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Graduate Nurse Transition Programs in Western Australia: A Comparative Study of their Percieved Efficacy

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CHAPTER 4: FINDINGS

4.1 Introduction

The purpose of this chapter is to present the data from the graduate nurse survey questionnaire and the graduate nurse coordinator web-based survey in the manner prescribed by mixed methods research Triangulation Design; and as described in the previous chapter. The data from the postal survey questionnaire returned by the graduate nurse cohort has been presented as frequencies and percentages of occurrence to provide a comprehensive description of the transition programs offered within WA in 2010. Transformation of the data has enabled comparative depiction between the findings of the UWA (2000) study and the current graduate nurse survey, and facilitated comparisons within the current research by demonstrating the variations between the individual specialty rotation data with each progressive rotation. The written responses are utilised in their qualitative forms in the next chapter to further support the interpretation of the findings.

A brief overview of the original and current survey questionnaires is provided in sections 4.2 and 4.3, the latter section including demographic data that provides context to the current study population. Data from the present study are compared with data from the UWA (2000) study to determine what differences were reported between the two timeframes (sections 4.4 and 4.5). The purpose was to determine how the newly graduated RNs' perception of transitional program efficacy may have changed. In addition to the comparative data, qualitative responses provided an insight into the perceived efficacy of formal transitional programs and demonstrated shifting perceptions over the past decade within the workplace (section 4.6). The

expanded quantitative and qualitative data that was collected in the current research, in relation to future career intentions, was used to depict the perceived influences that a GNP may have upon the novice nurse's career path choices (section 4.7).

Additional comment was invited in the 2010 study and provides further insight into the GRN's perceived integration experiences (4.8).

The secondary web-based survey of graduate nurse coordinators (section 4.9) provided data that validated portions of the primary survey questionnaire in terms of program length, and contracted hours offered to the GRNs during their transitional programs. Additional information that was not available from the GRN, such as recent program innovations, was also considered and is presented in Appendix F.

4.2 Original Survey Questionnaire (UWA, 2000)

According to the UWA (2000) report, literature suggested that alliances between universities and the workplace were limited and expectations as to the graduates' abilities during the transitional period differed between academia and industry. With the intention of assisting the health industry to provide more clinical support to the newly graduated nurse and to encourage their retention in the workforce, the WA Health Department commenced funding of programs in Western Australian public and private hospitals in 1998 and 1999 (UWA, 2000). The funding was to enable programs to offer "extra clinical support, educational materials and often the opportunity to attend education sessions in order to assist them with the transition from university to the workplace" (UWA, 2000, p. 1).

4.3 Current Postal Survey Questionnaire

The postal survey questionnaire for the current study was similarly managed by the NMBWA but in this instance was sent to *all* nurses who graduated and registered with the NMBWA as a RN for the first time in 2008, that is, those who participated in a transitional program and those who chose not to participate. Demographic data were collected in the present study to allow for further exploration of associations related to age-groups, undergraduate education, prior health experience, type of employing institution and potential influence upon perceptions and experiences. Data were also collected to investigate what influence the transitional period may have on future retention of the novice nurse within the nursing workforce and their intended career paths.

4.3.1 Demographics

The UWA (2000) survey did not collect demographic data. The decision to do so in the current research enabled an expansion of the data to examine relationships and comparisons between age groups; undergraduate institutions and prior experience; as well as transitional choices, experiences and perceptions.

4.3.1.1 Gender

The ratio of female to male for the response group was 93.6% to 6.4% respectively. The national ratio of female to male nurses recorded by the AIHW for the year 2008 is 90.3% to 9.7% and for WA is 90.9% to 9.1%, which indicates that the State is marginally behind the national trend of improving the attraction of more males to nursing as a profession (AIHW, 2010b).

4.3.1.2 Age Groups

Almost half the sample was aged 30 or older as indicated by Table 4.1. This is noteworthy given that the general consensus is to focus recruitment on newly graduated nurses to support resupply of the ageing workforce. It is possible a large proportion of the older cohort are those with previous experience as an Enrolled Nurse (EN) as 45% indicated prior employment as an EN, compared to only 19% of the 29 or less age brackets.

Table 4.1. Age Groups of Respondents

Age group - years	Percent of sample
≤ 21	4.9%
22-29	47.0%
30-39	22.1%
40-49	15.7%
≥ 50	10.3%
Total	100%

4.3.2 Prior Experience

More than half the respondents had prior experience as an EN or Assistant in Nursing/Nursing Assistant (AIN). A further 28.5% had prior experience as an Orderly or Patient Care Assistant (PCA). Slightly more than a third (34.8%) had no prior experience in a health related field. As indicated, the older age groups were more likely to have had prior EN experience.

4.4 Comparative Data

The UWA (2000) format of the survey questionnaire providing the comparative data for the current study was maintained to a degree, but where possible, opportunities to enhance data collection were optimised. For example,

industry employment type options were expanded, and options for *specialty unit* choices were increased.

4.4.1 Sector Employment Type

The UWA (2000) survey sought information on four items related to the type of health care institution the subjects were employed in: *Hospital, Community, Private Sector, and Other*. The current survey modified these items to include: *Tertiary, Secondary, Large and Small Rural, Private, Community, Mental Health and Aged Care*. As the transition programs evolve, more types of health organisations are offering graduate programs, an important step towards recruiting to areas that are less well staffed such as Community, Mental Health and Rural. A further element was included in the 2010 survey that asked for the type of health sector the subject was employed in 2008, (their year of first registration), and what their current employing sector was at the time of survey in 2010. While the terminology employed in the UWA (2000) survey was not discussed in the study's Report it is assumed the term *Hospital* referred to all other than Private or Agency, hence the 'grouping' together of the remaining data in the 2010 survey in Table 4.2 for ease of comparison.

Table 4.2. Health Sector Employment Type

Health Sector Type	2000 (n = 170)	2008 (n = 168)	2008 Grouping	2010 (n = 192)	2010 Grouping
¹ Hospital	91.8%		73.8%		80.1%
² Tertiary ^c		45.2%		56.2%	
² Secondary ^c		6.0%		10.4%	
* Community ^c		7.1%		2.6%	
² Mental Health ^c		6.0%		2.1%	
² Large Rural ^c		9.5%		8.8%	
² Small Rural ^c		4.2%		4.2%	
* Private	5.3%	19.0%		18.2%	
² Aged Care		19.0%		3.1%	
¹ Other (Aged Care or Agency)	2.9%				
Total	100%	116% [#]		106% [#]	

Note: 2000 Survey only included the items marked with ¹ or *, 2010 Survey included the items marked with ² or *. 2008 and 2010 'Grouping' is assuming the term Hospital is equivalent to Public Hospital so combines elements marked with ^c.

[#] Percentage totals for the 2008 and 2010 columns equate to more than 100% as some Sector types have been included in more than one group, for example, Mental Health and Tertiary where the Mental Health unit is in a Tertiary setting.

There was a large difference in the proportion of respondents working in Aged Care in 2008 (19.0%) compared to 2010 (3.1%). This is possibly contributable to many of the cohort (64.6%) not commencing their transitional program until 2009 and, as indicated earlier, many working as ENs, AINs or PCAs prior to graduating as a RN.

4.4.2 Types of Units Worked in for Specialty Rotations

GRNs were asked to indicate the specialty units they worked in during their GNP. The UWA (2000) survey responses were free-text whereas the 2010 survey provided 12 choices in a closed response format. While the responses were in

different formats, they were still generally comparable. Again, the detail of the reported results in the UWA (2000) survey were limited with Surgical and Medical combined, and areas that would normally be considered to belong to either of these areas singled out, such as Orthopaedic, Neurology, Palliative, Nephrology, Cardiovascular, Plastics and Gynaecology. For ease of comparison, these have been incorporated into the Surgical/Medical group. Because the current transitional programs have expanded the type of specialty rotations on offer, additional unit types were incorporated into the 2010 survey, and included the separation of Medical and Surgical, as well as the addition of Community, Domiciliary and Midwifery. A further change was made to the way the data in this section was collected by allowing for separate responses to each rotation. This was done as most programs offer a variety of placements, and the experiences of the graduate can vary considerably between rotations. Separating the rotations has the ability to more clearly identify the various experiences in different specialties and to determine if issues are more likely to occur in one area as opposed to another. Table 4.3 demonstrates the results for the types of units worked in for transitional program rotations.

Table 4.3. Type of Unit Worked in for Transitional Rotations

Unit Type	2000 %	2010 <i>n</i> (%) 1 st Rotation	2010 <i>n</i> (%) 2 nd Rotation
Medical	68.0%	76 (35.3%)	52 (29.9%)
Surgical	I/A	77 (35.8%)	69 (39.7%)
Community	N/R	2 (0.9%)	3 (1.7%)
Mental Health	9.7%	12 (5.6%)	8 (4.6%)
Midwifery	N/R	0 (0.0%)	1 (0.6%)
Paediatric	4.8%	14 (6.5%)	9 (5.2%)
Domiciliary	N/R	2 (0.9%)	0 (0.0%)
Rural	3.4%	4 (1.9%)	1 (0.6%)
Emergency	6.3%	4 (1.9%)	7 (4.0%)
Perioperative	2.9%	13 (6.0%)	14 (8.0%)
Critical Care (ICU)	1.4%	7 (3.3%)	9 (5.2%)
Aged Care	1.9%	4 (1.9%)	1 (0.6%)
Other	1.4%		
Total	99.8%	215 (100%)	174 (100%)

Note: I/A= Included Above; N/R = Not Recorded.

Totals for 2010 *n* = columns equate to more than the number of participants as some respondents indicated more than one specialty per rotation, for example, Paediatric Intensive Care Unit (ICU) and has consequently been counted under both Paediatric and Critical Care (ICU).

The main specialties indicating change were in the acute areas of Critical Care and Perioperative rotations with a four and three-fold increase respectively. In 2010, the number of respondents participating in rotations in Mental Health decreased to almost half that recorded in the UWA (2000) survey period. This is concerning given that Mental Health is an area of increasing need but seemingly diminishing resources (Happell, 2008; Taylor & Harrison, 2010).

4.4.3 Graduate Program Competence, Confidence and Support

The general intent of transitional programs is to assist the novice nurse gain confidence and competence on their journey to proficiency. The wording in the 2010

survey was modified slightly with the inclusion of an *unsure* option to allow for variations of opinion, and to give the opportunity for a more neutral response should that be preferred (Table 4.4).

Table 4.4. Response Choices for 2000 & 2010 Questionnaires

2000 Response Choices	2010 Response Choices
Strongly Agree	Strongly Agree
Agree	Mostly Agree
	Unsure
Disagree	Mostly Disagree
Strongly Disagree	Strongly Disagree

4.4.3.1 Graduate Program Competence

Respondents were asked to indicate the degree to which they believed the program had made them feel more *competent* in their nursing role. The vast majority of both the UWA (2000) and 2010 respondents (90.0% and 89.1% respectively) *agreed*, or *strongly agreed*, that the program had made them feel more competent in their clinical practice. The respondents of the 2010 survey were more strongly in *agreement* that the program increased their *competence* than the UWA (2000) group (Table 4.5).

Table 4.5. Agreement Graduate Program Perceived to Improve Competence

Response Choices	2000 (n = 143)	2010 (n = 156)
Strongly Agree	38.4%	48.7%
(Mostly) Agree	51.6%	40.4%
Unsure (2010 only)		5.8%
(Mostly) Disagree	7.6%	3.8%
Strongly Disagree	2.4%	1.3%

Note: The 2000 survey only gave the 'Agree' or 'Disagree' options. The 2010 survey gave the 'Mostly Agree' and 'Mostly Disagree' options, as well as the 'Unsure' option.

The percentage of those who *disagreed* that their program made them feel more competent in the 2010 cohort was half that of the respondents of the UWA (2000) survey. This may suggest that improvements to the program have resulted in enhanced transitional experiences for the graduate nurse; or alternatively, the inclusion of the additional neutral element of *unsure* allowed the respondents to make a choice that more closely reflected their perception of improved competence.

4.4.3.2 Graduate Program Confidence

Respondents were asked to rate the degree to which they believed the program had made them feel more *confident* in their clinical practice. There was a slight difference between the cohorts that may again be attributable to the inclusion of the *unsure* choice in the 2010 survey. The Report of the UWA (2000) survey only gave a breakdown of the *strongly agree* and *agree* components, and did not give a breakdown of the two components related to *disagreement* (disagree or strongly disagree) and are therefore reported under the *Disagree* category (Table 4.6).

Table 4.6. Agreement Graduate Program Perceived to Improve Confidence

Response Choices	2000 (n = 141)	2010 (n = 156)
Strongly Agree	37.1%	45.5%
(Mostly) Agree	51.6%	39.1%
Unsure (2010 only)		5.1%
(Mostly) Disagree	11.3%	2.6%
Strongly Disagree		7.7%
Total	100%	100%

Note: The 2000 survey only gave the 'Agree' or 'Disagree' options. The 2010 survey gave the 'Mostly Agree' and 'Mostly Disagree' options, as well as an 'Unsure' option.

There is a small difference between the *agreement* groups, with more of the 2010 respondents claiming they *strongly agreed* the program had helped them feel more *confident* in their clinical practice, whereas over half the UWA (2000) cohort indicated moderate *agreement* that the program had helped them feel more *confident*.

4.4.3.3 Preceptor Support

Respondents were asked to indicate their level of *satisfaction* with the *support* provided by their preceptors during their transition. The concept of a preceptor is generally agreed to be a formalised support and supervisory person who takes responsibility for induction and guidance of the novice in their initial phases of transition (Hayman-White, et al., 2007; Johnstone, et al., 2008), and is discussed to a greater extent in the following chapter (5.3.3.2). Feedback from the survey questionnaire test group suggested the need to cater for mixed levels of experience and consequently, an additional response level was included. This decision was validated with one third of the respondents indicating a *mixed* degree of satisfaction with their level of preceptor support (Table 4.7). Similarly, the more moderate levels of agreement were changed to *Mostly Agreed* and *Mostly Disagreed* to minimise the

seemingly absolute connotation of purely *Agreed* or *Disagreed*. The combined level of *dissatisfaction* with preceptor support has decreased considerably from 23.9% in 2000 to 11.2% in 2010.

Table 4.7. Satisfaction with Preceptor Support

Response Choices	2000 (n = 155)	2010 (n = 195)
Very Satisfied	21.9%	22.0%
(Mostly) Satisfied	54.2%	33.3%
Mixed (2010 only)		33.3%
(Mostly) Dissatisfied	18.1%	9.2%
Very Dissatisfied	5.8%	2.0%
Total	100%	100%

Note: The 2000 survey only gave the 'Satisfied' or 'Dissatisfied' options. The 2010 survey gave the 'Mostly Satisfied' and 'Mostly Dissatisfied' options, as well as the 'Mixed' option.

4.4.4 Full Patient Load

Respondents were asked how long they were in their assigned unit before being given the responsibility for a full patient load. Additional time frames were incorporated into the 2010 questionnaire in response to feedback from the survey questionnaire test-group. Table 4.8 shows considerable increases in the amount of time graduates were allowed to assimilate into new areas between the two survey groups. Because the 2010 survey separated rotations it is easier to surmise that experience will help reduce the time needed for orientation to new units (Chang & Hancock, 2003).

Table 4.8. Supernumerary Time to Allocation of a Full Patient Load

Time Period to Full Patient Load	2000 (n = 167)	2010 1 st Rotation (n = 166)	2010 2 nd Rotation (n = 150)	2010 3 rd Rotation (n = 71)
* First day	15.6%	4.8%	7.3%	9.9%
* 1 day	29.3%	6.0%	20.0%	22.5%
* 2-3 days	40.1%	40.4%	41.3%	36.6%
* 4-7 days	7.8%	32.5%	20.0%	8.5%
² 7-14 days		12.0%	4.0%	14.1%
¹ > 1 week	3.0%			
² Up to 1 month		3.6%	4.7%	4.2%
² > 1 month		0.6%	2.7%	4.2%
¹ Varied	4.2%			
Total	100%	99.9%	100%	100%

Note: 2000 Survey only included items marked with ¹ or *; 2010 Survey included items marked with ² or *.

4.4.5 Performance Evaluation

Performance evaluation is used to provide structure and direction for the transitioning nurse and to encourage self-reflective and critical thinking. While most transitional programs advocate regular performance evaluation, it is evident from the data that this did not always occur. The majority of respondents were assessed within the first six months. However, a total of 6% of respondents were evaluated only at the end of their employment and 7% were not evaluated at all. It needs to be noted, however, that the first column of the 2010 data is inclusive of *all* respondents, not just those who indicated participation in a GNP, which is shown in the final column (Table 4.9).

Table 4.9. Performance Evaluation Completed

Time Period	2000 (n = 170)	2010 All (n = 199)	2010 GRN Only (n = 167)
End of each placement	52.0%	26.6%	32.9%
Monthly	6.6%	4.5%	5.4%
Every 2-3 months	25.7%	41.2%	43.7%
Every 4-6 months	8.4%	14.1%	13.2%
Every 7-12 months	1.2%	6.5%	2.4%
At completion of employment	1.8%	2.0%	1.2%
Never	4.2%	5.0%	1.2%
Total	99.9%	99.9%	100.0%

Note: '2010 All' column shows response rates for *all* 2010 survey respondents and '2010 GRN Only' column shows percentages for 2010 survey respondents who indicated participation in a GNP.

A secondary question asked who was most involved in the performance evaluation (Table 4.10). The UWA (2000) survey did not include 'Manager' in the selection of available options; however, inclusion of this element in the 2010 survey indicates that almost a quarter of respondents had a manager involved in their performance evaluation. Both surveys enabled demonstration of the collaborative contribution to evaluation; with almost half the respondents indicating more than one person was involved in their assessment; most commonly, their preceptor and Staff Development Nurse (SDN).

Table 4.10. Performance Evaluation Involvement

Person Involved	2000 (n = 170)	2010 (n = 189)
* Preceptor	74.8%	37.6%
* Staff Development Nurse	45.9%	68.2%
* Clinical Nurse	10.7%	18.5%
² Manager		23.3%
* CNS	5.7%	10.0%
¹ Other	4.4%	
Total	141%	158%

Note: The 2000 survey only included the items marked with ¹ or *; the 2010 survey included the items marked with ² or *. Totals equal greater than 100% as most often more than one person was involved in performance evaluation.

The proportion of personnel involved in the graduate nurse assessment is greater than 100% as figures are inclusive of the multiple contributions to assessment (Table 4.10). The UWA (2000) survey indicated almost three quarters of the assessments were done by the preceptor, whereas in the 2010 study there were a larger number of respondents who nominated the SDN as the primary person responsible for their evaluation.

4.4.6 Night Shift Participation and Preparation

In both studies, the cohorts were asked how long it was from the commencement of their program before being rostered onto night shifts. To elicit a more detailed data set, the choice of time periods available was once more expanded in the 2010 survey (Table 4.11). Again, the 2010 data includes all respondents.

Table 4.11. Time Prior to Night Duty Rostering

Time Period	2000 (n=164)	2010 (n=202)
² < 3 months		20.8%
² 3-6 months		45.5%
¹ < 6 months	29.3%	
² 6-9 months		9.4%
¹ > 6 months	28.7%	
² 9-12 months		3.5%
* Did not do night duty	42.0%	20.8%
Total	100%	100%

Note: 2000 Survey only include the items marked with ¹ or *, 2010 Survey include the items marked with ² or *.

In the UWA (2000) study, there was little difference between those who commenced night duty in less than six-months, and those who were given more than six-months before being rostered to these shifts. The 2010 survey shows two-thirds of respondents were rostered onto night shift in less than six-months from commencing their transition year. In the UWA (2000) study, 42% of respondents did not do night duty in their graduate year, compared to 20.8% in the 2010 group.

Respondents were asked how well they felt they were prepared for night duty. To enable more intermediate choices than the *Yes* or *No* of the UWA (2000) survey, the 2010 survey responses were expanded to include the options of *well prepared* and *somewhat prepared*, and *poorly prepared* or *no preparation* (Table 4.12). Over three quarters of respondents in the 2010 survey felt they were sufficiently prepared for the responsibility of night duty, which is comparative to the UWA (2000) group, where only slightly fewer indicated that they felt well prepared.

Table 4.12. Preparedness for Night Duty

Time Period	2000 (n = 170)	2010 (n = 165)
² Well prepared		26.6%
² Somewhat prepared		50.9%
¹ Yes (well prepared)	73.5%	
² Poorly prepared		12.7%
² No preparation		9.7%
¹ No (not well prepared)	23.0%	
Total	96.5%	99.9%

Note: 2000 Survey only included the items marked with ¹, 2010 Survey included the items marked with ². It is unknown why the 2000 total is not equivalent to 100%.

Almost 40% of respondents in the UWA (2000) survey cited a lack of experience as the most problematic area with night duty. Only 20% of those who did night duty in the 2010 survey took the opportunity to comment on their preparation, and of these, only two respondents felt that they had insufficient experience for the role. The mix of positive and negative comments in the 2010 study regarding night duty was similar.

4.4.7 Undergraduate Influences

The issue of the theory-practice gap, referring to the perception of novice nurses' lack of preparation for their RN role responsibility, has been widely discussed in the literature (Evans, et al., 2008; Fox, et al., 2005; Kelly & Ahern, 2009).

4.4.7.1 Undergraduate Preparation for Registered Nurse Role

Respondents were asked to indicate if they felt their university education had prepared them adequately for their role as a RN. The 2010 cohort was in much

stronger accord that their university preparation was adequate, with almost three quarters (73%) indicating they felt they had received sufficient grounding for their role as a RN (Table 4.13). These findings contrast markedly with those of the UWA (2000) survey.

Table 4.13. Agreement that Undergraduate Education Prepared for RN Role

Response Choices	2000	2010
² Strongly Agree		12.8%
² Mostly Agree		60.6%
¹ Yes	42.5%	
² Unsure		13.3%
¹ No	57.5%	
² Mostly Disagree		10.8%
² Strongly Disagree		2.5%
Total	100%	100%

Note: 2000 Survey only included the items marked with ¹, 2010 Survey included the items marked with ².

Despite these positive findings, there were still a number of respondents in the 2010 study who believed there were ways their undergraduate education could be improved. Responses were categorised into themes to demonstrate the main commonalities (Table 4.14). More than half the respondents (54.1%) felt more practical experience would have helped to better prepare them for their RN role and almost one quarter (22.3%) believed more clinical education would have been of benefit.

Table 4.14. Undergraduate Education Improvements

Theme	Total Responses (n = 148)	Total Responses (%)	Uni A (n = 52) %	Uni B (n = 73) %	Uni C (n = 16) %	Uni D (n = 7) %
More Practical	80	54.1%	44.2%	65.8%	37.5%	42.9%
More Clinical	33	22.3%	23.1%	21.9%	25.0%	14.3%
Time Management	8	5.4%	5.8%	6.8%	0	0
Pharmacology	7	4.7%	1.9%	2.7%	18.8%	14.3%
Less Theory	5	3.4%	1.9%	4.1%	6.3%	0
More Reality	3	2.0%	1.9%	0	12.5%	0
Documentation	3	2.0%	1.9%	0	6.3%	14.3%
Total	139	93.9%	80.7%	101.3%	106.4%	85.8%

Note: Uni A = University A; Uni B = University B; Uni C = University C; Uni D = University D. Totals in the bottom row do not equal the n = Total Responses; or 100%, as only the more common themes have been depicted here. Total percentages greater than 100% occur where a respondent has indicated more than one theme, and has therefore been counted in each of those themes.

