practice. For example, there were supportive doorways that represented a genuine welcoming to the agency and community, effective support and guidance from experienced clinicians, and being able to meet clinical challenges positively. However, there were also challenging portals that involved barriers to effective transition, such as tests to prove themselves capable of the workload. For example, tests included being able to cope when understaffed, and conforming to workplace practices. Also, not rocking the boat, having to do things the way of the more experienced registered nurses and having to tolerate disturbance to their self-esteem because of unprofessional behaviours from experienced staff. For example, being referred to as ‘the new grad’ and having to tolerate passive aggressive behaviours from enrolled nurses. Another example was not being allowed to work to the extent of their professional licence and having to work at an enrolled nurse level. The most significant barrier encountered was the lack of identifiable cohesion within the professional team, where the new graduates felt that the nursing team closed ranks against them. The participants in this study also identified coping strategies that were necessary to survive in the environment. Some examples are learning when to conform and when to challenge the work ethic and practices of other staff and also how to ‘arm’ themselves by reverting back to textbooks and asking the appropriate questions.
Conversely, the responses of the experienced clinicians who took part in Mosel Williams’ study were likened to having a genie in a bottle, where the clinicians did not know if the genie [new graduate] was good or evil. Mosel Williams (2000) describes concepts such as: ‘controlling the genie, restraining the genie, walking the genie and freeing the genie’. For example; ‘controlling’ was related to graduates being well skilled but unprepared for practice, as well as a belief that exposure to the clinical area and not their university education was responsible for the graduate being skilled with technology. Another strategy for controlling the genie was not referring to new graduates as registered nurses in their own right and reluctance to acknowledge their increasing competence. ‘Restraining the genie’ was characterised by passive/aggressive and unprofessional behaviours and attitudes demonstrated by more experienced colleagues towards new graduates. ‘Walking the genie’ related to the fact that the workplace is a hostile environment and new graduates needed to work it out for themselves indicating that support or advice was not freely offered but rather the new graduate had to ask. Competency was measured by proficiency with bedside tasks, that is, an ability to get the work done efficiently. ‘Freeing the genie’ was characterised by acknowledging that the new graduate needed collegial support, accepting the graduate as a colleague and accepting responsibility for fostering the development of the new graduate.

The above study highlighted the finding that clinicians believe and support the idea that new graduates should seek more experiences in larger facilities upon completion of the twelve-month program. According to Mosel Williams, the new graduates in her study had undertaken ‘defacto training’ where their experience ‘was characterised by trials and tests that bore little relationship to the pre-registration preparation or experiences’ (Mosel Williams, 2000, p. 103). This author further asserts that the new graduates are often ‘discarded’ after their initial twelve months; they are not encouraged to stay on in rural facilities and are in fact encouraged to seek further experience in larger facilities. As a result, Mosel Williams believes health agencies in rural areas have virtually wasted their investment, as new graduates are not encouraged to continue their career in rural nursing.

Furthermore, findings from this study did not support the notion that graduate nurses are not suitably skilled for rural hospital environments. This is an important finding and Mosel Williams (2000) argues that undergraduate nursing programs aim to develop practitioners who are able to practise within a wide variety of environments and across specialities at a beginning level. Additionally, Mosel Williams (2000) states new graduates are inexperienced
rather than clinically unskilled for rural practice. Furthermore, this author believes that undergraduate education cannot teach years of experience and development as experienced professionals, qualities that are desirable for rural practitioners (Mosel Williams 2000, p. 101–104). Hegney (1996) also believes that the nature and scope of rural nursing practice is one for which new graduates cannot be adequately prepared, because the rural registered nurse is multi-skilled and has years of experience.

Kenny and Duckett (2003) in a large qualitative descriptive study explored the issues that impact on service delivery in rural hospitals of Victoria. Although interviews were conducted with doctors, chief executive officers and rural nurses, the findings from this study specifically related to the rural nursing workforce. These findings have implications for preparation of nurses for rural nursing practice and undergraduate nursing curricula. For example as previously mentioned, their study identified that the future rural nursing workforce will be predominately recruited from regional and rural universities and as such there is a need for rural and regional tertiary education providers to ensure that graduates are prepared to meet the needs of rural communities. Furthermore, they found that management, mental health, advanced health assessment and advanced life support were areas of particular need in rural nursing practice and advanced knowledge and skills in these areas need to be included in undergraduate nursing courses and would enable nurses to make the transition to rural practice more readily.

However, the findings from Lea and Cruickshank’s (2005, 2007) phenomenological study that investigated the experience of transition into rural nursing practice for ten new graduate nurses employed on a transition to practice program, indicate that new graduates in rural practice feel that they have been well prepared, but as beginning registered nurses they lack confidence and experience in their practice. The Lea and Cruickshank (2007) study found that a lack of structured support during the graduate nurse program negatively impacted on their transition experience, the expectations staff have of new graduates as they enter the workforce as well as the workplace cultural issues present in the rural setting impacted on the transitional experiences of new graduate nurses and the subsequent retention of graduates within the rural practice environment. This present study aims to build on these findings by investigating the provision of effective support and identifying the functional elements of the rural Transition to Practice Program.
A further small qualitative study conducted by Lea (2007) investigated the perceptions of eight rural Registered Nurses regarding the barriers surrounding the recruitment and retention of new graduate nurses in rural nursing practice. The findings from this study supported those from the Lea and Cruickshank (2007) study regarding a lack of structured support during the graduate nurse program, no recognition of the new graduate nurse’s beginning level status with respect of workload and responsibilities, and the culture of the ward influencing the support new graduates received. Lea’s (2007) study identified that staff ratios and skill mixes within the rural practice environment means the new graduate is working under extreme pressure and often graduates have misconceptions about what they will be required/expected to do in rural practice. Further, this study found that registered nurses believed that new graduates are not adequately prepared for management roles such as delegation and being in charge and that in the graduate year these higher order skills need to be continually developed.

The writer agrees with Mosel Williams (2000), that new graduates do not have the experience to cope with the workload and level of responsibility that comes with professional nursing practice and as such should not be expected to enter rural nursing practice with the skills required of their more experienced rural nursing peers. From my own observation and personal communication with new graduates during the course of employment at a rural university, their experience of rural practice is vastly different from their initial expectations of beginning practice. Their experience in rural agencies was also very different from what they had experienced during their undergraduate preparation in rural health care agencies. For example, during undergraduate clinical experiences a student nurse is not expected to assume total responsibility for patient care, nor have they experienced ward management, but rather were only able to observe a more experienced clinician. Findings from Lea and Cruickshank (2007) and Lea (2007) indicate that there is an expectation from health services and staff that the new graduate will have to hit the decks running, that is they should be able to assume the workload responsibilities of their more experienced peers. Present staffing ratios and skill mixes within rural health facilities often prevent the new graduate having time to ease into the nursing workforce. Anecdotal evidence indicates that the present rural transitional programs are offered as a 12 month continuum program derived from a metropolitan Area wide program that is not specific to the rural practice context. Furthermore, they appear to have been developed without any recognition that a new graduate progresses through distinct stages when transitioning and each stage has different support requirements.
Thus, as previously mentioned, the case in this study is the rural Transition to Practice Program and the focus of this study is to investigate the effectiveness of the rural Transition to Practice Program in providing a supportive transitional journey to rural nursing practice.

2.4 Conclusion

This literature review has provided an overview of the difficulties and complexities of the role transition from student nurse to registered practicing nurse. Section One provided an overview of rural nursing and the issues for newly graduated nurses in rural nursing practice. The experience of transition in rural practice was identified as being complicated by the role and scope of the rural nurse, the availability of staff to provide adequate support in rural agencies, as well as the elements of role stress that are unique to the new graduate in rural practice settings due to the close knit rural community.

In Section Two Transition Theory and The Stages of Transition as a theoretical framework was presented and discussed. The role transition from student to registered nurse is associated with professional socialisation and reality shock and transition shock thus the utilisation of a situation specific transition theory, as a theoretical framework for this study was deemed appropriate.

In Section Three, the literature review focused on and presented research-based studies that pertain specifically to the beginning registered nurse and the transition to professional practice. These studies ranged from the effects of professional socialisation and reality shock, to perceived deficits by the service industry, in the new graduate’s practice. In addition it was identified that there is a growing concern for the effect the culture of the environment has upon the new graduate entering the nursing workforce. The unrealistic workload expectations of new graduates upon entry into the workforce, as well as a lack of support and failure of agencies to provide an appropriate environment for the on-going learning and development of beginning registered nurses were also discussed. This section also examined the expectations and role of a graduate nurse program and then presented the literature specific to the graduate nurse making the role transition in rural practice settings. It can be concluded that the reviewed research literature indicates there is a great deal of evidence which supports the findings from the researchers own research to date, and the concerns held about the adequacy for support provided to new graduate nurses. The research also provides clear indication of
the urgent need for adequate support for new nurses as they make the transition to rural nursing practice.

The following chapter, Chapter Three, will describe the research design and the methodological approach used to investigate the phenomena of support for the new graduate nurses making the transition within a Transition to Practice program in rural practice settings.
CHAPTER THREE

Methodology

3 Introduction

This chapter describes the research paradigm, design and the methodological approach used to investigate the research problem. It commences with a justification for the research paradigm, the research design and methodology adopted in this study. The research setting, samples, data collection procedure, data analysis technique and ethical considerations are described and discussed. Finally, the methodological limitations are identified and discussed.

3.1 Justification for the Qualitative Paradigm

The researcher chose a qualitative framework for this study because qualitative research methods have been acknowledged in the literature (Hallett, 1995; Willis, 2007; Anthony & Jack, 2009) as most appropriate for nursing research where the focus of the research is on the nature and meaning of human experience. In this study, the researcher wanted to provide an in-depth understanding of the nature and timing of support during the transition to rural nursing practice as experienced and required by new graduate nurses. In addition, the researcher wished to explore a sample of experienced rural nurses’ thoughts, beliefs and feelings about the nature and timing of support that would provide for a ‘safe’ and supportive journey of transition into the rural nursing workforce for new graduate nurses. Thus, the researcher believed that a qualitative approach would be the most appropriate framework to expose and understand the meaning of the phenomenon of support during the transition to practice within a Transition to Practice Program in rural health settings.

In social science research a quantitative framework requires the researcher to adopt an objective position to collect facts about the social world so that explanations and a chain of causality can be built around the facts (Noor, 2008). In this study, the researcher rejected the
use of a quantitative framework because the research problem did not lend itself to quantifying factors, nor to generate, construct or test theories or hypotheses regarding the phenomenon of support for new graduates nurses in rural practice. Rather in this study, the qualitative paradigm enabled the focus to be on examining factors, in the natural setting, interpreting and attempting to gain a better understanding of the phenomenon being examined. The research interest is on insight, discovery and interpretation (Merriam, 1998, p. 27), the emphasis is on processes and meanings rather than on rigorously measuring or examining in terms of quantity, amount, intensity or frequency (Denzin & Lincoln, 1994 cited in Noor, 2008). The researcher, in exploring the reality of practice in relation to the phenomenon of support during the transition process for new graduate nurses in rural practice, wished to explore real life experiences and situations that aimed to illuminate understanding of the phenomenon.

Denzin and Lincoln (2003, p. 5) describe qualitative research as an interpretive, naturalistic approach to the world that involves ‘studying things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them’. The theoretical underpinnings of this study arise from interpretivism. Interpretivism is an approach to social research that is concerned with what the world means to a person or a group being studied and rejects the use of the same methods and paradigms as used in the natural sciences. Rather, the qualitative paradigm arises from the work of philosophers such as Kant, Dilthey and Weber (Schwandt, 2003, p. 295) and favours research methods that allow ‘better ways of getting at how humans interpret the world around them’ (Willis, 2007, p. 6). The interpretivist approach is concerned with Verstehen or understanding (Crotty, 1998, p. 67) the lived experiences of humans. With this theoretical perspective, understanding can only occur in context and true understanding is a holistic process (Willis, 2007, p. 53). In this study, the researcher specifically wanted to develop understanding of what the new graduate nurses had experienced or perceived, as support during their transition to practice programs within the context of the rural practice setting. In addition, the researcher wished to explore the perceptions, thoughts and feelings regarding the provision of support from experienced rural registered nurses who, at the time of the study, were working with the new graduate nurses.
3.2 Justification for the Research Design and Methodology

This research case study is grounded in the interpretivist, constructivist paradigm of qualitative inquiry (Willis, 2007). There is much discussion in the literature as to whether case study research is a research strategy, research design or research method, because this form of research draws on many aspects of qualitative inquiry (Anthony & Jack, 2009, p. 1175) and so is frequently situated in the qualitative paradigm, and recognised by many as qualitative research (McGloin, 2008; Yin, 2009). However, case study research does not specify any particular methodology or paradigm and has no ‘fixed ontological, epistemological or methodological position’ (Luck, 2006 cited in Rosenberg & Yates, 2007, p. 47). Sandelwoski (2010, p. 154) agrees and states that ‘the research case study does not specify any methodology’. Rather the positioning and focus of the case study in its particular social and historical context will determine whether the study is descriptive or experimental (Bryar, 2000, p. 66). The methodological position best suited to answer the research question will mean that the research is ‘pragmatically driven rather than paradigmatically driven’ (Rosenberg & Yates, 2007 cited in Casey & Houghton, 2010, p. 45). Thus, the researcher believed because the major aim of this study was to expose and understand the meaning of the phenomenon of support for newly graduated registered nurses during their Transition to Practice Program within the rural practice context, a qualitative approach, utilising a case study design, would be the most appropriate framework to guide the study.

A form of empirical inquiry, case study research has evolved from social research (Anthony & Jack, 2009) where defined cases were used to investigate social phenomena in context, over a defined period of time, often gathering data from multiple sources (Brophy, 2008, p. 20).

Yin (2009, p. 13) states that a case study research method is best suited to answer how and why questions regarding a set of events over which the investigator has little or no control. Fitzgerald (1999, p. 75) concurs that a case study design is appropriate for when the field of inquiry is under-researched, if there is minimal or limited foundational research in the area and furthermore, that it is useful in exploring and describing the issues within a given context. Stake (1995) and Yin (2009) also state that this type of research design is suitable for describing, exploring and understanding a complex phenomenon in its real life context. It is a
method used when the researcher is interested in both the phenomenon and the context in which it occurs (Salminen et al., 2006).

For this study, the how questions are: how does the new graduate nurse perceive the adequacy of support provided during the rural Transition to Practice Program? And, how can support be provided within the rural Transition to Practice Programs to ensure an effective and safe transition to the rural nursing workforce?

As discussed in the background to this study in Chapter One, very little is known about what constitutes support for new graduate nurses in rural areas where the role of the rural nurse is multidimensional and diverse and the skill mix, workload and rurality can impact on the graduate nurse’s journey of transition into the rural working environment. Thus, in this study the researcher utilised an exploratory, descriptive, qualitative case study design to gain in-depth understanding of a real life phenomenon, that is, the nature and timing of support during the role transition, within the real life context of rural nursing practice.

The case study research method is defined by Yin (2009, p. 18) as one that ‘investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident’. Schneider, Whitehead, LoBiondo-Wood and Haber (2013, p. 277) go further in defining case study research as a method that ‘enables a detailed examination of a single ‘case’ or ‘unit’ within a real life contemporary context using multiple data sources’ and utilisation of triangulation. The term triangulation is used in research design to describe the use of a variety of data sources or methods to examine a phenomenon so that a more comprehensive and accurate account of the phenomenon under investigation is produced (Schneider et al., 2013, p. 399). Denzin and Lincoln (2003, p. 66) describes four types of triangulation that can be used in research designs as investigator triangulation, theory triangulation, method triangulation and data triangulation. In case study research triangulation refers to data triangulation. That is collecting information or evidence from a range or multiple sources to develop converging lines of inquiry that are aimed at corroborating the same fact or phenomenon (Yin, 2009, p. 114). Polit and Hungler (1999, p. 428) further explain three types of data triangulation as time triangulation, space triangulation and person triangulation. These authors state that time triangulation refers to collecting data on the same phenomenon at different points in time to determine a comparison of the phenomenon across time. Space triangulation refers to collecting data on the same
phenomenon and different sites with the aim to validate the data by testing for consistency across sites. Finally, person triangulation involves collecting data from different levels of persons with the aim to validate the data through multiple perspectives (Polit & Hungler, 1999, p. 428).

An all-encompassing method that covers research design, data collection techniques and specific approaches to data analysis (Yin, 2009), as mentioned above, case study research involves intensive study of one or more cases, the case being defined by the researcher, with cases being selected for their informational representativeness rather than their statistical representativeness (Sandelwoski, 2010, p. 156).

Merriam (1998, p. 30) describes characteristics of case study research design as being *particularistic* because they are focused on one particular context and *naturalistic* because case study research is about real people and situations where data collection occurs in real environments. Furthermore, Merriam (1998, p. 30) states that case studies are *descriptive* because they provide rich descriptive data and are also *inductive* because they rely on generalisations, concepts or hypotheses to emerge from examination of the data. Finally case studies are *heuristic* because they aim to illuminate the reader’s understanding of the phenomenon under study (Merriam, 1998, p. 30-31). Given that the present study was undertaken in the hope of developing a detailed picture of what and how was happening in an under-researched area, the case study method was eminently suited.

Case study research designs share some common characteristics with other qualitative research designs, such as ethnography, critical theory or phenomenology. However, the researcher rejected the use of other qualitative designs for this study for three reasons. First, the research questions were ‘how’ questions that aimed to obtain an in-depth understanding and meaning, for all involved, of the situations under study (Merriam, 1998, p. 20) and where such understanding must encompass important contextual conditions (Yin, 2009, p. 27). In addition, Flyvbjerg (2006, p. 422) states that the case study design is well suited to provide context dependant knowledge that is required in this research, given that the present study looked specifically at rural practice settings and involved rural sites with different contextual characteristics.
Second, Payne, Field, Rolls, Walker and Kerr (2007, p. 236) state that case study research methodology is considered appropriate to use in practical disciplines such as nursing that are based in organisational and service environments that are ‘complex, dynamic and arise from, and are embedded within, local social structures’. These authors cite Walsh (2005), stating that a case study design is advantageous when situations are complex, the real world context is central, multiple perspectives are required, flexibility is desired, there is no obvious suitable theory and when other methods present practical difficulties. Thus the researcher believed it is a suitable methodology for this study where interest was in transitional support programs for graduate nurses, within the real world context of rural nursing practice, where the perspectives and experiences of the new graduates themselves, as well as the experienced nurses who also work with them in the complex and dynamic rural practice environment, were sought (Payne et al., 2007, p. 236).

Third, Keyzer (2000) acknowledges the flexibility and usefulness of case study methodology in exploring the complexities of rural health in the Australian context. This author believes that because nursing practice is highly contextualised, case study research design is a suitable and a practical methodology for conducting research in rural nursing as it can provide new knowledge specific to the practice of rural nursing which is the ultimate aim of this study.

According to Yin (2009) and Sandelowski (2010), the design of the case study can be prospective or retrospective, cross-sectional or longitudinal, and may include both single and multiple cases that generate both quantitative and qualitative evidence. Yin (2009, p. 47) states that there are four types of designs for research case studies that is, single or multiple, embedded or holistic. Yin (2009, p. 47-49) explains that a single case study design, is appropriate for when the case represents one of the following criteria; a critical case to test theory; if the case represents an extreme or unique case; if the case is a representative or a typical case where the aim is to capture an everyday or commonplace circumstance or condition; and a longitudinal case where the aim is to study the same case at two or more different points in time. An embedded case study design involves more than one unit of analysis as opposed to a holistic design that uses a single unit of analysis (Yin, 2009, p. 50). Salimen, Harra & Lautamo (2006, p. 50) state that a case study design is a suitable design when studying professional practice, and in particular, an embedded case study design is suitable when it is clear what the researcher is looking for. For this study the researcher chose a single, representative, longitudinal, embedded case study design.
Casey and Houghton (2010, p. 43) cite Stake (2000) in discussing the classification of case study designs as: intrinsic, instrumental or collective. They state that a collective case study is focused on a number of cases, when the aim is to understand a phenomenon or population and that an instrumental case is where the researcher selects and investigates the case to provide insight into a particular issue (Casey & Houghton, 2010, p. 43). Sandelwoski (2010, p. 155) adds that the interest in an intrinsic case study lies in what the researchers need to learn about a particular case as opposed to an instrumental case that seeks to understand about something other than the case. However, Sandelwoski (2010) also claims that all research case studies are instrumental case studies because the target case will be instrumental to understanding other cases and other cases will be instrumental to understanding the target case (2010, p. 156). The present study can be described as an instrumental case study design (Stake, 1995; Drew, Hay & White, 2009) because the researcher selected and investigated the case of the rural Transition to Practice Program to provide insight into the nature of support that participants experienced.

This researcher chose a single-embedded case that was descriptive, exploratory, representative and longitudinal in design. In this study, the single case was the Transition to Practice Programs in the rural context. The issue to be explored was the nature and timing of support that is required for the safe transition of the new graduate nurse into the rural nursing workforce. The case study was exploratory rather than explanatory because it aimed to explore the support needs of new graduate nurses throughout their transition to practice within rural practice settings. Furthermore, the case is representative because the researcher wanted to ‘capture the circumstances and conditions of an everyday or commonplace situation’ (Yin, 2009, p. 48). That is, it aimed to describe the support needs of new graduate nurses throughout their transition to practice within rural practice setting. The study was also longitudinal and descriptive in that the aim was to describe and examine the support needs over time, specifically how the support needs of the new graduate nurse changed. Thus the longitudinal aspect of the design involved capturing three points of time where data was collected from the new graduate nurse participants. The embedded units of analysis in this study are the actual rural Transition to Practice Program, the experiences of the new graduate nurses as well as the beliefs and perceptions of the experienced rural nurses with whom the new graduates worked at the time of the study.
A major strength of a case study research design is the ability to collect evidence from many different sources in the development of ‘converging lines of inquiry’ to enable the process of triangulation of data sources (Yin, 2009, p. 115). The collection of detailed, unstructured information from a range of sources that can include accounts from the subjects themselves (Bergen, 2000, p. 926), is aimed to achieve corroboration of the same phenomenon, so the events or facts of the case study are supported by more than a single source of evidence (Yin, 2009, p. 116). In this study, data was collected and triangulated from three sources. In-depth individual interviews with new graduate nurses, individual interviews with experienced rural nurses and an environmental survey of the current Transition to Practice Program within the rural health services where the new graduates and experienced rural nurses were employed. Thus data triangulation in this case study was achieved using what was deemed by the researcher to be the three most valuable sources of data for this study. This study utilised the three types of data triangulation as described by Polit and Hungler (1999) and as explained previously. For example, time triangulation was utilised as data were collected from the new graduate nurses at different points in time so a comparison could be made concerning the nature of support at different stages of their transition. Further, space triangulation was achieved by collecting data concerning the phenomenon of support for new graduate nurses from fourteen different rural health services and person triangulation was also utilised as data were collected from different levels of registered nurses within the rural health services. That is, data was collected from clinical nurse educators, nurse unit managers, health service managers, health service educators, experienced senior rural registered nurses and the new graduate nurses themselves.

3.3 Research Procedure

3.3.1 Setting

This study was conducted from December 2010 to December 2011 in health services in rural towns of northern New South Wales (NSW), which, at the commencement of the study, had new graduate nurse positions available within a graduate nurse Transition to Practice Program in 2011. Figure 3.1 illustrates the location for this study, the setting of which is indicated by the green shaded area.
Fig 3.1 Adapted from The Australian Government Department of Health and Ageing (2013). *National Health Reform*.

Rural towns chosen as sites for inclusion in this study had a population base classified to be *outer* regional according to the Australian Government Department of Health and Ageing (2010) and/or those towns whose population base is classified as *rural*, according to The Australian Bureau of Statistics, Australian Standard Geographical Classification Remoteness Areas Classification (ABS 2001, accessed 22nd April 2010) within one Area Health Service of Northern New South Wales. This system classifies areas depending on their distance from different sized urban areas where the population size of the urban centre is considered to govern the range and type of services available. The Australian Institute of Health and Welfare (2008) use the terms *rural* and *remote* when referring generally to areas outside major cities. In this study the terms *large rural* and *small rural* will be used when referring to the settings of this study.
A total of 14 rural health services where selected. They came from within one Area Health Service (see Figure 3.1) that met the criteria of large and small rural health services, and intended to employ new graduate nurses on a 12-month graduate nurse Transition to Practice Program in 2011. Each program was independent of larger regional or metropolitan Transition to Practice Programs. Of the 14 rural health services initially identified, five are considered to be *large rural* and 9 are considered to be *small rural*.

Five of the large rural health services are located within large rural towns and provided similar medical and nursing services. According to the Australian Government Department of Health and Ageing (2010, p. 49) these large rural health services are located in outer regional areas and as such would be classified according to the number of admissions per year as ‘medium acute hospitals in regional areas’. At the time of this study, the staff ratios, skill mixes, and graduate nurse programs within these health services were very similar. These five large rural sites have between 2-6 new graduate positions each year.

The remaining nine health services included in this study are located in outer regional areas. Five of these nine health services, according to the Australian Department of Health and Ageing (2010, p. 48), would be classified as ‘small regional acute hospitals (mainly small country town hospitals)’ because of their admissions per year and treating fewer than 2,000 patients per year. Four of the nine health services were classified as Multipurpose Services or according to the Australian Government Department of Health and Ageing (2010, p. 48) ‘small non-acute hospitals’ with ‘patient throughput of less than 2000 admissions per year with 40% non acute…’. The bed capacity ranged between 30 and 50 and medical and nursing services within these health services were similar, as was the content and structure of graduate nurse Transition to Practice Programs within these services. These small rural health services have between 1-2 new graduate nurse positions available per year. Table 3.1 below illustrates the setting and sites included in this study. As shown in this table three large rural health services offered two new graduate nurse positions per year, however at the commencement of the study the three health services each had a vacant new graduate nurse position. As well, two small rural health services (one designated as a multipurpose service) each had vacant new graduate nurse positions.
As previously stated, the health services within these rural towns form part of one Area Health Service of northern NSW. This large Area Health Service was considered by the researcher to be an appropriate site for three main reasons. First, as illustrated in Figure 3.1, (located in green) the Area Health Service covers a broad geographical area of more than 130,000 square kilometres, it is one of the largest area health services within New South Wales, plus it has many large and small rural health services that could be utilised for participant selection and recruitment. Second, approximately 50% of the new graduates nurses employed each year by this area health service are employed within rural health settings, thus ensuring that the researcher would be able to recruit a relevant sample of new graduates. Third, this region is well known and geographically accessible to the researcher, and this facilitated recruitment of participants and also facilitated data collection, in particular the longitudinal aspect of the study, where the researcher needed to travel repeatedly to a range of locations throughout the area to collect data. Being geographically accessible assisted with time constraints and resources with which to conduct the study.

It was hoped that utilising a range of rural health services in this case study would provide a comparison of geographical and social environments in which new graduates are employed.
that would provide variations in experiences and perspectives on the provision of support, as well as providing insights into the diversity of rural nursing practice that new graduates experience in their first year. An advantage of selecting new graduate participants from within these health services was that they would provide a cohort of graduates from a range of tertiary institutions that have diverse curricula and clinical preparation. For example, there are differences in the timing and number of hours for clinical experience as well as the content, structure and delivery of nursing pre-registration curricula among tertiary institutions within Australia.

3.3.2 Sampling Procedure

In this case study, nonprobability purposive sampling was used for selecting the three samples for this study. Merrian (1998) cites Patton (1990, p. 60) in stating that purposive sampling in case study research involves selecting information-rich cases for in-depth study. This method of selecting participants involved the researcher deciding who could best provide the desired information (Schofield & Jamieson, 1999, p. 158). The purposive selection of the participants could also be termed representative because they were in no way extreme, atypical or intensely unusual, and it was hoped they would be able to provide the maximum amount of information about the case because they were considered to be the most information-rich (Salimen et al., 2006, p. 5). They represented or ‘reflected the average person, situation or instance of the phenomena or interest’ (Merriam, 1998, p. 62; Ritchie, Lewis & Elam, 2003, p. 78). The three samples used in this case study were representative of the population who had knowledge of the rural Transition to Practice Program within the geographical area, representative of the new graduate nurse making the transition to practice and representative of experienced rural nurses who had knowledge and experience of the support needs of rural graduate nurses.

Merriam (1998, p. 64) further states that in case study research there can be two levels of sampling, the first is the case to be studied and the second is sampling within the case. As previously stated, the case in this study is the rural Transition to Practice Program thus all registered nurses responsible for the Transition to Practice Program within the included rural health services were invited to participate in the Environmental Survey. Sampling within the case is concerned with the units of analysis in this study, that is, the new graduate nurses and the experienced rural nurses who worked with them at the time of the study.
As stated above registered nurses, who at the time of the study were responsible for the Transition to Practice Program in each rural health service that met the inclusion criteria for the study, were invited to participate in an environmental survey to provide information regarding the Transition to Practice Program within the health service.

A unit of analysis in this study is the new graduate nurse at the chosen sites making the role transition to rural nursing practice within a rural Transition to Practice Program. All these new graduate nurses were invited to participate in individual interviews at intervals throughout their 12 month rural Transition to Practice Program.

The second unit of analysis involved experienced rural registered nurses. However, it was not the researcher’s intention, nor was it possible, to interview all registered nurses in rural practice settings. Rather, only those experienced registered nurses who, at the time of the study, were employed with new graduate nurses within the rural health services were invited to participate in the case study, thus sampling within the case was also purposive and representative. The following sections present the procedures for sampling within this case study.

### 3.3.3 Sampling Procedure for the Environmental Survey

Each of the registered nurses (RN) responsible for the Transition to Practice Program within the fourteen health services was invited to participate in this study. Through her role as a Clinical Co-ordinator this researcher had professional links with the registered nurses who, at the time of the study, were responsible for the rural Transition to Practice Program in each of the rural health service sites. In recruiting this sample of registered nurse participants to complete the Environmental Survey the researcher approached potential participants in one of two ways. First, as discussed in Chapter Two, within rural health services staff often fulfil multiple roles and so the RN responsible for student nurse clinical placements is also responsible for the new graduate nurse Transition to Practice Program. In discussions with these RNs, during clinical visits to the agency the researcher enquired as to whether they would be interested in participating in the study. Second, as it was not always possible to discuss participation in the study during clinical visits to the rural health services, the researcher also emailed potential participants inviting them to participate.
The telephone survey was conducted in January 2011. Once the initial contact was made with the RN responsible for the Transition to Practice Programs, as described above, the researcher sent an email to each potential participant to organise a convenient day and time to conduct the telephone survey. Prior to conducting the telephone survey participants were sent by mail a copy of the Participant Information Sheet and two copies of the Informed Consent Form and a reply paid envelope as well as the list of questions to enable them to prepare for the survey. The telephone survey took approximately 15 minutes to complete.

3.3.4 Sampling Procedure for the New Graduate Nurses

To enable the objectives of the study to be met, the criteria for the new graduate nurse participants included participants who were employed in a rural Transition to Practice Program that commenced in early 2011, in one of the selected rural health services. As previously mentioned, one of the study aims was to examine and describe the support needs of new graduate nurses over time, specifically if the needs changed over time. Therefore, it followed that the new graduates had to have commenced their Transition to Practice Program in either January or February of 2011 so that the interviews could be conducted at three intervals throughout their 12-month program. The timing of the interviews will be discussed later in this chapter.

All new graduates who met the above criteria were initially approached by the researcher and asked if they would be interested in participating in this study. At the time of the study, as discussed previously, the researcher was the Clinical Coordinator of a pre-registration nursing program in NSW and a regular visitor to rural health services, and it was not unusual for her to enter into conversations with new graduates. During these visits the researcher discussed the research project individually with the new graduates and registered nursing staff and enquired as to whether they would be interested in participating in the study. Those who indicated an interest were telephoned at a later date to arrange dates, times and venues for the interviews. Six new graduate participants were asked to consider participation in this study via a telephone conversation, as the timing of the visits did not always mean that the new graduates were present in any one agency at one time. Also, due to the nature of the clinical setting at the time of the visit, it was not always possible for the new graduate to engage in an in-depth and lengthy conversation with the researcher.
The new graduate nurse sample consisted of fifteen participants, thirteen of the participants were female and two were male. Demographic details of the new graduate participants are presented in Chapter Four.

3.3.5 Sampling Procedure for the Experienced Rural Registered Nurses

Whilst visiting rural health services as part of her Clinical Co-ordination role, the researcher discussed the research project with registered nursing staff and enquired as to whether they would be interested in participating in the study. Those who indicated an interest were telephoned at a later date to arrange dates, times and venues for the interviews. Sixteen registered nurses who worked with new graduate nurses participated in the individual interviews. Consistent with qualitative research, the sample of experienced rural registered nurses, did not aim to provide representativeness of the registered nurse population (Beanland, Schneider, LoBiondo-Wood & Haber, 1999, p. 280). Rather, the researcher aimed to obtain descriptions from those who have experience of the phenomenon of support for graduate nurses within rural Transition to Practice Programs. At the time of the study, the registered nurse participants occupied various positions within the rural health services. For example, the study sample included interviews with Senior Registered Nurses, Nurse Unit Managers, Clinical Nurse Educators, Health Service Managers, Health Service Educators, Clinical Nurse Specialists and a Deputy Director of Nursing. All registered nurse participants were female and their demographic details are also presented in Chapter Four.

3.4 Instrumentation

3.4.1 Phase One: Environmental Survey

The Environmental Survey assisted to establish a picture of the current transition program and also to ascertain that there would be a sufficient number of new graduate nurses for a purposive sample. The structured questions in the survey were developed from the literature and were related to the development of graduate nurse support programs. In addition, the researcher’s role as a Clinical Coordinator and her experience in delivering workshops to registered nurses in rural health services informed the survey questions.

The survey included a combination of open-ended and closed-ended questions. The closed-ended questions were mostly what Polit and Hungler (1999, p. 336) describe as dichotomous questions aimed at gathering factual information regarding the Transition to Practice
There were a number of closed-ended question items requiring Yes/No answers and single word answers. For example, the number of graduate nurse positions available, whether the positions had been allocated for the year 2011, and the month in which the program commenced each year. These questions were important to confirm sites for selecting new graduate nurse participants for Phase Two of the study. In addition, open-ended question items were included after each closed ended question that required participants to respond and describe in their own words answers to questions relating to the content and structure of the programs such as the number of supernumerary days, clinical rotations, type of support offered within the program as well as specific new graduate education study days. For example,

*Are there supernumerary days for newly graduated nurses?*
*If Yes, how many?*
*Is there a structured support model at the ward/unit level?*
*If Yes, can you describe the model?*
*Do newly graduated nurses have a performance evaluation?*
*If Yes, how often?*
*If Yes, who is responsible for completing the evaluation?*

The researcher also included a closed-ended question to ascertain if any of the rural agencies employed new graduate nurses outside of the Transition to Practice Program. This was to ensure that only new graduate nurses employed on a 12-month graduate nurse Transition to Practice Program were recruited into this study.

The survey was delivered via the telephone because the researcher believed that gathering up-to-date and comprehensive information using this method would be quicker and more reliable as opposed to completion of a postal survey. As previously discussed, in rural agencies staff fulfill multiple roles and the researcher was concerned that this would affect the return rate for a postal survey that would in turn pose a risk of delay to data collection in Phase Two of the study.
3.4.2 Interview Schedules for New Graduate Nurses

A semi-structured interview was the primary mode of data collection to enable the researcher to obtain ‘detailed and richly textured person-centred information’ (Minichiello, Madison, Hays, & Parmenter, 2004, p. 412). The structure of the interviews was consistent with a qualitative research approach, utilising a recursive method of in-depth interviewing as described by Minichiello et al. (2004). This method of in-depth interviewing involves questioning that has a conversational style which enables the development of a rapport between the researcher and the participants, which assists in achieving a greater level of understanding of their experiences. A further advantage of using the recursive method of questioning was that it enabled the researcher to treat each participant and situation as unique, allowing the researcher to change or modify the interview technique because of information gathered from previous interviews.

The interview questions within the interview schedules for new graduate nurses and the experienced rural nurses arose from three sources. First, and as previously mentioned, the researcher had obtained information from new graduate nurses in rural practice, when visiting rural health services as Clinical Coordinator of a pre-registration nursing program. Second, some of the questions emerged from the research-based literature surrounding the transition experiences of new graduate nurses. Third, emergent interview questions were guided by concepts such as role transition and professional socialisation as well as the concepts central to the Stages of Transition as outlined by Duchscher (2008) and utilised in this study as the theoretical framework.

A separate interview schedule was developed for each round of the new graduate nurse interviews thus there were three interview schedules for the data collection for this sample of participants. The interview schedules are attached as Appendix 1, 2 & 3. The schedules did not necessarily determine the order of the conversation but rather they served to assist the researcher to focus on the participant, and assisted with ensuring that all topics had been addressed (Minichiello et al., 2004, p. 421). When necessary the researcher used a series of prompts to help guide and focus the interviews. That is, the prompts and headings in each of the interview guides were used to jog the researcher’s memory regarding concerns or issues that the researcher wished the participants to address. Prompting questions were also used if the participants lost train of thought or became side tracked. The three interview schedules were revised following each interview to include important issues or topics that were raised.
by the participants that had not been previously covered by the researcher, and this helped to refine and guide the research process (Minichiello et al., 2004, p. 421).

On each occasion that the new graduates were interviewed, the researcher asked the same or similar set of questions. The questions were aimed at gaining rich descriptions of the new graduate experience, in particular their experience of support within the Transition to Practice Program. Specifically, the participants were asked the following questions:

*Can you tell me about your experience of your transition journey, what has it been like for you so far?*

*Can you tell me about the support you have received so far?*

*Can you describe some actions at this time that you feel are providing you with support?*

*Can you talk more specifically about the support provided to you at the ward/unit level, for example by individual RNs, NUM, CNE?*

*Do you think the support at the ward level at this time in your journey of transition could be improved?*

As stated earlier, the interview schedule did not necessarily determine the order of the conversation but rather it served to assist the researcher to focus on the participant, and assisted with ensuring that all topics had been addressed. For example, when answering the first interview question, a neutral question aimed at gaining descriptive information that would lay the foundation for more specific directed questions (Merriam, 1998, p. 82), some participants covered areas such as support and the source of support. These were topics the researcher had included in the interview guide, to be addressed at a later stage of the interview only if they were not previously addressed in the conversations. In addition, the final question is one that Merriam (1998, p. 7) describes as an ‘ideal position question’ as it is designed to elicit information and opinion. In this study the researcher used this question to gain ideas, thoughts, and opinions from the new graduates regarding their requirements of support during the transition to rural practice.
Following each set of new graduate interviews, as information and experiences emerged that were important to describing the phenomenon of support, the researcher refined and added two questions so that more in-depth understanding could be provided and to assist in clarifying concepts, meanings and understanding. For example, following the first round of interviews conducted at the three-month stage of their transition, the researcher added the following question:

*Are there things you are seeking help for, or that you would like support for at this time?*

This style of question could be described as a ‘leading question’ and this type of question should be avoided in a qualitative interview because it may reveal a bias or an assumption that the researcher is making (Merriam, 1998, p. 82). However, in this case study, the researcher felt it important to add this prompt only if the participant did not specifically describe or volunteer what they were seeking help with. It was felt that this description would add significantly to understanding the nature and timing of support, so that in the data analysis a comparison could be made between clinical agencies, settings, and between participants of their specific support needs at that particular time in their transition. Therefore this question was only used as a prompting question for the second and third interview rounds with the new graduate nurses.

In addition, in the final interview as the graduates were nearing completion of their programs, the researcher felt it was important to ascertain their future career intentions, in particular their intention to stay within the rural nursing workforce, and so the following question was included in the final interview schedule.

*Now that you are nearing the end of your transition program what are your future plans for immediate employment and or career intentions?*
3.4.3 Interview Schedule for Experienced Registered Nurses

An interview schedule for the data collection from the sample of experienced rural nurse participants was also developed. The questions for the interviews with experienced rural nurses who worked with the new graduate nurses at the time of the study are attached as Appendix 4. There were four broad questions that aimed to gather their thoughts, feelings, perceptions and beliefs regarding the nature and timing of support required by the new graduate nurse in rural settings to ensure a safe transition to the rural nursing workforce.

The first two questions were aimed to determine the level of knowledge the registered nurses had about the Transition to Practice Program within their health service at the individual ward or unit level. The researcher believed this information was important to obtain because it would indicate the level of engagement the sample of rural registered nurses had with the Transition to Practice Program.

*Can you talk about the structure and content of the graduate program within this health service?*

*Can you talk about the structure of the graduate program at the ward/unit level?*

The third question aimed at discovering support measures currently implemented at the ward or unit level.

*Can you talk about the support measures for new graduates that are in place at the ward/unit level?*

The fourth question, a ‘ideal position question’ Merriam (1998, p. 77), was asked to elicit information and opinions from the experienced rural nurses regarding the provision of support at the ward or unit level.

*Are there changes to the ward/unit level support you think could be beneficial to new graduate nurses?*

Once again prompting questions were used to guide the interviews and to keep the participants focussed. The interview guide was revised following each interview, to include
important issues or topics, raised by the participants that had not been previously covered by
the researcher, and this helped to refine and guide the research process (Minichiello et al.,
2004, p. 420). For example, the following questions resulted from this process:

*What are your indicators for timing of support?*

*What are the sorts of things you find the new graduates need support with the
most in this setting?*

*In an ideal world what sort of changes to the program would you like to see at the
ward level?*

The last question was also posed as an ‘ideal position’ (Merriam, 1998, p. 77) question that
aimed to elicit the participants’ opinions and views on how they would like to see the
structure and content of the rural transitional programs.

### 3.5 Data Collection Procedure

As previously stated, a triangulation of data sources was used in this case study. Data was
collected via a telephone survey, individual interviews with new graduate nurses and
individual interviews with experienced rural nurses. Data collection occurred in two phases
over the 12-month period. The first phase of the study was to conduct an environmental
survey via the telephone that provided a snapshot of the content and structure of the
Transition to Practice Program within the rural health services chosen as sites for this study.
This data was gathered from registered nurses who, at the time of the study, were responsible
for the new graduate nurse Transition to Practice Program within the rural health services and
it was used to supplement and inform the in-depth interview data.

#### 3.5.1 Pilot Telephone Survey

Prior to conducting the telephone survey, the researcher piloted the survey with an
experienced nurse academic who also holds the role of Clinical Nurse Educator at a large
regional health service because she had similar characteristics to the intended respondents of
the survey. Administering a pilot of the survey assisted to refine the questions, identify any
ambiguities and to clarify the wording of the questions (Noor, 2008, p. 1603). It also ensured
that respondents understood the questions in the same way as the researcher intended and
assisted to determine whether the format of the questions was the most suitable for the population thus ensuring the quality of the survey (Parahoo, 2006, p. 309). Feedback obtained from the pilot survey participant regarding the appropriateness and clarity of the questions and the interview technique resulted in the addition of one further question concerning the employment of graduates outside of transitional programs. This question was included to ensure that only new graduate nurses employed on a 12-month graduate nurse Transition to Practice Program were recruited into this study as the pilot survey participant identified that within some health services new graduate nurses were being employed on a casual basis outside of transitional programs.

3.5.2 Pilot Interview for Individual Interviews

The purpose of this study was to obtain descriptions from participants so that an understanding of the support needs of transitioning nurses within the rural environment could be obtained. Thus, individual face-to-face interviews were the main method used for data collection. Face-to-face interviews are considered to be an appropriate data collection tool for qualitative research when the purpose of the research is to uncover participants’ thoughts, perceptions, and feelings regarding an experience (Minichiello, Aroni, Timewell & Alexander, 1999; Schneider, et al., 2013).

The researcher has experience in conducting individual in-depth interviews with new graduate nurses through prior research projects and has developed the required interpersonal skills to engage in open and frank conversations with new graduate nurses. In the abovementioned prior research projects the researcher had trailed the questions for appropriateness and clarity with new graduate nurses in rural health facilities in New South Wales. Thus while the researcher decided not to perform a pilot interview with the new graduate nurse participants in this case study she did ensure, however, that two senior academics and a senior nurse educator reviewed the new graduate nurse interview schedule to ensure appropriateness and clarity of the questions and validated the questions for suitability in line with the research aims.

