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A case study of factors influencing remote university nursing graduates and their decision to work in a remote hospital

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Abstract

The health of the rural population in Western Australia (WA) is predicated on equity and access to healthcare facilities with nurses being the main component of front line staff. There continues to be a nurse shortage particularly in remote regions of Australia where the poor health status of Australian Indigenous people, and an increasing ageing population are a perennial problem. The Kimberley, the setting for this study, is a remote region in the north of WA. It has a landmass of 423,517 square kilometres with a significantly low-density population compared to the total WA population. Nearly half of the Kimberley population is comprised of Indigenous peoples. Broome is the largest town in the Kimberley with a population of 14,997 and is the location of the University of Notre Dame Australia, Broome Campus School of Nursing and Midwifery. Strategies to encourage nurses to work in the region are crucial to the health of the local population. Recruitment from outside the area provides short-term relief, but providing nursing education within this remote region may well provide a more self-sufficient, sustainable workforce.

This study explored and described the factors that influenced remote school of nursing graduates from the University in their decision to work in a Kimberley hospital. A single, exploratory, descriptive case study was chosen to underpin the framework of this study with decision-making theory providing a theoretical perspective. This approach enabled an in-depth exploration of the phenomenon and the context. In keeping with the principles of a case study approach to qualitative methodology, there were several sources of data collected from graduates, workforce nurses, nurse managers, documents and a promotional DVD. Collection of data and analysis was a continuous iterative process with themes and patterns emerging until the point of saturation was established.

The findings of this study revealed multiple, complex and interrelated influencing factors. Three major themes emerged from the analysis of data: Local exposure, personal factors and professional factors. These influences were further delineated into enabling, or inhibiting influences but it was local exposure that underpinned all factors. It was the balancing of these opposing issues that ultimately led to the graduate's final decision.

Declaration

I declare that except where due acknowledgement has been made this research thesis is my own work and has not been submitted in any form for another degree at any university or other institution of tertiary education. To the best of my knowledge, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signed
Sally Clark

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Thanks are also extended to the participants of this study, the graduates, nurses and managers. I hope many of you will be involved with the implementation of some of the recommendations.

Chapter 1
Introduction

This study was set in the remote Kimberley region of Western Australia (WA) and explores the factors that influenced the decision of nurse graduates from Notre Dame Broome Campus to work in hospitals in the Kimberley. This introductory chapter provides the foundation for the study and details the arrangement of future chapters.

Overview of the problem under investigation

Population growth within regional and remote areas of Australia and an ageing workforce are factors that continue to have an increasing demand on the employment of nurses. Challenges in recruiting and retaining nurses into regional and remote areas are not specific to Australia (Humphreys, Wakerman, Pashen & Buykx, 2009; Kenny & Duckett, 2003; Neill & Taylor, 2002). Within the next ten to fifteen years, however, the shortage of nurses in these non urban areas could reach a crisis point (National Health Workforce Taskforce, 2009; Health Workforce Australia [HWA], 2012). Factors that are intrinsic to this problem include the poor health status of Australian Indigenous people, an increasing ageing population and as a corollary an ageing nursing workforce (Hegney, McCarthy, Rogers-Clark & Gorman, 2002; Lenthall et al., 2011; National Health Workforce Taskforce, 2009; Preston, 2009).

Nurse shortages in regional and remote areas are a global phenomenon with a crisis predicted in the next 25 years. Recruitment of nurses from outside the region provides short-term relief as nurses leave these areas. Given the ongoing problem of nurse shortages in the regional and remote regions of Australia there is a growing need to improve recruitment and retention strategies (Bushy, 2002; Courtney, Edwards, Smith & Finlayson, 2002; Hegney et al., 2002; Lenthall et al., 2011; Preston, 2009).

Several strategies have been employed in addressing the issue of recruiting and retaining nurses in regional and remote areas in Australia, Canada and the US. These have included financial incentives, bonded scholarships, housing subsidies,

increased professional development, and advertisements about the regions local tourist attractions (Bushy, 2002; Hegney et al., 2002; Huntley, 1995; Miller, 2011; Rogers, Searle & Creed, 2010). These strategies, however, have yet to prove successful.

Recruitment of nurses into rural areas from the local population is considered a viable strategy to address the nursing shortage. This strategy enables the opportunity for residents to gain pre-registration nursing qualifications in their local community (Lea, Cruikshank, Paliadelis, Sanderson & Thornberry, 2008; Nugent, Ogle, Bethune, Walker & Wellman, 2004). There is growing evidence that providing nursing education within rural areas may well provide a more sustainable workforce (Playford, Wheatland & Larson, 2010; Wood, 1998). It is mooted that a self-sufficient nursing workforce in these non urban regions could partway assist in solving the problem of nurse shortage. Self-sufficiency, where net movements are close to zero, could reduce the reliance on recruitment outside the region.

It has been identified that completing part of a nursing program in a rural setting is an effective workforce strategy in both Australia and the US (Playford et al., 2010). Studies have not delineated between regional or remote areas and analysis of the research has shown that the settings have been in large inner regional areas or outer regional areas (Birks, Al-Motlaq & Mills, 2010, Gum, 2007; Playford et al, 2010). Given that there are differences in healthcare provision and education opportunities between regional and remote towns and communities, it appears pertinent to make an investigation specific to a remote area. Paucity exists in the literature on graduates from nursing schools in remote areas.

Since 1999, Notre Dame Broome Campus has offered pre-registration nursing programs, in an attempt to improve access to tertiary education for people in the remote region of the Kimberley. Prior to this study it was not known how many graduates from the University pursued employment in Kimberley hospitals, nor the factors that influenced their decision to stay or leave the region.

It was the researcher's knowledge of the recruitment and retention issues within the nursing workforce in the Kimberley, together with an increasing concern

regarding meeting the healthcare needs of the community, which led to this study. The researcher has worked as a nurse and midwife in various hospitals within the region for 25 years and in addition has undertaken several roles at Notre Dame, Broome for the past 11 years. These roles have included sessional lecturing, clinical coordination, program development, and course coordination. It could be argued that the researcher's role during this study was prejudiced, but concern for quality healthcare for people in the remote Kimberley area was the impetus for this study. Additionally, use of reflexivity and dialogue with others minimised potential biases.

Aim

The aim of this study was to explore and describe the factors that influenced remote school of nursing graduates in their decision to work in a Kimberley hospital in the remote region of WA.

Objectives

The objectives addressed in this study were:
- To describe the demographic characteristics of nursing graduates and their connections to living in a remote area;
- To describe the factors that influenced nursing graduates to seek employment in Kimberley hospitals;
- To describe what factors influenced the Kimberley nursing workforce and their choice to work in a Kimberley hospital;
- To determine if nurses in hospitals in the Kimberley considered graduates from Notre Dame, Broome to be prepared for work in Kimberley hospitals and whether there was sufficient professional development to support them;
- To describe the factors that nurses, and nurse managers in Kimberley hospitals considered might influence Notre Dame, Broome nursing graduates to work in a Kimberley hospital.

Significance of the study

This study is the first to focus on graduates from a remote university school of nursing and the factors influencing their decision to work in a hospital in a remote area. Whilst other studies in Australia have focused on the effect of attending clinical

placement in a rural area, they have not differentiated between regional or remote settings. Neither have they investigated whether students from urban backgrounds attending study, or clinical placement, have been recruited into a hospital in a remote area. Thus, the findings from this study could have significant implications for healthcare agencies recruitment and retention strategies.

Further, this study has relevance to other remote areas attempting to address nurse workforce shortages. Additionally, it will provide relevant information to policy makers to consider adjusting the current nursing workforce model to suit remote areas. The model would have implications for an appropriate nursing skill mix and educational support. The findings could also have an effect on shaping future policy and funding to rural tertiary education campuses in Australia, and nursing recruitment into regional and remote healthcare agencies.

Summary and thesis structure

This chapter has provided an introduction to the study. It discussed the problem underpinning the study together with its aim, objectives and significance. The brief background introduced in this chapter is further explored in chapter two, where the geographical location and context of the study is presented. This study hinges on an understanding of remoteness; the difference between regional and remote contexts and the challenges isolation presents to the healthcare workforce in particular the recruitment of graduate nurses. As such, an explanation of the various classification systems used in Australia to define remoteness, are discussed.

The context will also cover the provision of pre-registration nursing education in remote areas of Australia as well as describing the Kimberley nursing workforce. An explanation of the curriculum Notre Dame, Broome School of Nursing and Midwifery uses is also provided.

Chapter three provides a comprehensive overview of the literature surrounding the nursing workforce shortage in Australia, with a particular focus on the challenges to recruitment and retention in non-urban areas. The literature rarely differentiates between rural and remote, rather it discusses rural and remote together

under the term rural. This has the potential, for an undiscerning reader, to assume that there is little difference between a rural or remote setting. Highlighted is the paucity of literature addressing recruitment and retention challenges for remote areas, as is the lack of literature on what influences a graduates decision to work in remote nursing. The final part of this chapter discusses the theory of decision–making as it was considered a theory that could highlight underlying factors that influenced graduates to work in a remote area of Australia.

Chapter four presents the methodology of the study, including the case study approach and rationale for its use. Details of the design, data sources, sampling and recruitment processes and the steps taken for data analysis are also provided. The following diagram (Figure 1.1) illustrates the data collection process and timeline which is described in more detail in chapter four.

Week 1

Ethics approval gained
Participants contact
details collated

Week 2

Information sheets

Consent forms

Questionnaires

Sent to potential
participants

Weeks 3 - 16

Consent forms and
questionnaires coded
and catalogued

Data from
questionnaires
entered into Excel

Interviews scheduled

Interviews conducted

Weeks 8 - …

Interviews transcribed

Analysis commenced

Documents and DVD
reviewed

Figure 1.1 Data collection process

As demonstrated in Figure 1.1 the data collection process commenced immediately after ethics approval. Questionnaires and interviews were conducted during the researcher's 6 months sabbatical. Transcription and analysis of this data was intertwined with data gathered from all participants, documents and a promotional DVD. The methodology chapter concludes with the steps taken to ensure rigour, along with ethical considerations and the process used for approval to undertake the study.

Chapter five details the findings of the study. It discusses these in relation to the four distinct data sets; graduates, workforce nurses, nurse managers and archival documents including a promotional DVD. Findings from the graduates are juxtaposed with the remaining data sets. A synthesis of the findings concludes the chapter.

Chapter six brings the thesis to a conclusion. It discusses the findings in relation to the literature identified in chapter three together with current studies, which assist in interpretation from a holistic perspective. The decision-making theories form part of the concluding chapter. It closes with the study's limitations and recommendations.

Conclusion

This introductory chapter has provided the prologue to the thesis. It identified the problem of nurse shortage in remote areas and has portrayed the aim, objectives and significance of the study. Since this is a qualitative study the following chapter will discuss the context surrounding the influences on graduates decision to stay, or leave the Kimberley. The context is an important component of case study research, it provides the situation and background to the phenomenon in question (Yin, 2014).

Chapter 2
Background and context to the study

Introduction

This chapter introduces the geographical location of the study and sets the scene for the context of the study. The concept of remoteness, the nursing workforce and the provision of pre-registration nursing education in remote areas of Australia will be elucidated. Since the focus of the study are the graduates from Notre Dame, Broome School of Nursing and Midwifery, explanation about the curriculum is also provided.

The location of the study

The Kimberley is a region in the north of WA and is the setting for this study. The region has a low-density population and covers a landmass of 423,517 square kilometres, which is approximately 3 times the size of England. In 2013, the population of the Kimberley was nearly 39, 900, which was 2% of the total WA population (Government of Western Australia Department of Regional Development, 2014). Currently, the population growth rate in the Kimberley is 2.5% in comparison to the rest of WA, which is 1.4% (Kimberley Australia, 2014). Notably, 43.5% of the Kimberley population is of Aboriginal and Torres Strait Islander origin, with parts of the population living in communities with as few as 50 residents (Australian Bureau of Statistics [ABS], 2011a). The region also has a large transient population, with an extensive increase during tourist season. Visitors to the Kimberley exceed 340, 000 per annum (Kadar, Pearson & Partners, 2009). Broome is the largest town in the Kimberley and has a population of 14, 997 (42% of the total Kimberley population) and is the location of the University of Notre Dame, Australia, Broome Campus.

The Kimberley comprises areas that are considered remote and very remote (Australian Government Department of Health [DoH] 2015; ABS, 2011a). Studies of people living in regional and remote areas of Australia revealed that; compared to people living in urban areas they have poorer physical and mental health and lower levels of education as a consequence of reduced access to medical care and educational facilities (Australian Institute of Health and Welfare [AIHW], 2014;

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National Rural Health Alliance, 2013). The level of health is also known to decline relative to remoteness and a further subsequent reduction in healthcare availability (DoH, 2008; Miller, 2011). Quantifying these differences and providing relevant resources relies on an understanding of the concept of remoteness and a system to enable comparison of the data collected.

Defining remoteness

Distance is central to the concept of being remote. The Oxford Dictionary provides a definition of remote as "far away in place or time: out of the way: situated from main centres of population, society etc" (Remote, 2004, p. 1195). Living in a remote area means being part of a sparsely distributed population and a long way from services. Remote communities have been defined as, "spatially defined communities which are distant from urban centres where supplies of goods and services, and opportunities for social interaction are concentrated" (Faulkner & French, 1983, p. 3). The term distance requires further explanation. It can mean different things to people who live in remote areas. Distance when measured, in a straight line, as the "crow flies" (The phrase finder, 2015) or by driving on bitumen roads can be quite a different concept to a remote community where travels on dirt roads that are inaccessible during the wet season are the only means of access.

The Kimberley region experiences a tropical monsoon climate and is separated into two seasons, the dry season from May to August and the wet season. During the dry season daily temperatures are usually between 25 – 30 degrees centigrade. During the build up to the monsoonal rains the temperature and the humidity increase. Cyclones are known to occur from November through until April, when the daily, average temperature increases to above 30 degrees centigrade. Extensive rainfall, at times in excess of 200mm per day increases the amount of water in the rivers and creeks causing swift torrents over the roads making them impassable to all traffic. As perishable goods and other groceries are delivered by road train, it often means towns and communities in the Kimberley have few supplies during the wet. It is the degree of accessibility to overcome the distance that is important to those living in remote communities and defines their concept of remoteness; not just the distance measured in kilometres between towns.

There have been a number of different models to conceptualise remoteness. These different models can be divided into two main approaches. The first is a sociological approach that concentrates on the socioeconomic characteristics of a population that impact on access to goods and services. The second is a geographical approach that defines remoteness in terms of physical distance with the major focus being on distance affecting social interaction (ABS, 2011b; Kaltenbrunner, Volkovich, Currie, Jutemar, Scellato, Laniado & Mascolo, 2012). The literature argues that socioeconomic disadvantage can greatly exacerbate locational disadvantage by reducing mobility (Ryan & Whelan, 2010). In order to study the relationships between distance and socioeconomic status the ABS (2011b) adopted a geographical model to define remoteness.

There is little consensus in the literature with the use of the terms rural, regional and remote. Commonly the term remote is subsumed into rural or included as an addition to regional even though there is clear distinction between regional and remote areas according to classification systems, healthcare, education and resource allocation. A shared definition would be helpful for applicability of research findings to remote areas to be able to determine difference which in turn could lead to appropriate policy development, planning and resource allocation. The most commonly discussed geographical classification systems in Australia include: The Rural, Remote and Metropolitan Area; the Australian Standard Geographical Classification (ASGC); the Accessibility/Remoteness Index of Australia (ARIA); and the Remoteness Area Structure (ABS, 2011b).

The Department of Primary Industries and Energy and the, then, Department of Human Services and Health developed the Rural, Remote and Metropolitan Area classification system in 1994 (AIHW, 2015). The system was based on Statistical Local Areas. These areas were allocated to a category based on population numbers and an index of remoteness. The index of remoteness was based on population density and the distance to a centre with a population of 10,000 or more (AIHW, 2015). Australia was separated into seven categories, 2 metropolitan, 3 rural and 2 remote areas, however, anomalies were noted in this system. Both the size of Statistical Local Areas and the distribution of the population within them varied. This meant, for example, that within a remote Statistical Local Area there could be

pockets that were rural rather than remote, and vice versa (AIHW, 2015). The outcome for resource allocation and policy development was the potential to either favour or disadvantage an area.

In the late 1990's, the Commonwealth Government agency determined a need for a better definition process for remote areas. A review of the Australian Standard Geographical Classification system by the ABS, considered the issue of remoteness. At the same time the then Commonwealth Department of Health and Aged Care commissioned research into the development of a geographic measure of remoteness by the National Key Centre for Social Applications of Geographic Information Systems.

The result of the consultation process was the creation of the ARIA (ABS, 2001). This system classified remoteness in a physical, geographic way and was constructed on a continuous measure of remoteness based on terms of accessibility and distance by road. An index score between 0 and 12 was assigned by population and distance to service centres, such as health and social services. Any site in Australia could then be attributed an ARIA score. These scores were then further grouped and classified as: highly accessible, accessible, moderately accessible, remote, and very remote depending on the ARIA index it was assigned (AIHW, 2004).

In 2001, the ABS released the Australian Standard Geographical Classification Remoteness Area Structure (AIHW, 2004). According to ABS (2011b) this particular remoteness structure was designed as a reference to interpret the geographical context of ABS statistics. The system was based on an extended model of the ARIA and became known as ARIA+, which had scores of 0 to 15. These scores are defined after each census collection, providing an opportunity to evaluate population changes (ABS, 2012).

The terms regional, rural and/or remote, in previous studies, has been a confusing issue, thus, it was important to define the terms for this study. For consistency the ASGC Remoteness Areas structure that uses the ARIA+ scoring system, was used to measure remoteness (DoH, 2015). Australian Standard

Geographical Classification -Remoteness Area scores of RA4 (labelled Remote) and
RA5 (labelled Very Remote) were classified together and are referred to as remote
areas. Inner Regional (RA2) and Outer regional (RA3) were classified together and
are referred to as regional areas. Major cities (RA1) are referred to as Metropolitan,
City or Urban areas (see Figure 2.1). Throughout this study when referring to
Broome and the Kimberley, the term remote is used. In the literature, however, rural
and remote are characterised as the same entity, which has led to much confusion
with respect to studies related to this thesis.
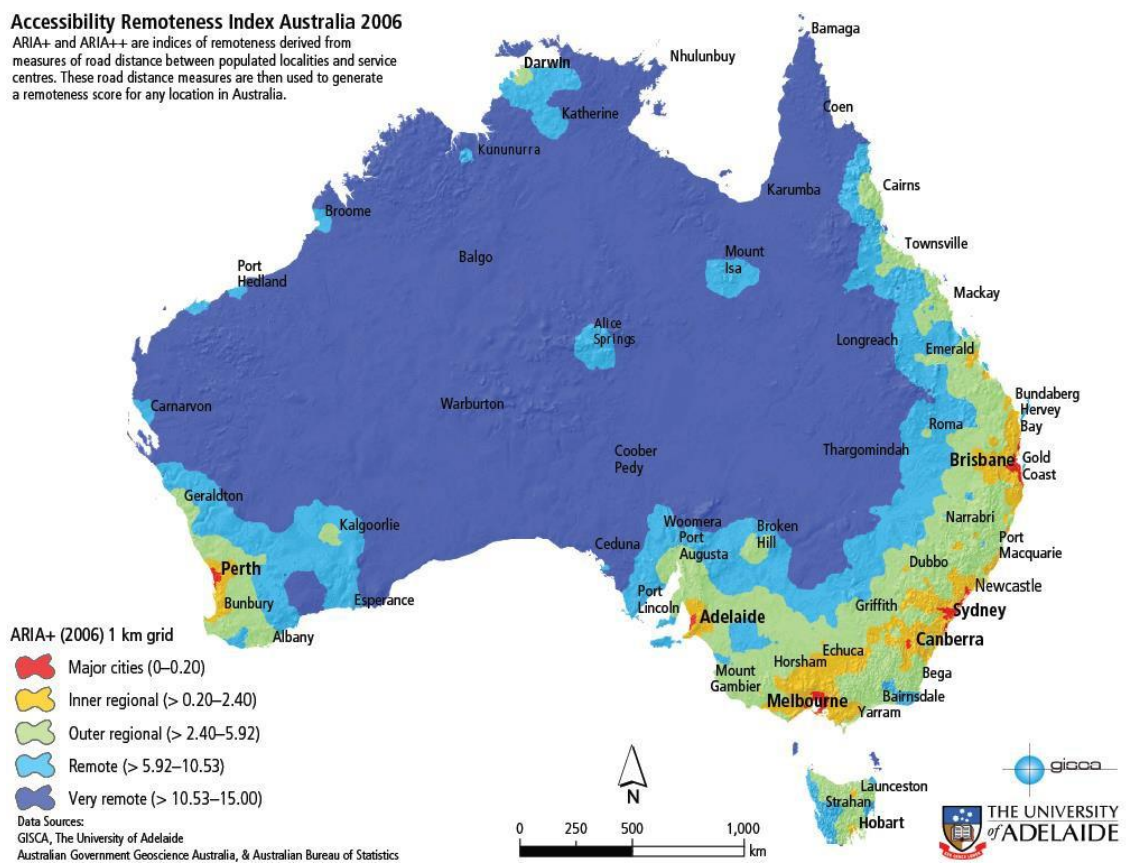
Figure 2.1 Accessibility Remoteness Index Australia

The map of Australia (Figure 2.1) identifies very remote, remote, outer
regional, inner regional and major city areas according to ARIA+ and the ASGC
classification system. The areas in red are the major cities, yellow and green the
regional areas and remote and very remote regions of Australia are light and dark
blue. The map highlights the notion of remoteness illustrating the distances between
remote areas, towns and cities. It clearly identifies the south west of Australia and the

Eastern seaboard as containing the most regional and urban areas of Australia. In Western Australia remote areas stretch from Geraldton in the south, to Kununurra in the north. In particular, the distance between Perth, the capital city of Western Australia, and Broome is clearly demonstrated. Thus, this study highlights the separation of rural and remote concepts since peoples' experiences differ. For example the distance between Perth, and Bunbury - an inner regional centre considered rural, is 172kms, and both towns have a university school of nursing. When the term rural is used there are differences in for example resources commodities and healthcare services. Broome whilst being rural needs to be considered very remote, owing to the distance (2240 kilometres) from the capital city.
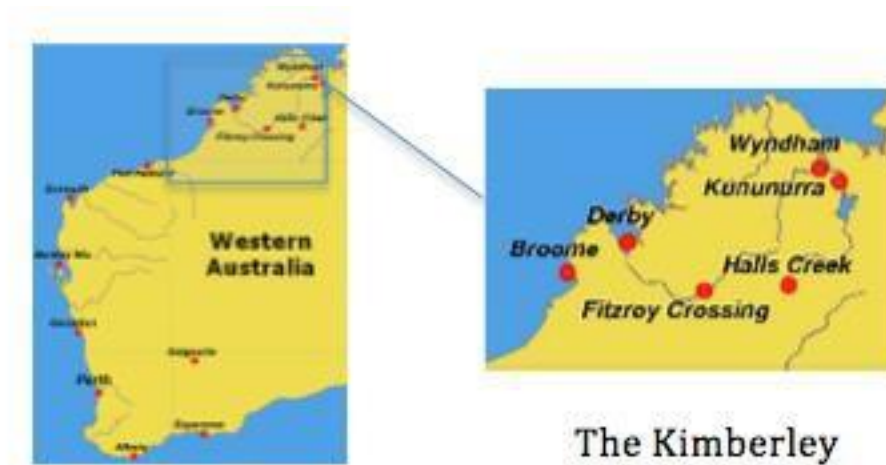
Figure 2.2 Towns in the Kimberley (Kimberley Australia Travel guide, 2015)

The Kimberley region is located in the Northwest of WA with Broome being situated on the coast of the Indian Ocean (see Figure 2.2). As can be seen in the above maps the Kimberley has six towns. Two of the towns, Broome and Kununurra are considered remote and the four towns Derby, Fitzroy Crossing, Halls Creek and Wyndham are considered very remote (AIHW, 2004; DoH, 2015). In addition there are also over 150 Aboriginal communities (not identified on the map), which are significant in terms of potential patients and clients that access the healthcare services in Kimberley towns. All Aboriginal communities are situated in very remote areas.

The Kimberley region has a higher level of people living with disadvantage compared to other regions in Australia. In 2011 the Socio-Economic Indexes for areas (SEIFA) within the Kimberley were all below 1000. The SEIFA are calculated from responses to the ABS Census and a score below 1000 indicates an area of relative disadvantage. At least one third of people living in the Kimberley live in areas with scores in the lowest 10% in Australia (ABS, 2011c). Notably the more disadvantaged an area the higher the risk factors for ill health and self-reported ill health (ABS, 2008).

Mining, tourism, construction and agricultural production are the major contributors to the economic output of the Kimberley region (Kimberley Australia, 2014; Government of Western Australia Kimberley Regional Development, 2014). The three biggest employment industries are: health care and social assistance; public administration and safety; and education and training. Most mining industry workers fly-in-and-fly-out to their homes in other parts of WA between work commitments.

Remote healthcare practice in Australia can be defined as having the following characteristics: geographical and social isolation; a multidisciplinary approach; high level of skill in public health, emergency and extended clinical skills suited to a cross cultural context; providing a service to small, dispersed and highly mobile populations with high healthcare needs (Wakerman, 2004). Healthcare provision in remote Australia is provided through clinics and hospitals. These institutions provide primary healthcare and acute services (Taylor, 2008). Services are provided through a range of funding providers including Federal, State, Territory Government or Non Government Organsations. Regional and individual Aboriginal Community Controlled health services and private aged care providers also provide healthcare services (Taylor 2008).

The hospitals in the Kimberley have been designed to respond to the lack of private general practices in the region. This accounts for the large number (75%) of emergency department attendances being classified as semi or non-urgent (triage 4 or 5). This proportion is more than 10% higher than the overall number of all Western Australian Country Health Service (WACHS) sites. The large influx of tourists

during the cooler months of the year, is in excess of 300,000 (Kimberley Health Profile, 2015). This number of people increases the workload of healthcare professionals and pressure on the regions healthcare services.

The size of the hospital facility, in each of the towns, reflects the population catchment area and range from an eight bed inpatient facility in Wyndham, to a 57 bed inpatient facility in Broome (Government of Western Australia Department of Health [WADoH], 2012a). A number of services are provided at each hospital and include: a multidisciplinary group of health professionals; a Day Hospital; Accident and Emergency unit; High Dependency Unit; Maternity Unit; Medical Imaging; Mental Health; Paediatrics Unit; Palliative Care; and Specialist Outpatient Clinics. Operating theatres are available in Kununurra, Broome and Derby (WADoH, 2012b). The Paediatric and Mental Health wing are discrete areas at Broome hospital as this is the regional health campus. In addition to these services a number of health clinics are spread throughout the Kimberley. Tele-health, and visiting medical and nursing staff specialists, provide a range of services which complement the care provided by the clinic nurses and Aboriginal Health Workers. When necessary patients are flown to Perth or Darwin for specialist treatment that cannot be provided by regionally based services or visiting specialists (Consumer health services directory, 2012).

Nursing workforce

Human resources for regional and remote healthcare have been noted as entering a critical period from a global, national and state perspective (Buchan & Aiken, 2008; Bushy, 2002; Duffield & O'Brien-Pallas, 2002; Smith, 2008). In 1999, the Australian Commonwealth Government health policy clearly indicated that strategies to encourage healthcare professionals to work in regional and remote areas were crucial to the local population (Healthy Horizons, 1999). In 2007 the then Prime Minister requested the Department of Health and Ageing (DoHA) to undertake an audit of the healthcare workforce, in regional and remote Australia with the aim of identifying where shortages existed (DoHA, 2008). The audit provided confirmation of previous anecdotal comments that the number of healthcare professionals working in regional and remote areas was insufficient to meet the

healthcare needs of the community.

In a workforce with limited supply of other health care professionals, nurses form the major professional group and are often the first point of contact in remote healthcare services (Burley & Greene, 2007; Lenthall et.al, 2011). Nationally, nurses are the largest profession in the healthcare workforce. In 2012, this number represented 60% of the entire professional healthcare workforce (DoHA, 2008; AIHW, 2014; Nugent et al., 2004). This is nearly three times as many as that of the next largest profession, medical practitioners (AIHW, 2014).

In Australia nurses working in remote areas are often described as RANs (Remote Area Nurses). The context of practice for a RAN most closely resembles the role of nurses in a primary healthcare clinic in a remote, or very remote region of Australia (Lenthall et al., 2011). There are, however, nurses who work in other settings including hospitals in remote and very remote areas of Australia. It is these nurses that are the context of this study.

Nursing education and registering authorities

The Nursing and Midwifery Board of Australia (NMBA) is the registering authority and accredits courses of study. It developed standards, codes and guidelines for nursing and midwifery (NMBA, 2015a). The Australian Health Practitioner Regulation Agency (AHPRA) manages the registration and renewal process for all nurses working in Australia (AHPRA, 2015). Accreditation by the Australian Nursing and Midwifery Accreditation Council (ANMAC) is required of all courses leading to nursing registration to ensure academic quality, public accountability and public safety. Once accreditation has been confirmed the NMBA lists the program as an approved program of study on their website (NMBA, 2015b).

In Australia an Enrolled Nurse (EN) completes a Diploma of Nursing (DN) as a Vocational Education and Training (VET) qualification, at a Registered Training Organisation (RTO), or at a University that incorporates an RTO within its university status. The education program is usually 18 months and on completion the graduate applies for registration through AHPRA. The role of the EN is to provide nursing

care under the supervision of a registered nurse (RN).

A RN completes an undergraduate degree, through a university, that is usually of three or three and half year's duration. Graduates of these programs are also required to register with AHPRA prior to employment. The range of responsibilities for a RN extends from direct patient care to coordination of healthcare delivery, health promotion, education and research (WADoH, 2015a). Experience is noted by the number of years following graduation, which is also equivalent to the annual salary increase. A RN progresses from a Level 1.1 to a Level 1.9 over 9 years of full time work.

Healthcare workforce in the Kimberley

There are no private hospitals in the Kimberley and as such only the Western Australian Country Health Service (WACHS) hospitals (public hospitals) were considered in this study. In WA the Nursing Hours per Patient Day model determines nursing staff numbers in public hospitals (WADoH, 2015b). This provides a shift profile and full time equivalent (FTE) cover for a ward or department. Nursing numbers are determined by the diversity and complexity of nursing tasks required. The career structure described earlier assists to provide an appropriate skill mix in relation to nursing numbers.

Whilst nurses, both RNs and ENs, have a wide range of employment opportunities in the Kimberley, public hospitals are the predominant employer. There are, however other employment areas such as: Regional Aboriginal Medical Services, Renal Dialysis Centres, the Royal Flying Doctor Service (RFDS), General Practice clinics and Remote Community clinics governed by WACHS or Aboriginal Community Controlled Health Services (ACCHS). There are limited employment opportunities for RN and EN graduates in these specialised areas. Some graduates, however, do obtain employment in some areas of high need such as the Renal Dialysis Centres, or Aboriginal Medical Services.

Aged Care services within the Kimberley are privately owned or governed by WACHS. These areas have limited employment opportunities for RNs and ENs as

they predominantly employ unqualified staff, or staff with certificate III, or IV level qualifications. The RFDS does not offer employment for RN graduates or ENs. Nurses in RFDS are often required to hold a midwifery certificate with an additional 3-5 years postgraduate experience in emergency or critical care. This requirement means a graduate would need to move to the city for at least 5 years to gain the qualifications and experience. Private general practices in the Kimberley have little staff turn over and require a RN to have a number of years of experience before employment will be considered.

Working in a remote area clinic as a RAN requires experience beyond that of a graduate RN or enrolled nurse (Lenthall, Wakerman & Knight, 2009). These nurses are required to work independently, but as part of a multi disciplinary team in a remote Aboriginal community. They are also required to have broad nursing experience with recent accident and emergency skills, relevant university qualifications and or post-basic qualifications such as midwifery, child health, psychiatry, primary healthcare or remote area practice (KAMSC, 2012).