4.4.7.2 Higher Education Contribution Debt

Although the term *Higher Education Contribution Scheme* (HECS) was replaced in 2005 with *Higher Education Loan Program* (HELP), the former term was retained in the 2010 survey for uniformity, and to inform those still familiar with the previous term. The respondents were asked if they were still paying an education debt and, if this had any influence on their choice of participating in additional, current or future study. Interestingly, the proportions of respondents still paying, or no longer paying off a higher education debt, were reversed in the two studies (Table 4.15). Just over three-quarters of responders in the 2000 study had a HECS debt, whereas only slightly more than one quarter of the 2010 cohort was still paying off their liability at the time of the survey.

Table 4.15. Higher Education Debt

Response Choices	2000 (n = 167)	2010 (n = 203)
Still paying	78.4%	26.1%
Not paying	21.6%	73.9%
Total	100%	100%

Table 4.16 shows that of those nurses who responded, exactly the same proportion in both studies were influenced negatively toward further study or, conversely, felt it had no bearing on their future intent to pursue additional studies.

Table 4.16. HECS Debt Influence on Further Study

Response Choices	2000 (n = 167)	2010 (n = 118)
Negative influence	61.0%	61.0%
No influence	39.0%	39.0%
Total	100%	100%

4.5 Additional Data Questions

Eliciting information regarding the university attended for their undergraduate nursing program was employed to determine if there were apparent differences that may be associated with the affiliated university, and the respondents' transitional experiences and future intentions. While each university's curriculum and content must be accredited by the NMBA, there are often some differences in terms of program structure, and the length and types of clinical practice.

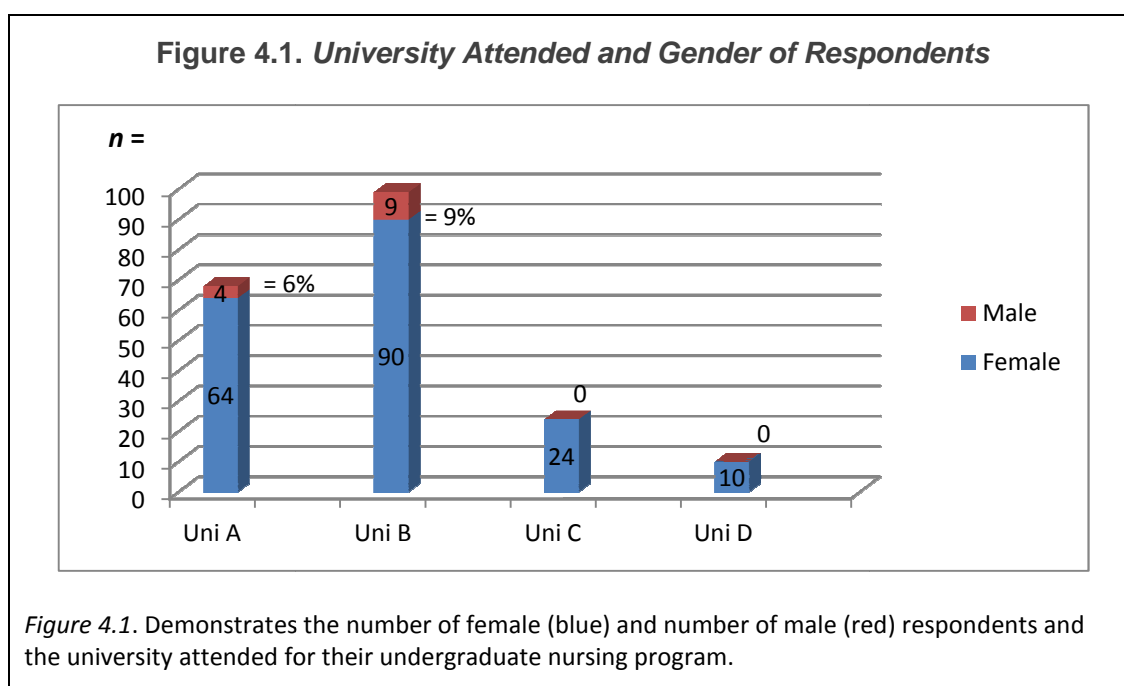
4.5.1 Undergraduate Nursing Program

Respondents were asked to indicate at which university they had completed their undergraduate nursing programs. The numbers are disproportionate as

universities that have been providing a nursing program for a longer period, and consequently are more established, are able to fund and offer a greater number of student places. The names of the universities that were provided for the respondents' selection have been de-identified for reporting purposes.

4.5.1.1 Undergraduate Nursing Program by Gender

Figure 4.1 shows the university where the respondents reported having completed their undergraduate nursing program, the overall proportions of all respondents for each university, and the mix of gender for each. University B recorded the greatest number of respondents and the largest number of males. University D recorded the least number of respondents and there were no male respondents from University D, or University C.



4.5.1.2 Undergraduate Nursing Program by Age Groups

Further breakdown of individual university demographics is given in Table 4.17 and shows the proportions within each age-group category in relation to the

university attended for their undergraduate nursing program. Data show University C to have the lowest age profile and University B the highest. With only 10 respondents from University D it would be unrealistic to claim any meaningful age-group profiles for this institute.

Table 4.17. Respondent Age-Groups for Individual Undergraduate University

Age Group	Uni A (n = 68)	Uni B (n = 99)	Uni C (n = 24)	Uni D (n = 10)
<21	0.0%	5.0%	20.8%	0.0%
22-29	53.9%	46.5%	41.7%	30.0%
30-39	22.1%	20.2%	33.3%	20.0%
40-49	16.2%	19.2%	0.0%	20.0%
>50	8.8%	11.0%	4.2%	30.0%
Total	101%	102%	100%	100%

Note: Uni A = University A; Uni B = University B; Uni C = University C; Uni D = University D.

Shows percentages of respondent age-groups from each undergraduate university.

4.5.1.3 Undergraduate Nursing Program by Participation in Formal Transition Program

Specific university data is further analysed (Figure 4.2), to show the number of respondents who participated in a formal transition program and in relation to the university they attended as an undergraduate. Again, due to the small numbers in the University D and University C cohorts, it is difficult to draw any meaningful comparisons. Between the two larger universities, there were more graduates who responded to the survey that were from University B (84.8%) and who participated in a formal transition program than did those from University A (76.5%).

Figure 4.2. Proportions of Graduating Nurses Participating in Transition Program

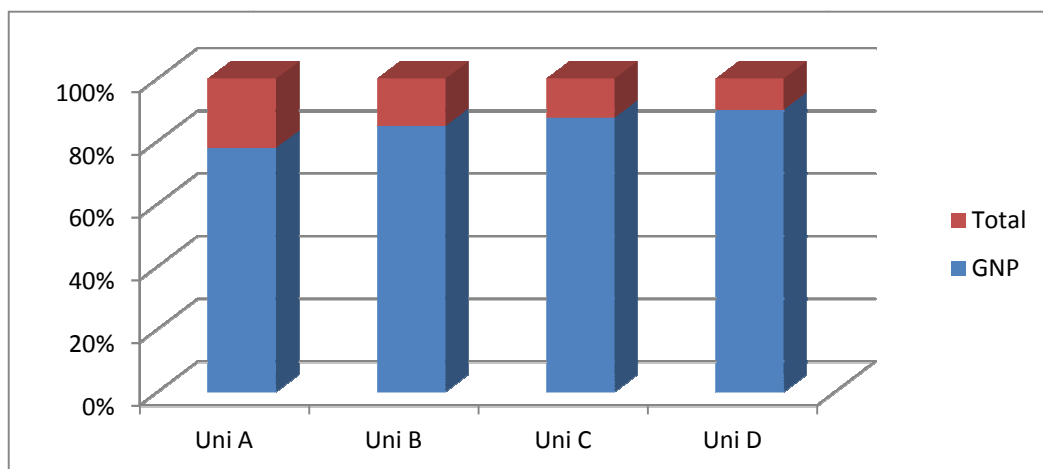


Figure 4.2. Demonstrates the proportion of participants (blue) who enrolled in a formal graduate RN transition program from each university attended for undergraduate nursing program.

Of the 17.6% (n = 36) RNs who chose not to do a formal program 65% had prior experience as an EN, and a further 24% as an AIN or equivalent. Reasons for not participating in a program were varied, but most commonly the respondents were returning to areas they had worked in prior to completing the undergraduate program (Table 4.18).

Table 4.18. Reasons for Not Participating in Formal Transition Program

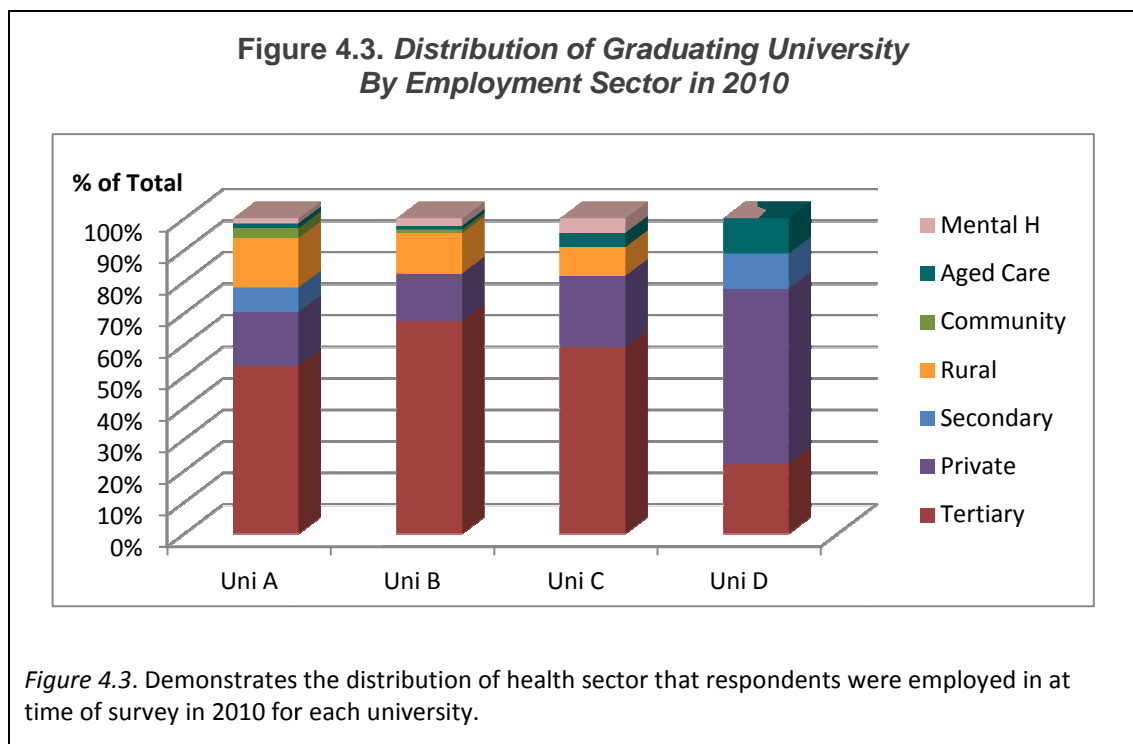
University Attended	% of Total	Return to pre GN Ward	Midwifery Grad Program	Needed Part-time	Maternity Leave	Didn't Appeal / Other	Resigned
Uni A	23%	7	1		1	5	1
Uni B	18%	4	3	3	1	5	1
Uni C	12%	1		1	1		
Uni D	10%	1					
Total	18%	13	4	4	3	2	2

Note: Uni A = University A; Uni B = University B; Uni C = University C; Uni D = University D.

'Percent of Total' is the proportion from each University that did not participate in a GNP.

4.5.1.4 Current Employment Sector by Graduating University

Data was collected related to current employment type at the time of the survey and evaluated in relation to the university the respondent had attended. This is shown in two figures to demonstrate the distribution of the graduates' current health sector, and the university at which the respondents completed their undergraduate program (Figures 4.3 and 4.4).



As can be seen from Figure 4.4, the majority of graduates were employed at a tertiary hospital, understandably, given that tertiary hospitals are the largest employers of professionals within the health system. Traditionally, tertiary hospitals have also been the ones offering the largest number of transitional program places with a wider variety of rotational experiences.

Figure 4.4. Employment Sector Distributions by Graduating University

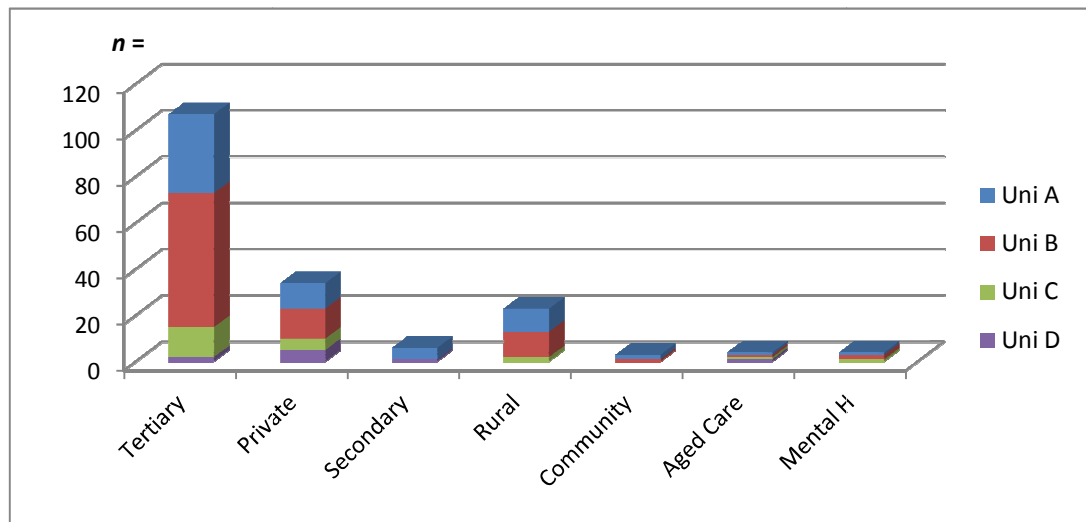


Figure 4.4. The proportion of RNs by graduating university in type of employment sector at time of survey in 2010.

4.6 Graduate Nurse Programs

Current Graduate Nurse Programs (GNPs) appear to be well planned and organised in terms of access to of specific specialties, support personnel and lengths of individual rotations. As discussed, the 2010 survey questionnaire included questions that related to each individual specialty rotation to separate out diverse experiences, and follow changing perceptions of proficiency and support. These are presented in the following sections.

4.6.1 Graduate Nurse Program Commencement and Completion

To cater for the varying time-frames that nursing students graduate from their program of study and complete registration processes with the professional registering body, most healthcare organisations have more than one commencement date for transitional programs. As such, transition program commencement dates for intakes may be staggered over two or three months at the beginning of a year, with

additional one or two intakes in the second half of the year. The query run by the NMBWA selected *all* nurses completing an undergraduate program who registered with them in 2008. This meant that some respondents would have registered early in that year and others, who most likely finished their undergraduate studies later that year, did not commence work as a RN until 2009 (Table 4.19).

Table 4.19. *Month and Year of Graduate Nurse Program Commencement*

Month and Year GNP Start	Number	Percent of total
January / February 2008	22	13.1%
March 2008	4	2.4%
June / July 2008	17	10.1%
August / September 2008	16	9.5%
January / February 2009	94	55.9%
March 2009	12	7.1%
July / August 2009	2	1.2%
Blank but rotations indicate participant	1	0.6%
Total	168	100%

At the time of the survey, and of those participating in a transitional program, 78% (n = 130) had completed the program, 15.5% (n = 26) still had the intention of completing, and 6.5% (n = 11) had not completed their program (Table 4.20). Four percent (n = 7) of the data was incomplete and not able to be analysed.

Table 4.20. Month and Year of Graduate Nurse Program Completion

Month and Year GNP Completed	Number	Percent of total
January / February / March 2009	14	8.9%
June / July / August 2009	26	16.6%
January / February / March 2010	87	55.4%
May / June / July / August 2010	11	7.0%
January / February / March 2011	12	7.6%
Incomplete Data	7	4.5%
Total	157	100%

The reasons for not completing the program included issues such as bullying, stress, and/or other reasons (Table 4.21), and are discussed further in the following chapter.

Table 4.21. Reasons Graduate Nurse Program Not Completed

Reason	Number
Resigned from program (reason not given)	2
Commenced Midwifery Post Grad Diploma	1
Unable to do / unsatisfactory shiftwork	2
Graduate Nurse Program too inflexible	1
Bullying	1
Stress (not stated from what)	1
Lack of Support	1
Completed 2 years of 3 year program	1
Started Grad Dip Perioperative Nursing	1
Total	11

4.6.2 Graduate Nurse Program Length

The available response choices for the GRNs to indicate when they commenced and completed their program were provided in month and year format (for example, January 2008). Of the 86 records with complete data enabling

estimation of GNP length, 52 were for 12-months and 20 for 13-months.

Consequently, a nurse may have commenced their GNP at the end of a month, and finished a week or so beyond the 12-months at the beginning of the thirteenth month. As data from the graduate nurse coordinators' survey was not indicative of 13-month programs, the 13-month data have been incorporated into the 12-month data. A total of 72 (83.7%) respondents participated in a 12-month program; 54.2% from the tertiary sector, 19.4% rural, 9.7% in private and 9.7% at secondary hospitals. Eleven respondents (12.8%) indicated a 24-month program with nine of these at tertiary hospitals and the remaining two in the private sector. Three respondents participated in an 18-month program, two in tertiary hospitals and one in a large rural establishment.

4.6.3 Rotation Characteristics

GNPs vary in structure, number of rotations, degrees of support and types of specialty rotations on offer, therefore the experiences of the GRN are expected to be similarly distinct.

4.6.3.1 Specialty Unit Type

The following section demonstrates characteristics, such as the type of unit or specialty, to which the respondent was allocated for their rotations. Specific options were provided to the respondents to indicate the type of unit they worked in for each rotation (Table 4.22).

Table 4.22. Specialty Unit Options

Medical	Surgical	Community	Mental Health
Midwifery	Paediatric	Domiciliary	Rural
Emergency	Perioperative	Critical Care	Aged Care
Other (please specify)			

Of the 168 respondents indicating participation in a transition program, the majority were allocated to either a medical or surgical specialty for their first rotation. In Table 4.23 most specialties are shown with two dimensions, the first where the graduate indicated only one area was worked, and the second, *plus others*, shows where more than one specialty was indicated, for example, 21 respondents worked in combined medical and surgical areas; and of those indicating Mental Health as the area of work (n = 8) an additional four also worked in other areas. Combined specialties were most common in rural centres, secondary hospitals and some private hospitals where individual units may not be large enough to provide sufficient experience within a single specialty.

Table 4.23. First Rotation – Unit Type, Number and Percent of Respondents

Main Unit Type	N =	(%)	Main Unit Type	N =	(%)
Medical only	50	(29.8%)	Surgical only	47	(28.0%)
Medical plus others	76	(45.2%)	Surgical plus others	77	(45.8%)
Medical and Surgical	21	(12.5%)	Aged Care	1	(0.6%)
Critical Care	3	(1.8%)	Aged Care plus others	4	(2.4%)
Critical Care plus others	7	(4.2%)	Mental Health	8	(4.8%)
Domiciliary	1	(0.6%)	Mental Health plus others	12	(7.1%)
Domiciliary plus others	2	(1.2%)	Paediatrics	4	(2.4%)
Rural	1	(0.6%)	Paediatrics plus others	14	(8.3%)
Rural plus others	4	(2.4%)	Emergency	2	(1.2%)
Perioperative	8	(4.8%)	Emergency plus others	4	(2.4%)
Perioperative plus others	12	(7.1%)			

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined, and paediatrics may be surgical, medical, critical care or perioperative.

Of the 168 respondents participating in a transitional program, 153 (91%) indicated participation in a second specialty rotation (Table 4.24), and 123 (73%) a third rotation (Table 4.25). Again, the specialties the graduates worked in are demonstrated with two dimensions, the first where the graduate indicated only one area was worked, and the second, *plus others*, shows where more than one specialty was indicated.

Table 4.24. Second Rotation – Unit Type, Number and Percent of Respondents

Main Unit Type	N = (%)	Main Unit Type	N = (%)
Medical only	38 (24.8%)	Surgical only	53 (34.6%)
Medical plus others	52 (34.0%)	Surgical plus others	69 (45.1%)
Medical and Surgical	12 (7.8%)	Aged Care	0
Critical Care	5 (3.3%)	Aged Care plus others	1 (0.7%)
Critical Care plus others	9 (5.9%)	Mental Health	7 (4.6%)
Domiciliary	0	Mental Health plus others	8 (5.2%)
Domiciliary plus others	0	Paediatrics	4 (2.6%)
Rural	1 (0.7%)	Paediatrics plus others	8 (5.2%)
Rural plus others	0	Emergency	5 (3.3%)
Perioperative	12 (7.8%)	Emergency plus others	7 (4.6%)
Perioperative plus others	14 (9.2%)		

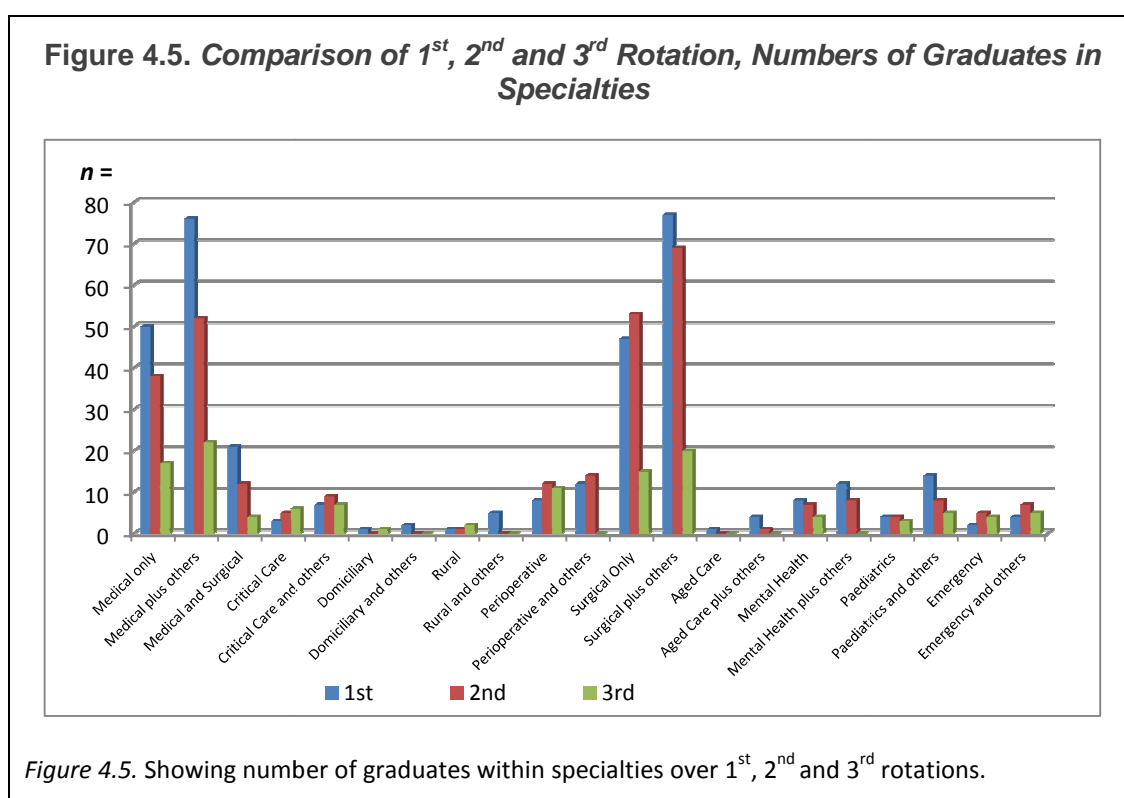
Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined, and paediatrics may be surgical, medical, critical care or perioperative.