In December 2010 the researcher decided to conduct a pilot interview with an experienced rural nurse who works closely with new graduate nurses within a large rural hospital. The pilot interview was recorded using a digital voice recorder and the recording was downloaded to the researcher’s personal computer and external hard drive for safe storage. The researcher
transcribed this recording verbatim and these data were included in the final results of the experienced rural nurse data for the study.

The pilot interview served to identify strengths and weaknesses in this aspect of the research plan (Roberts & Taylor, 1998, p. 259) and allowed the researcher to further refine her interview skills so that further experience with the data collection method could be gained (Nieswiadomy, 1987, p. 33). In addition, the pilot study allowed the researcher to identify problems with the data collection method. For example, it allowed her to test for clarity of the questions, to note how long the interview took, and to ensure that ‘the areas covered or the questions asked by the interview… measured what they are supposed to measure’ (Crookes & Davies, 1998, p. 143).

Feedback was gathered from the pilot participant regarding the appropriateness and clarity of the questions, the appropriateness of the setting and interview technique. Notes regarding the pilot interview from the researcher’s journal indicate that the interview was extremely long and that the researcher tended to let the participant wander ‘off track’ with descriptions and stories. This information was then used to refine the questions asked during the subsequent interviews. In the following section, the interview schedules are outlined, followed by a justification for the questions in each schedule.

3.6 Phase One: Environmental Survey

From December 2010 to January 2011, the researcher conducted an environmental survey via the telephone with fourteen rural registered nurses who were responsible for the Transition to Practice Program in rural health services within one area health service in New South Wales. As previously stated the telephone survey took approximately fifteen minutes to complete. The researcher commenced each telephone survey by thanking participants and then reviewing the aims of the study, verbally confirming consent to participate in the study and the right to withdraw at any time should they choose. The final question in the telephone survey invited participation in Phase Two of the study. The environmental survey is attached as Appendix 5.

All of the Registered Nurses invited to participate in this phase of the study completed the telephone survey (n=14). The participants in this phase of the study held positions of: Clinical Nurse Educator, Health Service Educator, Nurse Unit Manager, Health Service Manager and
Deputy Director of Nursing. Table 3.2 (see page 98) provides the location and number of participants from Phase One and Phase Two of the study. Table 3.2 (page 98) provides information of the location and number of participants in this stage of the data collection phase of this study.

### 3.7 Phase Two: Individual Interviews

Following the environmental survey, the second phase of the study included individual in-depth interviews with new graduate nurses and the experienced rural registered nurses employed within the rural health services. Table 3.2 provides information of the location and number of participants in this stage of the data collection phase of this study.

All interviews were conducted in the participants’ own time, and away from their employing facility and clinical area to ensure privacy and confidentiality. The researcher believed that conducting the interviews away from the workplace would reassure the participants that the study was in no way related to the conditions of their employment within that health care facility, and it would also assist the participants in speaking freely about their experiences and their perceptions of support in rural health care services.

Face-to-face individual interviews were conducted in quiet, private locations that had been suggested by each participant, for example, at the participant’s residence. However, two participants resided on properties located some distance from the township and so their interviews were conducted in a quiet location available to the public for example ‘quiet rooms’ within the health service. The researcher also used her office as an interview venue for some participants who had declined to have the interview conducted in their home.

A total of thirty-two interviews, twenty-three with new graduate nurses and nine with experienced rural nurses, were conducted via the telephone because the researcher was unable to organise face to face interviews due to the participants’ rostering arrangements. The telephone interviews were organised at least three weeks in advance and were conducted with the participant using a residential telephone.

At the commencement of each interview the researcher introduced herself and once again outlined the purpose and aims of the research and the interview process. Participants were given a Plain Language Statement (Appendix 6) that provided an outline of the aims and
purpose of the research as well as the names and contact details of the people who were associated with the research such as the researcher’s supervisors. Also included with the Plain Language Statement was a consent form in duplicate. The participants were encouraged to ask questions after reading the Plain Language Statement and prior to signing the consent forms. The participants were informed that the interview would be recorded with a digital voice recorder with their permission.

All interview participants were asked at the commencement of the interview to complete a Participant Profile Sheet (Appendices 7 & 8). The purpose of the Participant Profile Sheet was to collect demographic data related to age and relationship status. For the new graduate participants, data were also collected related to date of commencement of the graduate nurse program, and location and name of the tertiary institution where the graduate had studied. For the experienced rural nurse participants, data were also collected regarding the number of years of experience plus post-graduate qualification. Collecting this information allowed the researcher to obtain a demographic profile of the interview participants that is used to describe the samples for this case study (LoBiondo-Wood & Haber, 2010, p. 277).

For the individual interviews conducted via the telephone, a covering letter (Appendix 9), the Plain Language Statement, the Participant Profile Sheet, and two Consent Forms plus a reply paid envelope were mailed to each of the telephone interview participants, with instructions to keep one Consent Form for their personal records. Upon receipt of the signed Consent Form and the Participant Profile Sheet, the researcher once again made contact with the participants to confirm the date and time of their interview. The day before the scheduled interviews the researcher telephoned or sent an SMS message to the participants to remind them of the arrangements, and to see if the participants had any questions.

### 3.8 Individual Interviews with New Graduate Nurses

There were a total of forty-two interviews conducted with the new graduate nurses between the months of April and December 2011 with an interview schedule for each of three interview rounds. The interviews were conducted at time intervals of three-four months, six-seven months and ten-eleventh month and each interview lasted between 30-60 minutes. Data collection ceased for the new graduate participants once the third interview at the 10-11 month time was completed.
This timeframe for this data collection is consistent with Duchscher’s (2008) Stages of Transition Theory (2008, p. 443), as discussed in Chapter Two. Also, Johnstone et al. (2008, p. 52) identify that the first four weeks and the beginning of each clinical rotation, are significant milestones for the provision of support in the graduate nurses’ transition year. The researcher believed that by commencing the interviews following completion of the first three months of employment, the graduates would have settled into their new positions and subsequent interviews would capture experiences from clinical rotations.

Sixteen new graduate nurses agreed to participate in the first round of interviews in this study. However, only fifteen interviews were conducted in the first interview round as one participant withdrew from the study just prior to the date of the scheduled interview. The interviews in this round were quite lengthy, lasting for approximately one hour, because this is where the majority of data collection occurred. The second and third interviews were thirty to forty minutes in length and participants at this time were clarifying and adding any new information since their last interview. Fourteen participants were interviewed for the second round of interviews as one participant did not make the appointment for the second interview and the researcher had several failed attempts at trying to contact her. For the third and final interview round there were thirteen participants as one graduate had left the Transition to Practice Program for more permanent employment and so withdrew from the study.

The longitudinal nature of the data collection method for the new graduate nurse participants had the advantage of allowing the researcher to study the phenomenon of support over time with the same sample of new graduate nurses. By conducting the interviews with new graduate nurses at intervals throughout their transition the researcher was able to capture any changes that may have taken place in their perceptions of support requirements and or their experience of the provision of support throughout the Transition to Practice Program (Schneider et al., 2013, p. 171; Parahoo, 2006, p. 189). Thus it was important to ensure retention of the new graduate nurse participants in the study. According to Schneider et al. (2013, p. 171), a disadvantage of using a longitudinal design is the ability to re-recruit and re-sample precisely the same people at each stage of the data collection. The loss of participants during the course of a study is called attrition (Polit & Hungler, 1999, p. 695). Two ways attrition can occur are through discontinued participation in the study and/or a lack of success in re-contacting participants for follow up in the study (Young, Powers & Bell, 2006). To reduce attrition of the new graduate nurse sample in this study the researcher used strategies
of sending messages via mobile phones and via email and also used face-to-face contact that assisted with retaining the sample of graduates in this study. For example the researcher sent all new graduate participants messages via SMS one week before their scheduled interview, one day prior to each interview and on the day of their interview to remind them of the appointment. In addition, the researcher sent an email message at the completion of each individual interview thanking the new graduate for their participation and reminding them of the date for the next interview. In between each interview round, the researcher maintained contact via face-to-face interactions during visits to clinical agencies as part of her role as Clinical Coordinator. If the researcher was unable to make contact with the new graduate participants during the site visits she sent a friendly email to participants that inquired after their wellbeing and reminding them of their next interview appointment. These strategies to maintain the sample were effective because attrition was low in this study.

3.9 Individual Interviews with Experienced Rural Registered Nurses

There were sixteen interviews with experienced rural nurses that occurred between December 2010 and December 2011 that also lasted for between 40-60 minutes. To protect the privacy and confidentiality of participants and to ensure that the focus of the conversations was focused on support rather than individual new graduate nurse performances within the rural health services, these interviews were conducted prior to or at the completion of the graduate nurse Transition to Practice Program. Thus the majority of the interviews with the experienced rural nurses were conducted before the new graduate nurses commenced their Transition to Practice Program in December 2010 and January 2011 and the remainder were conducted in December 2011 when many of the Programs were coming to a close.

A recursive method of questioning was used with the experienced rural nurse interviews that enabled the researcher to treat each participant and their situation as unique, allowing the researcher to change or modify the interview technique because of information gathered from previous interviews. The interviews continued in this way, until the researcher recognised that during the fifteenth interview and throughout the sixteenth interview, no new data was emerging, rather the information from participants was becoming repetitive, and thus it was deemed that data saturation had been reached, and no further interviews with experienced rural nurses were conducted (Beanland et al., 1999, p. 281).
Table 3. 2 Location and Number of Participants in Case Study

<table>
<thead>
<tr>
<th>Setting</th>
<th>Site</th>
<th>Survey Participants</th>
<th>New Graduate Nurse Participants</th>
<th>Rural Registered Nurse Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large rural</td>
<td>1</td>
<td>Clinical Nurse Educator</td>
<td>4 *</td>
<td>2 Nurse Unit Managers 1 Clinical Nurse Educator 1 experienced RN</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Health Service Educator</td>
<td>1 **</td>
<td>1 Health Service Educator</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Clinical Nurse Educator</td>
<td>1</td>
<td>1 Clinical Nurse Educator</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Health Service Educator</td>
<td>2 ***</td>
<td>1 Health Service Educator</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Nurse Unit Manager</td>
<td>2</td>
<td>2 Nurse Unit Managers 2 experienced RNs</td>
</tr>
<tr>
<td>Small rural</td>
<td>6</td>
<td>Health Service Manager</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Health Service Manager</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Health Service Manager</td>
<td>1</td>
<td>1 Clinical Nurse Manager</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Clinical Nurse Educator</td>
<td>1</td>
<td>1 Clinical Nurse Educator 1 experienced RN/RM</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Deputy Director Nursing</td>
<td>0</td>
<td>1 Deputy Director Nursing</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Health Service Manager</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Health Service Manager</td>
<td>1</td>
<td>1 Health Service Manager</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Health Service Manager</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Health Service Manager</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total
15 NG commenced
13 NG completed
Total
16 experienced RN’s

*1 withdrew after 2nd interview  **1 withdrew before 1st interview  ***1 withdrew after 1st interview
3.10 Researcher’s Journal

For two major reasons the researcher kept a journal throughout the study and in particular during the data collection stage. Yin (2009, p. 122) states that to increase the reliability of the information in a case study the researcher must maintain a chain of evidence so that an external observer can follow the case study from the initial research questions through to the case study conclusions. In this study the journal was used to record handwritten case study notes regarding all aspects of the research process. Thus the researcher’s journal forms part of the ‘chain of evidence’ (Yin, 2009, p. 120) for this case study.

Second, keeping a reflective journal assisted the researcher during Phase Two of the data collection. For example, when conducting the individual in-depth interviews, the journal served to guide and refine the inquiry process to ensure that the data obtained were rich and focused on the participants’ account of the experience rather than the researcher’s perspective. As well, the journal was kept so that notes could be made by the researcher regarding important information such as facial expressions, details of the setting and perceptual impressions and also speculation regarding themes and connections between data that were ‘invisible’ to the tape recorder during the interviews (Minichiello et al., 1999, p. 216).

In addition, the journal allowed the researcher to make decisions regarding subsequent interviews. For example, the researcher made notes regarding changes to interview techniques, and the interview schedule for subsequent interviews to ensure that the information obtained was relevant to the topic under investigation and focused on the participants’ experience. In the interviews with the experienced rural nurses the journal notes assisted with recognising when data saturation was reached, that is, when no new information was emerging.

3.11 Data Analysis

3.11.1 Phase One: Data Analysis Procedure for the Environmental Survey

The researcher undertook content analysis of the responses to the Survey collected in Phase One of the data collection. LoBiondo-Wood and Haber (2013, p. 275) describe content analysis as a method of analysing word responses to questions by counting similar responses and grouping the responses into themes or categories. In analysing the responses to the survey, content analysis of each item of the closed-ended questions was undertaken. This
process of counting similar responses enabled ‘the objective, systematic and quantitative description of the manifest content’ (Polit & Hungler, 1999, p. 2019) of the surveys. For the open-ended items, the researcher followed a process of conventional content analysis as outlined by Hsieh and Shannon (2005, p. 1284). These authors state that conventional content analysis is useful for data collected primarily through interviews and open-ended questions.

The summarised process involves reading all data repeatedly, highlighting words or text that captures thoughts or concepts, making notes of initial thoughts and impressions, labelling and organising data into categories.

3.11.2 Phase Two: Data Analysis Procedure for the Individual Interviews for New Graduate Nurses and Experienced Registered Nurses

The data analysis procedure for Phase Two of data collection consisted of several steps. First, the digital recordings were downloaded to the researcher’s computer as sound files and duplicated on a separate laptop computer and also onto an external hard drive device. Each digital recording was allocated an identifying code number with the date, time and location of interview to enable reliable management of the data because it was not always possible for the researcher to immediately analyse or process the data gathered (Huberman & Miles, 1998, p. 183). Second, the interviews were transcribed verbatim and due to the time constraints of the researcher and the quantity of data to be typed the researcher transcribed some recordings and some were transcribed by a separate external transcribing service employed for that purpose. Braun and Clarke (2006, p. 88) suggest that thematic analysis requires a rigorous and thorough ‘orthographic’ verbatim account and the transcribed material needs to retain the information from the verbal account in a way that was ‘true’ to its original nature. In this study to ensure that the transcribed data received from the external transcribing service were true to their original nature, the researcher spent time familiarising herself with the audio and transcribed data, checking each transcript against the original audio data (Braun & Clarke, 2006, p. 88) to ensure a verbatim account. The researcher checked each transcription for accuracy against the relevant sound file and any errors were corrected. When transcribing the interviews and when reviewing the externally transcribed material the researcher cleaned the data for punctuation and grammar to assist with reading and presentation of the data. Also, to ensure confidentiality and privacy the researcher removed any names of persons or agencies that participants may have referred to during the interview.
The data analysis method deemed appropriate for this study was thematic analysis as described by Braun and Clarke (2006). Thematic analysis is an analytic method that is compatible with constructionist paradigms of inquiry (Braun & Clarke, 2006, p. 102). These authors state that this analytical method ‘will allow the examination of the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society’ (Braun & Clarke, 2006, p. 81). It is a method that will allow the researcher to play an active role in identifying patterns and themes, selecting the ones of interest and thus reporting on them (Taylor & Usher, 2001 cited by Braun & Clarke, 2006, p. 81). A theme is defined in this analytical method as capturing something important about the data in relation to the research question that represents a patterned level of response or meaning within sets of data (Braun & Clarke, 2006, p. 82). Thematic analysis can provide rich descriptions of an entire data set or it can provide a detailed account of a group of themes that relate to a specific question and an area of interest within and across the whole data set. In this study the aim of thematic analysis was to provide a detailed, distinct account of an aspect of the data that relates to support required in the role transition to professional practice in the rural context. According to Braun and Clarke (2006, p. 84), in this method of analysis themes can be developed at a semantic/explicit level or at a latent/interpretive level. Themes identified in this study will go beyond a description where the data are organised and summarised to show patterns, to include a latent or interpretive approach, where the researcher attempts to theorize the significance of the patterns, their broader meaning and implications (Braun & Clarke, 2006, p. 84). Thematic analysis as described by Braun and Clarke (2006, p. 87) involves six phases of: familiarizing with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing a written report. How each of these six phases of thematic analysis were employed in this study will be described in more detail in Chapter Four where the findings of this case study will be presented.

3.12 Ethical Considerations

Ethical approval for this study was sought and granted from the Charles Darwin University’s Human Research Ethics Committee prior to the commencement of the study (Approval Number H10053). In addition approval was granted from the University of Canberra’s Human Research Ethics Committee. Included in the ethics application were the combined Plain Language Statement and Participant Consent Forms, the Environmental Survey and the
This research study was guided by Charles Darwin University’s Human Research Ethics Committee Guidelines (2008) as well as the University of Canberra’s Human Research Ethics Committee Guidelines that comply with the established guidelines, on *Ethical Conduct in Human Research*, specifically The *National Statement on Ethical Conduct in Human Research* (2007) (National Health and Medical Research Council, 2009). These guidelines aim to ensure that the welfare and rights of participants in research are protected (National Health and Medical Research Council, 2009). They aim to prevent or reduce the potential risk of physical harm, as well as the risk of social harm that includes the privacy and reputation of participants involved in research (Parsons, 1999, p. 77). The participants in the study were all volunteers who at no time during the study were under any pressure to participate. The participants were not considered to be part of a special population or cultural group that may have been at risk because of their vulnerability or inability to provide an informed consent (Parsons, 1999, p. 86), but were capable of providing a voluntary informed consent. Participants were not offered any financial reward or compensation for their participation in this study.

### 3.12.1 Phase One: Environmental Survey

The researcher initially approached potential participants for Phase One of this study whilst visiting rural health services in northern NSW. To obtain an informed consent from each participant the researcher provided two copies of the Plain Language Statement and the consent form (Appendix 9) written in plain and accessible language. The Plain Language Statement outlined the aims and purpose of the study; duration of the participant’s involvement; a description of the procedure; confidentiality of records as well as names and numbers for contacts should the participant have any queries or require clarification. In addition, a statement clarifying the participant’s right to withdraw from the study at any time, without penalty or prejudice and the right to confidentiality and privacy was included. The information and consent form also advised each participant that their name would be kept confidential and that only the researchers (the researcher and the principal supervisor) named on the consent form would have access to the survey information. The information and consent forms further provided, the participant with the names and contact details of the researcher, her principal supervisor and the Charles Darwin Human Research Ethics
Committee Officer for any questions, complaints or praise the participants may have regarding the research or for information regarding participants rights. Participants in the current study indicated their willingness to participate by signing the informed consent, which stated they had read and understood the information provided and that all questions had been answered to their satisfaction. A stamped addressed envelope was included with the participant information and consent forms so that one copy of this form could be signed and returned to the researcher. The second copy was retained by the participants for their future reference and information. After receiving the signed consent form the researcher contacted the potential participants by telephone or by email, to discuss a mutually convenient date, time and location to conduct the telephone survey.

3.12.2 Phase Two: Individual Interviews

The researcher also initially approached potential participants for Phase Two of this study, the individual interviews with new graduate nurses and experienced rural nurses, whilst visiting rural health services in northern NSW. The researcher followed the same procedure for acquiring informed consent for potential participants in Phase Two of the study, as those outlined above for Phase One. That is, each participant was provided two copies of the Plain Language Statement and consent form (Appendix 9) that outlined the aims and purpose of the study; duration of the participant’s involvement; a description of the procedure; confidentiality of records as well as names and numbers for contacts should the participant have any queries or require clarification. In addition, a statement clarifying the participant’s right to withdraw from the study at any time, without penalty or prejudice and the right to confidentiality and privacy was included. The information and consent form also advised each participant that with their permission the interview would be digitally recorded, their name would be kept confidential and that only the researchers (the researcher and the principal supervisor) named on the consent form would have access to the interview recordings and interview transcriptions. The information and consent form further provided the participant with the names and contact details of the researcher, her principal supervisor and the Charles Darwin Human Research Ethics Committee Officer for any questions, complaints or praise the participants may have regarding the research or for information regarding participants rights. Participants in this Phase of the study indicated their willingness to participate by signing the informed consent, which stated they had read and understood the information provided and that all questions had been answered to their satisfaction. A stamped addressed
envelope was included with the participant information and consent forms so that one copy of this form could be signed and returned to the researcher. The second copy was retained by the participants for their future reference and information.

After receiving the signed consent form the researcher contacted the potential participants by telephone or by email, to discuss a mutually convenient date, time and location to conduct each interview. The researcher acknowledged that the nature of the information concerning the participants’ experience of the phenomena of support for new graduates during the transition into rural practice could prove uncomfortable and emotionally distressing to the participants. Thus, the individual interviews were held in quiet, private areas away from the employing agency at a location nominated by the participant. This helped to ensure confidentiality for the participant. The researcher further explained that any identification of the participant’s name or the health facility would not be included in the transcriptions. The researcher coded the tapes and allocated a pseudonym to the transcriptions, to further ensure confidentiality for the participant.

The researcher informed all participants in each phase of the study that dissemination of the study results in subsequent journal articles or conference papers would contain no identifying information. Participants were also informed that all survey data, transcriptions, Consent Forms and Participant Profile Sheets, would be stored in a locked filing cabinet in the researcher’s office for a period of five years and that all electronic data such as digital recordings, would be kept in the researcher’s password protected computer. Participants were informed that all data would be accessed only by the researcher and her supervisors, in accordance with the NH&MRC Guidelines (2009), and that after a five-year period they would be destroyed.

3.13 Rigour and Trustworthiness of the Study

Parahoo (2006, p. 410) outlines several measures that must be adopted by researchers to ensure rigour and trustworthiness of qualitative research. These measures include ensuring that the work has ‘credibility or truth value’ (Parahoo, 2006, p. 410). That is, the data are a true reflection of the participants’ understanding of the phenomenon under study. In addition, the research must have auditability, and/or consistency. That is, to what extent did the researcher make clear their actions to the reader in reporting on the research and also the extent to which those actions can be recognised as logical and consistent? Additionally, the
research must have *confirmability*, that is, the data presented is recognisable by the research participants as their own views, serving to confirm the researcher’s neutrality (Parahoo, 2006, p. 410). Finally, Parahoo (2006, p. 410) states that the research must demonstrate *transferability*, that is, the extent to which the findings can be of use to other populations or settings similar to those in the study. These measures will now be discussed in relation to the strategies utilised by the researcher to ensure that rigour and trustworthiness were achieved.

To ensure rigour and trustworthiness in this study the researcher first used a research design that was consistent with qualitative methods (Casey & Houghton, 2010), and the research process has been outlined in detail in this chapter. Second, to ensure credibility of the data, the researcher purposively recruited study participants who met the inclusion criteria, that is, new graduates who were employed in a rural Transition to Practice Program and experienced rural nurses who worked with the new graduate nurses within the rural setting.

To ensure confirmability and neutrality the researcher adopted several strategies that are consistent with qualitative research methods. First, the researcher kept a journal that served as a chain of evidence and assisted in Phase Two of the data collection to focus on the participants’ account of the experience rather than the researcher’s perspective. Second, the researcher ensured that the interview data was transcribed verbatim and was validated by participants and by experts such as the researcher’s principal supervisors. The interview transcripts from the experienced rural nurses were returned to them for validation and participants were invited to make any changes or corrections. Formal validation or member checking of the interview transcripts for the new graduate nurses posed practical problems because of the longitudinal nature of the data collection process. Thus, at the beginning of the second and third interview rounds with the new graduate nurses, the researcher provided an informal verbal synopsis of the content of their previous interview. Participants were asked to comment if the researcher’s understanding was a true representation of the interview and if there was anything they wished to add or change. Third, the developed themes from the data were verified by the researcher’s principal supervisors as being applicable and relevant to the context of the research.

Buchbinder (2010, p. 107), quotes Lincoln and Guba (1995) stating that ‘member checking is a crucial technique for establishing credibility’ in qualitative research. Thus, member-checking strategies were used as a further measure to ensure credibility in this study. Member
checking involves the researcher returning the data analysis and the researchers emerging findings (Polit & Hungler, 1999, p. 429) to participants to ensure accuracy and to confirm that the interpretation of the data is in keeping with what participants meant. Cho and Trent (2006, p. 322) state that member checking occurs throughout the inquiry process where collected data are returned to participants for accuracy and reactions. However, Buchbinder (2010, p. 107) adds that the data analysis may also be returned to participants via a validation interview to allow them to check the researchers’ analytical categories and interpretations, to confirm, substantiate, verify or correct the researchers’ findings. In this study it was not practical nor was it possible to meet with all participants for a validation interview because of the geographical distances and also because many of the new graduate nurses had since completed their graduate nurse program and had left the rural area at the time of the data analysis. Thus to overcome this the researcher either sent by post or by email a condensed report of the data analysis that included a discussion of the major themes and sub-themes to a sample of ten participants that included five new graduate nurses and five experienced rural nurses for them to make comment should they choose. Two new graduate nurses and three registered nurses replied via email to verify the researcher’s analytical categories and interpretations, and confirmed the researcher’s findings as accurate.

The extent to which the findings from the data can be transferred or generalised to other groups is concerned with the sampling and design of the study where there must be sufficient descriptive data in the research report so that its applicability to other contexts can be evaluated (Polit & Hungler, 1999, p. 430). In this study the use of thick descriptions, that is, rich and thorough descriptions of the research setting, context and the processes and transactions observed during the study (Polit & Hungler, 1999, p. 430) have assisted to establish transferability.

Finally, when using a case study research design, Yin (2009, p. 43) specifically recommends utilising triangulation of data sources, as used in this study, as an approach to ensure reliability and credibility.
3.14 Methodological Issues and Limitations

The researcher acknowledges that there were two main limitations in this study. First, this study was conducted in only fourteen rural towns of northern NSW and therefore is not representative of the new graduate nurse or the experienced rural registered nurse populations in rural areas in this state and second, the sample sizes were small.

While the study was conducted in one Area Health Service in NSW it was not the intention of the researcher to make statistical conclusions, or to generate or construct theories that could be generalised either to the new graduate nurse population in rural practice or to the experienced rural registered nurses. Rather, the aims of the study required collecting specific subjective data regarding the participants’ experience and perceptions of support during the transition to practice for new graduate nurses within the rural practice context.

It could be viewed by the reader that a limitation of this study was that all the data were collected and interpreted for this study by a single researcher, who had prior involvement with many of the participants because of her role as a Clinical Coordinator within a regional university. However, as stated above, the researcher adopted several measures to ensure neutrality, credibility and trustworthiness of the data. The researcher also assured participants at the commencement of each interview that she was only interested in exploring their experiences of support in their transition to practice purely from a research perspective and she encouraged the participants to speak freely about any issues, which they felt impacted on their experience of support thus far. Additionally, the researcher had for many years previously been a rural nurse, and so had experienced social and cultural environments similar to those the graduates and experienced registered nurses were experiencing. Thus, the researcher’s experience informed her awareness and understanding of the experiences of the graduate nurses and the experienced rural nurses within this study.
3.15 Conclusion

This chapter commenced with a justification of the research paradigm, the research design and the methodology utilised in this study. A qualitative design using a case study approach was demonstrated most appropriate.

The chapter then identified the research methodology including the setting, samples, and data collection procedures used in the two phases of the data collection. The interview schedules were presented and discussed and the means of addressing the ethical issues relating to the participants were presented. Finally, methodological issues and limitations were identified. The following chapter will present the data analysis and identify the themes and subthemes that emerged from the data.
CHAPTER FOUR

Data Analysis

4 Introduction

Chapter Four presents an interpretation of the data collected from the research study that explored the experience of support during the transition from student nurse to new graduate nurse within a Transition to Practice program in rural practice settings. First, an explanation and justification of the data analysis procedures that were used for this study are presented. Second, the presentation and discussion of Phase One of data collection, the environmental survey will be presented. Following this will be the presentation and discussion of Phase Two of data collection, that is, the individual interviews with new graduate nurses and experienced rural nurses. Demographic data for the new graduate respondents is first provided followed by a presentation and discussion of the findings from the analysis of the taped and transcribed interviews conducted at intervals of three-four months, six-seven months and eleven-twelve months with the new graduate nurses. Finally, the demographic data and discussion of the findings from the analysis of the taped and transcribed interviews conducted with experienced rural registered nurses who worked alongside new graduate nurses at the time of the study is provided.

A qualitative exploratory, descriptive case study approach to the study was used to gain an in-depth understanding of the nature and meaning of support during the role transition, within the context of a Transition to Practice Program in rural nursing practice. Thus, the overall aim of the study was to explore the nature and timing of support that is required in the first year of practice for the safe transition of the new graduate nurse into the rural nursing workforce. In exploring the phenomenon of support for new graduate nurses in rural practice the researcher sought to address the following research questions:
- What are the new graduate nurses’ perceptions and experiences of support throughout a rural Transition to Practice Program?
- What are the experienced rural nurse’s beliefs, perceptions and experiences of the nature and timing of support provided to new graduates during a Transition to Practice Program that would provide for a ‘safe’ and supportive transition in a rural health setting?
- What functional elements should be included in a rural Transition to Practice Program?

The first section of this chapter presents the results of Phase One of the study, which was to conduct an environmental survey in the form of a researcher administered telephone survey. The environmental survey aimed to provide a profile of the content and structure of the new graduate programs within rural health facilities that met the inclusion criteria as sites for this study. The data gathered by the environmental survey assisted the researcher to identify potential sites and participants for this study and also supplemented and informed the in-depth interview data from both the new graduate and the experienced rural nurse participants in this study.

4.1 Justification of the Data Analysis Technique for the Environmental Survey of the Potential Study Sites

The researcher undertook content analysis of the responses to the questions within the environmental survey. As described by LoBiondo-Wood and Haber (2010, p. 275) content analysis is a method of analysing word responses to questions by counting similar responses and grouping the responses into themes or categories. Eight categories were identified from the survey data. They are: Employment of New Graduate Nurses within the Rural Transition to Practice Programs Responsibility for the Rural Transition to Practice Program, Structured Clinical Rotations within the Rural Transition to Practice Program, Formal Employee Orientation and Induction within the rural Transition to Practice Program, Formal Education Activities within the Rural Transition to Practice Program, Supernumerary Days within the Rural Transition to Practice Program, Model of Structured Support within the Rural Transition to Practice Program and Performance Evaluation of New Graduate Nurses within the Rural Transition to Practice.
Conducted in December 2010 and January 2011, fourteen registered nurses (RN) responsible for the Transition to Practice Program within the fourteen health services chosen as sites for this case study completed the telephone survey. This included five large rural health services and nine small rural health services. As previously stated the environmental survey provided initial data that would inform the sampling frame for the new graduate nurse participants in this research. For example it was learned that three sites (S10, S13, and S14) at the time of the telephone survey had not filled new graduate positions that were to commence in February 2011, thus no new graduate participants were recruited from these sites.

In addition, the environmental survey provided information regarding the current structure and content of the rural Transition to Practice Program and the context in which these programs are delivered. This information was important to gather for two reasons. First, the case in this case study is the rural Transition to Practice Program and the data will provide important detailed information concerning the program within the sites for this case study. Second, past studies have highlighted concerns regarding the effectiveness of graduate nurse programs, specifically whether they deliver what they are supposed to deliver. For example, Lea and Cruickshank (2007) highlighted that new graduates have unmet expectations of rural graduate nurse programs. In addition, Lea et al. (2008) highlighted the concerns of final year nursing students regarding the ability of rural health agencies to meet expectations for graduate nurse programs. Thus, the information gleaned from the environmental survey regarding structure, content and implementation of these support programs informed topic areas for the in-depth individual interviews with participants in this study allowing comparisons to be made regarding expectations and experiences of the provision of support throughout the rural Transition to Practice Program.

A further advantage of conducting the environmental survey was that the information gleaned informed the development of questions pertaining to demographic data collected from new graduate participants. For example, the survey conversations revealed that some agencies had previous experiences with new graduates who were not familiar with rural nursing practice, had never visited nor resided in a rural area of Australia and, whose first language was not English. Thus, questions regarding secondary education and English as a first language as well as past clinical experiences in a rural practice area were included when collecting demographic data pertaining to the new graduate participants.
4.2 Phase One: Results and Profile of the Rural Transition to Practice Programs

The environmental telephone survey was conducted at 14 rural health sites. See Chapter Three for the selection criteria, demography of the sample of the experienced rural nurses and justification for the data collection method. Each participant was asked at the completion of the survey for permission for the researcher to recontact them for an in-depth interview at a later date. Table 4.1 provides a profile of the content and structure of the rural Transition to Practice Programs within the rural health services of this case study.

Table 4.1: Profile of Rural Transition to Practice Programs

<table>
<thead>
<tr>
<th>Large Rural Health Service</th>
<th>Structure and Content of Rural Transition to Practice Programs (TPP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-200 beds</td>
<td></td>
</tr>
</tbody>
</table>

Site L1
- 6 NGN positions (also NGN employed casually), HSE responsible for TPP
- 3 days orientation/induction, clinical rotations every 3 months (medical/surgical/paediatrics/mental health)
- 3 onsite study days, mandatory skills learning package
- *2-5 supernumerary days initially and 1 day each rotation, mentor model
- Performance evaluation every 3 months by NUM

Site L2
- 1 NGN position, HSE responsible for TPP
- 5 days orientation/induction (includes 1 day offsite at large regional site)
- Rotate between medical/surgical areas, 8 week elective in OT or ED
- 6 offsite study days, mandatory skills learning package
- 3 weeks supernumerary, preceptor/mentor allocation for 3 weeks then buddy system
- Performance evaluation every 3 months by NUM

Site L3
- 2 NGN positions (includes 1 mid year), CNE responsible for TPP
- 3 days orientation/induction on site
- Rotate between medical/surgical areas, 8 week elective in OT, ED or community
- 10 study days on and off site, mandatory skills learning package
- 2 weeks supernumerary, no structured ward support buddy system
- Performance evaluation by HSM (no timeframe)

Site L4
- 1 NGN position, NUM responsible for TPP
- 5 days orientation/induction (1 day at large regional site)
- Rotate between medical/surgical areas, 8 week elective in either OT, aged care or community
- 9-10 study days at other large rural site, mandatory skills learning package
- 5 days supernumerary, no structured ward support buddy system
- Performance evaluation every 3 months by NUM

Site L5
- 2 NGN positions (1 mid year), HSE responsible for TPP
- 5 days orientation/induction (1 day offsite at large regional site)
- Rotate between medical/surgical areas, 12 week elective OT or ED
- 10 study days at metropolitan site, mandatory skills learning package
- *5 days supernumerary then 1 day per elective rotation
- Mentor model
- Performance evaluation every 3 months by NUM
<table>
<thead>
<tr>
<th>Small Rural Health Service</th>
<th>Structure and Content of Rural Transition to Practice Programs (TPP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-50 beds</td>
<td></td>
</tr>
<tr>
<td><strong>Site S6</strong></td>
<td>• 1-2 NGN positions, HSM responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 3 days orientation/induction (2 days at other large rural health service)</td>
</tr>
<tr>
<td></td>
<td>• No rotations (combined medical/surgical/aged care/ ED attached)</td>
</tr>
<tr>
<td></td>
<td>• 3 study days at large regional site, no learning package</td>
</tr>
<tr>
<td></td>
<td>• 2 days supernumerary, no structured ward support</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by HSM (no timeframe)</td>
</tr>
<tr>
<td><strong>Site S7</strong></td>
<td>• 1 NGN position, NUM responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 5 days orientation/induction (2 days at large regional health service)</td>
</tr>
<tr>
<td></td>
<td>• No rotations (combined medical/surgical/aged care/ ED attached)</td>
</tr>
<tr>
<td></td>
<td>• 4 study days at large regional site, no learning package</td>
</tr>
<tr>
<td></td>
<td>• No supernumerary days, no structured ward support-buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by NUM at 3 &amp; 6 months</td>
</tr>
<tr>
<td><strong>Site S8</strong></td>
<td>• 2 NGN positions, CNM responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 5 days orientation/induction (1 day at large regional site)</td>
</tr>
<tr>
<td></td>
<td>• No rotations -combined medical/surgical</td>
</tr>
<tr>
<td></td>
<td>• 8-10 offsite study days, no learning package</td>
</tr>
<tr>
<td></td>
<td>• 5 days supernumerary, no structured ward support-buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by NUM at 6 &amp;12 months</td>
</tr>
<tr>
<td><strong>Site S9</strong></td>
<td>• 1 NGN position, HSM responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 3 days orientation/induction (1 day offsite at large rural health service)</td>
</tr>
<tr>
<td></td>
<td>• No rotations-combined medical/surgical (may rotate to other rural site for general medical/surgical/ community if desired by NGN)</td>
</tr>
<tr>
<td></td>
<td>• 5 study days at large regional site, no learning package</td>
</tr>
<tr>
<td></td>
<td>• 1 day supernumerary, no structured ward support-buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by NUM at 3 &amp; 6 months</td>
</tr>
<tr>
<td><strong>Site S10</strong></td>
<td>• *2 NGN positions (not offered ever year), DDON responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 3 days orientation/induction at large regional health service</td>
</tr>
<tr>
<td></td>
<td>• No rotations -combined medical/surgical (*may rotate to large regional site for medical/surgical/ED, OT, ICU)</td>
</tr>
<tr>
<td></td>
<td>• 8 study days at regional site, mandatory skills learning package</td>
</tr>
<tr>
<td></td>
<td>• 1-2 days supernumerary, no structured ward support-buddy system</td>
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<tr>
<td></td>
<td>• Performance evaluation by NUM at 3 &amp; 6 months</td>
</tr>
<tr>
<td>(MPS) &lt;30 beds</td>
<td></td>
</tr>
<tr>
<td><strong>Site S11</strong></td>
<td>• 1 NGN position, CNS responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 2 days orientation/ induction (at large regional site)</td>
</tr>
<tr>
<td></td>
<td>• No rotations (combined medical/ surgical/ED attached)</td>
</tr>
<tr>
<td></td>
<td>• 4-5 study days at large regional site, no learning package</td>
</tr>
<tr>
<td></td>
<td>• 5 days supernumerary, no structured ward support- buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by HSM at 3 &amp; 6 months</td>
</tr>
<tr>
<td><strong>Site S12</strong></td>
<td>• 1 NGN position, HSM responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 5 days orientation/induction (at 2 other large rural sites)</td>
</tr>
<tr>
<td></td>
<td>• No rotations combined aged care/acute/ED</td>
</tr>
<tr>
<td></td>
<td>• 5 study days at 2 other large rural sites, no learning package</td>
</tr>
<tr>
<td></td>
<td>• 5 days supernumerary, no structured ward support- buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by HSM at 3 &amp; 6 months</td>
</tr>
<tr>
<td><strong>Site S13</strong></td>
<td>• 1 NGN position, CNS responsible for TPP</td>
</tr>
<tr>
<td></td>
<td>• 5 days orientation/ induction (at large rural site)</td>
</tr>
<tr>
<td></td>
<td>• No rotations, combined aged care/acute/ED attached</td>
</tr>
<tr>
<td></td>
<td>• 10 study days at 2 large rural sites, mandatory skills learning package</td>
</tr>
<tr>
<td></td>
<td>• 2 days supernumerary, no structured ward support- buddy system</td>
</tr>
<tr>
<td></td>
<td>• Performance evaluation by CNS (no timeframe)</td>
</tr>
</tbody>
</table>
4.2.1 Category One: Employment of New Graduate Nurses within the Rural Transition to Practice Program

All of the Transition to Practice Programs in the selected agencies commenced in February 2011, with all of the positions offered within the Transition to Practice Programs for fulltime employment only.

At the time of the study, most sites employed one to two new graduates per year within a graduate nurse transition program. However, one site, (L1) had six graduate nurse positions per year and this facility was also the only site to offer employment to new graduate nurses within the casual staffing pool.

Two agencies (L3 and L5), as well as having February positions available, also had positions that commenced mid year. However, at the time of the study, the mid year positions had not been filled.

4.2.2 Category Two: Responsibility for the Rural Transition to Practice Program

In terms of responsibility for the Transition to Practice Programs, the Clinical Nurse Manager or Health Service Manager was responsible most commonly, at the smaller agencies. Two agencies (L1 and L2) had Health Service Educators whose roles included the development and implementation of the Transition to Practice Program for new graduate nurses, as well as education for all health service staff including medical, allied health, nursing and any other staff on site. Two sites (L3, S13) had senior Registered Nurses that were responsible for the program, one of whom held the position of Clinical Nurse Specialist. At one site (S10) the Deputy Director of Nursing was responsible and at the time of the telephone survey, one site (L3) had a part-time Clinical Nurse Educator who was responsible for the program. Two other sites (S9 and S8) indicated that a part-time Clinical Nurse Educator would be commencing in
the future who would have responsibility across several sites for the graduate nurse Transition to Practice Programs.

4.2.3 Category Three: Structured Clinical Rotations within Rural Transition to Practice Programs

Results of the content analysis showed that of the nine small rural health agencies only two (S9 and S10) offered structured rotations to other larger health services because the capacity of the health service was limited to general medical/aged care clinical areas. However, all of the nine agencies had Emergency Departments attached to the acute section of the health service where the new graduates could spend the occasional shift or part of a shift when they were more established in their graduate year. Three of these small rural services (S6, S8 and S9) were also able to offer one or two days experience per week or per month in operating and recovery room areas for day surgery cases.

Within the five large rural health services three (L2, L4 and L5) offered new graduates to rotate to other smaller rural sites as part of the Transition to Practice Program. The length of these offsite rotations is generally between one and three months to gain community nursing experience. As well the graduate could rotate to a larger regional site for experience in surgical, paediatrics or, for example, for an elective in other clinical areas such as high dependency or mental health if they desired. Such rotations were not always strictly enforced at some sites as needs and arrangements for staffing dictated the availability.

Four of the fourteen sites (L3, L4, L5 and S9), offered rotations to community health as part of the TPP. This included one small rural site (S14) that offered it as an extra to their general medical/aged care experience if staffing arrangements allowed. This rotation to community health was for a short period, usually a couple of weeks towards the end of the graduate year.

Six sites offered structured clinical rotations. Five of these were large rural sites with only one site (L1) having the capacity to offer inpatient paediatrics and mental health rotations as part of the usual Transition to Practice Program. One small rural health service (S9) offered rotations to a larger regional health service. All of the six sites offered an elective rotation to areas such as emergency department, operating and recovery room and high dependency units. One site (L1) offered an elective in a renal unit and another site (L2) offered a two-
week elective in maternity only if there was no student midwife on clinical placement at the time.

4.2.4 Category Four: Formal Employee Orientation and Induction within the Rural Transition to Practice Programs

Findings showed that arrangements for conducting orientation programs within the rural agencies were sometimes complicated. The only commonality for all sites was that the initial orientation period allocation was for one week. Many of the rural Transition to Practice Programs had all or part of an orientation program conducted at other sites, where the length of time the new graduates from rural agencies attended varied. For example, the small rural health services sent their new graduates to larger regional hospitals for what they termed an Area specific or corporate orientation for varying amounts of time, ranging for 1-2 days to up to one week for three smaller sites (S12, S13, S14). This Area or corporate orientation mentioned by respondents refers to employee induction to the organisation that includes information concerning human resource processes, occupational health and safety awareness and responsibilities of employees as well as specific policies and procedures particular to the organisation. One health service’s (S12) orientation program included offsite corporate orientation for one day at a larger regional hospital followed by 3 days at another rural site before commencing at the employing agency. Other rural health services (L3, L2, S14) in geographical proximity, that is, within a 100-kilometre radius to each other came together for orientation and rotated the site for conducting the orientation each year.

Conversely, three large rural health services (L1, L2, L4) held an orientation program on site for one week where new graduates from smaller agencies were also included. Graduates who had travelled to these sites for orientation may attend all or only some of the program. For example, graduates attend one day to gain the corporate knowledge, returning to their employing agency for the remainder of the week to have an orientation at the ward or unit level and to complete mandatory online learning packages.
4.2.5 Category Five: Formal Education Activities within the Rural Transition to Practice Program

The results show that the arrangements and content of formal education that is offered to new graduates during the rural Transition to Practice Program varied between sites and geographical areas within the Area, as did the number of days allocated to formal education.