Kimberley graduate programs

Graduate programs offer newly registered ENs and RNs support in their transition from student to clinical practice. Whilst undertaking a graduate program is not obligatory for employment, they do provide the novice nurse with additional support. The programs are structured, with some supernumerary time in clinical practice and paid study days. Nurses in these programs are part of the staffing skill mix at the same time as gaining exposure in a variety of clinical settings, while consolidating theoretical learning and critical clinical skills and judgment (WADoH, 2015c).

GradConnect is a streamlined online recruitment system that provides a wide choice of employment opportunities for newly qualified nurses and midwives (WADoH, 2015d). This is a collaborative system that works with WA public hospitals and healthcare services and participating private hospitals. The Nursing and Midwifery Office, located in WADoH, centrally coordinates applications for all graduate programs offered via GradConnect. The online system allows applicants to

apply for graduate opportunities in all of the participating hospitals and healthcare services across WA.

Currently, the Kimberley graduate program is only offered to RNs. Nine programs are offered each year and include six rotational programs and three Broome based programs. The rotational programs consist of a minimum of 16 weeks in Broome, Derby and Kununurra with some graduates being offered a 4 week rotation in Fitzroy Crossing or Halls Creek (WADoH Country Health Service, 2011). The number of graduates accepted into the Kimberley graduate program ranges from 9 to 12. The Broome based programs are dependent on the successful applicant being able to provide their own accommodation. Enrolled nurses are not offered a graduate program and thus seek direct employment from a hospital in the region.

Nursing education in regional and remote Australia

In the Australian context, pre-registration undergraduate nursing programs are primarily offered from regional or city based university campuses, or RTOs. The majority of the Australian population is situated on the Eastern seaboard and consequently this is where the majority of education providers can be found (see Figure 2.3).
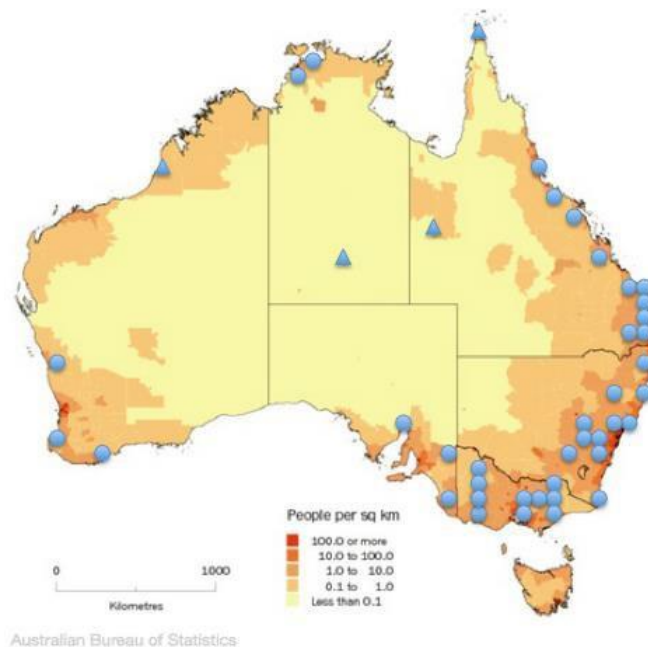
Figure 2.3 Regional and remote universities in Australia

The above map of Australia identifies population density and the location of Schools of Nursing. Population density of Australia is identified with the shaded orange areas; very light colouring identifies the remote and very remote areas of Australia (ABS, 2011b). The dots and triangles identify Schools of Nursing (CDNM, 2007).

Universities in regional areas offering RN education can be identified in the above map by a blue dot. Figure 2.3 draws attention to the vast distances that students have to travel from a remote area to a regional university campus. The remote campuses (identified by the blue triangle) are a significant distance from available resources, major tertiary healthcare services and are in low-density population areas (ABS, 2013). Providers of EN programs are also situated throughout Australia in a similar fashion to the RN providers (NMBA, 2015b). The map also identifies Notre Dame, Broome as the only remote campus in WA offering an RN program.

The majority of Australian pre-registration nursing programs are delivered through face-to-face study options where students live in the locality of the education provider (NMBA, 2015b). Teaching across geographical boundaries is where students reside in a geographical area other than where the course is being delivered. It is this type of delivery that enables students in remote and regional areas to access educational opportunities without having to relocate. This requires delivery to learners by distance mode rather than a face-to-face onsite program. Notre Dame, Broome offers both the BN and DN programs through distance learning across geographical boundaries.

Context of the case

In this study the case is the influencing factors on remote university nursing graduates decision to work in a remote hospital. The context refers to the internal and external environment that nurse graduates have studied and practiced. Thus, a description of the Broome campus and the nursing curriculum, including clinical placements will be highlighted in this section of the thesis.

The University of Notre Dame, Australia's first campus, was founded in 1989 in Fremantle, a major city in the southern part of WA. A second campus was established in Broome in 1994, at the invitation of the Bishop of Broome (Bishop John Jobst) with the aim of being a centre of reconciliation between Aboriginal and non-Aboriginal Australians (Tannock, 2014). The fundamental objective of the campus was to meet the needs of the people of the Kimberley region in terms of tertiary education and in particular to provide education for the professions of nursing and education in a context of Catholic faith and values.

Currently, Notre Dame, Fremantle, through its School of Nursing and Midwifery in Broome offers DN and BN programs together with the Certificate II in Health Support Services and the Certificate III in Health Services Assistant. These certificates can be used as entry-level qualifications to the DN program.

The BN program offered through Notre Dame, Fremantle and Broome follow similar curricula. This model provides the students the opportunity to travel between campuses for part or all of their studies. Some Notre Dame, Fremantle students take this option with some deciding to stay for their graduate year. The point of difference between the campuses is the core curriculum units. There are three core curriculum units which are designed to act as a: Central platform through which the University aims to achieve its intention of producing graduates of outstanding quality, whose personal spirituality and public spirit allow them to take their place in public life, and to make a significant contribution to the human, economic, social and spiritual development of Australia and its region (Notre Dame, 2015).

The three Notre Dame, Fremantle core units are: Introduction to Philosophy, Ethics and Introduction to Theology. In keeping with its focus of reconciliation Notre Dame, Broome, replaced the Philosophy and Ethics units with Aboriginal People and Spirituality and Challenges of Reconciliation. The three core units for Broome are designed to "challenge the students to consider the theological and spiritual foundations of the Christian faith in dialogue with the history, worldview and political context of our time and particularly with the Aboriginal people of Australia" (Notre Dame, 2012b. p.24). Whilst the DN does not have a core curriculum the theme of reconciliation through cultural awareness is interwoven

throughout the program.

Contextualisation of the curriculum

The Registered Nurse Accreditation Standards allow for course contextualisation when delivered in different modes and from different campuses as long as equivalence of outcomes can be maintained (ANMAC, 2012. p13). This criterion has enabled Notre Dame, Broome to focus tutorials and simulated clinical situations to the remote context where there is a predominance of Indigenous people.

A particular focus of the curriculum for Notre Dame, Broome is the way it addresses the Aboriginal and Torres Strait Islander Peoples' history, health, wellness and culture. It exceeds the minimum of a discrete unit as directed by the Registered Nurse Accreditation Standards (ANMAC, 2012, p. 14) through its core curriculum and cultural awareness sessions for clinical placement. Students are also exposed to the chronic disease and mental health conditions prevalent in the Aboriginal population.

Local nurses provide the tutorials and customise the tutorial content with scenarios and case studies with a remote healthcare focus. This focus enables students to learn about healthcare provision in dialysis units, hospital settings and remote health clinics. Clinical laboratory sessions provide students with the practice necessary to enable them to function in an independent fashion while on placement. Engaging tutors from the local healthcare workforce creates opportunity for students to become intrinsically aware of the nature of the workplace and to understand that being prepared for the clinical practice setting is essential.

Clinical placements and supervision

Students in both the DN and BN are immersed in the culture of the region and the workplace during their clinical placement. Both courses provide significantly more workplace experience hours, than directed by accreditation authorities. Students in the DN attend 600 hours of clinical placement throughout the 18 month program, 200 more hours than the minimum set by the accreditation body (ANMC,

2009). Students in the BN attend 1240 hours of clinical placement over a three-year program (440 hours more than the minimum 800 hours set by the accreditation body (ANMAC, 2012).

Clinical placements are organised throughout WA with placement availability governed by the appropriate healthcare facility. All students undertake their first placement within the aged care sector followed by placements in acute healthcare settings. The majority of students attend clinical placements at hospitals in towns of the Kimberley such as Broome, Derby, Fitzroy Crossing, Halls Creek and Kununurra. Other remote areas hospitals south of Broome may also be utilised such as those in the regions of the Pilbara, Midwest and Gascoyne. Some placements are also provided in regional settings such as Geraldton and Albany. Students can also request a clinical placement throughout the Perth metropolitan area in a variety of hospitals and healthcare agencies, but are required to enrol through the Fremantle campus.

There are also opportunities for students to attend the Renal Dialysis Centres and the Aboriginal Medical Services in Broome and Derby. The remote communities managed by WACHS including Lombadina, Looma, One Arm Point, Kalumburu and Warmun are also sites of clinical practice for BN students. Currently, there are limited opportunities for DN students at these remote clinic sites.

All students experience aged care, medical and surgical care, paediatrics, community health settings, primary healthcare, mental health and midwifery. Bachelor of nursing student's, gain additional experience in accident and emergency departments and the peri-operative setting. Formal agreements with the healthcare facility provides the framework for the provision of clinical placements. These agreements (see Appendix A) stipulate the support provided by the health service and the responsibility of the education provider and include such items as access, supervision, emergency care, orientation, patient care requirements, disciplinary action, security and safety.

All placement bookings are approved by the Director of Nursing and managed by staff development nurses. In the Kimberley, staff development nurses

occupy a senior position and are situated within the ward areas of the hospital. These nurses (usually one at each site) coordinate the rosters and arrange mentors for the students. Student nurses sign a declaration acknowledging their clinical placement takes precedence over work and social commitments (see Appendix B). This process enables students to be placed on a 24/7 roster system similar to all other nurses. This means students can attend placement on any of the three shifts (0700-1530; 1300-2130 or 2100- 0730).

Students on clinical placement are supernumerary to staff in the healthcare facility (see Appendix A, p. 5). This means that students do not form part of the workforce case mix. This supernumerary status provides learning opportunities across the facility. The mentor model of clinical support utilised by Notre Dame, School of Nursing and Midwifery ensures that the student is immersed into the life and culture of the remote healthcare workforce. Mentors are "chosen as role models for the profession and excellence in practice" (Notre Dame, 2012, p. 12). The mentor's role is to challenge the student to develop new skills and to seek out excellence in a relationship that provides support, open communication and guidance. This relationship enables students to learn the nuances of remote nursing practice in a supportive collegial fashion.

Conclusion

This chapter has described the geographical location of the study and the concept of remoteness. The geographical spread of nursing pre-registration providers has also been displayed. The chapter presented a description of the nursing workforce in a remote context with specific emphasis on the Kimberley and the Graduate Program. Since the context of this study is the remote campus of Notre Dame, Broome a brief description of the curriculum has also been provided.

Chapter 3

Literature review

Introduction

The literature review was conducted prior to, during and following the study findings. Initially it was conducted after the development of the research questions to define concepts and clarify relationships. During the collection and analysis of the data there was a continual process of searching for confirmation or rejection of concepts and theories that could be linked. It was this process that assisted in shaping the study. Whilst there were some Australian studies on the topic most were conducted in Canada and the US.

As an introduction to this chapter an overview of the nursing workforce shortage in Australia and the challenges this issue posed to the recruitment and retention of nurses, particularly in non-urban areas of Australia is discussed. This review elaborates on factors that could have influenced nurses to work in non-urban areas and will also discuss the strategies used to recruit nurses into these areas. Gaps in the literature are highlighted with particular reference to the recruitment and retention of nurses into remote areas of Australia and in particular the recruitment and retention of graduate nurses. The final part of this chapter discusses the theory of decision–making as it was considered a theory that could highlight underlying factors that influenced graduates to work in a remote area of Australia.

Nurse workforce shortages

It has been widely recognised that in Australia, like many other countries, there is a problem in attracting and retaining nurses in the workforce (Duffield & O'Brien-Pallas, 2002; Hodges, Williams & Carman, 2002; Hogan, Moxham & Dwyer, 2007; Holland, Allen & Cooper, 2012; Johnstone, 2007; Moseley, Jeffers & Paterson, 2008). The last decade has been labelled the worst nursing shortage in the last 50 years, and if measures are not taken to address the problem it has been estimated that there is likely to be a shortfall of around 109,000 nurses in Australia by the year 2025 (HWA, 2012). In WA, recent projections on nurse shortage demonstrated that by 2025 there could be a shortage of 9000 registered nurses (RNs)

and 3000 enrolled nurses (ENs) (HWA, 2012). Similarly, it was identified that not only was there a shortage of nurses, but also a recruitment problem particularly in non-urban areas of WA (AIHW, 2012).

It is understood that the provision of healthcare to people living in regional and remote communities differs from those in urban areas (Long & Weinert, 2006). Significantly, studies have concluded that there is a relationship between the reduction in health and rural living (DoHA, 2008; Miller, 2011). Further to this the health status of Australians declines as remoteness increases, and as a corollary there is also an increase in the healthcare needs of people (AIHW, 2014).

The literature in Australia rarely identifies remote healthcare service or providers as an area of interest. It has been suggested that there needs to be a common understanding of remote healthcare in order for a distinction to be made between the practice of remote healthcare practitioners and their rural colleagues. The argument was that a shared understanding could assist with preparing appropriate education models as well as the provision of more relevant policy and funding opportunities (Wakerman, 2004). Currently, remote health is either subsumed under the term rural health, or incorporated alongside the dual terms rural and regional. Studies have rarely considered the differences, with inferences being made that the findings from rural studies relate equally to remote.

Recruitment and retention of nurses into remote areas

Studies over the past decade have speculated that student nurses are more likely to enter the nursing workforce in a regional or remote location, if they have existing associations in such areas. Influences cited included clinical practice, (Francis & Mills, 2011; Hegney et al., 2002; Henry et al., 2009; Neill & Taylor, 2002; Playford et al., 2006; Spencer, Cardin, Ranmuthugala, Somers & Solarsh, 2008; Tre`panier et al., 2013) growing up in a rural area (Dussault & Franceschini, 2006; Hegney et al., 2002), living there (Birks, Al-Motlaq & Mills, 2010; Bushy & Leipert, 2005; Courtney et al., 2002; Lea & Cruickshank, 2005; Smith, Edwards, Courtney & Finlayson, 2001) and family connections (Bushy, 2002; Henderson-Betkus & MacLeod, 2004). Likewise the links between rural exposure and

recruitment into rural practice were found to be positive (Bambrick, 2002; DoHA, 2008; Gibb, Anderson & Forsyth, 2004; Hegney et al., 2002; Orpin & Gabriel, 2005; Preston, 2009). As students' exposure to remote area practice prior to study was not clearly defined in these studies; it was difficult to determine if length of stay in non-metropolitan areas influenced a person's career choice following graduation (Birks, Cant, Al-Motlaq & Rickards, 2011; Nugent et al., 2004; Playford et al., 2010). Further to this shortfall in findings no definitive information on employment statistics relating to increases in the nursing workforce was investigated.

There has been a growing body of knowledge in Australia that recognises rural nursing as separate and unique from urban-based nursing (Blue, Howe-Adams, 1993, Bridgewater 1998, Francis & Mills, 2011; Handley & Blue, 1998; Hegney 1996,). Rural nursing has been defined as "the provision of healthcare by professional nurses to persons living in sparsely populated areas" (Long and Weinert, 1989, p. 114). The provision of a stable nursing workforce to these areas has been noted as being essential and challenging, but recruitment and retention is complex, costly and difficult (Lenthall et al. 2011; Molanari, Jaiswal & Holiner-Forrest, 2011; Preston, 2009). Stability in the workforce is dependent on the relationship between recruitment (attraction into the workforce) and retention (retaining in the workforce). It has also been suggested that recruitment relates to aspirations and retention to satisfaction (RHW, 2013). Further to this shortfall in findings no definitive information on employment statistics relating to increases in the nursing workforce was investigated.

As an illustration of the problem concerning studies relevant to remote areas, a quasi-experimental pre-post-test survey was conducted on 121 final year BN students to investigate the relationship between rural clinical placement and intentions to work in rural and remote areas (Courtney et al., 2002). Whilst the term remote was used it was not defined, but rural was identified as an area outside a capital city or a major urban area with a population over 100,000. This definition was extracted from the National Rural Health Alliance NRHA, 1998). Whilst the study found an increase (12%) of student's intention to work following clinical experience in rural areas, results could not be extrapolated for students' intention to work in a remote area. Thus, the findings from the study are limited in terms of nurses'

intention to work in a remote area.

A similar study in South Australia explored the likelihood of recruitment and retention of students into the rural nursing workforce, but did not discern between a regional or remote setting. The pilot study was conducted in Renmark South Australia, classified as Outer Regional and situated 258kms from the city of Adelaide. It involved the first cohort of eight students studying for the BN at Flinders University. The majority of students indicated they would be living in a rural area in the following five years (Gum, 2007). In contrast Broome is 2240 kilometres from Perth: WA's capital city, and 1875 kilometres from Darwin in the Northern Territory. Thus, the findings from the study cannot be generalised to a remote area such as Broome.

Another concerning issue for nursing is that generally, studies about rural recruitment of healthcare professionals has been exclusively within the discipline of medicine (Dalton, Routley & Peek, 2008; HWA, 2012; Henry, Edwards & Crotty, 2009; Krahe, McColl, Pallant, Cunningham & DeWitt, 2010; Murray and Wronski, 2006; Rogers, Searl & Creed, 2010). Reference to this issue has dominated the rhetoric about influencing medical practitioners to engage in rural practice. Whilst there may be similarities in influencing nurses there are also factors specific to medicine such as the lure of private practice and specialisation in the urban area (Dussault, & Franceschini, 2006; Krahe et al., 2010). The Commonwealth funding for recruiting medical practitioners has been in excess of other health professionals including nursing (Dalton et al., 2008; Playford et al., 2010). This anomaly ignores the fact that nurses and midwives, in rural healthcare, make up a greater proportion of the healthcare workforce (Francis & Mills, 2011).

An Australian study of nursing and allied health students, found that nursing and physiotherapy graduates had the lowest proportion of graduates entering rural practice (Playford et al., 2006). This study used a rudimentary measurement that considered rural as being greater than 100 kilometres from the Perth General Post Office. It did not, however, distinguish between rural and remote.

A later study compared two cohorts, one from an urban nursing program

(with an established rural placement program), and one from a rural nursing program. Findings from the study suggested that rural nursing schools that deliver all the undergraduate program, are more effective in terms of influencing workforce recruitment than those that provide limited rural clinical placement from an urban based nursing school (Playford et al., 2010). The rural setting was located in a large regional town with a population in excess of 40,000 located only 180kms from Perth. Whilst Playford's study showed that there was a positive relationship between studying in a rural location and recruitment into the rural workforce, it was limited in its significance to a remote setting. Additionally, participants identified a rural background, which as previously mentioned is different from nursing in a remote area. The study was useful, however, in pointing to the interplay between rural clinical placements and the impact on the rural workforce.

A number of studies have provided information on nursing students from urban and regional universities and their expectations about working in regional areas after their studies (Courtney et al., 2002; Playford et al., 2010; Wood, 1998). To date, however, there are no studies that have provided information from a remote school perspective in terms of nursing students, or graduates.

Factors influencing graduates to work in regional and remote areas

A contemporary review of the international literature, including Australia, Canada, Scotland and Scandinavia, concerning factors affecting recruitment and retention of the rural workforce, identified factors along a continuum from modifiable to non-modifiable. These factors were grouped into five categories: educational, financial, professional, social, and external. These factors were further categorised into personal and professional aspirations, and personal and professional satisfaction that led to workforce retention (Rural Health Workforce [RHW], 2013). The definition used in the study for rural workforce was the professional working in rural and remote primary health care and more specifically to non-metropolitan areas, including regional towns and other settlement/areas. There was no specific reference to remote sites. Thus, factors for retention into remote areas of Australia could not be determined.

Studies from North America and Australia highlighted factors that influenced a student or a nurse graduate to choose a rural location, but they did not consider the factors that disillusioned a graduate from staying in such an area. Instead, attention was given to the negative aspects of rural nursing (Bushy & Leipert, 2005; Playford, Larson & Wheatland, 2006). Whilst these negative aspects of rural nursing could be linked to a reduction of graduates, it is the factors that are intimately related to pulling graduates away from rural nursing that could be vital to understanding how graduates from remote universities are to be encouraged to remain in remote locations.

An international review, found that few studies used a systematic approach to identifying factors that influenced decisions made by nursing students, or graduates to go work in rural practice (Tre`panier et al., 2013). The review located a number of studies in the US, Australia and the United Kingdom. Findings from the review were broadly categorised into personal and professional factors that influenced nurses to work in rural areas, but not remote areas of practice. Personal factors included a background of living in a rural area and the location of family members in the same area. It was support from this social network that assisted adaptation into unfamiliar surroundings and assisted in times of stress (Young & Valache, 2004). Professional factors included peer support in the workplace and a comfortable working environment (Tre`panier, et al., 2013).

A Canadian mixed method study, reviewing international studies, identified that there were multiple factors that influenced the initial plans and final decision of nursing students or graduates to choose a rural area as first employment. The factors were grouped into personal, professional and financial. The study identified that attending rural schools and prior experience of living in a rural area were strongly linked to the intention to practice rural nursing following graduation. This review, however, did not consider formal transition or graduate programs, which could have been an influencing factor. Additionally, these studies focused on an intention to settle in a rural area not the factors that influenced settlement (Tre`panier et al., 2013). Findings from this study may have relevance to remote area recruitment considering the rural context in Canada is similar to the remote context in Australia.

The first few years in nursing employment are a critical learning period where new graduate nurses progress from novices to experienced nurses. Critical to this development is ongoing education, experience and support to socialise into the real work of nursing (Scott, Engelke & Swanson, 2006). High attrition in the first year of nursing can be attributed to the heightened work stress felt by graduates in their first year of nursing (Casey, Fink, Krugman & Propst, 2004). Transitional programs, also known as Graduate Programs, are aimed at supporting and facilitating the integration of new graduates into the nursing workforce (Rush, Adamack, Gordon, Lilly & Janke, 2013). Their design enables the graduate to adapt to their new role and responsibilities and consolidates the linkage of theory to practice: important facet of the process of professionalisation (Duchscher, 2008). Their success, however, has had mixed reviews (Evans, 2008). Efficacy and cost effectiveness have not been measured well and further research to include more rigorous study designs to include longitudinal studies to measure outcomes has been suggested (Rush, Adamack, Gordon, Lilly & Janke, 2013).

In the mid-1990s studies demonstrated that providing pre-registration nursing students with clinical placements in rural sites improved the likelihood of students practicing in these areas following graduation (Murphy, McEwan & Hays, 1995). This experiential learning has shown propensity to reduce the experience of reality shock and possible reduction in graduate attrition (Cowin, Hengstberger-Sims, 2006). These findings have also been confirmed by more recent studies (Lea et al., 2008; Neill & Taylor, 2002; Playford et al., 2004). The findings were, however, broadly applied to rural settings not specifically for a remote setting.

A retrospective study, conducted in the US, identified that students who attended a nursing program focusing on rural nursing, were twice as likely to practice in rural areas as those who completed an urban-focused nursing program (Wood, 1998). The definition of rural, was a county with less than 50, 000 people. This definition, however, did not encompass distances from urban communities. Disadvantages experienced by these rural communities were noted as: social; healthcare; fewer job opportunities; chronic disease; and injury. These issues are similar to those experienced by people living in remote areas of Australia.

Factors that influenced nursing graduates and medical students were found to be similar. Studies pointed to those who have rural experience are more likely to practice in rural area, but motives were different. For example from a medical practitioners point of view their expectations regarding specialisation and private practice together with subsidised accommodation and assisted travel costs are variables that were not available to nurses (Henry et al., 2009).

In terms of medical practice, five factors had a negative impact on choice of a rural medical career. These were: a perception of lack of support in the workplace, perceived professional and personal tensions, a belief that rural placement limited career options, a preference for a metropolitan lifestyle, isolation from metropolitan based family and friends and most significantly a partner who was not committed to a rural location (Henry et al., 2009). Whilst this study was specifically aimed at medical practitioners, it could be suggested there may be some relevance to nursing graduates not settling in rural areas.

Recruitment strategies

Working parties, including Action on Nursing in Rural and Remote Areas, (National Rural Health Alliance, 2003) and more recently the Rural and Remote Health Workforce Innovation and Reform Strategy (Miller, 2011) have recommended strategies to support recruitment and retention of nursing staff. These strategies have included local incentive programs such as, accommodation subsidies, increased annual leave entitlements, and increased access to salary packaging. There is little evidence, however, that these have been beneficial to the recruitment and retention of rural nurses and midwives (Francis & Mills, 2011). It is of concern that whilst student nurse enrolments are expected to prepare registered nurses for practice graduate attrition, within the first year of professional practice, continues to be problematic (Gaynor, Gallasch, Yorkston, Stewart & Turner, 2006). Understanding how nurses make decisions about their career choice is an essential component of recruitment and retention strategies (Price, 2008). It is especially important in realising a sustainable nursing workforce in remote areas.

Building a self-sustaining local workforce for remote nurses has been

suggested as a viable option to external recruitment. This initiative has been defended in Canada and Australia as a process whereby pre-registration nursing programs are offered to people within their area (Birks et al., 2011; Dalton et al., 2008; Zimmer, et al. 2014). This framework would also include the provision of clinical placements in the local healthcare services and those identified for future employment. This model of recruitment closely aligns to the rural pipeline used in medical practice (Henry et al., 2009).

The rural pipeline concept was initially designed for the recruitment of medical graduates into rural areas of the US in the late 1900s (Council on Graduate Medical Education, 1998; La Ravia et al., 2002). It has also been effective in Australia to address the medical workforce shortage (Henry et al., 2009). The model included; structured contact between rural secondary schools and schools of medicine, selection of applicants with a rural background, exposure to the clinical environment in the rural healthcare services, and measures to address retention of graduate practitioners into rural medicine.

Recent attention has been paid to the rural pipeline model to address shortages in nursing and the allied healthcare workforce in regional and remote areas in Australia, New Zealand, Europe, the US and Canada (Bell, 2011; Fisher & Fraser, 2010). Also of note is that the pipeline focused on early recruitment by introducing awareness and opportunities within healthcare services to school children during their career selections. It did not, however, include the types of incentives required to retain staff already in the workforce, or strategies to increase recruitment (Reuter & Volmink, 2009; Wilson, Couper, De Vries, Reid, Fish & Marais, 2009). Both of these reviews evaluated strategies designed to increase numbers of health professionals in general, but not specifically nursing. The first review did not locate any studies that met their inclusion criteria of: randomised controlled trials, controlled trials, controlled before-after studies, and interrupted time series studies. This limitation led to a further review that included quasi-randomised studies. Despite widening the search, there were no studies found that evaluated strategies aimed at increasing health professionals into rural regions (Wilson et al., 2009).

Strategies utilised to address the problem of recruitment have included

increasing numbers of educational places for rural nursing students and encouraging them to complete their course of studies (Bambrick, 2002; DoHA, 2008; Gibb et al., 2004; Preston, 2009). Another approach to increase numbers was the offer of financial support to students by the Australian Federal Government distributed by the Royal College of Nursing. Whilst these nursing scholarships have been beneficial, the funding was not as substantial as that offered to medical students (Francis & Mills, 2011).

In the late 1990s and early 2000s, a number of regional and satellite campuses were established, funded by the Australian Federal Government, to increase access to nursing education for people living in rural areas of Australia (Bambrick, 2002; Playford et al., 2010). In 2004 there were 24 (Nugent et al., 2004). By 2007, these campuses had increased to 55 (CDNM, 2007). Identifying the number of schools of nursing situated in remote areas of Australia was difficult, as the method used to identify these campuses was based on population rather than the distance from a major city (Nugent et al., 2004). It was noted that rurality is a complex and multifaceted process that changes according to the purpose for which the definition is being used (Halfacree, 1993). Without using a recognised classification system, however, such as the ASGC, these studies were limited in their usefulness to remote areas. Additionally, the studies did not indicate whether any campuses offered their courses on campus, or by distance education methods.

Currently, in WA there are four university campuses identified as being rural (CDNM, 2007). These campuses include Albany, Geraldton, Mandurah and Broome. Despite the campuses being identified as rural, there is significant difference in terms of access to resources and population between Broome and the other towns. Utilising the ASGC remoteness area structure, Mandurah was identified as inner regional, while Geraldton and Albany are identified as outer regional. Broome, by contrast, is considered remote (DoH, 2015). The CDNM (2007) identified that 25% of all nursing students in WA who commenced a pre-registration course were enrolled in one of these regional or remote campuses. The survey was limited, however, in that it did not provide information regarding completion of studies, workforce employment into the local area, or the number of enrolled students. Additionally, the factors that influenced students' choice of location for employment were not

investigated.

Australian studies suggested students who had an opportunity to study, or attend clinical placement in rural and remote areas, were more likely to work in a rural or remote area after registration (Playford et al., 2010). There is, however, limited information on what influences them to stay or leave the rural area following graduation. Moreover, none of the studies differentiated between a rural, regional or remote campus, clinical placement, or student origin. There was some discussion on pre-registration programs, but little information on whether graduates remained in the local workforce.

It is clear that there are fundamental strategies utilised to increase the likelihood that nursing students will work in rural areas after graduation. These strategies include: providing opportunities for rural students to study all their nursing program in a rural area, a rural focus in the nursing curricula, well supported clinical places in rural areas, and encouraging the uptake of nursing courses by rural residents. There is, however, little evidence on whether graduates from such schools are recruited into rural areas, or what influences their decision to stay, or leave following registration.

Notre Dame, Broome is the only university in the Kimberley delivering a pre-registration nursing program. It is a private University with a Registered Training Organisation (RTO) status. To date there have been no studies undertaken to identify the number of graduates seeking employment in Kimberley hospitals, nor the factors that influence their decision to undertake a graduate program. This study, therefore, aims to explore these factors and describe the influences that affect graduates decision to stay in the Kimberley following graduation.

Theoretical perspectives of decision-making

At this juncture in the literature review it was useful to view decision–making theories to provide a perspective on graduates decisions in terms of career goals. In a practical sense humans are cognitive agents, who evaluate the world and various aspects of it according to their beliefs, followed by adopting a plan, and initiating an

action (Pollock, 2006, p. 1). As such, decision-making theories have generally been regarded as a subarea within cognitive psychology (Decision Making Theories, 2006). It has been argued, however, that decision theory is fundamentally a mathematical tool for assessing and comparing the utility of different courses of actions in terms of probabilities and utilities that are assigned to different outcomes (Bermudez, 2009).

Making decisions is an essential aspect to life at an individual, community and corporate levels. In a developing world a combination of economic, social and technological situations need to be considered when people make decisions about their relationships, family life, education and careers (Crozier, & Ranyard, 1997). Decision theory is in part a theory of how to choose and act rationally. In its action-guiding guise, decision theory is a theory of deliberation. It also counts as a rational choice at a given time and is solely a function of the person's utilities (Pollock, 2006). Criticism of this perspective is that there is a body of social research that reveals people often act impulsively and emotionally, or by force of habit (Hechter, & Kanazawa, 1997).

Classical Decision Theory (CDT) assumes that a plan can be adopted by focusing on the individual actions comprising the plan. In reality, a plan is somewhat schematic with further decisions being made as time passes. Actions cannot be evaluated in isolation, but within the context of other actions that may either act destructively or constructively (Pollock, 2006). The CDT suggests that when one is deciding what to do, rationality dictates choosing the alternative with the highest value (Pollock, 2006). The decision problem is deciding which act to perform and arises when a person has a number of alternatives to act upon, each with a range of possible outcomes based upon facts that the person may/may not control (Bermudez, 2009).

According to Pollock (2006) the CDT is not reflected in everyday decision-making. What is missing from decision theory is the social dimension of reasons and reasoning which can only be understood through seeing how people are embedded in their social and cultural contexts (Bermudez, 2009). Human beings, whilst being cognitive agents are also social beings that bring with them social norms, and

institutional rules that may not fall within the purview of decision theory. Whilst a cognitive agent's choices are a given, there are constraints and controls within the social context (Bermudez, 2009). Choices appearing attractive in the short term may not turn out to be the best choice in the long run (Pang, Ross-Otto & Worthy, 2014).