Table 4.25. Third Rotation – Unit Type, Number and Percent of Respondents

Main Unit Type	N = (%)	Main Unit Type	N = (%)
Medical only	17 (23.3%)	Surgical only	15 (20.5%)
Medical plus others	22 (30.1%)	Surgical plus others	20 (27.4%)
Medical and Surgical	4 (5.5%)	Aged Care	0 (0.0%)
Critical Care	6 (8.2%)	Aged Care plus others	0 (0.0%)
Critical Care plus others	7 (9.6%)	Mental Health	4 (5.5%)
Domiciliary	1 (1.4%)	Mental Health plus others	0 (0.0%)
Domiciliary plus others	0 (0.0%)	Paediatrics	3 (4.1%)
Rural	2 (2.7%)	Paediatrics plus others	5 (6.8%)
Rural plus others	0 (0.0%)	Emergency	4 (5.5%)
Perioperative	11 (15.1%)	Emergency plus others	5 (6.8%)
Perioperative plus others	0 (0.0%)	Midwifery	1 (1.4%)

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined, and paediatrics may be surgical, medical, critical care or perioperative.

Rotations to the more general specialties in the third rotation were not as frequent as in the earlier rotations, and, when compared to previous rotations, those allocated to the more acute specialties, such as Critical Care, Emergency and Perioperative showed an increase in proportions (Figure 4.5).



Fewer graduates (14.3%) completed a fourth rotation and even fewer (4.8%) a fifth. As such, only a brief statistical summary of the main characteristics is presented in Table 4.26.

Table 4.26. Additional Rotations – Unit Type, Number and Percent of Respondents

4 th Rotation		5 th Rotation	
Main Unit Type	N = (%)	Main Unit Type	N = (%)
Medical	6 (25.0%)	Medical	
Surgical	7 (29.2%)	Surgical	1 (12.5%)
Medical and Surgical		Medical and Surgical	1 (12.5%)
Critical Care	3 (12.5%)	Critical Care	
Perioperative	3 (12.5%)	Perioperative	3 (37.5%)
Mental Health	2 (8.3%)	Mental Health	
Emergency	1 (4.2%)	Emergency	3 (37.5%)
Rural	1 (4.2%)	Rural	
Midwifery	1 (4.2%)	Midwifery	
Total	24 (100%)	Total	8 (100%)

4.6.3.2 Specialty Rotation Length of Stay

The majority of rotations were approximately six-months in duration, with a one year program generally consisting of two specialty rotations, and most usually providing a mix of either a medical or surgical experience. Some organisations offer 18 to 24 month programs, with latter rotations to the critical care specialties, such as Intensive or Coronary Care. From the data provided, it was evident that some who participated in a perioperative rotation considered each specialty within that area to be a rotation. A perioperative rotation is generally considered a single rotation. This data was still included in the findings as it contributed some pertinent points in regards to the written feedback. The choices for *length of stay* in a specialty rotation provided to the respondents are shown in Table 4.27.

Table 4.27. Choices Available to Respondents to Indicate Rotation Length

Less than 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks
40-52 weeks	More than 52 weeks	Other (please specify)	

The total figures given for each component for the GRNs' first specialty rotation in Table 4.28 add up to more than the total number of respondents who participated in a transitional program due to the many combined specialty rotations, as described previously.

Table 4.28. First Rotation – Weeks Spent in Specialty by Type

Unit Type	< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	40-52 weeks	> 52 weeks
Medical	1 (rural)	12	34	28	1	
Surgical	1 (rural)	14	30	28	2	2
Aged Care	1	1		2		
Mental Health		2	6	4		
Critical Care			4	3		
Domiciliary	1 (rural)					1
Emergency		1	1		2	
Paediatrics		1	6	6	1	
Perioperative		1	4		4	2
Rural		2	1		1	

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined; paediatrics may be surgical, medical, critical care.

Table 4.29 shows the number of participants within each category of weeks spent in their first rotation, and the proportion that number represents of the total responding to that element.

Table 4.29. First Rotation – Proportions of Total Weeks Spent

Weeks	< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	40-52 weeks	> 52 weeks	Blank	Total
Number of Total	4	23	73	58	6	3	1	168
Percentage of Total	2.4%	13.7%	43.5%	34.5%	3.6%	1.8%	0.6%	100%

The greatest number of respondents indicated their first rotation was of 13 to 25 weeks duration (43.5%); followed by those who indicated their initial rotation was of 26 to 39 weeks duration (34.5%).

Data for the number of weeks spent in their second specialty rotation are shown in Table 4.30.

Table 4.30. Second Rotation – Weeks Spent in Specialty by Type

Unit Type	< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	40-52 weeks	> 52 weeks
Medical		7	17	26	1	1
Surgical	2	13	27	27		1
Aged Care	0	0	0	0	0	
Mental Health	1	3	1	2		
Critical Care				7	1	
Community	1	1		1		
Emergency			2	4		
Paediatrics		2	1	5		
Perioperative	1	1	10			
Rural				1		
Endoscopy			2			

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined; paediatrics may be surgical, medical, critical care.

Table 4.31 again, includes the number of participants within each category of weeks spent, and the proportion that number represents of the total responding to the element.

Table 4.31. Second Rotation – Proportions of Total Weeks Spent

Weeks	< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	40-52 weeks	> 52 weeks	Total
Number of Total	5	27	56	62	2	1	153
Percentage of Total	3.3%	17.6%	36.6%	40.5%	1.3%	0.7%	100%

The majority of respondents, (40.5%) indicated their second rotation was of 26 to 39 weeks in length; closely followed by those denoting 13 to 25 weeks for their second specialty rotation (36.6%).

For their third rotation, GRNs predominately spent between 13 and 25 weeks in the specialty, and no respondents indicated a stay greater than 40 weeks (Table 4.32); and similarly for those GRNs participating in further rotations (Table 4.33).

Table 4.32. Third Rotation – Proportions of Total Weeks Spent

Weeks	< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	40-52 weeks	> 52 weeks	Total
Number of Total	5	20	37	11	0	0	73
Percentage of Total	6.8%	27.4%	50.7%	15.1%	0	0	100%

Table 4.33. Additional Rotations – Proportions of Total Weeks Spent

Rotation		< 8 weeks	8-12 weeks	13-25 weeks	26-39 weeks	Other	Total
Fourth	Number of Total	5	8	6	3	2	24
	Percentage of Total	20.8%	33.3%	25.0%	12.5%	8.3%	100%
Fifth	Number of Total	2	3	2	1		8
	Percentage of Total	25.0%	37.5%	25.0%	12.5%		100%

4.6.3.3 Contracted Hours of Work

Hours the GRNs were contracted to work in their first rotation were predominately what is considered full time, that is, 38 to 40 hours per week. There were a small number of graduates contracted to work fewer hours. Responses from the graduate nurse coordinators' survey indicated that most full-time contracted hours for the GRNs were 40-hours per week, with two metropolitan hospitals indicating the contracted hours were 37-hours per week. Full-time hours given by one private organisation's graduate nurse coordinator were 35-hours per week. As the options given in the survey questionnaire for the first two ranges of contracted hours were 38-40 or 30-37 (Table 4.34), the GRN responders working the 35 and 37-hour week would have been forced to choose a value that suggested fewer hours were worked.

Table 4.34. Choices Available to Indicate Average Contracted Hours per Week

38-40	30-37	20-29	Other (please specify)
-------	-------	-------	------------------------

No respondent chose the *other* category, which suggests that half of full time equivalent (38 to 40 hours per week) is the minimum a GRN is required to work in order to participate in a transitional program. The total number of hours worked by the respondents in their first rotation in relation to specialties (Table 4.35) equates to

greater than the number of nurses participating in a transitional program as many (22%) indicated a combination of specialties such as surgical and paediatrics.

Table 4.35. First Rotation – Specialty by Average Contracted Hours

Unit Type	38-40 hours	30-37 hours	20-29 hours
Medical	49	22	5
Surgical	53	18	6
Aged Care		2	2
Mental Health	9	2	1
Critical Care	6	1	
Domiciliary		2	
Emergency	2	2	
Paediatrics	11	3	
Perioperative	9	2	1
Rural	1	3	

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined; paediatrics may be surgical, medical, or critical care.

Table 4.36 shows the number of participants who indicated each category of contracted hours worked during their first rotation, and the proportion that number represents of the total responding to that element.

Table 4.36. First Rotation – Average Contracted Hours

Ave Contracted Hours	38-40 hours	30-37 hours	20-29 hours	Blank	Total
Number of Total	114	40	13	1	168
Percent of Total	67.9%	23.8%	7.7%	0.6%	100%

More than two-thirds of respondents indicated full-time hours, and slightly fewer than a quarter indicated 30 to 37 hours were their average contracted hours.

Of those working 20 to 29 hours per week, six were from tertiary, three private, two secondary and one from the rural health sector. More than half (n = 25) of those working 30 to 37 hours per week were from secondary, rural or private health organisations, however, this may be attributable to the aforementioned data collection anomaly where respondents were forced to choose a value that was not reflective of their organisation's full-time hours. Two-thirds of those working full-time were from tertiary hospitals but this is most likely reflective of the greater number of respondents who were employed within this sector.

Hours the GRNs were contracted to work in their second rotation were similar to those indicated in the first, with a small decrease in the percentage who worked full-time hours and a slight increase in the 20 to 29-hour bracket (Table 4.37).

Table 4.37. Second Rotation – Specialty by Average Contracted Hours

Unit Type	38-40 hours	30-37 hours	20-29 hours
Medical	34	15	3
Surgical	47	18	5
Aged Care			1
Mental Health	4	1	3
Critical Care	7	2	
Community	2		1
Emergency	2	4	1
Paediatrics	7	2	
Perioperative	9	2	1
Rural		1	
Endoscopy			1

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined; paediatrics may be surgical, medical, critical care.

The total number indicated in Table 4.37 equates to more than the number of nurses participating in a transitional program, as many (13%) had indicated a combination of specialties, such as surgical plus paediatrics. The data for the average hours contracted to work during their second rotation are shown proportionately in Table 4.38.

Table 4.38. Second Rotation – Average Contracted Hours

Ave Contracted Hours	38-40 hours	30-37 hours	20-29 hours	Total
Number of Total	99	39	15	153
Percent of Total	64.7%	25.5%	9.8%	100%

Of those working 20 to 29 hours per week, eight were from tertiary, four in private, two in secondary and one in the rural sector. The increase in the number of those working less hours per week in the second rotation suggests that following their initial phase of transition, some graduands may choose to decrease their average weekly hours worked.

Hours GRNs were contracted to work in their third rotation were similar to those indicated in the first and second rotations, but with a further percentage decrease in those working full-time hours and a moderate increase in the 20 to 29-hour bracket (Table 4.39 and Figure 4.6).

Table 4.39. Third Rotation – Specialty by Average Contracted Hours

Unit Type	38-40 hours	30-37 hours	20-29 hours
Medical	12	5	5
Surgical	12	2	6
Aged Care			
Mental Health	3	1	
Critical Care	3	2	1
Community	1		
Emergency	3	2	
Paediatrics	3	2	
Perioperative	8	3	
Rural	2		
Angiography: Dialysis	1 ea		

Note: Totals are not given in this table as many specialties are included in others and would therefore be meaningless, for example, medical and surgical units are sometimes combined; paediatrics may be surgical, medical, critical care.

Figure 4.6. Comparison 1st, 2nd and 3rd Rotation, Average Hours Graduates Contracted to Work

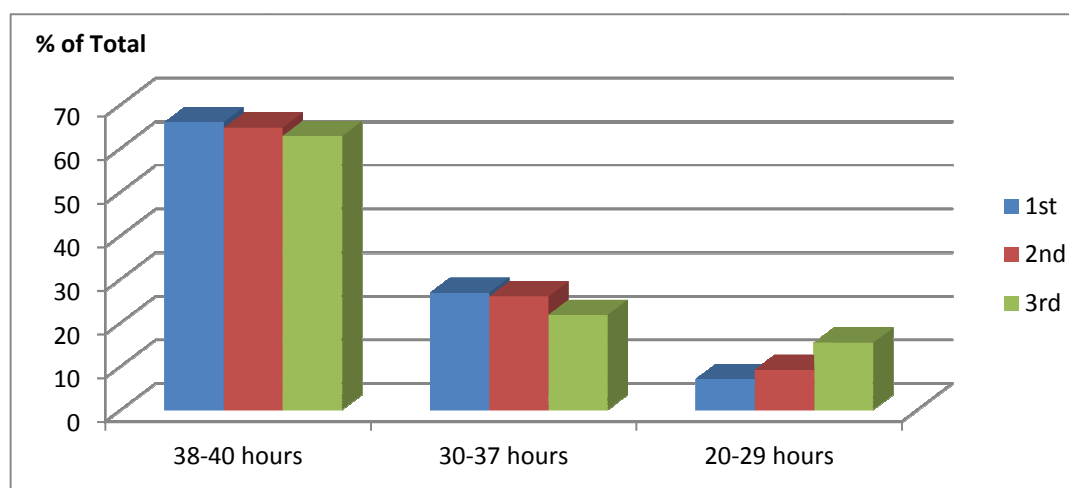


Figure 4.6. Showing the proportions of graduates within categories of average hours contracted to work over 1st, 2nd and 3rd rotations.

Hours worked by those indicating participation in additional rotations are shown in Table 4.40.

Table 4.40. Additional Rotations – Average Contracted Hours

Rotation		38-40 hours	30-37 hours	20-29 hours	Total
Fourth	Number of Total	13	4	6	23
	Percentage of Total	56.5%	17.4%	26.1%	100%
Fifth	Number of Total	2	1	5	8
	Percentage of Total	25.0%	12.5%	62.5%	100%

Note: One participant responding to this section was still to commence the fourth rotation so data is not included.

4.6.3.4 Support Provision in Specialty Rotations

Respondents were asked to indicate the level of support they perceived was provided by various personnel throughout their rotations. Levels of support available for selection were *extensive*, *very good*, *average*, *occasional*, *negligible*, and *not applicable*. The options available for support personnel are listed in Table 4.41, with a brief description as to the general role definition.

Table 4.41. Support Personnel Definitions

Personnel	Description
Program Coordinator	Most organisations allocate a specific senior role to coordinate transitional programs
Staff Development Nurse	Usually a specific, promotional role to oversee personal development of unit nurses and provide educational support. Sometimes referred to as Professional Development Nurse
Clinical Nurse Manager/ Specialist/Coordinator	A senior level role in charge of a unit and/or of the relevant clinical practices and policies
Preceptor	Generally a specific task allocated to an experienced nurse to guide and assist the novice who is new to an area
Ward/Unit nursing staff	The graduate nurses' colleagues, peers and supervising staff in a ward or specialty area
Other	Of the 11 indicating 'other' 6 specified support came from other graduates and 4 from a graduate support nurse

Tables 4.42 to 4.47 show the degree of support the GRNs perceived they received from the various personnel in their first rotation. The organisation affiliation is given in the parentheses next to the totals.

Table 4.42. First Rotation – Extensive Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 8)	(T = 26)	(T = 9)	(T = 14)	(T = 20)	(T = 3)
(S = 2)	(S = 6)	(P = 3)	(P = 2)	(S = 4)	(R = 1)
(P = 1)	(P = 6)	(R = 1)	(R = 3)	(P = 4)	
(R = 2)	(R = 4)		(MH = 1)	(R = 6)	
	(MH = 1)				
13	43	16	20	34	4

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/unit staff = ward or unit nursing staff.

Table 4.43. First Rotation – Very Good Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 36)	(T = 46)	(T = 37)	(T = 38)	(T = 52)	(T = 5)
(S = 6)	(S = 4)	(S = 8)	(S = 8)	(S = 9)	(P = 1)
(P = 11)	(P = 13)	(P = 9)	(P = 10)	(P = 14)	(R = 1)
(R = 8)	(R = 5)	(R = 5)	(R = 2)	(R = 10)	
	(MH = 1)	(MH = 2)	(MH = 2)	(MH = 2)	
63	69	61	60	87	7

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/unit staff = ward or unit nursing staff.

Table 4.44. First Rotation – Average Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 29)	(T = 16)	(T = 30)	(T = 20)	(T = 22)	
(S = 4)	(S = 3)	(S = 2)	(S = 1)	(S = 3)	
(P = 5)	(P = 5)	(P = 6)	(P = 4)	(P = 7)	
(R = 4)	(R = 5)	(R = 5)	(R = 6)	(R = 5)	
(MH = 1)	(MH = 2)	(MH = 1)		(MH = 2)	
43	31	44	31	39	

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; AC = Aged Care; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/unit staff = ward or unit nursing staff.

Table 4.45. First Rotation – Occasional Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 15)	(T = 6)	(T = 16)	(T = 14)	(T = 3)	
(S = 2)	(S = 1)	(S = 4)	(S = 2)	(P = 2)	
(P = 6)	(P = 3)	(P = 5)	(P = 5)	(R = 1)	
(R = 4)	(R = 3)	(R = 6)	(R = 5)		
			(MH = 1)		
27	13	31	27	6	

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.46. First Rotation – Negligible Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 8)	(T = 1)	(T = 4)	(T = 6)	(R = 1)	
(S = 2)	(P = 1)	(S = 1)	(S = 3)		
(P = 4)	(R = 3)	(P = 3)	(P = 5)		
(R = 6)		(R = 6)	(R = 5)		
(MH = 1)		(MH = 1)			
20	5	15	19	1	

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/unit staff = ward or unit nursing staff.

Table 4.47. First Rotation – Support Personnel Not Applicable

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 1)	(T = 2)	(T = 1)	(T = 4)	(D = 1)	(MH = 4)
(S = 1)	(S = 2)		(S = 3)		
	(R = 2)		(P = 1)		
	(C = 1)		(R = 2)		
			(C = 1)		
2	7	1	11	1	4

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health; AC = Aged Care; C = Community; D = Domiciliary

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

The prevailing level of support as perceived by the GRNs in this study is shown to be in the *very good to extensive* range (Figure 4.7).

Figure 4.7. Level of Perceived Support to GRNs in First Rotation

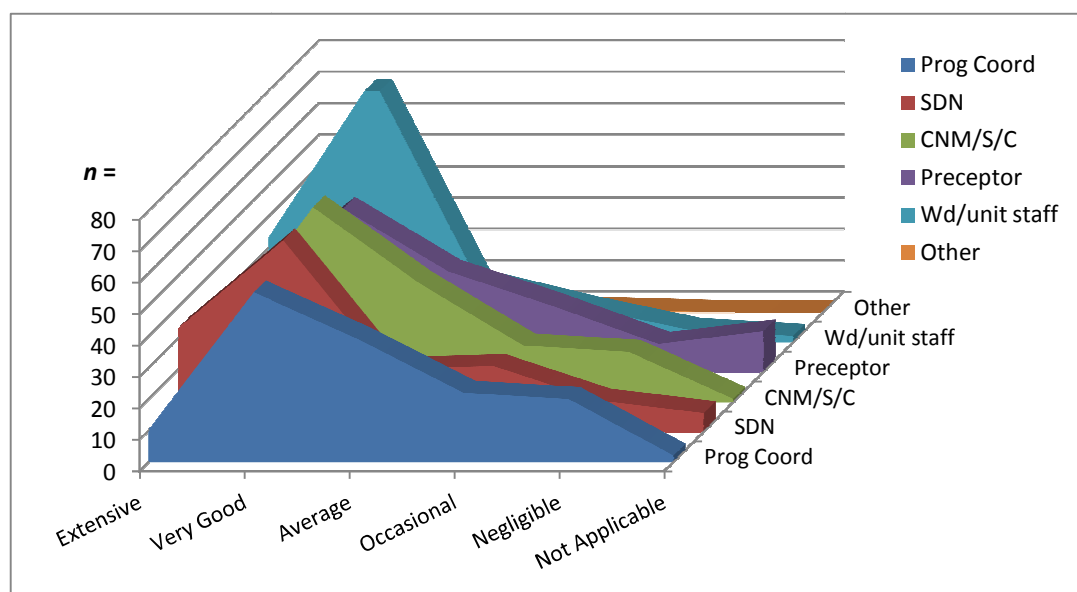


Figure 4.7. Shows the majority of perceived levels of support in first rotation for all personnel to range in the *extensive* to *very good* categories.

Tables 4.48 to 4.53 show the degree of support the GRNs perceived they received from the various personnel in their second rotation. The breakdown of organisation affiliation is again, given in parentheses next to the totals.