At the time of the study, many sites did not host formal education days thus for most of the graduates there was significant travel involved to attend education days at other rural sites or to larger regional sites. Two large rural health services (L1 and L3), offered education programs onsite. Four sites (S10, S6, S7, S9 and L4), had their graduates travel to larger regional sites and at one health service (L5) graduates travelled to a metropolitan site to attend single education days.

The content of the education days was often linked into a larger regional or metropolitan Transition to Practice Program so it was not context specific. This means that the rural graduates who travelled to attend formal education at other sites could be exposed to education content regarding clinical skills or practice guidelines/protocols that were not relevant to their particular rural clinical context or for which they may never practice or be exposed to.

The time allocated for attending the formal education part of the programs also varied significantly across sites. For example the number of days allocated ranged from no days to one day per month. Five health services (L3, L4, L5, S8 and S13), allocated one day per month to formal education and four agencies allocated five days throughout the year. One site (S6) allocated only three formal education days and another (S10) allocated eight days. In addition, all sites indicated that funding to release new graduates to attend specific new graduate education programs was problematic and depended on having enough notice for the impending education day and being able to replace the new graduate on the roster. All sites indicated however, that the new graduates could apply to attend any of the education sessions provided to health service staff, in particular what was offered to registered nurses within the agencies, at any time and their application to attend would be considered.

The findings also identified other education strategies that were included for new graduates during the Programs. These were cited as Area wide mandatory online education
competencies that were directed at clinical skills such as hand washing, handover and the NSW Ministry of Health DETECT (detection of the deteriorating patient) program. Many of these types of educational activities were expected by the organisation to be completed during the initial orientation period. In addition, at one small rural health service it was expected that new graduates would complete a self-directed education package throughout their program, the content of which was focused on clinical skill development.

4.2.6 Category Six: Supernumerary Days within the Rural Transition to Practice Program

The results showed that the supernumerary status of new graduates in clinical areas also varied across sites. The amount of time stated ranged from 3 days to 2 weeks at the initial commencement of the Transition to Practice Program (see Table 4.1, page 112-114). The agencies that offered clinical rotations also allowed between 1 and 5 days of supernumerary time at the beginning of each rotation. For several of the smaller sites there was no definite time allocated as supernumerary after the initial first day, rather the new graduate was allocated a workload but ‘buddied’ alongside a senior registered nurse for a few days. Budget and staffing constraints were mentioned consistently as considerations and restrictions to the allocation of supernumerary time.

4.2.7 Category Seven: Model of Structured Support within the Rural Transition to Practice Program

Only one of the fourteen health services (L1) identified that there was a formal model of structured support in place, such as mentoring, for new graduate nurses as they made the transition to the rural workforce. Many health services cited a number of reasons that prevented this. These included a lack of registered staff within the rural environment that results in problematic skill mixes for providing RN support as there is often a higher EN to RN ratio, inconsistent and inappropriate allocation of mentors to new graduates within rostering, coupled with a reluctance by some senior staff to provide or be involved in formal support. Rather, most agencies relied on creative rostering as a support mechanism, for example, being ‘buddied’ with an RN on the roster so that the new graduate was the second registered nurse on. Alternatively, some health services rostered the new graduate with an enrolled nurse for up to one month before allocating them to being the only registered nurse on shift with the Health Service Manager or Clinical Nurse Manager on site at the same time.
to provide support. In both examples, the new graduate would work alongside and be required to delegate to junior staff such as Enrolled Nurses or unlicensed personnel such as Assistants in Nursing.

**4.2.8 Category Eight: Performance Evaluation of New Graduate Nurses within Rural Transition to Practice Program**

As part of the formal Transition to Practice Program all participants completing the survey reported that new graduates were provided formal structured performance and progress feedback. However, once again the frequency was not consistent across health services. The results show that the timing of formal feedback to new graduates generally ranged from appraisal at one month, three months and twelve months, with some agencies also evaluating the new graduate at the six month mark. Three health services (S6, S13 and L3) reported that they had no set timeframe for formal appraisal rather they used ‘rounding’ as a method for providing feedback and appraisal. Rounding is a technique or tool used in the Hardwiring for Excellence Program- a transformational leadership strategy being implemented at the time of this study by some health care organisations in New South Wales (Burston, Chaboyer, Wallis & Stanfield, 2011). This technique involves connecting with employees and patients via conversations and discussions to build relationships and healthy workplace cultures that ultimately aim to improve outcomes and sustain quality in healthcare (Studer Group, 2011 accessed 2nd September 2012 from http://au.studergroup.com).

The results also show that the person responsible for providing formal feedback to the new graduate was most commonly identified as the Nurse Unit Manager or, in smaller agencies, the Health Service Manager or Clinical Nurse Manager.

In summary, the results of the environmental survey identify the number of sites where new graduate nurses were employed and if there was a new graduate commencing on the Transition to Practice Program that could be included in the purposive sample for this study. In addition, the survey provided a description of the structure of the Transition to Practice Program within the rural sites where the sample for this study was drawn. The environmental survey highlighted common elements within the rural Transition to Practice Program such as rotations and formal education and support systems. In addition it also provided insight into the factors specific to the rural context that influences the structure and implementation of rural programs.
4.3 Phase Two: Justification of the Data Analysis Technique for the Individual Interviews with New Graduate Nurses and Experienced Rural Registered Nurses

Phase Two of this study involved in-depth individual interviews with new graduate nurses and experienced rural nurses. As previously mentioned in Chapter Three, forty-two interviews were conducted with newly graduated nurses. See Chapter Three for details of Phase Two, the number of participants and the nature and length of the interviews. A professional transcribing service was used for 36 interviews with newly graduated nurses and for 10 of the sixteen interviews with experienced rural nurses because of the time constraints of the researcher and the volume of material that needed to be transcribed. For each of the professional transcriptions the researcher checked for errors against each of the sound files and made any corrections to the transcriptions.

At the commencement of the second and third round of new graduate nurse interviews the researcher provided a short synopsis of the previous interview to the participant. This served to provide the opportunity for each new graduate nurse participant to make any changes or to clarify any content from the previous interviews if desired. In addition, as part of this member checking process and as discussed in Chapter Three, the researcher returned a summary of the major themes identified from all of the interviews with new graduate nurses to a sample of five participants to ensure accuracy and to confirm that the interpretation of the data is in keeping with what participants meant. Only two new graduate participants replied to verify the researcher’s analytical categories and stated that the interpretation of the data to the best of their knowledge was an accurate representation.

All interviews with the sixteen experienced rural nurses were returned to participants for validation of the content and for each participant to make any changes to their own transcript should they desire. There were no changes requested to be made and feedback was recieved from one RN participant indicating that they were happy with the transcription as an accurate representaion of the interview. In addition, the researcher returned a summary of the major themes identified from all of the interviews with the experienced rural nurses to a sample of five of the experienced rural nurse participants to also ensure accuracy and to confirm that the interpretation of the data is in keeping with what the participants meant. Three Registered
Nurse participants validated that the data were in keeping with what they meant and that the interpretation of the data was accurate.

As discussed in Chapter Three, thematic analysis as described by Braun and Clarke, (2006, p. 87) was the analytical tool used in this study. According to these authors, thematic analysis involves a six-phase process that begins with the researcher noticing patterns, meanings and issues of potential interest in the data, to reporting the content and meaning of patterns as themes. The aim of the themes in thematic analysis is to capture and describe a consistent, re-occurring aspect of the structure of an experience that is experienced by those living the experience, thus allowing the reader to have some understanding of what it is like to experience the phenomenon under study (DeSantis & Ugarriza, 2000, p. 356). From the beginning to the end of the thematic analysis process, the researcher is constantly moving back and forward between the data, coded extracts of data, and the data that is produced in the analysis (Braun & Clarke, 2006, p. 86). Specifically, the researcher undertook the following steps as identified and discussed by Braun and Clarke (2006, pp. 87-93) to analyse the interview data.

1. **Familiarizing yourself with your data.** This involves immersion in the data that is achieved by transcribing data, reading and re-reading the data and noting down any ideas. As mentioned previously in Chapter Three, the researcher transcribed some interviews and a professional transcribing service was employed to assist with the remaining transcriptions. In familiarising herself with the data the researcher checked all transcripts against the original digital recordings for accuracy (Braun & Clarke, p. 2006, p. 88) and also cleaned the data for punctuation and grammar.

2. **Generating initial codes.** This phase involved the researcher systematically coding interesting features of either semantic or latent content across the whole data set and then organising into meaningful groups. In this case study a data set is equal to all of the new graduate nurse interviews undertaken in one point in time or the set of the experienced rural nurse interviews. Braun and Clarke (2006, p. 89) state that this phase can be data driven where the themes will depend on the data and the whole data set is coded. Alternatively, and as is the case for this study, this phase may be theory driven where only particular or limited features of the data set are coded. In this study the researcher coded features of interest related to the phenomena of support and to the
Stages of Transition Theory (Duchscher, 2008) that provided the theoretical framework for this study. Coding was performed manually across each data set by the researcher, using coloured highlighters to indicate potential patterns and then by collating data relevant to each code together in a separate computer file. In this coding process the researcher also included extracts of data, including any surrounding relevant data in order to not lose the context.

3. **Searching for themes.** In this phase all data has been coded. The researcher collated codes into potential themes, gathering all relevant data. During this stage, overarching themes and subthemes were beginning to be identified.

4. **Reviewing themes.** This phase involved refinement of the themes. Braun and Clarke (2006, p. 91) state that it is important in this phase to judge the categories for internal homogeneity and external heterogeneity. Thus the steps the researcher takes are aimed at refining themes and checking to see that the themes cohere together meaningfully and that there is ‘clear and identifiable distinction between themes’ (Braun & Clarke, 2006, p. 91). To do this the researcher reads all collated extracts for each theme to see if they form a coherent pattern and then considers if they accurately reflect the meaning of the data set as a whole. That is checking for validity of the themes in relation to the data set (Braun & Clarke, 2006, p.91).

5. **Defining and naming themes.** Further defining and refining of themes occurs in this stage. Braun and Clarke (2006, p. 92) state that in this phase the researcher aims to identify the ‘essence of what each theme is about’ organising them into ‘a coherent and internally consistent account’ by writing a detailed analysis identifying what is of interest in each theme and subtheme, and explaining why.

6. **Producing the report.** In this final phase, Braun and Clarke (2006, p. 92) recommend the researcher provide a written account that is concise, logical, non-repetitive and interesting using enough data extracts to demonstrate the prevalence of the theme, that capture the point being demonstrated and, that make an argument in relation to the research question.

After following the process outlined above the researcher identified four major themes from the textual data. The themes were identified from the narratives of the participants and
quotations from the participants are provided throughout the following sections to illustrate each theme.

4.4 Phase Two: Results of the Demographic and Interview Data of the New Graduate Nurses

This section presents the demographic data that were collected from each of the new graduate participants at the commencement of Phase Two. Demographic data was collected from each participant via the Participant Profile Sheet. For the telephone interviews, the Participant Profile Sheet was mailed to each participant prior to the commencement of the first interview (refer to Chapter Three).

The Participant Profile Sheet collected data on age; gender; relationship status; tertiary institution attended; month of commencement at health service; anticipated month of completion; whether employed previously or had clinical placement in a rural health service; level of English language proficiency; location for completion of secondary education. The researcher wanted to determine which if any of these factors impacted on the graduates’ expectations or experience. For example, the question about English proficiency was included in response to some of the experienced nurses claiming in their telephone surveys that they had experienced this as an issue when supporting new graduate nurses.

4.5 Profile of the New Graduate Nurse Participants

Two males and thirteen female new graduate nurses participated in this study. Of the fifteen participants, four indicated that they were aged between 20-24 years; four participants were between 25-29 years of age while four were aged over 45 years of age. Two participants were aged between 30-34 years and one participant was aged between 40-44 years of age. Fourteen of the fifteen new graduate nurse participants had completed a three-year Bachelor of Nursing Program while one participant had completed a one-year conversion program for internationally qualified nurses. Twelve participants had completed their higher education preparation within New South Wales, five from metropolitan universities and seven from regional universities. The remaining three participants had completed their pre-registration preparation interstate at metropolitan universities within Queensland. All participants commenced employment in February 2011. Thus, at the time of the first interviews, all were
established within the Transition to Practice Programs, having completed at least three months of continuous fulltime employment within a rural agency.

Of the fifteen participants, seven had previous nursing experience. One participant had previously qualified as an Enrolled Nurse but had not practised for many years. Two had previously qualified as Endorsed Enrolled Nurses (EEN), both having experience as an EEN in the agency in which they were now employed as Registered Nurses. Four participants had previous experience as Assistants in Nursing (AIN), with one now employed as a registered nurse in the same agency where she was previously employed as an AIN. One participant was an overseas-qualified nurse. Fifty per cent of the new graduates had attended rural clinical placements as part of their pre-registration preparation.

Nine participants had nominated the rural agency in which they were now employed as their first preference for employment in the graduate year. Four participants had nominated the rural agency as one of their ten preferences but it was not in their top two preferences. Two participants had applied privately for employment at a rural agency having been unsuccessful for their metropolitan preferences.

Only two participants indicated that they completed secondary education overseas. English was indicated as the first language for all participants except two.

The demographic data are presented in Table 4.2 (page 125). The participants are not listed in any particular order and to protect each participant’s identity their names have not been used. However to facilitate the reading of each participant’s comments the participants have each been allocated the title of NG (New Graduate) followed by a number, for example NG 1.
<table>
<thead>
<tr>
<th>New Graduate Participant</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Participant One (NG 1)</td>
<td>20-24 years of age and lives with her partner. She completed her pre-registration nursing program at a regional university within New South Wales and attended rural clinical placements as part of that program, including placements in the agency in which she is now employed. English is her first language and she is previously from a rural area. This agency was her second preference for a Transition to Practice Program.</td>
</tr>
<tr>
<td>Participant Two (NG 2)</td>
<td>30-34 years of age and moved with her partner and young child to the rural area. She completed her pre-registration nursing preparation at a metropolitan university in New South Wales and did not have any exposure to rural clinical placements. She is originally from a metropolitan area and English is her first language. She placed the Area Health Service as first preference on the New South Wales New Graduate Recruitment Consortium. As she was not successful with her choice of metropolitan agencies, however, the Area Health Service offered her a range of rural and regional health agencies including this small rural agency. Has previous experience as an Assistant in Nursing.</td>
</tr>
<tr>
<td>Participant Three (NG 3)</td>
<td>30–34 years of age and lives with her husband and children in the rural town. She attended a regional university within New South Wales and was exposed to, and experienced a wide selection of rural clinical placements including the agency in which she is now employed. This health service was her first preference on the New South Wales New Graduate Recruitment Consortium. Has previous experience as an Assistant in Nursing. English is her first language.</td>
</tr>
<tr>
<td>Participant Four (NG 4)</td>
<td>20-24 years of age and single, she is originally from a rural area. She completed her pre-registration nursing preparation at a regional university within New South Wales and was exposed to, and experienced a wide selection of rural clinical placements during her university preparation. English is her first language and she has previous nursing experience as an Assistant in Nursing. This agency was not her first preference but was listed as a lower priority preference.</td>
</tr>
<tr>
<td>Participant Five (NG 5)</td>
<td>20–24 years of age and single. She completed her pre-registration nursing preparation at a metropolitan university in Queensland and did not have any exposure to rural clinical placements. Originally from a metropolitan area in Queensland, she accepted this position through the New South Wales New Graduate Nurse Recruitment Consortium because she was not successful with her metropolitan Queensland Consortium preferences. English is her first language and she completed secondary education in Australia. She has qualifications as an AIN before completing a Diploma for EN.</td>
</tr>
<tr>
<td>Participant Six (NG 6)</td>
<td>25–29 years of age and lives with his partner. He completed his pre-registration nursing preparation at a regional university within New South Wales and was exposed to, and experienced a wide selection of rural clinical placements including the agency in which he is now employed and which was his first preference on the New South Wales New Graduate Recruitment Consortium. Originally from a rural area, he completed secondary education in Australia, English is his first language, and he has no prior nursing experience.</td>
</tr>
<tr>
<td>Participant Seven (NG 7)</td>
<td>25–29 years of age and lives with her partner. She completed her pre-registration nursing preparation at a New South Wales metropolitan university and no exposure to rural clinical placements. She completed her secondary education in Australia in a rural area of New South Wales. English is her first language and she has previous nursing experience as an Assistant in Nursing in the agency where she is now employed.</td>
</tr>
<tr>
<td>Participant</td>
<td>Age</td>
</tr>
<tr>
<td>-------------</td>
<td>-----</td>
</tr>
<tr>
<td>NG 8</td>
<td>25-29 years</td>
</tr>
<tr>
<td>NG 9</td>
<td>20–24 years</td>
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<tr>
<td>NG 10</td>
<td>Over 45 years</td>
</tr>
<tr>
<td>NG 11</td>
<td>Over 45 years</td>
</tr>
<tr>
<td>NG 12</td>
<td>25-29 years</td>
</tr>
<tr>
<td>NG 13</td>
<td>He is over 45 years</td>
</tr>
<tr>
<td>NG 14</td>
<td>She is over 45 years</td>
</tr>
<tr>
<td>NG 15</td>
<td>40-44 years</td>
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</tbody>
</table>
4.6 Results of the Thematic Analysis of the Individual Interviews with New Graduate Nurses in Rural Practice and the Experienced Rural Nurses

The first part of this section will present the results of the analysis of the transcribed interviews with the new graduate nurse participants. The first round of interviews was conducted at the three-four months’ stage of transition during April and May 2011. The second round of interviews was conducted at the six-seven months’ stage during August and September 2011 while the final round of interviews was conducted at the eleven-twelve months’ stage of transition during December and January 2011/2012.

The second part of this section will present the results of the analysis of the individual in-depth interviews with the experienced rural nurses that were conducted over a 12-month period. The interviews commenced in December 2010 and were completed in December 2011 with each interview lasting approximately 30-40 minutes, with five interviews conducted face-to-face and ten interviews conducted via the telephone. To ensure that the conversations were focused on the phenomenon of support required rather than individual new graduate nurse performance half of these interviews were conducted before the new graduate nurses commenced their Transition to Practice Program in December 2010 and January 2011 and the remainder were conducted in December 2011 when many of the Transition to Practice Programs were coming to a close.

Four major themes were identified from the individual interview data. To provide clarity for the reader and in accordance with the theoretical framework, each stage of the new graduated nurses’ transition year is represented by three overarching themes that represent each milestone within the transition year. Each major theme has three subthemes that assist with presenting the findings from the newly graduated nurses. The first major theme is: Getting Started at the 3-4 Month Milestone. The second major theme: Settling In at the 6-7 Month Milestone and the third major theme is: Just another nurse at the 11-12 Month Milestone. In addition, the perspectives and experiences of rural registered nurses (RNs) who worked alongside the newly graduated nurse at the time of the study is represented in the final major theme, Theme four: The Rural RNs Experience of support for Newly Graduated Nurses in Rural Practice. This theme also has three subthemes that assist with presenting the findings. The four major themes and their subthemes are illustrated in Table 4.3 (page 128).
<table>
<thead>
<tr>
<th>Theme one: Getting Started at the 3-4 Month Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subtheme 1.1</strong></td>
</tr>
<tr>
<td><strong>Subtheme 1.2</strong></td>
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<tr>
<td><strong>Subtheme 1.3</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Theme two: Settling In at the 6-7 Month Milestone</th>
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</thead>
<tbody>
<tr>
<td><strong>Subtheme 2.1</strong></td>
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<tr>
<td><strong>Subtheme 2.2</strong></td>
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<tr>
<td><strong>Subtheme 2.3</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme three: Just Another Nurse at the 11-12 Month Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subtheme 3.1</strong></td>
</tr>
<tr>
<td><strong>Subtheme 3.2</strong></td>
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<tr>
<td><strong>Subtheme 3.3</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Theme four: The Rural RNs Experience with Newly Graduated Nurses in Rural Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subtheme 4.1</strong></td>
</tr>
<tr>
<td><strong>Subtheme 4.2</strong></td>
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<tr>
<td><strong>Subtheme 4.3</strong></td>
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4.7 Results of the Interviews with New Graduate Nurses

4.7.1 The First Stage of Transition

4.7.1.1 Theme One: Getting Started at the 3-4 Month Milestone

Fifteen new graduate nurses participated in the first round of interviews and this theme arises from participants’ descriptions of their first few weeks, their initial impressions of the Transition to Practice Programs as well as their experience of support in taking on the RN role. The three identified subthemes (see Table 4.3) will be individually presented and discussed in this section.

The first interview question: *Can you tell me what the experience of your journey of transition has been like so far?* Was aimed at gaining descriptive information that would lay the foundation for more specific directed questions (Merriam, 1998, p.82).

In reply to this question the respondents used terms and phrases such as *shock, stressful, daunting, a challenge and thrown in at the deep end*, to describe how they felt about their experience so far. In recounting what it had been like for them it appeared from the data that the change of role from student nurse to registered nurse and all it entails, as well as the reality of nursing practice were common elements that contributed to their perceptions at this early stage of their transition. Seven participants who stated they had rural nursing experience either from previous employment or during rural clinical placements as part of their university preparation, felt that their transitional experiences so far was what they had expected it would be. However, they said that they did not anticipate the role change to be such a *shock*, even though they had previous experience working in rural agencies.

In addition, the acuity and nature of the clinical work where new graduates commenced their program influenced the intensity of their feelings and how much support they felt they needed at this early stage of their transition. For example, two graduates commenced their employment in clinical areas of paediatrics and mental health at a large rural hospital. These two participants spoke about a somewhat more relaxed *pace* in these clinical areas that permitted them to spend time talking with staff and have staff interact with them, and this was perceived by these graduates as providing them with time to ease into the workforce. This was in contrast to the majority of graduates who commenced in faster paced medical/surgical
clinical areas. These graduates described feelings of *being chucked in*, where there was no time for easing into the role.

In describing their time so far the respondents also expressed their thoughts and opinions related to their initial expectations of the Transition to Practice Programs which are depicted in the following subtheme: ‘Influences on Support while Stepping into the Rural RN Role’.

**4.7.1.1. Subtheme 1.1: Influences on Support while Stepping into the Rural RN Role**

This subtheme demonstrates the challenges specific to the rural environment when new graduate nurses initially commence in the Registered Nursing role and illustrates their support needs at this time. It significantly relates to the context of rural practice and the scope of practice that is expected of the rural graduate nurse not only at the organisational level but also the expectations of their nursing peers as they enter rural practice.

The narratives in this subtheme reveal that workload expectations and level of responsibility, as well as expectations of their ability to manage clinical care that they felt unprepared for, were significant influences on their experience of support in this initial stage in their transition and their socialisation to the professional nursing role in rural health care facilities. Variations in the size and services offered by rural agencies and the staffing ratios in rural agencies resulted in differences between respondents regarding the type and level of responsibility that they were expected to undertake and the amount of settling in time they were allowed. In addition, there were differences between the respondents in the workload that they were expected to carry in the first few months.

Half of the new graduate participant sample had not had any previous experience with rural nursing and their initial experience of their transition in the rural environment was influenced by feelings of being unprepared. The following quotes from three participants, two of whom were working in very small rural sites and one at a larger rural site in general medical clinical areas, illustrate their initial perceptions.

*It is quite a different experience. Working in a country hospital is quite different from being trained at big hospitals like... and... [mentions hospital names here] they are quite big and like one nurse to four patients and here it is one RN on the ward at each shift accompanied by an EN (NG 8).*
It is stressful for a new graduate. Drs expect you to know so much. They expect you to do bloods, cannulations and assess the patient from head to toe without them...and they won’t come and it’s really difficult if you don’t know what to look out for and what he (sic) expects... (NG5).

Working in a district hospital where they are structured quite differently to other hospitals where I did my pracs as a student...there is no doctor on site here. There is slightly more paperwork and more emphasis on teamwork and communication (NG 4).

All of the participants in this study acknowledged that they were inexperienced with carrying a full workload and the responsibilities associated with it and believed that sometimes there did not appear to be any recognition of this by the health care agencies. This is illustrated by the following comments.

The workload is ridiculous and not appropriate for a new grad. 2 EENs and 1 RN [me] for all of the patients (NG 9).

Like 19-20 patients and only 1 RN (NG 12).

They just let me go, because we don’t have allocations. We have two nurses and everyone looks after everyone. I find it quite difficult actually. They wanted me to do the meds for 28 patients, and another person is doing the Drs rounds, you get mixed up (NG 2).

As previously identified in the literature, the size of the health service, the services it provides and the staffing ratios present in that agency influence not only the workload expectations but also the level of responsibility and an extended role that the new graduates were expected to undertake. The interviews identified inconsistencies throughout rural health care agencies concerning the level of responsibility that the new graduate was expected to assume, and the level of performance and the role they were expected to function within. All the respondents, except for the two participants who commenced in specialty areas, believed that there were not clearly designated new graduate nurse workload responsibilities or, sufficient recognition in the workload for their beginning nurses status.

The staffing is not conducive to that [having workload recognition for beginning status] (NG 6).

The nurse manager said I would not be in HDU [high dependency unit], but within a couple of weeks I was, so yes I am doing everything (NG 2).

The downsizing and rationalisation of rural health services, specifically within NSW to larger regional centres, means that the individual wards within rural health services may
accommodate a mix of patients. That is, there may be paediatric, maternity and medical patients accommodated in one area. Alternatively, one ward may be allocated for long stay medical, psychiatric and geriatric patients, and one ward for acute patients that may also involve accommodating different mixes of patients. Furthermore, it is not uncommon in rural health services for the Emergency Department areas to be left unattended until a patient arrives. This means that the registered nurse working at that time not only manages a patient load and coordinates the activities of the enrolled nurses and assistants in nursing, but also attends to patients when they arrive in the ED.

The new graduate nurses in this study who were employed in the smaller rural agencies, were expected to assume extra responsibilities sometimes with limited supervision or guidance. They were almost immediately placed in charge of whole wards and were also expected to attend the Emergency Department should the need arise during the course of their shift and, as beginning registered nurses, they had not been prepared to fulfil these roles that are generally required of more experienced registered nurses. For example, NG 5 explains her expected level of responsibility in the small rural health service.

*If you do have an EN, they take care of the aged care section and the RN is for the acute side and the ED presentation. It is a huge learning curve, I am not extremely confident in ED because I have had no experience in ED and to have to go and actually try and assess a patient (NG 5).*

Thus, there are differences in the level and type of responsibilities that new graduates in rural practice settings will be expected to assume upon entering the rural nursing workforce especially when compared to their peers in metropolitan and large regional practice settings. This is due to the skill mix in rural areas where there is a reliance on enrolled nurses and assistants in nursing. There are very few Registered Nurses and team nursing is a necessity. The following quotes identify experiences with skill mix and level of responsibility in the larger rural sites.

*It pretty much varies [skill mix] some days there are more RNs and other days maybe only one or two on the shift ...if there are less RNs it puts more responsibility on me (NG 4).*

*Usually there is a senior RN, an EN and I. So usually three, but what happens here is you have three people and usually one of these people is on the pink dot, so when you are on the pink dot if the maternity gets busy you have to go and help them, and I have had it [the pink dot] (NG 8).*
In this case if the new graduate was sent to maternity, then they were in a clinical area where they had no specific preparation. Alternatively, if the senior RN went to the maternity area, the graduate would then be placed in charge of the ward with an EN for support.

As stated above, the skill mix necessitates the team leader model of nursing care delivery where coordination and delegation to other staff such as ENs and AINs occurs with the RN ultimately responsible. This has implications for new graduates in rural areas that will have to step up to the role of team leader very early in their graduate year. These aspects proved to be difficult for the majority of the respondents who had not had sufficient preparation or the opportunity to practice management or leadership skills and so were not overly confident in delegating and who also felt frustrated in their attempts to delegate.

The whole teamwork approach has its negative things. Nearly every shift I have been assigned team leader, there are staff members who feel intimidated by a new grad being in that position. They don’t really follow instruction or offer any help, they just go about and do their own thing so there is no communication and you don’t know what is going on (NG 4).

There is a lot of AINs on shift and that can be difficult. I do find delegating difficult at times particularly with the ENs that I worked with when I was an EN (NG 11).

I am having difficulty with the team-nursing thing. I find I am missing a lot of things and I don’t know about changes that are occurring. The other day I was doing the medication round and the midwife said she would do the other end, but I was the one who got into trouble because she missed one. That was frustrating (NG2).

In addition to these examples, many respondents were also able to tell of experiences in the first three months where they were sometimes left on their own to manage the ward and other staff, because of staffing issues.

A couple of times there have been people off [on leave] and I have been the only RN. I’ve been there on my own. And like one minute you have a whole bunch of nurses working, the next they are called off to emergency and they left me to look after them [patients] (NG 10).

The RN was sick and I had to ring the day coordinator and say ‘I am not comfortable being in charge’ and they couldn’t find anybody at the time so I had to be in charge for that shift which was scary (NG 1).

In addition, the respondents ability to cope with the workload allocation and responsibility was influenced by the shift to which they were rostered and where staffing and skill mix differ significantly from what is allocated during the morning shift. For example, respondents said
that evening duty in the rural agency was always worrying because there was often more responsibility to assume and even fewer senior staff available for support.

*I am finding the evenings are the busiest time and you don’t have much support. There is really not anyone around to help you. A lot of the time on evening shifts we will be in our segregated ends, so I will be up one end by myself and another RN will be up by herself [sic] and there will be an EN drifting (NG 1).*

*I have found the skill mix daunting. We might have one Midwife, one EN and one RN and there have been times I have been the RN with the EN and you find yourself sort of making fairly critical decisions (NG 13).*

Many of the respondents at the smaller rural sites had been rostered to night duty shifts where they found the workload more manageable. However, they were concerned about the level of responsibility during this time because there was limited staff support available to them. For example, NG 8 stated that at approximately 8 weeks into her program she was being rostered 4-5 nights per month with another senior RN. Another graduate had also been allocated night duty, initially as the second RN on shift, however at the time of the interview, she had just completed a night shift as the only RN on duty for the whole hospital thus she was in charge of the hospital.

*Yes I have done a couple of nights, most nights with another RN, however I have just done one with only me, and an EEN (NG 5).*

Having to take on these extra nursing roles and the extra responsibilities associated with rural nursing, coupled with sometimes limited support or guidance, was a frequent occurrence for several of the new graduates in this study. This was a cause for concern to the graduates who found it ‘frustrating’ and they also experienced self-doubt and loss of confidence regarding their practice ability, especially since the expectation was that they would be able to assume these extended roles and extra responsibilities almost immediately upon entering the rural nursing workforce. The respondents also expressed concern for their RN peers with respect to the skill mix and staff allocation. They could see that everyone else was also busy with their own workload commitments due to staff allocation. For example NG 12, who previously qualified as a nurse overseas, spoke about her level of responsibility and workload in the rural environment when she is often the only RN rostered for the clinical area.
Many things are happening on the ward so I need support from a very experienced nurse... and there is often a more experienced nurse in emergency but sometimes she is very, very busy so she can’t help. Sometimes she needs help (NG 12).

As mentioned previously, in this study there were inconsistencies throughout rural health services with respect to the level of responsibility that the new graduate had to take on, the level of performance expected of new graduates and the roles they had to assume. For example, some wards immediately rostered the new graduates at an Enrolled Nurse level. This type of rostering is used as a support measure to ease graduates into the workload and to assist them to develop their time management and prioritising skills. However, although the aim was to ease workload responsibilities for the new graduate, it could also add confusion and an element of conflict for some of the new graduates, as they were unsure of what their role really was and what was expected of them. This element of confusion was further compounded since this was not a consistent occurrence and only occurred in some wards of some health services where staff ratios and skill mix necessitated this type of rostering and staffing. For example, NG 3 explained how she was allocated to the EN rostering line in the first three months because usually in the specialist clinical unit where she commenced, the staffing allocation was one RN and one EN on a shift. However, working on the EN rostering line meant that she was delegated to, and expected to do all the EN specific duties rather than learn how to take on the RN specific role.

Some of them would not let me do medications, they were happy to do all the medications and then anything else that needed to be done you were just expected to fall into that role and do it, as would the permanent EENs that have been there for years (NG 3).

In addition, the skill mix in rural agencies sometimes means that the new graduate will be expected to take on supervisory roles for pre-registration nursing students who are undertaking clinical placement within the rural health services. For those new graduates who had experience of rural clinical placements this was not surprising to them. As a Clinical Coordinator of a pre-registration nursing program at a regional university, this researcher knows that in rural agencies nursing students are often placed with a new graduate nurse during their clinical experiences. Insufficient registered nursing staff in rural areas, the requirement of accrediting bodies that pre-registration nursing students are to be supervised and assessed by registered nurses, coupled with a push to increase clinical placement capacity in rural areas, means that the new graduate is required to provide learning support for nursing students very early in their graduate year, as they often may be the only RN allocated to the
clinical area. For the respondents who had never attended placements outside a metropolitan area, this extra responsibility was unexpected when they first commenced employment in the rural agency. Supervision of student nurses added extra responsibilities and workload pressure for some of the graduates as the following quote from NG 5, who was in a small rural agency with generally just her and an EN on shift plus the Health Service Manager onsite for support, demonstrates.

_It’s really difficult when first placed on the ward with a student nurse because I am a post grad and I have to learn and I was buddied up with a student nurse. It was difficult because I could not find my way around to show them what to do and teaching them, that put a lot of pressure on me in the first week (NG 5)._

The new graduate respondents at this stage of their transition to professional practice said they were surprised with the workload, skill mix and level of responsibility that they were expected to assume in the first three months. All the respondents expected the first three months to be somewhat challenging. However, they believed that the level of responsibility that they were expected to fulfil in the rural agencies was beyond their level of competence, knowledge and experience at this beginning stage of their nursing careers. Respondents who had this experience felt strongly that they were not sufficiently prepared for either working independently or being in charge of these areas. All respondents had limited exposure to emergency nursing in their undergraduate preparation and lacked experience with ward management and responsibilities of being in charge and had expected the Transition to Practice Program to provide support in fulfilling these aspects of rural nursing practice. The new graduates were very much aware, from their undergraduate preparation, of the Australian Nursing and Midwifery Council Competency Standards (ANMC 2006) required for beginning registered nurses, and that they were required to practice within the boundaries of their knowledge and skill acquisition. Yet in the smaller rural services staffing practices and staff expectations necessitated the beginning registered nurse to be frequently practicing in ED as well as take on roles of being in charge. The respondents who worked in the smaller agencies expressed concern that the management and staff of these agencies expected that because they were now Registered Nurses they would be able to assume all levels of responsibility very early in their graduate nurse year.

In summary, this second subtheme highlights the concerns the respondents had for the volume of workload, the level of responsibility and the roles they were expected to assume, almost
immediately upon entry to the rural nursing workforce. These findings show that the new graduates were surprised with the workload allocation and the consequent level of responsibility they were expected to cope with upon initial entry to rural practice. This theme has provided a backdrop from which to now view the perceptions of the effectiveness of support provided to new graduate nurse participants in this first three months of transition.

4.7.1.1. Subtheme 1.2: The Rural Transition to Practice Program

Many participants discussed their perceptions of ‘getting started’ on the Transition to Practice Program and their experiences of orientation, supernumerary time, support mechanisms, rotations and formal education.

While the experiences of orientation were positive for many of the respondents, it involved movement between two and sometime three sites. Of the participants that travelled for orientation the concern for them was that often the content within the offsite orientation was not relevant to their situation, nor did it factor in that some attendees were from other sites and may have had different needs. For example, the orientation was often tailored to the needs of those who were employed onsite so once the corporate information was delivered, graduates would then have more specific site and clinical unit orientation that did not include graduates from the smaller agencies. NG 10 explains how at the regional agency where she was sent for her orientation/induction, the program for the day included going to their allocated clinical area to have a ward based orientation that she did not believe was all that relevant to her needs.

It [the orientation] dealt with a whole bunch of things fire drill, basic life support, DETECT. We were supposed to do some other things. The thing I didn’t like was that on Thursday we were supposed to go to whatever ward we were on; they just said ‘everybody go to their wards’. Well I couldn’t. I would just turn up to a ward and start twiddling my thumbs (NG 10).

NG 5 recounted how she had orientation at three different sites but she did not have a car or a driver’s license nor was she familiar with travelling in the rural area as she had relocated from a metropolitan area. She explained how the health service had it all organised for her via patient transport that would pick her up and take her to the two separate sites where she was required to be for orientation.
According to the respondents, once orientation was finished, participants in larger agencies had various lengths of supernumerary time. Most commonly one-week supernumerary time was given with one participant stating she had two weeks of supernumerary status. Participants in smaller rural agencies were concerned with the actual amount of supernumerary time they were allocated. In the smaller rural agencies, it was common for the respondents to only have two days supernumerary allocated to them. These respondents had expected to have at least a week and a specific mentor. However, having no formal support model such as mentoring in place added to their initial, difficulty and disappointment at this time.

_Chucked in and that’s it. I only had three days orientation (NG 2)._ 

_Very stressful specially the first two months, I have not enjoyed it at all. I knew there would be no rotations but expected some on-ward support and education (NG 9)._ 

_There hasn’t been anything in place onsite for the actual new grad program (NG 4)._ 

Another graduate, after relocating to the rural agency away from her family, expressed how disappointed she was with the situation she found herself in.

_I just find it really hard at times. I’m trying to hang in there and my husband has been really good. It’s been very, very hard for us (NG 10)._ 

For this respondent, the realities and the context of rural practice, coupled with immediate unmet expectations of the graduate program, the isolation and the change to personal and family life was challenging. When comparing her experiences with other graduates she discovered that graduates were able to secure RN positions without being on specific programs within her metropolitan home base area and that her metropolitan peers were enjoying a better program than what she was experiencing. She stated ‘I could have just done that’, meaning that she could have stayed with her family and be employed as a nurse without having to have moved. This respondent who was disappointed with the program did not feel well supported up to this three-month stage and commented to the researcher that she might not stay on in the rural agency.

As previously mentioned, the results of the environmental survey revealed that only one of the rural sites had a formal support structure to their Transition to Practice Program at the time of the study. Four respondents in this study who had the content and structure of ‘The
Program’ clearly articulated to them during orientation stated that their expectations of the program had been met so far. These graduate nurses experienced formal support structures such as mentoring which they stated was working well for them. However, they had not had much contact with their mentors following the initial orientation, as their mentors were not necessarily working in the same clinical areas. Despite this, they still perceived this structure as supportive and they took comfort in knowing that there was someone there for them should they need it. Also they felt that the staff had taken the mentor role very seriously and were going out of their way to ensure they felt supported in this initial stage of transition. Two respondents illustrated this, as follows.

*My mentor is in another clinical area and some of the staff in this ward who are mentors for other grads come and say, ‘I know I am not your mentor but if you need anything’ (NG 6).*

*When we first started we went through what our rotations were going to be and what kind of support we would actually have and the mentoring program that they have just brought in recently (NG 1).*

The participants in this study, who at this time were comparing programs and experiences from other graduates in larger metropolitan and regional areas, had expected rotations as part of ‘The Program’. However, the rotations did not eventuate as they had anticipated, nor as their metropolitan and regional peers were experiencing. The environmental scan revealed that six sites indicated they had clinical rotations as part of the program. However, at this three-month stage of the transition only one respondent from one large rural health service had rotated to another clinical area as expected. It was not clear to the respondents who expected rotations, how the rotations would come to fruition nor who was responsible for ensuring the rotations eventuated.

*I have no idea when my rotations will commence. I think I have to go to another site but it’s all a bit vague (NG 7).*

*I was wondering about my rotation, and I’ve asked quite a few times and finally I’ve been told I will probably go to...[mentions another rural site here]. The other new grads have everything printed out, they have got where they are going to and when their rotation commences and finishes, they have all their rotations written out and they can see when they are starting and when they are finishing and they have an idea of what is happening in their lives and they can get organised for themselves and they can prepare. For me I was told the first day I have just got to wait and get someone to allocate staff and they finally said ‘you are counted as a staff member here and until that time...’ and then the Nurse Manager came down and we were just having afternoon tea, a bunch of us, and she said, ‘Oh you must be...*
due for your rotation?’ And then the next minute she said, ‘Organise with [mentions another rural town here]…’ And my mouth just dropped down (NG 10).

In addition, in rural areas organisational staffing requirements largely determine the timing of the rotation or if indeed the health service is able to follow through with the expected rotation. This is due, in some cases, to the skill mix and staff ratios in rural areas plus the availability of registered staff within the roster allocation. The following quotes demonstrate the ‘vagueness’ by agencies in fulfilling expected clinical rotations.

*I was initially supposed to be there for two months but they extended to another month and I am not sure why (NG 3).*

*They did not tell me about rotations, I had to ask them. I am going to surgical and an RN said I should ask because it will give me good experience but I don’t know, nobody knows (NG 8).*

At this stage of the transition to rural practice at least half of the participants had attended one mandatory specific formal new graduate education study day. Those who had attended this formal education study day were satisfied with the content that included graduates presenting a case study to their peers, as well as presentations related to clinical care for example, conducting mental health assessments. However, half of the respondents had not attended any formal education study days at the time of this milestone. These participants stated that there was no onsite formal education program but they were aware that specific new graduate education study days were happening within the Area. However, during the interviews the new graduates did not appear to know much about the process for accessing the study days. They did not seek nor initiate at this stage any involvement in offsite education that was available to them.

*There is always stuff [education] but we have to travel and organise it ourselves, I don’t really know about them, is it one day per month? (NG 4).*

*No specific new graduate education provided. I have to organise my own (NG 9).*

*They said they would let me know about anything that might be happening, but I have not heard of anything (NG 11).*

In this study, the new graduates said that a reason they had not attended formal education study days was because the notification for any upcoming new graduate study days was sent via email to clinical areas. As a result, in some clinical areas of some agencies information
regarding education study days was not being relayed to the new graduates. One graduate nurse did seek her own education opportunities but could not access email so missed being notified of when the education days were scheduled.

*I was actually left in the lurch about it completely, I didn’t know. We are not allowed emails... I had requested a work email and I was told that new grads don’t get a work email (NG 3).*

Whilst discussing their initial impressions of the structure of the formal education provided within the Transition to Practice Programs several respondents spoke about learning packages that they had received during orientation. They were vague and unsure of the purpose of the packages thus during the interviews the researcher delved deeper into this issue and discovered that overall only five respondents acknowledged that they had been given a learning package on commencement. According to the respondents, mandatory skill competencies were included in the package but it was not clear to participants when the package had to be completed. Some respondents thought it had to be completed throughout the rotation while some thought it needed to be completed by the end of the graduate year. Furthermore, the type of skill competencies included in the packages varied across sites. One new graduate made the following statement that captures the initial perceptions of graduates regarding the learning packages.

*A rehash of what was done at Uni (NG 13).*

At the time of interview only three new graduates had actually completed any of the learning package. One respondent had received it from a larger regional hospital and felt it was not all that relevant to their clinical context so had not attempted it while one stated she was unable to find time so had not opened it. The remaining respondents said they did not have any knowledge of a learning package.

In conclusion, it would appear that only one site had a structured Transition to Practice Program that met the expectations of the graduates within that agency at this time. Orientation/induction programs at the commencement of their Transition to Practice Programs generally met expectations for most graduates. However, most of the respondents were somewhat disappointed with inconsistent attempts and what appeared to be ad hoc arrangements for formal support mechanisms and for education and learning opportunities within the Transition to Practice Programs during the initial first three months of transition.
The next subtheme also arises from the first interview question posed to the participants and encompasses their perceptions and feelings surrounding support in this first three months, specifically participant’s experience of support whilst taking on the rural registered nursing role.

4.7.1.1. Subtheme 1.3: Support Experiences Versus Support Needs

This subtheme arises from the researcher asking the participants about the support that they had received as new graduates. In particular, the researcher sought to explore the source of the support, their perceptions of the timing and effectiveness of support as well as the nature of the support or what the new graduate was seeking or needing support with at this stage of their transition to rural nursing practice.

All the respondents stated that the majority of support came from experienced registered nurses and that overall the support from individual registered nurses was more than they had expected. While many of the respondents stated that they believed it was up to the new graduate to speak up if needing support, it was sometimes not offered in a timely manner and this was because many felt that even though the registered nurses were kind they were just as rushed and busy so they were not always available to provide timely support.

Many participants identified that the culture of the ward influenced their perceptions of the provision of support from staff. NG 13 perceived good support at this time to be about help with the workload and getting the jobs done.