The social cognitive theory offers an alternative perspective related to decision- making. According to Bandura (2001) whilst a person operates within a broad network of socio structural influences they act mindfully to make desired things happen. The human agent acts intentionally, with forethought, self-reactiveness and self-reflection. People set goals, anticipate the consequences, and select a course of action likely to produce desired outcomes. As people move through their life courses they plan ahead, reorder their priorities and structure their life accordingly. Within this construct people display self-direction in the face of competing influences and adopt personal standards, which shape the appropriate course of action, motivate and regulate their execution. These mechanisms are based on the person's belief in their capability to exercise some measure of control (Bandura, 2001).

The social learning theory has some relevant arguments regarding decision-making. It addresses the social and cultural factors, which become enmeshed in the individual's identity over time. Social experiences are seen as external influences whereas Hodkinson & Sparkes, (1997) argue that they are an integral part of the decision-making process. Moreover, some sociological analysts suggest that career decisions are made serendipitously and that planned decision-making bears no resemblance to how career decisions are made (Baumgardner, 1992; Miller, 1983).

In reviewing career decision–making from a sociological perspective Hodkinson & Sparkes (1997) coined the term careership as a model of rational decision-making. Their model was based on the work of Pierre Bourdieu. They described the model as integrating three dimensions: pragmatics located in the habitus of the person making the decision, the interaction with others, and the location of decisions within partly unpredictable patterns of turning points and routines that make up the life courses.

In simple terms, habitus refers to the relationship between the disposition of the person (inner self), the role they play (social self) and the context of the situation. How people make choices is captured in these interlocking relationships. It is the nature of these three dimensions that characterises the way people act, feel, and think. Thus, to understand practice there is a need to understand both the evolving context within which people are situated, and the evolving habitus that people bring to their social fields of practice. Habitus is not a synonym for socialisation; rather it is the crucial relationship and dynamic qualities within the context that generates practices (Maton, 2012).

Whilst the model of careership was developed with students making the transition from school to work, it is useful in terms of the professional socialisation of nurses and their transition from student to graduate nurse (Hodkinson & Sparkes, 1997). The model attempts to meld social and cultural factors with personal choices to build a model of learning, whilst merging individual choices with serendipity. Within the context of the situation it is argued that people make practical rational decisions. A characteristic of careership is the turning points a person faces on the career trajectory when a person is forced by a range of personal and professional factors to take stock and re-evaluate their career progression and development (Hodkinson & Sparkes, 1997).

The transition period from student to graduate nurse is an individual experiential journey; likewise, the decisions made about a career trajectory are also individual and experiential. This adaptive process requires an opportunity for exploration of self and environment (Flum & Blustein, 2000). Clearly, career decisions are not entered into lightly. Graduates have invested time and money into their studies, but need to consider many factors, and perhaps make compromises, in order to fulfill their goals. Finding out the factors that influence the graduates decision may assist in decreasing graduate attrition.

Conclusion

This chapter has briefly discussed issues and concepts related to the research question. It has portrayed the field of inquiry focusing specifically on those studies

and theories relevant to the study. It has uncovered some consensus amongst the studies both from an international and Australian perspective. It has also revealed some limitations placing this study clearly within gaps that have been exposed. An overriding problem with most studies was the lack of specificity to the remote context. Many studies included the term remote within rural or added it to regional without clear definition. Many explanations were provided, but without a consensus findings were difficult to generalise to the context of this study. Significantly few studies identified factors influencing a graduate's decision to work in a remote area following graduation. The chapter closes with a discussion on the theories of decision making to provide a perspective on graduates' decision for their choice of workplace.

Chapter 4

Methodology/Design

Introduction

This chapter will provide the overall approach taken in the study, including the rational for the methodology and the design. It will also provide a description of the sampling techniques, data collection processes and data analysis procedure, together with ethical considerations and approvals.

In deciding the approach for this study it was necessary to pose a research question based on its purpose and objectives. The question posed was, "What are the factors that influence remote school of nursing graduates in their decision to work in a hospital in the Kimberley?" The purpose was not to predict, control or generalise as in a positivist approach, rather it sought to explore and describe the experiences of nursing graduates and the context that surrounded their decision for employment. Given that the researcher was interested in talking to graduates about their decision to work in the Kimberley, it was deemed appropriate to take a naturalistic approach to the study.

Naturalistic inquiry

Naturalistic inquiry is a general characteristic of qualitative research and refers to the study of phenomena in a natural setting. Such a characteristic provides an alternative to a positivistic inquiry (Lincoln & Guba, 1985). Qualitative research is interested in how people interpret their experiences, how they construct their worlds and what meaning they attribute to their experiences (Liamputtong, 2013; Merriam, 2009). A qualitative approach provides an opportunity for voices to be heard as participants explain their feelings about the phenomenon under study, including the process and the significance it has on their lives (Liamputtong, 2013). As well as asking, "what is it?" naturalistic studies ask "explain it to me – how, why, what is the process, what is the significance?" (Denzin & Lincoln, 2008; Hesse-Biber & Levy, 2005, p. 28). Asking the participants to describe their point of view enabled the meaning of the phenomenon to be uncovered from their perspective, rather than

the researcher's viewpoint. Fundamentally, every qualitative design has basic qualities such as a focus on meaning, understanding and process (Creswell, 2009; Denzin & Lincoln, 2011; Patton, 2002; Yin, 2009).

Case study

A case study design was chosen for this study as the researcher was interested in gaining an in-depth description from the graduate's perspective and interpreting their responses within the context of a remote area. It is argued that this approach acts as a guide to researchers when investigating the relationship between a phenomenon and contemporary real life experience in which there is little control over events. It also supports the deconstruction and subsequent reconstruction of the phenomenon under study (Yin, 2014). Contemporary events are better considered utilising a case study method particularly when the relevant behaviours cannot be manipulated (Yin, 2009). In this study the graduates were powerless to manipulate the environment and the culture, including influences from the nursing culture, in the Kimberley.

From a case study perspective the context of the case was situated within boundaries, but they were not clearly defined; the phenomenon and context were intertwined (Merriam, 2009; Stake, 1995; Stake 2005; Yin, 2014). The case was the graduates, who were surrounded by the context within which they operated. The phenomenon of interest was their decision to work in a Kimberley hospital. An illustration of these linkages can be visualised in Figure 4.1.
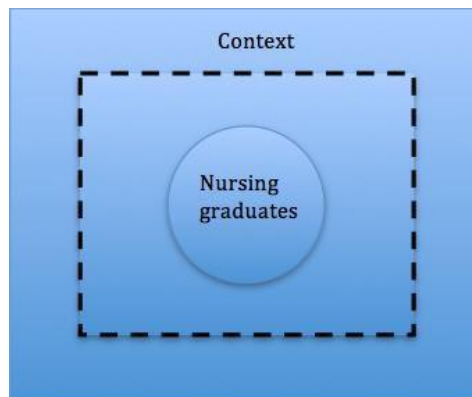
Figure 4.1 The context and the case

The relationship between the case and context represented in the above diagram is not clear-cut. The dashed line represents the blurring of the boundaries between these aspects. The context encompassed the factors that influenced graduates decision, and was understood to consist of multiple layers in an ever-changing dynamic state. Decisions made by the graduates could not be made in isolation from the context. It was assumed that graduates would understand and experience their world differently depending on: perceptions; expectations; values; background; culture; and relationships. This was naturalistic enquiry, where the world and reality as human context, cannot be considered and appreciated in isolation from the context (Lincoln & Guba, 1985; Patton, 2002). To make sense of these influences the context was explored using in-depth data from multiple sources (Creswell, 2009).

The case study method provided a research approach to explore, in depth the phenomenon and context. The nursing graduates were the key to the study; they unlocked the door to the bounded system. The rationale for using a case study approach was based on the notion that "a case study can inform professional practice or evidenced-informed decision making, in both clinical and policy realms" (Baxter & Jack, 2008, p. 544). Juxtaposed was the researcher's unique situation of being an experienced nurse immersed in the context of the study. The common features of a case study that assisted the researcher in choosing such an approach included: the natural setting in which the study could take place, the researcher's ability to

immerse herself in the context, and the availability of multiple data sources (VanWynsberghe, 2007).

This study was exploratory in that the topic had not been previously studied and was able to identify new insights and understandings of the phenomenon (Merriam, 2009; Philliber, Schwab, & Samloss, 2005; Stake, 1995). As such this single case study was revelatory (Yin, 2014). It was also descriptive in that it described the phenomena and the real life context in which it occurred (Yin, 2009).

Philosophical underpinnings of the case study research approach

The use of a case study inquiry has been described as a methodology, design or method (Anthony & Jack, 2009; Cresswell, 2013; Gerring, 2004; Merrium, 2009; Stake, 2005; VanWynsberghe, 2007; Yin, 2014). The foundational writers describing the case study approach; Stake (1995) and Yin (2014), agree that the constructivist paradigm underpins case study as a methodology, despite their own methods for undertaking research differing (Anthony & Jack, 2009; Baxter & Jack, 2008). A premise of constructivism is the social construction of reality, with multiple realities from which one can make sense of the world (Brown, 2008; Crabtree & Miller 1999; Crotty, 2013). Its meaning is assumed to be subjective and based on ones own experiences, but is influenced by interaction with others, and historical and cultural norms (Cresswell, 2013).

Constructivism claims that the truth is the result of perspective; it is relative (Crabtree & Miller 1999). It is from this perspective that case study aligns with the theoretical assumptions of the qualitative paradigm (Anthony & Jack, 2009). Both Stake (1995) and Yin (2014) contend that the topic of interest, or phenomenon, should be well explored from different perspectives, enabling the researcher to better understand the participant's reality (Baxter & Jack, 2008). The strength of the case study approach is its reliance on multiple forms of data sources that increase the trustworthiness of the findings (Ridenour & Newman 2008; Yin, 2014).

Study design

An effective research design is imperative when engaging in systematic

inquiry as it provides guidance to the researcher from the initial question to analysis of the results (Philliber et al., 1980). There are three conditions to consider when choosing a research design. First, the type of research question posed; second, the extent of control the researcher has on the events being studied; and finally the degree of focus on recent events as opposed to historical events (Yin, 2009).

In the design phase of a case study, it is advocated that constructing a preliminary theoretical proposition will guide data collection. It keeps the study within feasible limits, and assists with analysis of the data and increases the feasibility of completion (Baxter & Jack, 2008; Yin, 2014). It will also avoid the potential of evidence not fitting the research question (Yin, 2009). A theoretical proposition is an educated guess about the possible outcomes of the study (Baxter & Jack, 2008; Stake, 1995). Unlike a hypothesis in a quantitative approach, where a prediction is made about the relationship between two variables using statistical analysis, a proposition is "a hypothetical story about why acts, events, structures and thoughts occur" (Sutton & Staw, 1995, p. 378).

Theoretical propositions have also been likened to the term "issues" used by Stake (1995). Issues are seen as being intrinsically linked to the "political, social, historical and personal contexts" (p. 17). The suggestion is that a theoretical proposition leads to the purpose of the case study inquiry (Yin, 2014). Both Yin (2014) and Stake (1995) agree that propositions/issues are necessary elements in case study research as they lead to a conceptual framework that guides research. The theoretical proposition for this study was that a graduate's decision to work in a hospital in a remote area such as the Kimberley is influenced by both professional and personal circumstances.

Importantly, the stated proposition was tempered with alternative or rival assumptions as data collection progressed (Miles, Huberman & Saldana, 2014; Yin, 2014). This design provided an opportunity to explore all aspects of the topic and enabled development of new knowledge (Crowe, Cresswell, Robertson, Huby, Avery & Sheikh, 2011; Merriam, 2009).

Data sources

Both Stake (1995) and Yin (2014) advocate the use of a qualitative approach to case study, but there is a risk of missing important data using this approach. Thus, to ameliorate this potential problem and in keeping with case study approach, data was collected from a variety of sources (see Figure 4.2) providing a holistic picture of the case and its context (Baxter & Jack, 2008; Crowe et al., 2011; Luck, Jackson & Usher, 2006; Punch, 2005; Yin, 2014).
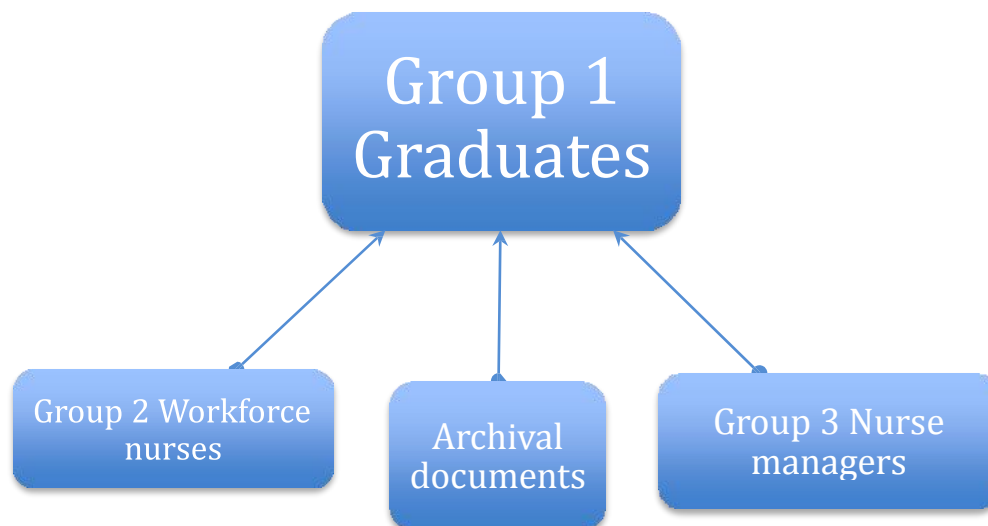
Figure 4.2 Data sources

The focus of this study was the graduates (participant group 1), but it was also important to gather data from workforce nurses (participant group 2), their managers (participant group 3), and archival documents (see Figure 4.2). These three additional data sets were selected to provide rich information about the context of the study surrounding the graduates and the influences on their decisions to stay or leave the remote area following graduation.

Graduates, as nursing students, had spent a significant number of hours, greater than 400 in most cases, on clinical placement in the local hospitals and healthcare services of the Kimberley. Workforce nurses and their managers acted as mentors, influencing graduates either explicitly, through conversation with graduates or implicitly, through their actions. The archival documents were chosen to add context, they provided information on the nursing course curriculum, student handbooks as well as the recruitment data and practices in the region.

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Qualitative samples are generally smaller than those used in quantitative studies (Ritchie, Lewis & Elam, 2003). Nevertheless, smaller samples must be sufficient to assure that most perceptions of participants are uncovered and the concept of saturation reached (Glaser & Straus, 1967). Although the concept of data saturation is rooted in the grounded theory approach to qualitative research, it is a concept that has emerged in other methodologies to assist the researcher in determining the amount of data to be collected (Bowen, 2008). Data saturation is concerned with reaching a point in data collection where further gathering of data becomes counterproductive and repetitious (Denzin & Lincoln, 2011; Neuman, 2006; Taylor, Kermode & Roberts, 2007). Authors of qualitative studies generally agree that a fairly low level of data can enable the development of meaningful themes and interpretations (Bowen, 2008; Green & Thorogood, 2009; Guest, Bruce & Johnson, 2006; Mason, 2010). Furthermore, it has been suggested that expertise in the chosen topic can reduce the number of participants (Jette, Grover & Keck, 2003; Mason, 2010). This section of the chapter will identify each group and include sampling and recruitment together with the number of participants.

Sampling and recruitment

Participant group 1 graduates.

Purposive sampling technique was used to select participants for this case study as it corresponded with the need to discover, understand and gain insight into the case. Accordingly, the case focused on graduates from either the BN, or DN program undertaken at the University of Notre Dame Broome campus. Whilst the University commenced the BN program in 1999, the first students did not complete their course until 2002. In order to maximize the number of participants in the study, graduates were chosen, irrespective of gender or age, from both programs, between 2002 and 2011. All graduates who completed a nursing qualification leading to registration between these dates, and attended a minimum of one semester of study on the Broome campus, were invited to participate. It was not the intent of the study to differentiate between factors of influence for DNs or BNs although if there were differences they were noted. These people formed participant group 1.

The Reporting and Statistics Officer in the Office of University Relations and

Development, together with the VET administrator, provided a list of possible students who fitted the criteria for selection. The list contained basic demographic data such as name, gender and date of course completion. The researcher reviewed the list for potential participants and returned it to the Reporting and Statistics Officer. This process was vital in gaining permission to access the alumni database for contact details in order to facilitate a mail-out of information. Currently, students enrolled at Notre Dame retain their email account for a lifetime. Unfortunately, the currency of these details was not known, but private emails, student emails, postal addresses, and mobile telephone numbers were identified. This basic data was emailed to the WACHS Human Resource Manager. Cross-referencing of data sets determined whether graduates had worked or were still working with WACHS within the Kimberley.

Student lists were separated into emails, mobile telephone numbers and postal addresses. Names were crosschecked with the AHPRA registration database to determine if addresses correlated with the Notre Dame database and current place of practice. Currently, all nurses and midwives are required to register with AHPRA on an annual basis and enter details as to their principal place of work. If this information did not match the alumni database; the private email address was used. The Reporting and Statistics Officer sent a group text message to mobile telephone numbers, asking students to update their contact details on the alumni register.

Potential participants were emailed, or mailed: an information sheet (Appendix C); a consent form (Appendix D); a demographic questionnaire (Appendix E); and an invitation to participate in an interview. Participants who were emailed, had the option of completing the demographic questionnaire online through SurveyMonkey® (www.surveymonkey.com).

Participants with a mailing address had a self-addressed reply paid envelope enclosed and a request to return the consent form and demographic questionnaire within two weeks of receipt. Returned consent forms and demographic questionnaires (both hard copy and electronic) were then coded and stored in the study's research database (Appendix F), as well as being catalogued in the researcher's journal. The researcher then emailed participants who had provided

consent and arranged interview dates, times, and mutually convenient venues.

Participant group 2 workforce nurses.

Workforce nurses were vital in providing additional information on what they thought could influence a graduate's decision to work in a Kimberley hospital. Additionally, it was useful to know what influenced them to work in the Kimberley, as this may also have influenced what they communicated, explicitly or implicitly, to the students during their clinical practice. A purposive sampling technique was again implemented in selecting participants who could provide relevant information on the topic. Thus, workforce nurses who were familiar with Notre Dame students and graduates were chosen. All health care agencies that provided clinical placement for the graduates during their course were contacted to provide this sample of nurses (RNs and ENs) including WACHS, Correctional Services, Aged Care facilities, RFDS, General Practice clinics and Aboriginal Medical Services; including the Kimberley Aboriginal Health Service Council (KAMSC).

Permission to recruit workforce participants was requested from the line managers in these services. The managers also requested ethics clearance letters, from the WACHS Research Ethics Committee and the Notre Dame Human Research Ethics Committee. Following ethics approval, the Directors of Nursing and Clinical Nurse Managers from the healthcare agencies, were emailed seeking their support to contact workforce nurses. Two of the healthcare services, WACHS and KAMSC, allowed global email contact as well as requesting information sessions provided for their staff.

Global emails contained all the information that potential participants might need. These included: information sheets (Appendix G), consent forms, demographic questionnaires and an invitation with consent to an interview (see Appendix H). Each manager was also mailed an information package that included: laminated posters (see Appendix I), copies of a synopsis of the study and a brief literature review (Appendix J), pre-paid return envelopes, information sheets and contact details forms (see Appendix K). The contact details forms were designed to gain details from interested participants so the questionnaire and consent form could be dispatched.

The researcher conducted information sessions to nursing staff at WACHS sites in Broome and Derby Health Services (see Appendix L). Hard copy packs were left for the staff to complete with directions for their return directly to the researcher using the pre-paid return envelopes (see Appendix M). The researcher emailed the participants who provided consent to be interviewed arranging dates and times, at mutually convenient venues.

Additionally, the researcher presented information about the proposed study to senior nurses at three health service sites in order to obtain support and participation. These sessions included a fifteen-minute presentation allowing time for questioning. Attendees were also provided with: a synopsis of the study and a brief literature review, information sheets, consent forms, and contact details forms.

On receipt of the contact details, the researcher dispatched the consent form together with a questionnaire. The participants were given the option of completing the questionnaire in hard copy and posting it back using the pre-paid return envelope, or to complete it on line through SurveyMonkey®. Once consent forms were received they were invited to participate at a date, time and venue of mutual convenience.

Participant group 3 nurse managers.

In addition to the graduates and the workforce participants, there were a group of prominent nurse managers who provided additional insight into factors that could influence the graduate's decision to stay and work in the Kimberley healthcare workforce. This group was vital in providing information on recruitment and retention of the graduates, by virtue of their nursing responsibilities. These nurse managers were chosen through a purposive sampling technique and were well known to the researcher as she had previously worked in various healthcare agencies in the Kimberley. To counteract any potential bias, the researcher checked interview questions and responses with her supervisor.

The researcher made initial informal contact with the managers followed by an official email containing an information sheet and a consent form. On receipt of

these, the researcher organised a convenient time, date and venue for an interview. Some participants, however, chose to provide information by return email, rather than through an interview process.

As previously mentioned the rationale for choosing a case study approach was to inform professional practice. It was impossible, however, to recruit all graduates to investigate what influenced their decision of workplace. Additionally, to gather all relevant data and provide alternative or rival assumptions to form the holistic picture, other data sources were needed. Thus, workforce nurses and their managers were chosen specifically to expand existing knowledge. These participants were known to have rich information about the phenomenon under study (Patton, 2002; Streubert & Carpenter, 2011). The aim of the study and the criteria set to recruit participants were the ultimate drivers of the sample size to commence data collection. The following section will discuss the data collection process for each group of participants together with the analysis of data.

Data collection

The data collection process was not linear rather it was iterative. All data gathering was entwined; moving between documents and interviews enabling the researcher to obtain rich data and add insight to the case study (Yin, 2009). Methods such as interviewing different participants and collating questionnaires were intertwined occurring over many weeks. This process enabled the researcher to move between different data sets; building insight into the phenomenon. A characteristic of qualitative research is that the process is inductive. This means the researcher gathered data to build the case, rather than deductively testing hypotheses as in a positivist research inquiry (Merriam, 2009).
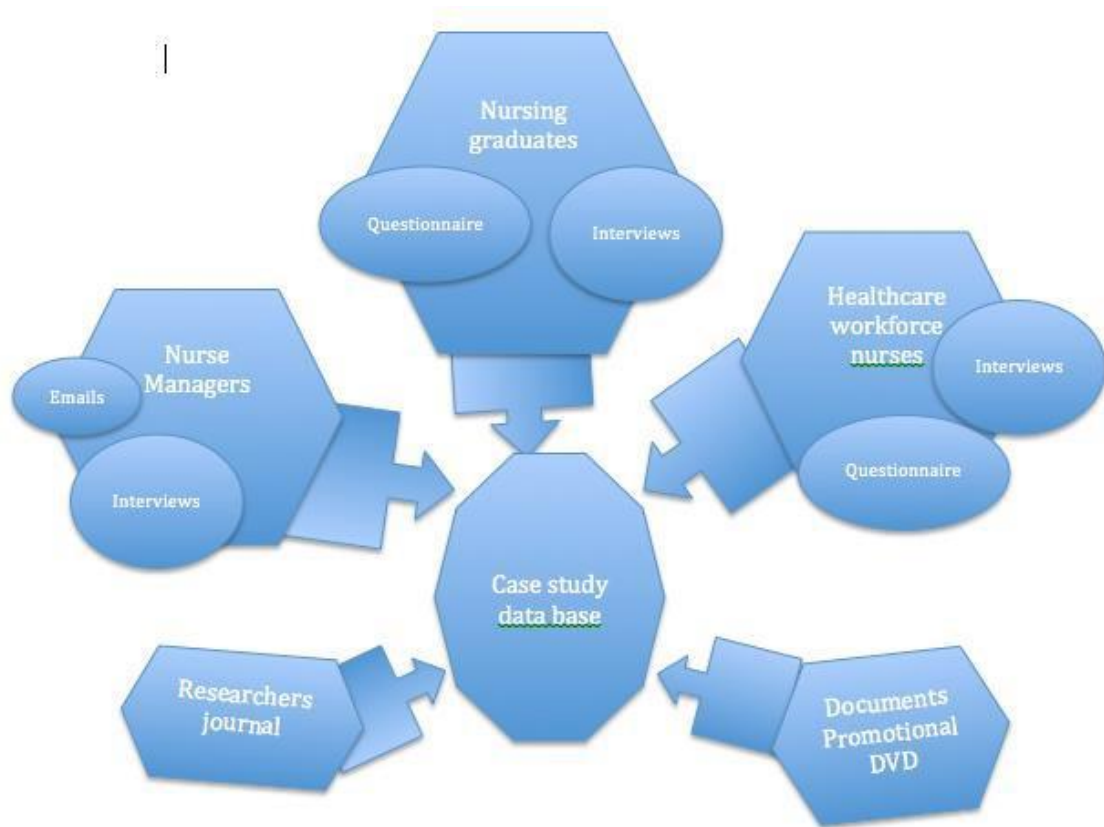
Figure 4.3 Data collection occurred in an iterative process

Data was collected by a variety of methods: questionnaires, interviews, documents, the researcher's journal, web pages, and a workforce recruitment DVD. Figure 4.3 illustrates the data collection as being an iterative process with a constant interweaving of collection and analysis of data (Miles et al., 2014). The process depended on: when the interviews took place, the timing of return questionnaires, locating and retrieving pertinent documents, and viewing the DVD. This range of data provided the means to collect rich facts required for the study. The method of using multiple sources of data enabled a broad range of issues to be investigated as well as reporting on human events and behaviours.

Participant group 1 graduates data collection.

Data from participant group one was collected using a questionnaire and an in- depth semi-structured interview. The questionnaire aimed to determine if participants met the inclusion criteria for the study as well as to explore information

about the graduates and their previous connection with remote living. Additionally, it enabled the researcher to gain consent from the participants to be interviewed. Demographic data from the questionnaires were displayed on a spreadsheet together with dates and times of interviews, enabling the planning of data collection across a variety of demographics.

Initial questions on the questionnaire were intended to determine whether graduates were registered with AHPRA. The questions also determined if graduates had worked, or had any social connections in a remote town since graduating. Additionally, participants were asked if they had lived outside a capital city and if so the location. The questionnaire was also designed to determine the remote index and the length of time a graduate had lived in a remote area prior to studying in Broome. The DoctorConnect® search map was used to determine the remote classification of the town where the graduates had lived or worked (DoH, 2015).

The second part of data collection for participant group one was an in-depth semi-structured interview. It is suggested that a researcher undertaking a qualitative study needs to have competent interviewing skills including a questioning stance, to be a careful observer, and to think inductively (Merriam, 2009). Nurses and academics also require similar competencies (National League for Nursing, 2005; NMBA, 2006). As the researcher had been practicing for 25 years, and an academic for 12 these competencies were inherent in her day-to-day activities.

Interviews were conducted once the questionnaires and consent forms were received. Participants were contacted and interview times were scheduled and confirmed at a mutually convenient time and place. This information was recorded on an excel spreadsheet. A specific routine for scheduling interviews was not required, as information from one group of participants was not needed to inform interviews of the other groups. Interviews were conducted on an individual basis, but the researcher began to discern patterns in the responses, which allowed her to use these as cues and prompts to clarify responses with other participants.

The recording of the semi-structured interview commenced following an initial introduction. The interview was designed to build rapport and clarify results

from the questionnaire as well as determining what influenced the graduate's decision to stay or leave the Kimberley following registration. Interviews were mostly held face-to-face and recorded, with participant permission, using an Ipad with application Audio-note. This application had the ability to synchronise notes and audio recordings, which enabled transfer of data to the electronic database. Teleconferencing was utilised when travel constraints inhibited face-to-face interviews. The telephone placed on a loudspeaker enabled recording using the same method as the face-to-face interviews. Each interview lasted approximately 40 minutes. During the interviews the researcher made the occasional notation on the Ipad, (journaling) which was used later to assist in data analysis. An interview schedule logged in the researcher's journal, kept the researcher on track as the evidence unravelled and accumulated.

Discussion occurred around the following topics:

- History of remoteness and whether they considered this impacted on their decision to stay or leave the Kimberley;
- Perceptions of the benefits and challenges to beginning employment as a graduate nurse in a remote area hospital;
- Clinical placement (location, metropolitan, remote or regional);
- Perceptions of workplace after graduation and current work place;
- Perceptions about studying remotely;
- Perspectives on what influenced decisions regarding employment following graduation.

Each interview was transcribed verbatim as close as possible to the time of interview. The researcher employed an external transcription service to assist in transcribing the data. Privacy was agreed through the signing of a confidentiality agreement (Appendix O). This person, who resided in the US, transcribed three interviews, but the Australian accent proved too difficult for her to understand. Consequently, the researcher transcribed the remainder of the interviews. This change in plan proved to be beneficial, as it assisted the researcher in becoming more immersed in the data and facilitated accuracy of the transcripts.

Participant group 2 workforce nurses data collection.

The researcher considered that workforce nurses could pose an influencing factor on graduates' decision to work in a Kimberley hospital, thus it was important to discover their point of view. Participants from group 2 completed a questionnaire with the addition of some open-ended questions, together with an in-depth semi-structured interview. The questionnaire was designed to gather demographic data and to pose questions where answers could be expanded in a later interview. Exploration of the participant's connection with remote areas was also of interest. Questions were therefore designed to investigate the length of time participants had worked in their current location and what had attracted them to the Kimberley. Participants were also asked if they thought graduates had the requisite skills to work in a Kimberley hospital following graduation, and if there was sufficient professional development and support for graduates undertaking the Kimberley graduate program.

The interviews were designed to introduce the study and to build rapport as well as providing an opportunity to explore participant's thoughts on the factors that they considered influenced nurses to work and live in a remote area. Interviews were semi-structured with questions designed to maximise participant feedback. Interview times were arranged as consent forms were received. Some respondents did not reply to meeting requests and others could not agree on a suitable time.

Questions were designed to explore participants:

- Role within the healthcare agency;
- Knowledge of recruitment and retention strategies within the Kimberley nursing workforce;
- Thoughts on what influenced them to work in the remote nursing workforce;
- Involvement working with graduates from the school of nursing;
- Thoughts on what they considered would influence graduates decision to work in the Kimberley.

Participant group 3 nurse managers data collection.

Data collected from participant group 3, used a semi-structured interview and emails. The following points were discussed with participants:

- Positions available to new graduates within the Kimberley healthcare

workforce;

- Experience/level of education required of graduate's employment;
- Incentives to attract nurses to the workforce;
- Influences that could affect a graduate decision to remain in the Kimberley.

Archival documents.

The documents studied included: annual reports, curriculum papers, student handbooks, a recruitment audiovisual DVD from WACHS, and WACHS workforce recruitment data. Information in the documents included: education delivery strategies, student numbers, graduate numbers, and other events that added depth and multiplicity to the context of the study. Data collected also provided insight into: the School of Nursing, the participant's reasons for working in a hospital in a remote area following graduation, the context of their responses, and the factors that influenced the graduates decision. These data collection techniques assisted in preserving the integrity and reliability of the study findings (Merriam, 2009; Schwandt, 2011; Yin, 2009).

Evidence from the initial research question to case study conclusions, were documented in an electronic journal stored in an Ipad and backed up on the researcher's computer. The journal was organised into categories and included an annotated bibliography of events and documents reviewed. It clearly documented in chronological order, notes, including the date, time and condition, under which the data was collected. This process was designed to enable an audit of the data collection process and address the issue of trustworthiness and credibility (Guba, 1981; Yin, 2009).

All data was stored in an electronic database in the researcher's home. Folders were clearly labelled identifying: notes, documents, questionnaires, and interview transcripts. It was essential that the data were kept in order, with clear evidence showing the links between questions asked, data collected and the conclusions drawn (Yin, 2009). The database provided a formal assembly of evidence, distinct from the final conclusions, which could be used in an audit trail by other researchers for further exploration.