Table 4.48. Second Rotation – Extensive Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 6)	(T = 25)	(T = 12)	(T = 13)	(T = 18)	(T = 3)
(S = 1)	(S = 1)	(S = 1)	(S = 4)	(S = 4)	
(P = 2)	(P = 6)	(P = 3)	(P = 4)	(P = 7)	
(R = 1)	(R = 2)	(R = 1)	(R = 4)	(R = 4)	
			(MH = 1)		
10	34	17	26	33	3

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.49. Second Rotation – Very Good Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 34)	(T = 37)	(T = 30)	(T = 33)	(T = 54)	(T = 5)
(S = 4)	(S = 8)	(S = 9)	(S = 3)	(S = 8)	(P = 2)
(P = 6)	(P = 7)	(P = 11)	(P = 9)	(P = 9)	
(R = 7)	(R = 6)	(R = 9)	(R = 4)	(R = 11)	
(MH = 3)	(MH = 3)	(MH = 3)	(MH = 2)	(MH = 2)	
			(AC = 1)		
54	61	62	52	84	7

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health; AC = Aged Care

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.50. Second Rotation – Average Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 27)	(T = 14)	(T = 27)	(T = 24)	(T = 12)	(T = 1)
(S = 7)	(S = 1)	(S = 4)	(S = 3)	(S = 3)	
(P = 2)	(P = 2)	(P = 3)	(P = 1)	(P = 3)	
(R = 3)	(R = 3)	(R = 5)	(R = 4)	(R = 1)	
39	20	39	32	19	1

Note: T = Tertiary; S = Secondary; R = Rural; P = Private;

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.51. Second Rotation – Occasional Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 11)	(T = 9)	(T = 11)	(T = 13)	(T = 5)	(T = 1)
(P = 7)	(S = 1)	(P = 4)	(S = 2)	(P = 4)	
(R = 3)	(P = 6)	(R = 3)	(P = 2)	(R = 1)	
(AC = 1)	(R = 5)		(R = 4)	(MH = 1)	
22	21	18	21	11	1

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; AC = Aged Care; MH = Mental Health

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.52. Second Rotation – Negligible Level of Support

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 12)	(T = 1)	(T = 9)	(T = 3)	(P = 1)	
(S = 3)	(S = 3)	(S = 1)	(S = 2)	(R = 3)	
(P = 6)	(P = 3)	(P = 3)	(P = 3)		
(R = 5)	(R = 3)	(R = 2)	(R = 1)		
		(AC = 1)			
26	10	16	9	4	

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; AC = Aged Care

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

Table 4.53. Second Rotation – Support Personnel Not Applicable

Prog Coord	SDN	CNM/S/C	Preceptor	Wd/Unit Staff	Other
(T = 1)	(T = 3)	(T = 1)	(T = 4)	(T = 1)	(T = 80)
(C = 1)	(S = 1)		(S = 1)	(R = 1)	(S = 15)
	(R = 2)		(P = 4)		(P = 22)
			(R = 3)		(R = 21)
			(C = 1)		(MH = 3)
2	6	1	13	2	141

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health; C = Community;

Prog Coord = Program Coordinator; SDN = Staff Development Nurse; CNM/S/C = Clinical Nurse Manager / Specialist / Consultant; Wd/Unit Staff = ward or unit nursing staff.

The *other* areas of support were mainly from fellow graduate nurses; either as part of the ward staff or via graduate nurse networks. Clinical Coach was also given as *other*, as were Doctors.

The proportions of total responders for each group from the first and the second rotation are diagrammatically presented to enable better comparison of the levels of support as perceived by the graduates (Figures 4.8 to 4.14).

Figure 4.8. Comparison of 1st and 2nd Rotation, Perceived Support from Program Coordinator

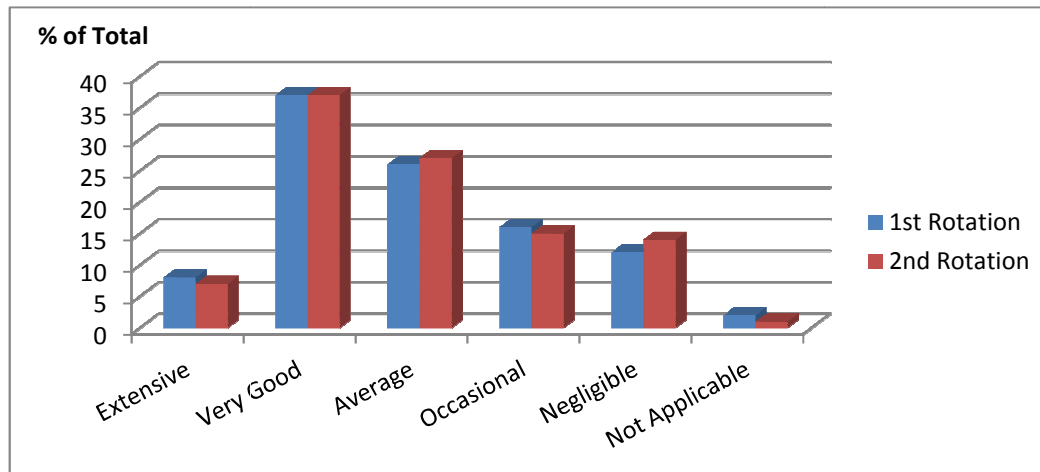


Figure 4.8. Comparison of 1st and 2nd rotation support from Program Coordinator.

There was minimal change in the perceived support from the Program Coordinator between the two rotations. The more common areas to record less support from the Program Coordinator were from either the Private or Rural sectors (Figures 4.9 and 4.10).

Figure 4.9. 1st and 2nd Rotation, Perceived Support from Program Coordinator in the Private Sector

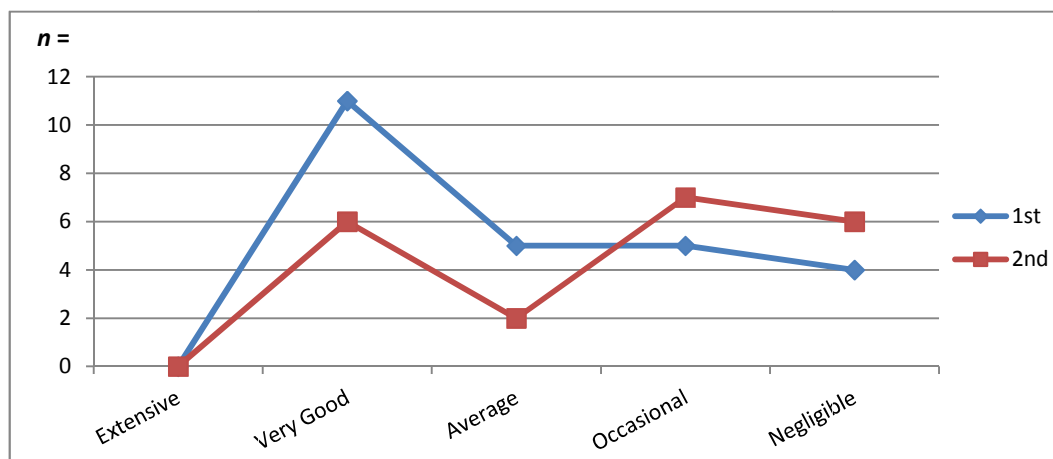


Figure 4.9. Comparison of 1st and 2nd rotation support from Program Coordinator in the Private sector.

Figure 4.10. 1st and 2nd Rotation, Perceived Support from Program Coordinator in the Rural Sector

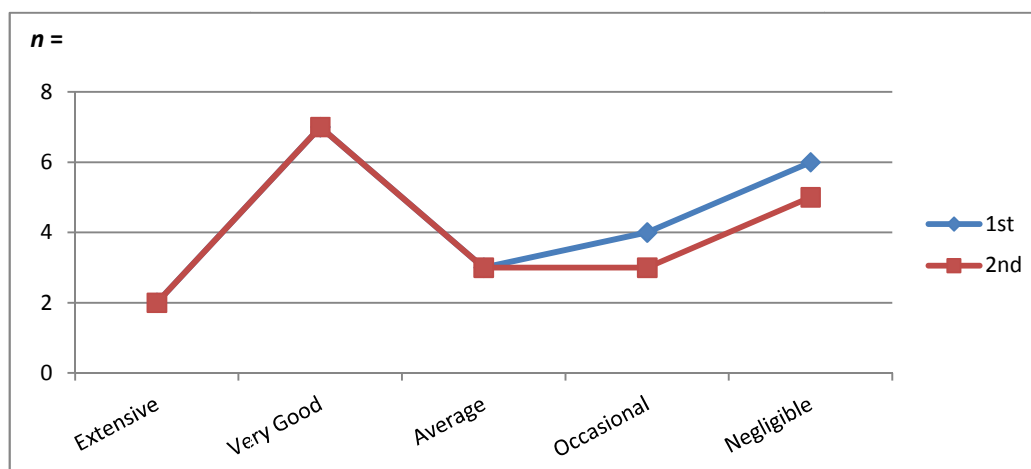


Figure 4.10. Comparison of 1st and 2nd rotation support from Program Coordinator in the Rural sector.

Figure 4.11. Comparison of 1st and 2nd Rotation, Perceived Support from SDN

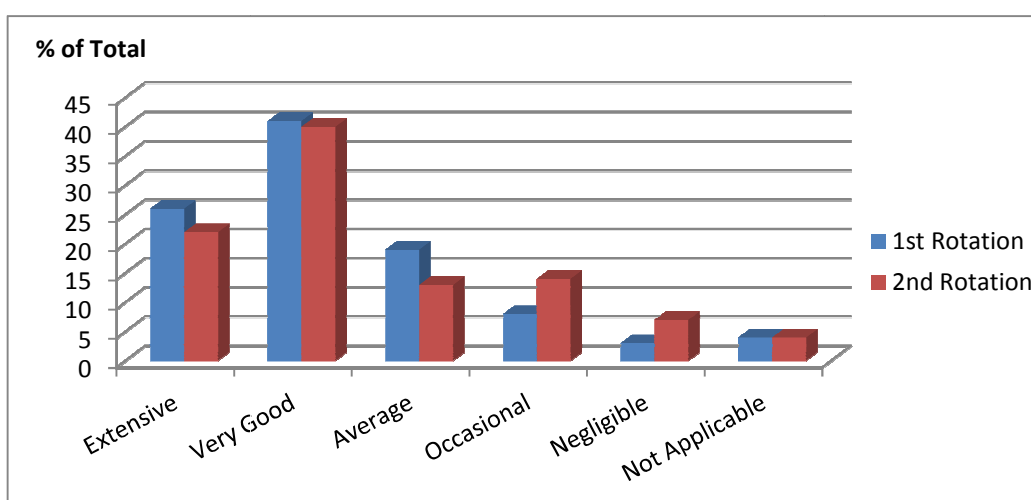


Figure 4.11. Comparison of 1st and 2nd rotation support from Staff Development Nurse.

While the *extensive* and *very good* ratings remain at a reasonable level of support from the SDN, frequencies of *occasional* and *negligible* support show an increase in the second rotation. This appears to have occurred predominately within the secondary and private sectors.

Figure 4.12. Comparison of 1st and 2nd Rotation by Sector; Perceived SDN Occasional & Negligible Support

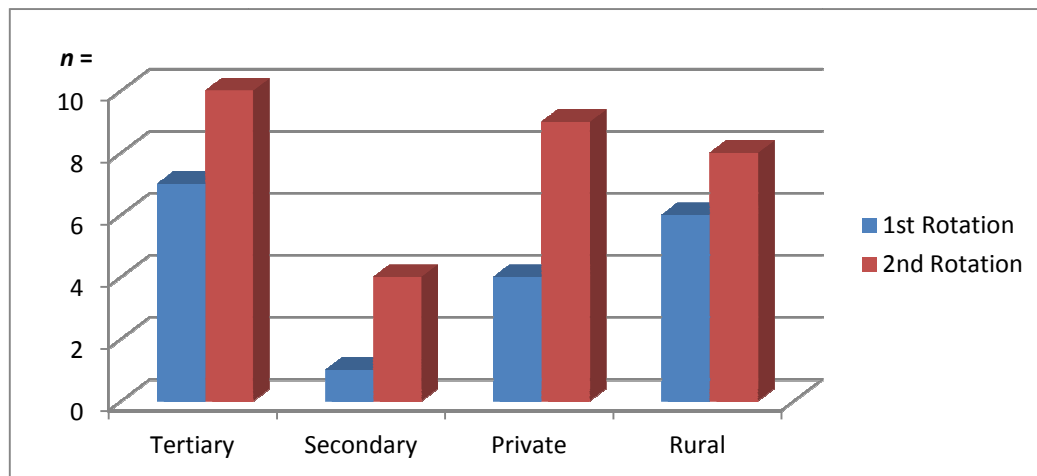


Figure 4.12. Comparison of 1st and 2nd rotation Occasional and Negligible support by sector from Staff Development Nurse.

Figure 4.13. Comparison of 1st and 2nd Rotation, Perceived Support from CNM/S/C

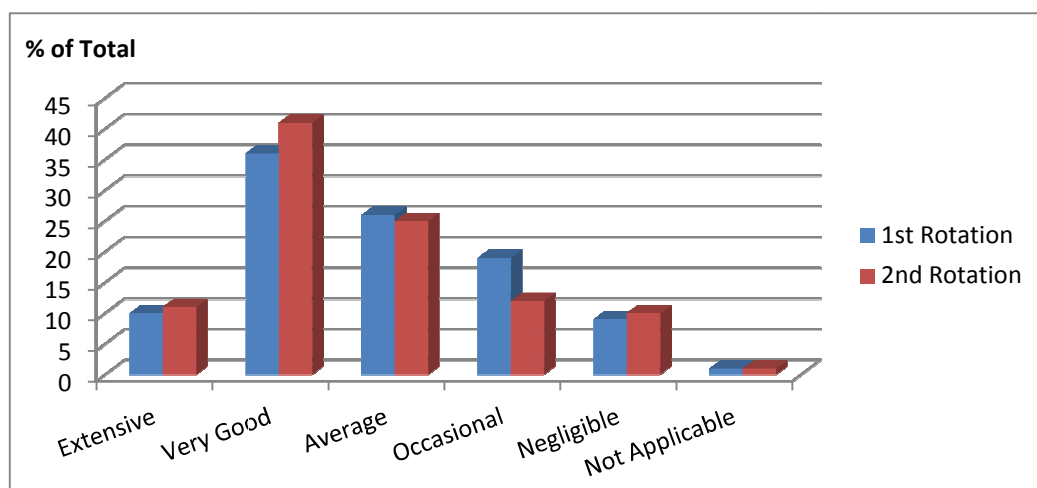


Figure 4.13. Comparison of 1st and 2nd rotation support from Clinical Nurse Manager/Specialist/Consultant.

The perceived support from the Clinical Nurse Manager, Specialist or Consultant (CNM/S/C) appears to have improved slightly between the two rotations (Figure 4.13). Minor differences between the two rotations emerged for preceptor or

mentor support, in particular an increase in the *extensive support*, predominately in the secondary and private sectors; and a decrease in the *negligible* group that was distributed amongst all areas (Figure 4.14).

Figure 4.14. Comparison of 1st and 2nd Rotation, Perceived Support from Preceptor/ Mentor

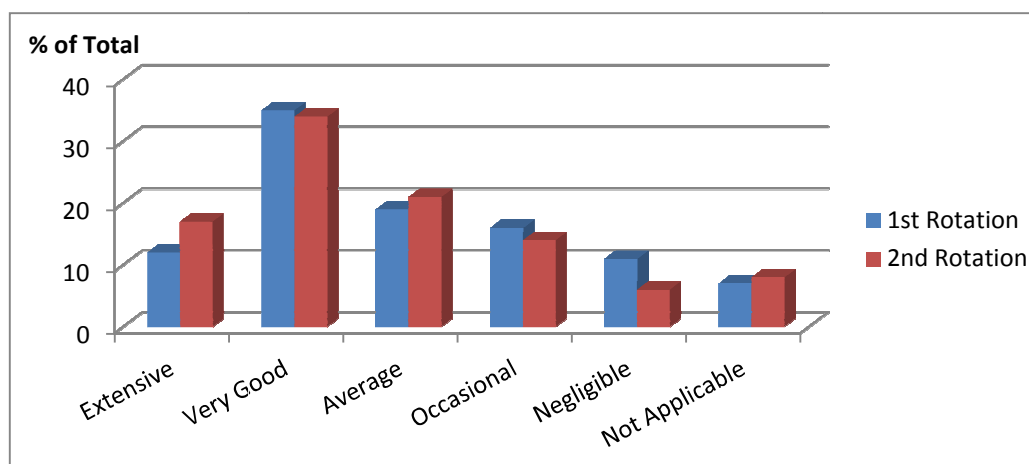


Figure 4.14. Comparison of 1st and 2nd rotation support from Preceptor/ Mentor.

Third rotation perceptions of *support* show that the perceived levels of *extensive* and *very good* have continued to decrease in the categories of Program Coordinator and SDN, but have retained similar ratios as previous rotations for other elements of support (Figure 4.15).

Figure 4.15. Comparison of 1st, 2nd and 3rd Rotation, Perceived Extensive and Very Good Support from all Categories

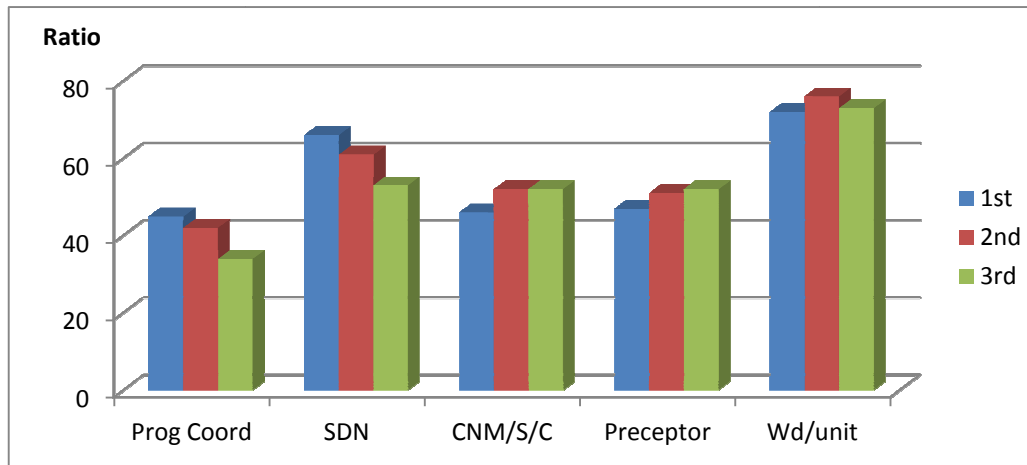


Figure 4.15. Comparison of 1st, 2nd and 3rd rotation levels of *extensive* and *very good* support.

Conversely, the incidence of *occasional* or *negligible* support provided between the rotations shows a marked increase across all personnel (Figure 4.16).

Figure 4.16. Comparison of 1st, 2nd and 3rd Rotation, Perceived Occasional and Negligible Support from all Categories

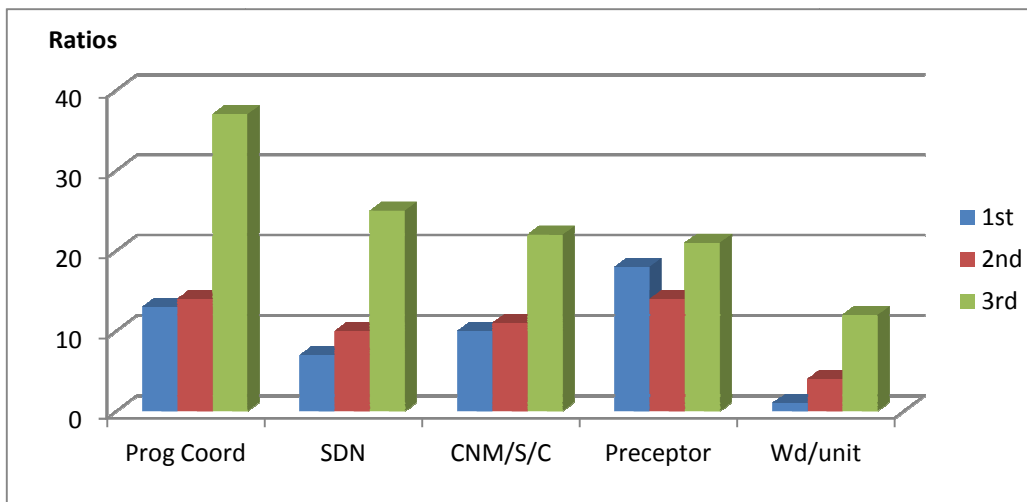


Figure 4.16. Comparison of 1st, 2nd and 3rd rotation levels of *occasional* or *negligible* support.

Levels of support provided to those GRNs who participated in further rotations are demonstrated in Table 4.54 and show a continued trend of an increase in ward or unit based support and a corresponding decrease in the more senior levels of support.

Table 4.54. Additional Rotations – Levels of Support in Fourth and Fifth Specialities

Rotation	Level of Support	Program Coord (n =)	SDN (n =)	CNM/S/C (n =)	Preceptor (n =)	Wd/Unit Staff (n =)
Fourth	V Good/Extensive	7	12	9	11	18
	Occasional/Negligible	7	7	7	3	2
Fifth	V Good/Extensive	0	3	4	5	6
	Occasional/Negligible	5	4	4	2	1

4.6.3.5 Supernumerary Time to Full Patient Load Allocation

For each specialty rotation, respondents were asked to indicate how long they had worked in a supernumerary capacity before being given the responsibility of a full patient or client load. It is assumed that, as the graduand becomes more competent and confident with their skills and knowledge, the consequent rotations to different units will require shorter periods of time for orientation. Table 4.55 shows the number of respondents for each supernumerary time period and the type of organisation they were working in for their first rotation.

Table 4.55. First Rotation – Supernumerary Days to Full Patient Load

Time	Total	T	S	Private	Rural	MH	AC	C
1 st day	8	3	1	2	1	1		
1 day	10	5	1		4			
2-3 days	71	37 (inc MH,AC,P)	10	11 (inc S,T,R)	9	2	2	
4-7 days	53	33	2	10	5		1	2
7-14 days	20	14	1	2	3			
Up to 1 month	6	4	1	1				
> 1 month	2			2 (Periop)				
Total	170	96	16	28	22	3	3	2

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health; AC = Aged Care; C = Community; Periop = Perioperative.

Shows the number of respondents from each sector indicating the supernumerary days allowed prior to being allocated a full patient load.

Of the 18 respondents who indicated that they were required to take a full patient load, either on their first day on the ward or unit, or following one day's orientation, eight had previous experience as either an AIN or a PCA, and seven had no prior experience in healthcare. Of those with no prior experience, four of the seven were from tertiary hospitals.

Table 4.56 shows the second rotation respondents' length of time worked in a supernumerary capacity before being given a full patient or client load.

Table 4.56. Second Rotation – Supernumerary Days to Full Patient Load

Time	Total	T	S	Private	Rural	MH	AC	C
1 st day	11	5	1	4	1			
1 day	30	21	2		7			
2-3 days	62	34	8	10	6	2	1	1
4-7 days	30	21	1	5	3			
7-14 days	6	4		2				
Up to 1 month	7	2	2	1	2			
> 1 month	4	3		1				
Total	150	90	14	23	19	2	1	1

Note: T = Tertiary; S = Secondary; R = Rural; P = Private; MH = Mental Health; AC = Aged Care; C = Community; Periop = Perioperative.

Shows the number of respondents from each sector indicating the supernumerary days allowed prior to being allocated a full patient load.

When compared to the first rotation, there was an increase in the number of respondents who were expected to take on a full patient load within one-day of their new specialty rotation and a marked decrease in those who were allowed four to seven, or seven to 14 days as a supernumerary staff member (Figure 4.17).