They would just pick up on that [needing help] and I think that is part of the culture of the ward; that everyone looks out for each other. They identify very well who has the harder patient allocation and are all, quick to jump in and help (NG 13).

This was in contrast to one respondent who was disappointed with the negative attitude of her registered nursing peers, with some not going out of their way to offer support.

Be positive about this place instead of saying to me this is not the best place. They should say ‘oh that’s really good that you are here you will really learn a lot of things’ (NG 8).

However, another respondent, a previous EEN with many years of rural nursing experience, had mixed feelings at this stage. She identified with more junior RNs who provided more encouraging support than some of the senior RNs.
Senior staff members make comments that make me doubt myself, and my skills. The second year post grads can see how you are going and they can understand what it is like (NG 15).

The respondents also described actions by RNs that were perceived as unhelpful and unsupportive. Two respondents explained how they felt in the first three months with the provision of clinical support from more experienced RNs.

People felt I was struggling. I felt criticised for not being up to speed. On the one hand they are saying you know the new grads are supported and we know they need help but on the other hand they are saying ‘you have to have exactly the same workload as everybody else’. So that was difficult (NG 14).

I usually have to ask them [for support] and I have had people just walk away. I ask them to help me with the drugs and they just looked at me and walked away (NG 2).

When asked what constituted good support from the registered nurses for them on a typical day, the majority of the respondents used terms such as approachable, friendly and encouraging to describe ways in which the registered nurses displayed their support. The graduates also described behaviours by RNs that were perceived to be supportive such as checking in frequently with them throughout the course of a shift to ensure they were okay or if they needed assistance and providing clinical support when requested. The following quote demonstrates what the respondents valued from the Registered Nurses who were perceived as providing effective support.

Always available to talk to you, always there if I had a question, there were no silly questions, they weren’t insulting or saying ‘well why are you asking that you should know that.’ They offered on-going support ‘if there is anything you get stuck with let me know’ (NG 3).

The new graduates also identified that in this first stage the Enrolled Nurses were often best placed to provide them with support. This was particularly true in the clinical areas where the number of ENs on a shift at times outnumbered the number of RNs, or, if there were just the new graduate RN and the EN as the staffing allocation for that clinical area. Most often the support the enrolled nurses provided was in relation to assistance with the workload and assistance with learning the clinical care routines within specific clinical units. However the support from ENs was also varied with the perception of the culture of the ward and how long the EN had been employed in the rural agency.
The ENs are the worst ones I hate to say. Most of the ENs are hospital trained here and they have been here for thirty years and there are a couple that I just don’t like working with at all (NG 2).

As well new graduates felt that ENs would show support by asking what would you like me to do? However, many of the graduates expressed that at this stage they were not yet confident in delegating and that they did not really know at this stage what had to be done or where they were up to with getting the work done. Two respondents identified how most participants felt about working with the ENs and the expectation of delegating.

One of the big things with ENs is that I find it hard to delegate and differentiate what I am supposed to be doing as opposed to what the EN is doing (NG 6).

The most difficult is being so much younger than a lot of staff and they have been doing it for years and me taking that leadership role and trying to delegate tasks and things to them I feel like I haven’t really earned their respect yet (NG 1).

The results of the environmental survey revealed at the time of the first interviews that there was only one site where the respondents had access to a ward-based clinical nurse educator. At this site (L1) the nurse educator’s position was part-time and only based in one clinical area. Other sites had health service-based nurse educator positions that were responsible for the implementation and management of the Transition to Practice Program but they were not directly involved in the education and support in patient care areas for new graduate nurses. Most of the respondents had had limited contact with a nurse educator in the first three months following the initial orientation period and for the majority of the respondents there were no Clinical Nurse Educators on the wards to provide support.

It just all fell through like other times. I have had no real education. An educator on the first day introduced herself and said that she would be doing education, she is in another clinical area and she said ‘I probably won’t get to see you a lot’. And I thought ‘oh well she is probably just saying that’. And she was serious; I have hardly seen her (NG 10).

However, two respondents who had the benefit of access to a ward-based educator during this initial stage of transition felt that the support provided by the educator was effective learning support that assisted in easing their stress.

They now have a CNE of a morning. So that person is on the ward, so I’m not annoying another staff member doing a medication round where that staff member has got her own or his own patients and stress. I’m actually going to this CNE so I’m not stressed about asking someone who is busy. I’ve got someone that is supporting me every day (NG 15).
The participants who were fortunate enough to have someone specifically to support them identified the type of support given by the person in this position and why it was effective as shown by the following two respondents.

*She is constantly coming up to me during the day and asking me how am I going and where am I up to? Seeing how I have structured my day (NG 1).*

*The CNE picks up that you might be a bit.... She will just come up to me and will get out the patient list and go through it with me again. She makes sure I am prioritising the right patients and in what way. She identifies where I might be struggling and gets me to identify and make sure that I have actually got it [workload priorities] all in the right order (NG 15).*

From the participants’ descriptions of who provided support it is apparent that they were disappointed with the level of support provided by management in particular from the Nurse Unit Managers. Only two participants stated that they felt the NUM of the ward or unit where they were working was providing what they perceived to be effective support. These participants had experienced *rounding* by the NUM, as previously described earlier in this chapter. This made the NUM visible and accessible to the graduates and also provided acknowledgement by the NUM that they were there.

*The NUM frequently does rounding and about every two weeks, asks me ‘how are things going?’ (NG 7).*

The majority of the respondents had expectations that the Nurse Unit Managers would be visible to them and engaging with the graduate and acting as an advocate for them, as illustrated by the following quotes.

*Come out and show some interest in the ward. Don’t just come out and say ‘good morning’ and then go back into your office (NG 15).*

*When I ask her for help she is quite willing to come and help me. She does not really come out of her own accord (NG 5).*

There was an expectation evident in the participants’ transcripts that the nurse managers would more openly demonstrate support. Participants expected emotional support from the nurse managers and the NUMs. For example, acknowledgement that they were new learners, encouragement to attend education and in some cases, protection from organisational requests and demands on the graduates, as well as giving feedback and formal appraisals.
I don’t really have too much to do with them [Nurse Managers] because I am too busy running around. They are not as open and approachable, they are just too busy and every time you go past they are in a meeting (NG 10).

The roster has not been supportive. Four nights on, one day off, back on a morning shift. Too many shifts one time and nothing would be done about it. It was my problem. Not enough shifts one fortnight and that was my problem to find another shift. Movement of ADOs [accrued day off] without notice and allowing me to be moved to other wards when they are short staffed (NG 15).

The NUM was not someone that you could really have a conversation with (NG 3).

NG 3 felt isolated in the specialty unit in regards to attending formal education sessions and although she felt the NUM was not all that approachable she did try to seek her own educational opportunities. She provides the following account of trying to access educational opportunities for herself:

I requested to the NUM that I take an hour to attend an in-service and she said ‘No you have to stay on the ward’. She just bluntly said ‘No that’s not going to happen’. I guess because it was a specialty area, she wasn’t happy for me to leave but there were four staff members there at the time (NG 3).

The [workload] allocation is not geared up for your learning it is pretty much about meeting the needs of the ward and staff coverage (NG 1).

With regard to what the new graduates in this study were seeking support for at this time and what they would have liked support with, by far the most common responses were for clinical support as well as feedback on how they were progressing. The respondents identified that the clinical support that they were seeking was for assistance with the workload, clarification of unfamiliar procedures, medication management and clarification of medication prescriptions, assessment and making clinical decisions as well as completing the day-to-day paperwork. In addition, the responsibilities related to patient transfers and retrievals of acutely ill patients to metropolitan or larger regional centres, discharges and referrals of patients to other health professionals and services, particularly after hours, were also areas that participants stated they were struggling with and were requesting clinical support.

For many of the respondents, support was not all that forthcoming in this first three-months of transition unless they specifically sought it. Two participants had received timely feedback through rounding that has been previously mentioned. However, the majority of participants were yet to receive any formal feedback regarding their progress. The respondents had
expected feedback on their progress from the NUM so this became a topic area for the researcher to explore with the respondents in the second and third rounds of interviews in this study.

As stated above, many of the respondents struggled with the workload expectations and tried to seek specific support to manage this issue. The following quote demonstrates what would have been supportive for one respondent and for what she sought support. In addition to the workload difficulties, this respondent found it hard to manage specific RN duties such as checking Schedule 8 and Schedule 4 drugs for which she had not had any preparation and was not exposed to during clinical placements.

Lighten the load would help or if people would help me when I did have a big workload. I had hardly any experience with S4 and S8s because we were not supposed to sign the book [dangerous drug book] and on prac everyone is always busy and they run off and find someone to sign and do it without you knowing (NG 14).

If I am stressing about some one’s fluid balance, should I adjust something somewhere? Am I on the right track with this? Just being able to talk though my decision-making through the day is my best support (NG 15).

As previously mentioned in Chapter Two, rural health services also experience problems with recruitment and retention of medical and other allied health staff and because of the downsizing and restructuring of health services, many services are no longer available in rural areas thus patients often have to travel vast distances to access health care. Many of the respondents in the smaller rural health services also sought support for organising services for patients that were not available routinely in their agency or the town and organising the transfer or retrieval of acutely ill patients via land or air transport to larger metropolitan and regional centres. The organisational and documentation requirements needed in this specific aspect of the rural nurse’s role were difficult for many of the graduates as they had not been educationally prepared for this aspect of the role.

How to get the physio to come in? They have to come in because they are not on site. That was one of the major things that took a while to get used to. The transfer, who do I ring? Who do I ring to get the ambulance? All of that sort of stuff, that is the biggest one, it is just so different (NG 2).

We don’t have medical officers on site, knowing who to call, when to call ….the weekend on-call medical officer, organising the retrieval or the transfer (NG 13).
When there are no medical officers onsite the rural nurse has to be able to make thorough patient assessments and communicate findings appropriately and in a timely manner via the telephone to a medical officer. Several of the respondents who had very little access to immediate RN support during a shift, commented that their priority for support and further education was related to the assessment of patients and confidence in communicating their assessment findings to medical staff.

Clinical support to do the assessment before you go to the Doctor. You never know who will walk through ED and it is really scary because I have no ED experience (NG 5).

I was asked to call the Doctor and he said to me ‘don’t ask me stupid questions’. I am really scared to talk to the Doctors because of that attitude (NG 8).

The final interview question for participants was do you think the support could be improved and if so how? The most common responses from the respondents included staff, particularly having extra ward staff particularly RNs to provide support during a shift, more visible support from the NUM, structured support at the ward level such as mentors, access to a CNE during a shift to provide on-ward learning support and more frequent access to specific new graduate education study days. Furthermore, the respondents wished to have feedback regarding their progression. The following suggestions are representative of what the respondents proffered for improvement to the rural Transition to Practice Programs.

More support in the first couple of weeks because a couple of days supernumerary is not enough (NG 6).

The RN nursing ratio. Having another RN around would be good. To be in charge on your own is difficult and I think the doctors put pressure on the new grad because they expect us to be able to do things that we cannot do or are not competent enough to do (NG 5).

More structured meeting times to discuss, where you can get some constructive feedback, if there is anything you can do better (NG 11).

In summary, up to and including this 3-month period where the graduates were adjusting to the RN role they acknowledged that within the transitional programs the Enrolled Nurse was best placed to provide support via orientation to the ward practices and procedures, and by providing timely assistance with the workload and care regimes. Expectations of support from nursing management, was for most of the graduates largely unmet. In particular, the respondents believed that the Nurse Unit Managers did not often go out of their way to
acknowledge the graduates. Despite this, individual RNs were perceived to be supportive through providing educational support for clinical care and assistance with RN specific roles when requested. The graduates identified that they specifically wanted support for clinical care, managing the workload and for medication administration in particular, the large medication rounds. All the respondents stated that, also at this time, they would have liked advice and assistance with their clinical decision-making and prioritising of care. In addition, specific support and education with organising and completing the volumes of paperwork required for patient transfers and retrievals, particularly after hours when there is no clerical support within the rural environment would have been helpful. The majority of the graduate respondents in this study were employed in agencies where there is no onsite medical staff and they found the assessment and reporting of patients’ conditions to off-site medical staff were areas that also required more specific support. Finally, the workload and the level of responsibility they had to assume influenced the respondents’ suggestions for Programs to have more structured and clearly defined support at the ward level.

4.7.2 The Second Stage of Transition
4.7.2.1 Theme Two: Settling in at the 6-7 Month Milestone

This second major theme arises from the second set of interviews conducted with the new graduates at the six to seventh month of their transition to rural practice. There were only 14 participants for this round of interviews as one new graduate did not make the appointment for the second interview and the researcher had several failed attempts at trying to contact her. The interview schedule for this round of discussions was similar to the first interview schedule in that the researcher clarified and checked in on the new graduate participants to see if anything had changed for them and what they had experienced in terms of support since the first interview, as well as how they were feeling about the provision of support at this stage of transition and what they felt they required in terms of support. Thus, the interviews conducted at this milestone were shorter in duration than the interviews conducted at the first milestone. The researcher commenced each interview with the question. How has your time been since I last spoke with you?

It was clear from the conversations and from reading and re-reading the transcripts that this second stage of transition was concerned with the graduates settling in to the practice environment, hence the overarching theme is Settling In at the 6-7 Month Milestone.
Subsumed within this major theme are three subthemes that provide an exploration of common experiences, perceptions and feelings of support at this stage of the graduates’ transition to rural practice. The three subthemes that emerged from the conversations by the graduates at this stage are: *Influences on Support while Settling in to the Rural RN Role, The Rural Transition to Practice Program, Support Experiences versus Support Needs*

When listening to the interviews the majority of respondents sounded more confident during the conversations. They used terms such as *confidence, more settled now and feeling good* to describe how they felt at this time. In addition, many respondents commented that they felt their feelings were partly influenced by having formed more satisfying relationships with their work colleagues as the following respondent demonstrates.

*It is getting better because some of the people are getting to know me more, so it is getting easier (NG 12).*

**4.7.2.1. Subtheme 2.1: Influences on Support while Settling into the Rural RN Role**

At this six to seventh month of being in rural practice the researcher noted that the participants’ perceptions and accounts of what their time had been like since the last interview were, for many, focused on being more comfortable with clinical care routines, being able to manage the workload and feeling more comfortable with the level of responsibility. All graduates stated that they felt that their experience was *getting better* or was *improved* when compared to their experience at the first interview. When asked what was better or improved the responses were mostly about how they were feeling in themselves. Respondents acknowledged that the workload allocation and support had not changed, however, they felt that their ability to cope and manage the workload had improved. They felt that their increase in confidence was the result of further development of time management and prioritising skills. The following quote by NG 9 illustrates a common feeling amongst the new graduates at this time.

*I have gained confidence, which is the thing that has helped me with my practice, but there is still a lack of support (NG 9).*

The researcher had noted in the research journal that after each interview in this stage of transition she had written comments such as *appeared happy, sounds relieved and pleased with themselves*, to describe the mood during the interviews with the majority of participants.
The following quotes demonstrate the increase in confidence, the resilience and determination to move forward that was evident during the conversations, particularly now that the initial transition phase had passed for respondents.

*I hit the wall big time and I thought I cannot do this transition. Once I had that done and got those emotions out of the way I just took off again and I just loved it. I just fell into the role and felt more comfortable, it all started to work. The workload did not change but you were able to cope with it more and you have a better time management, understanding changes (NG 15).*

*I was really in at the deep end, now I am more settled (NG 9).*

For two participants who had commenced employment in specialty areas, the move to the fast paced medical and surgical areas of the agency was difficult. NG 3 describes to the researcher her adjustment to a faster paced clinical area where she felt challenged with the workload allocation and where she also felt staff have little time to offer support with the workload compared to the staff within the specialty area where she was previously.

*I feel I have been thrown into the deep end sometimes. You either have to sink or swim. It is still a shock when you go from two specialty areas. In hindsight I would have preferred to have had commenced [the program] here [medical ward] (NG 3).*

For some participants particularly those who were not expecting formal clinical rotations the increase in confidence is also characterised and influenced by the staffs’ increasing trust in the graduates’ abilities. In the following quotes the respondents talk about events that assisted with their feelings of confidence and competence such as having nursing students placed alongside them, being moved to the Emergency Department to assist more senior staff and being allocated “in-charge of the unit”. It was also evident that the educational opportunities that these events presented to the graduates were exciting for them and added interest.

*I’m changing more, I am not just on the same ward all the time and we have had some students through (NG 2).*

*I have had more opportunities to be involved in staffing in ED (NG 4).*

As previously mentioned, many graduates were becoming more accepting and comfortable with the level of responsibility that they were expected to assume in the first three months. Participants who had not previously been expected to be in charge and who felt somewhat more protected from assuming such levels of responsibility in the first three months, were
now finding themselves in positions where they were in charge particularly on weekends and night duty when there was limited support for them. NG 8 recounts to the researcher how she initially asked to have one shift per roster to practice being in charge alongside another RN because she knew the time would come when she had to step into the “in-charge of shift role”. She had practiced this in the medical ward where there was another RN rostered and she was told that she coped very well with it. However, on a subsequent roster allocation was found that she was rostered to the surgical ward on night duty, an area that only ever has one RN rostered, and is isolated from other clinical areas and senior nursing staff. She was obviously upset when recounting her story.

_I was meant to work upstairs where I didn’t have much support. It was an EN and myself. She was not even an EEN. I said ‘look I don’t feel comfortable in this environment’ but they said they were short staffed, and that they cannot do anything. ‘All we can do is put you on ground floor and have the ED nurse look after you’ (NG 8)._  

The outcome for this graduate was that whenever her turn for night duty came up she was moved to the medical ward and continued in the surgical ward for the day and evening shift.

For many the focus of their concerns with the level of responsibility had shifted slightly. Initially it was characterised by feeling frustrated at their perception of _being thrown in at the deep end_, but at this stage it was a more mature view of the level of responsibility that was centred around the realisation that their accountability and responsibility extended to more junior staff. In addition, for the graduates in agencies where paediatrics and maternity care are part of the general ward area, responsibility and accountability extended into these areas that they did not feel prepared for. This further intensified their level of responsibility.

_As the only RN you are the one who is responsible. So you have to work really hard and keep an eye on everyone. I have to ask them [junior staff] to do the observations on the babies. Also I have not worked in maternity and I am not a midwife (NG 8)._  

NG 13 recounts an event that was disturbing for him. He had just rotated to the surgical ward after completing the first three-months in a medical unit. He had worked nine weekends in a row and was struggling with managing surgical patients on weekends where there was limited support for him. He felt that there was little recognition of his beginning registered nurse status and stated that on that ward _you are just another nurse on the ward._
Sometimes it has been extremely scary. On my second shift on the ward there was a midwife, myself and we also had high school based trainees. That was the skill mix for the ward. It was in the surgical bay so we had people coming back from surgery and going into surgery (NG 13).

NG 3 explained an incident that was distressing for her where she felt unsafe because staff members were being moved to other clinical areas. In addition she was uncomfortable with the limited support available to her when she needed to make critical clinical decisions.

I had half the ward as the RN and an AIN under me. The Nurse Manager came around and wanted to take someone away. There was a bit of an argument over whether any staff could actually go and then I was told to go (to another clinical area) (NG 3).

NG 3 in recounting this experience the respondent was distressed because it was she who had to leave her patients and go to another ward and help out with their medications. She went on to explain that she was uncomfortable with the move because one of her patients was acutely ill, she was contemplating calling what is known as a rapid response and she had several unsuccessful attempts at trying to get a medical officer to review her patient. Whilst she was away helping in the other ward the only RN on her allocated ward had to initiate a rapid response call for the patient that NG 3 was forced to leave despite her concern for the patient’s welfare.

Although this type of staffing may not always be the case, it demonstrates how the skill mix in the rural agencies, particularly after hours and on weekends influences the new graduate nurse’s level of responsibility, feelings of safety and the provision of effective timely support for new graduates by senior staff.

In addition, many participants were still struggling with delegating to more junior staff and taking the lead with clinical care, as the following quotes highlight.

I still struggle with delegating to the ENs and the AINs (NG 11).

Previously an enrolled nurse in the agency, this respondent stated that she was often busy doing the work on her own and acknowledged that she should be delegating. Her quote illustrates how many of the participants acknowledged in the interviews that they often tried to do everything themselves, rather than utilising other capable staff.
Sometimes I think I’m just doing it [the work] where I should be asking someone else to do the job, while I should have been doing something else (NG 11).

In contrast, many other respondents did not feel confident or comfortable in delegating to staff that were more experienced than them. NG 6 explains:

I have been three years at university and I come into an environment where an EN has been working for thirty odd years and I feel like ‘who am I to tell you what to do’ I am in a position where I have to take the lead and do all this delegation and I find it hard (NG 6).

Graduates in the smaller rural health services experienced that their accountability also extended to the management of the health service, particularly on weekends and after hours. At these times they were the only RN allocated for the whole hospital with more senior staff available for support via the phone. Participant 11 explains:

It is stressful working on my own on the after hours shift... You are responsible for anything that goes wrong in the whole place. Responsible for calling in the maintenance man, responsible for anyone who rings in sick- you have to replace them (NG 11).

Given the frustration that the researcher perceived many participants were expressing with this level of responsibility the researcher enquired of participants if anyone had ever provided mentoring or used a role reversal teaching strategy to assist them to practice the leadership and management skills required in the team leader role. Only three participants had had some isolated instruction or mentoring with taking on the “in-charge” or team leader role within the ward or units where they were working.

In summary the respondents were more comfortable with the registered nursing role at this six-month stage of their transition. They were all working extremely hard to manage the workload, and although the workload responsibilities had not changed the new graduates could perceive a change that they believed was bought about by their increasing confidence and familiarity with care regimes and unit protocols of where they were working rather than the support offered within the Transition to Practice Program. The level of responsibility specific to rural nursing practice was still evident as an area that the graduates were struggling with causing significant stress to them, in particular the leadership required in team nursing such as delegating and expectations of being in charge at times when there was insufficient RN support available to them was of concern for the graduates.
4.7.2.1. Subtheme 2.2: The Rural Transition to Practice Program

For the majority of participants their initial hopes and expectations from earlier in the year that more structure to The Program would eventuate were unmet. At this six-month milestone and for most participants the orientation/induction days, at the commencement of employment, were the sole content and structure of The Program. Conversations with new graduates centred on the continued lack of access to formal education at the agency and Area level, as well as a lack of structured consistent support within and between clinical units in the rural agencies. In addition, respondents discussed an absence of appropriate and timely feedback regarding their progress that for the majority of participants added to their disappointment with the programs.

There still is not much structure. It is still the same. I am sort of blind when it comes to opportunities like training days, conferences and what not. I have to seek all that myself (NG 4).

In my previous rotation it was quite structured, we had a meeting in the first week. We had a meeting at the end of the month and at 3 months and I was appointed a mentor.... Whereas, here I just turned up, there was no orientation, there was nothing (NG 13).

I am not entirely happy but I am just trying to get through it (NG 3).

The environmental survey had revealed that three agencies included structured rotations as part of their Transition to Practice Program. However, generally the organization and timing of rotations up to this six-month stage had been unreliable for the graduates employed within these three agencies. Three respondents listed the rotations they had had since the first interview with the researcher. It appeared to the researcher that the graduates were either being moved around constantly with no real time to become acquainted with a clinical area or were being left in areas longer than they had anticipated.

I have been to kids ward, mental health and now medical and then I go to surgical for a while then back to medical (NG 3).

I started in kids, went to medical had a 2 week stint in theatre before going on annual leave, now I am back in medical (NG 6).

I spent 20 weeks in surgical, then 6 weeks in mental health and now I am in paediatrics (NG 1).
The respondents did not know why the rotations eventuated as they did. Some stated they felt it was possibly due to staffing allocations or lack of staff. However, whatever the reason the new graduates who were moved frequently experienced another transition. NG 1 in her conversation about being moved around is representative of how it felt for the graduates who were being moved constantly.

_You start a new rotation and you have to basically start all over again. And I am pretty good with being able to learn things quickly, so it has taken me about a week to a week and a half to get into it again (NG 1)._ 

For other respondents their rotations were yet to occur. They had been in the same clinical area for six months, which was disappointing for them given that they had anticipated clinical rotations.

_She [Health Service Educator] was doing her best to give us rotations in other parts of the hospital but that has not quite worked out (NG 13)._ 

_I ended up here for the whole 6 months; they kept me here a little longer (NG 15)._ 

For one respondent the formal rotations that were expected as part of The Program did not occur and like two other respondents she was moved between clinical units on a daily basis. NG 8 recounts how her rotations did not eventuate. However, she found the confidence to talk to someone about her rotations. From then on she was moved frequently for one or two days at a time to experience different types of nursing.

_On my coming roster I am working one day ED, one day ground floor [medical], another day surgical, then surgical again, something like that (NG 8)._ 

The quotes from the respondents below illustrate that clinical unit changes for them were mostly to ED departments. This again was organised to provide some variation for new graduates in agencies where it was not possible to have structured rotations because the agency only had one general medical area where the new graduate was always rostered. However, these changes, as with the situation for NG 8 could only occur if there was another more senior RN allocated in the ED to support them.

_Stay here [general ward] all the time and on the weekend I would be the 2nd on in ED (NG 12)._
I am a bit frustrated that I don’t have any rotations. I will be working in ED tomorrow. I have done a couple [shifts] in there (NG 2).

Access to structured formal specific education for new graduate nurses remained problematic for them at this six to seventh month of the rural Transition to Practice Program. Plus, the lack of quarantined time for the graduates to attend specific new graduate nurse education study days was disappointing for most of the participants.

The thing I am disappointed with is I still have not had any education days (NG 7).

The participants at this stage had been eagerly anticipating formal education study days and many of the participants reported that in light of no specific new graduate education forthcoming or what they perceived as inadequate access to education, they had adjusted their expectations and were commencing to pursue their own educational needs. However, not all were successful in their pursuit, as rostering arrangements and ambiguity as to whether new graduates could attend often thwarted their attempts as NG 3 and NG 9 explain.

I have requested a couple of times to have days off to be able to do education. I am going out and finding education for myself to do and then I have not been allocated the time off (NG 3).

I tried to apply to do another course but unfortunately because I am a NG I wasn’t allowed to attend (NG 9).

The participants who were able to access and attend formal new graduate nurse education study days were satisfied with the content. For example two respondents had attended study days on paediatric assessment and recognition of a sick child. Four had presented a clinical case study to their peers, and one had attended skill development for clinical procedures such as catheterisation. Another respondent had attended mental health education while another had attended DETECT training (NSW Health Detection of the Deteriorating Patient) and an in-service on legal and professional issues. In particular, the two new graduates who were being allocated to work frequently in ED had attended a larger regional centre for specific rural emergency department training. This education was not specific to new graduate nurses but was open to any rural nurse. As much as the graduates in the small rural agencies welcomed this education, they felt that it was too late and perhaps they should have had access to this training and education earlier in their Transition to Practice Program.
I went for a series of courses for post grad training in ED for the rural sector. It was very good for what to expect with triage and different outcomes for patients when they present to the hospital. It sort of improved my confidence a bit. I think it should have occurred earlier because I feel it’s a bit too late (NG 5).

One other respondent had successfully applied to attend a series of diabetes education workshops that were held in another health service and she stated that this helped with her pursuit of knowledge surrounding chronic disease progression which is what she felt she needed to focus her learning on at this time given that she had recently moved from a specialty area to a medical unit.

As mentioned previously, the researcher decided to investigate with respondents the education packages that some respondents had discussed in the first interviews. At this stage there still did not appear to be any general consensus amongst the new graduates as to the content or the purpose of the packages, some felt they were just orientation stuff to be done only in the first few weeks of employment whereas others thought they had to be completed throughout the year. However, regardless of the purpose and content, all participants who had received a learning package stated that nothing had eventuated with them. This was partly because the respondents felt that the content was not appropriate or relevant and partly because they were left to their own devices to complete them. As far as the graduates were concerned there was no follow up because in some cases there was no designated person to follow them up and in addition it seemed to the graduates that the ward staff did not take interest in them. The new graduates were not challenged nor interested in the content, thus the packages were ignored.

*The paediatrics one was out of date* (NG 14).

*It needs to be taken up a lot more* [the learning packages], *because it falls on the grad completely. But they are not specific to each ward-you could do them anywhere-basic skills like BP, basic observations* (NG 6).

Two graduates who had received the learning packages had suggestions about what could have been included that would have provided more effective learning support for them.

*The mental health section expanded into different medications. It was really helpful* (NG 14).

*More ward specific things. For example, this is what we do on this shift, the paperwork because each ward is different* (NG 6).
And the following quote which demonstrates the need for learning support around performance of specific registered nurse procedures that frequently occur in the rural clinical area. NG 15 relates what she feels would have helped her when she was in a busy surgical ward where the orthopaedic patients may be required to have Autologous Blood Transfusion (ABT), a type of postoperative cell salvage system performed within the immediate 12 hour post operative time frame. She struggled with this particular procedure on evening duty when most of these types of infusions occurred and when there was very few staff to support her with the procedure.

*It’s too basic it needs to cover ward specific things like can you, have you done an ABT? [Autologous Blood Transfusion] (NG 15).*

As part of the formal Transition to Practice Programs all participants expected to have some measurement of their progress undertaken. However, in reality very few new graduate participants had received any formal feedback regarding their progress. Rather the majority relied on casual conversations or overheard conversations to measure their progress as respondent six explains.

*The NUM was talking to another RN and I heard my name mentioned. I thought they were calling me and I said ‘did you call me?’ and she said ‘no I was just saying that you get on with the job and that you do a good job’. It was nice to hear that. It gives you a boost (NG 6).*

The graduates’ self-determination to do well and to be thought of as good nurses is evident in the following quote.

*No I am not getting any feedback but I have my goal of what I want my practice to be and I try to not let that get anything under 10/10 (NG 9).*

*Rounding* was still experienced by three of the graduates. However all three who had experience of rounding via casual conversations stated that they would have liked some quarantined individual time to sit with someone and discuss their progress and goals and to have some formal debriefing.

When investigating with the participants any suggestions that they would have for the Transition to Practice Programs at this stage, respondents focused on the provision of structured formal support mechanisms at the ward or unit level. As well, more clearly defined access to specific education study days for new nursing graduates with suggestions for the
focus of learning to be around disease progression, in particular chronic disease management. Learning support around fulfilling the documentation requirements specific to rural practice and the rural registered nurses’ role in, for example, the retrievals, transfers and referrals that the participants were identifying as still problematic for them at this stage. And, accessing and implementing specific policies were ideas graduates had for formal education at this time. For those in smaller agencies more timely education support for triage and assessment of presentations to the ED were suggested.

In summary, it is evident that the rural Transition to Practice Programs examined at this time were clearly not recognisable by the respondents as formal structured programs. Rather they were perceived as ad hoc arrangements with no structure or access to formal educational opportunities or formal structured on-ward support.

4.7.2.1. Subtheme 2.3: Support Experiences Versus Support Needs

Overwhelmingly at this time of their transition all of the new graduates stated that they had feelings of isolation from other new graduate nurses. It is apparent when listening to the interviews that participants felt that support from their new graduate peers was very important for them at this time. Many stated that they had not seen or interacted with other nursing graduates since the initial orientation programs and they discussed that having time with other graduates to debrief and compare experiences would be a valuable support strategy that could be included within the rural Transition to Practice Programs. Two new graduates specifically stated that they looked forward to the interviews with the researcher in order to have someone to talk with about their emotions and experiences as they make the transition. Participants who were released to travel to other agencies for education, or who attended onsite education with their peers stated that they valued this opportunity to interact and debrief with their new graduate peers as illustrated by the following quote.

*We have had three education days that are allocated but it would be nice if we had a few more because it is also nice support just seeing the other grads which I haven’t had the opportunity to at all (NG 1)*.

Being the only new graduate in an agency as well as not having access to specific new graduate education study days were reasons new graduates felt isolated. As well, where there was a number of graduates in an agency, rostering prevented new graduates ever coming across each other so this is another reason why new graduates had feelings of isolation. Their
feelings of isolation were further validated, as they knew graduates in larger regional and metropolitan agencies were having different experiences.

*I feel like I am isolated from other new graduate nurses (NG 12).*

Once again the respondents’ expectations of management support was not as forthcoming as they expected or would have liked. Respondents talked of NUMs who stayed in their office, who were in close proximity but not accessible to the graduates and they felt that they were not visible to the NUMs as the following quotes demonstrate.

*There is always room for improvement. She is supportive in a far off manner (NG 4).*

*I have found so far that with all my rotations the NUMs haven’t really been a big support (NG 1).*

*She was my allocated mentor and acting NUM, and on my first day she didn’t even say good morning to me (NG 14).*

At this stage the new graduates were looking for some indication from the managers of their progress. They were also expecting acknowledgement of their presence in the ward and desired to have some meaningful interaction with the managers. In the quote below the new graduate tells the researcher how she has no idea how she is progressing, or if staff are happy with her progress. The researcher enquires as to whether she has approached the NUM for this type of support.

*I think I feel a little bit scared with her…she comes down almost every day to the ward …we speak… but not for other things (NG 12).*

This quote, and the responses below, typifies how many of the respondents felt about interactions with many of the Nurse Unit Managers. All but a couple of the respondents felt the managers were not available to them and this was important to them because in the absence of specific ward-based nurse educators they were relying on the managers for feedback and support, particularly debriefing support.

*I would have liked her to seek me out. I would have liked that support because sometimes I feel like there is nobody to talk to. I can’t debrief to anybody and she is just there, because you can’t talk to anybody (NG 5).*
**I always think that with the NUM where I have been that they could have been a bit more supportive, they could have been interacting with us and asking us is there anything we would like to know and just stepping up (NG 3).**

Not all graduates experienced a lack of support by the nursing managers and many felt that they were beginning to develop relationships with the managers. However, they all stated that they had to seek the support from people in these positions because it was not routinely volunteered. The managers who were perceived by respondents as supportive at this stage displayed their support via supportive rostering, protecting new graduates from responsibilities that were beyond their scope of practice or which were out of the graduate’s comfort zone. They were also seen as being approachable and accessible to the graduate.

*SHE has been fantastic with rostering and really open, you can go up and say anything. If she is busy then you have to step back a bit (NG 6).*

When discussing the provision, timing and adequacy of support, and from whom it was coming, respondents’ conversations were positive surrounding the type of support offered by staff they were working alongside. The majority of respondents felt that they were forming positive relationships with staff and that this affected the support they received. However, they also felt that it depended on the individual personalities of the nursing staff and the culture of the clinical unit as to whether they displayed supportive gestures. NG 4 had relocated to another rural agency for her rotation and was thrilled by the reception she received and the support that continued.

*They were just really excited to have me here. I feel like one of the team (NG 4).*

Many graduates were able to state that they knew by now, this six-month stage, who to go to for help or rather who not to go to seek help from, as NG 3 explains.

*I soon learnt which ones were approachable and which ones I thought I was learning the most from, and I would go to them (NG 3).*

The graduates were becoming attuned to picking the time and the staff member from whom they sought support. For example if they had a *why* question that was not urgent they would wait until an approachable staff member was on shift rather than asking someone who they deemed to be unsupportive and not receptive to questions. However, for the new graduates in the smaller rural agencies there was no choice about who they could turn to for support as
there was most frequently only one or two others onsite from whom to draw support. If the staff working with them were not forthcoming or not perceived as supportive then this was very isolating for the graduates. NG 5 who had relocated from a metropolitan area for her rural Transition to Practice Program, had never been in a rural hospital before and who was required to be managing ED presentations as well as was frequently being rostered to work on her own without RN support, felt quite marginalised by some staff’s lack of support. She describes an incident where she feels a particular RN always tries to find fault with her and her abilities and does this in front of patients which is quite distressing for her.

_I can just say that only a few are [supportive] because some tend to criticise the post grad, they just make you feel bad all the time. She tries to find fault with me all the time (NG 5)._  

The majority of respondents they were able to state that most staff were supportive if they sought help but many nurses did not routinely volunteer their support and it was up to the graduate to seek support. As a Clinical Coordinator and from a previous unpublished study conducted by this researcher, the researcher knows that there is an expectation by more senior RNs and nurse management that new graduates would seek help. However, it is this researcher’s belief that it is not clear to new nursing graduates exactly what it is okay to be seeking help for and in many instances new graduates do not recognise what it is they should be seeking help with. In the absence of clearly designated new graduate responsibilities or workload allocation there is an assumption by graduates that they have to cope with the workload on their own. For example NG 14 in her conversation regarding the provision of on-ward support compares the support she is receiving in a specialty unit where she is treated as a new learner and junior staff member compared to a fast paced medical area where she felt they had high expectations of graduates’ abilities. She felt that in her first few months she was treated as a person who did not really need support and that she was left to flounder with the workload. She states that it would have been helpful if somebody had asked her how are you going with your patients, or what is happening in here? Rather she stated that she just battled on until a conversation she had with a senior RN regarding her progress enlightened her on the expectations by senior staff that the new graduate will seek support and will know what to seek support for.

_I was asking for feedback from one of the people I had worked a fair bit with and she said ‘well you are not asking for help enough’. And that was right at the end of my rotation and I said ‘I didn’t realise I could ask for help’ and she said ‘well, now we have cleared that up’ (NG 14)._
In recounting her experience that occurred in her first three months of practice this participant is still very emotional regarding her early transition experience and her feelings of being unsupported with managing the workload.

Respondents were also prompted to discuss who was support coming from at this time or who were they seeking support from? For all the respondents it was the registered nurses that they sought support from at this six-month stage of their transition.

There is one RN who helps me out with learning and when we have quiet times she often helps me but that is at my request (NG 9).

The midwives, because they are RN midwives, they are very supportive, they were all very keen to help, but it was not as structured as the other ward. Half the time I had to go looking for it and the half of the people knew that I needed their support. It was forthcoming if I went looking for it (NG 13).

The respondents were prompted by the researcher to discuss what they perceived to be good support at this time for them. They described behaviours such as checking in frequently, being available, offering assistance and initiating snippets of education during the course of the shift in quiet times. Also, displaying support through friendly conversations that made the graduates feel part of the team and that made a big difference for them.

Just time support, being available to do things, they were busy with mothers and babies but still took time out to help me (NG 13).

This particular nurse is really good at explaining things and she does recognise that I am only a first year out. She expresses herself in an understanding manner and her expertise is displayed in the support that she does give me when I need it. Sometimes she initiates support, there was one shift when she pulled me aside and she asked me if I needed help with performing ECG’s and just running over the resus [resuscitation] trolley, that sort of thing with me, she initiated that (NG 4).

For NG 11 who was frequently on her own in charge of the hospital after hours and on weekends plus managing the ED, good support was the offer by senior staff to telephone them if she was unsure or had a problem. The acknowledgement by senior staff that she would be on her own and that they encouraged her to contact them was comforting and perceived as good support.

Even on the shifts when I was on my own they said ‘you can always ring me if you need advice’ (NG 11).
However, the participants acknowledged that insufficient RNs during each shift influenced the amount of learning support they received from the senior nursing staff. This was evident when the researcher asked the respondents: *what does a good day look like for you when you are on the ward?* Adequate staffing allocation was the biggest factor that influenced their perceptions of what a good day looked like. Respondents stated that *a good day* for them was influenced by the presence of senior registered nursing staff in the clinical area to provide learning support for the specific rural registered nurse workload and responsibilities.

*That would be the day when there are 3 of us on. That would be a midwife, an RN and an EN (NG 2).*

*An RN coming up and asking if you are okay? Can I help with anything? Asking if you need assistance with any procedures, if you are comfortable with things? (NG 6).*

*I often find the casual staff and the ENs are often more supportive than the RNs who had been there for ages. This casual, the first few times I worked with her kept coming up to me and saying- ‘are you okay, where are you up to?’ And that was really good. Rather than how it was in the other ward- ‘have you done this, have you done that?’ (NG 14).*

For the majority of respondents they felt that the Enrolled Nurses were generally supportive. However, unlike the first interview where the participants were relying on the Enrolled Nurses for support with clinical care routines, the focus had at this stage of the transition shifted to ENs displaying support by being receptive to the new graduate delegating care to them. For example NG 8 recounts an experience when she was in charge on a night duty shift with no senior RN support and how she perceived a lack of support from the Enrolled Nurses that resulted in her feeling unsafe and worried about *losing my licence.*

*They were really rude to me and not doing things. The ward was full on [busy], and I had a really bad shift. There was sick people coming in and the ENs refused to do what I asked them (NG 8).*

Consistent with the first interviews those new graduates who had access to a specific ward-based clinical nurse educator were very satisfied with the level, timing and provision of support provided by this position. The researcher prompted respondents who had experienced this type of support to explain what was effective about the support. NG 15 explains how when she had *hit the wall* the CNE was there to help.

*She would come and make sure you were all right with your medication round, for starters. ‘Did you understand what the patient had wrong with them? What other things did you have*
to look at in the big picture? What were you going to think of next?’ so she prompted you a lot and that got your thinking processes happening (NG 15).

As stated previously and noted from the environmental survey data, only two agencies had ward-based clinical nurse educators, however several agencies indicated that they were expecting ward-based CNE positions to be filled later in the year. Participants stated that their understanding of these positions was that they were part-time and that they would be roving between agencies. So at this stage of the transition to practice, most graduates had still not had any contact with a ward-based clinical nurse educator to provide any direct education or support with clinical care. However, two respondents had described a brief corridor conversation with a Clinical Nurse Educator and were eagerly awaiting more focused individual contact with a CNE. Their experience of access to a CNE became a focus for conversations with these two graduates in the final interviews.

I met a lady the other day and she was a CNE from [mentions hospital name here]. We had about a two second brief ‘Hi I’m the new grad’ and that was it (NG 7).

We got a new educator and she is going to talk to me in September (NG 12).

Five graduates stated they had minimal contact with a Health Service Educator who provided assistance with rotations and provided in-services for all staff, and two participants had not had any access to any person who held the title of educator or who was responsible for education.

At this stage of their transition into rural nursing practice the participants were seeking support and assistance with unfamiliar clinical care but mostly seeking support and advice regarding clinical decisions and making clinical judgements. For example, many participants stated that recognition of a deteriorating patient and when and if to call a rapid response, as well as managing ambiguous medication regimes, prescriptions and standard treatment protocols from medical staff that were not on site, made the graduates feel uncomfortable and were reasons why they were seeking support. In addition, the respondents also cited clinical conversations with medical staff as being problematic for them. For example having to call a doctor to come and perform a medical review and voicing opinions concerning patient conditions to medical staff.
The graduates who had rotated to other clinical units sought support for clinical care and unfamiliar procedures that were unique to those clinical areas. For example, NG 13 and NG 7 both moved to a surgical unit so sought assistance for surgical nursing skills such as removal of drains and pre and post-operative care regimes and patient controlled analgesia systems. NG 3 commenced employment in mental health and was often rostered to the EN line in this area, which meant that she was not given opportunities to perform specific RN duties. However, now in the fast paced medical ward environment was seeking support and assistance for medication administration, the RN specific duties for which she had not had an opportunity to practice in the mental health area.

NG 4 explains what she mostly seeks support for now, and although she is in a smaller agency without medical support many of the graduates cited the same reasons for seeking direction and support.

*It is probably more clinical because we don't have a doctor on site here. If there is a deteriorating patient or someone that needs reviewing, I consult with the senior RN first before contacting the Doctor. I would ask their advice (NG 4).*

NG 5 was also struggling with not having onsite doctors and was seeking support for assessment procedures that she was expected by medical staff to perform and which she felt were beyond her scope of practice. She also experienced difficulties in knowing what to assess the patient for and then how or what exactly to communicate back to the doctor.

In addition the organisation, documentation and reporting requirements surrounding such things as patient transfers and retrievals, ED presentations and referrals to other health services particularly after hours and on weekends were still current concerns that most of the participants stated they were still seeking support for at this six-month milestone of their transition to rural practice.