Analysis of data

In qualitative studies the researcher is the primary instrument for data collection and analysis (Merriam, 2009). Moreover, analysis and collection of data is a continuous iterative process until the point of saturation is established (Dierckx de Casterlé, Gastmans, Bryon & Denier, 2012; Miles et al., 2014; Speziale & Carpenter, 2007).

Demographic data was collated from each questionnaire and entered into Microsoft excel; an electronic spreadsheet program (http://microsoft-excel.en.softonic.com). Although the data collected in this study was qualitative, it was necessary to identify some basic facts from the demographic data. The spreadsheet enabled the data to be analysed, stored and organised. It contained all data from each set of participants and included: participant's assigned confidential code, all elements of demographic information and answers to all questions (Appendix O provides a sample of the spreadsheet from Group 1 and 2 participants). The spreadsheet enabled the researcher to gain a holistic view of the participant data and discern emerging patterns consistent with analysis of qualitative data.

A step-by-step process was undertaken in analysing the data collected from the interviews. Initially the researcher listened to the audio recording of each interview to establish a holistic understanding of the participant's perspective. Transcription of the interviews occurred as soon as practical, and were read several times to discern the participant's perspective. This process was repeated several times in search of patterns, insights or concepts to find the essence of the participant's responses to the researcher's questions. The researcher reflected on the transcripts and manually scored key phrases of the participant's story. This preliminary interpretation assisted the researcher to conceptualise the data, which has been recommended as a preparatory phase of data analysis prior to the coding process (Dierckx de Casterlé et al., 2012).

Coding is the process of "symbolically assigning a summative, salient, essence capturing, and/or evocative attribute to a portion of language-based, or visual data" (Saldana, 2013, p. 3). Codes allow for cross checking and grouping large

amounts of data. They are markers that assign representative meaning to the data collected (Miles et al., 2014). Coding is recommended as the first step in pattern detection, categorisation and theme building. The analysis of data and coding process in this study utilised the framework designed by Miles et al., (2014). This framework is illustrated in Figure 4.4.

First cycle coding (In Vivo coding)

Revising and comparing codes

Second cycle coding (Pattern coding)
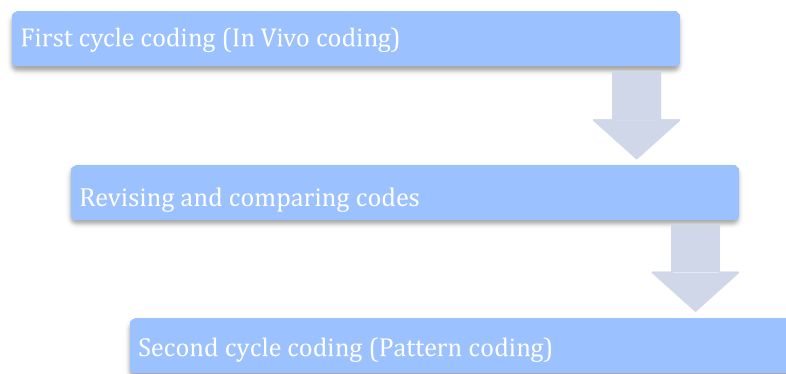
Figure 4.4 Coding and analysis framework (Miles et al., 2014).

Figure 4.4 displays the sequence of events that were undertaken in coding the data. It was heuristic in that the codes were discovered through careful reading and reflection, which allowed time to develop meaning and understanding of all aspects of the data. The researcher highlighted words and phrases in each section of data in an attempt to capture the essence of the participant's stories. The codes were assigned labels that had relationships with the proposition and research question.

During the transcription process, common topics started to become evident after the first three interviews, which enabled the coding process to commence. Using codes enabled chunks of interview transcripts to be categorised to assist with analysis. This In Vivo coding process prioritised and honoured the participant's voice (Miles et al., 2014). Initially, coding was undertaken using a table in a word document, but as the researcher became more confident, the coding process was transported to a computer software package.

The software package, NVivo10 (QSR International, 2014), assisted in the management of data and supported the analysis (Bazeley, 2013). The software enabled data to be collected, assigned codes, and later retrieved to be revised. The

codes were listed and assigned a number for backtracking to transcripts. Using the software, codes were exported into a word document to facilitate analysis (see Appendix P).

Cognisant of the research question, words and/or short phrases that captured potential answers from participant's transcripts were highlighted, and coded in the first cycle of coding (Miles et al., 2014). Codes have been defined as "essence capturing" and when they share characteristics they form categories (Saldana, 2013, p. 3). Codes were analysed and grouped using a pattern coding process (Miles et al., 2014). The researcher was immersed in the data and used her tacit and intuitive sense to undertake this process (Saldana, 2013). It enabled data to be categorised and themed with the aim of forming a structured and coherent pattern of similarities and variations in factors that influenced the graduate's decision to work in the Kimberley. The researcher made every effort to seek rival or alternative explanations to the study's proposition by checking data with her supervisor and other nurses in the field of remote nursing. There were 16 transcripts that produced 95 first cycle codes from participant group 1. The initial codes were then further refined and collapsed into three categories.

A similar process was applied to the data collected from the second and third participant groups. Data from the nursing workforce became repetitive after the eighth transcript. It was deemed beneficial, however, to analyse a further three for additional codes, but this process proved unsuccessful. Only three nurse managers were available for interview so all transcripts were coded as well as information received through email communication from two other nurse managers.

Data from documents, journal and DVD

Analysis of the Kimberley nursing workforce employment statistics and recruitment and retention strategies added further to the context of the case. It also provided additional points for discussion with the participants. The audio from the Kimberley health workforce promotional DVD was transcribed and analysed providing material to compare and contrast from the finding of the graduate's responses. Answers provided in the questionnaires were also coded and stored in the

study's database as well as being catalogued in the researcher's journal.

Summary of analysis process

Chronological journaling recorded the researcher's thoughts, evolving interpretation of evidence, insight and connections between data and preliminary analysis (Yin, 2009). The research journal was vital for keeping track of the evidence, alternative theoretical propositions and for ongoing analysis and interpretations. The notes and interpretations were substantiated with other evidence from interviews, or documents and were reviewed by the researcher's supervisor to lessen the risk of the researcher's personal bias contaminating the analysis.

Additional, interpretations were compared with other evidence either from interviews or documents to assist in maintaining the trustworthiness of the data (Koch, 1994; Long and Johnson, 2000; Streubert and Carpenter, 2011). Perceptions of the graduates and staff were linked to the documents and reports with theme matching based on the theoretical proposition. This iterative process of collecting, coding and analysing data was undertaken throughout the study. The data was triangulating by looking for contradictions, inferences, convergence and supportive evidence to the emerging themes (Yin, 2014). From this analysis overall themes emerged that revealed the factors that influenced students to work in a Kimberley hospital. By aligning the codes from the interview, combined with evidence from the questionnaires, documents and the researcher's journal, broad themes emerged. The findings of this process are elaborated in the following chapter.

Rigour/Trustworthiness

As this study used multiple sources of data, both rigour and trustworthiness of the findings were essential. In qualitative research the term trustworthiness is used to describe the strategies used to ensure findings can be trusted (Speziale & Carpenter, 2007). The operational terms that describe this process are credibility, dependability, confirmability and transferability (Lincoln & Guba 1985).

Credibility

The researcher had prolonged engagement with the phenomenon, which could be considered evidence of credibility (Speziale & Carpenter, 2007). Although the researcher was situated within the context of the study there was no direct personal influence on the graduates in their decision to stay or leave the Kimberley healthcare workforce. Intimate involvement in the context of the study, however, could be interpreted as a personal bias. Reflexivity and dialogue minimised any potential bias. The following steps were undertaken to demonstrate credibility and achieve neutrality: personal and professional values in collecting and analysing data were evaluated with the researcher's supervisor, the supervisor checked journal entries and processes used in analysing the data and participants were provided with a copy of the transcripts to check for accuracy (Baxter & Jack, 2008; Stake, 1995; Yin, 2014).

Dependability

One of the advantages of amassing data from various sources is that triangulation can occur. This process was undertaken by juxtaposing the data to determine the consistency of findings (Speziale & Carpenter, 2007). As alluded to in the data analysis section, all data was synthesised into final themes, which addressed the research question and will be described in the following chapter.

Confirmability

The researcher systematically recorded and managed data in order to leave an audit trail for another individual to follow (Anthony & Jack, 2009; Brown, 2008; Patton, 2002; Speziale & Carpenter, 2007). This process was especially important in addressing the potential bias of the researcher.

Transferability

The concept of transferability refers to the possibility that the findings will have relevance to others. Moreover, exploring nurses' sources of knowledge has relevance across many practice settings (Estabrooks, Rutakumwa, O'Leary, Profetto-

McGrath, Milner, Levers, & Scott-Findlay, 2005). This concept will be addressed in the limitations and recommendations of the study in the final chapter of the thesis.

Ethical considerations

While this study had minimal risk for ethical concern, it was still important to consider the ethical rights of the participants during the development and subsequent conduct of this study. The greatest ethical concern was the relationship between the researcher and the participants. The existence of power differential was acknowledged, as the researcher is the Assistant Dean of the Broome School of Nursing and Midwifery. The researcher, at the time of this study, had also worked within the Kimberley healthcare workforce and had developed a level of rapport with all participants. It was essential to assure the participants that the study would take place outside the researcher's academic position, since it has been argued that a hierarchy exists in any research process between the researcher and the participant (Seidman, 2006). To this end the researcher undertook data collection during six months sabbatical.

Being conscious of the likely effects of the researcher position within this study was the first step towards ensuring a process of a balanced relationship with the participants and increased the trustworthiness of the study. Developing a partnership with the participants, asking permission, and using clear communication skills to build trust also assisted with resolving possible bias. Questions for the interviews were aimed at developing rapport and encouraging participants to share their experience, rather than the information being driven by questions (Seidman, 2006). Part of the interview process included informing the participants that information gathered would be used for purposes of the study and would have no bearing on future studies, or employment prospects. All participants were given opportunity to review their transcripts, to add comments, make corrections or withdraw from any statement (Rubin & Rubin 2012; Seidman, 2006).

The consent form outlined the rights and responsibilities of the participant and the researcher. Participants were informed that they were under no obligation to participate in the study. Interviews took place at sites and times mutually convenient

to both researcher and participant. Sites included the Notre Dame library both in Broome and Fremantle, participant's homes, community libraries, together with conducting interviews by telephone. The participant performed the lead role in determining these arrangements and the researcher paid the small fee required for the community centre locations.

All data gathered was identified in a way that assured confidentiality. Meeting times were private and once coded the data was recorded in a spreadsheet and cross- coded with the participant's contact details. This spreadsheet was stored securely in accordance with Notre Dame Policy: Code of Conduct for Research (Appendix Q) in a password-protected Ipad and backed up on the researcher's password protected computer. At the completion of the study all participant data inclusive of field notes and memos were stored securely at the Notre Dame, Broome School of Nursing and Midwifery for a period of 5 years. To ensure confidentiality the researcher and her supervisor were the only people permitted access to the data.

The Deputy Vice Chancellor and the Dean of Nursing and Midwifery provided access to the School for data collection purposes. The University of Notre Dame Ethics Committee and the WACHS Research Ethics Committee provided ethics approval. Permission to access student information and archival records was sought and approved by the Reporting and Statistics officer at Notre Dame.

Conclusion

This chapter outlined the approach used to explore and describe the factors that influenced the graduates' decision to work in a Kimberley hospital. A single exploratory descriptive case study was seen as the appropriate method of understanding and answering the research question. In keeping with the method the boundaries were set with data being collected from various sources including the graduates, workforce nurses, nurse managers, archival documents and a promotional DVD. Both questionnaires and interviews were used to collect data. Questionnaires were either in hard copy or electronic format and interviews were conducting face to face or by telephone. Data was analysed using a thematic analysis approach. The chapter concluded with the issue of rigour and ethical consideration being discussed2

Chapter 5

Findings

Introduction

The findings of this study revealed multiple, complex and interrelated factors that influenced graduate nurses in their decision to work in a hospital in the Kimberley. In keeping with the principles of a case study approach to qualitative methodology there were multiple sources of data with the phenomenon and context being intertwined (Merriam, 2009; Stake, 1995; Stake 2005; Yin, 2014). These sources were organised into four distinct data sets. Graduates were labelled participant group 1. Group 2 were registered nurses employed in Kimberley hospitals, with nurse managers from hospitals and other healthcare agencies constituting participant group 3. A promotional DVD and archival documents that were used in supporting or refuting the findings were classed as the fourth data set. The sources of data collection are displayed in Figure 5.1.
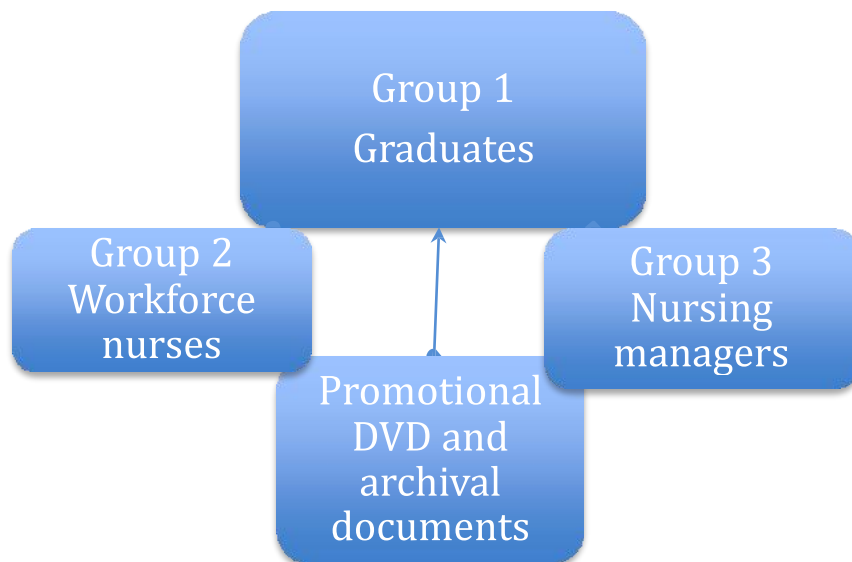
Figure 5.1 Sources of data collection

In analysing the data gathered from the above multiple sources the researcher was cognisant of the case study proposition, which stated that: A graduate's decision to work in a hospital in a remote area such as the Kimberley is influenced by both professional and personal circumstances. Data analysis was also guided by the

research question: "What are the factors that influence remote school of nursing graduates in their decision to work in a hospital in the Kimberley?"

This chapter will consist of two distinct parts. Part one will provide general demographics of group 1 and 2 and present a synopsis of findings from each data set, supported by the participant's comments. The resultant findings from each group were not possible until all data had been collected.

Part two will portray the findings from juxtaposing data collected from the graduates (participant group 1) with all the other data sets. It was important to see if data from the other participant groups contradicted or concurred with the findings from the graduates. A synthesis of the findings, with evidence from archival documents, together with the final themes and sub-themes will conclude the chapter.

Part one: Findings from all participants

Participant group 1 graduates.

General demographics

The first set of potential participants chosen for this case study were the students who had completed either the BN or DN course at Notre Dame, Broome and studied at least one semester on the Broome Campus. The BN program was offered in both Fremantle and Broome providing a choice of location for students to study the whole, or part of the undergraduate program.

Between 2002 and 2011, there were 150 BN and 25 DN students who completed all or part of their undergraduate degree on the Broome campus. Broome campus commenced the Bachelor Program in 1999 but students did not complete their program until 2002. This number provided a population of 175 potential participants. Data in Table 5.1 identifies that 89 BN students completed a full program on the Broome campus. The DN program was only offered from the Broome campus, which meant that all students remained in Broome to complete their studies.

From the figures obtained from the Broome and Fremantle records, the population demographics in terms of gender and qualifications could be identified and are further detailed in Table 5.1. Females comprised the largest proportion of the population. This percentage (89%) is consistent with the National ratio of approximately 10% males to 90% females in nursing (AIHW, 2013, p. 11). This ratio differs for the DN participants, where there were a higher percentage (24%) of males. These statistics for the male DNs was markedly different to the national statistics provided by the National Health Workforce, which identified in 2008 and 2012 the number of employed male ENs was 8.7% and 9.2% respectively (AIHW, 2013, p. 11). There were six groups of DNs in the time frame of this study and one cohort in 2010 consisting of 38% males. This could have led to the higher than average percentage of males in the DN population.

Table 5.1 Graduate demographics

	Bachelor of Nursing	Diploma of Nursing
Completed program	150	25
Full course Broome	89	25
Part course in Broome	61	0
Male	16 (11%)	6 (24%)
Female	134 (89%)	19 (76%)

Employment

The list of graduates from Notre Dame Broome Campus, was cross-referenced with the employment list at the WACHS Kimberley office. This organisation was the largest employer of registered and enrolled nurses in the region. The findings indicate that Notre Dame, Broome provided a sizable number of graduates for the local healthcare care workforce.

The majority of graduates, however, chose to seek work outside the Kimberley. A total of 30% of the graduates had worked in the Kimberley since graduating. Just over half of this group (16%) still worked in the region at the time of data collection (see Figure 5.2). A number of these graduates had worked within

WACHS for greater than 10 years and two were currently undertaking further studies at Notre Dame, Broome.

There was a marked difference between the percentage of DN graduates and BN graduates who chose to stay and work in the Kimberley. Of the DN graduates 68% (17) stayed in the Kimberley, while only 25% (38) of the BNs stayed. Only two graduates were known to have worked for another employer in the Kimberley, one in aged care and one at BRAMS.
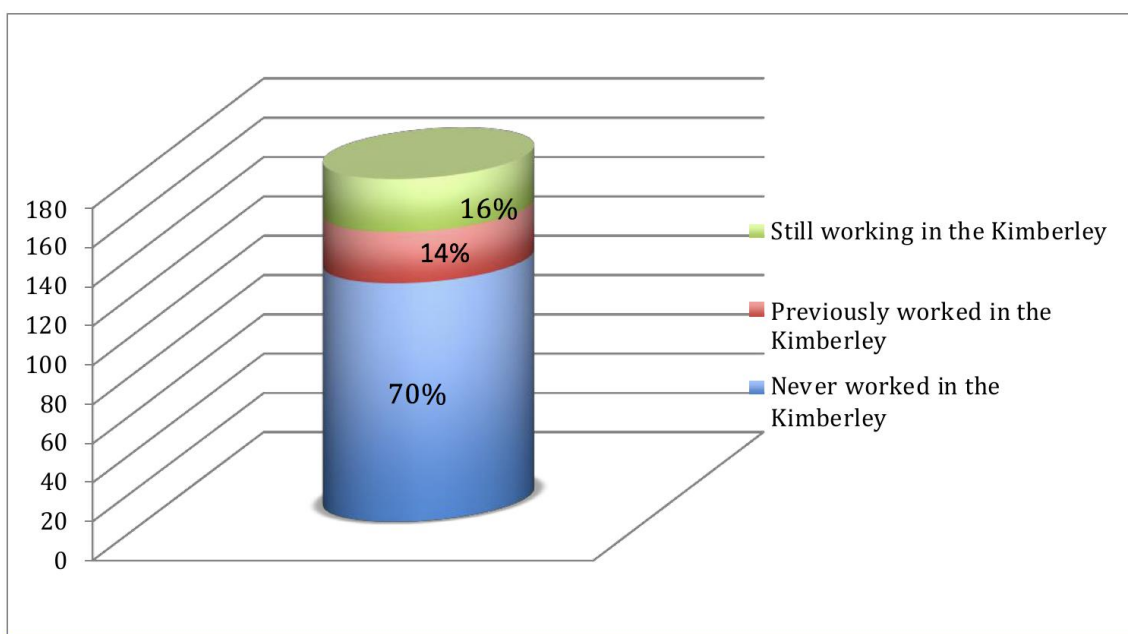
Figure 5.2 Graduates employed in the Kimberley healthcare workforce

Participant group 1 graduates questionnaires.

Due to discrepancies in contact details, it was not possible to contact all potential participants from the total population of 175 graduates. As depicted in Figure 5.3 one hundred and fifty nine (136 BN and 23 DN) questionnaires were distributed with 24 being completed and returned. This number constituted a 15% response rate. Seventeen of group 1 participants (12.5%) had completed a BN degree. A much higher percentage (29%) of the DNs responded. This percentage was not surprising since contact details of these potential participants were easier to

locate from the Broome campus records.

Table 5.2 Completion dates of participants

Dates	2003	2004	2005	2006	2007	2008	2009	2010	2011
BN	3	0	2	1	1	4	2	0	4
DN	0	0	0	0	0	0	0	5	2

The first cohort of BN students completed their studies in 2002 and the DN in 2010. As shown in table 5.2, the course completion dates for the 24 participants ranged between the years 2003 and 2011. As interviews for this study were undertaken in 2012 there was recent recall for some graduates, whilst for others it was nine years previous, which may have accounted for a memory lapse. Where relevant this length of time is noted during the display of the findings and in the analysis phase of the study.
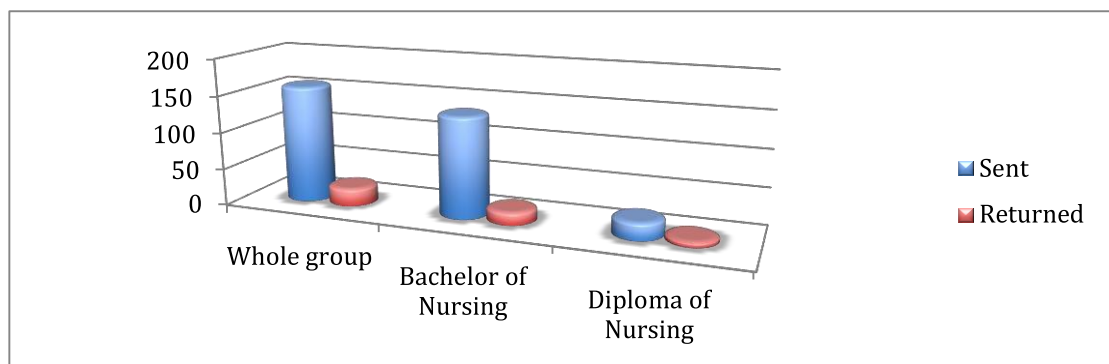
Figure 5.3 Questionnaire response rate

The reason for a lower percentage of BN responses was probably associated with the discrepancy in contact details from the Office of Human Relations at Notre Dame in Fremantle. A further reason may have been the length of time since BN students had graduated, so their records might have been out of date. One other point of relevance could be that a number of the BN graduates may have completed only one semester on the Broome campus and, therefore, could not see the relevance of the study.

Distributing a questionnaire to group 1 participants, prior to conducting an interview, was designed to meet the objectives of the study and to assist the researcher in posing relevant questions during the interview. The last section of the questionnaire invited participants to make comments related to the study's research question. The qualitative findings were then thematically analysed. These questions included exploring the background of nursing graduates and their work profile together with the factors that influenced their decision to work in the Kimberley. The ASGC system in the DoctorConnect® search map was used to label each town that a student had lived or worked (DoH, 2015). The results of the questionnaire can be seen in Table 5.3.

Table 5.3 Participant group 1 graduates demographics

Demographic	Number N = 24 T(BN)[DN]	Percentages of N
Bachelor of Nursing (12.5% of all BNs)	17	71%
Diploma of Nursing (29% of all DNs)	7	29%
Male	3 (1) [2]	12%
Female	21 (16) [5]	88%
Age group 20s	11 (10) [1]	46%
Age group 30s	6 (5) [1]	25
Age group 40s	7 (2) [5]	29%
Lived remote prior to studying in Broome	13 (9) [4]	54%
<1yr	1 (1) [0]	8%
<10yr	8 (6) [2]	61%
>10yr	4 (2) [2]	31%
Family or friends in Broome	16 (9) [7]	67%
Worked remote since graduating (all Kimberley)	14 (8) [6]	58%
Had family and friends there (of the 14 who worked remote)	12 (6) [6]	85%
Lived remote prior to study (of the 14 who had worked remote since graduating)	10 (6) [4]	71%
<1yr	1 (1) [0]	10%
<10yr	6 (4) [2]	60%
>10yr	3 (1) [2]	30%
Not worked remote since graduation	10 (9) [1]	42%
Not worked remote or lived remote prior to study	3 (2) [1]	30%
BNs completed full course in Broome	6	35%
Completed a graduate program	15	62%
Completed graduate program in remote (of the 15 who completed a graduate program)	5	33%
Completed grad programs in other regions/cities	10	67%
Currently employed in a major city	12	50%

Responses from questionnaires

As displayed in Table 5.3 slightly more than half (54%) of group one participants, had lived in a remote area prior to studying in Broome. This finding was similar to both BN and DN participants. The majority of these (92%) had lived in a remote area for more than one year with 31% living in a remote area for more than 10 years. More than half (67%) of the participants had family and friends in Broome prior to enrolling in their studies. A large proportion of participants (71%) had worked in a Kimberley hospital since graduating (86% DN and 47% BN). Eighty five percent of the 14 respondents who had worked remote since graduating had family and friends living in the same area. All DN graduates had family or friends working in the Kimberley and all but one had worked in the Kimberley following graduating.

Of the 14 participants, who worked in a remote area since graduating, 71% had also lived remotely prior to studying in Broome. Of these, 90% had lived in a remote area for more than one year prior to studying in Broome. The remaining students, whilst not living remotely, had a history of living in an outer regional area in Australia prior to studying on the Broome campus.

It would appear that having a strong historical connection associated with family, friends and schooling in a remote region was a sufficient motive to remain in the Kimberley. There also appeared to be a strong connection with staying or moving remotely when family and friends were also living and working in the area.

Interestingly, nearly all BN graduates completed a graduate program: eight in a major city, five in the Kimberley and two in regional areas of WA. The remaining two BN graduates worked full time within WACHS Kimberley, but did not complete a Graduate Program. Six of the DNs had worked for WACHS at some point and one had moved to a major city in Queensland. It is worth noting that there were no Graduate Programs available to DNs in the Kimberley. At the time of this study half of the graduates were working in a major city.

Participant group 1 graduates interviews.

Participant group 1 had a wide range of demographics. It was, therefore, important to be aware of the potential bias when interviewing participants who had historical connections with living remotely, or who had decided not to work in the Kimberley after graduation. With such variances it was important to ensure that the interviews accounted for all aspects of the phenomenon (Morse, Barrett, Mayan, Olson & Spiers, 2002). The phenomenon was the factors that affected graduates decision to work in a Kimberley hospital.

Nineteen of the 24 participants were booked for an interview in the first three months of the study. Interviews for the remaining five participants were problematic to arrange due to ill health, work commitments and holidays. These particular participants were advised that they would be contacted should an interview be required. Owing to saturation of data, these participants were not required for interview.

Following the analysis of 10 transcripts, from the graduate participants, it was evident that the data was becoming repetitive. A review of the demographics revealed that participants with DN qualifications had not been coded. Thus, a further inclusion of five DN transcripts and one more BN were analysed. The BN transcript was included to see if there were any alternative interpretations of the factors that influenced graduates decision to work in the Kimberley. This latter participant was in her early 20s and had completed part of the course in Broome. She had no prior history of living remotely, had completed a graduate program in the city, with no intentions of moving back to a remote area. Data became repetitive with no new patterns emerging following the 16th transcript. At this stage data was considered saturated.

Data from transcripts were analysed, grouped and regrouped. Rival or alternative explanations were explored. The researcher made memos after each phase of analysis and coding to compare thoughts and findings. These were explored and discussed further with her supervisor to reduce the risk of personal bias. During second cycle pattern coding, 95 codes were grouped, clustered and collapsed into 13

sub categories. Codes were further sorted, resorted and clustered until it became apparent there were two categories: personal and professional influences, consistent with the study's proposition. On further scrutiny of these categories, a third category emerged and was labeled 'local exposure'. Whilst each of the categories could be delineated there was interplay between personal and professional factors and local exposure that ultimately influenced their decision to work in the Kimberley (see Figure 5.4).

Local exposure

The category, Local Exposure, was related to the graduates exposure or connection to Broome. The factors within this category were further grouped into four sub categories.

Figure 5.4 Participant group 1 graduates local exposure

The sub-categories of local exposure were titled: University, Learning extra skills, Cultural exposure, and Clinical placements (see Figure 5.4). Whilst each of these sub-categories were demarcated, there were linkages with possible factors that may have influenced graduates to work in the Kimberley. The following section provides details of these sub-categories, with commentary from the participants.

University

A number of graduates commented that having a university campus in Broome, provided them with an opportunity to study nursing. Living in Broome and being able to study was beneficial. Student's who had never left home appreciated the opportunity to study in a remote region with locally provided support. More than one graduate said that if there had not been a university in Broome they would not have studied to be a nurse.

Interestingly two BN graduates commented that they had been offered a place in Broome. They had applied to the Fremantle campus and at interview made mention that they might be interested in studying in Broome. Rather than being given an option of location they were offered the Broome campus. These participants were not offended, but were thankful of the opportunity.

Other students chose to move to the Kimberley to study and experience life in Broome. Some did this for a 'life change,' others moved because they considered that creating a connection and moving to Broome to study might increase their opportunity to stay in the region after graduation. One DN participant said that, "being able to study in Broome definitely had a positive influence to remaining in the workforce".

A large percentage of graduates (46%) were in their 20s, and had not lived in a remote area prior to moving to Broome. Moving over 2000 kilometers from home was daunting for most of the graduates as students. One of these participants a BN graduate commented:

> Providing a long-term study opportunity rather than just clinical placement provided me with a safe base with which to explore the option of living in a remote environment and we had accommodation on campus, so its good that that's all set up so you didn't have to worry about looking up where to stay and all that… it's a pretty good opportunity to do that sort of exploration from a safe place. You know you had the University there it wasn't just like going up there for a clinical placement.

One more BN (from a town south of Perth) commented:

> It's fantastic to create that family feeling that you belong to someone you're not the only one studying, and sometimes struggling. That was very rewarding for me, because I didn't feel I got it here [previous place of study], but that's a numbers factor, I think, and being a country girl at heart probably helps. So for me, that was – I mean, that may come down to not necessarily having a campus per se, but still trying to encourage that group team-building, whether it be a block week where everyone gets together. I don't know. I mean, that doesn't necessarily mean you need a campus, I suppose. But I did enjoy that factor.

Having a local university, which created a 'welcoming community' environment was important to these participants. Other participants commented on the connection between study, staying, and finding employment. For example one DN participant said, "yes and I think that [studying here] helped me get a job here. Being a small place and knowing people helped. Doing the clinical practicum placements up here certainly helped."

One participant, when asked if they felt that their study and remote clinical experience assisted them with being able to walk in and do the job, responded by saying, "yes absolutely, I think it makes you a bit more independent and self manage your own study, and it gives you that, umm, I don't know that autonomy to do things. I thought it was a good thing."

The opportunity to study remotely through Notre Dame, Broome as well as being on clinical placement within the healthcare workforce, provided the requisite skills for working in a remote nursing workforce. Such nurses have been reported as: being resilient, resourceful, adaptable, and creative (Bushy, 2002). One participant's comment confirmed this analysis:

> I think it's a lot to do with the fact that the University is more appreciative of the differences that you've got in the remote areas as opposed to just living and working in city areas and I liked the teaching up on the Broome campus. It taught you to be resourceful it taught you to utilise the people, utilise what you have available, think broadly, and I really liked that.

Students attended clinical placement throughout the Kimberley, which

enabled them to become familiar with the local healthcare context. It also provided an opportunity for local employers to observe the students at work. Studying locally however, did not mean that finding employment was guaranteed. One BN participant who did not secure a job in the Kimberley commented:

> In the hope that having more of a remote education, a rural education would give me a better standing to be able to get a job within the hospital system their or outlying communities, which I didn't find to be accurate. But anyway, the experience has certainly helped, the study and the prep experience [clinical placements] has certainly helped prepare you for when you did get the job.

Application to the local healthcare services, or the Kimberley Graduate Program did not always secure jobs for local students. The Director of Nursing, on a number of occasions, had commented that preference could not be made to local students. They were obliged to apply like all others and were shortlisted using the same criteria as other applicants. A number of graduates were amazed that local high school educated nurses, were not given priority in their application. It is the researcher's opinion that local students should, through their local exposure and practice, be high on the list of applicants.