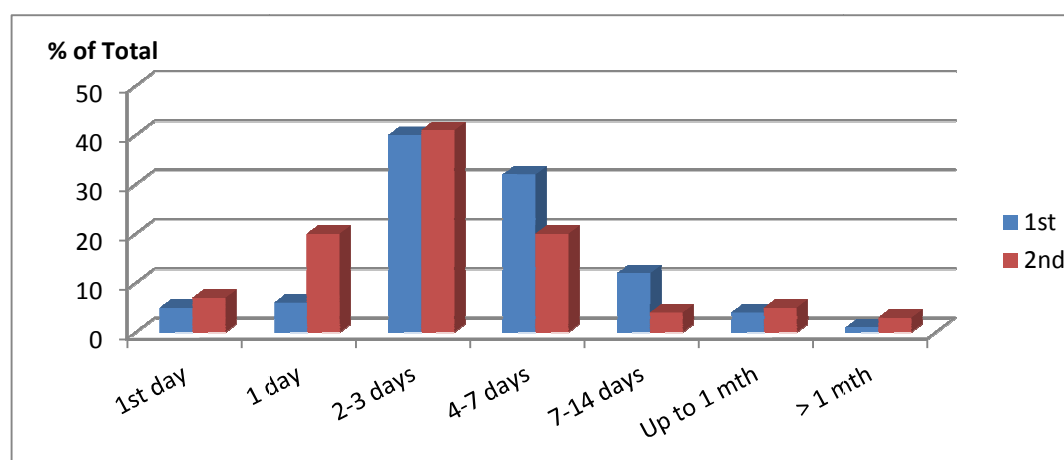
Figure 4.17. Comparison of 1st and 2nd Rotation, Supernumerary Days to Full Patient Load

Figure 4.17. Compares proportions of respondents in 1st and 2nd rotation indicating supernumerary days in ward or unit to full patient or client load.

Changes in the number of supernumerary days allocated to the GRN for their new specialty rotation occurred across all sectors (Figures 4.18 to 4.20).

Figure 4.18. Comparison of 1st and 2nd Rotation, by Sector, One Day to Full Patient Load

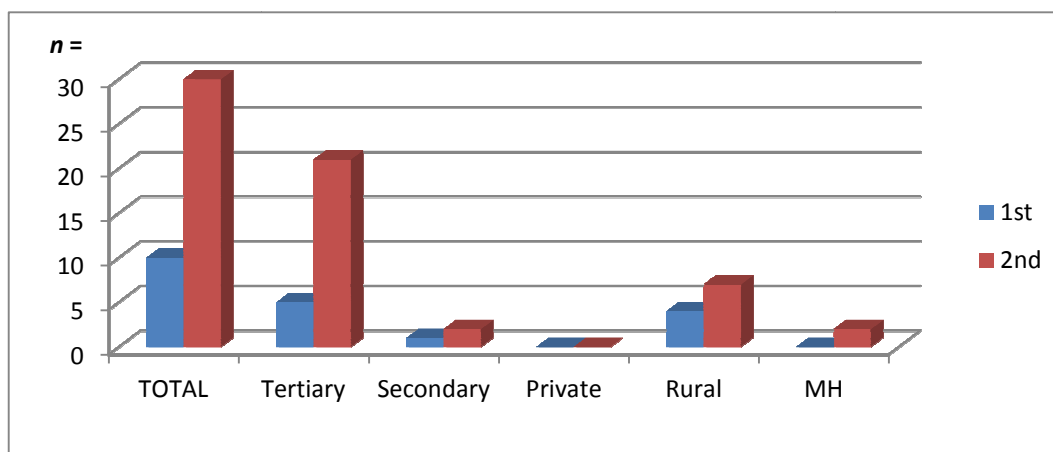


Figure 4.18. Shows increase in number of respondents between 1st and 2nd rotation taking full patient load after one day.

Figure 4.19. Comparison of 1st and 2nd Rotation, by Sector, 4-7 Days to Full Patient Load

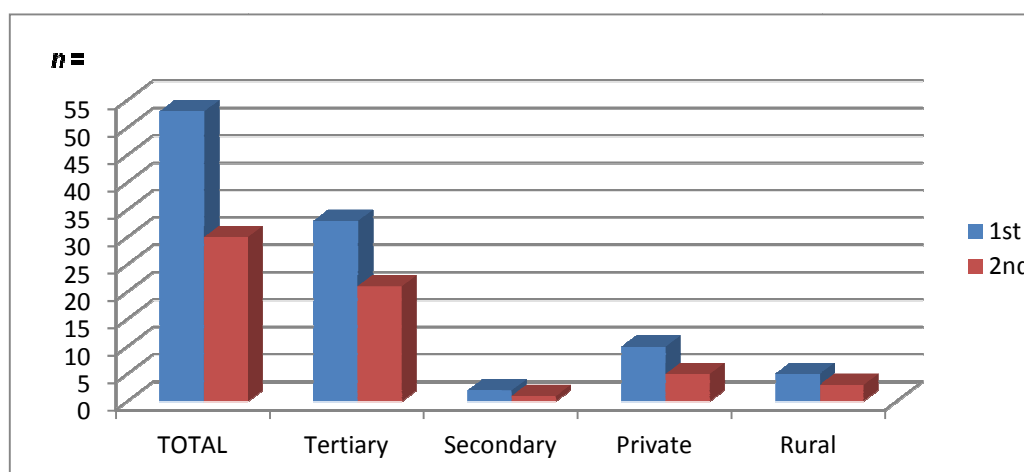


Figure 4.19. Shows decrease in number of respondents between 1st and 2nd rotation taking full patient load after 4-7 days.

Figure 4.20. Comparison of 1st and 2nd Rotation, by Sector, 7-14 Days to Full Patient Load

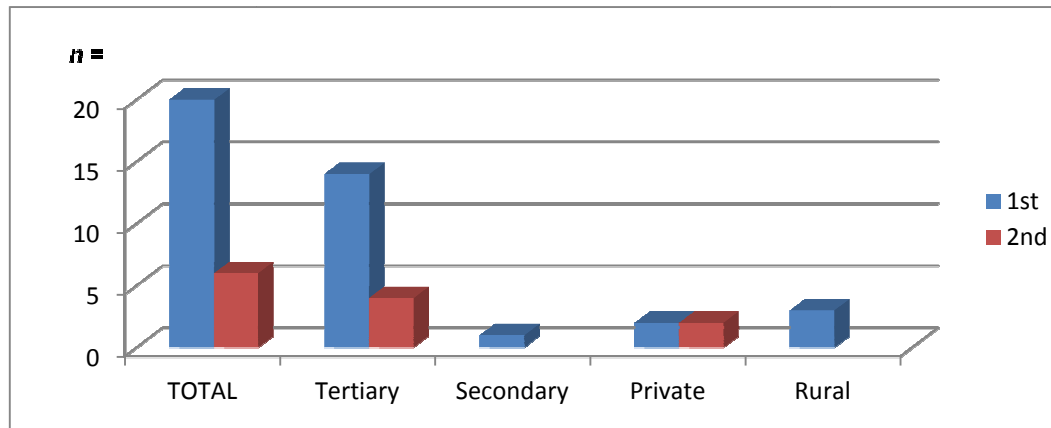


Figure 4.20. Shows decrease in number of respondents between 1st and 2nd rotation taking full patient load after 7-14 days.

While there was an overall decrease in supernumerary time for the GRNs second rotation, there was an increase in the number of respondents who indicated their supernumerary time for their second rotation was up to, or more than, one month (Figure 4.21). The majority of these were for perioperative rotations, or other specialised areas such as paediatrics, Critical Care or the Emergency Department.

Figure 4.21. Comparison of 1st and 2nd Rotation, by Sector, Up to, or More than One Month to Full Patient Load

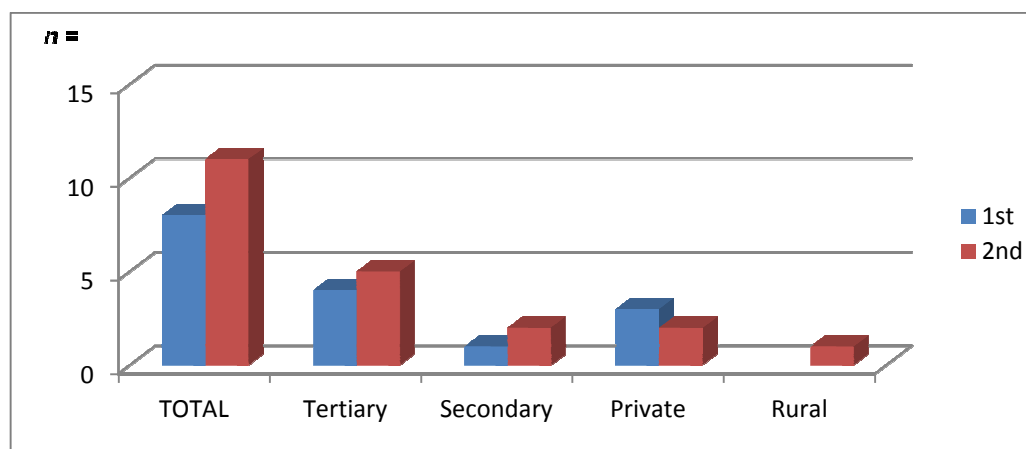


Figure 4.21. Shows increase in number of respondents between 1st and 2nd rotation taking full patient load from up to, or more than one month.

Respondents participating in a third rotation demonstrated a small increase in the proportion of respondents who were expected to take on a full patient load within one-day of their new specialty rotation and a marked decrease in those who were allowed four to seven days as a supernumerary staff member (Figure 4.22).

Figure 4.22. Comparison of 1st, 2nd and 3rd Rotation, Supernumerary Days to Full Patient Load

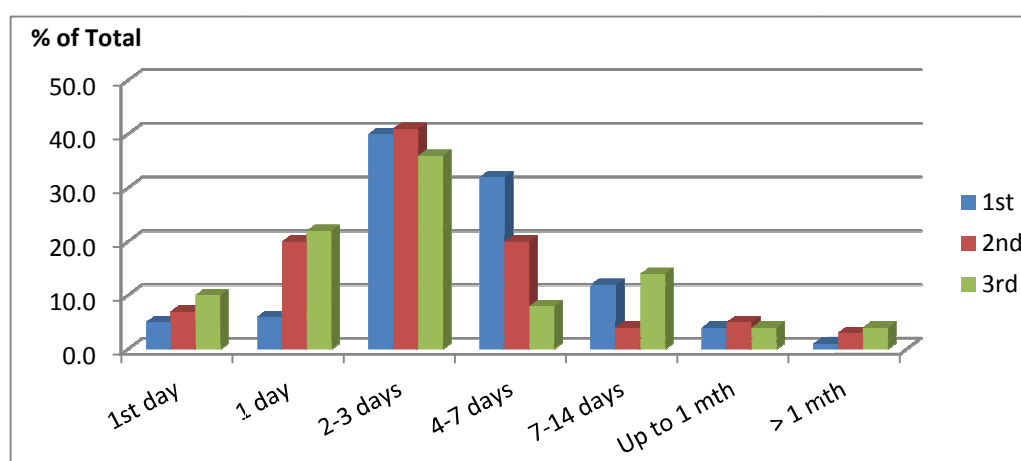


Figure 4.22. Comparison of proportions for 1st, 2nd & 3rd rotation supernumerary days in ward / unit to full patient or client load.

While there is an increase in the proportions of GRNs who were allocated fewer supernumerary days for their third rotation (Figure 4.22), there is again an increase in the number of respondents who indicated their supernumerary time was between seven and 14 days, or more than one month. Half of the respondents indicating thus were for perioperative rotations and the remaining were for other specialised areas, such as paediatrics, where previous more generalised experience is not able to be drawn upon to base much of the required new knowledge and skills and, as such, is to be expected. Table 4.57 demonstrates the continued trend of a reduction in supernumerary days to a full patient load for the additional rotations, with the exception of the specialties requiring an increased orientation time.

Table 4.57. Additional Rotations – Length of Time to Full Patient Load

Rotation	First Day (n =)	1 Day (n =)	2-3 Days (n =)	4-7 Days (n =)	>7 Days (n =)	> 1 Month (n =)	Total
Fourth	3	5	10	1 (MH)	1 (periop)	1 (periop)	23
Fifth	2		3	1	1		8

Note: MH = Mental Health; periop = Perioperative.

4.6.3.6 Perceived Benefits of Specialty Rotations

The final segment within each section relating to questions on specialty rotation experiences gave respondents the opportunity to provide open-ended responses to the following questions:

- *What areas were beneficial with this rotation?*
- *What areas were problematic with this rotation?*
- *What caused the most stress for you in this rotation?*
- *Do you have any other comment you would like to make about this rotation?*

Comments in relation to *beneficial areas* were themed into four basic streams of *learning* (knowledge), *clinical* (gaining clinical skills), *support*, and *time management* so these could be quantified for further comparison. Of the 153 participants who took the opportunity to respond to this question, the majority (43.8%) found *learning* to be of the greatest benefit in their first rotation, followed by *clinical* (35.9%), *support* (27.4%) and *time management* (19.6%). Many responses were themed under more than one concept as they were deemed to contain multiple perceptions of *benefits*.

In the second rotation, of the 138 participants who took the opportunity to respond to the question of perceived areas of *benefit*, the majority of graduates (56.5%) once more found *learning* to be of the greatest benefit of the rotation; followed by *clinical* (41.3%), *support* (34.8%) and *time management* (8.7%). As with the first rotation, many responses were deemed to contain multiple perceptions of benefits and, as such, were themed under more than one concept. While the ranking of the most common themes were the same as the first rotation, the percentage of the whole number of responses increased for all, with the exception of *time management*, which decreased by more than half from the first rotation responses (Figure 4.23).

Figure 4.23. Comparison of 1st and 2nd Rotation, Perceived Benefits Response Themes

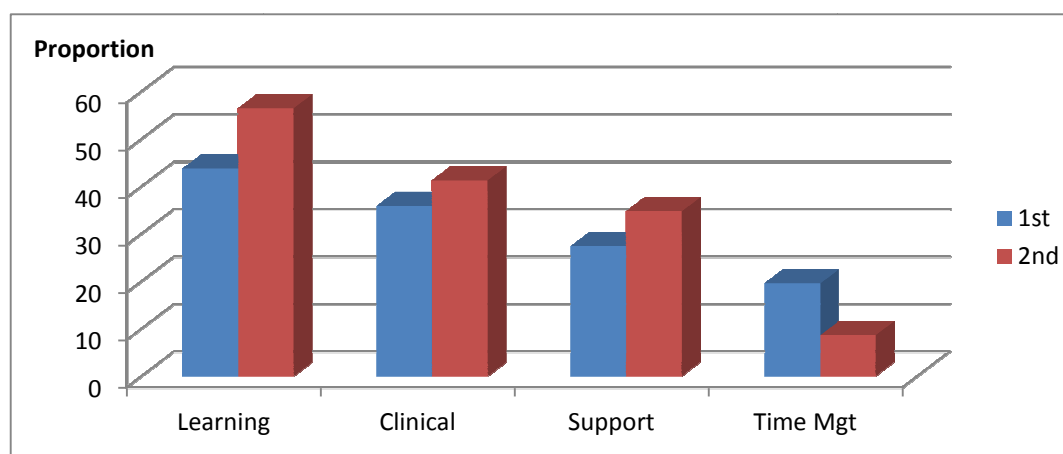


Figure 4.23. Shows increases and decreases in proportions of responses between 1st and 2nd rotation, indicating learning, clinical, support, and time management themes of perceived areas of *benefit*.

Of the 64 participants in the third rotation who took the opportunity to respond to the question of perceived areas of *benefit*, the majority of GRNs (56.5%) once more found *learning* to be of the greatest *benefit* in the rotation. *Support* (29.7%) rated the second most common theme and *clinical* (21.9%) moved to a lower

ranking; with *time management* (8.7%) remaining the same (Figure 4.24). An additional theme of *confidence* became evident in this rotation with 7.8% indicating it to be a *benefit*.

Figure 4.24. Comparison of 1st, 2nd and 3rd Rotation, Perceived Benefits Response Themes

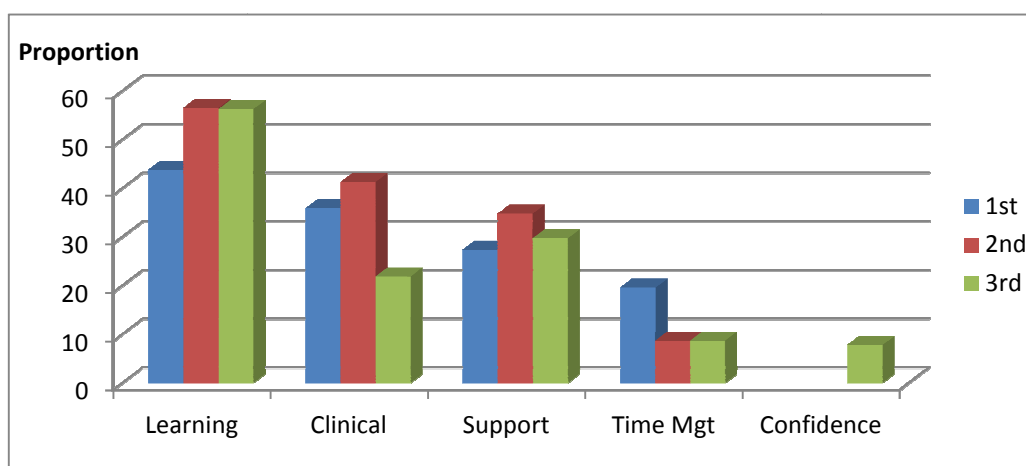


Figure 4.24. Shows increases and decreases in proportions of responses between 1st, 2nd and 3rd rotations, indicating learning, clinical, support, time management and confidence themes of perceived areas of *benefit*.

In the fourth and fifth rotations *learning* continued to dominate the themes (more than half in both groups), followed by *support*, *confidence* and *competence*.

4.6.3.7 Perceived Problems in Specialty Rotations

Respondents were also asked to describe what areas they felt were *problematic* in their specialty rotations. There were more themes used for this sector than the areas of *benefit* as it was felt any further compaction of themes would diminish the context and lose the sense of the issues that concerned graduates the most (Table 4.58). Of the 168 who participated in a GNP, almost one-quarter reported that they did not experience any real problems.

Table 4.58. First Rotation – Perceived Problems

Theme	Number	% of Respondents (n = 168)
Nil (no problems experienced)	40	23.8%
Lack of support	33	19.6%
Workload	27	16.1%
Lack of competence	25	14.9%
Busyness of the unit	15	8.9%
Poor skill mix of staff	11	6.5%
Bullying	7	4.2%
Other	22	13.1%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each theme.

In their first rotation, responders who were in a secondary sector hospital were most likely to indicate a *lack of support* as being a *problem* with 26.7% denoting thus; and the least likely to report a *lack of support* as a *problem* were respondents from tertiary hospitals. Where a respondent has indicated a dual organisational type, for example, a tertiary private hospital, the response has been included in each of those categories (Table 4.59).

Table 4.59. First Rotation – Sector Respondents Reporting Lack of Support

Type of Organisation	Total Responses for Perceived Problems	% of Total in Sector Citing Lack of Support
Secondary	18	26.7%
Private	27	18.5%
Rural	24	18.2%
Tertiary	99	17.7%
Total	168	19.6%

Further breakdown of those describing that *lack of support* was perceived as a *problem* in their first specialty rotation showed more than half (57.6%) were aged less than 30-years, and slightly less than half (48.5%) indicated they had no prior employment in a health related occupation. Those who attended University D as an undergraduate student showed a slightly higher proportion (22.2%) detailing *support* related problems than other universities, with University A showing 21.2%, University B 20.2%, and University C the least, with 14.3%. Conversely, University D had the greatest proportion of respondents who indicated that they had *no problems* in their first rotation (this is including all problem themes), and University C showed the least number of graduates (9.5%) indicating they had *no problems* during their first rotation.

Of the 168 responding to the first rotation *problems* question, three respondents cited they felt that they were not using the knowledge and skills they had gained during their undergraduate education. All three of these indicated that University A was the place of their undergraduate nursing program; they were in the 20 to 29 year-old age bracket; were female; and, had not indicated any prior health care experience before graduating. The specialties they worked in for their first rotation were paediatrics, rehabilitation and mental health. Two of the three indicated future careers in nursing, however, the third had resigned during her graduate program to pursue a non-nursing degree.

During their second specialty rotation a greater proportion of respondents indicated they had not experienced any areas they perceived as *problematic*. For those who did, the theme *lack of support* was again the most predominate *problem*

indicated and was reported more commonly in their second rotation than their first (Table 4.60).

Table 4.60. Second Rotation –Perceived Problems

Theme	Number	% of Respondents (Total = 153)
Nil (no problems experienced)	46	30.1%
Lack of support	41	26.8%
Workload	14	9.2%
Lack of competence	21	13.7%
Busyness of the unit	8	5.2%
Poor skill mix of staff	7	4.6%
Bullying	4	2.6%
Other	32	20.9%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each theme.

Data proportions in relation to perceived *problems* are compared between the first and second specialty rotation response (Figure 4.25).

Figure 4.25. Comparison of 1st and 2nd Rotations, Perceived Problems Themes

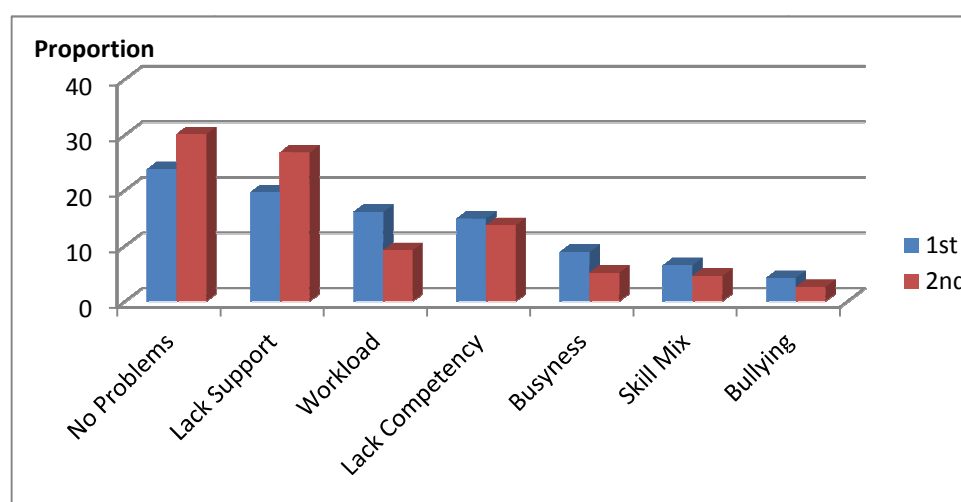


Figure 4.25. Shows changes in proportions of respondents who perceived problems between 1st and 2nd rotations according to themes allocated.

Themes such as *busyness*, *lack of competence*, *poor skill-mix* and *bullying* were reported by the graduates as a perceived problem. Additional themes of *poor communication* (6.5%) and *unprofessional behaviour* (5.6%) emerged in their second rotation, as did those of *not using skills* learned in their undergraduate nursing program (2.8%) or, where the work was *repetitive* or *boring* (4.7%). The concept of *program structure* as an issue was also evident from the responses in this rotation, with 4.7% (n = 5) indicating thus.

As in the findings of the first rotation, responders who were in a secondary level hospital were more likely to indicate that a *lack of support* was as a *problem*, (62.5%) and at more than twice the rate of the first rotation. Those from the rural sector were the least likely to report a *lack of support* as a *problem*, with the rate half of that recorded in the first rotation (Table 4.61).

Table 4.61. Second Rotation – Sector Respondents Reporting Lack of Support

Type of Organisation	Total Responses for Perceived Problems	% of Total in Sector Citing Lack of Support
Secondary	15	40.0%
Private	24	37.5%
Tertiary	93	24.7%
Rural	21	9.5%
Total	153	26.8%

Comparison of the ratios between the first and second rotations of total responses themed as *lack of support* clearly illustrates the substantial increase in occurrence within three of the four organisational sectors (Figure 4.26).