In summary this subtheme has presented the respondents’ perceptions of provided support at the ward level at this the middle stage of their transition to rural practice. Consistent with the first three months the participants remain disappointed with what they perceived as a lack of support from the unit managers. The support that they experienced at the ward or unit level at this time was mainly coming from the registered nursing staff who were displaying effective support through methods such as checking in, being available, and initiating education on the
run with the graduate frequently throughout the shift. However, participants stated that they had to seek and initiate support from their Registered Nursing peers because it was not always volunteered routinely. The majority of participants had not had any exposure to or access to a clinical nurse educator, but those that had experienced this type of support stated that it was initiated and volunteered by the clinical nurse educators and was effective in assisting with their transition and with leadership and management expectations that the organisation had of the graduates at this stage. As well, the graduates felt very isolated from their peers and suggested that more exposure to other recent graduates would be of benefit to them at this half way mark.

Finally, the participants in this study wanted support at this time with unfamiliar clinical care regimes and procedures, higher order assessment and communication skills such as those required in the ED or when managing acutely ill patients and managing the documentation and reporting requirements for retrieval, transfers and referrals.

In conclusion, this second theme that represents the second round of interviews at the six-seventh month milestone of transition indicates that the workload and level of responsibility within rural practice was still of concern for the participants. However, their increase in confidence and familiarity with the rural clinical environments had assisted to ease the initial difficulties that many had encountered in the first three months. At this stage, problems with leadership and management of more junior staff remain a concern particularly the team leader role that has expectations of delegation and accountability that the respondents did not feel comfortable in performing and for which they did not receive any support during the Transition to Practice Program.

For the majority of participants the Transition to Practice Programs had not eventuated as they expected. There were very few or no specific formal education study days for at least half of the new graduate nurses and many respondents sought and explored their own educational opportunities. In addition, there was an absence of formal measurement of their progress. The participants at this stage felt isolated from their peers and the lack of access to formal education study days specifically for new graduate nurses compounded their feelings of isolation. The graduates’ perceptions of the timing and provision of support at this time was that they had to seek support and that the timing of support was influenced by the skill
mix and workload allocation that often negated against effective workplace learning and support.

4.7.3 The Third Stage of Transition

4.7.3.1 Theme Three: Just Another Nurse at the 11-12 Month Milestone

This third and final theme arises from the final round of interviews conducted with the new graduate nurse participants during December and January 2011, that corresponds to the eleven to twelve month stage of their transition to rural practice. Thirteen interviews were conducted in this final round of interviews as one participant had secured more permanent employment in a specialty area within the rural agency and so had left the Transition to Practice Program.

In this round, each interview lasted for approximately 20-30 minutes and for the majority of participants they had no new information to add regarding their time so far. Rather they wanted to clarify and reflect on their transition experiences.

In this final interview the narratives were reflective as respondents compared and contrasted their experiences and feelings throughout the year to describe where they were at now, this the final stage of their transition. Many of the respondents looked back to where they had been and had come from and were also looking forward to where they might or might not go. This time was again influenced by the forming of relationships and friendships, disappointment with the content, structure and delivery of the Transition to Practice Program and also with what the participants perceived as a lack of access to timely and appropriate educational support at the ward level. Three subthemes characterise the participants’ experiences and feelings at this final stage of their experience of transitioning to the rural RN role, the transitional support programs and of the provision of timely and effective ward based support. The three subthemes are; Influences on Support while Immersed in the Rural RN Role; The Rural Transition to Practice Program; Support Experiences versus Support Needs.

Two participants, NG 13 and NG 7 make comments that resonate with how many of the participants were feeling about their journey at this time and which influence the title for this stage of the rural new graduates’ transition to rural nursing practice.
My whole journey has been up and down. It has been a rollercoaster (NG7).

I guess it has become fairly apparent that the whole new graduate thing has definitely died off a bit and I guess you just become another nurse I would say (NG 13).

4.7.3.1. Subtheme 3.1: Influences on Support while Immersed in the Rural RN Role

At this final stage participants were once again asked how are things going for you? This question revealed a mix of responses as participants talked about everything from education days, rotations through to support, and where their career was going on completion of the twelve-month program.

The interviews revealed that two other participants had left the Transition to Practice Programs. One at the nine-month stage due to accepting a more permanent part-time position within the rural agency, however still accommodated a final interview. Another had left the Transition to Practice Program at the eleven-month accepting employment in a metropolitan agency and in the interview was able to make comparisons to what she had received in the rural environment to what she was now receiving in the metropolitan environment.

When listening to the interviews and re-reading the transcripts from this final round of interviews it was clear from the narratives that all of the respondents now felt more comfortable with the rural nursing role and also felt they were accepted as valuable team members by their nursing colleagues. Many attributed this to having honed their skills and being able to manage the expected workload and level of responsibility within the rural environment. The majority acknowledged the steep learning curve they had experienced and the learning journey they had been on and were still on.

One example is NG 2 who stated everything is coming together now. Her increase in confidence was evident as she recounted to the researcher an emergency incident that had occurred on the ward the previous day. Involving resuscitation and retrieval she realised she had taken the lead with making clinical decisions and clinical judgements and was very pleased with her actions and response.

I said ‘Ok let’s see what the options are? Whereas before I would have asked what are we going to do? (NG 2).
Two participants who had commenced their transition year in specialty clinical areas and now near the completion of their programs, and placed in fast paced medical-surgical areas, were still coming to terms with the expected workload and skill mix within the rural environment. Adapting to another rotation, specifically adapting to the workload allocation, was significant for them at this time. NG 3 explains how she felt moving into a surgical environment.

*I think just the workload in general, turning up and knowing that you might not stop all day, you might get a short break, but then you are going to be busy* (NG 3).

However, many were still struggling with the team leader role and the responsibilities and accountability required of new graduate nurses in the rural environment at this time. In reflection the respondents perceived that there is insufficient registered nursing staff within the rural environment and this results in graduates having no alternative but to take on responsibilities that they do not and were not prepared for in their educational preparation nor supported with by the workplace in the transitional year. As the three quotes below demonstrate:

*I did not expect to be placed in some of the situations I was placed in-being the only RN on the ward some weekends* (NG 13).

*Basically it’s all your responsibility, and it is a lot of work* (NG 3).

*There are times when you just didn’t have enough... There just was not enough staff* (NG 14).

NG 12 who had already left the rural agency for a metropolitan position reflects on the workload and responsibilities that she has experienced in the rural environment.

*The patient staff ratio here [metropolitan health service] is very good. Where I was before a smaller rural hospital, the workload and the patient to staff ratio...you never have enough staff the RNs take on lots of responsibilities and it is very risky for new graduates* (NG 12).

At this stage of the transition all except two participants stated that they were routinely in-charge of clinical areas, some as the only registered nurse rostered to the clinical unit particularly on weekends and after hours.

*If I am the only RN on the floor I am automatically in-charge* (NG 4).
As mentioned in Theme Two the researcher in this final interview enquired of all participants if they had experience with role reversal or any other teaching strategy to assist them to practice the leadership and management skills required in the team leader or the in-charge roles that they were required to assume. At this stage only two more participants had been able to state that they had been given support to develop these skills. Thus only five participants over the 12 month period were provided with learning support such as role reversal to develop the leadership and management skills expected of the new graduate nurses within the rural setting.

The concerns the participants had with delegation to more junior staff and the team leader role in the first and second interviews had for the most part abated as a result of the graduates’ comfort, familiarity and confidence with the roles they were fulfilling.

In particular, NG 6 states that the responsibility of delegating care to junior staff members up until now (the 11-month of his transition) was a massive issue for him. He attributes his recently found confidence in these skills to support by an RN as well as his improved abilities in time management and managing the workload.

I was paired up with a nurse I wasn’t sure if she was an RN or an EN. We started working together and I just began delegating. ‘OK this is what we need to get done, this is what we need to do, if you do this, I will do this’. I didn’t find out until the end of the shift that she was one of the senior RNs, so that boosted my confidence—she stepped back to see what I was going to do (NG 6).

However, three participants were still struggling with the team leader role and the delegation aspects. For them it was the personal traits of individual staff members that influenced their experience of support within these roles. NG 12 states that some nurses are very lazy when talking about support or lack of it that she received from enrolled nurses. NG 5 is frustrated and angry that when working with AINs she has to ask them to do stuff and feels that they should know by now what they are expected to do she believes they are intentionally being unhelpful. These respondents were still finding it hard to trust some staff specifically, if more junior staff had followed through with delegated care. Two recounted disturbing experiences where they felt they could not trust the enrolled nurses to carry through with tasks or care delegated to them and that had added to their feelings of being unsupported when in the role of team leader.
I am seeking support from the staff to work because sometimes some of them [ENs] don’t want to do anything (NG 8).

A lot of the ENs are good support, not all of them, but most of them you could delegate to and know that it would get done. It wasn’t always necessarily getting done (NG 3).

All of the new graduates had been exposed to providing supervision for nursing students on clinical placement by this stage of their transition to rural practice. Their experiences of supervising and working with students also added to the difficulties with the ever-increasing role and responsibility. NG 6 in his conversation acknowledges how he had not realised the responsibility involved with supervision of students and how it added another dimension to the workload, accountability and responsibility.

Some of the nurses out there you don’t notice as a student, or I didn’t notice as a student. They [RNs] are really busy and you are sort of an extra person on top of that and I did not notice that until I had a student nurse placed with me. They [RNs] don’t have time to recognise—well this is what they should be doing and I should be facilitating that (NG 6).

In summary, nearing completion of their Transition to Practice Program and their employment with the health service, participants in their conversations were comfortable and confident in their nursing abilities. However, they were still in awe of the workload and level of responsibility that is part of everyday rural nursing practice, that they attribute to a general lack of registered nurses within the rural environments. All except two participants were assuming almost daily team leader and in-charge roles. The management of more junior staff and the associated accountability and responsibility whilst undertaking the team leader and in-charge role remains a concern for all participants.

4.7.3.1. Subtheme 3.2: The Rural Transition to Practice Program

Participants reflected on what they had experienced in the Transition to Practice Program and it was clear in the conversations and when re-reading the transcripts that the Program did not meet the expectations of this sample of new graduate nurses. Clinical rotations, specific new graduate education study days and structured on-ward education plus formal feedback were areas suggested by respondents that need to be improved within the programs. NG 3 summarised the general consensus surrounding the programs by this sample of graduate nurses.
I would suggest they make it more of a program because it has not been a program for me as such (NG 4).

Six participants had experienced a clinical rotation since the second round of interviews conducted at the six-month stage of transition. As noted earlier in this section, two participants had rotated from specialty areas to medical-surgical areas with NG 6 describing the move into a surgical area as a massive shock to the system. One other participant NG 7 had experienced a two-month rotation to another health service with one month of that time in community health as well as another rotation of two weeks to another smaller rural health service. She had experienced two new rural health services as well as a community health setting, all of which required her to commute some distance. Throughout the year the researcher had noted in her journal after each interview with NG 7 very happy and still happy for the first and second interviews. In recounting her experience of her time since the previous interview in particular where she had been since the second interview and how it eventuated she gives the impression of frustration and disappointment in this final interview and comments to the researcher that the biggest hurdle for her has been being flexible.

It was not long enough [the rotation]. I was not too keen to go because I was being stuffed around a bit with my rotations. When I first arrived I got to pick where I wanted to go and for how long, the HSM had organised it and booked it all in. When it actually came time to go and I am doing my three month roster before I am due to go, I am asking ‘am I going or am I not?’ So I was just all over the shop for about three months (NG 7).

Three other graduates had moved between the medical and surgical units within the rural agencies where they were employed. One of these was disappointed that the promised theatre and paediatric rotations at the beginning of the program never eventuated because of the closure of wards and cessation of surgery over the December-January period. Two participants were now experiencing specialty areas of paediatrics and mental health, also within the employing agency. Four participants who were not expecting clinical rotations continued to be swapped between clinical units, such as the emergency department and the general ward on a daily basis. NG 2 had been rostered frequently for individual shifts in the ED and Operating Theatres and although she appreciated the change and the chance to work with a senior RN in these areas she was disappointed that the formal longer-term rotations had not eventuated.

They told me that I would [have clinical rotations] and it is written in the contract that you would rotate (NG 2).
Overall the experiences of participants of clinical rotations were not positive. And, even though they eagerly awaited the rotations, the majority were frustrated with how the rotations had eventuated. No participant could state that they occurred as initially planned. Participants felt that the rotations were disorganised, either too short or too long or did not eventuate. When they did eventuate it caused stress and the experience of another role transition as NG 1 illustrates.

*I moved again from paediatrics to medical ward and it is a totally different experience being an RN there. Again it’s starting a whole new rotation therefore you go from having high confidence in an area to having low confidence again (NG 1).*

NG 1 acknowledges that *having experience in different areas is good* but the constant rotations had *been stressful* for her. She talks about the discrepancy between what was expected and what they were told to expect. That is, that a lot of her rotations and those of the other new graduates in her agency *have not ever been for three months. They have been for less.*

NG 14, although she enjoyed her final rotation because she was feeling that *the expectations of the ward just seemed a bit more realistic*, also felt that the rotations and the way they eventuated were of concern.

*I would prefer six-month rotations not all this moving about (NG14).*

The experience of education, formally within the Transition to Practice Programs and at the ward level was also disappointing for the majority of the participants. It is evident that the perception by participants of the organisation and communication of specific new graduate education days was disorganised and prone to ad hoc arrangements that never eventuated for many. The lack of access to and appropriate notification of specific new graduate education study days continued to be problematic for several graduates. Missed emails or receiving information too late to be released from roster allocations, coupled with coinciding annual leave, were cited as reasons why participants did not attend any education since the second interview.

Ten of the participants were required to travel for any continuing education they received. Eight of the ten who travelled to other rural agencies for specific new graduate education study days were happy with the content that they received. Although the content for specific
new graduate education differed between agencies participants gave examples of the content that they had received which they were generally pleased with. NG 14 felt that the three education days she attended were not valuable or effective education for her and makes a suggestion for content.

*Education days were a waste because we all had to do a presentation, which was not really valuable. I would have rather worked through issues and challenges and maybe some case studies (NG14).*

Two participants when they did attend new graduate education study days had to travel to larger regional agencies. NG 13 reflected on travelling to attend education at a larger regional agency and makes the following comment.

*People who attend these days are from [mentions hospital name] so it has become more concentrated on meeting their needs rather than the people who come from the smaller hospitals in the district and it has become not worth going to (NG 13).*

NG 2, up till and including the second interview at the six-month stage had not had any access to formal education but was pleased to have attended some education in the last three months of her program. She attributed this development of her attendance to the new roving Clinical Nurse Educator who had organised for her to attend one day per month at another rural health service with other new graduate nurses.

Suggestions by respondents for specific new graduate education included having clearer processes and communication with ward staff and managers on the timing of the education. In addition, more education/study days that are focused on new graduates identified learning needs and more frequently occurring short education sessions were required. NG 3 who had three education days over the year explains her suggestion.

*I think we need education sessions where new grads are pulled off the floor. Where you go and do two hours every so often to have education on day-to-day things. For example care plans. You can get feedback on if you are doing them okay (NG 3).*

In addition, participants in the smaller health services had suggestions for education that they would have liked at this time to support their increasing responsibilities in managing deteriorating patients and emergency department presentations.
I need some more education on managing critical people, with severe cardiac problems or trauma (NG 8).

The provision of on-ward education or education on the run was specifically a topic for conversation initiated by the researcher in response to earlier interviews where respondents had stated that they had no education. When asked if they were receiving any on-ward education participants responses reflected a general perception of a lack of on-ward education. NG 13 is disappointed and states this whole program thing of guidance and stuff is... not really there, it’s finished. Then proceeds to discuss his belief surrounding educational opportunities offered to him onsite.

Not a whole lot, and it is only motivated to meet their end, to meet their obligations rather than giving me skills (NG 13).

In this comment NG 13 is telling the researcher how it was offered that he could attend dialysis education and training although he did not think that he was ready to be working with dialysis patients just yet. He had other goals for learning that had not been fulfilled and thought this offer was premature.

NG 6 believes that the lack of on-ward education can be attributed to the fact that the only other RN has a heavy patient load as well, thus there is very little time for the experienced RN to be providing education support.

It is a bit hard for the RNs who have a patient load as well as a grad to teach and other student nurses (NG 6).

On the topic of completion of ward-based or agency-based education packages the majority of participants who had received these materials did not complete them or did not engage with them. Respondents suggested that perhaps someone could provide follow up and support with this type of education. For example, someone spend some time with graduates going through completed components. As well, respondents felt there was no incentive to complete the education packages particularly since they perceived the content to be out of date, not relevant and did not encourage critical thinking. Also, as NG 14 points out, all you could do really was your workload, there was no time to engage with and or complete the learning or assessment components. Suggestions for what would be more effective in terms of content included: care protocols for different wards, specific procedural skills required in different
clinical areas. For example, one respondent would have liked content related to patient-controlled analgesia. Another respondent felt disease progression and management for common presentations to the specific clinical area, and surgical nursing routines particularly pre and post-operative care would have been valuable additions to the on-ward education packages. NG 3 suggests ways of presenting the content that would foster and encourage critical thinking regarding patient management and clinical decisions that would be more effective and supportive.

*How would you deal with this situation if this were to happen? That sort of thing to get you actually thinking. So that you are learning to manage the ones [post operative patients] that are not routine (NG 3).*

The concern by graduates surrounding the lack of formal feedback continues in this final interview. It appeared from the narratives that respondents perceived that staff did not take the completion of formal feedback seriously in the rural health services. All respondents at some stage over the year were disappointed with the lack of formal feedback and the timing of formal feedback. For the majority of the graduates no formal feedback was forthcoming and for the couple that had actually received formal progress reports the timing was problematic. NG 1 explains her feelings regarding formal progress reports. In this conversation she is telling the researcher how she attempted to get a formal evaluation report in one clinical area but failed because the NUM refused because she had not spent time with me. In addition, this participant felt that the feedback she received was always too late.

*At the end of the rotation you get your evaluation from the NUM or the RN you have been working with. But it would be nice to know throughout the rotation how you are going, what you can do better rather than at the end when you have finished. It would be nice if it were constructive feedback (NG 1).*

NG 6, who had the benefit of a CNE, was pleased to receive feedback throughout his time in the ward via a brief update on how she thought I was going rather than receiving feedback some time after he had left the clinical area that he stated had generally been the case for him throughout his Program.

As was the case at the six-month stage the majority of participants were still relying on informal conversations and often overheard conversations regarding their progress. *Rounding* for those that initially experienced this method of feedback, reported that it too had dropped off. One of the suggestions for improvements in the Transition to Practice Programs from
participants was for a more structured serious approach to feedback and that the formal progress report actually occurs in a timely manner.

In summary, this sample of new graduates reflecting on their experiences overall showed that they were disappointed with the absence of learning support that they had experienced within the rural Transition to Practice Programs. They experienced a lack of consistency and commitment to many aspects of learning support that Transition to Practice Programs aim to provide. This includes a lack of structured support such as mentoring, clinical supervision or preceptoring at the ward level and a lack of appropriate and timely specific new graduate education both formally and informally at the ward or unit level. There is a perception by respondents in this study that insufficient registered nurses within rural agencies means that very little education occurred at the ward or unit level and also this lack of RNs prevents them attending off-site specific new graduate education. In addition respondents feel that there is a lack of formal feedback regarding their progress.


The provision and timing of support and from whom support was coming had not really changed for the participants. All participants were now familiar with the workplace cultures and individual personalities in the rural agencies and consistent with their comments at the six-month stage knew whom to seek support from and how to circumnavigate around those not interested in supporting them.

All except one participant, who had moved to a fast paced surgical area and who needed support with clinical care routines, stated that it was the registered nurses they were mainly seeking support from at this time. The support they were seeking was focused on reassurance and direction for complex clinical decisions and clinical judgements. NG 3 articulates what all other participants stated they were seeking support for at this final stage in their transition to rural nursing practice.

*Could you come and check this patient? Just tell me your thoughts, I’m contemplating calling a rapid response (NG 3).*

Many participants at this time were identifying how difficult they felt it was for the experienced rural nurses to meet the new graduates’ expectations of support, because they
were in environments where there were very few Registered Nurses present and those that were present were also busy and stressed with the workloads.

NG 6 commented on how he had always felt the support at the ward level to be mostly forthcoming when he asked for it. He believes the personal attributes and attitudes of the learner influence the quality of support from more experienced colleagues.

*I think as a grad you have to go into it with the right attitude to start off with. If you are going in there and you are not willing to learn and you are not showing enthusiasm, what incentive is there to teach you? (NG 6).*

For NG 1 it had taken most of the year for the support that she required to be forthcoming. In the conversation below she explores why she thinks it may have taken so long for her to develop supportive relationships.

*Things are good. I'm getting a little bit more support because friendships are forming and people are more willing to provide support. At the start I was very reluctant to ask for support. I think that comes down to maybe they didn’t know me and now staff are more willing to help me experience new things and its taken a whole year for that to happen (NG 9).*

Staff checking in to see if the new graduate was okay and frequent communication throughout a shift, initiated by the more experienced staff, was considered good support for many graduates at this time. In addition, the support of nurse educators was still valued and desired. NG 8 was disappointed that since the resignation of the Health Service Educator she had no access to an educator. Whereas NG 7, who had never experienced the support of a clinical nurse educator, was happy that the arrival of the part-time roving clinical educator had kick started some things, in particular, opportunities for her to attend offsite, specific new graduate education study days. Two other participants since the second interview, had experienced the support of a ward-based Clinical Nurse Educator and were extremely satisfied with the level and timing of support that the positions were delivering. NG 14 who had an unhappy experience of support during her initial stage of transition now found, in this final rotation, the support that was required and desired by her and by all other graduates particularly those who had no access to a clinical nurse educator. On-ward education regarding direct patient care, the *debriefing when things fell over* and having a support person specifically for them to assist in navigating ward relationships was valued by the participants who had consistent exposure
to a CNE. The comment below, demonstrates what was effective about the support provided by a ward-based clinical nurse educator for one participant.

They have a permanent CNE and that made all the difference. That person gave me a lot of support and helped smooth my way with other staff. I felt she had given me the emotional support as well as the professional and educational support. And that was really important (NG 14).

The on-ward educational opportunities that the ward-based Clinical Nurses Educators provided were effective and desired by new graduates as NG 6 explains his experience of this type of educational support.

We had a post-op come back from theatre and she basically took me through a knee replacement and said ‘OK, this is what we are looking for post op, this is what we are observing for’. She took me through all of it, and no one had ever done that with me before in my whole grad year (NG 6).

Support from management was still a disappointment for the majority of participants as very little had changed with their experience of management support. In addition the majority of participants felt that the Enrolled Nurses were generally supportive in their approach. For the new graduates of this study support by enrolled nurses was often exhibited through open communication throughout the shift, checking in and following through with delegated tasks.

Suggestions for improvement of the provision and timing of support at this time are consistent with all other stages of the transition in that all participants felt that a structured support mechanism at the ward level, such as a mentor, would be effective in easing their transition to the rural workforce.

NG 12 had already left the rural agency when the final round of interviews were conducted. However, in her final interview she compared her experience of support in the rural agency where she had no one to turn to for support because she said there was never enough staff compared to what she was now receiving in a metropolitan agency.

I have a buddy and she has shown me the routine for a couple of weeks. And I am not by myself (NG 12).

Only four participants in this study were placed within a mentoring structure at the commencement of the programs. However, the mentors were not always in the clinical units
where the graduates were rostered and so participants felt that a mentor in the unit where they are currently working would be an effective support for them.

Finally, the major concern for participants at this stage and consistent also at the six-month stage was the isolation the graduates were experiencing. Two graduates were experiencing significant social isolation in the rural town as well as isolation from their peers. Two respondents also touched briefly on what the researcher felt were feelings of social isolation in the second interview and the researcher has noted this impression in her journal after the second interview with both participants. In this final interview respondents were able to express and articulate more clearly to the researcher what the experience was like for them. NG 12 who had already left the rural agency for more permanent employment and to be closer to her cultural community explains to the researcher how she felt isolated because she felt that she did not meet anybody else during her time except *people from work* and also because of her culture and background she found it difficult to form friendships.

*I did not grow up in an English cultural background. I don’t really care if people ask me or not but if they invite me I will go but I am too shy to ask and I don’t know anybody here (NG 12).*

NG 5 who was from a metropolitan area also experienced cultural differences and felt isolated in the small rural health service where she was. She had no family support, no transport, no license and as with small rural areas no access to public transport, so was not able to leave the area unless she had several days off at a time.

*I actually don’t have a social life. I just work and go home (NG 5).*

For all participants the isolation was also attributed to the fact that there was no contact with other graduate nurses whom they could reflect and debrief with. This is not only for the graduates who were in rural agencies on their own, but was also important for all the graduates because in the small close-knit rural nursing environments participants were worried about privacy and confidentiality if they debriefed with staff from the health service. NG 1 explains how she feels.

*We have our mentors with us. They work in the hospital and you are not sure whether you should tell them certain things, you are not sure that it won’t get passed around and whether they are going to keep things confidential. It’s just nice to talk to each other we are on the same level (NG 1).*
In summary, at this final stage in their transition the respondents had no new information in terms of support since the second interviews. Clinical Nurse Educators at the ward or unit level were providing effective, timely support, however, the majority of participants had no exposure to this type of support. New graduates perceived that support at the ward or unit level was not as forthcoming as they expected due to what they felt was insufficient registered nurses present to provide on-ward support in the rural environment. All participants were experiencing significant isolation in one form or another and felt that effective support for them would have been opportunities to debrief and reflect with other graduate nurses.

Finally at the close of the interviews the researcher asked participants where to from here? At this stage of their transition, the Transition to Practice Programs were coming to an end, most of the participants had already had annual leave and those that had not were finishing their employment in December as they are required to take leave over January due to the closing of clinical areas in rural health services that occurs over the Christmas and New Year Season. Thus all were busy at this time applying for positions. All participants were staying in nursing. As previously stated two participants had left towards the end of their programs for more permanent rural nursing positions. A further two respondents were intending to move interstate and two more were intending to stay on in the rural agency and were at the time applying for positions. One had applied for further study to undertake a rural midwifery education program. Five were applying to undertake second year graduate nurse programs, four within a large rural health service and one in a large regional health service and one participant had secured a position within a rural community-nursing organisation.

This concludes the data analysis of the individual in-depth interviews conducted at three points in time over the twelve month graduate nurses’ transition year within rural nursing environments. The following section will present the demographic data and the results of the individual in-depth interviews conducted with experienced rural nurses who, at the time of the study, worked alongside new graduate nurses.
4.8 Results of the Demographic and Interview Data of the Experienced Rural Registered Nurses

This section presents the demographic data that were collected from each of the interviews with the sixteen experienced Registered Nurse participants also conducted as part of Phase Two of the data collection. Demographic data were collected from each participant via the Participant Profile Sheet. For the telephone interviews, the Participant Profile Sheet was posted to each participant prior to the commencement of the interview (refer to Chapter Three).

The information from the Participant Profile Sheet was gathered in an overall attempt to provide a description of the experienced registered nurses who participated in this study. Data gathered from the Experienced Registered Nurses Profile Sheet included: age of participants; years of experience as a Registered Nurse; years of rural nursing experience; and attainment of qualifications including any post graduate certificates or higher degree achievements.

4.9 Profile of the Experienced Rural Registered Nurse Participants

All sixteen of the experienced rural nurses who participated in the in-depth individual interviews were female. Five participants indicated that they were over 50 years of age; four participants indicated they were between 45-49 years of age and three participants were between 40—44 years of age. Two participants were between 35-39 years of age and two indicated that they were between 25-29 years of age.

Ten of the fifteen Registered Nurse participants initially qualified as a Registered Nurse via a hospital-based General Nursing Certificate. Of these, five had no other nursing qualifications and five held post-graduate qualifications. Three held a post-graduate hospital-based certificate qualification in the following areas: cancer care, oncology nursing and intensive care nursing. Two of these three participants also had a tertiary education qualification at the Graduate Certificate level. One had attained a Graduate Certificate in Health Education and one held a Graduate Certificate in Intensive Care. One participant had two hospital-based post-graduate certificates in cardiothoracic nursing and trauma nursing and one General Nursing Certificate respondent had a tertiary qualification with a Graduate Certificate in Adult Education.
Six participants had tertiary preparation for registered nursing practice. Two participants’ initial qualifications as a nurse were at the Diploma of Health Science level. One of these participants also held a Bachelor of Nursing qualification. Three participants had initially qualified as a nurse at a Bachelor of Nursing level and two of these three participants also held a Graduate Diploma in Midwifery while one had a Masters of Nursing.

Nine participants had twenty years or more rural nursing experience. Five of these participants indicated that they had at least twenty years in the rural nursing environment and four indicated that they had more than thirty years as rural nurse, with one participant indicating close to forty years as a rural nurse. One participant had seventeen years’ experience, three participants indicated between ten to fourteen years’ experience in rural nursing. Two participants had between two and five years’ experience. Finally, seven participants indicated that they had never worked anywhere else except in a rural nursing environment.

The participants in this study held the following positions within the rural agencies chosen as sites for the study. Three held titles of Nurse Unit Manager, one had the title of Deputy Director of Nursing, one Health Service Manager and one Clinical Nurse Manager. There were two Health Service Educators and one Nurse Educator, and two participants held positions of part-time Clinical Nurse Educator, with one also a Clinical Nurse Specialist. In addition, there were five senior Registered Nurses who participated in the study and one is also a Registered Midwife.

The demographic data of the Registered Nurses are presented in Table 4.4. The participants are not listed in any particular order and to protect the participants’ identity their names have not been used. However, to facilitate the reading of the participants’ narratives, the participants have each been allocated the title of RN (Registered Nurse) followed by a number, for example RN 1.
| Registered Nurse Participant One (RN 1) | RN 1 is a Clinical Nurse Educator and Clinical Nurse Specialist in a surgical unit. She is 40-44 years of age and has been a nurse for 20 years all of that time spent in rural nursing practice. She has a Bachelors and Master degree in Nursing. |
| Registered Nurse Participant Two (RN 2) | RN 2 is over 50 years of age, she has a General Nursing Certificate and Certificate in Cancer Care. She is currently a senior RN in a medical ward and has worked for all of her 30-year nursing career in a rural environment. |
| Registered Nurse Participant Three (RN 3) | RN 3 is 40-44 years of age and has worked in rural nursing for 20 years. She is currently a Health Service Manager at a small rural agency. She has a Diploma in Health Science, a Bachelor of Nursing and a Graduate Certificate in Advanced Nursing, Emergency and Clinical Management. |
| Registered Nurse Participant Four (RN 4) | 40-44 years of age. RN 4 has worked for all of her 17-year nursing career in rural nursing. She is currently a Nurse Unit Manager of a surgical unit and holds a Diploma in Health Science. |
| Registered Nurse Participant Five (RN 5) | 25-29 years of age, RN 5 holds a Bachelor of Nursing and a Graduate Diploma in Midwifery. She has five years’ experience as a nurse, 2.5 years in the rural environment. She is currently a Clinical Nurse Manager. |
| Registered Nurse Participant Six (RN 6) | Over 50 years of age, RN 6 holds a Registered General Nurse Certificate, has spent all of her 30-year nursing career in the rural environment and is a senior RN in a general medical/surgical area of a large rural agency. |
| Registered Nurse Participant Seven (RN 7) | 25-29 years of age, RN 7 has been a registered nurse for 7 years, 3.5 of those years in a rural environment. She has a Bachelor of Nursing and currently works in a general medical area of a small rural agency. |
| Registered Nurse Participant Eight (RN 8) | Over 50 years of age, RN 8 holds a Registered General Nurse Certificate and an Oncology Certificate. She is currently the Deputy Director of Nursing at a small rural hospital. She has 39 years’ experience as a nurse, 38 years spent in the rural environment. |
| Registered Nurse Participant Nine (RN 9) | 45-49 years of age, RN 9 has 28 years’ experience as a nurse, 26 of those in the rural nursing environment. She is a Nurse Unit Manager of a medical unit within a large rural agency and holds a Registered General Nurse Certificate, a Cardiothoracic Certificate and a Trauma Nursing Certificate. |
| Registered Nurse Participant Ten (RN 10) | 45-49 years of age, RN 10 is a Health Service Educator for a large rural hospital. She holds a Registered General Nurse Certificate and a Graduate Certificate in Health Science Education. She has been a nurse for 32 years with 28 years as a rural nurse. |
| Registered Nurse Participant Eleven (RN 11) | 35-39 years of age, RN 11 holds a General Nurse Certificate and a Certificate in High Dependency Nursing plus a Graduate Certificate in Intensive Care. She currently holds a part-time position as a Nurse Educator in a large rural agency and has 14 years’ experience as a nurse all within the rural setting. |
| Registered Nurse Participant Twelve (RN 12) | 40-44 years of age, RN 12 has a Bachelor of Nursing and a Diploma in Midwifery. She has been a nurse for 12 years and has spent all of that time in the rural area. She is currently a senior Registered Nurse/Registered Midwife in a general medical/surgical area of a small rural agency. |
| Registered Nurse Participant Thirteen (RN 13) | Over 50 years of age, RN 13 is currently a Health Service Educator in a large rural health service and has more than 30 years experience as a rural nurse. She holds a Registered General Nursing Certificate. |
| Registered Nurse Participant Fourteen (RN 14) | RN 14 is aged between 35-39 years and is currently a part-time Clinical Nurse Educator in a small rural agency. She holds a Registered General Certificate and a Graduate Certificate in Adult Education. She has been nursing for 20 years, 10 of those years within a rural environment. |
| Registered Nurse Participant Fifteen (RN 15) | RN 15 is over 50 years of age and is currently a Nurse Unit Manager of a medical unit within a large rural hospital. She holds a Registered General Nursing Certificate and has 38 years as a nurse, with over 20 years’ experience as a rural nurse. |
| Registered Nurse Participant Sixteen (RN 16) | RN 16 is aged between 45-49 and has a General Nurse Training Certificate and has 28 years as a rural nurse. She is currently a senior Registered Nurse in a medical unit of a large rural hospital. |

4.10 Results of the Thematic Analysis of the Experienced Rural Registered Nurse Individual In-depth Interviews

4.10.1 Theme Four: The Rural RNs Experience with Newly Graduated Nurses in Rural Practice

4.10.1. Subtheme 4.1: Rural RNs Engagement and Experience of Rural Transition to Practice Programs

This first subtheme arises from the first interview question with the experienced rural nurses that sought to gain descriptive information that would lay the foundation for more specific directed questions (Merriam, 1998, p. 82). In their response to the question: *Can you talk about the structure and content of the graduate program within this health service?* The participants spoke about their own understanding of the Transition to Practice Programs offered within their agencies.

Half of the respondents did profess to not have a good understanding about the specific programs within their agencies. Eight of the respondents who were well informed regarding the content, structure and implementation of the Programs within the rural health services were either Registered Nurses who were in services where there was a clearly designated staff member responsible for the implementation and delivery of the Transition to Practice Programs, or they were the person designated as responsible for the Programs. Respondents were unclear as to where the content and the structure of the Programs within the rural agencies originated and who developed them. Two participants believed they were
replications of a metropolitan program and one stated that it was a direct replication from a regional agency while several of the respondents believed that components of the Programs were in fact derived from an Area wide program that had a metropolitan focus. One respondent stated the following regarding her experience of the Transition to Practice Program in her agency.

To tell you the truth I don’t think it is that well run. We don’t have the resources or the money to put into it (RN 11).

Eight participants were unsure of how specific aspects of the program were implemented and in some cases exactly who was actually responsible for the Program. As identified in the environmental scan, many of the rural agencies did not have access to educators although several were anticipating the arrival of staff into part-time positions, thus it was not clear to many of the respondents who was actually responsible. In many rural environments staff fulfil multiple roles and sub-roles and responsibility for implementation of the Transition to Practice Program was often another role that many managers filled. For example, the Health Service Manager or Nurse Unit Manager was cited as responsible for implementation of the Program in some of the smaller rural agencies. RN 12 acknowledges the ambiguity as to whose role it was to maintain and deliver the Programs and as a senior Registered Nurse the person visible to her as responsible for the program was the Nurse Unit Manager.

I don’t really know if there is an external person co-ordinating the post grads. I know our NUM was certainly sort of behind a lot of things they did. She put in as much work as her time permitted (RN 12).

Three respondents stated that there did not appear to be anyone in their agencies who was responsible for overseeing the new graduates in the workplace. They also believed that there was limited information for the staff at the ward level regarding the Programs and new graduate nurses.

As the RNs on the ward, we don’t really get a lot of information about what the program involves (RN 7).

We will see their [new graduates] names appear on the roster, that’s the first indication that we are getting a grad (RN 12).
From the narratives, areas of uncertainty regarding the content and structure of the programs for the experienced rural nurses were in regard to the amount of supernumerary days, the length of the clinical rotations and number of education days within the Programs.

The uncertainty in the number of supernumerary days as well as the timing and length of clinical rotations that participants thought new graduates received varied across the rural agencies and within the rural agencies. Respondents attributed the uncertainty and variations of these aspects of the Programs to staffing levels, skill mix and acuity of the clinical areas at any given time that may affect the support that could be offered to new graduate nurses. As well there was limited communication to the respondents regarding the new graduates and the Programs:

*They try to give them supernumerary days and buddy them up but it does not always work that way. It depends on how busy we are or staffing levels at the time (RN 2).*

Another respondent’s experience was that many of the graduates who she had worked with were disappointed with how the rotations eventuated.

*They get upset because they have been rostered to ED or to maternity and then pulled out because of staffing issues. Or they are on surgical ward and it closes because there is no staff to keep the ward open and then theatre will close and it’s a bit of a fight for them really (RN 11).*

One respondent who is employed in a small agency described the arrangements for providing clinical experiences in a variety of clinical areas where there are no specific clinical rotations. Her description is similar to what other respondents from smaller agencies also described.

*If they are interested we will rotate them through ED and the same with theatre. But it is more to do with if we have got the staffing that can allow it (RN 5).*

In addition, how these particular aspects of the Transition to Practice Program eventuated for each new graduate nurse was also dependent on how the staff believed the new graduate was ‘coping’ with their transition. For example, during the interviews participants cited various lengths of time for supernumerary days. However, RN 3 and RN 10 state that their experience of not having rigorous timeframes for allocation supernumerary status is concerned with a judgement regarding the graduates’ progress in the initial few days of the transition experience.
They are supernumerary for maybe two weeks. What we found though is that no graduate is the same and you just need to go virtually week-by-week (RN 3).

The key is that every individual is different so you cannot just have a blanket ‘they’ll be right after two weeks or they’ll be right after two months’ (RN 10).

Three respondents believed the previous experience working in or attending clinical placements in a rural agency positively affected the graduates’ initial progress in the first few days of the transition experience and this in turn would impact on how many supernumerary days staff decided were needed by the graduate.

In addition, when discussing clinical rotations or whether experiences in different clinical areas were introduced as part of the Programs, participants stated that these too depended on how the new graduate was perceived to be coping with the transition experience. For example, new graduates would not be rotated through some areas or given exposure to fast paced clinical areas, such as some surgical wards, until agency staff observed that they had developed and refined their time management and prioritising skills. This was because the skill mix and staffing levels in some clinical units will require the new graduate to take on higher levels of responsibilities and there were insufficient registered nurses to provide the intensive support that new graduate nurses would need, as RN 4 explains,

*We tend to try and start them [new graduates] in the other ward where they can have greater support, because they have to get their time management and the other ward has a greater number of senior staff than this ward (RN 2).*

This was also the case in smaller agencies where emergency departments maybe attached to the acute areas. New graduates would not commence their Programs in these types of clinical areas because staff believe new graduates need to consolidate their time management and prioritising skills. Alternatively they would be kept in the general medical/aged care areas until staff felt the graduate had gone some way to refining and further developing skills in these areas and was ready to take on higher levels of responsibility.

The other aspect of the Programs where participants were unsure was access to formal specific education study days for the new graduate nurses. The senior RNs at the ward level did not know how many education days were allocated to new graduate nurses.
I would not have a clue about how many education days they get, formal education face to face. I know they have to travel (RN 7).

Several participants thought the new graduates received a lot more education study days than what the environmental scan revealed and what the new graduates said they received. Other respondents were able to state that the new graduates joined other larger regional, rural or in some cases metropolitan sites for education study days but no respondent was able to state whether the graduates actually attended.

In re-reading the transcripts there is concern from the registered nurses surrounding education study days that occur at larger regional and metropolitan sites for new graduates. Respondents did not feel that off-site education in regional and metropolitan areas was *rurally focused enough* and also for those who have to travel off-site that there was any encouragement or support by the organisation for the graduates to attend. RN 6 and RN 14 explain their perceptions of the education provided to new graduate nurses.

*I was talking with one [new graduate] not so long ago about their study days at [mentions agency name here] and it was geared toward that hospital specifically. It just was not clinical enough for them and they thought that they were not really learning enough out of the day. They were not happy with the education* (RN 6).

*They are supposed to get education days, which sometimes they will go to and at other times they won’t because they will look at the agenda and decide it is not relevant. So they won’t go. And there is no one actually pushing them to go and if they don’t ask for the days off to attend then nobody checks to see that they are actually attending any of the education days* (RN 14).

In at least two small rural agencies the access to off-site education study days was dictated by the skills required by the organisation of the new graduate nurse. For example, the following respondent explains the priorities for new graduate education in the small rural health service where she works. In this small site graduates are expected to quickly develop skills in managing the acute care section as well as the emergency department that is attached to the acute section. Specific education was sought that would address this urgent need rather than sending the new graduate to larger regional health services for education that may not be relevant to them within this particular rural context.
I try to get them into triage and a patient assessment course when I think they are ready for it. So you know where possible I will get them into the education that I think is appropriate for them and it’s not so easy because I know they [education provider] are not keen on anyone in their first year doing emergency type training. But they are in there and so it’s [education providers preference] not helpful in a way. But that’s the way it is (RN 3).

Respondents’ knowledge of education packages was vague and many respondents stated that they knew graduates had skill competencies to be completed but most could not recall what they specifically were, only three respondents could recall the content. RN 2, a senior ward RN, mentions skills that are included. RN 1 as a ward based educator believes the whole formal structure for ward based learning needs attention and has a clear idea of what should be included and RN 14 states that she believes the packages are ‘metro centric’.

There is a package specific to our ward. Care of Portacaths, PICC lines for example and management of Chemo patients (RN 2).

There are no formal competencies specific to the ward. I have taken some out and tried to broaden it so that they understand more of surgical nursing not just skill-based competencies, more goals rather than skills. I think a holistic, big picture stuff knowing how the obs affect medication administration, the effect of post op assessment related to the Rapid Response rather than knowing how to do a skill (RN 1).

In relation to the structure of the Programs respondents from two rural agencies stated that they were involved in formal mechanisms of support at the ward level. RN 10 explains that in her experience although they have staffed prepared for this role, in reality the allocation of mentors to a new graduate often does not eventuate as planned.

They have a group of people that have done a mentoring course but quite often because of rostering and a high percentage of part-timers it is basically whoever is there on the day (RN 10).

Respondents from the only other agency that had a mentoring program said that due to the issue of part-time staff, and in some cases insufficient RNs to provide mentoring support, the mentoring program was developed as a hospital wide program. This meant that the mentors may not be in the clinical area where the new graduates were rostered so could not provide daily on ward support.
Thus all the respondents’ discussions focused on the on-ward support provided to new graduates as an ad hoc ‘buddy system’. This described was by respondents as a system where the new graduates are still given a full workload, with maybe a lighter workload initially. As well, they are rostered with, and work alongside, more experienced registered staff. RN 8 explains her experience of how this buddy system works.

The first three months they are put on the general ward and either, the NUM or a senior registered nurse buddies them up but they are also included in the numbers (RN 8).

They are on the roster and off you go. And we certainly try to buddy up with them (RN 6).

However the ‘buddy system’ was also not always consistent due to staffing levels, skill mix as well as the acuity and workload of the clinical area that at any one time also influenced this arrangement.

Respondents identified formal progress appraisals and formal feedback as the responsibility of the Nurse Unit Managers where the new graduates were working. Time frames for delivering formal feedback were consistent amongst the respondents, namely every 3 months and at the end of every clinical rotation.