Learning extra skills

The Notre Dame Broome nursing program, offered students an opportunity to learn clinical skills relevant to rural and remote nursing practice. These specialist skills such as venepuncture and intravenous cannulation, supported the students in their endeavour to gain as much as possible from their clinical practicum. Tutors in the skills laboratory were employed at the Broome hospital and ensured clinical skills were relevant to the local workplace. Comments made from graduates who had moved to the metropolitan area, highlighted their appreciation for the extra skills they had learnt. As one BN who studied in both Broome and Fremantle and completed their course 5 years previously commented:

> Broome was never about stepping outside your scope, but taking opportunity to broaden your scope. I found in Freo [Fremantle campus] it was more working within your scope of practice, don't step out of your scope of practice. Instead of taking that opportunity to say to someone can you show me this, can you teach me that,

can you tell me more. It was almost like a fear of taking on new opportunities sort of stepping outside of that comfort zone for Freo students.

Another student felt that they were well prepared for clinical placements in a remote hospital setting. She had moved to the Fremantle campus to complete her studies so was in a position to make a comparison. She stated that, "At Broome they gave us a lot more information…another example is that in the crit. [critical] care unit in Freo we were doing ECGs [Electrocardiographs] and stuff and I was thinking we covered this already up in Broome." A further participant felt that she, "Didn't know if it was from necessity as in rural areas you need to be a lot more multi skilled and in Perth you needed to focus on the basics. I found rural places were a lot more comprehensive than the city place." This comparison between the Fremantle and Broome campus students, was made by several participants, for example, they commented that being from Notre Dame they felt more advanced during their placements and got in there and did things a lot better and that preceptor's said the same thing as well.

When asked to comment on differences between city and clinical placements in the Kimberley, graduates were very quick to comment that they thought they gained more from placements in the Kimberley with one graduate commenting that:

> You are kind of made to think for yourself [in a remote placement]. In Murdoch [a city tertiary hospital] the doctor is the one that says do this, check bloods or do the urinalysis, do this do that…. Whereas when you're in remote you sort have to put yourself out there to think for yourself before you have the doctor come in to assess.

In reference to the scope of clinical practice experienced by participants when they were students, one participant commented that:

> Broome students would take on any opportunity that we had it was almost an adventure, they were more likely to be adventurous and I do remember someone saying that about Broome students as there was a bunch of us that went down together [to Perth] and there was that Broome students seemed to have a broader scope. I think that's the best way to put it.

It was apparent from participants' comments that they considered the clinical

skills experience they gained during their studies, prepared them well for their placements and work in remote hospitals. Clinical skills, clinical experience and workplace experience are all related so it was considered important to raise these concepts under local exposure rather than considering it was the locality of the experience that could prove the discerning factor for their decision to stay or leave the Kimberley. There were no rival propositions in this theme. No graduates, either BN or DN considered that exposure to clinical skills during their studies had influence on them leaving the Kimberley.

Cultural exposure

Central to the Broome campus is its mission to promote the process of reconciliation between the Indigenous and non-Indigenous peoples of Australia. Cultural skills are embedded into the everyday activities on the campus, as well as being reflected in the course curriculum and course design. Both the BN and DN curricula on the Broome campus provides cultural training in excess of the minimum required to address Aboriginal and Torres Strait Islander peoples' culture, history, healthcare (ANMAC, 2012; ANMC, 2009). In relation to the cultural components of the curricula one participant made the following comments:

> I think firstly the University course, the Aboriginal healthcare … that was brilliant as an overview of the history. Just knowing the people just interacting with them and just seeing. … Just everyone sort of knows one another. That's country again people just know people. I found Broome gave you that very much … better opportunity to learn about working with people and utilising them [non- Aboriginal people] as part of your team to help improve their healthcare…I think it largely came from that emphasis on cross cultural skills and actually really realising that these people, this person, may think very differently to me…I think Broome offered that experience particularly because of that cross cultural setting.

Cultural awareness training and exposure in the clinical environment was seen as highly valuable to graduates and positively influenced their nursing career. Even though this exposure may not have had a direct influence on a graduates decision to stay in Broome and work in a remote healthcare service, they felt their

ability to care for Indigenous people was improved. One participant, when asked whether they felt that the cultural awareness training had been a positive influence, said:

> Yeh, absolutely I think you relate to things a lot more you're more open minded about things. How do I say this...you see things a bit more openly in regards to. Before I went up to the Kimberley say for example I was oh the Aboriginal issues and that, but you see the real side of the Aboriginal issues up there its not just what you see and what the Greens [political group] like to present to us there is a another side to it all mmm. You can understand things a little bit better. And I think that gives you a better perspective I think and reality.

Another participant remarked:

> I always remember that rural experience where you've always got to work with people particularly largely working with people cross culturally there is a lot more cross cultural experience being such a remote place. In a remote area having such a huge Indigenous population and working very hard with their culture and their cultural beliefs umm you didn't get that in Freo even though Perth is a very multi cultural city there isn't that same emphasis on cross cultural skills and I think because of that emphasis in Broome of cross cultural skills of working with people to get a desired result, you know full well you couldn't stand there and preach to people and say if you don't eat 3 times a day and take your insulin your diabetes is going to get out of control and that's very very bad and you'll get sick, and it just goes over someone's head and you've sort of got to look at the cultural influences and say what have these people got available to them.

Cultural awareness training is a pre-requisite for any student attending clinical placement. The students undertake two online cultural awareness packages within their first two semesters on campus. They also attend a locally provided cultural awareness workshop (Appendix R).

Even though the theme of cultural awareness was a positive influence on participants nursing experience, rarely did it appear to being a reason to stay and work in the remote healthcare workforce. The exception was where one participant who had a history of living in remote areas wanted to spend some time learning and

working within the Aboriginal healthcare sector following graduation.

Clinical placements

While following up on one conversation with a participant about what it was that the University provided that encouraged students to stay. The participant commented that, "it was more than what the University offered during the course it included the clinical exposure provided during the course".

As student nurses, BN and DN graduates had been placed in a variety of remote locations and healthcare settings. One participant said she took up the opportunity of requesting clinical placements choosing, "a broad range of clinical placements to be prepared for country".

Most participants felt that the clinical practice experience was definitely a significant factor for them to stay in the remote healthcare workforce. Such comments included, "doing the prac definitely… because I loved Kununurra so doing the rural thing was awesome and I'm actually looking to move up to Darwin, so well hopefully it will work out." A DN graduate commented that, "Yeah, I'd say the [clinical placement experience] did, yeah. I can't think of any significant factor that was like I really want to come back and work here, but I know that I really did enjoy my time in Derby and here in Broome and in Carnarvon".

One BN graduate while discussing the differences she had found between city and remote placements commented, "it [remote] was more you know lets have a look at the people, it [city] was not very people focused".

Graduates comments revolved around their extra experience and exposure. Some commented that their mentors, in the remote placements, were much keener to have students explore more opportunities than the allocated patient load could provide. In contrast students who attended placements in the city felt they were too protected and their opportunities to see more were restricted by their mentors. It is interesting to note that a number of graduates used the term rural in their interviews. All placements provided to students were mostly in the Kimberley. Some students,

however, were placed in large urban hospitals such as Geraldton and in the Perth metropolitan area. A BN student who had experienced placements in Kununurra and Derby commented:

> Comparing metro places and rural places. Rural places give you a little bit more freedom if you like. People are a little bit more willing to let you do things. In the city they're like oh no maybe you had better not, they seem worried that a patient will sue, or they are a private patient…I don't want a student. Up in the country people [patients] don't seem to care so much they are much more willing to let you be hands on and do things…I think I felt like I had more involvement with the nurses and doctors up there because even the doctors knew I was a student there and they would come and find me if there was something going on they would come and get me, like if there was a resus [resuscitation] or something they would come or they'd get one of the nurses and say come down and check it out.

A number of participants talked about a sense of belonging, which they gained from placements, "Yeah, I think just that feeling, that belonging" it was a definite pull for some participants. From practicum to practicum [clinical placement] and then to employment, "Having nurses acknowledge on your familiarity with the work environment was a very positive and enriching feeling." One other participant commented, "You know, after all these years I feel that I do belong… a good, strong feeling of belonging. And seeing what we all face, like the girls that have been through Notre Dame with me and after me." One participant remarked it was the nurses that she had worked with that drew her back. This participant had been on placements in Perth and commented:

> Sometimes it was a bit disheartening when they had even second and third-year nurses who really didn't like their job at all down in the city, whereas up here [in the Kimberley] I found the nurses enjoyed their job a lot more. It was a very supportive workplace.

Whilst it is clear that having a local exposure provided graduates with an association and a familiarity to the region, it was not the only factor that influenced their decision-making. It was the additional interplay of personal and professional factors that ultimately influenced their decision.

Personal

Factors grouped as personal were those that had a connection with the person on an individual level; they were factors that sat outside of the workplace and contributed to the enjoyment of the graduates' life. These factors (see Figure 5.5) were grouped into sub-categories entitled: lifestyle, family connections, and facilities. Graduates were often not prepared to compromise if the region was not going to provide for their personal needs or family they chose to go. The following section elaborates on these sub-categories
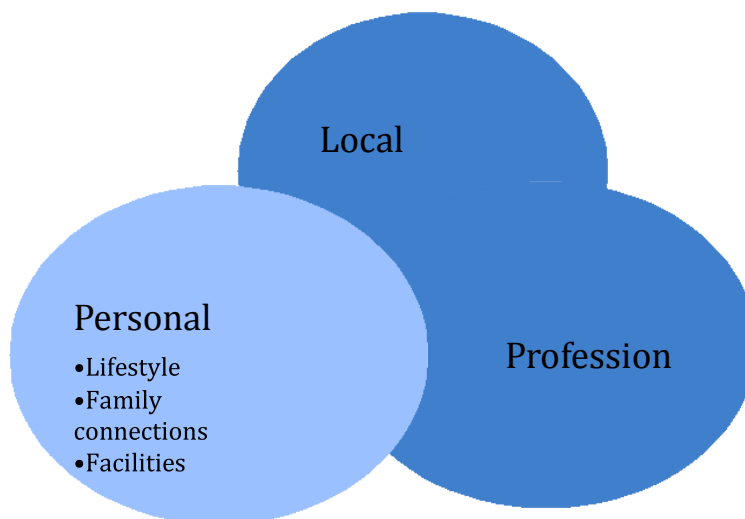
Figure 5.5 Participant group 1 graduates personal factors

Lifestyle

A number of comments from participants in relation to staying in the Kimberley, related to lifestyle factors. Lifestyle was a term originally used by Alfred Adler (Vujisic, 2013). It was a composite of motivations, needs, and wants that was seen to assist a person to create, or build a particular way of life. There were a number of factors in the data, which were categorised to lifestyle. These factors were extrapolated from the following comments when graduates were asked what influenced them to work in the Kimberley. One particular graduate who did not stay and work in the Kimberley after graduating due to family commitments in Perth, chose a metropolitan graduate program which had a "country feel to it". She added:

> I don't know I think it is just the lifestyle for me mainly
> that sticks out. But like I said before with Kununurra just
> to get exposed to everything and then studying in Broome

it was something new and the lifestyle I really enjoyed that.

This same participant's goal was to move back to the Kimberley and she commented:

> I just liked the fact that you're not stuck in the traffic it's so much more laid back and chilled out than what it is down here. So for me it was about lifestyle as well as getting the experience. I wasn't prepared to just get my certificate and then go somewhere small and just plod along. It was about consolidating, but being comfortable too. If I'd gone to Royal Perth or somewhere you probably would have just gone to a cardiac ward or just done a bowel ward.

Making friends was important for one graduate who felt this was easier in a remote area. It was the local people and their friendly attitude that attracted her to stay in the region and she commented:

> You know having no understanding of the local Indigenous culture and no understanding of anything and I think that the only thing that ever saved me is that I'm a friendly person who'll make friends with anybody and I was very open to anyone and you know walking into a country town they don't care who you are. I walked into Derby wearing knee high silver boots and still managed to make friends, I don't know how that happened.

Sometimes lifestyle factors were linked to the topography, as one participant said, "I like the remoteness. I know lots of people complain and whinge about it, but I like it." One participant who was positively influenced by the lifestyle commented that "the country is in you." Probing for clarification brought the following comment:

> Ummm I don't know I just think it makes me open minded I like being out in the country air like I said I had to get to the city and then I got here and I went away again and then when I got back I realised it was just hustle and bustle and lights. Lots of people doing the same thing and it made me realise more and more that they're sheep. I say to Mark they're sheep they're sheep they all want to do the same thing. So I love just being out [in the country] and being creative and being unique and doing our own thing and not sort following the trend. And our friends from down here our city friends yeh they think we're country bumpkins I

suppose but they admire that uniqueness yeh I don't
know yeh its hard to explain what the country is I just
know I love it.

One BN graduate who had lived in Broome prior to studying was very clear
that she wanted to remain, making the statement, "If I wasn't successful [in applying
to Broome hospital]…I would have gone back to drug and alcohol [working in
community health]".

Although comments about family were interwoven in other participants'
comments it was clear that it was the lifestyle that attracted graduates to the
Kimberley. One participant planned her move around family travel and commented:

We took that long service leave and we moved up here
because of the attraction to Broome for me and for the
family. And it was an agreement between the three of
us that if any one of us, after that three months, had any
misgivings, that we'd just go back to our comfortable
old home in Bunbury. But in that three months, we got
a taste of what it would be like to actually live here. It
was just going into the wet season then, so we thought
we'd be able to cope with that as well. And business
opportunities came along. I was able to do a little bit of
work in three different places. I think I was making
cappuccinos at a café, making ice creams at Wendy's [a
local ice creamery] and doing the odd shift at the
hospital on the permanent care unit. And that's how it
stayed until the degree first came along. So that's
basically what drew me to Broome, it was more about
probably Broome itself and family, my younger sister
[who lived in Broome] being my only sister, and having
three little kids.

There were no participants who commented negatively on the lifestyle or
what could affect them from a lifestyle point of view. Many commented on the
positive aspects of the weather and the ability to experience the outdoors for many
months of the year. There were no negative comments about the extremes in weather
or that the weather played a part in them not working in the Kimberley.

This finding was particularly interesting considering the extreme weather
conditions at specific times of the year and the lifestyle hinging on outside sporting
and camping activities. Even though a number of participants interviewed had not

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stayed or moved back to the Kimberley they did not consider the weather as an impediment to returning. From experience there are a number of people I have met that would not consider moving to the Kimberley because of the extreme weather, particularly the heat and humidity in the wet season.

Family connections

Family connections were associated with the graduates' reasons to stay or leave the area. Some of the participants comments on lifestyle were interwoven with family connections others mentioned family specifically. For example one participant was very clear in her opinion and commented, "A husband or boyfriend finding a partner, that's definitely one significant factor to stay in the region".

The following comment from another graduate when asked what keeps them from moving back to a remote area highlights the family connection by saying "not having had a 7-year-old in school and a partner who wants to stay here". This summed up a number of graduates responses that family was important in their decision making. Another graduate who moved to the city with an intention of moving back to Broome commented:

> My original plan was to stay the 12 months and then go back to the country but then umm I suppose having my family and all my friends here in Perth and the job I am doing is okay and I am enjoying myself. That influenced my decision that I might as well stay here and stay in touch with everybody.

One graduate participant, who had a history of living in a remote area and would have liked to stay in the region, moved to the city for her boyfriend. They had both lived in Broome and she was going to apply for a graduate program in Alice Springs when her boyfriend got a job in the city and decided he was not going to follow. She recollected her thoughts from the time:

> What about Alice Springs and he said oh well you know you can go there if you want but I'm off to Perth…. and I thought gosh blood is thicker than water clearly so I tagged along. I can't be stubborn so we set a goal. 5 years down here and we bought a house out in Jarradale because it was

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the most country we could get with him still being able to get to Bibra Lakes about 45 minute drive it was a compromise that we made.

Another who was about to become a Grandma and had decided to stay in the city commented, "I'm going to be a grandma, so I'm kind of hanging around … so I'm going to be sticking around for a while." Hanging around and sticking around were terms that participants used to denote staying in the same location. In this particular case it meant staying in the city.

Another graduate's partner who had extended family in the city commented about his circumstances and said that he would have worked in a remote area if his wife had been amenable to the idea and they had not had children. The participant commented that he:

> Wouldn't go remote only because of the family things that are happening here. Grandchildren and all that sort of thing…she trained in England so she's pure mental healthcare. No I can't see it because she's got four children. One of them is over here and she's got grandchildren and another one on the way in November. If I hadn't been married or things had gone differently I probably would have gone you know, I could see myself in Broome with my boat.

Family and social connections were highlighted a number of times in my journal. Over the years of living in the Kimberley and North West there is certainly a cycle that occurs with friends and work colleagues. The length of time someone stays is often connected to their closeness to family in other locations and their own life stage. Young singles tend to come up for the party life, camping and sporting activities. Those who stay longer term have met a partner, particularly enjoy the lifestyle or have a job that they love. There is a propensity for people to leave once they start having children and feel the need to have wider family support, most leave when children are toddlers.

Facilities

A number of influencing factors were linked to the facilities and infrastructure of Broome that families needed. These factors were grouped as

descriptors titled: Parks and Gardens, Schooling, Healthcare, Accommodation and Work. One general comment typifies this, "Six years in a remote and rural area … opens your eyes very quickly about what is available and what is not available."

One graduate, who had a relationship breakdown during her degree and moved back to the city, recollected a conversation she had with her son where she highlighted the lack of resources such as playgrounds and parks:

> He asked yesterday if we could go back to Derby he wanted to see where he came from. I said I don't really want to take you to Derby and he got a bit upset. I told him there was nothing there. I tried to explain to him that you don't have the water park just up the road, we don't have this centre just up the road, we don't have the city or the zoo or Kings Park. When he realised that he said oh okay.

Schooling was identified as a challenge to reconcile with one graduate commenting:

> I think it's more that you still worry about school up there. But then we've got a friend whose kids are in high school up there and they seem to be doing all right…and there is always the option of sending them away. But when you've got one child, you think, I don't want her to go away. Not really, not for me. I want to enjoy that part of her life.

A number of graduates commented that they did not consider the healthcare services in remote areas were adequate for their needs or their families. Some commented on access, "there is limited access to healthcare in remote" and "travelling to Perth for specialist treatment is expensive." Some comments highlighted the inconsistencies of healthcare, "one doctor will recommend one course of treatment and you'll start with that and then the next one will come in and say they don't know what they're talking about; we'll start this." One participant commented on needing to, "make do… that type of experience made me realise how reliant you are on the services in the remote areas and how you have to make do."

One of the graduates considered that telehealth might solve some frustrations and offered the following comment:

> Hopefully telehealth will have the same consultant the same medical team, they will be familiar with the

patient, their story, what's going on with their healthcare you know the other influences in their lives. I'm hoping telehealth will make a big difference.

Availability and cost of accommodation was a topic mentioned numerous times amongst the graduates. One graduate's comment elaborated on this, "There are students from here that have applied for a graduate program and because they already lived here even if on the Broome campus they were not entitled to a house."

The resilience and motivation, seen by the graduates, of nurses who worked in the region was reflected in the following comment, "I saw dreadful things, nurses doing night shift and living in tents it was just insane conditions and it was the wet season… staff left… there was no continuity of staff." Others considered themselves lucky and commented, "I was lucky I had a place up there."

One graduate participant who had moved to Perth after her course found a number of factors related to facilities were challenges to overcome before returning to the Kimberley and commented, "I'm limited as my husband has the business here, we can't just up and leave and obviously we are just buying this house so we have to see where we are financially. We have to house all these children [three]."

Professional

There were several factors that related to the professional nursing context of the graduates and their reason for staying or leaving the Kimberley. These factors were coded as Professional and formed the third group of influences. These categories included: Marketing, Workplace experience, Support, Staffing, Incentives, and Opportunities outside a graduate program. These categories are displayed in Figure 5.6. Commentary and explanation of each of these are presented in the following section.
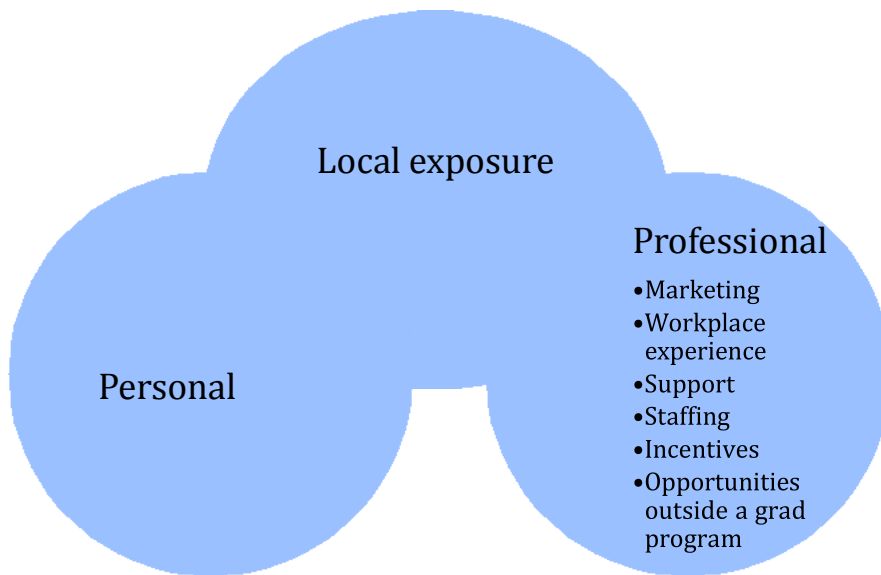
Figure 5.6 Participant group 1 nursing graduates professional factors

Marketing

Several comments by the graduates in terms of influencing factors concerned the lack of information regarding graduate programs and employment after graduation. One participant who had completed the Graduate Program and was recommended by a friend said:

> I first heard about it because my friend did it last year and I was pretty keen to do it. I thought that sounded like a really great opportunity because I'd been up here before and I really enjoyed it.

Some graduates said they were surprised that they did not hear much about the graduate programs offered while they were doing their clinical placements in the Kimberley and Pilbara. It appeared those students who studied all of their degree or at least the last few years were aware of the graduate programs offered but not the graduates who only studied one or two semesters in Broome. One graduate commented that her reason for not returning to the remote area workforce, "was probably … not knowing enough about it. I suppose. I know I did a semester up there, but I didn't know much about rural grad programs and what they had to offer. So not knowing may have been why."

Another graduate who was very keen to move back to the Kimberley

healthcare workforce, specifically to work in a remote community, could not find any contact to determine if there were job vacancies. She felt that she had been given the run around. She commented:

> Yes as far as I know there is one nurse... I'm trying to get the information at the moment; it's a bit difficult. I did Google it, I thought it was BRAMS [Broome Regional Aboriginal Medical Service] looking after it and then BRACS no WACHS and now its actually DAHS [Derby Regional Aboriginal Medical Services], okay so I've got to get hold of them. The lady that gave me the most information was the lady at the Mt Barnett roadhouse.

Normally, graduates who have completed all their studies in Broome use their experience during clinical placement, and their own networks, to discuss options of employment.

Workplace experience

A number of influencing factors were related to experience gained whilst on clinical practice as a student. These factors stemmed from either their own experience or from conversations with their peers or mentors. Other comments reflected on the pace of clinical practice, and suggested that remote practicums were not so fast paced which enabled more time to learn. One graduate commented:

> I think because they're smaller hospitals, it's a lot more personal ... Yeah! and then, as a student I guess… not too much difference. Just maybe they're more personal and, I guess, there are more opportunities to take a bit more time, because it's just a little bit slower pace ... And you have a bit more time to get to know patients, that sort of thing.

Some graduates considered that going to the city for a graduate program would provide them with more experience. The following example illustrates one graduate's reasons for choosing to move to the city:

> I wanted to work … in an ED like at RPH [Royal Perth Hospital, a tertiary hospital in Perth], I wanted the experience of working in a busy environment to build up my skills where there was the support of the graduate programs and that kind of thing that gave you very firm learning directives and you know to build up the skills

that you needed umm my original intention was to do that and then return to the rural area. I had plans to go back up to the country so I did the graduate program through SCGH [Sir Charles Gairdner Hospital, a tertiary hospital in Perth], then worked in the hepatology and renal wards, and then dialysis, and then went to Graylands [mental healthcare facility] for 6 months and got hooked into there.

One other participant who moved to the city thought a broader experience would be better gained by moving to the city and commented:

Maybe if you go away and look at other hospitals and the experience you can get in nursing, it just opens your eyes up a little more to what happens in other places. It just gives you that wider world-view of what goes on outside Broome Hospital.

Some graduates did not believe the Kimberley graduate program would suit their needs. The following comment, by one participant, demonstrates this notion:

I chose metro over country um it was more to do with the grad program that you know if it was comprehensive I might have gone for it however my choice was to the Charles Gairdner hospital [SCGH in Perth] an 18 month program and in that I could cover surgical medical um and mental healthcare and then they provide what I wanted you know the renal, hepatology and dialysis.

A number of graduates commented that experience had proved the theory of 'better elsewhere' wrong and if given the opportunity again they might have chosen to stay in the Kimberley. One of these graduates, a BN in her thirties and had graduated seven years earlier stated, "I think because whilst you sort of have a tendency, I think it's a false tendency to think that in the city you're going to have more opportunities. I don't think that is necessarily the case."

Some of the graduates, both BN and DN, had assumed that they would have fewer skills than city graduates and as a consequence had chosen to move to the city. One graduate, a BN, who thought she needed to go the city to build her skills, found this misconception to be unfounded and commented:

Because I still had this feeling that I needed to just work at a bigger place for a little while just to get a few skills up, I guess. Little did I know that I had developed

skills… once I got out there, I wasn't that lacking, as much as I thought I perhaps would be.

Most graduates believed that they had to complete a graduate program to secure employment in their second year as a registered nurse. They did not equate this with consolidating their practice and continuing to learn the skills of nursing. The DN graduates had a different perspective, being more focused on the job they could get once they graduated. This might have been related to the fact there was no graduate program for DNs.

One BN graduate who had not completed any clinical placements in the city said:

> I wanted to have a look at mainstream healthcare because I hadn't been part of it at all. But it was very straight. The only word, I suppose, I can use to compare and it felt to me I felt quite challenged when I first got here [city hospital], because I thought God, they're a bit sort of finicky and there is too much red tape I think. Not saying we want to cut corners at all, that's not the road I'm thinking.

In further conversation with this graduate she found the city hospital intimidating as there was more hierarchy. In clinical placements in remote hospitals decision-making was done at the patients' beside, whereas the city hospitals had more layers of staff before decisions could be made. This constituted a bureaucracy and gave the impression of the 'red tape' and a delay in patient care.

Discussion with another graduate about students being able to do their graduate year and then being advised to get experience and then come back led to the researcher to ask about the necessity to go to a tertiary hospital for experience. One graduate's response highlighted individual differences:

> I think it is different for every body, it depends what you want out of nursing if you were younger then yes I think it is a good idea I think you need to do that personally anyway to get that experience and that maturity behind you. But if you are older and have family and kids there then no it's what you want to get out of it as well. Not everybody wants a big nursing career; they just want to do the basics of nursing. So I think it's very different what you want to get out of it. It is a little bit different for me as I

already had experience and I developed into it. But otherwise I would probably say yes … it is possible to gain the experience in the Kimberley.

Another participant's comments suggested that a remote graduate program was better suited to certain people over others and clarified this by stating:

I think somebody that is the more mature age or the more mature thinking person that has, yeah, sort of not been stuck in a cocoon, in a bubble, and hasn't got any idea of what goes on out in the real world. And that only comes with life experience. So I would probably direct it [a Kimberley graduate program] more at the more mature, life-experienced person than someone straight out of uni, straight from home, that sort of situation.

One particular graduate, who was very interested in returning to the Kimberley to work in a remote community had gained two years experience in ED and coronary care, completed a midwifery qualification and was currently studying for a community healthcare qualification. This graduate who assumed, from clinical placements as a student, she would need all of these qualifications and experience had not managed to speak to an employer. The researcher recently discovered her working as the regional coordinator for maternity services in the Kimberley. She had worked in a remote clinic for a short time but found the role too isolating. This clinic was a one nurse post and her husband was often away for a number of days at a time.

Support

One of the factors that graduates mentioned as vital in undertaking a graduate program was the support they anticipated. They identified the notion of support as; encouragement, reassurance, back-up and help from peers as well as from their families. One graduate who considered there was more support in the country commented:

I found everyone pretty supportive. Compared to the city, I found probably more support in the country, I suppose. When I was in the city I did a lot of prac and I had grads as mentors and sometimes they would be getting the hang of things themselves. They weren't ready for a student yet.

Other graduates considered that they would get more support during a

graduate program in the city. One graduate who completed their program in the city commented, "I planned to go metro [city] for my first year because I was going to get better support in the metro." One of the graduate participants who had completed a graduate program in the Kimberley felt she needed to be more confident and that more support was needed in her situation she remarked:

> The only thing I found was that you weren't supported in those areas [specialist areas like paediatrics and emergency] I was thrown into paediatrics when I felt I didn't have enough experience so that was really quite daunting and dangerous and I had to jump up and down. I wondered if I were younger … would I have had the courage to say hey that is not safe.

The same graduate compared Notre Dame, Broome with clinical practice support. She reflected on her time as a student:

> Definitely I got more support as a student from the Uni and you had a preceptor at the hospital that was definitely there all the time. As a grad, I mean you were supposed to be rostered on the same shifts as them but that didn't always happen umm and I don't know if they were always interested in being your preceptor either.

Another mature aged graduate who had also stayed in the Kimberley for a graduate program described the experience as:

> Sink or swim … I've spoken to colleagues that did programs in the metro [city] areas and they were very, I'm not going to say mollycoddled, but they were very looked after. And I just found that for me, it wasn't like that. It was a sink or swim. You were basically told what you needed to achieve, go do it. Whether that is because I was older going into that role as a novice, I'm not sure.

This graduate also considered that she learned a lot from this approach and also felt that she already had a high level of motivation and self-determination to succeed remarked "In the setting that I was in? Yeah, we all felt we were sinking. But it was the best thing that could have happened, because I don't have any doubts of being able to take on anything now."

One participant, who had completed a graduate program in the city because she thought that there would be more support, had a similar experience. "That's what

happened at Murdoch [private tertiary hospital in Perth], finding the support I needed, especially on my first rotation up on first floor was horrifying because you'd get thrown in". This graduate went on to recount a situation where she was quite out of her depth and had been unable to gain the support she required. The situation had caused her some severe anxiety to the point that she had considered resigning from the program.

Whilst one participant felt unsupported in the Kimberley graduate program, another commented on how over time this experience had changed her. As an EN she remained working in the Kimberley healthcare workforce for more than 5 years. She reflected on the improvements in preceptors over the time and the support the students and graduates were given:

> I think that they do get supported really well. There are some great nurses up there now [in the Kimberley] who are precepting. And the girls also seem to be so much more confident than I did. I think the fact that I was an enrolled nurse for so long and was so deeply entrenched. You always had someone to look up to, to direct you that could answer for you.

Another graduate confirmed that for her the Kimberley program offered a great deal of support to participants. Her reflection included comparisons with other graduates who had undertaken their study at other universities. Sinking or swimming, however, was a metaphor used by many participants. Commenting on the positive side of this experience one participant who had undertaken a graduate program in the city said:

> It did weed some people out. I noticed that you could certainly see in the grad program… you could definitely tell the difference in the universities. With the other few girls that I did the grad program with, I was definitely more advanced than they were. And I don't think that was my age or previous experience. Like some of the basic things they struggled with … and they hadn't done a lot of prac [clinical placement]. That was one thing that was really good [at Notre Dame, Broome] and of the reasons for picking Notre Dame. Most definitely, there was a heavy lot of mentoring, a lot of one-on-one…they certainly made every attempt to support and get you through, definitely.

Even though there were some participants who felt unsupported there were

those that, "Would recommend it [the Kimberley graduate program]".

Staffing

Support for graduates was directly related to the number of available staff and their ability to mentor or support the novice practitioner. There were graduates who considered that "there is not enough staff to support graduates, or an inexperienced workforce" and this had an impact on future employment. Sometimes it appeared that there were times when "there may be enough nurses, but there may not be the consistency of staff. It is fairly transient at different times of the year." Another graduate commented that once you completed the graduate program, "you could not work in the emergency department" as there were not enough nurses on a shift to provide the necessary guidance and education.