Figure 4.26. Comparison of 1st and 2nd Rotations, Lack of Support – Sector Type

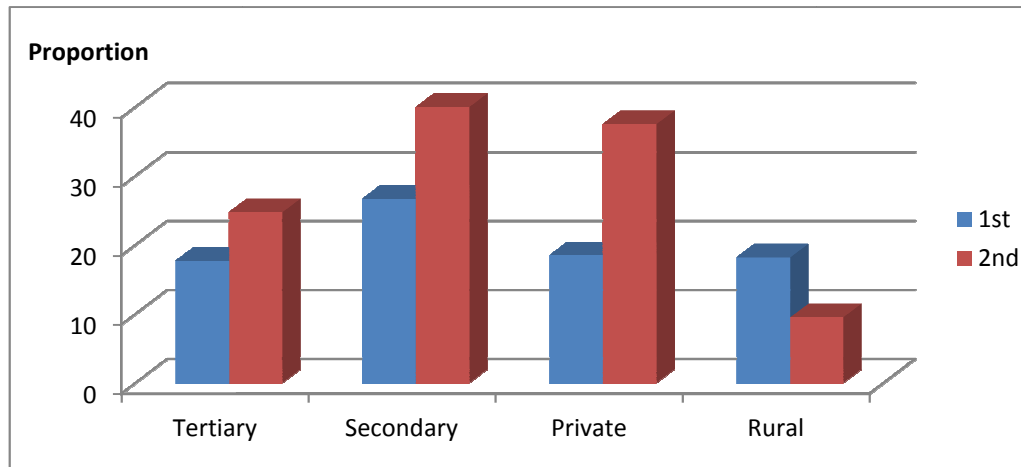


Figure 4.26. Changes in proportions of *lack of support* theme between 1st and 2nd rotations by Sector type.

Of those GRNs who perceived that *lack of support* was a *problem* in their first specialty rotation, more than half (57.6%) were aged less than 30-years; similarly, in the second rotation, 61% were aged less than 30-years. Figure 4.27 also compares the proportion of respondents reporting *lack of support* as a problem and is related to the university the GRN attended as an undergraduate. For the second rotation, those who attended University B as an undergraduate student showed a higher proportion (32.4%) who indicated *support* related problems than did respondents who had attended other universities, with University A showing 22.4%, University D no change from the first rotation (22.2%), and University C the least again, but with somewhat more for the second rotation (21.0%) compared to the first rotation (14.3%).

Figure 4.27. Comparison of 1st and 2nd Rotations, Lack of Support - Undergraduate University Attendance

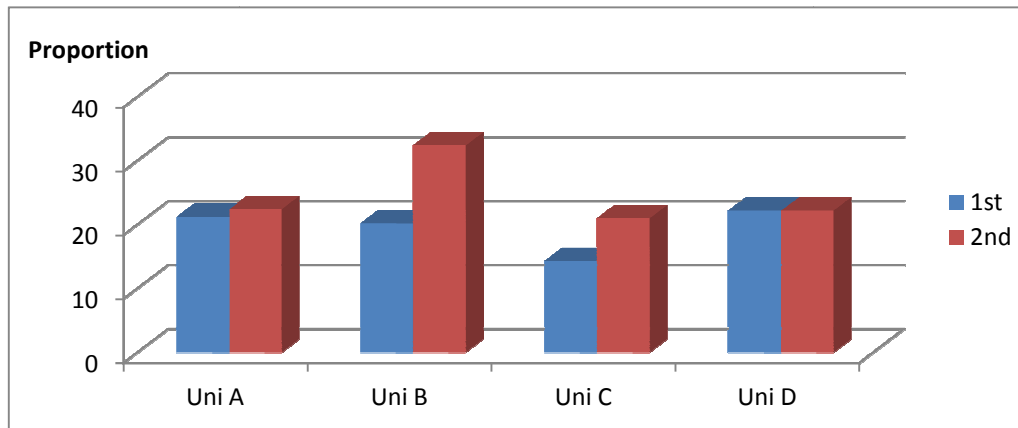


Figure 4.27. Shows changes in proportions of *lack of support* theme between 1st and 2nd rotations by the university attended as an undergraduate.

As in the first rotation, while the GRNs who had attended University B recorded the largest proportion of *lack of support* as a *problem*, this cohort conversely had the greatest proportion of GRNs who recorded that they experienced *no problems* (35.1%). University C GRNs who recorded the lesser proportion of *lack of support* as a *problem*, had the least proportion (10.5%) of GRNs indicating that they experienced *no problems* (Figure 4.28).

Figure 4.28. Comparison of 1st and 2nd Rotations, Ratios of Nil Problems by Undergraduate University Attendance

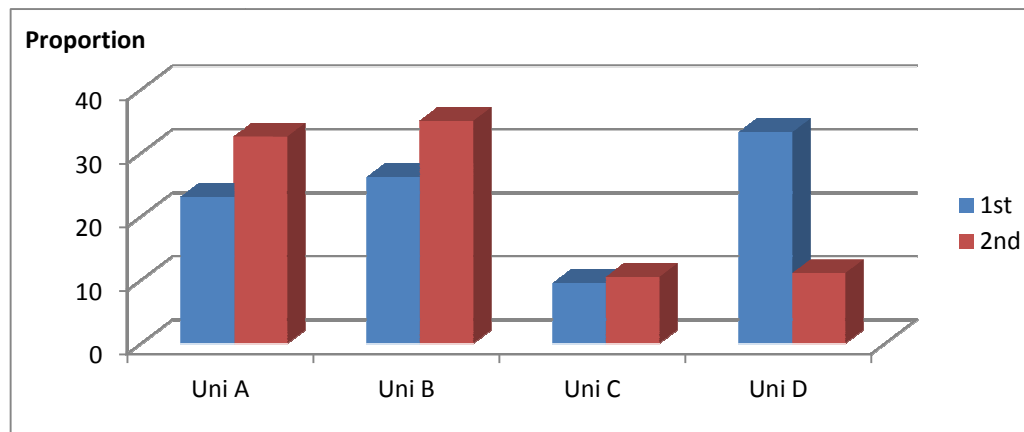


Figure 4.28. Shows changes in proportions of *no reported problems* between 1st and 2nd rotations by university attended as undergraduate.

There was an increase in comments related to poor communication, unprofessional behaviour and bullying, as well as graduates who felt that their second rotation was either boring, repetitive or was not adequately utilising their undergraduate education.

For their third rotation *lack of support* was once more the stronger theme of the areas that respondents felt were *problematic*, although not as commonly as in the second rotation. The more frequent themes are depicted in Table 4.62 with the numbers and proportions of all responding to the question compared. The first and second rotations are further illustrated in Figure 4.29.

Table 4.62. Third Rotation – Perceived Problems

Theme	N =	% of Total
Nil (no problems experienced)	27	37.0%
Lack of support	16	21.9%
Workload	5	6.8%
Lack of competence	7	9.6%
Busyness of the unit	3	4.1%
Poor skill mix of staff	1	1.4%
Bullying	2	2.7%
Minimised experience	8	11.0%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each theme.

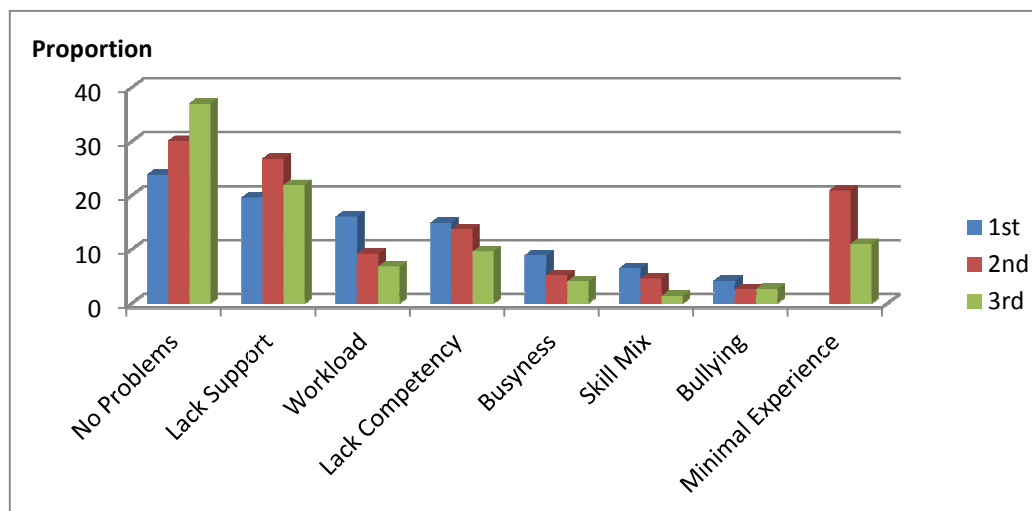
Figure 4.29. Comparison of 1st, 2nd and 3rd Rotations, Perceived Problems Themes

Figure 4.29. Shows changes in proportions of perceived *problem* themes between 1st, 2nd and 3rd rotations.

Themes such as *lack of competence*, *workload* and *busyness*, reported by the graduates as a perceived *problem* continued, but at much lower rates than the previous specialty rotations. An additional theme of *minimised experience* (11%) appeared in this rotation and was included to depict the reported perception that a

rotation did not provide an adequate amount of clinical encounters and learning opportunities. The responders included in this cohort were all in the younger age groups; half were at tertiary hospitals with the remainder in private or rural sectors. The GRNs felt the rotation lacked challenge, was boring or there were not enough patients for whom to provide nursing care. Two were in perioperative rotations and another two were in Critical Care units.

As with both the first and second rotations, a greater proportion of secondary sector responders were more likely to indicate that a *lack of support* was a *problem*, with more than double the average; and the least likely to report *lack of support* as a *problem* were those from rural organisations (Table 4.63).

Table 4.63. Third Rotation – Sector Respondents Reporting Lack of Support

Type of Sector	Total Responses	% Citing Lack of Support
Tertiary	35	22.9%
Secondary	11	45.5%
Private	15	13.3%
Rural	12	8.3%
Total	73	21.9%

Comparison of the ratios of total responses themed as *lack of support* between the first, second and third rotations illustrates a marked decrease in lack of support being perceived as a problem in private organisations and a moderate decrease in both tertiary and rural sectors (Figure 4.30).

Figure 4.30. Comparison of 1st, 2nd and 3rd Rotations; Ratios of Lack of Support Theme by Industry Sector

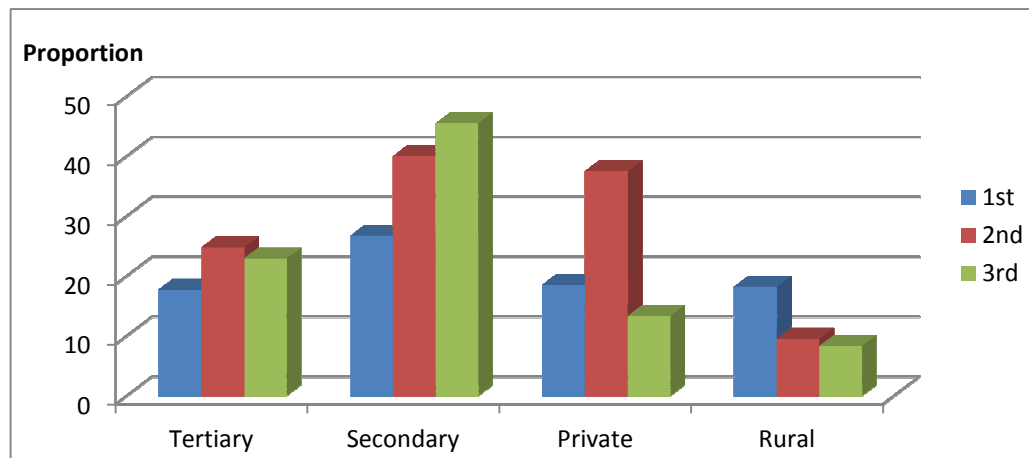


Figure 4.30. Shows changes in proportions of *lack of support* theme between 1st, 2nd and 3rd rotations by sector.

There was an increase in comments related to a sense of lacking *competency* for the specialty rotation, as well as GRNs who felt the rotation was not sufficient in offering *learning experiences*.

In the remaining specialty rotations, *lack of support* continued to feature strongly in the *problem* themes and similarly in the cause of *stress* themes. A new theme emerged in the fifth rotation related to *problems* and was coded *lack of respect*, with comments from older age-groups such as: “*lack of respect from younger staff; few staff not prepared to accept my judgement and treated me like a student*”.

4.6.3.8 Perceived Causes of Stress for Specialty Rotations

The responses to the question that asked *what caused most stress for you in this rotation* were again coded under more than one theme when more than one cause

was expressed. First rotation causes of *stress* as perceived by the GRNs are shown in Table 4.64.

Table 4.64. First Rotation – Theme Proportions for Perceived Causes of Stress

Theme	N =	% of Total
Nil (no causes of stress reported)	24	14.3%
Workload	27	16.1%
Lack of support	26	15.5%
Time management	24	14.9%
Lack of knowledge	18	10.7%
Poor communication	13	7.7%
Busyness of the unit	11	6.5%
Bullying	9	5.4%
Poor skill mix of staff	7	4.2%
Work-life balance	6	3.6%
Total	165	99.9%

The majority of responses relating to the *causes of most stress* were themed under *workload*, *lack of support* and *time management*. *Poor communication* was cited on several occasions and related predominately to colleagues (76.9%) and, on two occasions, to medical staff. Secondary hospitals had the greatest ratio of respondents who cited their *workload* was a major *stressor*, while those from tertiary organisations had the least (Table 4.65).

Table 4.65. First Rotation – Sector Respondents Reporting Workload Cause of Stress

Type of Sector	Total Responses for Perceived Stress	% of Respondents Citing Workload by Sector
Secondary	18	26.7%
Private	27	22.2%
Rural	24	18.2%
Tertiary	99	7.3%
Total	168	16.1%

As with causes of *problems*, the second most commonly mentioned cause of *stress* as perceived by the GRNs was a *lack of support*. The responses were again tabulated against the type of organisation where the respondent worked (Table 4.66). While *lack of support* was seen as a *problem* by a greater ratio of secondary hospital respondents, the largest ratio of GRNs who perceived *lack of support* was a major *stressor* was from the rural sector. Once more, tertiary hospital respondents had the smallest ratio of responders who indicated a *lack of support* was a cause of *stress*.

Table 4.66. First Rotation – Sector Respondents Reporting Lack of Support Cause of Stress

Type of Sector	Total Responses for Perceived Stress	% of Total in Sector Citing Lack of Support
Rural	24	31.8%
Private	27	14.8%
Secondary	18	13.3%
Tertiary	99	10.4%
Total	168	15.5%

Responses were similarly themed for the second specialty rotation, and again, due to the open-ended nature of the responses, were often coded under more than one issue (Table 4.67).

Table 4.67. Second Rotation – Theme Proportions for Perceived Causes of Stress

Theme	N =	%
Nil (no causes of stress reported)	40	26.1%
Workload	33	21.6%
Lack of knowledge	32	20.9%
Lack of support	26	17.0%
Patients / clients	17	11.1%
Time management	9	5.9%
Poor communication	8	5.2%
Poor skill mix of staff	7	4.6%
Busyness of the unit	7	4.6%
Bullying	6	3.9%
Work-life balance	5	3.3%
Patients dying	5	3.3%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each theme.

As for the first rotation, the majority of responses relating to the *causes of most stress* were coded under the themes of *workload*, and *lack of support* (Table 4.66). However, *lack of support* was superseded by *lack of knowledge* in the percentage rankings, and further changes were seen with an increased proportion of *patients/clients* originating perceptions of *stress* (Figure 4.31).

Figure 4.31. Comparison of 1st and 2nd Rotation, Ratios of Stress Themes

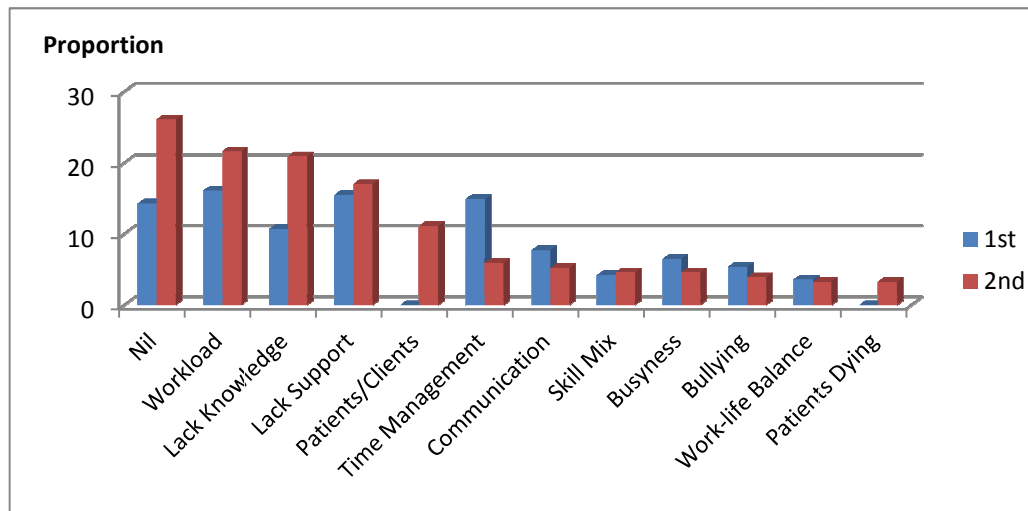


Figure 4.31. Shows changes in proportions of various stress themes between 1st and 2nd rotations.

The second rotation data related to *workload*, as cause of the respondents' stress, was analysed (Table 4.68), and when contrasted with the percentages of the first rotation responses, divergent findings are seen between the workplace sectors (Figure 4.32).

Table 4.68. Second Rotation – Sector Respondents Reporting Workload Cause of Stress

Type of Sector	Total Responses for Perceived Stress	% of Total in Sector Citing Workload
Tertiary	91	22.0%
Secondary	14	7.1%
Private	24	29.2%
Rural	19	15.8%
Total	148	21.6%

Figure 4.32. Comparison of 1st and 2nd Rotations, Ratios of Workload Themes in Relation to Stress

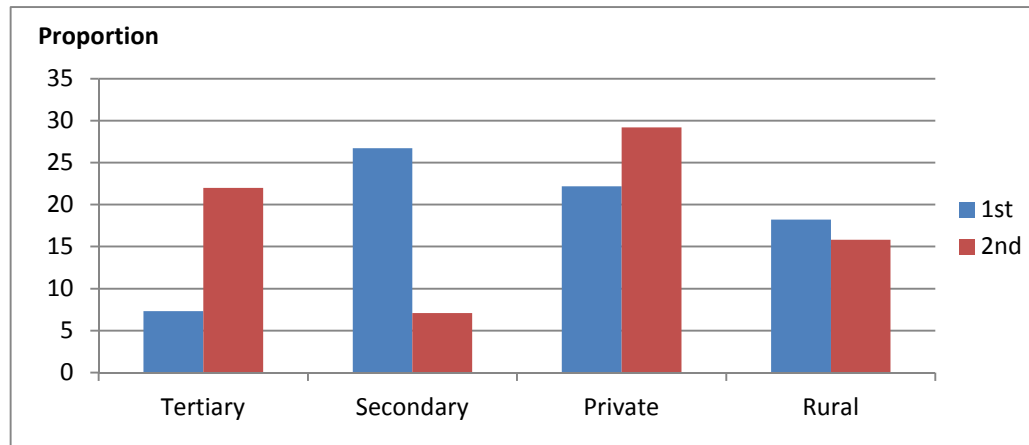


Figure 4.32. Shows considerable changes in sector proportions of *workload* related stress themes between 1st and 2nd rotations.

Unlike the first rotation, the second most commonly mentioned source of *stress*, as perceived by the graduates in their second rotation, was a *lack of knowledge*. Both the tertiary and secondary sector respondents had the highest ratio of respondents who reported a *lack of knowledge* contributed to *stress* (Table 4.69).

Table 4.69. Second Rotation – Sector Respondents Reporting Lack of Knowledge Cause of Stress

Type of Sector	Total Responses for Perceived Stress	% of Total in Sector Citing Lack of Knowledge
Tertiary	91	25.3%
Secondary	14	28.6%
Private	24	8.3%
Rural	19	15.8%
Total	148	20.9%

As *lack of support* was the second most common theme reported in the first rotation, the data from that rotation are shown for comparison against those for the

second rotation (Figure 4.33) and illustrate some differences between the data sets, predominately within the rural, private and secondary sectors.

Figure 4.33. Comparison of 1st and 2nd Rotations, Ratios of Workload Themes in Relation to Stress

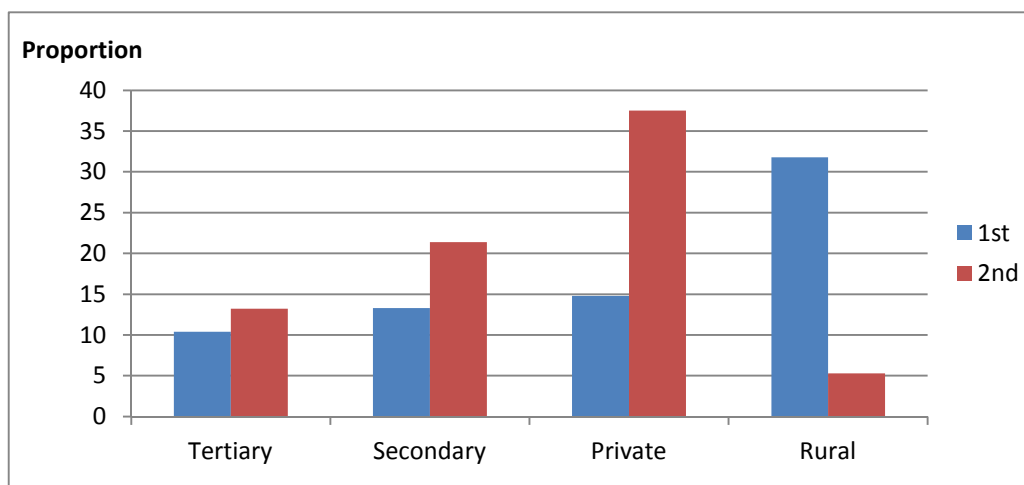


Figure 4.33. Shows changes in sector proportions of *workload* related stress themes between 1st and 2nd rotations.

Other *stress* related themes reported in their second rotation were *poor communication* (n = 6), all from the tertiary sector, with four in surgical and one each in medical and perioperative units; and *patients dying* (n = 4), also from the tertiary sector, with three of the specialty rotations in medical wards and the fourth a critical care unit.

Third rotation responses again showed an increase in the proportion of respondents who reported *nil* stress (Table 4.70).