In summary, the respondents’ experience and perception of the structure and content of education materials and study days in the rural Transition to Practice Programs were that these were often components of Area-wide programs that they believed were not specific to the rural agencies or indeed the rural nursing environment. Furthermore many of the rural registered nurses were not actively aware or engaged with the content of the programs. In addition, staffing allocations and skill mix within the rural environment that affect workload allocation and level of responsibility were seen by respondents as barriers to implementing or following through with structured support mechanisms within Transition to Practice Programs within the rural environment.
4.10.1. Subtheme 4.2: Providing Support to Newly Graduated Nurses

The researcher asked participants to talk about their experience of providing support and their perceptions of the support needs for newly graduated nurses who were making the role transition to rural nursing practice. Participants were also asked about the timing of support and who was best placed to provide support at the ward or unit level. In the conversations respondents talked about strategies for providing support such as through rostering, through allocation of the workload as well as ways in which they provide individual support to new graduate nurses during a rostered shift with a newly graduated nurse.

After re-listening and re-reading the transcripts it became clear to the researcher that the participants’ experience of the provision of timely on-ward support for new graduates was affected and influenced by the skill mix and staffing allocation within the rural environment. Coupled with this there was a perception that there was a lack of awareness by rural nurses of how to meet the on-ward support needs of new graduate nurses. In addition, many respondents believed that the transition experience within a rural practice context can be isolating for many new graduate nurses and there was concern that the graduates were unable to access support from their new graduate peers.

All the respondents believed that the skill mix and staffing allocations in rural areas acted as the most significant barriers to the provision of daily supervision and support for newly graduated nurses at the ward level. All participants stated that too often there was not enough senior staff to provide the support that they would have liked for the newly graduated nurse. One respondent stated that the support was affected by *skeleton type staffing levels* that are commonplace in rural environments. Respondents felt that staff provide the best support they can, given the pressure of the rural work environment and what they were given in terms of staffing allocation and skill mix. Examples of the skill mix within the rural environments included one Registered Midwife, one Registered Nurse (usually the graduate) and one Enrolled Nurse on a morning shift. RN 1 explains how it usually looks in the fast paced surgical ward where she works and from the conversations with all of the experienced RNs this skill mix configuration was typical of the rural environments where new graduates were making the transition to professional practice.
It could be a 2nd year grad with 2 EENs and a new grad on an evening. A new grad and a 2nd year grad on the evening shift or, a new grad and a 2nd year grad on a morning shift. Worse case scenario is a new grad and only EENs on a morning. Night duty there is only the two of them and it could be a 2nd year grad and an EN or a new grad and an EN (RN1).

In these types of skill mix, respondents stated that the registered staff are very stretched and are not able to provide the learning support required of a newly graduated nurse. It is also clear why new graduates are expected to hit the decks running and become responsible and accountable as quickly as possible. RN 7 and RN 6 explain what it is like for them to be the only senior RNs available during a shift where the support they can provide is really only aimed at ensuring that the new graduates are able to complete the work and consequently there is not a lot of time for learning support from the RNs.

If it is an afternoon shift that is where I find a high possibility that I am in charge as well so I find it really difficult to try and support them so I just have to make sure they are okay, I cannot oversee them (RN 7).

It is difficult sometimes to give them the time they need, depending on the workload. If the workload is fine, then they are probably coping well anyway. If everything is going to pieces for them, then that’s when everything else is happening as well (RN 6).

In the small rural health service where RN 3 works she describes the support that she provides with respect to the new graduate having to take on higher levels of responsibility very quickly.

If I think they are progressing really well I will put them on a morning shift where I am on the Admin. So I am here, but not on the ward. And I will just monitor and see how they go. If they progress further I will actually put them on shifts by themselves with experienced endorsed enrolled nurses and I am on call (RN 2).

Despite this barrier to the provision of on-ward learning support, the rural nurses were able to discuss creative attempts at providing support. However, often their attempts to provide supportive learning environments were thwarted by a lack of resources and or a lack of awareness and understanding of the actual support needs of the new graduate nurses. Participants gave descriptions of trying to provide support through rostering. For example, rostering the new graduate as the second RN so they are never the only RN on the ward or rostering the graduate to an EN line on the roster allocation. As well as shielding the graduate from night duty, and attempting to allocate more staff so that senior staffs have more time to spend with the graduates to assist with heavy workloads and to protect the graduates from...
being placed in positions that are not within their scope of practice or competence. RN 2 explains what happens in the medical ward where she works and RN 7 gives an example of attempts to provide support through rostering.

*Look at the workload of the patient and how sick they are and if you don’t want them [the new graduate] totally on their own then the NUM is good at looking at the roster and thinking they need just another person to pick up the load so they [the graduate] have more time to concentrate on what they are doing (RN 2).*

*They have been paired up with a casual nurse who is very knowledgeable and she is able to come in for a few hours in the morning each shift but pretty much only for the first week. She is able to help them find their feet a little bit (RN 7).*

However, the respondents all acknowledged that ultimately these attempts could only work for a short time in the initial transition stage as the new graduate was immediately counted as staff and budget constraints would not allow this to occur too frequently.

*They are on the roster as a staff member and are counted in the numbers (RN 15).*

Four respondents perceived that many of their RN peers and junior staff did not fully understand the support needs of new graduate nurses. For example, they believed that many rural staff did not understand how formal support mechanisms such as mentoring, clinical supervision or preceptoring worked, or the expectations of their roles within these models. They also believed that many staff members were unsure of how to implement structured models of support within a rural environment where there was limited staff. In addition, there was the perception that the staff expectations of the new graduates abilities’ were too high.

*I think a lot of it is knowing what they can and can’t do, what their skills are. I think some of our staff think that new grads should come out of uni and know it all. They forget they are beginning practitioners (RN 5).*

Both RN 16 and RN 10 also believed that nursing staff at the ward level would benefit with education on how to provide learning support for new graduates, specifically providing mentoring support.

*They don’t understand and they get the preceptor and mentor role mixed up so they don’t understand they have to work side by side with that person to be their mentor (RN 10).*
Another respondent RN 5 also felt that staff struggle with how to support new graduates stating *they struggle with what they should teach the new grad and how to look after them.* In addition, respondents stated that because of the absence of senior staff, most often the person best placed to provide support was the Enrolled Nurse. However, one respondent said that although enrolled nurses and junior staff are often required to take on a support role, often the more junior staff members have little or no preparation to provide the work place learning support that is required.

*If you have junior staff on with a new grad they don’t really know how to support that new grad because they are only very junior themselves (RN 14).*

RN 1 as an Clinical Nurse Educator felt that there are many support measures that RNs could implement at the ward level that would assist with overcoming the barriers that staffing and skill mix pose. However, she has also observed that more junior staff and also senior staff fail to think about ways to be supportive not only of new graduates but of other staff as well. In the conversation below she speaks about support for the new graduates and other junior staff with respect to workload allocation at the commencement of each shift.

*Probably where we need to work [with staff] is with ward management because people will change the allocation and break up the rooms without thinking. The allocation should be done after handover because staff on the wards making those decisions [doing the allocations] are not thinking of scope of practice and it is done without any thought and it is sometimes the numbers rather than recognition of their beginning status. Like you know having an EN looking after TPC [total patient care] with someone that has a PICC line who we know is out of their scope of practice (RN 1).*

RN 11, also an educator, agrees and gives an example of what she perceives to be poor staff allocation and management practices which are not supportive and which she stated *do not make sense* to her at anytime let alone when there are new graduates on the ward.

*You know I have seen one RN on a morning and then there are four [RNs] rostered to the afternoon and the ENs were not up there with it all [not experienced] (RN 11).*

However, for RN 7, a senior registered nurse at an agency where the ED is attached to the general ward, sometimes there is no choice with respect to the allocation. Her comment below reflects how many other respondents also felt about the inability to provide timely support for new graduates.
I know that a few shifts that I had worked I wanted to cry for those poor new grads. I had two new grads on the ward and I was left in emergency and that was devastating for me because I could not support them. The ENs were not being very supportive on that shift either (RN 7).

In conversations surrounding who was best placed to provide support enrolled nurses were frequently identified by the respondents as best placed to provide on-ward support for patient care practices, orientation and for assisting with time management and prioritising of workload in the initial phase of transition. Nurse Unit Managers were also identified as being well placed to provide support in terms of their support for the implementation of formal structured mechanisms of support within the wards or units, providing feedback and debriefing for the graduates as well as checking in to see how they were faring with the workloads and their overall transition.

Three respondents who were at agencies where attempts had been made to implement formal models of structured support believed that the NUM should play a role in helping to sustain this type of on-ward support. RN 10 explains how she feels that NUM in her experience do not promote these types of relationships.

I think the trouble is the NUM believes that the mentor is more of a preceptor and they don’t promote the relationship with the mentor-the clinical supervision side of it and I think we could do a lot better. We need to engage staff that want to take on the role and that currently is not happening (RN10).

In her conversation regarding supportive rostering for new graduate nurses and whether or not the new graduates get any supernumerary time RN 11 acknowledges that the NUMs try to be supportive through rostering but that there is probably not as much support as could be given and further states, I find too that our NUM’s are not that supportive.

As mentioned previously in Theme One, all respondents stated that measurement of the new graduates’ progress throughout the twelve-month transition was the responsibility of the NUM or Health Service Managers, however, many respondents could not be certain that the formal feedback occurred as it was supposed to. RN 1 explains her perception and expectation of the NUM role in giving feedback.

No I don’t see the NUM providing much support and I think they need that regular meeting in the office, giving them feedback. Not waiting three months before they do an evaluation but doing it before that. It is up to the NUMs to really go and seek that feedback about them [the graduates] and give it back constructively to the grads (RN 1).
However, just as the respondents acknowledged how hard it was for the ward RNs to give timely support so too did the respondents acknowledge that while the NUM is probably the best placed to be providing support it was often difficult for them given the expectations by the organisation of the role of a Nurse Manager and in particular Nurse Unit Managers within the rural environments. RN 10 provides a comment that reflects other respondents’ beliefs and experiences.

*Their [NUMs] portfolio is so wide that they really are not involved in the clinical running of the ward. You know they are not out there with the patients and they are not giving that support to any staff. There is such an onerous degree of paperwork that unless the NUM realises the importance of being seen as a clinical leader it’s really easy to get swallowed up in the paperwork and day-to-day computer work. They are not seen as a support to a new grad. They are just someone to go to for a roster request (RN 10).*

Whilst all respondents stated there was no specific new graduate nurse designated responsibilities all cited examples of patient care, patient conditions or clinical skills that they would not allocate to the graduates until staff felt the graduates were confident. For example, respondents stated that allocating the graduate a lighter load initially, avoiding the allocation of acute and/or paediatric patients to the graduate and where possible, avoid sending the graduate to help the midwife or help out in ED. However, sometimes these plans did not work out as RN 5 explains how they try to implement this as a support measure in the small rural agency where she works, however they often have to compromise because of staffing.

*SOMETIMES IT IS THE NEW GRAD WHO IS ASSISTING IN MATERNITY, SO THEY MIGHT BE DOING LIKE A POST CAESAR [sic] LADY, DOING THE POST-OPERATIVE CARE FOR HER. BUT WE DO NOT EXPECT THEM TO HELP IN A BIRTH OR IF THERE IS AN EMERGENCY IN MATERNITY (RN 5).*

Most respondents discussed the informal arrangements for what is considered appropriate workload responsibilities for new graduates as the new graduate initially is not expected to care for patients who may be unstable or acutely ill. Rather, the more senior nurse is expected to look after unstable or critically ill patients. RN 4 explains her thinking and actions around this that reflects most other respondents’ thoughts and experience of support through designated workload responsibilities for graduate nurses.

*There is a lot of stuff that I probably would not give them straight off until they have been deemed competent. For example, accessing central lines and PICC lines and I would not give them the critically ill patient (RN 4).*
When asked what did they feel new graduates needed support with or for during their transition all said that the first priority in the initial stage of transition was for the graduates to develop and refine their time management and prioritising skills. This was because as previously stated in Theme One the graduates’ ability to manage the workload as soon as possible affected not only their supernumerary status, and timing of rotations but also the level of responsibility they would be expected to assume given the staffing allocation and skill mixes within the rural environments. Several participants stated that they felt that new graduates also needed this support because they believed university education programs were variable in their preparation of graduates particularly in the areas of basic care delivery, time management and prioritising workloads within the rural environment.

The thing is they [new graduates] are so variable. You don’t even know exactly what they come in with and what skills they have completed and what they know and what they don’t know, what they are comfortable with? So we need to get a basis of where they are at (RN 3).

They really have not been taught good time management and I think especially in rural settings they need to be aware of time management and they need to be able to work without calling on a lot of resources. Look outside the square a bit and don’t rely on resources (RN 8).

I find the hardest for them is the time management and it’s very difficult to try and get through to them what has to be skimmed over and what has to take your focus for that immediate time. They can’t sort of determine how they are going to manage their day and probably that’s where you have to start, just working out that time management (RN 6).

The team nursing model of care delivery and the team leader role, in particular, the specific registered nurse’s responsibilities and accountability within the team leader role and within the rural environment was another priority area where respondents had observed new graduates needed support. RN 8 explains her experience of priority areas for support with respect to the responsibilities that new graduates need to assume.

You have to teach them time management, then individual policies, procedures, statutory stuff that you are responsible for. You are the Registered Nurse on, the buck stops with you to a degree (RN 8).

Other examples given by respondents of specific RN responsibilities within the team leader role include managing the vast medication rounds in a timely fashion and interpreting medication prescriptions. In addition, the senior registered nurses experienced that they were providing support to new graduates for aspects of the team leader role such as communication
with junior staff and delegation within the team. RN 1 explains how she provides support to new graduates regarding team nursing.

_Not just concentrating on technical skills but I talk about things with them like communication and how do they work with that EN and the importance of working together to work it like team nursing (RN 1)._ 

In addition, respondents stated that new graduates need support for basic nursing care and managing and prioritising aspects of clinical care. RN 11 feels that new graduates need to be reminded of basic nursing care.

_Everything is so rushed when they come out. And what is missing is the basic care (RN 11)._ 

According to the respondents, most often the experienced enrolled nurse was best placed to provide this type of support. However, they acknowledged that support from Enrolled Nurses was dependent on the individual personality of the enrolled nurses, the workplace culture and as previously stated, whether the enrolled nurse understood how best to provide support.

_Putting the new grad with an EN who has done extended education. Buddying them up with her [the EN] for the first few weeks sort of breaks them into the RN duties (RN 8)._ 

_Sometimes it can be difficult like in terms of our EENs. Sometimes the ENs can be a little bit picky and choosey with whom they work with (RN 7)._ 

Two respondents identified that in their experience new graduates also needed support with communication skills in particular handover and clinical conversations with medical staff regarding how to seek outside medical assistance, since there is often no medical staff onsite. In particular, in the small rural hospital where RN 3 works her experience with new graduates was that they were very comfortable in the aged care section working alongside the Enrolled Nurses giving clinical care. However, as they progress throughout their graduate year they are expected and required to move into the acute section where the ED is attached. Support is then needed for the new graduate with specific ED skills of triage and assessment as well as communication and having clinical conversations with medical staff.

_Certainly communication is another problem and getting the point across to the doctor over the phone (RN 3)._
Respondents from the larger rural health services also observed this difficulty for new graduate nurses but perceive that it extends to also having to negotiate with allied health staff as well medical staff particularly in the first three-months as RN 10 explains.

*A lot of it is confidence and learning the language, sometimes it is very, very difficult for the new grads to even want to engage with allied health staff and the doctors. Especially because in rural there is more of a perceived divide between the doctors and the nurses because they are GPs on call, so you are dealing with someone that you have to interrupt in their daily business. So people are reluctant to ring them. There is that feeling of needing to have confidence to talk to the medical officers and seeing them as a member of the team (RN 10).*

In addition respondents felt that new graduates in general needed support to seek support. That is, respondents felt that in their experience new graduates often do not ask for assistance or communicate with other staff if they are experiencing difficulties. Respondents stated that they were worried when new graduates failed to come near them to seek support. RN 3 had concerns for culturally diverse new graduate nurses who had not had any rural nursing experience or clinical placement experience outside metropolitan centres. In this RN’s experience it is difficult to determine and assess if the new graduate nurse’s failure to seek assistance and support for the higher-level RN responsibilities was due to communication, cultural or preparation for practice barriers.

Expectations that the new graduate nurse would speak up and seek support were common to several of the respondents. Their expectation that new graduates will seek support was due to the difficulty that RNs have with supporting new graduates given their own workload and responsibilities within the rural environment. RN 6 explains her expectations, which RN 9 also has, regarding their ability to ask for help and seek support.

*You would also hope that they can speak up if they were not comfortable doing something but it is not always the case. Sometimes it’s the least confident ones [new graduates] that don’t have the confidence to speak up either (RN 6).*

RN 4 believes that new graduate nurses have to realise that being the RN requires them to take the ultimate responsibility. She also believes that graduates are concerned that they do not know enough and has experienced that they need constant reassurance. She states that ‘they have to be patient that it will all fall into place, they have too high an expectation of themselves’.
The researcher also asked each participant about specific support or learning strategies they use with new graduate nurses and the timing of the provision of support. All respondents talked about using strategies such as checking in to see if the new graduate was okay. In addition to this strategy, two respondents used debriefing and reflection as support mechanisms following stressful or traumatic events or just at the end of the shift.

*Spending time with them at the end of each day to say what made the shift good? Was it the people? Was it the time? What worked? What didn’t work? I don’t think we reflect enough on not only the bad but also the good (RN 1).*

Three participants who had education as a focus of their employment stated that they encourage other RNs to engage in role reversal where the new graduate takes the lead and the senior RN steps back. However, because they were only part-time they were not always there to ensure that this teaching strategy was employed by the ward RNs.

*I encourage the other RNs to provide support and basically let the post grad sort of be in charge and just provide them with advice, support and you know let them have the acute care end and be there to make sure, especially in ED, that they review everything (RN 3).*

Another strategy was spending time with the new graduate at the end of handover to go through the patients they have been allocated which would assist them to critically think about the priorities for their patients and the team for the shift. However, respondents stated that often ward RNs were time poor and not able to consistently offer this type of learning support.

RN 12, a senior RN in the general ward that includes midwifery, explains how she provides support on the run during a shift and RN 2, a senior RN in a fast paced medical ward, also describes her supportive actions.

*After handover I try and get them [new graduate] into the treatment room and say right let’s just have a quick run through. I ask are they happy with what’s happening? I check after I have done my rounds and just going back and checking on them. Making sure they have a tea break and go to lunch (RN 12).*

*If it’s really busy I just go up and check on them and say ‘are you okay?’ And I talk all day to them ‘we are doing this, this and this, and, this has changed’. And I help them to do all of the basic things, sit them up, clear their meal tables, toileting etc. (RN 2).*
RN 1 in her role as the part-time ward-based clinical educator explains the type of support she is now able to give in this role, which is a luxury for the graduates in the fast paced surgical environment.

**Starting after handover I talk about ‘these are the 6 patients, what are the priorities?’ And then I get them to touch base with the person they are working with at 9 o’clock, 10 o’clock and all these times so that we know we are on the same road because our priorities can change so quickly. Getting them to look at the big picture and recognising that there is assistance out there [the ENs] and where to go to get it (RN 1).**

With regard to the timing of support there were several common indicators that respondents identified as to when they, the senior RNs, may need to increase the support. In addition, there were also common timeframes of where respondents expected new graduates’ practice and capabilities to be at different times throughout the year.

Common indicators for needing to increase the support were factors such as observing the new graduate for signs of being flustered, noticing their demeanour or their mood or noticing that they are consistently still giving out pills at a time when you think they should not be, leaving the shift late and by reviewing of patient notes and documentation at the end of the day. In addition, respondents relied on verbal cues from the enrolled nurses that the graduate may be struggling a bit.

Expectation of the timing of support and the common milestones within the graduate year were mostly consistent amongst the respondents. RN 10, who is in an educator role, in her earlier discussion identifies that for the first three months new graduates have difficulty communicating with medical and allied health staff. She also goes on to say that in her opinion, the graduates in the rural environment need support at other milestones

*At the six-month mark I think it is still the advocate role. They come most of them with great clinical skills but it’s more about stepping up to the RN role and taking on and planning care. They do fall back into tasks sometimes but they start to feel confident enough to be able to ask clinical reason questions so it’s more about their professional role at the six-month mark I think, rather than the day-to-day management. By 11-12 months they are usually fully functional (RN 10).*

Depending on the skill mix and availability of RNs within the rural agency the expectations might be higher in terms of how quickly they are expected to be able to take on the full rural
Registered Nurse’s responsibilities as RN 8 in her management role describes expectations of milestones for support and capabilities in her agency.

*On the three-month mark you would be hoping that they would have their head around after hours stuff, weekend stuff, extra roles, knowing how the hospital functions, referrals, transfers, patient flow. In six months you want them to confidently be able to man [sic] any ward, look at the ability for staff replacement after hours, extending to more direct ward management. Probably at nine months you would hope that they are confident, accepting their total role as a registered nurse. I reckon that realistically six to eight months in, then, they are a Registered Nurse (RN 8).*

The perception of the senior RNs working alongside them on the ward regarding common milestones for support is best described by RN 6.

*You would hope that given six to eight weeks they are going to feel part of the team and feeling better about themselves starting to get on board with their time management. Definitely by six months you can certainly identify whether they are still having struggles and whether extra support is needed (RN 6).*

In summary, by far the most important consideration and the most influential factor for the provision and timing of on-ward support for new graduate nurses as they make the transition to rural nursing practice is the skill mix and the workload allocation within the rural environment. In the absence of clinical nurse educators within the rural environments senior RNs use support measures such as rostering and workload allocations as measures to protect the new graduate from practicing beyond their scope. Learning support strategies such as checking in and debriefing were implemented by several respondents however there was the opinion that many rural RNs do not know how to support the new graduate as they make their transition. This is particularly because the workload and responsibilities prevent RNs spending any length of time with new graduates. Also there is a perception that rural staff including junior staff working alongside new graduate nurses are not well prepared for the learning support role.

Milestones for providing support and the specific support needed at particular times include further development and refinement of time management and prioritising skills, as well as assistance with having clinical conversations with medical and allied health staff within the first three months. By the six-month stage there are expectations of confidence in management of care and support required to develop skills in taking on responsibilities associated with the team leader role plus development of critical thinking and clinical
judgement skills. By the 10-11 month there is an expectation that they will be fully practicing rural registered nurses who are able to step into in-charge roles.

4.10.1.Subtheme 4.3: Rural RNs Recommendations for Provision of Support within Rural Transition to Practice Programs

As a final question the participants were asked what improvements they would like to see in regards to support provided during the transition to practice for the newly graduated nurse? By far the most common suggestions and those that were deemed to be priorities were to make the Transition to Practice Programs more structured and to have the Programs clearly articulated with the allocation of more resources to support and sustain the Programs.

Suggestions for improvements to the structure of the programs that would provide more learning support included having a designated person to oversee and implement the programs and to ensure that the Programs follow through with what they were intended to provide. That is, a person is required to ensure the graduates receive their education days and ensure the clinical rotations occur. In addition respondents felt that more formal support structures need to be implemented at the ward level such as clinical supervision, mentoring or preceptoring. However, four respondents identified that there is also a need for support and resources to prepare staff to take on these learning support roles. In particular participants felt that there is a belief by respondents that the enrolled nurse needs to be encouraged and supported to be actively involved in new graduate support as they are often best placed to provide support in areas that were not specific to RN responsibilities. For example, one respondent explained that support by EENs could be more effectively utilised if the EENs were allowed to be fully functioning in their extended scope of practice to ease the workload for new graduate nurses.

*The EENs don’t get a chance to give pills and things so if they were given a chance it might help to break things up for the grad. However the NUMs don’t like them taking on pills and patient loads (RN 2).*

Respondents were also concerned and acknowledged that in the current structure of the Programs many graduates were isolated from their peers and believe that the existing Programs did not provide nor allow for peer support from other new graduates. The reflections below from RN 11 sum up the feeling from respondents particularly those in the small rural agencies where there might only be a single graduate, where the concern was for their professional isolation.
It’s a tough post grad out here, no structure and it is quite isolating to be a grad here (RN 11).

RN 12 and RN 10 also agreed and suggested that there needs to be a support network amongst the graduates’ so that new graduates can rely on each other have and have access to someone who knows what they are going through. The allocation of time and money resources to enable video conferencing amongst rural graduates was a suggestion for how this could be implemented.

In addition two respondents who had experience with graduates from culturally diverse backgrounds believed that some graduates were fairly well isolated within the community and that this was a significant issue that needs to be addressed within the Programs either by encouraging and supporting social activities with their new graduate peers and with staff within the rural health agencies. As one respondent commented:

*I have worried about the social isolation (RN 3).*

In addition, other suggested strategies to reduce the isolation included more specific face-to-face education sessions for new graduates and with other new graduates. Respondents stated that education sessions and attendance at education sessions need to be organised, managed or overseen by someone who has designated responsibilities for the Programs and new graduate nurse support.

*Someone overseeing education in the facility that acts as an advocate to the new grad because it is always quite often a fight to get them [new graduates] released for study days (RN 10).*

The allocation of more resources for positions such as ward-based clinical educators to provide the daily support was also identified and deemed by all respondents to be an important priority and a necessity to sustain the rural Transition to Practice Programs. This was seen as particularly needed in light of the workloads and the skill mix present within the rural practice environment that make it problematic for RNs to provide ward-based learning support. RN 10 states the following that also reflects other respondents’ views of provision of resources to sustain rural Transition to Practice Programs.

*You are running pretty close to the bone with most things. The most difficult is getting staff released that’s from new grads right across. I think for any program to succeed there has to*
be a budget for it and it has to be an explicit black and white new graduate budget where study days are recognised. Because we don’t tend to recognise that education is important (RN 10).

In summary, all the respondents believed that the support offered during rural Transition to Practice Programs is not clearly structured and that often no-one was responsible or accountable for ensuring that structured support occurred. Furthermore, the respondents believed that the rural Programs require more resources in terms of dedicated ward-based educators, education for existing staff regarding how to provide learning support as well as more resources to support formal education and structured models of learning support.

4.11 Conclusion

The following chapter will discuss the research findings and review the major findings of the study. Conclusions regarding the research questions and the implications for nursing and undergraduate nursing education at the practice and policy levels, including recommendations for further studies will conclude this thesis.
CHAPTER FIVE

Discussion and Conclusion

5 Introduction

In the previous chapter the findings and the major themes that emerged from the data were presented. This chapter will discuss the major conclusions that arise from the findings. The findings and conclusions of this study are discussed within the context of the Theoretical Framework and the previous relevant research as described in Chapter Two. A proposed framework that would support a TPP in the rural context is then presented and discussed. The framework consists of five major principles and each principle provides strategies on which to base structural decisions when designing and developing a rural TPP. Furthermore, this chapter will present implications for policy and practice including recommendations for nursing education and the recruitment and retention of graduates within rural practice. The chapter concludes with recommendations for further research into this field of study.

As explained in Chapter One the purpose of this study was to investigate the new graduate nurses’ transition into rural nursing practice within a Transition to Practice Program. A qualitative case study framework was the most appropriate methodology and the major aims of the study were to:

- Explore the new graduate nurses’ perception and experience of the level and timing of support throughout their Transition to Practice Program in a rural setting
- Investigate the experienced rural nurses’ beliefs, perceptions and experiences of providing support to new graduates during a Transition to Practice Program in a rural health setting and;
Identify the functional elements of rural graduate nurse transition programs and develop guidelines that will assist in the design of Transition to Practice Programs that match with the rural context and capacity.

This study specifically aimed to investigate and describe the nature and timing of support required during the transition to rural nursing practice that is specific for the rural context and capacity. Data was collected by:

1) A telephone survey of rural health services to establish which health services had a Transition to Practice Program, and if so the content and structure of the program
2) Individual interviews with new graduate nurses, three times through their Transition to Practice Program year at intervals based on Duchscher’s (2008) Stages of Transition Theory (see Fig 5.1); and
3) Individual interviews with experienced rural nurses who worked with new graduate nurses in the rural practice environment.

Thematic analysis revealed three themes representing the new graduate’s experience of support at each milestone, and a fourth theme emerged regarding the rural RNs experience with the new graduate nurse in rural practice (see Table 5.1).
Table 5.1 Themes and Subthemes that Emerged from the Data

Theme One: Getting Started at the 3-4 Month

| Subtheme 1.1: | Influences on Support whilst Stepping into the Rural RN Role |
| Subtheme 1.2: | The Rural Transition to Practice Program |
| Subtheme 1.3: | Support Experiences versus Support Needs |

Theme Two: Settling In at the 6-7 Month Milestone

| Subtheme 2.1: | Influences on Support Whilst Settling in to the Rural RN Role |
| Subtheme 2.2: | The Rural Transition to Practice Program |
| Subtheme 2.3: | Support Experiences versus Support Needs |

Theme Three: Just Another Nurse at the 11-12 Month Milestone

| Subtheme 3.1: | Influences on Support whilst Immersed in the Rural RN Role |
| Subtheme 3.2: | The Rural Transition to Practice Program |
| Subtheme 3.3: | Support Experiences versus Support Needs |

Theme Four: The Rural RN’s Experience with Newly Graduated Nurses in Rural Practice

| Subtheme 4.1: | Rural RN’s Engagement and Experience of the Rural Transition to Practice Program |
| Subtheme 4.2: | Providing Support to Newly Graduated Nurses |
| Subtheme 4.3: | Rural RN’s Recommendations for Provision of Support within Rural Transition to Practice Program |

5.1 Major Conclusions and Discussion

There are two major conclusions arising from the findings of this case study. The first conclusion is that the findings support and confirm the Stages of Transition Theory posed by Duchscher (2008) as an accurate representation of the transition continuum experienced by the new graduate nurses in this rural case study. Whilst Duchscher’s (2008) study was conducted in a metropolitan setting utilising a sample of graduate nurses from two major city hospitals who were not employed on a formal support program, this current study, was conducted in one Area Health Service across 14 rural towns in northern New South Wales. The Stages of Transition Theory (Duchscher, 2008) was utilised as the theoretical framework to guide this study, and was also applied to the findings from this study to provide a
comparison. To see if there is consistency with findings of other related research was also of interest.

This study found that the graduates experienced the three distinct Stages of Transition and the accompanying processes within each stage throughout their twelve-month transition to professional practice. However, whilst the graduate nurses in this study experienced the three stages congruent with the Stages of Transition Theory, this study found the structure of the rural Transition to Practice Program did not take into account the distinct stages graduates progress through during the transition to professional nursing practice that is detailed within the Stages of Transition Theory. Rather, the Transition to Practice Program has been developed as a year long, continuous program with no recognition that graduates progress through three distinct stages. Further there is no recognition within the Program that each stage of transition has different learning and clinical support needs as demonstrated by the findings of this study.

The second conclusion is that there is minimal understanding at the local health service level and the individual clinical unit level of the support needs of the new graduate nurse who is making the transition to rural practice within a Transition to Practice Program. The different stages of the graduate nurse transition to professional practice illustrated within the model of the Stages of Transition Theory (Figure 5.1) are not clearly understood or recognised and as a result the distinct stages, each with their different learning and support requirements, are not reflected in the structure of the rural Transition to Practice Program. Based on both the findings of this study and the review of the literature, it would appear that very little progress has been made in the past fifteen years to implement a Transition to Practice Program that incorporates specific support and educational requirements for new graduate nurses in the rural context. In addition, operational and workplace barriers such as heavy workloads, insufficient registered nurses, inadequate skill mix and a lack of resources impact on the implementation of the rural Transition to Practice Program.
5.2 The Findings and Conclusions within the Context of the Theoretical Framework (Refer to Fig 5.1) and Previous Research

Figure 5.1 Stages of Transition Theory


5.2.1 Conclusion One: The Stages of Transition within the Rural Practice Context

The first conclusion addresses a specific aim of this study, which was to explore the new graduate nurses’ perception and experience of the nature and timing of support throughout their Transition to Practice Program in a rural setting. In addition, the transition continuum that is represented by Duchscher’s Stages of Transition Theory (2008) and the findings specific to each stage identified from this study have been presented in three tables, one for each stage of the transition. Table 5.2 illustrates the Doing Stage which occurs at the first three to four months. The next stage which is the Being Stage occurs between four to seven months and is presented in Table 5.3 Finally, Table 5.4 illustrates the final Knowing Stage of
transition occurring at eight to twelve months. In the following sections, the findings from this study are discussed in relation to each of the three Stages of Transition.

5.2.1.1 The Doing Stage of Transition at the 3-4 Month Milestone (Refer to Fig. 5.1)

In the first three to four months of the Doing Stage, graduates work through the processes that are characteristic of this stage (see Chapter Two and illustrated in Figure 5.1). Duchscher (2008, p. 443) states that graduates at this stage are concerned with, and struggle with, basic clinical work; they are intensely focused on the job and completing tasks within ward timeframes. Uncertain of whom they can trust, graduates are driven by a need to belong and ‘go to great lengths to disguise their emotions and work to conceal any feelings of inadequacy’ (Duchscher, 2008, p. 444). Lacking experience with the unpredictability of clinical practice graduates are stressed about everything, which causes their confidence to waiver (Duchscher, 2008, p. 444). High levels of stress at this time are associated with dealing with acutely ill patients, speaking with medical staff and also with being expected to multitask while giving clinical care (Duchscher, 2008, p. 444). A lack of skills in communicating with others and workplace expectations of delegation and making clinical judgements also contribute to their stress (Duchscher, 2008). Graduates struggle with the level of responsibility, feel unprepared to make clinical decisions that they will be completely responsible for and which they feel are beyond their capabilities (Duchscher, 2008, p. 444).

Duchscher (2008, p. 448) recommends that support at this stage should include allowances for reduced workload, access to a dependable, consistent and experienced nurse and repeated practice of nursing skills during an orientation period. Furthermore, Duchscher (2008) advocates for supernumerary staffing arrangements, a prolonged orientation period that balances classroom theory and clinical practice. Because the graduate during this initial stage needs predictability, stability and familiarity, expectations of floating between clinical units, ‘rapid turnover shifts’, being in charge of units, as well as overtime or rotating to high acuity observation units should be avoided, as these situations ‘may create unsafe environments for patients and staff” (Duchscher, 2008, p. 448).
### Table 5.2 Doing Stage of Transition

<table>
<thead>
<tr>
<th>Author</th>
<th>Duchscher</th>
<th>Lea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>2008</td>
<td>2012</td>
</tr>
<tr>
<td>Country</td>
<td>Canada</td>
<td>Australia</td>
</tr>
<tr>
<td>Methodology</td>
<td>Qualitative Interpretive Inquiry, interviews @1, 3, 6, 9, 12 months. Plus focus group discussions and process revealing exercises</td>
<td>Qualitative Case Study, individual interviews @ 3-4, 6-7, 10-12 months</td>
</tr>
<tr>
<td>Setting</td>
<td>2 major cities</td>
<td>14 rural towns</td>
</tr>
</tbody>
</table>

#### Doing Stage (Duchscher, 2008) @ 3-4 months of practice

<table>
<thead>
<tr>
<th>Activities</th>
<th>Duchscher</th>
<th>Lea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipating</td>
<td>Orientation, Disparities in education/responsibility &amp; practice support</td>
<td>Orientation remote from the health service, Disparities in workplace &amp; education, No formal mentoring, Full responsibility, Insufficient RNs for practice support</td>
</tr>
<tr>
<td>Discovering</td>
<td>Workload</td>
<td>Workload, Full patient load, Focused on completing tasks</td>
</tr>
<tr>
<td>Learning, Performing &amp; Concealing</td>
<td>Multi-tasking, Speaking with physicians, Processing orders, Managing patient and family issues, Anxiety &amp; self doubt, Worried about missing something</td>
<td>Team leader role, Speaking with medical staff, Transfers &amp; retrievals of acutely ill patients, Documentation/reporting requirements, Unfamiliar clinical procedures, Medication management, Anxiety &amp; self doubt about missing something</td>
</tr>
<tr>
<td>Adjusting &amp; Accommodating</td>
<td>Advanced judgments/practice decisions, Clinical responsibility, Wavering confidence, Delegation, Sociocultural-changes to personal life</td>
<td>Clinical judgment/clinical decisions, Assessment, Clinical communication, In charge/team leader role, Delegation/supervision of junior staff &amp; nursing students, Rural policies/procedures/documentation, Sociocultural-result of relocation/isolation</td>
</tr>
</tbody>
</table>
Similarly, in this case study research, the graduates experienced the feelings and emotions associated with professional adjustment and role adaptation to professional nursing practice previously reported in the nursing literature (Kramer, 1974; Duchscher, 2001; Winter-Collins & McDaniel, 2000; Chang & Hancock, 2003) and more recently identified by Duchscher (2008) in the Stages of Transition Model. The new graduates identified emotional, physical, sociocultural, developmental, and intellectual responses as they adjusted from the role of student to the less familiar role of professionally practising nurse that are the concepts associated with Transition Shock Theory (Duchscher, 2008). As well, as described by Duchscher (2008, p. 444), the graduates were discovering the realities of the workplace and learning the expectations the rural workplace has of them, realising that these expectations did not match with their own expectations as summarised in Table 5.2.

Heavy workloads and a perception of inadequate skill mix within all of the rural health services were significant in shaping the support experiences during the transition to rural practice for new graduates within this case study. This finding is consistent with those from Casey et al. (2004), Johnstone, Kanitsaki and Currie (2008), Duchscher (2008), Bennett et al. (2012), Ostini and Bonner (2012), who also indicate that workload, skill mix and organizational pressures are of concern for new graduates particularly in this early stage of transition. Graduates in this current study acknowledged that initially in the first three-four months they were inexperienced with carrying a full workload and the responsibilities associated with it. This is consistent with findings from Lea and Cruickshank (2007) who identified in their rural study that there was no recognition of graduates’ inexperience with workload expectations as well as no difference between the new graduates’ workload and the workload of more experienced staff within the rural environment.

The findings indicate that support for patient care practices, orientation and assisting with time management and prioritising of workload in the initial phase of transition needs to be a priority for the provision of practice support provided in the rural environment within the first three months particularly, because the educational preparation of graduates was variable. Furthermore, intensive clinical support at the ward level to assist with adjustment to the rural clinical environment and at the beginning of each rotation was identified as an important priority at this stage. Parker et al. (2009) and Duchscher (2008), have reported the importance of adequate support early in the transition experience and findings from Johnstone et al. (2008, p. 52), further identify that support during the first four weeks and at the beginning of
each new rotation is crucial to a safe transition process. Duchscher (2008) also states that it is essential for graduates to be able to repeatedly practice nursing skills required within the clinical units during this initial stage of transition.

Similar to the findings of Lea and Cruickshank (2007) this study also found that the size of the particular rural health service, the services it provides and the current staffing ratios and skill mix influenced not only the workload expectations but also the level of responsibility and the extended role that new graduates undertook in this initial stage of the transition. In addition, there were differences throughout rural health services concerning the level of responsibility that the new graduate was expected to assume, and the level of performance and the role they were expected to undertake without mentoring assistance. This is consistent with Duchscher (2008) who also found that often graduates went from being ‘buddied’ to full responsibilities without graduated progression. The experienced rural registered nurse participants in this current study confirmed that the skill mix and availability of RNs within the rural health service influenced the expectations of how quickly graduate nurses are expected to be able to take on the entire rural RN responsibilities. This is because in the rural practice environment the skill mix necessitates the team leader model of nursing care delivery where the RN has ultimate responsibility and accountability for the coordination and delegation of care to other staff such as ENs and AINs. This had implications for the new graduates in this study who were not yet familiar with the clinical care regimes so found it difficult to delegate because they felt uncomfortable delegating to staff that were more experienced and also in many cases older than them.

Similar to findings from Duchscher (2008), aspects of the team leader role such as delegating and managing junior staff and unlicensed personnel proved to be difficult for the new graduate nurses in this study at this stage of transition. A lack of confidence and self-doubt in performing this role was attributed to inadequate educational preparation and a lack of opportunity to practice management and leadership skills. Thus, towards the fourth month milestone, this study identified that clinical support needs to be focused on assisting the graduate to manage the specific registered nurse’s responsibilities such as team leader roles, communication with medical staff as well as the organising and completion of the specific documentation required for patient transfers, retrievals, discharges and referrals particularly after hours when there is no clerical support within rural health services.
In this current study, the majority of the graduate respondents were employed in rural health services where there was no onsite medical staff or very limited after hours medical staff. The data identified that rural graduates found assessment and communication of assessment findings to medical staff stressful. This is consistent with findings from Duchscher (2008) (Table 5.2) who identified that as well as caring for patients who were clinically unstable, communication with medical staff is also part of the new graduate nurse’s stress at this time. When there are no medical officers onsite, the rural registered nurse has to be able to make thorough patient assessments and communicate findings appropriately and in a timely manner via the telephone to a medical officer. Thus a priority for clinical support at this milestone was identified by all participants as being the clinical decisions and clinical judgements surrounding the assessment of patients, clinical judgements and the appropriate and timely communication of assessment findings to medical staff. This finding is consistent with the Doing Stage (Table 5.2) of Transition (Duchscher, 2008) where the new graduate is moving through processes of adjusting and accommodating to making advanced judgements and practice decisions.

The nature of support identified at the three to four month milestone of the transition to rural practice included behaviours from RNs such as ‘checking in’ frequently with graduates throughout the course of a shift, and offering assistance with the workload and care regimes. In addition, time support in terms of spending time at the beginning of the shift and after handover, to ensure graduates have prioritised appropriately and assisting to identify priorities for care and how to delegate care during the shift, were identified by graduates in this study to be effective and valuable support strategies at this stage that were not included in the Transition to Practice Program. Throughout this stage, the new graduates were also seeking support from the Enrolled Nurses. The support that the enrolled nurses provided included assistance with the workload and assistance with learning clinical care routines, clarification of unfamiliar procedures, medication management, plus completing the day-to-day paperwork within specific clinical units. This clinical support provided by the enrolled nurses to the new graduates was recognised by all study participants as invaluable support at this initial stage of the transition to rural nursing practice, however it was not included as part of the Transition to Practice Program.

During this initial stage of transition Duchscher (2008, p. 448) recommends a balance of classroom theory and clinical practice to ‘wean the graduate into the rigors of being a fully
responsible and accountable professional’. This study found that opportunities and quarantined time to participate in new graduate education study days that are focused on aspects of the rural nurse’s role were seen as important for the graduates’ learning and adjustment to rural nursing practice at this three-four month stage of transition. This finding is consistent with Duchscher (2008) who advocates graduated and facilitated learning in the first six months.

Examples for the focus of graduated learning and development at this stage identified by this case study include incremental development of skills and knowledge in the team leader role, patient assessment in the ED and communication of findings to remote medical staff, the responsibilities related to patient transfers and retrievals of acutely ill patients to metropolitan or larger regional centres, discharges and referrals of patients to other health professionals and services. These, as well as, opportunities for debriefing and reflecting on practice in a safe environment away from the clinical units were identified by all participants as important priorities for structured learning support at this early stage. These were not included as part of the Transition to Practice Program.

Finally, as illustrated in Table 5.2, participants in Duchscher’s (2008) study associated the disparities regarding what they anticipated their role to be and what they actually encountered, to be associated with a lack of educational preparation. Interestingly, however, participants in this current study, felt strongly that the disparities they encountered within their transitional program at this stage were also due to the unrealistic expectations of the workplace where there was no gradual introduction to the roles and responsibilities of the fully practicing rural nurse. Rather, respondents felt the expectation was for them to be fully functioning as quickly as possible without the mentoring or practice support that Duchscher (2008) identifies graduates anticipate receiving at this stage.

Clinical support from a designated graduate facilitator and educational support from ward-based educators has been identified by Cubit and Ryan (2011, p. 70) as part of an ideal ‘trilevel’ support mechanism for inclusion in transitional programs. However, this study reveals that although these measures were considered to be ideal support mechanisms, educators are lacking in numbers within rural environments and so this type of support system was not possible. Duchscher (2008) recommends allowances for a reduction in the graduates’ workload, supernumerary staffing arrangements, being able to repeatedly practice skills,
having dependable and consistent access to experienced nurses and, skilful preceptoring as important support measures to include at this stage of transition. The findings from this study indicate that the support measures advocated by Duchscher (2008) were absent in the Transition to Practice Program and that Nurse Unit Managers and Nurse Managers within the rural health services are the major ones available to play the support role in helping to sustain this type of on-ward support within the transitional program.