Incentives

Several graduates considered there were professional incentives to working in a remote healthcare workforce mostly through the provision of additional workplace opportunities. Comments such as "more opportunity for indigenous stuff", and it "would be easier to get a job", and one considered that promotional opportunities might be "easier". Only one graduate commented about the possibility of a financial incentive. This influence was identified in the following quote:

> I think you get more money as a remote rural nurse…
> I'm not sure that Darwin will be any different from what
> I am earning now…because I am a graduate it is crap. I
> mean if I was on my own and wanted to buy a house
> there would be no way I could afford it so I am hoping
> the money up there will be a bit different.

Opportunities outside a graduate program

Graduates had been successful in securing casual nursing positions outside of the Kimberley graduate program in: Broome, Derby, Kununurra, Halls Creek, and Fitzroy Crossing hospitals. They were also employed in the BRAMS and in an Aged Care facility. As one graduate said, "As a casual you have an opportunity to show that [you] have the skills and knowledge to work in a remotely based hospital and

work increases to a point where you are eventually upgraded to a contracted position." This model of employment was colloquially termed try before you buy. It was used as a recruitment strategy in areas that were difficult to staff, "where you want to make particularly certain someone is well suited to the position." One graduate who had been employed locally in this way commented at interview, "I felt well supported by the other nurses on the ward and eventually worked my way in to a contracted position." A couple of graduates said that they had requested to stay on the casual pool, as they were able to attain flexibility in their lifestyle and work commitments. One graduate from the DN program who had been successfully recruited using this approach summed up her experience:

> I wanted to get to theatre. With only one hospital up here I thought it would take a while. I was surprised it would happen so quickly. I am employed as a casual. I managed to step into the specialist centre, so I am now not available on the ward. I've managed to pick up days in day surgery. Opportunities have been good for me. If there had been a grad program I'm not sure if I would have done one. I jumped in the deep end and was supported by the registered nurses.

This same participant added that this arrangement suited her as she felt, "stable on casual doing three days a week, this suits me with my youngest. They said they would keep me casual. Which suits me. Being able to have my holidays when [it] suits and I give about three months notice".

One participant considered that it would be easier to get a job in the remote area rather than the city and commented that "Because … opportunities arise. As you know from Anne Maree getting her job up here, it's not very often that doors open so freely for people who are fairly new to the region or even new to the job".

One graduate reflected on what her parents had said about the ease of gaining nursing employment in the North by provided the following comment:

> If we get, or if Danny gets a job first up in Darwin because mum and dad reckon don't apply for a nursing job until he gets a job because I should be able to get one really easily up there, fingers crossed.

Another BN graduate said she was concerned about what job prospects there might

be in the future and stated that:

> There are only so many places with nursing that you can go. Although you can go from the hospital to population health, but then usually to get into population health you need a bit of nursing experience behind you … to get that different perspective.

Some graduates discussed that ongoing contracts for employment were not offered after the graduate programs because they were inexperienced. One graduate who had completed the graduate program but had not been retained was asked whether they felt they had experience to stay, commented that:

> Absolutely. I mean I know there was probably policy and red tape. They wanted to bring in level 1.5 [a registered nurse with 5 years experience] and above. But what about nurturing the people that live there, the people that want to work there? There's nothing to say that they can't get to the 1.5 experience level, because you have such a variety of experiences. It's not just a medical ward or just a surgical ward. You have everything. You do have the HDU [High dependency unit] as well. So whilst they're not the most severe cases, sometimes you are in ED managing a severe case that's wanting to go out to RFDS. So I think there is plenty of room to nurture lower levels up to a 1.5.

The topic of specialising after graduation featured prominently in the participant's conversations. Such specialised areas included; Remote clinics, RFDS, ED, OR [Operating room or theatre] and Midwifery. Graduates commented that if they were working in a remote area they would not have access to the required education for these positions. The consensus was that they might have more opportunity "securing further educational opportunities in areas of speciality" if they completed a graduate program in the city.

Summary of findings from group 1 nursing graduates.

In summary, the findings from interviewing the graduates demonstrated an extensive number of factors that influenced them in their decision to work in the Kimberley healthcare workforce. Local exposure provided them with insight into life in a remote area as well as access to the clinical area. There was a range of personal factors that influenced their decision and mostly centred on the lifestyle that the

Kimberley brought them and their families. Additionally, the facilities either brought positive feelings to their life or might have caused detraction. Exposure to the workplace provided participants with an awareness of what work would be like, once they graduated. They knew the towns that they could work in and what support and learning opportunities could be provided to them.

Whilst the findings from the graduates were central to answering the research question, it was necessary to corroborate, or seek rival explanations from nurses working in the healthcare workforce and their managers. The research question and proposition of the study continued to guide the analysis of data.

The researcher attempted to keep the findings from group 1 participants separate, so as not to force the findings into group 2. It must be argued, however, that a characteristic of qualitative research is that it is an iterative process of constantly interweaving the collection and analysis of data (Miles et al., 2014).

Participant group 2 workforce nurses.

The researcher identified, by virtue of her academic position and nursing experience in the Kimberley, that nurses in the workforce had some influence on a student's career decision. Such experiential data has been acknowledged as technical knowledge and experience derived from personal and professional knowledge (Strauss, 1987). Given this experiential knowledge the researcher was well equipped to make insightful comparisons and perspectives. As student nurses mix and are mentored by registered nurses in the healthcare workforce during their clinical practicum, it was essential that a sample of these nurses should be questioned about what they thought influenced graduates to work in the Kimberley. It was equally important to extrapolate their perspective on what motivated them to work in the area, as the same factors could have influenced students from the University, when they undertook clinical practicum. The workforce participants' motivation to work in the remote area could have been biased and influenced graduates.

Prior to being interviewed all potential group 2 participants (24) were invited to complete a questionnaire. The questionnaire was aimed at identifying the

demographics of the group. Additionally, it posed questions that could help identify important information, within the context of the study, and provide useful information to prompt further questioning during the interview. The following part of the chapter is divided into two sections. First, the findings from the questionnaire are presented followed by data gathered from the interviews.

Questionnaire findings.

All 24 nurses who responded to the invitation to participate in the study were provided with either the online questionnaire, or a hard copy. Twenty participants completed and returned the questionnaire (Eight mailed responses in and 12 completed them online through SurveyMonkey®) and consented to be interviewed.

All 20 participants who returned the questionnaire were registered nurses; three were male and 17 were female with 11 having been registered for more than 20 years. Three had been registered between 11 and 20 years and six had been registered for less than 10 years. All respondents had worked for varying lengths of time in WACHS hospitals throughout the Kimberley and none had studied at Notre Dame in Broome. Six of them had more than 11 years experience (see Table 5.4).

Table 5.4 Participant group 2 workforce nurses demographics

Status	Gender		Years of experience as a RN in the Kimberley healthcare workforce (Years since initial registration with NMBA)			
RN	Male	Female	>20	11 - 20	6-10	≤ 5
20	3	17	3 (11)	3 (3)	0 (3)	14 (3)

The majority (14) had less than five years experience in the Kimberley workforce, which, could be suggestive of a workforce with a low retention rate. Additionally as can be seen from the above table (Table 5.4), the majority of respondents were highly experienced (as assumed by the number of years since registration), this finding could be associated with a preference for a remote health

workforce to have high numbers of experienced staff, or it might be indicative of more experienced staff being interested in the research topic.

Questions posed on the questionnaire were aimed to investigate:

- What had influenced them to work in the Kimberley;
- Whether they thought graduates had the requisite knowledge and skills to work in a hospital in the Kimberley;
- If they considered that their own workplace provided sufficient professional development to support graduates from Notre Dame, Broome.

As described earlier the responses to the above questions were considered important, as the opinions of the workforce registered nurses could have influenced advice given to students on their career choices. Having this information enabled the researcher to arrange interviews with a range of respondents to reduce any possible researcher bias. The responses are presented below and correspond with the three questions above.

Question 1. Factors influencing registered nurses to work in the Kimberley

There was a range of factors that influenced workforce participants to work in the Kimberley. These influences were grouped into the categories: personal and professional, and corresponded with the categories from participant group 1.

Personal influences

Personal factors were those that were considered to directly relate to the individual, and were divided into two sub-categories. These sub-categories were: Family connections and Lifestyle (see Figure 5.7).
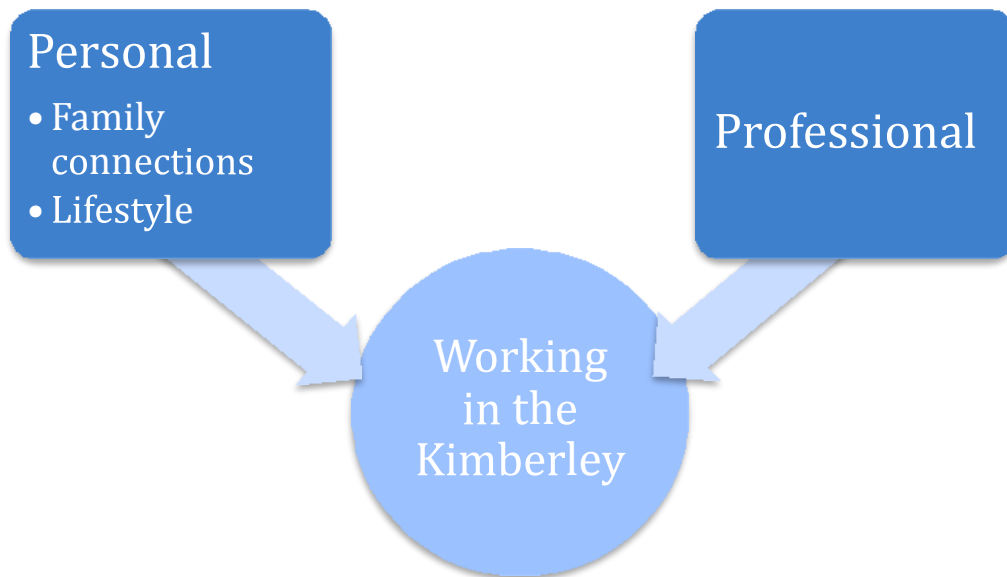
Figure 5.7 Participant group 2 workforce nurses personal factors

Family connections

The importance of family connections was evident in a number of responses from the workforce. Some participants made comments such as their "partner [was] employed in Broome", "partner works with RFDS [in same town] so relocated" and "chance to live with husband" all reflected the importance of having their partner close while they were working in the region. One participant made the comment "came for work, met husband and stayed". Another commented on her "husbands increased income". One participant commented on the benefits for children and that "there was more for kids to do after school".

Lifestyle

The comments on lifestyle reflected on what the region provided outside of the workplace. Within this category comments such as "amazing nature, access to the Kimberley [the tourist attractions]"; "people love Broome, love the Kimberley"; "the climate, I needed this warmer climate" and "the remoteness, it's low key for us and really enjoyable" all reflected the positive side to the region.

Some of the participants had previously worked in the Kimberley or remote area and made the following comments "had previously worked in Derby [town in

the Kimberley]", another said "they had previously worked in Derby for 16years and wanted to come back to the Kimberley" and another, simply said "have worked here before and loved the region and the people". Participants also commented on the negative aspects that affected lifestyle. For some the "climate was too extreme" or they considered it to be "too remote".

Professional influences

Factors grouped as professional (Figure 5.8) were those that were related to the work of a nurse and could also be categorised as opportunities provided by the workplace. Within this category three sub categories were also identified: Experience, culture, and incentives.
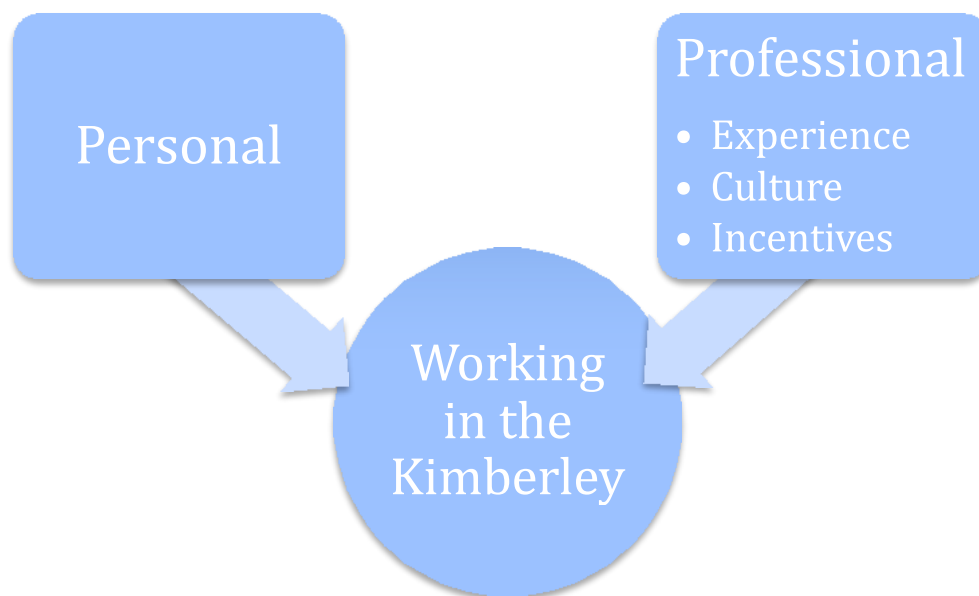
Figure 5.8 Participant group 2 workforce nurses professional factors

Experience

A number of participants commented on the extra experience they gained while working in a remote hospital. Comments such as "variety of work and responsibilities" and "to gain experience of working remote and with Aboriginal people" were included in questionnaire responses. A general consensus was the positive nature of the challenges the workplace provided. One participant

commented that she wanted "to work in an area where there are challenges such as cultural, burden of disease, [and] chronic health". It was these challenges that the participant viewed as "providing extra experience".

A number of participants commented that they felt that working within a small team provided opportunity to practice with a certain degree of independence that gave them a "perception of more autonomy". These participants considered that the autonomy provided them with a level of "self-sufficiency", which they enjoyed. One participant commented on her particular experience in "having an adventure in setting up a new remote mental health unit".

Culture

Culture had two elements. One was the culture as it related to the Aboriginal people of the region. Participants valued the opportunity to work within the Indigenous community and wanted to gain more experience. These participants commented that they "wanted to work with CALD [culturally and linguistically diverse] groups" and "Aboriginal populations".

The second element to culture was associated with the culture within the workplace, the attitudes, values and behaviours, which were shared in direct relation to the workers within the organisation. Participants commented about the "friendly nature of the staff" and how positive it was working within a team where there was a "predominance of good team spirit".

Incentives

A number of comments were identified and grouped as incentives, or enticements to working in the remote area. Such comments included "benefits of WA health" and "accommodation assistance with relocation expenses". One wrote on the questionnaire, "$ rewards" and another "remuneration" but neither were specific in their responses so it was difficult to know exactly what they meant.

Question 2. Requisite knowledge and skills to remain in the Kimberley

It was important to investigate if the participants from the workforce considered that Notre Dame, Broome graduates had the requisite knowledge and skills to be 'industry ready'. This term is currently used in Australia, to indicate graduates attainment of the required level of knowledge and skills for entry to practice (Haddad, Moxham & Broadbent, 2013). A negative response to this question could have meant that the participants would have encouraged graduates to seek experience elsewhere for their graduate year. The majority of respondents (15) agreed that Notre Dame, Broome graduates had the required skills and knowledge to work in a hospital in the Kimberley after registration. Four participants, however, did not agree and one participant did not provide a response.

The participants had a variety of opinions and provided a number of reasons for their responses. Some participants who had worked with graduates commented that "many have been excellent" and "their skills would develop over time". Others considered that "graduates would learn a lot more in a hospital like Broome as opposed to most city hospitals". There were others that considered "that they would benefit from a grad year" and that a "practicum [in their course] at a tertiary hospital would be beneficial".

The respondents who commented positively on the requisite knowledge and skills of graduates and their readiness to practice had a range of experience in the remote nursing environment. Most of the participants had more than 10 years nursing experience. Even though 11 had less than five years experience in the Kimberley, eight of them had more than 10 years nursing experience. It would seem from this range of experience that their comments should be valued. The four who considered that Notre Dame, Broome graduates were not industry ready had less than 10 years nursing experience and the majority had less than 5 years experience in the Kimberley. Whilst their opinions are still worthy, their reasoning could be due to their limited experience.

Question 3. Professional development to support graduates from Notre Dame, Broome

Anecdotal comments made by students during their studies, influenced the researcher to ask workforce nurses about professional development opportunities. Students had remarked that professional development opportunities and support would influence their decision to either stay, or move to the city for their graduate program. To establish the evidence to support this notion it was deemed necessary to ask workforce participants their opinion on professional development opportunities.

There were a similar proportion of participants who agreed, to those that disagreed, as to the amount of professional development opportunities the workplace provided for graduates. Eleven of the 20 respondents felt that there was sufficient professional development to stay and continue working in the remote healthcare workforce. Some thought that there was, "significantly more than metro [metropolitan]" yet another said "compared to regional I would say no".

There was also a difference of opinion as to whether there were sufficient staff development nurses (SDN) in the hospital to support the graduates. The role of SDN in Australia is defined as a nurse who provides education to new or existing nurses at the ward or unit level (WADoH, 2015e).

Some participants commented that there was "not enough SDNs to support grads at present" and others considered that the: "increase in SDNs", "online training", "VCs [videoconferencing]", and "in-services" were plenty to provide the education required. Others considered that, "if professional development was a priority then the answer would be yes". One participant considered that the professional development was not suitable for the grads and they were expected to, "tag along to existing professional development, which is not suitable for new grads".

As the views of the workforce participants could have been dependent on their workplace experience, information was gathered on the length of time participants had worked in their current work setting (see Table 5.4). The majority

(14) of participants who had been working in a hospital in the Kimberley for less than five years considered there was enough professional development to support new graduates. Despite having limited experience in the Kimberley eight of these participants had been registered for more than 10 years. This finding could have been more of a measure as to whether they, themselves, had sufficient professional development rather than the graduates.

Findings from the questionnaire suggest that the workforce participants considered that graduates did have the requisite level of knowledge and skills to be industry ready. Whether there was sufficient professional development to support them, however, remained inconclusive. After juxtaposing responses from the two questions; skills and knowledge and professional development it is evident that the majority of workforce nurses considered that graduates from Notre Dame, Broome had the required skills and knowledge, and that there was sufficient professional development to support them in the workplace. This conclusion was explored further during the interviews.

Participant group 2 interview findings

Questions posed in the interviews to the workforce participants, were designed to follow up on responses made on the questionnaire, as well as exploring their perspectives of what influenced graduates to work in a remote area workforce. It was important to interview a wide range of workforce participants since opinions of nurses with differing levels of experience and demographic data may have provided an unbalanced viewpoint. A decision was made to interview a cross section that included a range of demographics including nursing experience, gender and length of time working in the remote healthcare workforce. To assist in this selection process, data collected from the questionnaires was displayed on a spreadsheet (see Appendix N).

Thirteen participants consented to be interviewed and the recordings were transcribed verbatim. However, by the eighth transcript, data became repetitive. In order to improve representation of the group, three more transcripts were analysed. These three were chosen because the respondents had either suggested that graduates

did not have the requisite knowledge and skills, or thought that the workplace did not provide sufficient professional development. Whilst this procedure enabled a more representative group, no new factors emerged. The demographics of the participants who were interviewed are displayed in Table 5.5.

Transcripts were coded in a similar fashion to those from participant group 1. In keeping with the proposition of the study the two categories personal and professional influences were used as criteria for coding the potential influencing factors.

Table 5.5 Participant group 2 workforce nurses questionnaire results

Demographics		Total number of participants interviewed (13)
Male		3
Female		10
Length of time (years) as RN	> 20	6
	11-20	3
	6-10	2
	≤ 5	2
Length of time (years) in Kimberley workforce	> 20	0
	11-20	2
	6-10	0
	≤ 5	11
Notre Dame grads skills and knowledge	Yes	10
	No	3
Adequacy of professional development for graduates	Yes	8
	No	5

Personal

Personal factors were grouped into the sub categories of Family connections and Lifestyle (see Figure 5.9). These factors were the same as those produced through the questionnaire, however, the interviews provided more in-depth

responses. For example the aim on the questionnaire was to investigate what influenced them to work in the region, but the interview was to determine what they considered would influence the graduate. It was difficult to determine whether the factors that the workforce participants perceived as influencing them were the same as those that might influence graduates. The descriptions of these sub-categories and comments from participants are presented in Figure 5.9.

Personal
• Family connections
• Lifestyle

Professional
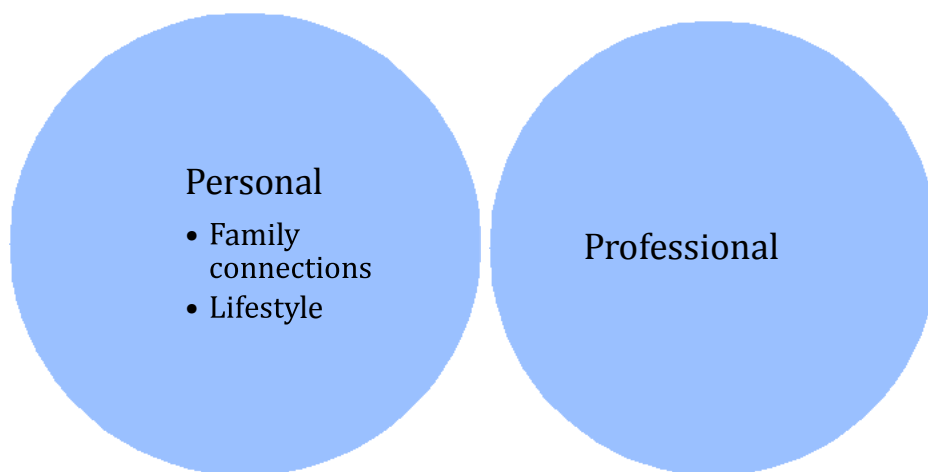
Figure 5.9 Participant group 2 workforce nurses interview results personal factors

Family connections

Family connections were one of the two sub-categories of personal. A number of comments from the workforce participants were associated with staying and working in the Kimberley and included the importance of, "partners having availability of work" and "accommodation being suitable for families". Others commented on the "pull of extended family" and the need for people to leave the remote area to be closer to their extended families. Participants considered that graduates not local from the region may find this difficult and might ultimately move away. In contrast, those that were local to the area would have family and social connections. It was also noted that if graduates as students had met friends during their course, they would be more motivated to stay.

Lifestyle

The workforce participants who were interviewed, identified lifestyle factors as having an influence on living in a remote area. Lifestyle included opportunities to camp, fish and explore the Kimberley region. Terms such as: "adventure" and "adventurous" were repeated throughout the interviews. The weather was also coded to lifestyle as some participants were attracted to the Kimberley because of the "climate" and "others actually left because they didn't cope with the climate". Participants considered that the local students would already have insight into the lifestyle that the Kimberley could offer and considered this would influence their decision making.

Professional

The interviews with group 2 participants provided a larger range of descriptors than those provided by the data in the questionnaires. Under the category of professional factors that were seen as influencing the graduates were the sub-categories: workplace and incentives. Each of these sub-categories had descriptors that formed close relationships, but were deemed sufficiently different to form their own labels.

Workplace

The professional influence of the workplace was related to clinical practice and included the categories of: experience, support, professional development, and staffing. The descriptors in the sub-category Incentives were factors that were titled; financial and accommodation (see Figure 5.10).

Figure 5.10 Participant group 2 workforce nurses interview professional factors

Experience

There was a mixed response from the workforce participants in relation to graduates gaining sufficient experience in the Kimberley hospitals. Some thought they would gain, "extensive experience" and would "more likely be provided with a wider range of opportunities in remote areas", whilst others thought, "a better experience would be gained in a metropolitan graduate program". It was these opinions voiced by the workforce participants that were reflected by graduates during their interviews. More importantly, these opinions might have influenced graduates' decision in terms of applying for a graduate program.

Another comment from these participants was that new graduates would not be able to gain experience in some speciality areas like the ED or Operating Room. During the graduate program nurses are supernumerary for a very limited time. This length of time was not enough for them to gain extensive experience and there were not enough staff rostered to support them. Interestingly most students would have received a basic level of knowledge and skill in both these clinical practice areas, including a minimum of 3-5 weeks supernumerary time.

Support

Workforce participants provided comments such as, "there is not enough staff

to support the students and graduates", "staff get burnt out and then aren't keen to support junior staff". Due to the small number of staff the effective mentoring staff are buddied with students and graduates for weeks on end and become quite tired, as one participant commented, "the good ones will get students, then new staff and junior staff". Good staff were those that were considered to be proficient and were keen and willing to mentor. All staff like to feel supported and as one participant put it, "just from my experience, the minute something goes wrong, the first thing people say is that I don't feel supported".

Professional development

Other factors considered to have influenced a graduate choice of workplace, was professional development. Such continuing education was provided in the form of study days, videoconferencing or bedside clinical education. At least half of the participants said that they felt graduates were provided with adequate professional development. Some comments from participants were quite comprehensive and provided details on specific education and the mode of delivery such as:

> There's a lot of online stuff plus there's supervised practice as well, and we do acute case study days where it's a lot of… there's six or seven sessions ranging from ventilation to non-invasive ventilation to monitoring and…run locally through the staff development nurses.

Another participant commented on visiting educators and the use of videoconferencing;

> We're quite fortunate, there's a lot of courses that come to Broome, where we don't need to travel…there's a medical rep [representative] that does that online education and… there's burns and paediatric teleconferences …through PMH [Princess Margaret Hospital, a Paediatric hospital in Perth]…. And yeah, whatever is available, we try and do.

There were participants who did not consider there was adequate professional development for graduates. The following comment came from one interview:

> I think that education and support is not given the priority that it should be and I really think its 'penny wise pound foolish' and most of them will consider post grad [postgraduate – education] and for that they have

to go away.

One participant considered there was a need for more local opportunities for postgraduate education and offered the following comment:

> There is definitely a gap in the market for a progressive university to provide some post-graduate opportunities in the Kimberley ED, remote area nursing even mid [midwifery] but we would have to consider how that would work obviously.

Another participant considered that there were opportunities for education, but staff would "want to get paid while they are studying". The limitation of paid study days and the lack of payment for education courses were also discussed with several participants. Staff are just "not generally keen to fund training themselves even though they can claim it at tax time".

Staffing

Staffing in the workplace was considered a factor that could influence a graduate's decision to stay in the remote area. A high staff turn over affects both students and graduates in terms of support and education that can be provided. If students are not feeling supported or they notice that staff are jaded, then they are more likely to consider these effects when deciding to apply for a graduate program, or to work in the hospital.

One participant commented that a lot of staff, "tend to stay 3-6 months" and a good retention rate would be "staff staying more than 2 years". Some participants from this group mentioned transient staff and the inconsistency it caused. Comments included:

> There may be enough nurses, but there may not be the consistency of staff… from the recruitment and retention side of things its seasonal and sporadic, so you can be fully sorted with staff for a certain period of time then something would happen and then you know you're forever recruiting.

Not surprisingly it was junior nurses that seek work rather than experienced staff.

This was evidenced by comments such as:

> Yes we always have a shortage, but not a shortage of junior nurses that is the difficulty we have. The shortage is always with those with experience, those with ED experience, remote area experience or background … speciality areas OT [operating theatre] and midwives.

Having a diminished complement of experienced nurses would make the notion of growing your own workforce difficult and unsafe for patients. There were conversations with participants about the numbers of staff rostered to the ward and how these numbers made it difficult in supporting junior nurses. In these situations it was the number of staff rostered that was the issue, "Often in the smaller sites [those with only 1 or 2 staff rostered to ED] the nurses on the ward back up staff in ED, so having too many junior nurses is not safe". One participant explained the situation in ED where the difficulty lay with the possibility that a complex case could present, which would cause difficulty if only a junior nurse was present:

> The more senior nurse needs to have triage knowledge even though they are small sites and they might only see a complex case once in a blue moon they still have to have experience. They will work with a junior person, but you can't have two junior nurses working together.

Incentives

Workforce nurses identified incentives such as annual leave, financial benefits and the provision of accommodation as factors that influenced them to work in the Kimberley. One participant commented that a decision to work in the area was not just about making a decision based on the nursing job it was more, "can you afford to stay in the region" or "is there housing that goes with that".

Annual leave

Some participants discussed annual leave incentives that were provided if a nurse stayed for 12 months. Incentives were given in sites that were considered "difficult" to staff. One participant described it as a gratuity payment, "Broome didn't get any, but Fitzroy and Halls Creek got 100% and Kununurra got 75% of 3 weeks extra leave after 12 months. If you stayed 2 years you got 5 weeks [or part

there of] depending on where you worked".

Financial

Another explained "the gratuity had now ceased, but the annual taxation benefits were now in place which increased the annual salary by about $10,000". Others commented on the district allowance and "how it had gone up". A district allowance is paid to public sector employees as recompense for the disadvantages of working in regional and remote Australia (WADoH, 2015).

Also categorised under financial incentives were travelling expenses. One participant explained that because she was already travelling and on her way to Broome when she gained employment, "they refused to pay me compensation for coming up [travel and removal costs]".

Accommodation

A number of nurses commented on the lack of availability of suitable housing and how this could affect the graduates who were seeking employment. "Housing is not available to you if you live in Broome, so graduates will need to apply from Perth if they want housing". Another participant commented on her luck "I got subsidised housing which is nice 'cos' [because] in Broome the rent is so high".

Summary of findings from group 2 workforce nurses.

Workforce nurses were influenced by both professional and personal factors in their decision to move to the Kimberley. They considered the same factors would influence the graduates to remain in one of the Kimberley hospitals. Not surprisingly the pattern of responses from group 1 and 2 were similar, since students of Notre Dame, Brome had a close relationship with the workforce nurses during their clinical practicum. The majority of the workforce participants considered that the Kimberley could provide adequate experience for graduates. There were, however, some workforce participants who considered that experience in a city hospital, either during clinical placements or through their graduate program, was essential.

In addition to the graduates and the workforce nurses there were a group of prominent nurse managers who provided additional insight into factors that could influence graduate's decision to stay and work in a remote healthcare workforce.

Specific managers were chosen because of their position of responsibility on recruitment and retention of nurses in the healthcare work force including graduates. Managers were either interviewed or emailed about the factors they thought would influence graduates decision. Once again in line with the proposition of the study the coding of factors were grouped into: Personal and professional influences.

Personal influences

Participants discussed the personal factors that they thought influenced graduates. These factors included: lifestyle, family connections and accommodation (see Figure 5.11).
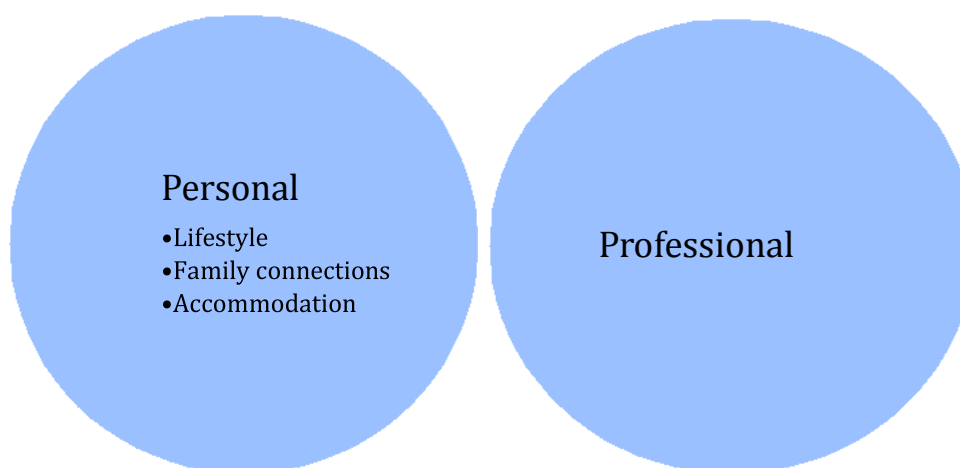
Figure 5.11 Participant group 3 nurse managers personal factors

Lifestyle

One of the factors seen as influencing graduates decision to experience the remote healthcare workforce was that, "they want an adventure, the remoteness suits them". Creating a "work life balance" was seen as an important factor for one

manager who considered that this could positively influence graduates, especially as they were mostly female.