Table 4.70. Third Rotation – Theme Proportions of Perceived Causes of Stress

Theme	Number	Percent
Nil (no causes of stress reported)	23	31.5%
Workload	5	6.8%
Lack of knowledge	10	13.7%
Lack of support	15	20.5%
Patients / clients	7	9.6%
Time management	0	0
Poor communication	4	5.5%
Poor skill mix of staff	3	4.1%
Busyness of the unit	4	5.5%
Bullying	4	5.5%
Work-life balance	1	1.4%
Patients dying	2	2.7%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each theme.

Unlike the earlier rotations, in the third rotation, the foremost perceived cause of *most stress* was *lack of support*. The perception of *workload* as the primary contributor to feelings of *stress* had reduced, and there were no reports of *time management* considered to be an issue. The *patients / clients* contributing to perceptions of *stress* continued to be seen as a problem (Figure 4.34).

Figure 4.34. Comparison of 1st, 2nd and 3rd Rotations, Ratios of Stress Themes

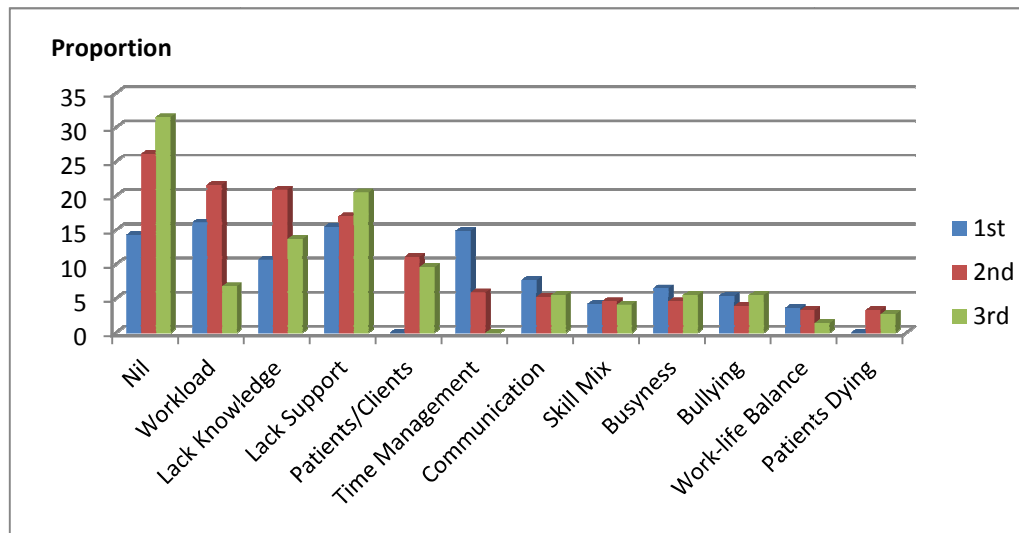


Figure 4.34. Shows changes in proportions of stress themes between 1st, 2nd and 3rd rotations.

4.6.3.9 Other Specialty Rotation Comments

Respondents were asked if they had any *further comment* they wished to make in regards to their individual specialty rotations. For this section the qualitative data were quantified into five categories ranging from *very positive* to *very negative*. Examples of *positive* comments included: “Fantastic rotation, great introduction to a busy post-operative ward, great team”, and “Loved it, chose to stay on this ward after the GNP”; while examples of *negative* comments included: “Most unenjoyable, worst experience, thought of quitting nursing for good”, and “Couldn’t wait for it to end”. For their first rotation, of the 72 respondents who took the opportunity to provide further information, 22 responses were coded *very positive* and an additional 22 as *mostly positive*. Only five responses were coded as *very negative* with a further 22 as *mostly negative*. Of the *very negative*, the sectors where the respondent worked were spread across each type. Tables 4.71 and 4.72 provide further breakdown of the responses in relation to the sector that the GRN worked in.

Table 4.71. First Rotation – Sector Type, Proportion of Positive Comments

Type of Sector	Total Responders	% of Total Positive Comments
Tertiary	99	30.2%
Secondary	18	26.7%
Rural	24	22.7%
Private	27	18.5%
Total	168	26.8%

Note: Includes both *very positive* and *mostly positive* comments and shows the proportion of all GNP participants within each sector expressing positive comments in their first rotation.

There were equivalent proportions of *positive* and *negative* themes from the GRN respondents from both the secondary and the private sectors.

Table 4.72. First Rotation – Sector Type, Proportion of Negative Comments

Type of Sector	Total Responders	% of Total Negative Comments
Tertiary	27	13.5%
Secondary	99	26.7%
Rural	24	18.2%
Private	18	18.5%
Total	168	16.1%

Note: Includes both *very negative* and *mostly negative* comments and shows the proportion of all GNP participants within each sector expressing negative comments in their first rotation.

The data related to the second rotation *further comments* were similarly coded into the range of *very positive* to *very negative* themes. Of the 74 respondents who took the opportunity to provide further information, 12 were coded as *very positive* and 28 as *mostly positive*. Only four responses were coded as *very negative* with a further 21 as *mostly negative*. Tables 4.73 and 4.74 give a further breakdown of the *positive* and *negative* responses in relation to the type of sector worked in. The ratio

of positively themed responses related to the additional comments from all sectors showed minimal change compared to those of the first rotation (Figure 4.35).

Table 4.73. Second Rotation – Sector Type, Proportion of Positive Comments

Type of Sector	Total Responders	% of Total Positive Comments
Tertiary	93	29.0%
Secondary	15	26.7%
Private	24	16.7%
Rural	21	23.8%
Total	153	26.1%

Note: Includes both *very positive* and *mostly positive* comments and shows the proportion of all GNP participants within each sector expressing positive comments in their second rotation.

Figure 4.35. 1st and 2nd Rotations, Additional Comments Ratios of Positive Themes

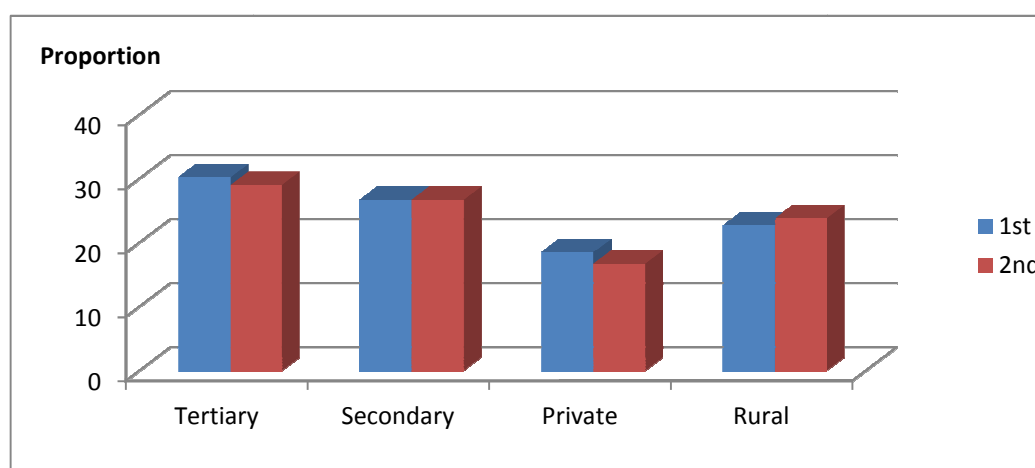


Figure 4.35. Shows changes in sector proportions of *positive comment* themes between 1st and 2nd rotations.

Table 4.74. Second Rotation – Sector Type, Proportion of Negative Comments

Type of Sector	Total Responders	% of Total Negative Comments
Tertiary	93	13.2%
Secondary	15	21.1%
Private	24	16.7%
Rural	21	21.4%
Total	153	16.3%

Note: Includes both *very negative* and *mostly negative* comments and shows the proportion of all GNP participants within each sector type expressing negative comments in their second rotation.

Again, there were minimal changes in the proportions of graduates providing a *negatively* rated response in the *further comments* amongst the tertiary, private and rural sectors. There was a moderate increase within the secondary sector and only a small reduction within the tertiary sector responses (Figure 4.36). Overall, the proportions of *positive* and *negative* comments have differed only marginally with less than a percentage point change between them.

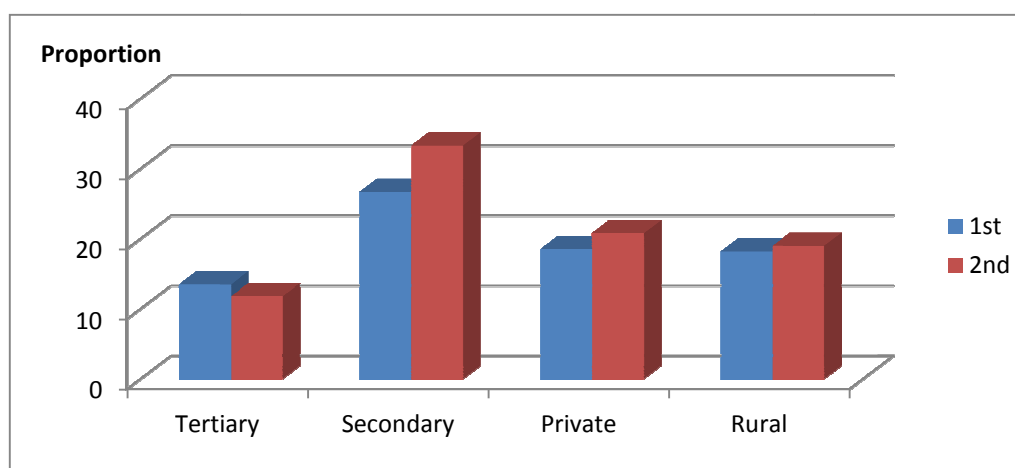
Figure 4.36. Comparison of 1st and 2nd Rotation, Ratios of Additional Comments Negative Themes

Figure 4.36. Shows changes in sector proportions of *negative* comment themes between 1st and 2nd rotations.

Of the third rotation GRNs (n = 35) who responded to the opportunity to provide *further comment* 16 were coded as either *very positive* or *mostly positive* and 13 as *very negative* or *mostly negative* (Tables 4.75 and 4.76). While Figures 4.37 and 4.38 suggest there were some differences within the ratios, caution needs to be adopted in making assumptions from these data due to the relatively smaller sample sizes of the latter rotations.

Table 4.75. Third Rotation – Sector Type, Proportion of Positive Comments

Type of Sector	Total Responders	% Positive Comment
Tertiary	19	47.4%
Secondary	5	0%
Private	4	25.0%
Rural	7	85.7%
Total	35	45.7%

Note: Includes both *very positive* and *mostly positive* comments and shows the proportion of all GNP participants within each sector type expressing positive comments in their third rotation.

Figure 4.37. Comparison of 1st, 2nd and 3rd Rotations, Ratios of Positive Themes in Relation to Additional Comments

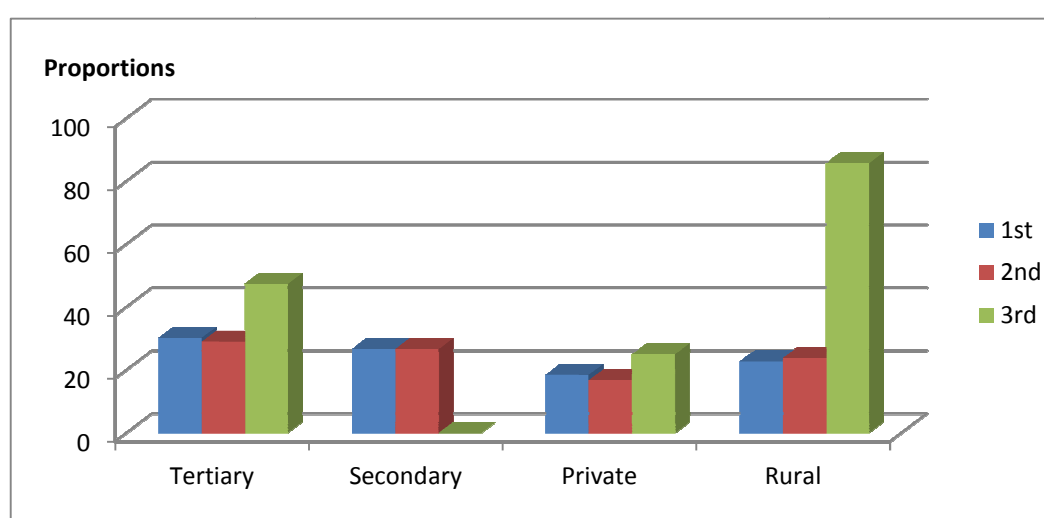


Figure 4.37. Shows changes in sector proportions of *positive comment* themes between 1st, 2nd and 3rd rotations.

Table 4.76. Third Rotation – Sector Type Proportion of Negative Comments

Type of Sector	Total Responders	% Negative Comment
Tertiary	19	36.8%
Secondary	5	40.0%
Private	4	75.0%
Rural	7	14.3%
Total	35	28.9%

Note: Includes both *very negative* and *mostly negative* comments and shows the proportion of all GNP participants within each sector type expressing negative comments in their third rotation.

Figure 4.38. Comparison of 1st, 2nd and 3rd Rotations; Ratios of Negative Themes in Relation to Additional Comments

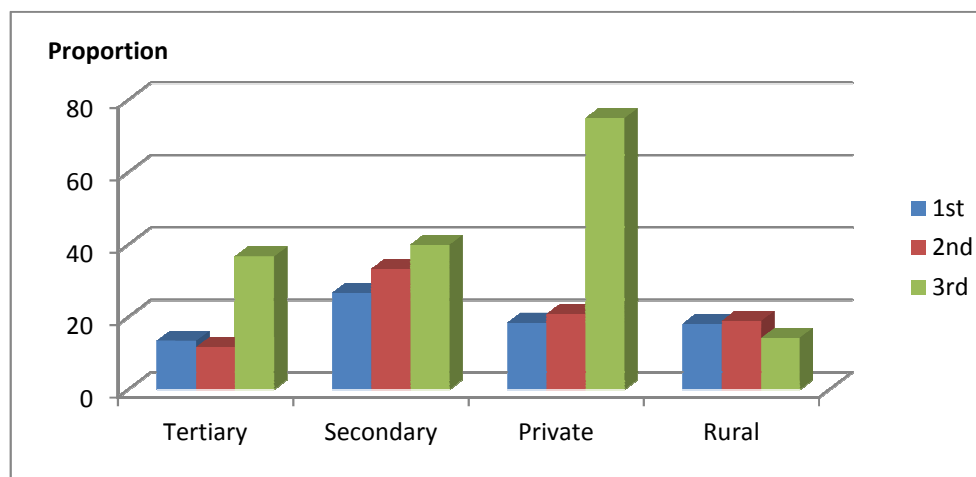


Figure 4.38. Shows changes in sector proportions of *negative comment* themes between 1st, 2nd & 3rd rotations.

4.6.4 Benefits of the Graduate Nurse Program

Respondents were asked to briefly describe what they believed were the *beneficial* components of a graduate program in facilitating their transition to the role of RN. Again, written responses were themed to quantify the components the GRNs believed to be of *benefit*. Of the 148 who responded to this question, the largest group (45.3%) indicated that *study days* were the most *beneficial*, followed by *support* (35.8%) and *educators* (20.9%). Proportions of more common themes

expressed are grouped by the employment sector to demonstrate the perceived benefits of a GNP (Table 4.77 and Figure 4.39).

Table 4.77. Benefits of GNP – Common Themes and Industry Sector

Theme	Total Responses (n = 148)	Total Response %	Tertiary (n = 87) %	Secondary (n = 14) %	Private (n = 26) %	Rural (n = 21) %
Study days	67	45.3%	47.1%	42.9%	46.2%	33.3%
Support	53	35.8%	43.7%	35.7%	26.9%	19.0%
Educators	31	20.9%	23.0%	21.4%	23.1%	9.5%
Supernumerary days	28	18.9%	17.2%	7.1%	26.9%	19.0%
Rotations	21	14.2%	11.5%	35.7%	11.5%	14.3%
Identified as GRN	12	8.1%	10.3%	7.1%	3.8%	9.5%
Mentors	9	6.1%	11.5%	7.1%	11.5%	4.8%
Orientation	7	4.7%	8.0%	0	3.8%	0
Debriefing	6	4.1%	3.4%	0	7.7%	4.8%
Grad Coordinator	6	4.1%	5.7%	0	3.8%	0
Networking	5	3.4%	3.4%	0	3.8%	9.5%
Transition	5	3.45	3.4%	0	3.8%	4.8%

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each component.

Figure 4.39. Comparison of Sector and Themes Related to Benefits of GNP

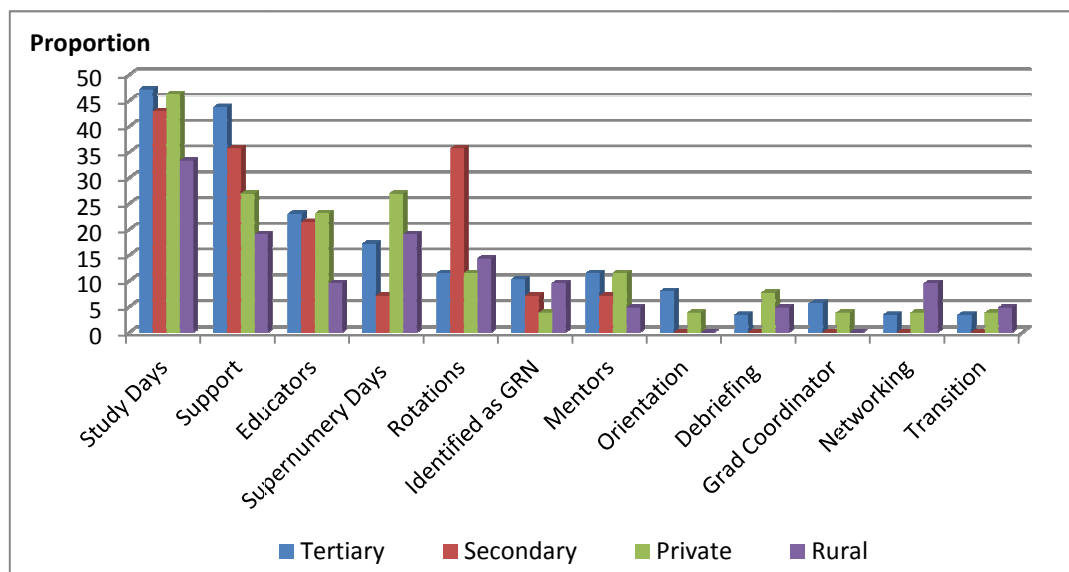


Figure 4.39. Shows proportions of themes of perceived *benefits* of GNP and organisation sector.

Respondents were asked if they believed there were any components of their graduate program they felt were *not* beneficial in facilitating their transition to the role of RN. There were 118 respondents who indicated *no*, and 50 who answered *yes*, to this question. When asked to provide details, the majority of reasons provided related to *lack of support* (36%), followed by *assignments* (32%), which included case studies respondents felt were not relevant, as well as ‘burdensome’ quality improvement projects, and a substantial clinical governance focus. A mixture of responses indicated *irrelevant* or *repetitive study days*, *staffing*, *workload* and *rotations* that were seen as non-beneficial; with each comprising a 6% (n = 3) proportion of the total *negative* responses (Table 4.78).

Table 4.78. Non-Benefits of GNP – Common Themes and Industry Sector

Theme	Total Responses (n = 50)	Total Response %	Tertiary (n = 24) %	Secondary (n = 4) %	Private (n = 11) %	Rural (n = 11) %
Lack of support	18	36.0%	29.2%	50.0%	36.4%	45.5%
Assignments	16	32.0%	20.8%	25.0%	36.4%	54.5%
Irrelevant/repetitive	3	6.0%	4.2%	25.0%	9.1%	0
Staffing	3	6.0%	4.2%	25.0%	9.1%	0
Workload	3	6.0%	4.2%	25.0%	9.1%	0
Rotations	3	6.0%	8.3%	25.0%	0	9.1%
Other	7	14.0%	29.2%	0	0	0

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each component.

The GRNs were asked how they believed the transitional program could be improved. Of the 168 respondents participating in a GNP, 47.8% either believed *no* improvement was required or did not give a response. Only slightly more (52.2%) believed there were ways the GNP could be improved. The most common theme for improvement was (more) *support* (38.7% of the total *improvement* themes) which included general, clinical and SDN support. *Program structure* (28.8%) was the next most common, with some suggesting fewer rotations, and as many proposing more; and several advocating an increase in the program length to allow additional rotations to the more specialised areas (Tables 4.79 and 4.80; and Figures 4.40 and 4.41).

Table 4.79. Improvements to GNP – Total by Industry Sector

Theme	Total Responses (n = 111)	Total Response %	Tertiary (n = 57) %	Secondary (n = 13) %	Private (n = 24) %	Rural (n = 17) %
No response	57	33.9%	43.6%	18.8%	14.3%	26.1%
No improvement	14	8.3%	6.9%	18.8%	7.1%	8.7%
Some improvement	97	57.7%	49.5%	62.5%	78.6%	65.2%
Total	168	100%	100%	100%	100%	100%

Table 4.80. Improvements to GNP – Industry Sector and Common Themes

Theme	Total Responses (n = 111)	Total Response %	Tertiary (n = 57) %	Secondary (n = 13) %	Private (n = 24) %	Rural (n = 17) %
Support	43	38.7%	35.1%	38.5%	37.5%	47.0%
Program structure	32	28.8%	31.6%	23.1%	25.0%	29.0%
Mentor training	17	15.3%	19.3%	15.4%	8.3%	18.0%
Communication	13	11.7%	10.5%	15.4%	12.5%	12.0%
Education	11	9.9%	15.8%	15.4%	4.2%	0
Networking	10	9.0%	12.3%	7.7%	4.2%	5.9%
Study Day relevance	8	7.2%	5.3%	7.7%	4.2%	18.0%
Debriefing	5	4.5%	5.3%	0	4.2%	5.9%
Feedback	3	2.7%	1.8%	0	8.3%	0

Note: Totals are not given for this table as some respondents indicated more than one theme in their response so are counted within each component.

Figure 4.40. Comparison of Sector and Proportions for GNP Improvement Themes

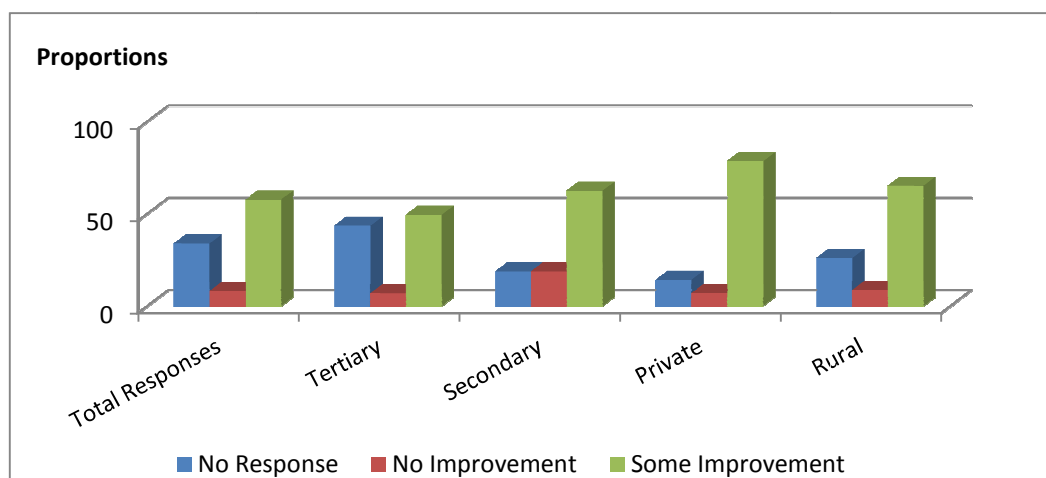


Figure 4.40. Shows organisation sector and proportions of responses related to GNP improvement.