In summary, it would appear from the findings that the strategies advocated by Duchscher (2008) to assist with the initial period of role transition to professional practice were not consistent with the Transition to Practice Program in this case study. As such, the Program within the rural health services was not structured to include intensive clinical support, nor the balance of classroom theory and practice that is recommended for this initial stage of transition. In addition to the above support measures not being included in the Program, there were other barriers such as heavy workloads, inadequate skill mix and insufficient registered nurses within the rural environments that resulted in limited supernumerary staffing arrangements preventing prolonged orientation periods and access to experienced registered nurses to provide mentoring and skilful preceptoring. As a result, this combination of a lack of support measures in the Program combined with operational workplace barriers did not provide the consistency, stability, predictability nor the familiarity that is ideally required at this first stage of transition to professional rural nursing practice.

5.2.1.2 The Being Stage of Transition at the 6-7 Month Milestone (Refer to Fig. 5.1)

In the second stage, the Being Stage, graduates are gaining comfort with roles and responsibilities and want to escape the constant newness and instead be ‘surrounded by familiarity, consistency and predictability’ (Duchscher, 2008, p. 446). Graduates at this stage of transition may feel ‘incompetent, inadequate, exhausted, disappointed, devalued, frustrated and powerless’ (Duchscher, 2008, p. 446). A ‘tenuous’ sense of self-trust means they seek validation for decisions and clinical judgements and, rather than prescriptive directives for particular clinical situations, the graduates express a desire for clarification and confirmation of their thoughts and actions (Duchscher, 2008, p. 446). Also, graduates feel overly vigilant supervision of their practice by experienced staff reflects doubt in their abilities, yet paradoxically feel abandoned without the support of experienced nurses in unfamiliar, unexpected or unstable situations (Duchscher, 2008, p. 446). This stage is characterised by graduates seeking challenges to their thinking, and seeking unfamiliar and new practice
situations. Also whilst feeling discomfort and worried about safety when placed in leadership positions they often do not refuse requests to undertake advanced responsibilities because they interpret the requests as a statement of confidence in their abilities.

During this second stage of transition graduates have also moved from Benner’s novice level of competence to an advanced beginner level (Duchscher, 2008, p. 448) and as such their support needs have changed. Duchscher (2008, p. 448) advises that after six months of graduated facilitated learning, graduates are comfortable with more common events such as stable patient presentations, consistent relationships and role expectations and can now be challenged to slowly advance their thinking and practice. Via the safety of a mentoring relationship and with coaching from advanced clinicians, graduates can adjust to more unstable patients and take on more responsibility for increasingly complex decisions and clinical judgements. Finally, because of the significant growth graduates have been through, they need time to recover and restore their energy levels, so placing them in complex and rapidly changing situations and advancing them beyond their capacity is counterproductive.
<table>
<thead>
<tr>
<th>Table 5.3 Being Stage of Transition</th>
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<tbody>
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<td><strong>Author</strong></td>
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<td><strong>Date</strong></td>
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<td><strong>Country</strong></td>
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<tr>
<td><strong>Methodology</strong></td>
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<tr>
<td><strong>Setting</strong></td>
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<tr>
<td><strong>Being Stage</strong> (Duchscher, 2008) @ 6-7 months of practice</td>
</tr>
<tr>
<td><strong>Doubting</strong></td>
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<tr>
<td>Professional identity</td>
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<tr>
<td>Confidence/Awareness</td>
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<tr>
<td>Gaining comfort in roles</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Examining</strong></td>
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<tr>
<td>Able to scrutinize practice context</td>
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<td></td>
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<tr>
<td><strong>Questioning</strong></td>
</tr>
<tr>
<td>Feeling exhausted, inadequate, disappointed, devalued, frustrated powerless</td>
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<td></td>
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<tr>
<td><strong>Searching</strong></td>
</tr>
<tr>
<td>Seeking validation for decisions &amp; clinical judgments</td>
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<tr>
<td>Clarification &amp; confirmation of thoughts/action</td>
</tr>
<tr>
<td>Can make safe, appropriate decisions</td>
</tr>
<tr>
<td>Leadership</td>
</tr>
<tr>
<td>Increasing responsibility</td>
</tr>
<tr>
<td>Feeling abandoned/ feeling staff overly vigilant</td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Revealing</strong></td>
</tr>
<tr>
<td>Committed to maturing their practice</td>
</tr>
<tr>
<td>A relaxed more comfortable space</td>
</tr>
<tr>
<td>Less physical energy</td>
</tr>
<tr>
<td>Seeking challenges to thinking</td>
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Graduates in this present study were progressing into a stage consistent with Duchscher’s *Being* Stage of transition (2008), outlined in Table 5.3. However, in the early phase of this period, graduates in this case study identified that their learning support needs continued to be concerned with managing care routines, performance of clinical skills and facing the realities of practice and coping, previously identified in aspects of the *Doing* stage (Duchscher, 2008). Also, consistent with previously reported findings from Duchscher (2001) and McKenna and Green (2004), graduates remained focused on task completion. However, the findings indicate that, towards the six month milestone, the graduates experienced feelings of confidence that arose from familiarity with the rural clinical environments, including care regimes and unit protocols of the unit where they were working thus the initial difficulties that many had encountered in the first three months of their programs were beginning to ease.

Duchscher (2008) found that in the initial months of this stage graduates feel discomfort with requests to be in leadership positions that they deem to be inappropriate, unsafe and beyond their clinical competence. In this study, as a result of the graduates’ increase in confidence and familiarity with the practice environment that influenced development of their time management and prioritising skills, there was increasing trust in the graduates’ abilities by health agency staff. This was evident by events such as having nursing students placed alongside them, being moved to the Emergency Department to assist more senior staff and being allocated team leader and in-charge of the unit as well as being moved between clinical units on a daily basis. Similar to the findings reported by Evans et al. (2008), graduates in this study were also in charge particularly on night duty and over weekends when there was very little clinical support available to them.

In this study, these new and unfamiliar practice situations, although they were not part of the Transition to Practice Program, assisted with the graduates’ feelings of confidence and competence. In the absence of access to formal education within the Program, the educational opportunities that these events presented to the graduates challenged their thinking and added interest. However, the constant newness and unpredictability also added to and compounded their feelings of stress. Consistent with findings from Duchscher’s (2008) findings for this milestone, in the absence of feedback graduates interpreted this type of advancing responsibility as over confidence in their abilities. They acknowledged that because there were no other registered nurses available to take on these roles and responsibilities, they felt unable and not comfortable in refusing requests to take on leadership roles. The team leader
role had expectations of delegation and accountability that the graduates did not feel comfortable in performing and for which they did not receive any support during the Transition to Practice Program resulting in graduates in this study exhibiting significant role stress and role strain at this stage.

Similar findings regarding level of responsibility within the rural environment were reported by Lea and Cruickshank (2007) who also reported that elements of role stress, such as role overload and role ambiguity, are experienced by new graduate nurses because of conflicting or impossible demands placed on individuals by the health care organisation, where the graduate’s role is clearly not delineated and where there is a lack of understanding of what is expected. Many authors advocate support mechanisms to be included in Transition to Practice Programs that are aimed at reducing the level of role stress experienced by graduates in the transition to practice (Chang & Hancock, 2003; McKenna & Green, 2004; Newton & McKenna, 2007; Johnstone et al., 2008; Duchscher, 2008; Cubit & Ryan, 2011; Ostini & Bonner, 2012).

Consistent with this stage, graduates in this study were also experiencing a loss of confidence with staff members who were overly vigilant, and at the same time felt abandoned because they experienced that there were insufficient experienced RNs to provide practice support. This study identified the safety net of ‘hands on’ clinical support, particularly after rotating to other clinical units, as valuable support in this stage. However, a further finding in this study is that early rotations into specialised units had hindered the graduates’ progress because it resulted in many frequent transitions. According to Duchscher (2008), during the first four months graduates require consistency, predictability, stability and familiarity thus moving the graduate between clinical units should be avoided. Evans et al. (2008, p. 21) agrees, acknowledging that although new graduates enjoy the rotational aspects of programs, the rotations actually lead to feelings of not belonging or being accepted as part of the team. Also rotations undermine the confidence of the new graduate and reinforce the notion that graduates are unable to cope with the work on the wards. And this is similar to the findings of this current study.

Graduates at this stage were seeking advice and clinical support from RNs for clinical decisions and clinical judgements. In particular they were seeking clinical support for recognition of a deteriorating patient, when, and if, to call a rapid response, managing
ambiguous medication regimes and interpreting prescriptions and standard treatment protocols from medical staff that were not on site.

In addition they were seeking support for the advanced assessment and communication skills they were required to use in the Emergency Department or when managing acutely ill patients. For example, difficulties associated with knowing what to assess in patients and the subsequent reporting of assessment findings to medical staff and other health professionals. Clinical conversations with medical staff, for example having to call medical staff to come and perform a medical review and voicing opinions concerning patient conditions to medical staff were identified as problematic and a cause of anxiety for graduates at this stage. As with the first stage of their transition, managing the documentation and reporting requirements required for retrieval, transfers and referrals to other health services particularly after hours and on weekends, continued to be aspects of rural practice about which graduates were seeking advice and clinical support.

The findings indicate that delegating to more junior staff and taking the lead with clinical care, remained a difficulty for the rural graduates at this stage, particularly because the graduates were often busy doing the work on their own rather than delegating. Consistent with the Being Stage, incremental learning and practice support to develop these leadership roles at this stage was suggested as a positive support measure to assist with further developing and refining of this leadership role because this type of support was not provided within the Transition to Practice Program.

Also, consistent with the revealing process of this stage (Table 5.3) identified by Duchscher (2008), graduates in this case study were seeking challenges to their thinking and were actively seeking educational opportunities. Respondents within smaller rural health services where the ED is attached to the acute section identified learning support for triage and assessment of presentations to the ED as a priority need because this learning support was not part of the Transition to Practice Program. Continued skill development around specific registered nurse procedures that frequently occur in the rural clinical area that graduates may not have had opportunity to develop were also not included within the Transition to Practice Program. In addition, incremental educational support for fulfilling the documentation requirements specific to rural practice and specific to the rural registered nurse’s role associated with retrievals, transfers and referrals, and accessing and implementing relevant
policies, were also not included as part of the transitional program. Specific documentation requirements were identified as remaining problematic for graduates at this stage and thus were identified as a priority for incremental learning support at this stage.

Duchscher (2008) identified that graduates function in a hypersensitive and self-critical state and that they expect feedback from senior colleagues. In the absence of feedback, however, they will use other indicators to ensure their own safety, competence and progression. Thus the nature of support identified in this study as ideal at this stage also included quarantined time to sit with someone and discuss their progress and goals and to have formal debriefing about what they were experiencing in their transitional journey. In many of the rural health services within this case study this type of support was not clearly structured into or provided within the transitional program. However, the findings indicate that nurse managers within each ward, clinical unit, or health service are well placed and were expected to facilitate the provision of this type of support mainly because of the absence of educators within the rural clinical environments.

In addition, this study found that the transition experience within a rural practice context can be socially and professionally isolating for many new graduate nurses and there is concern for graduates to be able to access support from their new graduate peers. Duchscher (2008) identified that the new graduate is going through processes of disengaging, questioning, searching, and revealing at this six-seventh month milestone. This study finds that a valuable support strategy at this milestone of the transition to rural nursing practice would be a ‘support network’ amongst the rural graduates so that they can ‘rely on each other’ to debrief and compare experiences. This type of effective support was not provided within the transitional program.

Unwelcoming and negative attitudes as well as unhelpful behaviours exhibited by experienced nursing staff toward new graduate nurses have been identified in the nursing literature as influencing graduates’ experience of the transition to the workplace (Mosel Williams, 2000; De Bellis et al., 2001; Thomka, 2001; Oermann & Garvin, 2002; Duchscher, 2001; Duchscher & Cowin, 2004, 2006). Findings from this study indicate that the forming of positive relationships with health service staff affected the graduates’ perception of support. This finding is also consistent with Lea and Cruickshank’s (2007) study of rural graduates where the workplace culture was perceived as problematic for some graduates.
At this six-month milestone ‘time support’ from RN peers and Nurse Unit Managers, having an experienced registered nurse spend time with the graduate to ask ‘How are you going with your patients?’ was found to be effective and valuable for graduates in this study. However, this type of support was variable and not consistently available throughout a shift because of insufficient registered nurses present and further was not structured into the transitional program.

Learning strategies such as the use of questioning techniques assisted the graduates to think critically about patient care and having Registered Nurses available, offering assistance, and ‘checking in’ frequently was the backup support that was identified as required at this stage. However, provision of this type of support was also variable, dependant on whether there was actually another RN present who felt able to offer this type of support and was not included as part of the transitional program. Initiating snippets of education in quiet times during the course of the shift and displaying support through friendly conversations and time support from the NUM made the graduates feel supported, however this type of support was not a regular occurrence for the graduates and was also not counted as part of the Program. These findings are consistent with Duchscher (2008, p. 446) who identified that new graduates feel abandoned at this stage without the support of experienced nurses for the unfamiliar, unexpected and unstable situations.

Overall the findings indicate that the rural Transition to Practice Program did not include structured measures to support the new graduates through the Being stage of transition as advocated by Duchscher (2008). At this stage graduates were frequently in charge and in team leader roles without practice support and as such were placed in situations requiring knowledge and skills beyond their capacity. An absence of incremental learning and practice support to challenge thinking and to assist graduates in making complex decisions and judgements was evident within the Program. Also, graduates experienced very little access to an RN for the coaching or mentoring from senior clinicians that is advocated at this stage and that they stated they desired. In addition, the graduates were isolated socially and geographically from their new graduate peers and the Program provided very little opportunity for new graduates to network socially to overcome their feelings of isolation.
5.2.1.3 The Knowing Stage of Transition at the 10-12 Month Milestone (Refer to Fig 5.1)

In the final stage, the Knowing Stage, (Table 5.4) graduates have reached a stable comfort level and have confidence with roles and responsibilities. They can assist others with workloads and their capacity to cope has changed, they are no longer stressed with roles or responsibilities and their frustrations are now focused on ‘dealing with the system’ (Duchscher, 2008, p. 447). Further, Duchscher states that graduates are now able to ‘critique the professional landscape’ and take notice of the political and sociocultural environments (2008, p. 447).

It is during this stage that Duchscher (2008) advises that graduates require support and encouragement from mentors and managers to formulate educational and organisational career plans and aspirations. Further, as the graduates are seeking to distinguish themselves from, but also unite with other practitioners and, also to develop a sense of agency and insight into a bureaucratic system, mentoring relationships and relationships with managers need to continue so that socio-developmental maturity is fostered in the graduate (Duchscher, 2008, p. 448).
### Table 5.4 Knowing Stage of Transition

<table>
<thead>
<tr>
<th>Author</th>
<th>Duchscher</th>
<th>Lea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>2008</td>
<td>2012</td>
</tr>
<tr>
<td>Country</td>
<td>Canada</td>
<td>Australia</td>
</tr>
<tr>
<td>Methodology</td>
<td>Qualitative, Interpretive Inquiry Interviews @ 1, 3, 6, 9, 12 months. Focus group discussions &amp; process revealing exercises.</td>
<td>Qualitative Case Study. Individual interviews @ 3-4, 6-7, 10-12 months</td>
</tr>
<tr>
<td>Setting</td>
<td>2 major cities</td>
<td>14 rural towns</td>
</tr>
<tr>
<td>Knowing (Duchscher, 2008) @ 10-12 months of practice</td>
<td>Separating</td>
<td>Separating</td>
</tr>
<tr>
<td></td>
<td>• From learner role</td>
<td>• Comfortable &amp; accepted</td>
</tr>
<tr>
<td></td>
<td>Recovering</td>
<td>• Forming relationships &amp; friendships</td>
</tr>
<tr>
<td></td>
<td>• From previous stages</td>
<td>• Able to navigate a shift with unhelpful staff</td>
</tr>
<tr>
<td></td>
<td>• Shift in relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exploring &amp; Critiquing</td>
<td>Recovering</td>
</tr>
<tr>
<td></td>
<td>• Professional, political &amp; sociocultural issues</td>
<td>• Able to manage workload/expectations &amp; level of responsibility</td>
</tr>
<tr>
<td></td>
<td>• Frustrations in dealing with the system</td>
<td>• Take the lead with clinical decisions and clinical judgements</td>
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<td></td>
<td>• Growing discontent</td>
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<tr>
<td></td>
<td>Accepting</td>
<td>Exploring &amp; Critiquing</td>
</tr>
<tr>
<td></td>
<td>• Comfortable confident in roles &amp; responsibilities</td>
<td>• Expected workload and skill mix within the rural environment.</td>
</tr>
<tr>
<td></td>
<td>• Compare skills</td>
<td>• Insufficient registered nursing staff</td>
</tr>
<tr>
<td></td>
<td>• Able to answer questions rather than ask them</td>
<td>• Social &amp; professional isolation</td>
</tr>
<tr>
<td></td>
<td>• Advancement in organization, prioritising and ability to cope</td>
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<tr>
<td></td>
<td>Accepting</td>
<td>Accepting</td>
</tr>
<tr>
<td></td>
<td>• Comfort, familiarity and confidence with roles</td>
<td>• Able to cope</td>
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The findings from this study indicate that at this milestone and final stage of transition graduates were forming positive relationships and friendships, were comfortable with the rural nursing role and were also feeling ‘accepted’ as valuable team members by nursing colleagues. Time in the practice environment had assisted to hone their workplace skills and helped them to be able to manage the expected workload and level of responsibility within the rural environment. Further the graduates were able to take the lead with making clinical decisions and clinical judgements and this is consistent with findings from Duchscher (2008) who identified that at this stage graduates are able to answer questions rather than ask questions.

The graduates had also met the experienced rural nurses’ expectations that at this final stage graduates would be ‘accepting their total role as a registered nurse’. These findings concur with McKenna and Green (2004) who reported that at twelve months, graduates in their study who were also employed within a graduate nurse program, had shifted to a higher order of thinking and self actualisation. The graduates could focus more on patients and their conditions, rather than worry about their own performance, apply assessment skills, and as well have reached a level of professional growth that allows them to be assertive, recognise their limitations and seek assistance.

Reflecting on and exploring the political and sociocultural landscape and expressing frustration with the system they were working in, graduates in this study identified that at this time, the team leader role and the responsibilities and accountability required of new graduate nurses in the rural environment continue to be a hurdle for them and that they require incremental support. This type of support was not included in the transitional program.

In investigating notions of support, Johnstone et al. (2007, p. 49) identified that as the graduates’ experience increases, having ‘backup support’ when needed rather than someone always there and knowing that someone is there when things do not go according to plan is important for new graduate’s confidence and feelings of safety.

Duchscher (2008, p. 448) states that, after six months of graduated facilitated learning new graduates are ready to be introduced to taking more responsibility for making complex decisions and judgements that will require graduates to have ready access to clinical backup and coaching from advanced clinicians. In this current study reassurance and direction for
complex clinical decisions and clinical judgements, for example, checking on patients ‘prior to initiating rapid response procedures, and/or debriefing when things fell over’ were identified as a the type of backup support graduates were seeking at this stage that was not included within the transitional program.

Duchscher’s (2008) findings indicate that at this stage, advancement in organisation and prioritisation facilitates the graduates’ ability to cope and they are more aware of the sociocultural aspects of the work environment. Findings of this current study indicate that graduates experienced comfort, familiarity and confidence with the roles they were fulfilling. They were often placed in charge of clinical units and were able to successfully navigate a shift with staff they may not have perceived to be as helpful and were selective in who they sought for advice and support. In exploring and critiquing the practice environments that Duchscher (2008) identifies is characteristic of this stage, graduates in this study also expressed concern for their RN peers. This study found that graduates were reluctant to approach RNs for support during a shift because they observed that the experienced RNs were often busy with their own workload.

Finally, and also through processes of exploring and critiquing (Duchscher, 2008), the graduates in this case study were preparing to move out of the learner role and were reflecting on the educational support offered within the transitional program. To have learning support at this time for their increasing responsibilities in managing deteriorating patients and emergency department presentations was considered important at this stage. In addition, Duchscher (2008, p. 449) states in this final stage an approach to advancing the career pathway of graduates is desirable as this may determine the retention of graduates in the workplace. In this study the graduates were seeking opportunities for more permanent employment and half of the new graduate participants in this case study indicated a commitment and desire to stay in rural practice environments in permanent positions or within second year rural graduate nurses programs offered within larger rural health services.

At this stage, many of the graduates felt the Transition to Practice Program had actually come to an end much earlier. In this final stage of transition the Program did not provide measures advocated by Duchscher (2008, p. 228) such as mentoring that is needed in this stage to assist with the graduates’ socio-developmental maturity, to assist them to develop ‘a sense of
agency’ and insight into a bureaucratic system, and that would also aid the graduates with career planning.

In conclusion, while this qualitative study did not set out to compare Duchscher’s (2008) study to this current study, the findings from this study demonstrate that graduates within the rural practice environments of this case study, proceeded through each of the three stages of the transition continuum that is described by Duchscher (2008), even though they were employed in a formal Transition to Practice Program that has as its aim to provide a supported transition to the workforce.

The graduates in this study suffered similar stressors and experiences to those in Duchscher’s (2008) study. This finding demonstrates that the rural Transition to Practice Programs do not recognise the individual stages of transition and were not structured to include support measures advocated to address the difficulties new graduates experience at each of the three distinct stages. Further, the findings from this study identify the particular and unique aspects of the rural nurse’s role and responsibilities for which new graduate nurses require incremental learning and intensive clinical support within a transitional program, to facilitate an effective and safe transition to professional rural nursing practice.

Currently the rural Transition to Practice Program has been developed and structured as a twelve month program that is not cognisant of, nor structured to be in alignment with each of the three milestones characteristic of the journey of transition, described by Duchscher (2008). As a consequence the learning support offered within the Program is not incremental to reflect each of the individual stages of transition. Nor is it structured to include the incremental development of the skills and responsibilities required of the graduate in the rural context. The findings from this case study demonstrate that for rural transitional programs to provide for a supported transition to professional rural nursing practice, the structure and implementation needs to occur as three modules within a larger program where each module is structured to incorporate support measures that reflect the learning and clinical support needs of graduates as they reach each of the individual stages of transition.
5.2.2 Conclusion Two: Barriers to the Rural Transition to Practice Program

The second conclusion is that the findings show there is minimal understanding of the support needs of new graduate nurses in a rural Transition to Practice Program at the local health service level and at the individual clinical unit level. The three distinct stages proposed by Duchscher (2008) of the graduate nurse transition to professional practice are not clearly understood and as a result the distinct stages, each with their different learning and support requirements, are not reflected in the rural transitional program. Based on both the findings of this study and the review of the literature, it would appear that very little progress has been made in the past fifteen years to develop a Transition to Practice Program that is congruent with each of the distinct milestones and stages characteristic of the first twelve months of the new graduate nurse’s transitional journey to rural nursing practice. In addition, operational and workplace barriers such as heavy workloads, insufficient registered nurses, inadequate skill mix and a lack of resources were shown as affecting and impacting upon the development, structure and implementation of a supportive rural Transition to Practice Program.

In this case study an embedded unit of analysis was the actual rural Transition to Practice Program. The utilisation of data triangulation where data were collected and triangulated from three sources, namely, a survey, individual interviews with experienced rural nurses and individual interviews with new graduate nurses, has enabled the researcher to identify the functional elements and the strengths and weaknesses of the current rural Transition to Practice Program.

The one functional component of the rural transition program identified by this case study was the initial orientation/induction conducted in the first week of the Transition to Practice Program. Graduates were generally satisfied that their expectations of support within the orientation to the rural health service and induction to the Area Health Service, provided by the Program, had been met, despite this involving travel to other rural sites.

Weaknesses in the structure and content of the current rural Transition to Practice Program identified by this case study include: an absence of formal structured ward-based support; no clearly defined workload responsibilities; a lack of access to formal educational opportunities and intensive clinical support; insufficient ward-based learning support; problematic clinical
rotations; social and professional isolation from other graduate nurses and an absence of feedback regarding progress.

The findings of the survey established a picture of the structure of the transitional program within rural health services and these findings also provided an overall view and indication of the operational and workplace barriers that impact on the structure and implementation of the rural Transition to Practice Program. The analysis revealed that there was not a designated fulltime position responsible for the Transition to Practice Program within the rural health services. Rather a range of different levels of nursing staff that fulfilled multiple roles and responsibilities within the rural health services were also responsible for either all or part of the Transition to Practice Program. The data indicate that the small rural health services did not offer clinical rotations. However, the individual rural health services aimed to offer the occasional shift in Emergency Departments (that were attached to the acute section of the rural health service) as the graduate became more established in rural nursing practice. In larger rural health services the graduates might be offered rotations to other smaller health services as well as structured clinical rotations to clinical units within the health service as part of the Program.

The findings reveal that the structure and content of the Program varied between health services and geographical areas and was often linked into a larger regional and/or metropolitan transitional program and as such the content of the education component was not always specific to the new graduates’ rural practice environment.

Supernumery status of new graduates also varied across health services with the amount of time ranging from three days to two weeks at the initial commencement of the program and, between one and five days at the beginning of each rotation. Smaller health services had no definite time allocated as supernumerary after the initial first day. Instead the new graduate was allocated a full workload and ‘buddied’ alongside a senior registered nurse for a short time. The buddy system, where the graduate is buddied with an RN on the roster so that the new graduate is the second registered nurse on during the shift, rather than the usual rostering in rural health services of one RN and one EEN on shift, was the preferred method for new graduate clinical support in most health services. Another strategy was to roster the new graduate with an enrolled nurse for up to one month before allocating the graduate as the only registered nurse on shift with the Health Service Manager or Clinical Nurse Manager on site.
at the same time to provide support. Budget and staffing constraints were cited consistently as considerations and restrictions to the allocation of supernumery time within the transitional program.

The survey revealed that many of the Programs often commenced with formal structured support such as mentoring. However, inconsistent and inappropriate allocation of mentors to new graduates within rostering, coupled with reluctance by some senior staff to provide or be involved in formal support, were reported as reasons why several larger rural health services did not consistently provide a formal model of structured support. As well, a lack of registered staff within the rural environment and a higher EN to RN ratio results in problematic skill mixes for providing support. This was cited as the main reason that prevented the use of structured models of support within the rural health services especially the smaller rural health services.

With no access to nurse educators or a member of staff responsible for the new graduates’ progression through the Program, the Nurse Unit Manager, Health Service Manager or Clinical Nurse Manager was expected to be providing formal feedback regarding the graduates’ progress throughout the Program.

Overall these findings are consistent with those from Parker et al. (2009, p. 19) who also found varying degrees of structure to graduate nurse programs across transitional programs within New South Wales in terms of orientation, clinical areas, allocation of mentors as well as access to support structures such as access to new graduate co-ordinators, clinical educators, education and supernumerary days.

Findings from the individual interviews in Phase Two of this study identify several inconsistencies when compared with the data reported in the survey of the structure and content of the rural Transition to Practice Program conducted in Phase One. For example inconsistencies throughout the Program and at each milestone of transition included ad hoc formal structured ward-based support, a lack of access to formal educational opportunities, insufficient ward-based learning support, problematic clinical rotations and an absence of feedback regarding progress. This finding suggests that there are two major concerns with the provision of effective support during the rural Transition to Practice Program. The first is a lack of knowledge at the local health service level and at the Area Health Service level
regarding the individual stages of transition that new graduate nurses progress through and the different types of support that are required at each stage of the transition. The second is that operational and workplace barriers such as heavy workloads, insufficient registered staff, inadequate skill mix and a lack of resources prevent and negate the implementation of an effective, supportive rural Transition to Practice Program.

This study identifies a need for a more formal, structured approach to support at the ward or unit level within the rural Transition to Practice Program that fulfils the needs of graduates at each milestone of transition. The current transitional programs have been developed with little recognition of the nature and timing of structured support that is required at the different stages of transition. Also there is no recognition of the human and budgetary resources required to provide this type of support within the rural Transition to Practice Program.

The Stages of Transition Theory (Duchscher, 2008) identifies, as does this case study, that close and intensive clinical support such as that provided by a clinical preceptor or mentor is required in the initial stages of transition. However, as the graduates progress through each of the milestones acquiring confidence and skill, intensive clinical support can be reduced. In this study very little intense clinical support and supervision occurred for new graduates. Structured ward-based support was very often not followed through or was not able to occur in the rural health services because the skill mix and staffing ratios prevented support mechanisms such as preceptoring or mentoring being sustained for periods longer than the first few days of the Program.

A designated unit preceptor at the ward or unit level to provide daily hands-on clinical support, however, was expected and desired by the graduates in this study who believed it would have been of benefit to them. And, although opportunities to have a mentor were initially viewed as a positive support mechanism, overall the findings from this study regarding the allocation of mentors concur with Ostini and Bonner (2012, p. 248) who found a lack of engagement and time to meet with mentors. This meant that ‘mentors did not appear to provide very much support’. In addition, Parker et al. (2009) found that allocation of mentors in transitional programs was ‘tokenistic’. This finding from this current study is also consistent with the findings of Cubit and Ryan (2011, p. 70). Their study showed that one aspect of a tri-level support system involved hands on clinical support from ward or unit
preceptors and was rated by participants to be one of the best aspects of the newly redeveloped graduate nurse program.

The findings from this study indicate that flexibility is key to navigating the current rural Transition to Practice Program, particularly uncertain aspects regarding the timing and length of clinical rotations, supernumerary time, workload allocation and access to formal study days. For example, the findings indicate that, despite the survey data indicating periods of supernumerary time to be between three days to two weeks at the commencement of the Program and between one and five days of supernumerary time at the beginning of each rotation, staffing allocation and skill mix within rural health services often prevented supernumerary time being allocated to the graduates as was expected. Cubit and Ryan (2011) identified supernumerary time as important for graduates to familiarise themselves with the clinical environment, routines and policies. However, they also identified that inconsistent rostering often prevented the allocation of supernumerary time for graduates. Ostini and Bonner (2012) also found that graduates in their study perceived supernumerary time as one aspect of providing a supportive learning environment. In addition, these authors found that correct allocation of supernumerary time was linked to an education or designated graduate support role where advocacy for the graduate was a key part of the role (Ostini & Bonner, 2012, p. 246).

The advocacy role of educators, was also supported in this present study by the experienced rural nurses. They identified the difficulties graduates experienced with no clear structure to the Program which meant that no structured formal learning support at the ward or unit level actually occurred for new graduates. Respondents in this study identified that no one appeared to be responsible or accountable for ensuring that the aims of the Program were being met. For example, no one ensured that graduates were supported to attend the programmed study days, with rostering and staffing allocations cited as reasons that often prevented the new graduates being released to attend study days offered within the Program. This finding is consistent with the findings from Parker et al. (2009) who also identified difficulties of graduates not being released to attend or not being given enough notice, as well as not being motivated to travel to other agencies, as barriers to attending education days specific for rural graduates. Findings in this current study indicate that barriers to attending study days also included perceptions and experience of the content as not relevant to the rural environments.
and, rostering difficulties because of missed communication regarding timing of the off site study days as well as no encouragement or support from ward managers or unit staff to attend.

Insufficient registered nursing staff within the rural environments of this study resulted in graduates having no alternative but to take on many responsibilities that they did not feel prepared for and for which they needed support to develop within the transitional program. For example, graduate nurses adopted workload expectations, similar to that of more experienced peers as well as responsibility and accountability for junior staff that extended to unlicensed personnel and nursing students. In addition, the findings showed that the graduates were being placed in-charge of wards after hours and during the weekends, and, in some cases they were the only RN rostered in the rural agency. Consistent with previously reported findings by Cubit and Ryan (2011), and Ostini and Bonner (2012), participants in this current study also identified an absence of designated educational support at the ward or unit level to provide hands-on clinical support within the transitional program. The findings from this case study concur with Evans et al. (2008) who identified that a weakness of transitional support programs was a shortage of registered nurses that subsequently reduced opportunities for graduates to seek assistance. Overall, the Evans et al. (2008) study revealed an absence of designated persons who are clearly responsible for ensuring that new graduates received effective and timely educational and practice support throughout their transitional program.

Casey et al. (2004) reported a lack of incrementally staged responsibilities for graduates within transitional support programs and similarly the findings in this study concur that there were no clearly designated or documented new graduate workload or responsibilities within the rural transitional program. Rather, the findings indicate that because of the varying nature of the rural nurses’ work, the rural health services were only able to provide ad hoc arrangements for support within the workload allocation. For example, decisions surrounding allocation of workload to new graduates within the transitional program were based on the graduate’s ability, patient acuity, staffing allocation and skill mix at the time. In addition, strategies such as not allocating the new graduate responsibility for patients who might be acutely ill or whose care was complex, and the allocation of an experienced enrolled nurse to work with the graduate in the absence of registered nursing staff, were support measures for the workload that were not included within the Program but provided by individual staff members. The findings from this current study support that as the graduates are attempting to adjust to the rural clinical environment, intensive clinical support within the transitional
program for the workload and clinical care routines is crucial in the first three to four months of transition and was not able to be provided in the rural transitional program in this case study because of operational and workplace barriers.

Of significant concern in this study are findings that graduate nurses are geographically, socially and professionally isolated within the rural environment. In particular the graduate nurse participants in this study who were from culturally diverse backgrounds experienced geographical, cultural and social isolation within the rural environment because they had relocated away from their family and friendship networks. These graduates found it difficult to connect with family and friends because of the problems rural towns have with access to public transport to regional and metropolitan centres. As well, social interactions outside of the workplace did not exist for the graduates and social activities were not included within the Program. All of the participants in this study believed that the isolation felt by new graduates is also compounded by a lack of access to formal education or study days specifically for new graduate nurses. Frequent scheduling of new graduate study days would provide important opportunities for graduates to interact socially and debrief with other rural new graduates and were viewed by respondents in this study as positive supports that needed to be included and adequately resourced within a rural Transition to Practice Program. This finding of more and frequent scheduling of study days for graduates is consistent with Ostini and Bonner (2012) who also found that new graduates identified more study days as one component that could be improved within graduate nurse programs. However, this current study also identified that the content of study days also needs to be focused on the rural environment, clinical decision-making and problem solving, in addition to providing an environment conducive to peer networking and social support.

The findings in this study also indicate an absence of structured, timely, formal feedback and measurement of the graduates’ progress within the transitional programs. This is despite the environmental survey data indicating that formal feedback to new graduates occurred frequently throughout the Program. This finding is consistent with Lea and Cruickshank (2007) who also reported rural graduates in their study were surprised and disappointed with the lack of formal feedback regarding their progress within a rural transition program.

Consistent with previous findings from Lea and Cruickshank (2007), many rural health services were unable to meet expectations of clinical rotations as outlined in the survey data.
and as expected by the graduates. Strategies to address this issue of problematic clinical rotations within transitional programs have previously been reported in the nursing literature. For example, flexibility within programs where graduates can indicate preferences for length of clinical rotations for example three, six or twelve month clinical rotations and preferences for clinical areas, have been reported earlier by Parker et al. (2009), Cubit and Ryan (2011) and more recently by Ostini and Bonner (2012) as positive support measures and supported by participants in this current study. However, in 2001, Duchscher reported that the rotation of graduates to different clinical units did not serve to adequately orientate new graduates nor did it contribute to new graduates’ clinical decision-making abilities or self-esteem. In 2003, Chang & Hancock recommended six-nine month clinical rotations in light of the significant roles stress, in particular the role overload graduates experience as a result of the more frequent three-four month rotations. Further Newton and McKenna (2007, p. 1236) questioned whether graduates need the ‘repeated distractions’ of having to establish where they fit in every time they rotate. These authors agree with Chang and Hancock (2003) stating that health agencies need to consider only offering one clinical rotation to enable the graduates to develop their skill and knowledge. In contrast, Parker et al. (2009) found that graduates felt that they benefited from experiencing different and diverse learning environments. The findings from this current study reveal that the transitional programs within the rural health services of this case study were often components of metropolitan-based Area wide programs. They were not specific to the rural health services or the rural nursing environment and as such many components of the program such as clinical rotations to other clinical units, were unable to be fulfilled within the rural Program due to operational and workplace barriers.

5.2.2.1 Operational and Workplace Barriers

The findings indicate that many of the rural registered nurses were not actively aware of or engaged with the transitional program. The experienced rural RNs in this case study believed that rural RNs and junior staff are unsure of how to provide support to new learners and struggle with how to meet the on-ward support needs of new graduate nurses given the skill mix, workload and responsibilities within the rural practice context. This study finds that the enrolled nurse was involved in the provision of practice support to new graduates and was best placed to be providing practice support in the initial Doing Stage of transition because of insufficient registered nurses present within the rural practice environments. This finding also concurs with findings from Parker et al. (2009) who found that experienced enrolled nurses
were often providing the primary support for new graduate nurses within the rural environment. Thus enrolled nurses need to be supported and encouraged by managers to perform in the extended practice roles for which they had been prepared. Furthermore, the EEN requires preparation to provide the workplace learning and practice support needed by new graduates in the early stages of the new graduate nurses’ transition.

This study found that insufficient preparation for the learning support roles required of registered nurses and also very little incentive or recognition for staff who repeatedly participate in taking on these extended roles resulted in reluctance by registered staff to provide mentoring or structured ward-based support. Formal and informal preceptorship programs have been advocated in the literature (Winter-Collins and McDaniel, 2000; Duchscher, 2001, 2008; Chang & Hancock, 2003; McKenna & Green, 2004; Maben, Latter & Clark, 2006; Newton and McKenna, 2007; Young, Stuenkel & Bawel-Brinkley, 2008; Zinsmeister & Schafer, 2009) to support new nurses. However, Parker et al. (2009), identified that support offered to new graduates such as mentoring and other ward-based processes were of questionable use to graduates because the ratio of registered staff to non-registered staff puts increasing pressure on senior staff to support and be responsible for new staff. Thus these authors state there is a lack of willingness and capacity for ward staff to support graduates (Parker et al. 2009, p. 1).

Duchscher (2001, 2008) advocates that incentives for senior staff should be considered for their expanded role and the personal commitment that is required to provide positive preceptoring and a nurturing environment for new graduate nurses. However, within the present rural practice environment, capacity to support preceptoring or mentoring programs was reduced because of the lack of senior staff. Upon employment, new graduates were immediately counted as staff and budget constraints mean that new graduates are ‘expected to hit the decks running’ (Lea & Cruickshank, 2007) with very little practice support. The experienced staff within the rural health services in this study utilised ad hoc methods such as creative rostering and workload allocation as well as ‘buddy systems’, to provide an initial small measure of support. In addition, because of the difficulty RNs have with supporting new graduates given their own workload and responsibilities within the rural environment, they expected that the graduates would seek the support that they needed. For example the experienced rural RN participants stated that during a shift they would hope that the new graduate would recognise when and how to seek the help they needed. Johnstone et al. (2007,
p. 52) describe this process of graduates actively seeking out staff that could help them as ‘self-support’. They identify that the graduate nurses themselves are often the best placed to decide the support they need, however, their ability to seek support depends on their confidence levels and own support seeking behaviours. However, a finding from this study is that often graduates in rural practice environments are not able to recognise that they should seek help and often they do not know what it is they need help with. Also it is not clear to graduates what staffs expectations are with respect to exactly what aspects of workload and responsibility they are expected or have license to seek support with. In addition, as previously mentioned, this study identified that graduates were reluctant to approach RNs for support during a shift because they observed that the experienced RNs were often busy with their own workload.

Johnstone et al. (2008, p. 52) contend that it is primarily attitudinal support that is the core concept for the provision of support during the transitional year. However, these authors also acknowledge that the provision of support is dependent on the availability of qualified staff. A lack of registered nurses to provide hands-on clinical support and educational support was the core concept identified in this current study as being needed in the provision of support. Parker et al. (2009) identified that educators were most often those who provided essential support in their study and also acknowledged that educators are noticeably lacking within the rural ward environment. As previously mentioned Cubit and Ryan (2011, p. 70) reported that a ‘tri-level support’ system that includes clinical support from preceptors, support from a designated new graduate nurse facilitator and educational support from ward-based educators mitigates the stress and anxiety of the first year of practice for graduate nurses and is fundamental to the success of transitional programs. However, the findings from this study demonstrate that most of the graduates had very little contact with a nurse educator particularly in the first three months following the initial orientation period.

In the absence of ward-based nurse educators, graduates in the rural health services within this case study relied on the Nurse Unit Managers for feedback support and debriefing, provision of emotional support, advocacy, openness, encouragement and protection (from organisational requests and demands placed on the graduates). Chang and Hancock (2003) discussed the role of the NUM in the provision of support for new graduate nurses. They advocated that the NUM was well placed to assess the impact of role conflict and role ambiguity on the adjustment of new nursing graduates’ to their role. Further, Chang and
Hancock (2003) suggested that NUMs should use management interventions to enhance the graduates’ coping strategies. Evans et al. (2008, p. 19) also identified that the Nurse Unit Manager plays a role in influencing the experiences of new graduate nurses in the workplace. These authors also found, as did this current study, that new graduates were ‘sensitive’ to recognition by the nurse managers. However, many nurse managers did not acknowledge graduates or get to know graduates even though they were responsible for completing their performance appraisals.

Unhelpful attitudes experienced by new graduate nurses have been consistently reported in the nursing literature as a barrier to graduate nurse support (Duchscher, 2001; Duchscher & Cowin, 2004; Lea & Cruickshank, 2007; Johnstone et al., 2008). However, in this current study, when the new graduates were critiquing the practise environments they perceived that the majority of their rural nursing colleagues were supportive in their behaviour and attitudes. Johnstone et al. (2008, p. 52), in discussing attitudinal support as a core component for new graduate nurses, comment that changing attitudes is a ‘perennial problem’ that will not be remedied unless the whole issue of support is reframed to be everyone’s responsibility, and refocused on the substantive issue of patient safety rather than simply framed as a graduate nurse transition issue. Thus the implementation of strategies throughout health services in New South Wales to address cultural change through channels such as the Essentials of Care Program, using principles associated with Practice Development, can be attributed to a change in the attitudinal support found within the rural environments of this current study when compared to the findings of Lea and Cruickshank (2007). The rural health services need to be commended for this change in workplace culture that has occurred and which is evident from the findings of this current case study.

The findings demonstrate that the education content within the rural Program needs to be relevant to the challenges graduates face within the rural environments and needs to incorporate the distinct educational requirements required at each milestone of the transition. For example, in the initial stages of transition the Programs need to be adequately resourced with experienced RNs to provide the intensive clinical support required. Also, the theory component of programs should be focused on skill development through practice and exposure to new practice situations. This is vastly different to the educational content and resources that graduates require during the last milestone of transition where the focus needs to be on educational opportunities that will prepare graduates for their career within the
healthcare system and to take on more advanced management and clinical leadership roles. Tertiary nursing education programs do not, and cannot, aim to prepare beginning registered nurses, to fulfil advanced roles that are generally required of more experienced registered nurses. Therefore, the rural transitional program needs to provide incremental development of the leadership skills required of the rural registered nurse.

Also this study found that supplied learning packages derived from the deficit model of transitional programs where ‘a shortfall, of knowledge or skills is assumed’ (Cowin & Duchscher, 2008, p. 323) did not serve to assist the graduates with their learning in the rural environment. This finding concurs with Evans et al. (2008) who state that in lieu of adequate clinical support learning packages and educational materials were often provided to graduates in an attempt to redress what the hospitals perceive as an inadequate preparation or lack of confidence by graduates. Graduates in the Evans et al. (2008) study further identified that new nursing graduates needed support to practise and apply their skills but it was difficult in busy environments where suitable role models were not available. In this study respondents identified that quarantined time for experienced nurses to foster and encourage critical thinking regarding patient management and clinical decisions, to provide context specific learning support, and time support for the clinical procedures being performed within the rural clinical units, was more relevant and useful to the rural clinical environment.

Staffing allocations and skill mix within the rural environment that affected workload allocation and level of responsibility were seen by respondents in this study as barriers to implementing and sustaining structured support mechanisms within the rural Transition to Practice Program. This study identified that the nature and timing of effective support is influenced by ‘skeleton type staffing levels’ where the registered staff are very ‘stretched’ and are not able to provide the incremental learning support required of a newly graduated nurse. It would appear that a weakness and a barrier to effective transitional programs is the issue of staff shortages where new graduates have to work without direct RN supervision and support and, as Evans et al. (2008) reports, this further adds to feelings of anxiety and apprehension for graduates.