Family connections

One manager discussed the difficulties some graduates might experience if they had a family. Some graduates had lived in the area either prior to or during their study and were now embedded in the community with a family, partner, friends or other social connection (sport or volunteer work). Some sites could assist by providing a placement in one site for a year, but this was limited:

> They don't want to rotate… people have to apply on the context that it is a rotational program… spending 4 months in Kununurra, Derby and Broome… there is then some allowance made by management [a local change] …it is usually at the discretion of the nurse director.

Accommodation

Some considered that graduates with families would have difficulties with the rotational nature of the graduate programs and the extra challenges that finding accommodation might pose. Managers were quite clear that there was not enough accommodation and that there were more difficulties if graduates had a family as there was only access to single accommodation nurses quarters. One manager's comment referring to the numbers of graduates as being limited by the availability of accommodation said, "they can't move too much on numbers [of grads] because primarily accommodation [prevents this]".

Professional influences

Nurse managers were more vocal on professional factors that might influence a graduate's decision to work in the remote area. These factors (see Figure 5.12) were sub-categorised into: marketing and workplace. There were also five descriptors within the sub-category workplace including: experience; support; professional development; staffing; and availability of positions.

Professional

•**Marketing**

•**Workplace**
•Experience
•Support
•Professional
 development
•Staffing
•Availability of
 positions
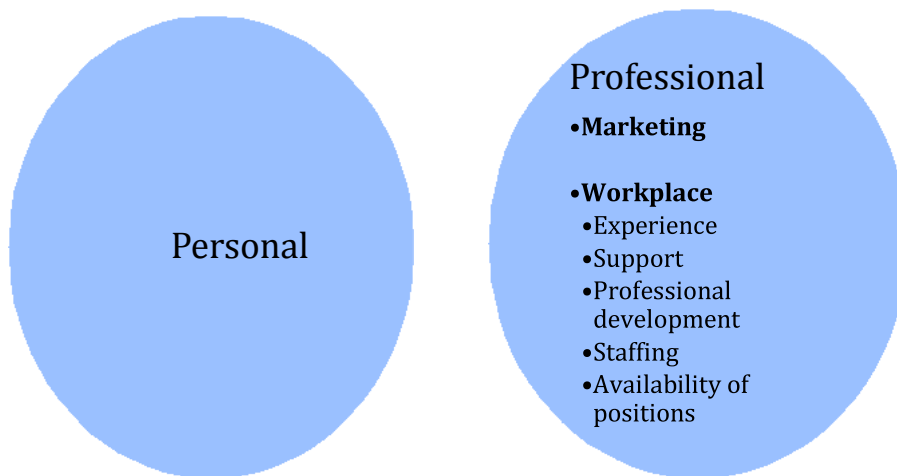
Personal

Figure 5.12 Participant group 3 nurse managers professional factors

Marketing.

One nurse manager commented that she was the, "middle person between the DoH GradConnect process and the sites to ensure there was consistency to public sector standards and the rest of it [assisting the sites through the recruitment process]. GradConnect, is a streamlined online recruitment system for newly qualified nurses to seek employment in graduate programs (DoH, 2015).

This participant acknowledged the challenges that had existed in the past and the need for promotion from a centrally coordinated base, this participant's workplace [outside the Kimberley]:

> I work closely with all of the coordinators in the different regions [each regional site eg Kimberley, Pilbara, Mid West has a coordinator for their graduate program] so I stay up to date with what they are doing. What their training is what their processes are what has changed those sorts of things. I do that central promotion [promotion of graduate programs and nursing employment in regional and remote WA] and attend Expo's [Exhibitions] in the city. I also represent country health services and what we have to offer the universities at their student expos in the metro area.

Workplace

The sub-category workplace had several descriptors, which were titled: experience, support, professional development opportunities, staffing, and

availability of positions. These descriptors were all related to the workplace and are described below with commentary from the participants.

Experience

There was a range of responses on whether the hospitals in the Kimberley could provide sufficient experience to graduates. Opinions tended to depend on whether the participant had first hand nursing experience in the area. The local nurse managers thought the region provided enough experience, whereas a participant from outside of the Kimberley thought that graduates would not get sufficient clinical practice. One participant, who lived outside of the Kimberley, had the opinion that the remote area, whilst having a clinical mix, "Couldn't provide the number of cases required to constitute experience so [I] would rather use the term exposure". The term exposure was explored more at interview and was explained to be a factor of limited contact and decision making during patient care. This participant also thought that a number of graduates left the region and then returned later, "they go to get, you know, more experience in bigger places…and then come back". This participant, however, could not produce evidence that they return to the remote area.

Another of the Nurse managers, who was local, had a different opinion and thought that experience could be gained within the hospitals of the Kimberley. The focus on experience was to do with the ED and the graduates who had, "tracked to the ED department [and] were clearly gaining experience and didn't need to go away to gain it". This participant also thought that the local graduates were more likely to progress into ED, or other areas of specialty like Community Health. She said, "they have already been exposed and understand that it is from 0 to 99 [age of patients] and they seem more able to cope".

Support

Graduates like any new staff member in the hospital become empowered and are motivated to learn if they work in a supportive nurturing environment. Some nurse managers thought that clinical nurses who did not have the responsibility of individual patient care could create such an environment. The clinical nurse is a

position designed to coordinate patient care, "one without a patient load". One participant reflected on feedback she had received and commented, "The clinical nurse is a difficult role, they coordinate and don't take a patient load. They don't always want to do this, they want to be a clinical expert by the bedside not an administrator". The same participant discussed trying to increase the number of graduates by stating:

> In order for us to take more grads and more students and be able to support them we have to have more beside clinical support. The clinical nurse managers their role is too much tied up in admin to be that clinical person. That is part of their role to be that clinical lead and clinical support. An interesting study from Princess Margaret Hospital (Children's hospital in Perth) just looked at the role of clinical nurse manager. The study looked at what percentage of the time is spent on clinical supports. Most of the time was spent on administration, ordering stores not clinical leadership.

Participants reflected on comments from new registered nurses saying they wanted a graduate program that would be supportive and thought they would get this from graduate programs in the city rather than from the country. One of the participants recalled the following comments from conversations with applicants:

> I get phone calls from them after 6 months and they say "I wish I had done my program in the country because I do really want to work in the country, but I thought it might have been better at home with my support network, but you know I find I am just as lost in a big hospital and maybe I would have preferred being in a small place".

Professional development

Professional development was identified as a descriptor of the sub category, workplace. Nurses understand that life-long learning is essential to remain a competent professional and to maintain registration with the NMBA. Registered and enrolled nurses are required to justify a minimum number of hours of continuing education, as well as maintain annual performance across national competency standards (AHPRA, 2015). Nurse managers highlighted this area of influence on the graduate's decision, particularly for those nurses who wanted to stay for a long time. As one participant commented:

> The professional development level that is required to get

staff competently trained here is really high. Because the staff across all areas of the Kimberley have to look after [people] from 0 to 99 years of age… that's a huge expanse of knowledge that you would expect. The amount of PD [professional development] that is delivered has increased because, it had to [previously there had been next to none], but you can never have too much.

This participant also suggested that a clinical bedside support person or a clinical consultant was needed, "we can send staff to courses and you can do in-service in the afternoon and all that but nothing beats that by the bedside and hands on training".

One nurse manager acknowledged that there were difficulties in building a local workforce by providing the following comment, "we still need to grow our own staff although they can only stay here until level 1.1 [an RN one year since registration]". This participant considered that "if they want to stay they have to stay on the general ward and they will have to go away and get a bit more education and then come back". She suggested that a strategy to alleviate this problem was to provide a "clinical bedside staff development position" this would provide the education that a "growing" workforce would require.

The distance from mainstream continuing educational opportunities was a point made by one of the managers in the following comment: "because they are so far away from educational opportunities. Even though there is a university here, it can only offer theory where it is actually clinical hands on that people need".

Further to the point concerning PD, another participant commented:

We need opportunities for those nurses to get positions in the areas other than the ward such as Midwifery, ED and theatre. Nurse managers in ED and theatre won't take a level 1.2 [an RN two years since registration] or a nurse who has just finished their grad program as they won't have the experience and they don't have the support that is required. There is not enough staff working in the area to provide that different level of skill mix.

Staffing

One of the nurse manager participants commented about the shortfall in the Kimberley workforce in terms of experience:

> There is a gap in the workforce of level 1.5 – 1.8 [five to eight years post registration] registered nurses, enrolled nurses and lots of students. We employ some 1.2 and 1.3 [two and three years post registration] and they might be the grads that have already been here. We'll take them.

Nurse managers said they were swayed to employing local staff, which often affected the experience level. One participant commented:

> We might have a nurse who comes and lives here and she might be a 1.2 or 1.3 or 1.4, their partner is here so we put them on casual first and say here you go and if they go okay, we build them up that way… But if anyone applies outside that unless they somehow in their application come through absolutely outstanding or unless we get desperate for staff we can't employ them.

This participant made the additional comment in regard to the anomaly of being short of experienced staff, but having numerous applications for the graduate program, or nurses at the lower level on the career structure:

> They can't be employed in ED or Theatre between Level 1.2 and 1.5. Graduates can't continue their employment if they want to work in ED or Theatre we don't have the support systems as they are one of our numbers we can no longer give them supernumerary. They can have one day orientation [this is their supernumerary time] and then on the second they are part of the team. We don't have enough clinical support systems to offer them jobs.

Availability of positions

A further attribute of the workplace factors was the availability of positions. There were only a specified number of graduate program positions available to RN graduates and applicants throughout Australia could access these positions. No preference was provided for graduates in the Kimberley healthcare workforce.

The nurse managers commented that many of the applicants for nursing positions did not understand the situation regarding the need for experienced nurses rather than novice practitioners. They understood there was a shortage of nurses, especially in country areas, but not that it was experienced nurses that were needed. The managers commented that, "It's difficult for a younger person to see that the opportunities are there, but they are just not there as a beginning practitioner. That doesn't mean that you can't get experience somewhere else and then go back to the region".

It would appear that students and graduates are being encouraged to gain experience elsewhere. One participant shared a comment she made to students and graduates that were not successful in their applications, "I say… you may have to get experience elsewhere say in the city and then come back in 12 months time when you have background experience and you won't be a very junior nurse". The misconception that graduates return to the region was again emphasised.

In the Kimberley WACHS offers graduate programs to registered nurses. These programs are one year in length and are designed to support a nurse through the transition from student to registered nurse. Graduates rotate through Derby, Broome and Kununurra attending four months in each site. The Kimberley offers nine places for graduates on an annual basis with three starting in Broome, three in Kununurra and three in Derby.

One nurse manager identified that "there have been exceptions to the guidelines in that if a graduate has had family ties to one of those places then the rotations differ to the point that some graduates have stayed in one location for their entire program".

In addition graduates can apply for a remote rotation to Halls Creek, or Fitzroy Crossing. The decision for a remote site accepting a graduate was dependent on their performance in the graduate program. One participant made the point that "whether they go out there, or not, will depend on how they have performed ... and also their capacity and confidence after the ED placement [provided in the first half

of their program] so they are never thrown out there".

In respect to the kind of nurse that applies for the Kimberley graduate program one manager said that they, "are often quite confident, they want an adventure, it is often a different type of person that applies for a grad program in those areas [Kimberley towns]".

Whilst there were more applicants than positions for the Kimberley, one manager said that the, "majority of applicants for the Kimberley rotation aren't local people they are often from the city and have experienced placements in the region [for clinical placement as a student] or are moving from interstate".

In terms of positions available for DN graduates, the number of positions is limited. This issue is directly related to fewer enrolled nurses being employed in the overall nursing workforce, compared to RNs. Additionally, there are not as many graduate programs available in WA. As one manager stated:

> Graduate programs for enrolled nurses are not currently offered in the Kimberley. The nearest site to offer grad programs for ENs is the Pilbara where two are offered annually, Geraldton in the Midwest and Albany in the Southwest have four places.

As there was no Graduate Program for DN graduates in the Kimberley, students who wanted to stay were required to apply directly to the hospital. They were then generally offered a casual appointment. The following is an extract from an interview with a manager:

> Our EN workforce is quite stable when you look at percentages of ENs to RNs. The RNs you know there are two to three times more RNs than ENs in a healthcare service. So in a workforce capacity there are a lot less ENs than there are RNs. The EN workforce tends to be quite stable. So it doesn't always measure with the expectations of the graduates that come out of the TAFEs [Technical and Further Education centres where the DNs are usually trained] so there are some regions where they are graduating a lot of students and the students want to come and work in acute care, but the positions are not available to them. The turnover is not there. [ENs tend to stay in employment in one place for quite some time]. Some of them have families and

just want to work part time in the EN positions. ENs just don't want to move as much as the RNs.

This participant continued describing the nature of the RN workforce, which was in contrast to the situation for ENs, "RNs seem to tire of working in one place and want to move onto somewhere else… [this enables recruitment possibilities]. So it is difficult, as you don't have the vacancy to provide that opportunity for the ENs". She goes on to say:

> Employing ENs is also difficult when the FTE [Full time equivalent staff member] quota is low as it is difficult to raise the quota of ENs when there are only a few RNs employed. We might have scope for ENs at some of our smaller sites where they work on a one RN [to] one EN roster, but it may not necessarily be where ENs want to be and may be a difficult place to have a graduate …we need to have someone with a bit of experience so it is a bit of a catch 22 situation [Low staffing numbers inhibits the employment of inexperienced staff].

Fourth data set.

A promotional DVD and archival documents were classed as the fourth data set. These provided context or additional insight into the factors discussed by each group of participants and were used to support or counter the findings.

Promotional DVD.

One of the nurse managers provided an audiovisual promotional tool for recruitment into the Kimberley healthcare workforce. The audio from the DVD was transcribed and categorised using the same process as participant groups 1, 2 and 3. The factors were again grouped to personal and professional influences.

Personal

A personal influence that was used to attract staff was lifestyle. It included the opportunities that living in a remote environment could provide such as a relaxed atmosphere with camping opportunities and weather that suited outdoor activities. One nurse stated a description of this environment as, "you definitely need to be an

outdoorsy person in the Kimberley … after work the beach is fabulous. After work we quite often go to the beach for champagne drinks and watch the sunset".

A description of the weather by one nurse, "even though spectacular, nature is often sometimes hard to live with", introduces the harsh climatic conditions. The narrator describes the weather in the Kimberley as a "wet season from October to April which can bring cyclones, storms, flooding and humidity. While the dry season from May to September is marked by temperatures in the mid 30s and above".

Other personal influences included accommodation, the cost of living and schooling for children. For example the narrator comments, "Remoteness though does have a cost. Living here is more expensive although offset by salary allowances and taxation concessions". The WACHS also recognises comfortable housing for staff and partners and families and the narrator added further comments, "The budget continually provides for new and improved accommodation to help offset the climate and conditions".

The narrator in the promotional DVD provided information on schools in the region. The Kimberley was noted to have 24 primary schools with the high schools, in the larger towns of Broome, Derby and Kununurra, providing Year 12 with some subjects offered through the School of Isolated and Distance Education (SIDE). Literacy and numeracy was also noted as a priority and comment was given of the Government's assisted travel scheme whereby families who chose to send their children to Perth for school were incentivised by the provision of travel arrangements for their children to return home a number of times per year.

Professional

In terms of professional influences that might have motivated a graduate to stay in the remote area workforce, the DVD showed a vast range of work experiences. It also highlighted the need to attract healthcare staff with a broad range of skills and expertise to manage the array of health conditions predominantly diagnosed in the Aboriginal population. It described these as being problems associated with chronic diseases, infections, drug and alcohol related illness, trauma

and mental health issues. In addition to these health issues nurses could also gain experience in gynaecological and obstetric related conditions. The following comment was provided by one of the nursing staff that was interviewed:

> Working in the northern most region of WA provides professional challenges beyond the norm. Additional to these day-to-day experiences the WACHS also actively facilitates professional development and staff training. Kimberley health is a passion not a position.

The population of the Kimberley was described by the narrator as, "35 000 people live in the Kimberley, half are Aboriginal and numerous language groups are among them and for many English is their second language. They make up nearly 100% of our clients". Cultural exposure and experience were also discussed as providing an added experience to staff. Interviews with nurses provided the following comments:

> My experience so far has been amazing I absolutely love working with the Indigenous women and I think as far as my own life experience they have really enhanced 'umm' just the things that I have done and experienced here. I have never seen such poverty in some ways but I have also never seen so much joy and happiness that I have experienced. And certainly these little babies are very close to my heart and have kept me here in so many ways.

All of the WACHS hospitals in the region were noted to have been recently upgraded or still being in the process of refurbishment. The narrator on the DVD spent some time orientating viewers to the health service sites by giving the following verbal description:

> Broome the regional resource centre is a 44 bed facility with 4 high dependency beds and 14 mental health beds. This is the largest hospital in the Kimberley and employs 90 nursing staff, 9 medical officers, an emergency and surgical registrar and a general surgeon. Derby the next biggest has 39 beds and has a staff of 50 nurses, 7 medical officers and a resident general surgeon supported by visiting specialist centres. This hospital is also unique in that it also runs the ambulance service for the town and local communities with nurses going out on scene. The third largest hospital is in Kununurra and is a 32 bed facility and also provides an outreach service for remote clinics and several small communities (in the Kimberley).

> Fitzroy hospital and Halls Creek have 14 and 12 beds and provide a range of health services to a predominantly

Aboriginal population in the Fitzroy Valley and outlying areas of Halls Creek. Wyndham hospital is also undergoing a major redevelopment to an 8 bed facility and offers medical, emergency and acute care services to the town and other remote communities. Outside the hospital system the community health and remote area clinics work with other providers, such as Aboriginal Community Controlled Health services, to reach into the day-to-day lives of people in remote towns scattered along the coast and inland areas. As well as delivering a strong health message in all health programs, nurses, Aboriginal Health Workers [AHW] and support staff target child and family health lifestyle related diseases, mental health and drug and alcohol abuse.

Archival documents.

Documents were obtained from a variety of sources including: WACHS employment statistics, Notre Dame School of Nursing and Midwifery handbooks and curriculum documents as well as pertinent websites. The researcher was directed to a number of documents through interviews with graduates, workplace nurses and managers. Data from these documents has been used within part two of the chapter to corroborate what the graduates said or to provide verification for the comments made by workforce nurses, nurse managers or the promotional DVD.

Part Two: Synthesis of findings from all participants

This second part of the chapter will synthesise the findings from all data sets by juxtaposing the graduates' responses with those from workforce nurses, their managers, the promotional DVD; and the archival documents (see Figure 5.13).
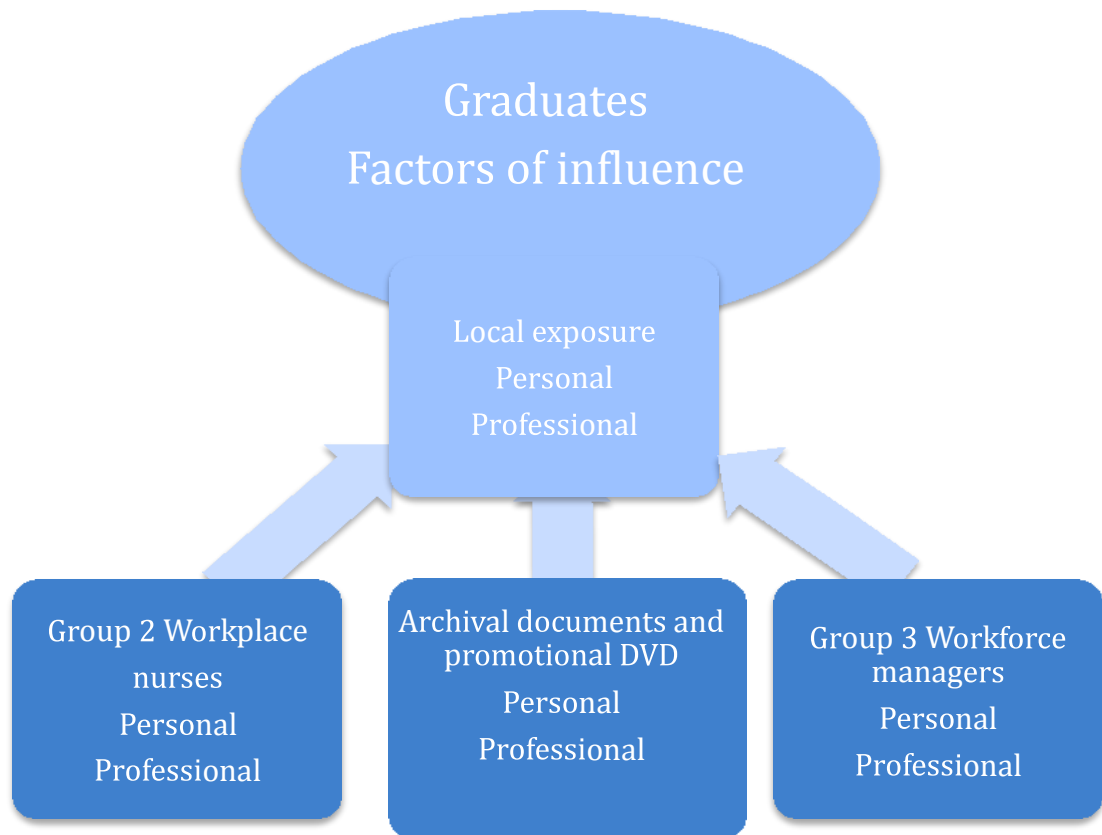
Figure 5.13 The links between data sets

Workforce nurses, their managers and the promotional DVD provided contradictory or supportive evidence on what graduates thought influenced their decision to work in the Kimberley healthcare workforce. There were no clear-cut boundaries between categories rather they were blurred, with influences from one category being linked to another. Initially, influences on graduates' decision were categorised into personal and professional factors consistent with the study's proposition. Further analysis, however, exposed a third set of influences titled: local exposure.

Local exposure.

Whilst local exposure was a significant influence it was not independent of the personal and professional influences. For example from a personal perspective being able to study at Notre Dame, Broome meant that as students, the graduates would have the opportunity to experience the lifestyle of living in a remote area. As one graduate commented "you live and breathe it". From a professional perspective experiencing clinical practice exposed students to what they could expect if they

became part of the healthcare workforce as graduates. This blurring of influences was evident in the response of one graduate who said:

> We have palliative care right through to mental health, broken bones to diabetes it's fantastic…the beauty because it's Broome…the nursing doesn't finish at the bedside… you have to made sure the community services are in place… I just feel comfortable here...I feel a sense it's home...it's not the friends keeping us here, it's not social for us, we don't go out a lot…it's really the red dirt and the heat and just nursing and my husbands loving it.

Experiencing life and the healthcare workforce in the Kimberley was a major influencing factor on graduates and their choice of workplace once they graduated. Workplace nurses and managers also corroborated this notion making comments about the ease of transition into the workplace for local graduates such as "familiarity assisted with their orientation", "they have familiarity with the clientele, their families and the community". One workforce participant commented that, "it wasn't necessarily the skills of the local graduates that set them apart it was more the "awareness they had…". Some workforce nurses advised students to consider gaining experience in other

locations, particularly the city, with some offering advice to "gain city experience during clinical placement or through a graduate program".

Personal factors.

Personal influences were those that could be attributed to the individual's lifestyle, family connections and facilities.

Lifestyle

All participants together with the DVD agreed that lifestyle was an influencing factor on graduates' decision to work in the Kimberley. Factors that were seen to create, or build a particular way of life were linked to this influence. These factors included having an appreciation of the outdoors and the landscape as well as the attraction of the climate.

The geographical landscape, in particular the aspect of remoteness, was

discussed by the narrator in the promotional DVD as a factor to increase recruitment. The remoteness of the Kimberley and the impact this can have on connections to other areas was a key feature that was highlighted as having the potential to affect someone's personal life in a remote area, "the Kimberley is remote and there is still some tyranny of distance, but with improving roads, air services and communication the balance is tipping". Neither the workforce nurses, nor their managers mentioned the tyranny of distance as posing an influence on the recruitment of graduates. The tyranny of distance, is a negative connotation for a substantial geographical distance from a significant population group.

Family connections

There was a consensus, however, among the participant groups that a decision to live and work in the remote area workforce was influenced by family connections. These connections included partners, children and extended family. The choice to stay in the Kimberley was, at times, dependent on the decision of a partner or the needs of children for example schooling. Of particular note was the "pull to leave the area to be closer to family" in other parts of WA in particular the metropolitan area. Graduates mentioned that family support and commitments were factors that influenced them to move away from the Kimberley. From the researches perspective these findings were not surprising. Over many years of living in the Kimberley, friends and colleagues have left to return to where they spent their childhood. Each year at Christmas time there is a mass exodus from towns where teachers and nurses (predominantly) leave town for the holiday season to travel to their 'home' towns. This is often a time for visiting extended family, but also provides an opportunity to meet up with friends who have left the Kimberley. It is not an unusual occurrence for annual 'get togethers' to occur in places like Kings Park and the Swan River foreshore in Perth.

Facilities

Factors associated with facilities, including healthcare provision, schooling, and accommodation, were highlighted by all participants. Accommodation was especially an important factor, since there was limited availability of appropriate

housing for nurses and their families. Significantly, however, the promotional DVD led the viewers to believe that there would be "comfortable housing for staff their partners and families". The narrator further commented that, "the budget continually provided for new and improved accommodation to help offset the climate and conditions".

Accommodation for single nurses was offered in Kununurra, Derby, Wyndham, Halls Creek and Fitzroy Crossing; the more remote towns of the Kimberley in the 1980s. This accommodation though was limited, or non-existent for families. In Broome, it was senior nurses, clinical nurses or midwives, who had an option to access accommodation. Currently accommodation is offered to nurses recruited from outside of Broome and who work in excess of six days a fortnight. Locally employed nurses are not entitled to a house. The average weekly rent in Broome at the time of this study was $640 for a 3 bedroom house (Realestate.com.au, 2015). This lack of affordable accommodation posed challenges for graduates in Broome who wanted to stay and work after graduation. As students most graduates would have lived on the campus at Notre Dame, Broome. Whilst some graduates pointed to the lack of healthcare provision and limitations on their children's schooling as factors that influenced them to move away from the Kimberley this finding was not corroborated by the other participant groups, or the promotional DVD.

Professional factors

Professional factors were those that related to the workplace. There were numerous factors in this category including; marketing, workplace experience, support, staffing, incentives and employment opportunities outside the graduate program as identified in Figure 5.6.

Marketing

Graduates considered inadequate marketing had a significant impact on their choice of workplace. In contrast managers considered the coordination of promotional activities from a central base, as a key to marketing success. Whilst this

issue was verbalised as one that could increase recruitment there was little evidence that promotional activities were filtering to potential graduates in the Kimberley.

Whilst rigorous efforts were made by Notre Dame, Broome to market or promote the graduate programs, limited opportunities for presenters in Perth to link with students in Broome significantly hampered marketing for recruitment. In the "Professional Issues in Nursing" unit of study in the BN curriculum, from the 4th data set, identified that students from the Fremantle campus could access a graduate exhibition in the city, but attempts to link one presenter to the Broome campus was thwarted by limitations in communication technology.

Workplace experience

Workplace experience was a contentious issue, as many graduates believed they would need further experience in a larger hospital to feel comfortable and confident in nursing practice. Most importantly some felt the graduate program in the Kimberley would not provide this experience. Nurses in the workplace, supporting this notion, may have unwittingly transferred their belief to students whilst they were on clinical practice. Interestingly one manager considered that graduates were more likely to gain "exposure" rather than "experience". Her consideration was that they would be observing situations rather than providing the actual nursing care. A number of participants from the workforce and managers discussed graduates needing to leave the region for "further education" [professional development] or experience and believed they would come back. Whilst some graduates expressed their fondness for the Kimberley few returned once they had family commitments.

These views contrasted with those graduates who considered they would gain sufficient experience when in the Kimberley workforce. Participants from the other groups concurred by saying they were "more likely to be provided with a wider range of opportunities in remote areas". Significantly, a manager with experience in the Kimberley clearly stated that graduates already in the workforce "were clearly gaining experience and didn't need to go away".

This argument raises an awareness of the uniqueness of nursing in small hospitals in remote areas and also raises the point that experience gained in this type

of area is quite different to working in a small hospital in a rural area. As the distance between hospitals increases the nature of nursing becomes more complex. Due to the extended length of time to transfer patients to larger hospitals in the city, (6-8 hours), nurses are required to spend more time working in critical situations to stabilise a patient. It becomes evident that experience can be quite variable between areas of care, such as general ward nursing and the emergency unit. Not only is patient acuity different the level of experience and number of nurses available on a shift can vary.

Support

It was not surprising that as novice nurses, graduates were looking for support from the workplace and from their social networks. It was this factor that crossed the boundary between personal and professional influences. Personally some felt having family and friends gave them support, which in the Kimberley may not have been available. From a professional perspective graduates looked at the kind of support they would get from the workplace as students, which influenced them to stay or leave. The workforce and managers concurred that support would probably be a significant influence on the graduates decision. Of note was the importance of support offered on an informal basis by their nursing colleagues. This peer support was considered by graduates and the workforce as much more significant than the formal support offered through coordinators or staff development positions. It was the lack of "clinical bedside support" that was considered to be of the most influence by graduates and managers.

Staffing

From the workplace perspective, graduates pointed out that it was the number of staff and the staffing arrangements that were a barrier to supporting them in the workplace. This factor was evidenced by workforce participants who stated that "there is not enough staff to support the students and graduates, staff get burnt out and then aren't keen to support junior staff". Workforce nurses and managers agreed with the graduates perspective that the limitation of numbers of nurses, particularly in a specialty area, was a prohibiting factor on graduates working in the Kimberley.

It was this limitation that was seen as a barrier to the notion of being able to a "grow your own" workforce. It was the "transient nature" of nurses in the Kimberley that was considered, by all participants in the study, to be an impediment to providing more staff support. Interestingly, however, graduates did not make the connection between staff support and professional development. Rather they were more interested in the experience they would gain and the support they would receive during their graduate program.

Incentives

A further factor considered by the graduates and related to the professional category, was incentives. Comments about opportunities through working in a remote environment were expressed as "more opportunity for promotion", and "it would be easier to get a job". Neither workforce nurses nor their managers discussed professional incentives as influencing graduates decision to become part of the Kimberley healthcare workforce.

One graduate mentioned a monetary incentive being a factor of influence, but others were more interested in gaining a registered nurse position than a financial reward. In contrast workforce participants, managers and the promotional DVD all considered financial incentives as being factors that might influence graduates and could be used as a recruitment strategy.

Opportunities outside a graduate program

Graduates considered the availability of positions that would be available following their participation in the graduate programs as an influencing factor. The Diploma graduates had more immediate concerns in terms of employment following graduation since they could not undertake a graduate program. Workforce nurses did not make mention of work opportunities outside a graduate program. Managers however commented on the limited number of places available to graduates and the lack of any placements for DN graduates within the Kimberley. One manager discussed "employing graduates outside of a graduate program on a casual basis". Another manager discussed the limitations to employing new graduates in and outside graduate programs, as well as the limited numbers of staff in some specialty

areas of employment at smaller sites. One manager commented that graduates might need to gain experience outside the area and then return.

The promotional DVD and specific websites provided information that a graduate program was not a necessity for a position. Information provided by the narrator on the DVD directed potential nurses to the WA Nursing and Midwifery website which stated that:

> Graduate programs assist you to transition into the nursing and midwifery workforce in a supportive environment. You will gain exposure to a variety of clinical settings, while consolidating theoretical learning and critical clinical skills and judgment (WADoH, 2015c).

Further information provided on the website advised students and new graduates that a Graduate Program was not mandatory, "Once you are registered to practice as an enrolled nurse, registered nurse or midwife you are able to gain employment in any health facility within Australia. Completing a graduate program is not mandatory". The narrator in the promotional DVD reiterates the fact that completing a graduate program is not a prerequisite for employment saying that:

> Undertaking a graduate program is not a requirement for initial or ongoing employment. Graduate programs have been designed to offer additional support for novice nurses and midwives to assist their transition to the professional role within busy clinical environments. Places within these structured graduate programs are capped for a range of reasons. You can still gain valuable experience outside of a designated graduate program.