Figure 4.41. Comparison of Sector and Themes Related to GNP Improvements

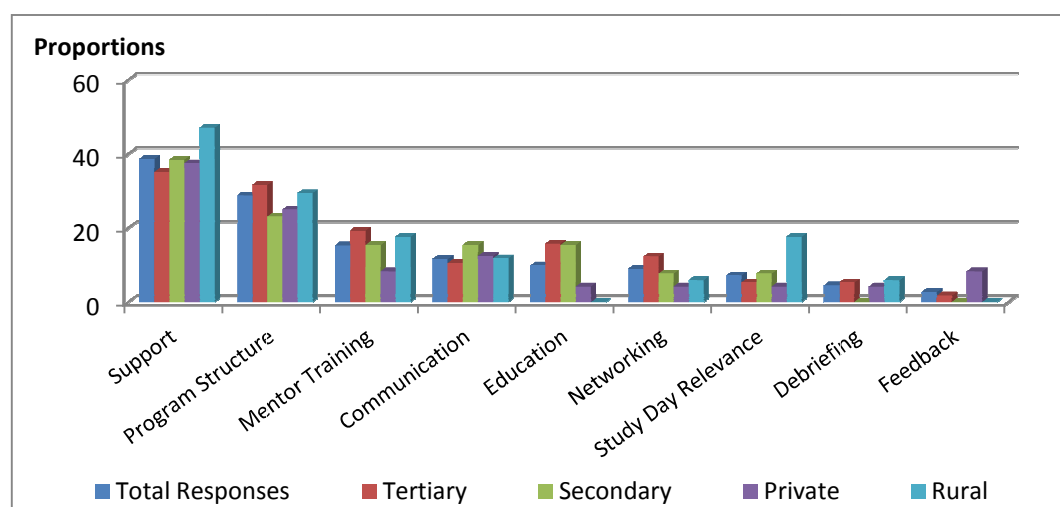


Figure 4.41. Shows proportions of themes by organisation sector and GNP improvement suggestions.

4.6.5 Formal Evaluation of Graduate Program

Four response options were offered for the question of undertaking a formal evaluation of the graduate program: *yes*, *no*, *haven't completed* (the program), or, *not applicable*. Of the 154 who responded to the question, 98 respondents (63.6%) had

completed a formal evaluation of their graduate program, 32 respondents (20.8%) had not, and 24 respondents (15.6%) had yet to finish their program (Table 4.81).

Table 4.81. Formal Evaluation of Graduate Program

Response	Total Responses (n=155)	Total Response %	Tertiary (n=89) %	Secondary (n=15) %	Private (n=25) %	Rural (n=22) %
Yes	99	63.9%	59.6%	64.0%	64.0%	72.7%
No	32	20.6%	19.1%	13.3%	28.0%	27.3%
Haven't finished	24	15.5%	21.3%	16.7%	8.0%	0
Total	155	100%	100%	100%	100%	100%

Note: Haven't Finished = the GRNs who indicated they had yet to finish their GNP, so had not yet evaluated their program.

Two responses were not included in this data as it was evident that they were both direct-entry participants into the Graduate Diploma in Perioperative Nursing that has an entirely separate governance and assessment structure to the GNP.

4.7 Graduate Nurse Program Influence on Career Pathway

Questions relating to the GRN's intentions following their transitional program were used to determine the impact their GNP experiences may have had on their future career choices.

4.7.1 Career Pathway Following Transition

Through a series of closed questions respondents were asked to indicate their career pathways following the program. The greater majority (56.4%) had stayed in either the last specialty rotation of their program, or returned to one they had experienced earlier in their program; only 14.7% indicated they had moved to a different organisation (Table 4.82 and Figure 4.42).

Table 4.82. Career Pathway Following Transition Program

Response	Total Responses (n = 150)	Total Response %	Tertiary (n = 86) %	Secondary (n = 16) %	Private (n = 25) %	Rural (n = 23) %
Last rotation	49	32.7%	34.9%	31.3%	24.0%	34.8%
Earlier rotation	40	26.7%	27.9%	25.0%	32.0%	21.7%
Same org, diff unit	28	18.7%	24.4%	18.8%	4.0%	13.0%
Diff org, similar unit	13	8.7%	5.8%	0	20.0%	13.0%
Diff org, diff unit	9	6.0%	0	18.8%	8.0%	17.4%
Other	2	1.3%	1.2%	0	4.0%	0
Non-nursing	2	1.3%	2.3%	0	0	0
Unemployed	7	4.7%	4.6%	0	0	0
Total	150	100%	100%	100%	100%	100%

Note: 'Response' column indicates where the GRN had specified was their intended career pathway following their GNP, for example, *Last rotation* means they stayed in their last specialty rotation of the program.

Diff = different; org = organisation.

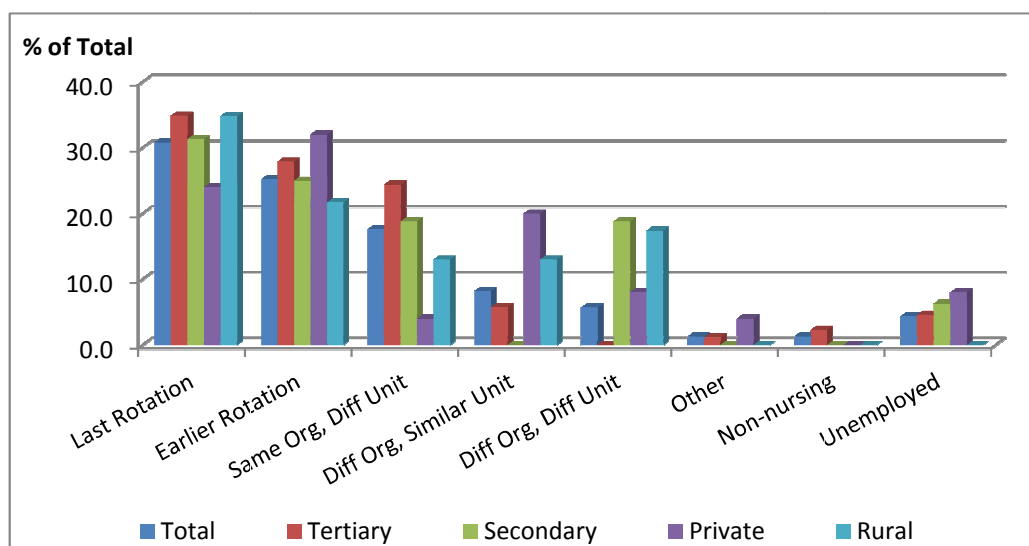
Figure 4.42. Career Pathway Following Transition Program

Figure 4.42. Demonstrates the proportions of graduate career pathway choices and Sector type.

Included in the data were three GRNs from Mental Health and two each from Aged Care and Community, some data of which has been included in other base

data, for example, *tertiary* Mental Health and *rural* Community; all seven remained within those specialties. Six percent of respondents were no longer in nursing; of those, 1.3% of were in non-nursing employment and 4.7% were unemployed.

Respondents were also asked to comment on how they felt that their graduate year experiences had influenced their choice of career path. The majority of responses were considered *positive*, particularly those from the rural sector (Table 4.83 and Figure 4.43). There were a few ($n = 5$) who indicated the Global Financial Crisis (GFC) had influenced the organisation's ability to offer them a position at the end of their program; this was most often in the private sector.

Table 4.83. GNP Influence on Career Pathway Themes

Theme	Total Responses ($n = 123$)	Total Response %	Tertiary ($n = 74$) %	Secondary ($n = 13$) %	Private ($n = 18$) %	Rural ($n = 17$) %
Positive experience	80	65.0%	73.7%	69.2%	44.4%	93.8%
Mixed experience	20	16.3%	10.5%	7.7%	11.1%	0
Negative experience	6	4.9%	7.9%	15.4%	11.1%	6.3%
GFC influence	5	4.1%	1.3%	7.7%	16.7%	0
Metro to rural	2	1.6%	2.6%	0	0	0
Pregnant	2	1.6%	1.3%	0	5.6%	0
Resigned	2	1.6%	2.6%	0	0	0
Other	3	2.4%	1.3%	0	11.1%	0
Total	123	100%	100%	100%	100%	100%

Figure 4.43. GNP Influence on Career Path Choices

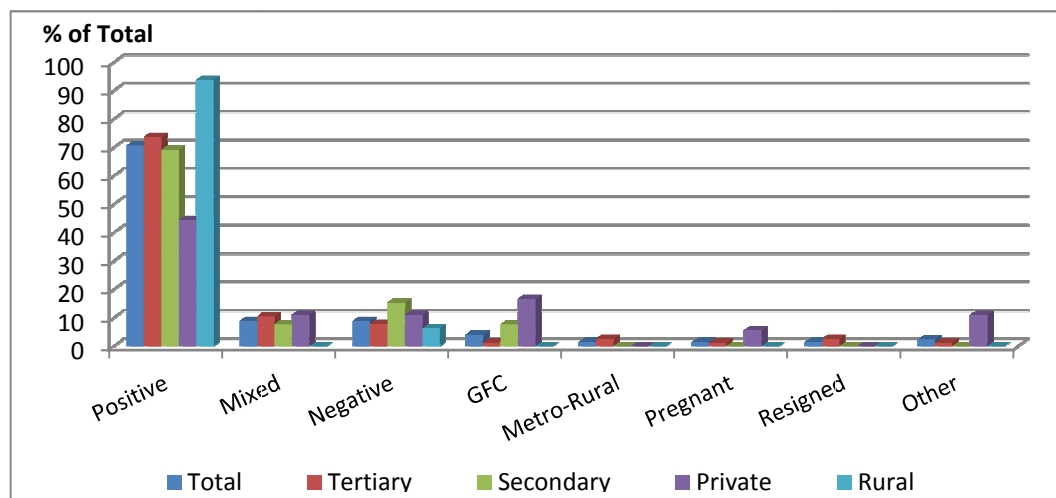


Figure 4.43. Demonstrates the sector type and the proportions of career pathways.

4.7.2 Influence of a Permanent Contract on Choice of Employment

Respondents were asked a series of questions related to an offer of a permanent contract at the commencement of their GNP, and related influences on their choice of venue for their program. Of the 165 who responded to the questions, 133 (80.6%) indicated they had been offered a permanent contract at the beginning of their program, and of these, 40.6% signified the offer had influenced their choice of sector for their transition program; 53.4% indicated that it had no influence, and the remainder did not specify either way. A further 9% indicated they had not been offered a permanent contract at the start of their employment but were offered permanency within the first year.

4.7.3 Five-year Professional Vision

Respondents were asked to indicate where they saw themselves professionally in five years' time. At least one-third saw themselves in a promotional position, with 27.5% as a Level-2 RN, 3.6% as a Senior Registered Nurse (SRN Level-3 and

above) or a Nurse Practitioner (SRN Level-7). Many planned further study (21.2%), and 2.1% planned to study for a medical degree. Almost 10% intended to pursue midwifery and 6.7% planned to work in rural areas. Equivalent proportions (3.6%) proposed to continue in either perioperative nursing or the critical care areas of ICU, coronary care, or emergency medicine. Only small numbers indicated their preference for Mental Health (2.6%) and Aged Care (2.1%).

4.8 Registered Nurse Integration, Final Comments

The final open-ended question of the survey asked the respondents if they had any further comments that may help identify how they felt about their integration into the workforce as a RN. Once more, the written responses were grouped according to the degree of *positive* or *negative* contexts, and included a *mixed* response. The individual groupings were compared in relation to the type of health care sector that the GRN worked in. There were 78 responses in total with the majority (37.2%) grouped as *positive*, and 26.9% *negative*. Where there were found to be a combination of both *positive* and *negative* comments (24.4%) the code of *mixed* was applied (Table 4.84 and Figure 4.44). The *other* comments (n = 7) were related to staffing, work-life balance and a single comment related to bullying.

Table 4.84. Further Integration Comments Related to Sector Affiliation

Theme	Total Responses (n = 78)	Total Response %	Tertiary (n = 40) %	Secondary (n = 11) %	Private (n = 14) %	Rural (n = 8) %	Other (n = 5) %
Positive	29	37.2%	47.5%	25.0%	33.3%	33.3%	0
Negative	23	26.9%	17.5%	16.7%	40.0%	66.7%	60.0%
Mixed	19	24.2%	25.0%	33.3%	20.0%	33.3%	20.0%
Other	7	9.0%	10.0%	16.7%	0	0	20.0%
Total	78	100%	100%	100%	100%	100%	100%

Note: Other 'Sector' includes GP and Community; Other 'Further Integration Theme' includes staffing, work-life balance and bullying and harassment.

Figure 4.44. Further Integration Comments Related to Sector Affiliation

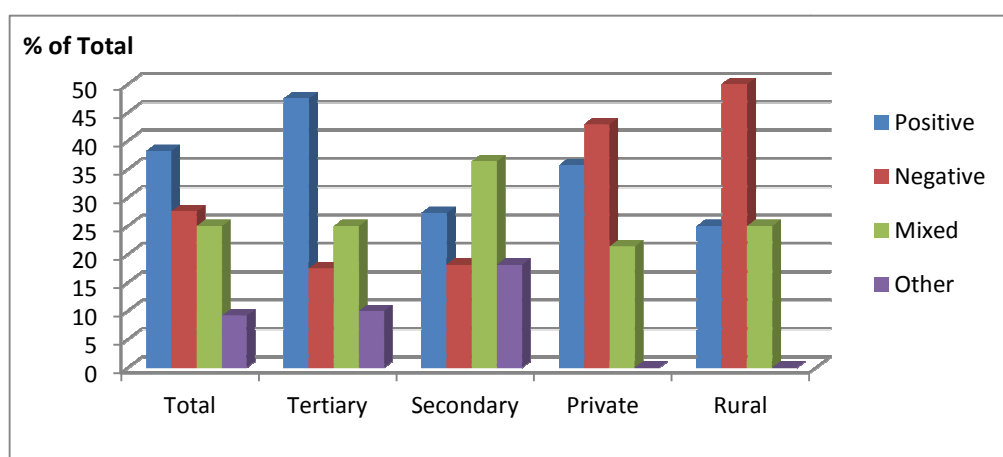


Figure 4.44. Demonstrates the proportions of further integration themes related to sector affiliation. Other 'Sector' includes GP surgeries and Community nursing.

The final *integration* comments were further interrogated to determine what relationships there were within the codes and the undergraduate university the GRN had attended for their nursing program (Table 4.85 and Figure 4.45).

Table 4.85. Further Integration Comments Related to Undergraduate University

Theme	Total Responses (n = 78)	Total Response %	Uni B (n = 35) %	Uni A (n = 28) %	Uni C (n = 10) %	Uni D (n = 3) %
Positive	29	37.2%	34.3%	46.4%	30%	33.3%
Negative	21	26.9%	22.9%	21.4%	40%	67.7%
Mixed	19	24.2%	31.4%	17.9%	30%	0
Other	9	11.5%	11.4%	10.7%	0	0
Total	78	100%	100%	100%	100%	100%

Note: Two respondents are not included in the university data as they indicated they were non-university graduates. Both were in the 50-plus age group and both gave a negative response and are included in the total. 'Other' includes a variety of comments unrelated to integration.

Figure 4.45. Further Integration Comments Related to Undergraduate University

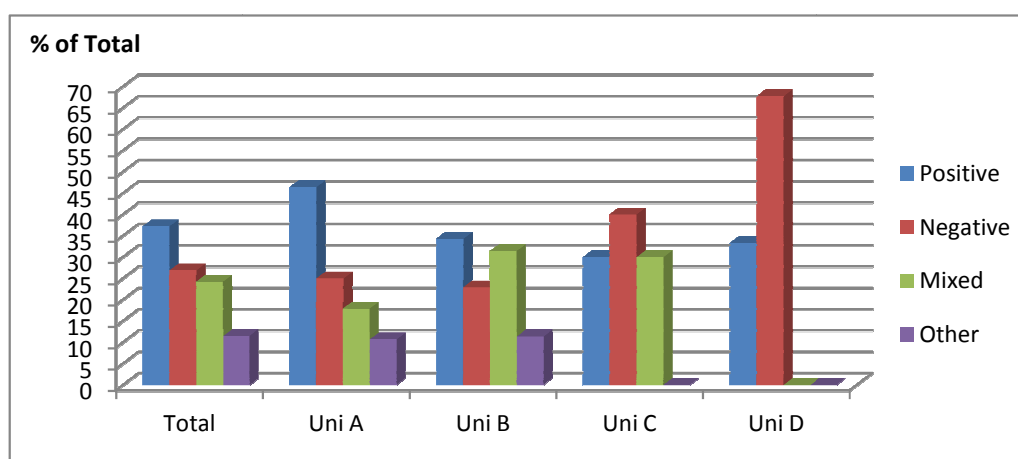


Figure 4.45. Demonstrates the proportions of further *integration* themes and affiliated university attended for undergraduate nursing program. 'Other' includes comments unrelated to integration.

As the total number of respondents from University D responding to the question regarding further integration comments was very small (n = 3) it would be imprudent to draw any conclusions from the data for that university.

4.9 Web-based Survey of Graduate Program Coordinators

When analysing the results of the newly graduated RN survey questionnaire, it became evident that elements of some questions may have been misinterpreted, such as when asked the number of graduate nurses working in a unit at the same time as the respondent. For this reason, this data has not been included in the previous section. In addition, data related to hours of work per week that would be considered full-time, suggested that the closed responses made available in the GRN survey may have been too restrictive. The secondary survey administered to the graduate nurse coordinators was incorporated, as per the mixed methods framework, to corroborate these aspects of the primary population responses. In addition, and to provide further information related to the graduate nurse transition programs within the different types of healthcare sectors, qualitative data was elicited to provide context surrounding GNP guidelines and recent, or planned amendments to their graduate nurse transitional programs. These data are presented in Appendix F.

Questions were asked that related to:

- the type of healthcare sector the respondent was from;
- the length of their graduate transition programs;
- the number of rotations within their transition programs;
- how many graduates would be assigned to an individual unit;
- the ratio of graduates to RNs on a typical ward or unit;
- the number of hours per week that the GRNs were typically contracted;
- levels of support available for the GRNs; and,
- number of graduates for which each support person was responsible.

4.9.1 Graduate Nurse Coordinators Survey - Quantitative Data

A total of 21 respondents of a possible 48 returned data, a response rate of 42%. One response appeared to be from a current graduate and so was withdrawn from the sample, giving a total of 20 graduate nurse coordinator respondents. The quantitative data indicates the sector origin of the responders; the length of the graduate program; number of specialty rotations; hours worked; maximum number of graduates per unit; graduate to RN ratio in a unit; and, the number of hours considered to be full-time (Tables 4.86 through to Table 4.90).

Table 4.86. Number of Organisations Indicating Graduate Program Length

Program Length	Metro Tertiary	Metro Secondary	Metro Private	Large Rural	Small Rural	Mental Health
6-12 months						1
12 months	1	4	1	3	2	
12-18 months	3		1	2		
24 months	2					
Total	6	4	2	5	2	1

Table 4.87. Specialty Rotation Length and Number by Organisation Sector

Number of Rotations	Metro Tertiary	Metro Secondary	Metro Private	Large Rural	Small Rural	Mental Health
2x3 + 1x6 months		2				
2-4x3 months						1
2x6 months + options	4	2	1	1		
4x6 months	2					
3x4 months			1		1	
Various - 7 rotations				4	1	
Total	6	4	2	5	2	1

Note: 2x3 + 1x6 months indicates there are two rotations of three months in length plus one rotation of six months.

Table 4.88. Full-time Hours by Organisational Sector

Full-time Hours	Metro Tertiary	Metro Secondary	Metro Private	Large Rural	Small Rural	Mental Health
40 per week	5	2		4	1	
38 per week		1	1	1		1
37 per week	1	1				
35 per week			1			
32 per week					1	
Total	6	4	2	5	2	1

The 32-hours per week indicated as full-time for the small rural sector is problematic as this amount of time is generally considered to be part-time hours. It is possible that the respondent was providing hours for a current graduate and did not fully understand that the request for what would normally be considered full-time hours.

Table 4.89. Number of Graduates per Unit by Organisational Sector

Number GRNs/Unit	Metro Tertiary	Metro Secondary	Metro Private	Large Rural	Small Rural	Mental Health
Max 7	1					
Max 5	3					
Max 4	1		1	3		
Max 3	1	3				
Max 2		1	1	2	1	1
Max 1					1	
Total	6	4	2	5	2	1

Note: This number may, or may not include Graduate Enrolled Nurses as well as GRNs in the 'Total Graduates'.

Table 4.90. GRNs per Unit and Ratio to Other RNs

GRN : RN Ratio	Metro Tertiary	Metro Secondary	Metro Private	Large Rural	Small Rural	Mental Health
1:1		1			1	
1:3	1	2	1	2		
1:4		1		3	1	1
1:5	3					
1:6	1					
1:10	1		1			
Total	6	4	2	5	2	1

Note: 1:1 means there is one GRN to one other RN in a unit at a time; 1:3 means there is one GRN to three RNs.

4.9.1.1 Graduate Support

Various categories of support roles were identified in the web-based survey and the responders were asked to indicate the Australian Nursing Federation Award (Australian Nursing Federation [ANF], 2010) salary level to determine the seniority of the personnel, and the number of graduates they were primarily responsible for. The majority (68%) of Graduate Coordinators were SRNs, with all tertiary, two of three secondary, one private and three of five large rural organisations indicating thus. One of the large rural and the remaining secondary and private organisations indicated the presence of a Staff Development Educator (SDE) at the same SRN level. A large rural, and one small rural, indicated the SDE to be Level-2, a level normally affiliated with the SDN position. All except the large rural organisation with the Level-2 SDE indicated the presence of a Level-2 SDN. It is possible that the role title of the large rural SDE may be incorrectly described by either the respondent, or the organisation. Only three tertiary hospitals indicated deploying a *clinical coach*, a relatively new role in the process of being assessed with a view to formalising the role in the future. It was evident, however, that two of these three

tertiary hospital respondents were from the same organisation. The *clinical coach* is discussed further in the following chapter. All respondents indicated the use of the *preceptor* role, with the majority (53%) performed by Level-1 RNs and only two indicating a Level-2 RN was the preferred designation.

4.10 Summary

This chapter has presented the results of both the primary postal survey questionnaire that was administered to the newly graduated RNs, and the second smaller, web-based survey of the graduate nurse coordinators. In the following chapter, the primary data from the newly graduated RN survey questionnaire, and the data from the web-based survey of the graduate nurse coordinators have been further integrated to provide a comprehensive description of graduate RN transition programs within a Western Australian context.