From the findings of this study recommendations can be made regarding feasible actions that would assist in developing a supportive Transition to Practice Program that is situated within the context of rural nursing practice. Table 5.5 illustrates five major principles and for each
principle strategies are provided on which to base structural decisions when designing and developing Transition to Practice Programs for new graduate nurses in rural practice. The recommendations presented in Table 5.5 are not intended to be prescriptive but rather are presented as guidelines that can be used to help achieve optimal transitional outcomes.
### Table 5.5 Guidelines for Contextualising a Rural Transition To Practice Program for New Graduate Nurses

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<tr>
<th>Principles</th>
<th>Strategies</th>
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| 1. A TPP should be learner-centred | A TPP should support transition and be understanding of the needs of new learners in the health workplace and provide:  
- Corporate, individual health service and unit-based orientation for new graduate nurses  
- Quarantined time to discuss and agree on learning goals and opportunities  
- Consistent access to experienced clinicians during each milestone of the transition  
- Student centered educational approaches and strategies to foster situational learning that meet the needs of all generations of learners. For example, the use of online learning management systems, simulation pedagogy to supplement and enhance situational learning and reflective practice |
| The program is New Graduate Nurse focused and should make allowances for, and be adaptable to previous nursing and educational experience, plus cultural and life experiences of the new graduate nurse. | The structure of the TPP should provide:  
- Flexibility for learners’ needs and the rural environment  
- Intensive clinical support that is needed in the first 3-4 months of transition  
- Incremental development of the roles and responsibilities required of rural RNs  
- Structured and quarantined time to foster learning via debriefing, feedback and access to experienced clinicians  
- Structured formal, incremental educational support relevant to each milestone of the transition and the rural practice context |
| 2. Structure of the transitional program should include a developmental or consolidation approach. | A rural TPP should be situated in the rural practice context and provide:  
- Access to experienced rural clinicians  
- Appropriate time support for incremental development and refining the advanced practice skills, clinical decisions and judgements required of rural nurses  
- Appropriate education to incrementally develop and refine the advanced practice skills, clinical decisions and judgements required of rural nurses  
- Provide resources and opportunities to manage professional and social isolation. |
| The structure of the program is explicit, flexible and adaptable to the diverse rural environment. Is well documented and consistently implemented. | A rural TPP should be clinical unit-based and provide:  
- Guidelines/recommendations ready to hand of how the TPP is implemented at each milestone. This could include allocation of supernumerary time, workload allocation, incremental development of roles and responsibilities  
- Opportunities for repeated practice of nursing skills relevant to the unit  
- Dependable and consistent access to experienced nurses who can provide skillful preceptoring  
- Implementation of teaching and learning strategies to enhance clinical learning at the unit level.  
- Educational resources and materials for specific learning that are relevant to the clinical unit |
| 3. Situated in the rural practice context | A state of readiness and preparedness of staff to engage and connect with new learners and provide:  
- Preparation for support roles that includes recognition and understanding of the needs of the new graduate nurse at each milestone  
- Ongoing professional development to further extend and refine clinical teaching skills of staff  
- Recognition by the organisation for the clinical education and support provided by staff for new learners. |
| A rural transition program should be specific to the rural context taking into account the roles and responsibilities of rural nurses. | Lea, J. 2013. *Guidelines for Contextualising a Rural Transition To Practice Program for New Graduate Nurses* |
| 4. Clinical unit-based |  |
| The transition program needs to have a clear structure and guidelines that are relevant to each clinical unit. |  |
| 5. A state of readiness and preparedness |  |
| The transition program should foster engagement and connection of staff with learners in the rural clinical setting. |  |
Finally, the findings from this study indicate an inequity of resource allocation when compared with metropolitan health services, in the provision of clinical learning support within transitional programs. In particular, there was a perception by all participants in this study that graduates employed within a rural transition program experience greater expectations by the organisation in what they are expected to manage with respect of workload and responsibility and also inequity in what the Transition to Practice Program actually offered in terms of support, when compared to the expectations and support offered to graduates in regional and metropolitan programs. There was a perception by participants in this study of a lack of consistency and commitment by the Area Health Service to many aspects of learning support that the rural Transition to Practice Program aimed to provide.

In summary, the literature demonstrates that development of graduate nurse transition to practice programs to provide a shelter in times of uncertainty and insecurity, to overcome job stress and to assist in the successful socialisation to the nursing role have been advocated for many years (Kramer, 1974; Boyle et al., 1996; Winter-Collins and McDaniel, 2000; Duchscher, 2001, 2008; Chang & Hancock, 2003; McKenna & Green, 2004; Maben, Latter & Clark, 2006; Newton and McKenna, 2007; Young, Stuenkel & Bawel-Brinkley, 2008; Zinsmeister & Schafer, 2009). In particular, components that should be included in graduate transition programs have been consistently reported in the literature as the provision of positive preceptor and/or mentoring experiences that promote quality co-worker interactions, clearly defined workload responsibilities to reduce role conflict and role ambiguity and, structured support systems such as continuing education and staff development. These structured support mechanisms have been reported to be particularly important and of the most benefit to any new graduate nurses within the first three months of transition (Duchscher, 2001; Lea & Cruickshank, 2007; Duchscher, 2008; Johnstone et al., 2008; Ostini & Bonner, 2012). However, despite this evidence, it is clear from the findings of this study that the rural Transition to Practice Program within this case study is not meeting the desired goals and objectives for formal workplace learning support advocated in the nursing literature. Twelve years ago De Bellis et al. (2001) found similar criticisms of graduate nurse programs to what the participants in this study have described.

The rural Transition to Practice Program has been developed as a twelve-month program and there appears to be no recognition that a three-stage structure is required. For effective supportive programs, rural health service staff need to be aware of support strategies that
should be included in a transitional program for each of the three individual stages of transition. Further the support strategies need to be implemented before the new graduates progress to the next stage of transition.

The majority of graduates in this current study had successfully managed their journey of transition without structured formal support and believed they would be at the same level of development with or without a transitional program. Unfortunately, this study finding is consistent with the findings from De Bellis et al. (2001); Lea and Cruickshank (2007) and Parker et al. (2009), who identified that transitional support programs are of questionable value given the unmet expectations of the content, structure, rotations and support presently offered to new graduates within this rural Transition to Practice Program.

5.3 Implications for Policy and Practice

This section addresses the implications of the findings of this study for practice and policy in relation to the support offered within rural Transition to Practice Programs. The implications and recommendations are discussed at both the macro level and micro levels and the implications for the rural nursing workforce are also discussed. The chapter concludes with recommendations for further research into this field of study.

In this case study half of the new graduate participants desired to remain in the rural environment because of their connections with the rural areas despite being disappointed with the support offered within the rural transitional program. It is important to note that these new graduates had exposure to rural clinical placements as undergraduate nursing students and had often completed prior clinical placements in the health services where they were undertaking the rural transitional program as graduate nurses. This would indicate that some graduating nurses are interested in pursuing rural nursing practice and that exposure during tertiary education preparation does have a positive influence on the recruitment of graduating nurses to rural health services. Previous authors (Chapman & Orb, 2001; Bushy & Leipert, 2005; Lea & Cruickshank, 2007; Lea et al., 2008) have highlighted the importance of offering health students experience in the rural facility of their choice where positive undergraduate clinical experiences can influence future employment intentions and also because health students with a rural background are more likely to return to the rural environment. In contrast, the graduates in this study who stated that they had not had experience within rural
practice environments during their pre-registration preparation were those who did not intend to remain within the rural environment at the end of the twelve-month program.

It is clear from this study that the graduates from metropolitan pre-registration programs who have not had prior experience of a rural practice environment have differing support needs to those whose programs have included rural experience and also from graduates from within regional and rural based pre-registration programs. As a result, the rural transitional program did not provide any incentive for them to remain within the rural practice environment despite the significant costs associated for the new graduate to re-locate from their metropolitan homes to the rural community to undertake the transitional program. Therefore, new graduate transitional support programs within the rural environment need to reflect the individual learning needs, and take into account any previous rural experiences, metropolitan or regional preparation for practice, and potential social and cultural isolation for the new graduate nurse who relocates to the rural community.

Recent initiatives such as the implementation of second year graduate program within larger rural health services and the permanent employment of graduates within some smaller rural health services is making some progress towards viewing graduates as an important and long-term workforce investment. This is indicated by half of the graduates in this study who intended to stay on in the rural environment as permanent staff or through a second year graduate program. Despite these innovations, while the graduate nurse year remains loosely unstructured, there remains limited capacity to build the rural nursing workforce to any extent, and as such, the problems with rural recruitment and retention will continue as, increasingly, graduating nurses are attracted to health services where there are more educational opportunities and support.

Crookes (2012), in discussing the nursing workforce shortage in Australia, states that a lack of adequate support post-graduation affects the retention of nurses and that retention of nurses is high where nurse educators and good nursing leadership at the clinical level support the clinical environment. Further, this author states that a recommendation arising from the Council of Deans of Nursing and Midwifery Australia and New Zealand [CDNM] (2012), is for increased support to health services so that greater numbers of less experienced nurses can be accommodated (CDNM Press Release April 2012). A lack of access to adequate support, education and training are consistent and continued themes that are identified as particularly
influencing the retention of the rural nursing workforce (Hegney, 1996; Bell et al., 1997; Kenny & Duckett, 2003; Mills et al., 2006; Australian Government Department of Health and Ageing, 2008; Mills et al., 2010; Bragg, 2012). These concerns regarding the rural nursing workforce have also been acknowledged by the Federal Government’s Rural Health Workforce Australia (2012) who believe that retaining the rural workforce requires future investment to focus on increasing the value of working in rural communities through provision of sufficient infrastructure, training and supervision, and access to professional and family support.

The implications for practice and policy are presented in relation to the provision of a safe and supported transition to rural nursing practice. The recommendations that arise from this study are i) the current rural Transition to Practice Programs need to be reviewed to incorporate a more sustainable model of new graduate nurse support and ii) if transitional programs are considered a viable alternative to new graduate support and, if graduate nurses are to be recruited and retained within rural practice environments, the operational and structural barriers currently impacting and influencing the support offered within the rural Transition to Practice Program needs to be addressed both locally and at the Area Health Service level. iii) A rural Program needs to recognise the individual stages of transition through which new graduates progress and include the specific support strategies advocated for each stage, thus, a review of the structure of the rural Transition to Practice Program is recommended where the guidelines provided in Table 5.4 can be used to inform the ongoing development of a TPP for new graduate nurses in rural practice.

The implications of the study for practice are as follows:

1) A review of the current Transition to Practice Program with updating of written resource and education materials needs to be undertaken. Currently the rural Transition to Practice Programs are metro-centric and have not been made relevant to the specific rural site and situation needs.

2) Reader-friendly information should be provided across all rural sites that offer a TPP regarding the research findings on the stages and experiences undergone by new graduate nurses. This should include practical advice such as the type of support needed at milestones throughout the transitional year.
3) Foster situational learning on the ward by providing better mentor support and making clear who is expected to do this, and providing guidelines such as debriefing at the end of shift, and encouragement to new graduates to ask for advice.

4) Accountability should be built in at each site by clear allocation of someone there to be responsible for the new graduates and their program.

5) There needs to be realisation and account taken of the conflict between work load of the new nursing graduates and the need for support.

6) Supernumerary release needs to be addressed and built in as a requirement rather than left to be undertaken if possible.

7) Expectations of all parties, and the current skill levels of the new nurse graduates need to be clarified and identified at the orientation sessions and taken into account.

8) Some form of incentive or special support is required for the RN who consistently takes on the role of mentor at each site

9) Address the problem of situational isolation by introducing conferencing and face-to-face contact with other graduates to happen at set, regular intervals throughout the Program.

At the macro level, the findings from this case study show that very little progress has been made in the past fifteen years to implement an effective Transition to Practice Program in rural areas. In particular this study found that inadequate support during the first two stages of transition influenced the workload and level of responsibility new graduates were expected to assume, particularly in the first six months. Operational and workplace barriers such as heavy workloads, inadequate skill mix and insufficient registered nurses within the rural environment impacted on supernumerary staffing arrangements, prevented prolonged orientation periods and access to experienced registered nurses, served to reduce the effectiveness of the current transitional support program. As well, the program was not clearly structured, and often no one person was responsible or accountable for ensuring that structured support actually occurred at the ward level for new graduates as they made the transition to rural nursing practice.

As this study showed, having an inadequate number of registered nursing staff that can provide effective clinical leadership within the rural environment resulted in graduates having to take on advanced responsibilities that were not included in the design of the transitional program. This meant that graduates did not receive the intensive clinical and learning support
that transitional programs are expected to deliver. As well, there was a perception of an inequitable resource allocation to provide learning support within rural transitional programs. This study found that respondents believed that newly graduated nurses making the transition into rural nursing practice experienced greater expectations by the organisation, in what they were required to manage with respect of workload and responsibility particularly when compared to the expectations of graduates in regional and metropolitan transitional programs. In addition, respondents believed that new graduates employed within a rural Transition to Practice Program experience inequity in what the Transition to Practice Program actually delivers in terms of support when also compared to their metropolitan and regional peers. Thus a recommendation for the development of a supportive rural transition to practice program that arises form this study is for a consistent, committed and co-ordinated effort in the design, structure and implementation of the program.

Several of the graduates in this study had studied at regional universities where their clinical preparation included mainly rural nursing placements and many of the graduates had previous nursing experience within the rural health services. The focus of this study was the rural Transition to Practice Program and thus a discussion of the educational preparation of new nursing graduates is not within the scope of this study. However, the respondents felt they were prepared for the rural practice environment. They believed the disparities they encountered within their transitional program were due to the unrealistic expectations of the workplace where the transitional program provided no gradual introduction or incremental development for the roles and responsibilities of the fully practising rural RN. Rather there was an expectation for them to be fully functioning as quickly as possible with insufficient practice support. The majority of participants in this study had successfully managed their journey of transition without structured formal support. This has significant implications for the rural nursing workforce as it indicates that some new graduates could successfully make the transition in rural practice with or without a transitional program and may therefore be retained in the workforce. However, for those who found the transition difficult, because they did not receive structured formal support within the Program, they were not inclined to stay in the rural environment. If new graduates are to be persuaded to stay in the rural environment, it is imperative that they are given incremental preparation for the advanced practice level required of the rural nurse (that graduates are expected to be working at quite quickly), within the transitional program, particularly during the second stage of transition.
Transition to Practice Programs have been implemented in response to the transfer of nursing education out of the hospital. They have been implemented for a number of years in rural health services across Australia and their value is questioned given the unmet expectations of the content, structure, rotations and support that is currently offered to new graduates in rural practice environments that this and previous studies (Lea & Cruickshank, 2007; Parker et al., 2009) have identified. Further, transitional programs have been viewed (Hegney et al., 2006; Seright, 2011) as a mechanism to increase and retain the rural nursing workforce. However, it is not clear if transitional programs actually increase the sustainability of the rural nursing workforce as very little evaluation of the outcomes of transitional programs has occurred (Parker et al., 2009). Francis (2012) comments that up to half of the rural graduates from rural nursing schools choose metropolitan graduate positions. This researcher believes that the inability of rural transitional programs to provide intensive support for new nursing graduates could contribute to why many graduates choose not to undertake a rural Transition to Practice Program.

At the macro level in the Australian health climate that is presently under-resourced and consistently exposed to expenditure cuts, these findings reinforce the view that current transition programs may not be a viable initiative for bridging the gap between health service expectations and educational preparation (Parker et al., 2009; El Hadadd et al., 2012). El Hadadd et al. (2012), believe that transitional programs are not providing the intensive support required for new nurses because the programs are not adequately funded. There are continuing tensions between what employers expect from graduates and the educational preparation of nursing students and this researcher concurs with El Hadadd et al. (2012), that if inadequate resourcing of transitional programs, particularly rural programs continues, the nursing profession may need to rethink transitional programs in favour of other alternatives. The introduction of an internship year for graduate nurses (El Hadadd et al., 2012) and rural nurse residency programs (Molinari, Monsrud & Hudzinski, 2008) are alternatives currently being discussed in the literature. However, this current study has found that rural health services already experience inadequate resources that affect the support that can be offered to new learners thus it is not clear how rural health services would independently be able to support and implement such models. What is required is a well-structured transition program that addresses the three stages of transition and is closely monitored. A combination of different models of support for the different stages of transition that matches with the rural clinical context is required. For example perhaps a combination of professional supervision
models utilised by medicine, social work and other allied health disciplines maybe alternatives to support during the final stages of transition. A rural nurse residency program as described by Molinari et al. (2008) provided in collaboration with tertiary education providers may be a viable alternative model to be implemented within the earlier stages of the transitional journey within rural health services.

At the micro level the findings of this study make a contribution to the advancement of the Stages of Transition Theory as documented by Duchscher (2008). As an accurate representation of the transition continuum, this theory can be applied to understanding the process of transition to rural nursing practice. In addition, because the theory demonstrates that measures taken to address the role transition for newly graduated nurses are sensitive to time, the theory is valuable for assisting with the development and structure of a supportive transition to rural nursing practice program. Therefore, the findings of this study could be utilised by rural health services and experienced rural registered nurses to assist in implementing adequate and timely support for new graduate nurses as they make the transition to rural nursing practice. Additionally, Rural Health Workforce Australia [RHWA] (2012), outlined priorities to ensure graduates are supported in the workplace, will encourage graduates to stay in the workforce and, enable them to work to the best of their abilities. Appropriate nurse to patient ratios and manageable workloads were specific goals identified by RHWA (2012) that will assist towards providing and developing supported rural transitional programs. Despite the RHWA (2012) priorities, Area Health Services will need to find ways to direct resources to rural health services to ensure that the rural working environment is supportive to the new graduates’ needs. As well to retain and recruit new graduates in the rural workplace, rural nursing staff need to be proactive in ensuring that their rural agency has an appropriate number of staff to support a Transition to Practice Program. Rural RNs need support and incentive to engage with an incrementally structured program that achieves the desired outcomes for new graduate nurse transition, promoting a positive supported transitional journey to rural nursing practice.

A significant finding of this study is that there is minimal understanding at the individual clinical unit levels, local health service level and at the Area level of the support needs of the new graduate nurse who is making the transition to rural nursing practice. The different stages of the graduate nurse transition to professional practice, specific for the rural nursing context, are not clearly understood by the rural nursing workforce and as a result, there is very little
structure and very little learning or practice support provided within the Program. Because the findings demonstrate that many rural nursing staff have minimal understanding of the graduate’s experience throughout the transition journey, and a limited understanding of the distinct characteristics of each stage and the level of support that is needed within each stage, the provision of ongoing professional development for existing rural nursing staff is a major recommendation arising from this study. Preparing rural health service staff, including junior staff for their role of providing support to new learners, via workshops, simulated learning activities and distance education technologies, staff would be better prepared to meet the needs of the new graduate nurse within the rural environment. Such preparation would also serve to foster engagement and investment by rural clinicians in the new graduate nurses’ transitional journey. Further, education programs offered in collaboration with the tertiary sector could assist rural health staff to understand the stages new graduates progress through and the beginning level, skills and knowledge that new graduates possess. In addition this preparation would assist program planners to develop and implement appropriate incremental support strategies that assist the new graduate to develop the advanced practice skills required of rural nurses.

Historically, and as this study found, most components of rural transitional programs arise from metropolitan based Area wide programs. This researcher agrees with Parker et al. (2009, p. 45) and Seright (2011, p. 10) who state that ‘a one-size fits all’ approach is not an appropriate response to new graduate support. Seright (2011) further states that standard orientation and residency programs in rural areas have not begun to meet the needs of new graduates. Molinari et al. (2008, p. 43) identify that the nature of rural nursing practice means that new graduates require specialised education and have different support needs to new graduates in urban settings. Thus, this study has identified the following recommendations that will be useful for rural nurses when developing a supportive Transition to Practice Program that aims to match the rural context and capacity which, in the long term, could assist with the recruitment and retention of graduates to rural areas.

During the period of ‘inbetween-ness’ (Duchscher, 2009, p. 1104), when the graduate is moving from the known role of the student to the less familiar role of professional practitioner, it is important that a rural Transition to Practice Program offers an incrementally staged workload and responsibilities. That is recognition for the graduates’ beginning nurse status in the workload allocation particularly during the first stage of transition. As well,
incremental preparation and support for the level of responsibility that graduates are expected
to assume during the first two stages of the transition to rural nursing practice. Also, the
Program needs adequate resourcing for the inclusion of a tri-level model of support as
advocated by (Ostini & Bonner, 2012) that includes on-site facilitators or program managers
who can monitor the new graduates’ progress and who can also provide the intensive clinical
and learning support new graduates require in the early stages of the transition to practice.

In addition, ongoing incremental education that focuses on the distinct aspects of the rural
nurses’ role and responsibilities needs to be provided in innovative and engaging ways that
foster learning and critical thinking in the newly graduated nurse. Very little learning or
practice support was provided within the Program in this study and the barriers to the
provision of support identified reduced the graduate nurses’ capacity for situational learning.
Seright (2011, p. 2) suggests that in rural settings, novice nurses are involved in decision-
making, often involving ill-structured problems set in dynamic and changing environments
and in high-stakes situations where patient safety is a concern. Thus, situational learning must
be fostered through support and mentoring with experienced nurses who are willing to advise
and reflect with them upon their decisions as they move from junior staff to experienced
individuals with increased responsibilities in the rural setting (Seright, 2011, p. 10). Simulated
interprofessional educational opportunities alongside clinical learning opportunities using
distance education technologies coupled with expert role modelling, hands-on clinical support
and ‘just in time support’ advocated by Molinari et al. (2008, p. 43) would assist the new
graduate to incrementally develop the decision making and advanced practice skills required
of rural nurses.

A significant finding from this study was the social and professional isolation of the new
graduate nurses. Graduates were not able to access any support from their new graduate peers,
which was compounded primarily by a lack of access to support and education within the
transitional program and geographical isolation because of the vast distances between health
services. The lack of access to educational opportunities identified in this study is consistent
with the problems acknowledged in the literature for rural nurses generally. That is, a lack of
consideration given to the rural nursing workforce in terms of support and access to
education, which compounds the rural nurses’ professional isolation (Kenny & Duckett, 2003;
Bennett et al., 2012).
Graduates in the smaller rural health services were not only professionally isolated but they were also socially isolated. Despite rural nurses having an interconnectedness with the community that is generally considered a positive outcome by rural nurses as it assists building social capital through the sharing of knowledge (Mills et al., 2010), participants in this study who were from culturally diverse backgrounds did not have the opportunity to develop this interconnectedness because they were also socially and culturally isolated. These ‘problems of a lack of systemic support and professional isolation’ have also been recognised by The Australian Government Department of Health and Ageing (2008, p. 39), as important factors that need attention in addressing the rural nursing workforce shortage. Rural Health Workforce Australia (2012) also identify that supporting the professional development of the health workforce is particularly challenging in rural areas. However, rural transitional programs can provide a vehicle for which isolation can be reduced. For example, Molinari at al. (2008, p. 43) believe that peer networking is important for new graduates in rural settings. A rural graduate support network that utilises distance learning technologies and social networking media will provide opportunities for graduates to gain support from other graduates. The introduction of a National Broadband Network to rural areas of New South Wales will assist with creating opportunities that currently do not exist for rural graduate nurses to connect synchronously and asynchronously for educational opportunities, to access peer networking and mentoring and professional support from experienced rural nurses. In addition, the distance education strategies will be valuable in supporting experienced rural staff in their clinical education role. However, these strategies will also require commitment and resource investment by Area Health Services in terms of time support, workload relief and Information Technology support if they are to be successful as these resources were identified as being lacking within the rural environments within this case study.

5.4 Recommendations for Further Research

As previously mentioned, it was not the intention of the researcher to generalise the findings from this study to the graduate nurse population. Rather the intention was to identify and explore the experience of support during the role transition within rural practice settings so that the findings could generate an awareness of support issues specific to graduates in rural areas. It is hoped that these research findings will assist program planners, health service managers and rural nurses to provide more adequate support during the transition for
graduates, which in the long term, could have a significant impact on the recruitment and retention of graduates to rural areas.

It is important to note that some of the findings from this study relate not only to rural nursing practice but, to the graduate nurse year in general. For example, the researcher believes the graduates may have had unrealistic expectations and assumptions regarding their graduate year, and may have entered the workforce with a knowledge deficit in workplace organisational and cultural issues as well as role transition processes. Graduates also experience a fear of the unknown in their graduate year because of the unpredictability of the nursing environment and the change in role from nursing student to that of registered nurse. This was evident by graduates stating they felt as well-prepared as possible, given the unpredictability of nursing practice. Despite this, the researcher believes that clinicians and nurse academics can address these issues to improve the support during the role transition process for graduate nurses. Thus, this study has exposed several areas that warrant further investigation.

The study explored the phenomenon of support for new graduate nurses as they made the transition to rural nursing practice. It provides further evidence to support Duchscher’s (2008) Stages of Transition Theory, as a model applicable to new nursing graduates making the role transition within rural environments. It also provides insights into the level, timing and length of support to provide for a safe transition to the rural nursing workforce and explores who is best placed to be involved in support for new graduate nurses within the rural practice environments. Further this study identified the barriers to providing effective supportive transitional programs in rural health services. While this current study provides important insights into the support needs of new graduate nurses within the rural environment it also raises further questions regarding the workplace-learning environment for new learners in rural health settings. In particular, further research in order to further extend the knowledge base regarding the provision of support during the transition from student to professional practising rural nurse is required. In addition, further research is required to build on and further test the Stages of Transition Theory, as posed by Duchscher (2008).

One recommendation for further research is a study that would build on and clarify the findings of this current study specifically related to the Stages of Transition Theory posed by Duchscher (2008). This current study utilised a qualitative approach to explore the
experiences, beliefs and perceptions of support within a new graduate nurse rural transitional program in rural practice environments from the perspective and experiences of a small sample of new graduate nurses and experienced rural nurses who work with them. A larger rural sample utilising a longitudinal mixed methods design that used participant observation, combined with individual interviews and the use of self-report measurement scale and tools at intervals throughout the first twelve months would provide complementary information to the findings of this current study. Furthermore, because this current study utilised a case study design in only one Area Health Service of Northern New South Wales, it is recommended that this study be replicated and extended to all rural regions of New South Wales and beyond to include all rural regions in Australia to determine and compare similarities and differences in the level of support offered within transitional programs within other rural health services.

In addition, second year rural graduate nurse programs are becoming increasingly popular within larger rural health services of New South Wales, therefore a similar study utilising a sample of second year graduate nurses would also provide valuable insights into their particular support needs as they enter the second year rural graduate nurse program. Understanding of support needs beyond the first twelve months is limited and there is a paucity of research that addresses the support needs and experiences of this group of novice nurses within the Australian rural context.

How rural health services overcome the barriers to the provision and implementation of support identified in this study lends itself to an organisational action research project as described by Schneider et al. (2013, p. 270). Levet-Jones and Fitzgerald (2005), suggest that there is very little collaboration between hospitals and the tertiary sector with regard to graduate transition. An action research project involving collaboration with the tertiary education sector, rural nursing and health staff, is warranted to foster strategies for the provision of support for new graduates and new learners within rural environments. This type of study would assist to map and develop support strategies that match the specific rural context and capacity, and would also assist to bridge the gap between health services and the higher education sector.

This study also identified barriers to the provision of learning support that impacted on and influenced the situational learning experiences of new graduate nurses. This finding warrants further investigation into the effectiveness of the situational learning that occurs during the
transition to rural nursing practice. Such a research study would also assist to further explore and investigate strategies for fostering and further development of the situational learning, critical thinking and clinical decision making by rural new graduate nurses that are sustainable within the Australian rural health service context.

In summary, this chapter has provided a discussion of the major conclusions and findings of this study. The nature and timing of support for graduate transition to the rural nursing workforce has been presented and discussed. And a proposed framework that would support the development of a TTP has been presented. The implications for nursing policy and practice have been identified and strategies for improving support for new graduate nurses as they make the transition to rural nursing practice and for improving the graduate nurse transition programs in rural health services have been proposed. Finally, the findings of the study have been used as a basis for recommendations for further research.

5.5 Conclusion

In conclusion, the researcher believes that this study which has explored the phenomenon of support for graduate nurses making the role transition to registered nurse within rural settings, will make a valuable contribution to the nursing literature as it has identified support issues specific to the rural nursing workforce. It has examined issues surrounding the timing, level and nature of support and has also provided an insight into the effectiveness of support within current rural transitional programs in easing the role transition. Further, this study has identified that The Stages of Transition Theory posed by Duchscher (2008), is an effective model that can be applied to understanding the process of transition to rural nursing practice.

It is hoped that the findings of this study will assist policy makers, the health industry and the nursing profession to address the sustainability issues that currently exist within the Australian rural workforce. Area and rural health services could utilise the findings to critically review the adequacy and viability of transitional programs. Further, the findings will assist with the planning, implementation and maintenance of sustainable models of support within rural practice settings which could, as a consequence, assist to increase the recruitment of new graduate nurses to a rural nursing career. Finally, it is hoped that the findings will inform and better prepare experienced rural nurses for their role in the provision of support for new learners, in particular new graduate nurses as they enter the rural nursing workforce.
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APPENDIX 1

Interview Schedule with New Graduate Nurses at 3 Months
Interview Schedule for Individual Interviews
with New Graduate Nurses at 3 Months

1. You are now at the 3-month milestone of your graduate transition year, can you tell me about what the experience of your journey has been like for you so far?

   **PROMPTS**
   - How you feel about your journey so far?
   - Can you talk about the structure of the graduate nurse program in the last few months?

2. Can you tell me about the support you have/are receiving so far?

   **PROMPTS**
   - Is the level of support what you expected?
   - Can you comment on the timing of support?
   - Where/who did support come from?
   - What types of support would you have liked to/expected to receive?

3. Can you explain/describe some actions/structure at this time that you feel would provide you with the support that you feel you need/ would be helpful to you during this 3-month period of your transition to the workforce?

   **PROMPTS**
   - Can you talk about the rostering and skill mix; is it/has it been supportive of your needs at this time?
   - Do you feel that the workload allocation at this time of your transition journey is supportive?
   - Can you talk about/identify designated new graduate workload/duties/responsibilities?

4. Can you talk more specifically about the support provided to you at the ward/unit level by individual RN’s, NUM, CNE?

   **PROMPTS**
   - What was ‘good’ support for you?
   - Who are you frequently turning to for support?
   - Do you feel that at this stage of your transition that you are getting appropriate constructive and timely feedback

5. Do you think the support at the ward level at this time in your journey of transition could be improved?
APPENDIX 2

Interview Schedule with New Graduate Nurses at 6 Months
Interview Schedule for Individual Interviews
with New Graduate Nurses at 6 Months

1. You are now at the 6 month milestone of your graduate transition year, can you tell me about what experience of your journey has been like for you so far?

   • PROMPTS
     • How do you feel about your journey so far?
     • Can you talk about the structure of the graduate nurse program in the last few months?

2. Can you tell me about the support you have/are receiving so far?

   • PROMPTS
     • Is the level of support what you expected?
     • Can you comment on the timing of support?
     • Where/who did support come from?
     • What types of support would you have liked /expected to receive?

3. Can you explain/describe some actions/structure at this time that you feel would provide you with the support that you feel you need/ or that would be helpful to you during this 6-month period of your transition to the workforce?

   • PROMPTS
     • Can you talk about the rostering and skill mix; is it or has it been supportive of your needs at this time?
     • Do you feel that the workload allocation at this time of your transition journey is supportive?
     • Can you talk about/identify designated new graduate workload/duties/responsibilities?

4. Can you talk more specifically about the support provided to you at the ward/unit level by individual RN’s, NUM’s, CNE’s?

   • PROMPTS
     • What was ‘good’ support for you?
     • Who are you frequently turning to for support?
     • Do you feel that at this stage of your transition that you are getting appropriate constructive and timely feedback

5. Do you think the support at the ward level at this time in your journey of transition could be improved?
APPENDIX 3

Interview Schedule with New Graduate Nurses at 11 months
Interview Schedule for Individual Interviews
with New Graduate Nurses at 11 Months

1. You are now at the 11 month milestone of your graduate transition year, can you tell me about what experience of your journey has been like for you so far?

PROMPTS
- How do you feel about your journey so far?
- Can you talk about the structure of the graduate program in the last few months?

2. Can you tell me about the support you have/are receiving so far?

PROMPTS
- Is the level of support what you expected?
- Can you comment on the timing of support?
- Where/who did support come from?
- What types of support would you have liked /expected to receive?

3. Can you explain/describe some actions/structure at this time that you feel would provide you with the support that you feel you need/ would be helpful to you in this 11-month period of your transition to the workforce?

PROMPTS
- Can you talk about the rostering and skill mix; is it or has it been supportive of your needs at this time?
- Do you feel that the workload allocation at this time of your transition journey is supportive?
- Can you talk about/identify designated new graduate workload/duties?

4. Can you talk more specifically about the support provided to you at the ward/unit level by individual RN’s, NUM’s, CNE’s?

PROMPTS
- What was ‘good’ support for you?
- Who are you frequently turning to for support?
- Do you feel that at this stage of your transition that you are getting appropriate constructive and timely feedback

5. Do you think the support at the ward level at this time in your journey of transition could be improved?

6. Now that you are about to finish your Program, where to from here?
APPENDIX 4

Interview Schedule with Registered Nurses
Interview Schedule for In-Depth Interview with Experienced RNs

1. Can you briefly outline/tell me about the structure and content of the graduate program within this health service?

2. Can you talk about the structure of the graduate program at the ward/unit level?

   PROMPTS
   - What does the structure look like?
   - Can you explain how the program works at the ward/unit level?
   - How do you feel about the structure of the program at the ward/unit level

3. Can you talk about the support measures for new graduates that are in place at the ward/unit level?

   PROMPTS
   - Rostering
   - Skill mix
   - Workload allocation
   - New Graduate designated workload/responsibilities

4. What changes to ward/unit level support do you think could be beneficial to new graduates nurse

   PROMPTS
   - Timing of support
   - Length of support
   - Strategies for support
   - Who is best placed to provide support
APPENDIX 5

Environmental Survey
Environmental Survey

Begin with introduction of self, check that this time is suitable/convenient and remind participant that I am taking notes and that they understand that they are consenting to proceed as outlined in the letter and the consent form.

1. Have you read the introductory letter? YES / NO
   Do you have any questions before we commence? YES / NO

2. How many new graduate positions does your health service offer every year?
   ........................................................................................................................................

3. Does your health service regularly fill the graduate positions each year? YES / NO
   Have you filled the new graduate position for 2011? YES / NO
   What month does the graduate nurse transition program commence?
   ........................................................................................................................................

4. Does your health service ever employ newly graduated nurse who are not on a graduate program? YES / NO

5. Does the graduate program have rotations to different clinical areas? YES / NO
   What are the rotations?
   ........................................................................................................................................
   How long are the rotations?
   3 months  6 months  No rotations  (Please circle appropriate period)

6. How many days of orientation does the new graduate receive?
   Hospital.................................................................................................................................
   Ward......................................................................................................................................
7. Is orientation held in your agency?  YES / NO
   If NO, where is it held?
   ..............................................................................................................................
   ..............................................................................................................................

8. Are there any education days included for new graduate nurses?  YES / NO
   If YES, where are they held?
   ..............................................................................................................................
   How many days?
   ..............................................................................................................................

9. Are there supernumerary days for newly graduated nurses?  YES / NO
   If YES, how many?
   ..............................................................................................................................

10. Is there a structured support model at the ward/unit level?  YES / NO / MAYBE
    Comments?
    ..............................................................................................................................
    ..............................................................................................................................
    ..............................................................................................................................

11. Do newly graduated nurses have a regular performance evaluation?  YES / NO
    If YES, how often?
    ..............................................................................................................................
    If YES who is responsible for completing the evaluation?
    ..............................................................................................................................

12. Which role / portfolio in this health service does new graduate support come under?
    ..............................................................................................................................
    ..............................................................................................................................
a. Are you available for an in-depth interview at a later date to discuss your experiences with graduate nurse support?  

YES / NO

13. Is there any topic / issue / concerns you would like to discuss with me regarding the graduate nurses when I interview you at a later date?  

YES / NO

........................................................................................................................................................................
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Finish with thanks and an invitation to contact me with extra comments / advice by email if they wish to. Add explanation of how and when I will contact them to arrange a time for interview. Offer to give them a copy of this completed survey.

NOTES / IDEAS
APPENDIX 6

Plain Language Statement
An investigation into the provision of support within a Transition To Practice Program for new graduate nurses in rural health settings.

December 2010

Dear Participant,

As part of my PhD studies with Charles Darwin University, I am conducting a study that explores the nature and timing of support required by new graduate nurses to provide for a safe and supportive transition into the rural nursing workforce.

On the following pages you will find more information about the study and what it will mean for you to participate.

I would be most appreciative if you would take a few minutes to read the information and, if you are interested in participating, complete and sign the attached consent form and return to me at:

Jackie Lea
Lot 10 Stoney Ridge Rd
Armidale NSW 2350

I have ethical approval from the CDU Human Research Ethics Committee to undertake this study.

Thank you for taking the time to read this letter and considering my invitation, I look forward to hearing from you in the near future.

Jackie Lea
PhD Candidate
Telephone: 02 67732974
Email: jlea2@une.edu.au
PROJECT  An investigation into the provision of support within a Transition To Practice program for new graduate nurses in rural health settings

CHIEF INVESTIGATOR: Jackie Lea

I am a Lecturer in Nursing in the School of Health University of New England where I have a responsibility for the clinical component of UNE’s undergraduate nursing program. I am currently enrolled in a Doctor of Philosophy degree at Charles Darwin University and this study will help me meet the requirements for this qualification.

PURPOSE OF THE STUDY

I am interested in gaining an insight into exploring the nature and timing of support required by new graduate nurses to provide for a safe and supportive transition into the rural nursing workforce. To do this I would like to talk to you about your perceptions and reflections on the nature and timing of support required by new graduates within the rural nursing workforce.

BENEFITS OF THE STUDY

This study will help in the development of a framework for the provision of support at the ward level that is specific for the rural context and capacity.

WHAT WOULD BE EXPECTED OF YOU?

If you agree to participate, I would like to interview you for about 60-90 minutes at a mutually convenient time and place. If you are unable to or don’t want to meet with me in person, you will offered the opportunity to complete the interview by telephone at a mutually convenient time.

The interview will be informal, more like a conversation than a question and answer session and, with your permission, it will be digitally recorded to allow accurate transcription. You will be offered the opportunity to read the transcription of your interview when it is completed to confirm that it is an accurate record of your thoughts or what you wanted to say and/or review the major findings of the study.

Prior to the commencement of an interview I will ask you to complete a participant profile sheet that will seek demographic information related to your age, sex, length of employment, content of graduate program, previous nursing education and/or experience. This information will be used to describe the participants of this study.

Your participation is entirely voluntary and it will have no impact on your current employment or any future relationship you may have with the University.
DISCOMFORTS/ RISKS

If you decide to take part in this research I don’t believe that there are any risks for you by participating in this study. There are no specific risks associated with this study. However, you may experience some personal discomfort as you reflect on your experiences, but you might also gain some insight or knowledge that you will find useful now or in the future.

CONFIDENTIALITY

Only the Principle Researcher will know your name, address and personal details. The interview recording will be given a pseudonym to protect your identity before it is transcribed into a word document. Upon receipt, the participant profile sheet will be coded and your name and address will be kept separately from it. Only pseudonyms will be used in any reports or presentations on the findings of the study.

Once the interview is completed, it will be transcribed into a word document for me to read and analyze. The results of all the interviews will be drawn together to identify common themes. The recorded interview will be stored electronically on a compact disc (CD) or electronic storage device. The transcription will also be stored as an electronic file as well as a hard copy document. All files and documents will only be identifiable by pseudonym and will be stored in a locked cupboard in my office. Only I will have access to the stored files and documents.

Once the study has finished, all the recorded interviews and transcriptions will be stored in a locked cupboard in my office for a period of 5 years. After that time, all transcripts and recordings will be destroyed.

WHO CAN I CONTACT FOR MORE INFORMATION?

If you have any queries or would like more information about the study, you can contact me at anytime. My contact details are

  Telephone: 02 67732974
  Email: jlea2@une.edu.au

If, during the course of the project, you have any concerns about the project or the researcher, you may contact the Executive Officer of the Charles Darwin University Human Research Ethics Committee, who is not connected with the project and can pass on your concerns to the appropriate people within the University. The Executive Officer can be contacted on any of the following:

  Phone: 08 8946 6498
  Toll Free: 1800 466 215
  Email: cdu-ethics@cdu.edu.au

YOUR PARTICIPATION

I would be grateful if you did participate in this study but you are free to refuse to participate. Even if you do decide to participate, you may withdraw from the research at any
time. It is important that participants are aware that there are no right or wrong answers, and that the researcher will remain neutral on the subject and that this research is unrelated to any employing body.

If you would like to participate in this study, please complete the attached consent form and return to me in the postage paid envelope provided as soon as possible, to the address below:

Jackie Lea
Lot 10 Stoney Ridge Rd
Armidale NSW 2350

You will not be asked to give any other information or to undertake an interview until I receive your signed consent form. Once you return your consent form, I will contact you to answer any further questions you may have and arrange a time and place for an interview.

RESULTS OF THE STUDY
A transcription of the tape will be made available to you and you are welcome to arrange a time to read it if you wish.

PERSONS TO CONTACT
If you have any questions about the project, please contact the researcher, Jackie Lea on ph:02 67732974.

If there is an emergency or if you have any concerns before commencing, during or, after the completion of the project, you are invited to contact the Executive Officer of the Charles Darwin University Human Research Ethics Committee on 08 8946 6498 or by email: cduethics@cdu.edu.au. The Executive Officer can pass on any concerns to appropriate officers within the University.

Whatever your decision about participating in this study, I thank you for taking the time to read this information sheet and for considering its contents.

This letter and information sheet is yours to keep.
APPENDIX 7

New Graduate Nurse Participant Profile
Participant Profile Sheet

Please tick appropriate box

Gender:

Male
Female

Nationality:

Is English your first language?

Yes
No

If no please state your first language..............................................................................................................

What is your age group?

20-24
25-29
30-34
35-39
40-44
Over 45

Relationship Status:

Single
Single parent
Partner
Partner + children
Did you complete your secondary education in Australia?
Yes
No
If no please state where: .................................................................

Did you complete your nursing qualifications in Australia?
Yes
No
If no please state where: .................................................................

Name of tertiary institution where you completed your studies?
...........................................................................................................

What month did you commence the Graduate Nurse Program? .................

What month you will complete the Graduate Nurse Program?
.................................

Have you any previous nursing experience? (e.g. AIN, EEN, EN)
Yes
If yes, what role? .............................................................................
No

Have you previously been employed within this health service?
Yes
If yes, what role? .............................................................................
No

Thank you for your participation.

Jackie Lea-PhD Candidate
APPENDIX 8

Registered Nurse Participant Profile
Participant Profile Sheet

Please tick appropriate box

Gender:
Male
Female

Designation: (e.g. RN, RM, NUM, CNE etc.) ..........................................................

Years as a Registered Nurse? .................................................................

Education Qualifications
........................................................................................................
........................................................................................................
........................................................................................................

What is your age group?
Under 25
25-29
30-34
35-39
40-44
Over 45

How many years have you worked in rural nursing? .................................

Thank you for your participation.
Jackie Lea-PhD Candidate
APPENDIX 9

Consent Form
Consent Form

An investigation into the provision of support within a Transition To Practice program for new graduate nurses in rural health settings

I, .............................................................. of ..............................................................

Hereby consent to participate in a study undertaken by ...........................................
of ..........................................................................................................................

I understand the purpose of the research is to explore support for new graduate nurses throughout the transition journey into rural health care settings

I acknowledge that:

- the aims, methods, anticipated benefits and possible risks of the study have been explained to me by Jackie Lea;
- on completion, my interview will be transcribed into a word document that will not have my name on it and that my name and address will be kept separately from it;
- any information that I provide will not be released in an identifiable form;
- combined results will be used for research purposes and may be reported in scientific and academic journals or at relevant conferences;
- Individual results will not be released to any person except at my request and on my authorization; and
- I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease, and any information obtained will be returned to me or destroyed at my request.

Signature: ..............................................................   Date: ...........................................