The above statements conflicted with the thoughts and practices of some managers who had the responsibility of employing nurses. Several nurses had difficulty gaining employment outside of a graduate program, unless they were accepted on a casual basis, on a try before you buy model of employment.

Enablers and Inhibitors.

In revisiting the factors that influenced graduates decision to work in a Kimberley hospital, it was apparent that local exposure was the underpinning platform for the two major themes, personal and professional influences. These themes were labeled enabling or inhibiting influences. It was the balancing, of push

and pull factors, of these opposing issues that ultimately led to the graduate's final decision (Figure 5.14).

Enablers

- Personal (lifestyle and family connections)
- Professional (opportunities and support)

Inhibitors

- Personal (lifestyle and family connections)
- Professional (experience and support)
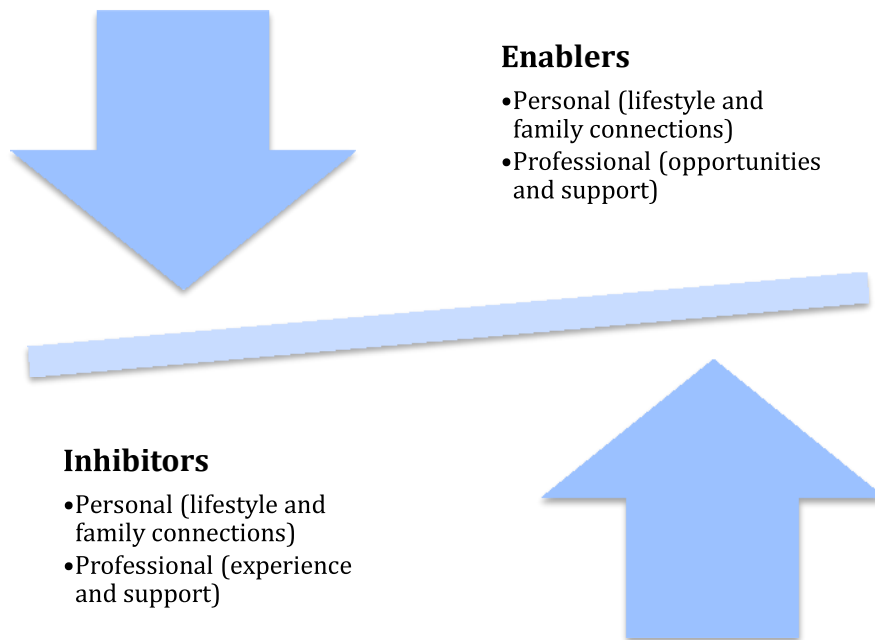
Figure 5.14 Enablers and inhibitors

Enablers

Factors considered to have had positive influence on the graduates' decision to work in a hospital in the Kimberley were categorised as enablers. From a personal perspective these were lifestyle, and family connections. Generally it was the adventure, the remoteness of the Kimberley, the quiet lifestyle and friendly atmosphere of people that had a positive influence on the graduate. From a professional perspective, it was the opportunities and support together with the underlying work experience, gained as students that were positive factors. Graduates and workforce nurses felt that Notre Dame, Broome had prepared nurses well for their rural practice and provided formal and informal support for them to return after graduation.

Inhibitors

Factors considered to have had a negative influence on the graduates'

decision to work in a Kimberley hospital were categorised as inhibitors. From a personal perspective these were family connections and facilities related to the healthcare needs of the family, schooling and partners not being able to find work. Lack of suitable, affordable accommodation was a significant inhibiting factor that graduates gave as a reason for not staying in the Kimberley after graduation. From a professional perspective some graduates felt that at the time of graduation they would gain experience and be better supported in a metropolitan graduate program. This perception changed, however, once they had left the Kimberley and undertook a graduate program in the city. Comparing the two programs, many commented that they could have gained as much experience in a graduate program in the Kimberley.

Many graduates who moved away from the Kimberley said they would like to return, but they considered they had become "hooked in the city". It was the personal inhibiting factors that influenced their inability to return.

Conclusion.

This chapter provided explanations of the findings from the study. Since data collection and analysis was an iterative process between the numerous sources of data, it was important to organise the findings relevant to the central unit of analysis. This was achieved by juxtaposing the differences and similarities between all participant groups. A synthesis of the findings resulted in identifying many factors that influenced graduates decision to stay and work in a hospital in the Kimberley. Initially these factors were categorised into personal and professional factors commensurate with the proposition of the case study. On further reflection, however, a third factor, local exposure emerged as a relevant theme associated with the graduates' decision. All the factors that emerged as inherent within the themes were identified as being enablers or inhibitors. One significant finding was the lack of opportunity for employment within the local workforce particularly from a sense of developing a specialty nursing expertise within the generalist setting of a remote hospital. A discussion of the findings together with relevant literature will form the basis of this final chapter.

Chapter 6

Discussion/Conclusions/Recommendations

Introduction

This discussion chapter will highlight specific findings relevant to the study's aim and objectives, and link these with the appropriate literature. Conclusions to the study will highlight the linkages to the theoretical perspective of decision-making and show that proposed actions cannot be considered separately, but must be evaluated in the context of the situation. Recommendations and limitations of the study will conclude the thesis.

This study aimed to explore and describe the factors that influenced graduates from a remote school of nursing in their decision to work in a Kimberley hospital. The objectives of the study were to describe characteristics of nursing graduates and their connections to living in a remote area, together with the factors that influenced them to seek employment in Kimberley hospitals. A further objective was to investigate the Kimberley nursing workforce, both registered nurses and their managers, about what influenced them to work in the Kimberley and what they considered would influence the graduates and their choices of workplace. Further these participants were asked whether they thought that Notre Dame, Broome nurse graduates were clinically prepared to work in Kimberley hospitals. Part of this objective was to investigate whether the workforce nurses believed there was sufficient professional development to support new graduates.

Factors of influence

There was no single influencing factor, which formed the basis for graduates' decision to stay or leave the Kimberley. Influences were many and varied; posing a balancing act between enabling and inhibiting factors. This finding concurred with Pollock (2006) who suggested that rationale choices are individualistic with decisions being made according to the alternative with the highest value at the time. The enablers were those that had a positive influence on the graduate to stay. The inhibiting factors were those that had a negative influence, and as a consequence

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graduates moved from the Kimberley to seek graduate programs and work in other areas of Australia, particularly the metropolitan region of Perth. Whilst categories of factors were grouped into personal and professional, in line with the study's proposition, local exposure emerged as a major underpinning theme.

Local exposure.

One of the most influential factors on whether a graduate chose to work in a remote Kimberley hospital was the local exposure provided by studying at Notre Dame University in Broome. Local exposure emerged as a major underlying theme and underpinned personal and professional factors. Whilst this study focused on nurses graduating from a school of nursing situated in a remote region, it would seem there are similarities regarding local exposure as an influencing factor for nursing graduates from campuses in rural and remote areas. The literature identified previous exposure as a significant factor influencing nurses to work in rural areas, but did not differentiate between rural and remote settings. Such influences included clinical practice (Hegney et al., 2002; Henry et al., 2009; Francis & Mills, 2011; Neill & Taylor, 2002; Playford et al., 2006; Spencer et al., 2008; Tre`panier et al., 2013) being brought up in a rural area, (Dussault & Franceschini, 2006; Hegney et al., 2002) having lived there, (Birks, et al., 2010; Bushy & Leipert, 2005; Courtney et al., 2002; Lea & Cruickshank, 2005; Lea et al., 2008; Smith et al., 2001) and having family connections (Bushy, 2002; Hegney, Pearson, & McCarthy, 1997; Henderson-Betkus & MacLeod, 2004).

Notre Dame, Broome provided an opportunity for people not only to study in the local environment, but also offered a substantial amount of clinical nursing practice in a range of remote area healthcare settings across the Kimberley. One graduate commented "providing a long-term study opportunity rather than just clinical placement provided me with a safe base with which to explore the option of living in a remote environment". At the time of this study, 170 nursing students had graduated with either a DN, or BN with 30% having entered the nursing workforce in hospitals within the Kimberley. Some of these students had the opportunity of cross campus enrolment, or opportunity to move to the Kimberley to study a whole course. This finding demonstrated the number of nurses from a remote university

entering the workforce in a remote area. Previous studies commented that intentions to work in a rural location after exposure to rural experience or having a rural background were higher than 30% (Hicky, & Harrison, 2013; Lea et al., 2008; Orpin & Gabriel, 2005). Whilst these findings were similar to those demonstrated in this study, they failed to follow-up with the number of students who actively sought employment in a rural area and did not identify if the area was remote.

Rural nurses have been described as generalist specialists by various researchers (Francis & Mills, 2011; Playford et al., 2006). This title confers that rural nurses work in a variety of situations and locations with a diverse set of patients. It was also argued that the generalist role increases as the population declines (Kruske, Lenthall, Kildea, Knight, Mackay, Laven, Wilkinson 2003). Thus, the more remote the context the more diverse the nature of a nurses work. Rural nurses scope of practice involves prevention, intervention and rehabilitation across the lifespan (Francis, Fletcher, Goold, Brans, Siegloff, Veitch & Anm, 2002; Francis & Mills, 2011; Hegney, 2010). This broad proficiency base requires a different level of responsibility and skill that enables nurses to practice in rural areas (Hegney et al., 2002 Hegney, 2010; Lea and Cruickshank, 2008). Often these skills are required where there is limited access to ancillary services and often with diminished medical support. In the Kimberley healthcare workforce there were numerous pockets of remote communities serviced by registered nurses without the support of a medical practitioner on site. These hospitals were also geographically isolated from each other, often over 500kms, which further limits support offered by first responders. Other studies recognised these issues, particularly in Canada where rural nurses, in isolated areas, have a diverse range of clients and are frequently in situations without medical or specialist assistance (Goh & Watt, 2003).

Notre Dame University in Broome prepared students for work readiness by facilitating various competencies specific to dealing with the diversity and variety of patient problems in the geographically isolated Kimberley population. The curriculum was designed to provide students with the propensity to be more independent in their learning, and to take initiative whilst on clinical practice. Learning extra skills and increasing their level of proficiency in preparation for remote nursing practice, was a positive factor in graduates decision to become part of

the Kimberley workforce. This finding corroborates an earlier study, which linked rural content in the curriculum to the recruitment of graduates into the rural workforce (Wood 1998). Further validation of this finding is provided through a Canadian study which identified that the provision of education programs that were relevant to the realities of rural nursing practice were an important factor in addressing the sustainability of the nursing workforce (MacLeod & Place, 2015).

Graduates from Notre Dame, were appreciative of the competencies learnt in their undergraduate program; viewing independence and autonomy as positive factors that gave them confidence not only in remote nursing, but also when they went back to the city. This increase in confidence was supported in other studies concerned with rural nursing (Hart, Morris, Collins, McMullen, Stanis. 2013). It was also the diversity, challenge, and autonomy of rural nursing that were seen as factors attracting nurses to rural practice (Hegney et al., 2002).

In this study, it was also apparent from workforce nurses comments, that local graduates were more prepared for the diverse workload than those of registered nurses recruited without remote nursing background. This level of practice was associated with the graduate's familiarity with the workplace and the diversity of the Kimberley population, especially from a cultural perspective. Notably, other studies concerning preparation for rural nursing, found that generally nurses in the city were not educationally prepared for the reality of rural and remote practice (Hegney et al., 2002).

Studies concerning preparation of graduates suggested that graduates entering the workforce found they have neither the practice expertise, nor the confidence, to navigate increasing levels of patient acuity in a dynamic working environment with a shortage of staff and heavy workload (Duchscher, 2008). Similarly, in a Canadian study it was nurses' inability to deal with the responsibility of rural practice that affected their decision to stay in rural sites (Pong & Russel, 2003). From the researcher's perspective, previous experience of working in the Kimberley played a part in how nurses coped with nursing practice in a busy geographically isolated hospital. Many nurses without previous experience had not coped with diverse populations across a broad spectrum of medical issues and dynamic day-to-day

changes. Their length of stay has been short, often only 6 months. This issues goes to the heart of retaining an effective nursing workforce.

There was a consensus among graduates that the curricula in Broome prepared them well for remote nursing. As one graduate commented, "I think it's a lot to do with the fact that the University is more appreciative of the differences that you've got in the remote areas. I like the teaching; it taught you to be resourceful, it taught you to utilise the people, utilise what you have available". This finding is consistent with other researchers who advocated that if rural nursing is part of the curricula both in theory and practice, graduates will understand the nuances of rural practice (Kenny & Duckett, 2003; Leipert & Anderson, 2012).

Flexibility to contextualise the Notre Dame, Broome curriculum for remote nursing was not without the challenge of being situated 2240 kilometres from the main campus in Fremantle. Generally, lecturers in Fremantle who had not experienced the Kimberley, or remote nursing practice, displayed a metrocentric view, or were not aware of NMBA guidelines recommending program equivalence rather than exactness. There was a suggestion that city centric lecturers who may have been inconvenienced by lecturing via media devices may have viewed themselves as intellectually more sophisticated than their country cousins (Bambrick, 2002). Whilst lectures were streamed live to Broome from Fremantle using a software package called Elluminate (now Collaborate), graduates did not overtly comment on this issue. In the researcher's experience, there was resistance from some city lecturers in providing lectures and including students in conversations, via live broadcast. It was evident that they lacked insight into the Broome campus and its ability to deliver the program to students who lived in remote sites. Moreover, provision of the nursing program to students in a remote area was seen as an extra burden on top of full teaching load. It may, however, have been the support students received from local Broome lecturers and tutors, that graduates did not feel disadvantaged. It was the tutors, employed in the local healthcare agencies, that mentored the students whilst on clinical practice. In these roles workforce nurses were able to apply theoretical principles to contemporary real experiences in the remote environment.

Whilst it was evident that local exposure played a positive influence on graduates staying in the region there were also examples of how local exposure inhibited them from remaining in the region after graduation. Being able to experience life in a remote area by studying on the Broome campus provided the exposure that students needed to determine that life in a remote area was not for them, particularly for the short term. Inhibiting factors were caught up in the personal and professional factors and included limited facilities for family and children, education and healthcare as well as a lack of support that graduates felt would be available to them in the clinical area.

Clinical experience.

The curriculum at Notre Dame University, enhanced the connection to remote nursing by immersing students in a variety of clinical placement opportunities. Clinical practicums were undertaken in hospitals with surgical, medical and maternity wards, together with busy emergency departments, and operating room facilities. They also worked in local and remote Aboriginal communities. The diversity of patient problems that students faced ranged from road traffic accidents often with multiple victims and fatalities, burns from camp-fires, childhood ear nose and throat problems, eye conditions in children and adults, chest problems particularly pneumonia in the cooler months of the year, chronic conditions of the lungs, diabetes, asthma, and coronary artery disease. There was also a higher incidence of alcohol and tobacco consumption together with the growing incidents of illicit drug use. Consistent with other studies was the influence of clinical experience on graduates during their student days. These factors were highlighted in the literature as being influential in recruitment following graduation (Courtney et al., 2002; Glover, Clare, Longston & De Bellis, 1998, Gum, 2007; Talbot & Edward, 2000). Studies have also shown that the quality of the clinical practice during formative education is a significant factor associated with workplace choice (Playford et al., 2006).

In this study, remote area workforce nurses were highly influential in transmitting the culture of the workplace and in nurturing the graduates. In other studies concerning rural nursing, it was through interaction with nurses during

clinical practice that students were socialised into rural nursing practice (Day, Field, Campbell & Reutter, 2005). Sometimes the mentoring was not formalised, with several of the participants in this study expressing how registered nurses had taken the initiative of calling them to interesting situations and critical incidents for additional learning experiences.

Likewise other studies on rural nursing have concluded workforce exposure can influence graduates decision on the location of employment (Courtney et al., 2002; Freeman, Baumann, Akhtar-Danesh, Blythe & Fisher, 2012; Glover et al., 1998; Gum, 2007; Mills, Birks & Hegney, 2010). The role of the mentor cannot be overstated, as improper management can lead to low motivation and more importantly decreased patient care (Chitty, 2005). Students find role models and take on behaviours, values and attitudes they come to associate with being a member of the profession (Day et al 2005). In this study it was not only the clinical practicum that drew some graduates back to the Kimberley, but also the influence of the mentors and preceptors. Likewise these people influenced graduates in their clinical practice as registered nurses.

It may have been graduates exposure to the remote area during their studies, which influenced their decision to work in the area once they finished their studies. From the experience of the researcher, some students who chose to study in Broome, for part of their course, decided not to stay remote after graduating, as they felt that they had gained the experience they desired at the time. This anecdotal experience was not found in the study, but may have been a reason for graduates not to participate in the study.

Cultural exposure.

Cultural training was vital for remote nursing practice in the Kimberley. The importance of this education was associated with the poor health of Aboriginal and Torres Strait Islander people who make up 43.5% of the population (ABS, 2011a). Moreover, there continues to be a deficit in the access to culturally safe primary healthcare services for Aboriginal peoples (HWA, 2011). Graduates in this study valued the opportunity to work with Aboriginal people and gained valuable

experience by being exposed to the nuances of an Indigenous culture. Whilst this exposure was not mentioned as an influencing factor to stay in a Kimberley hospital, graduates were appreciative of the knowledge they gained. This finding supported the suggestion that Western academic institutions instilled their values and assumptions; shaping the way nursing students are taught (Pijl-Zieber, 2011). Other studies have concurred with this finding, reporting that students' confidence in respect to recognising cultural differences and in community assessments was increased following a rural rotation in their education program (Coyle & Narsavage, 2012).

Nurses continue to play a significant role in managing the healthcare needs of Indigenous patients in hospitals, the community and specialised facilities such as renal dialysis (Goold, Turale, Miller & Usher, 2002). Notre Dame, Broome understood the significance of these roles by including the cultural preparation of students. The curriculum provided an overview of Aboriginal history and health in both the DN and BN curricula. An additional subject called Spirituality and the Challenges of Reconciliation was included in the BN program. All students completed two online cultural, awareness training programs, and had local Aboriginal guest speakers in lectures and tutorials. These units of study in the curriculum were over and above the requirements of the Notre Dame, Fremantle curriculum. Graduates commented on this preparation and the positive impact on them whilst they were studying, and in their current place of work. Interestingly, it was noted that in Canada there was an invisibility of Aboriginal health in nursing discourse (Martin, 2006).

Enabling personal factors.

Local exposure was cited as facilitating the ability to assess strengths and limitations and to develop a realistic plan based on a career vision (McGillis-Hall, 2008). Whilst local exposure in this study was a significant influence on graduates' decision to work in a Kimberley hospital, it was not independent of the personal and professional influences. For example from a personal perspective, being able to study at Notre Dame, Broome, meant that as students, the graduates had the opportunity to experience living in a remote area. In other studies it has been argued that fellow

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workers, friends and family members were important in shaping a persons career (Bosley, Arnold, & Cohen 2009).

Experiencing life and being part of the healthcare workforce in the Kimberley was a major influencing factor on graduates and their choice of workplace once they graduated. Likewise lifestyle factors were seen as important determinants of a nurses' decision to undertake rural nursing and were consistent with rural nursing theory (Molanari et al., 2011). In this study, both the workplace nurses and the managers corroborated this notion. Similarly, a study comparing rural nursing in Canada, the US and Australia found lifestyle affects nurses in terms of blurring the boundaries between personal and professional life (Bushy, 2002). Likewise, rural lifestyle has been reported as consistent across small communities in terms of informal social structures and a less hectic life (Bushy, 2002). The quality of life and family networks were cited as important in retaining nurses (Robinson, Murrels, & Griffiths, 2008). These social experiences are integral to the graduate's career decision process (Hodkinson & Sparkes, 1997). Other studies concurred with this finding suggesting that nurses who had a partner and children in their training area, were less likely to start their first job elsewhere. They were also less likely to move geographical locations so as not to disrupt their children's schooling (Robinson, et al., 2008). Whilst the researcher agrees through personal experience of the strong positive connection between family and decisions to stay in remote, it is also obvious that many parents of school age children are heavily influenced by schooling opportunities. They may also perceive few opportunities in a remote area and move to the city even though they prefer a Kimberley lifestyle.

Lifestyle was a term originally used by Alfred Adler (Vujisic, 2013). It was a composite of motivations, needs, and wants that was seen to assist a person to create, or build a particular way of life. In this study, generally, it was the adventure, the remoteness of the Kimberley, the quiet lifestyle and friendly atmosphere of people that had a positive influence on the graduate. One graduate's comment highlighted this experience "I found Broome gave you that very much … better opportunity to learn about working with people and utilising them as part of your team to help improve their healthcare". Similar studies on rural nursing have also commented on the friendly nature of rural communities and the deep attachments they have to their

communities (Fry & Anderson, 2011; Hegney et al., 2002). A sense of belonging was cited as having the potential for being difficult for some new graduates to experience, but was considered as part of professional socialisation process (Mills, Francis & Bonner, 2007). Similarly, it was the culture of the region that was a major aspect of Canadian nurses decision to stay in a region (De Valpine, 2014).

Enabling professional factors.

From a professional perspective, it was the opportunities and support together with the underlying work experience gained as a student, which were positive influencing factors on the graduates. Participants commented about the "friendly nature of the staff" and how positive it was working within a team where there was a "predominance of good team spirit". This effect of workplace culture was also found to be a significant impact on the retention of graduates in other studies (Lea & Cruickshank, 2005; Molanari et al., 2011). Similarly, it was suggested that impediments to career development was the lack of support in the workplace (Cleary, Horsfall, Muthulakshmi, Happell & Hunt, 2013).

Graduates and workforce nurses in this study felt that Notre Dame University in Broome had prepared them well for remote area practice by providing formal and informal support for them to return after graduation. This finding correlates with another study on rural nursing, which suggested that non- metropolitan campuses offer chances for professional development within a supportive community (Bambrick, 2002). Also consistent with the literature is that graduates in this study had realistic expectations about their limitations and the need for a supportive learning environment in the clinical arena (Bennett, Brown, Barlow & Jones, 2010).

Graduates in their first year of practice, experience increasing levels of knowledge and an expansion in their scope of practice. As such they need support in making the transition from theory to practice. The first year of nursing practice has been characterised as a predictable, non-linear involvement of intellectual and emotive changes; an evolution pattern of personal and professional experiences (Duchscher, 2008). As other studies have demonstrated, in this study it was the graduates learning experience as students that contributed to ongoing personal and

professional development (Dalton, 2004; Duchscher, 2008). Career development was seen as an iterative exploration of self and environment that requires an adaptive process (Flum & Blustein 2000). Studies have suggested that graduates can experience reality shock and that experiential learning opportunities were noted as decreasing this occurrence and possibly lessening graduate attrition (Cowin, Hengstberger-Sims, 2006). It was the support from family, friends and social networks that were noted as vital in assisting adaption to change in times of stress and uncertainty (Young & Valache, 2004).

Professional isolation has been cited as a reason for health professionals' reluctance to move to rural practice (Adams, Dollard, Hollins & Petkov, 2005). Included in this issue was the inadequate support for new graduates (Hegney et al., 2002; Lea & Cruickshank, 2005; Neill & Taylor, 2002). Graduates in this study, however, suggested that there was sufficient professional development to support them in the workplace. As students they were provided with preceptors during their clinical practicum and were in a position to judge the amount and type of professional development they could expect as a graduate. At least half of the workforce nurses said that they felt graduates were provided with an adequate amount, but were concerned that staff shortages meant that it was difficult to back-fill a position while the incumbent took study leave for professional development. This issue of study leave did not apply to participants in the graduate program, as they had study days allocated as part of the program. Workforce nurses were also divided in their opinion as to whether they considered there were sufficient professional development opportunities for career development. Availability and cost were inhibiting factors.

Graduates undergo a process of professionalisation where they adapt to new roles and responsibilities and accept differences between theory learnt in nursing school, and practicalities of the workplace (Duchscher, 2008). Lack of clinical knowledge and confidence in skill performance were issues commonly cited in the transition year from student to graduate nurse (Duchscher, 2008). In this study, one of the factors that graduate's mentioned was the support they anticipated in undertaking a graduate program. Support, was described by these participants as: "encouragement", "reassurance", "back-up and help from peers". These behaviours

were consistent with another study, which suggested that the younger generations age between 20 and 25, want prompt feedback, and need positive reinforcement regarding their work performance to improve their self-confidence. This feedback from multiple sources is considered critical in assisting adult learners to reach their maximum potential (Sachdeva, 1996). Graduates in this age bracket want to be led not managed and provided with positive mentorship (Wieck, Prydun, & Walsh 2002). The ages of participants in this study ranged between 20 and 50 with majority being in their 20s and 30s.

Participants in this study felt that as students the preceptors and other workplace nurses supported them the clinical environment. They commented that the friendly nature of people provided a sense of belonging. It was argued that neophyte nurses experience of finding a comfort zone in practice was a part of professional socialisation process (Mills et al., 2007). A feeling of autonomy and support for professional practice has been labelled as structural empowerment (Laschinger, 2012). Graduates professional self-perception was noted as being dependent on how others viewed them, particularly nurses in the clinical environment (Goh & Watt, 2003). In this study those graduates who decided to move to the city, remarked how they felt lost in a large hospital. Some commented that their mentors in the remote clinical placements were much keener to provide them with learning opportunities. Significantly, graduates who had returned to the city, and had the responsibility of precepting students after their graduate year, remarked how the, "country sort of thing has rubbed off". It was also the influence of the workplace nurses that drew some graduates back to the Kimberley.

Inhibiting personal factors.

Factors considered to have had a negative influence on the graduates' decision to work in a Kimberley hospital, were categorised as inhibitors. From a personal perspective these factors were related to sociological features including local exposure, family connections, and facilities. Often the personal factors that inhibited graduates from staying in the Kimberley were not straightforward, but had strong links with each other. As in other studies gender, cultural beliefs, values and social arrangements underpin how individuals choose to live their lives (Dombeck,

2003). Constraints and controls are brought to the decision making process through the social context (Bermudez, 2009) and it is these influences that can appear attractive in the short term, but may not be the best in the long term (Pang, Ross-Otto & Worthy, 2014) particularly when making decisions about career choice.

Graduates considered factors associated with family as influencing them to move away from the Kimberley. Family factors also prevented graduates from moving back to the Kimberley once they got "hooked in the city". This finding was not unreasonable since career decisions can be modified as time proceeds and life circumstances change (Ginzberg, 1984). Careership, as coined by Hodkinson & Sparkes (1997), is a rational decision-making process embedded within a three dimensional social context including pragmatism, interaction with others and points in time. Of particular note was the "pull to leave the area to be closer to family" in other parts of WA and in particular the metropolitan area. This finding corroborates other studies concerning the relationship between personal experiences and relocation (Molanari et al., 2011).

A number of inhibiting factors were linked to the facilities and infrastructure within the Kimberley. Inclusive within these factors were concerns associated with children's education and opportunities for partner's future employment. Outmigration of young people and families from regional areas due to lack of education and job opportunities is a concern for the sustainability of these communities through the loss of human capital (Geldens, 2007; Eversole, 2001). In Broome the high school is reaching a critical number where most specialty subjects are offered. The advantage of this is that a high number of primary school children now move onto the local high school instead of moving to bigger towns or cities. This is not the same in the smaller locations of Derby, Fitzroy, Kununurra and Halls Creek, where the town populations are not high enough for the schools to offer the complete upper school curriculum. In these circumstances children either go away to boarding school (some to Broome) or whole families leave. From a personal perspective the researcher would argue that these perceptions on adequate schooling were not based on fact, as a number of parents do not seek input from local teachers or the schools when making these decisions. Parents are making decisions through their peer groups and past history of family attendance at particular schools in Perth.

Of particular importance in deciding to move to the city were the graduates concerns over partners' employment and the compromises that would need to be made to stay in the Kimberley. As one city graduate explained "my original plan was to stay [in the city] the 12 months and then go back to the country, but then 'umm' I suppose having my family and all my friends here…changed my mind as well as my husbands work. He's settled in his job and wouldn't want to move.". This decision-making capability fits with Bandura's theory that people act with forethought, self reaction and self-reflection (Bandura, 2001).

A male graduate considered that if he had not had children, and if his wife had been amenable he would have moved back to the Kimberley. Graduates in this study who had undertaken their studies as cross campus enrolments and had family connections in the city, were more likely to leave the Kimberley to undertake a graduate program in the metropolitan area. Whilst some graduates expressed their fondness for the Kimberley and believed they would come back; few returned once they had family commitments. One of the managers in this study considered that graduates left the region and returned to get, "you know, more experience in bigger places…and then come back". This seemed to be an unrealistic idea based on the belief that graduates were single nurses without family ties or commitments. It was also based on the manager's perception. Living and working in Broome for 20 years, has given the researcher knowledge and experience. I have observed that whilst some nurses return, nurses who are considered long term, (over 10 years) are those that trained in the region, or came for clinical experience and stayed.

A few graduates commented that they did not consider the healthcare services in remote areas were adequate for their families needs. Some commented on the perceived limited access to healthcare in a remote area and the expense of having to travel to Perth for specialist treatment. This is a well known fact and underpins the reduced health of people living in remote regions. The researcher has first hand knowledge of the difficulties for families when a loved one requires treatment in the city. This treatment often has to be undertaken without family support due to the financial impact of travel and accommodation.

Accommodation during and following a graduate program, was an important

issue in graduates decision to move to urban areas. Rural areas of WA have limited housing for nurses and their families. Traditionally, all towns in the Kimberley, except Broome offered accommodation for single nurses, but not accommodation for married nurses. Managers in this study concurred that graduates with families would have difficulties finding accommodation, especially for those undertaking the graduate program which had a rotation between Broome and other Kimberley hospitals. It was also intimated that the capping of numbers for the graduate program was associated with the limited availability of accommodation in the hospitals.

The lack of affordable accommodation posed challenges for graduates in Broome, who wanted to stay and work after graduation. As students, most graduates would have lived on campus. As a measure of the resilience and motivation of nurses who worked in the region, graduates observed accommodation difficulties. One participant commented that she "saw dreadful things, nurses doing night shift and living in tents it was just insane conditions and it was the wet season". Studies have argued that the quality of life is affected not only by perceptions about the affordability of accommodation, but also about the cost of living (Robinson et al., 2008). In Broome a sudden influx of people during the tourist season placed a burden on residents who found the cost of living increased exponentially. In terms of accommodation, a Canadian study concluded that graduates seek out facilities that not only offer a position, but also residencies to assist in their transition (Molanari et al., 2011).

Interestingly, it has been argued that adequate accommodation for medical practitioners, in rural areas, is of equal concern (Hart et al., 2013). Most notably, in terms of accommodation, there was a plethora of Australian national reports concerned with attracting medical practitioners to the rural healthcare workforce. Although there were similarities in terms of influences on recruitment and retention of medical practitioners and nurses, accommodation rated as a point of difference. Since there are fewer medical practitioners (17.2%) in the rural healthcare workforce, they are cheaper to accommodate. Nationally there are 62.7% nurses and midwives (AIHW Australia's Health, 2012, p. 502). These statistics point to the urgency of providing more accommodation for nurses especially for those who are married. Gone are the days when nurses were single women.

The factors that influenced participants in this study were found to be similar to those in the recruitment of medical practitioners into rural health practice. Generally, they included rural exposure during undergraduate education, spousal commitments and opportunities for professional development and lifestyle issues (Brooks, Walsh, Mardon, Lewis and Clawson, 2002; Dalton et al., 2008). Similarly, personal factors such as location of family friends and employment opportunities have been endorsed by other studies (Hegney, et al., 2002; Smith et al., 2001). Factors also included: personal (age, gender, education), professional (specialisation, working hours, incentives), and contextual (community amenities, quality of life) (Dussault & Franceschini, 2006).

Inhibiting professional factors.

Nursing students, much like other novices, consider experienced staff to know best and often took advice without exploration. Significantly, it was the influence of the workforce nurses that was a major factor in the decision-making process of graduates in determining the location of their graduate program. This finding concurred with other studies in terms of the influence and support graduates experienced as students (Freeling & Parker, 2015; Gum, 2007). A major inhibiting factor in graduates' decision to stay and work in a Kimberley hospital, was associated with the perception they would have to leave to work in an urban environment following their graduate year. This decision was based on some workforce nurses and managers advice to go to an urban setting to gain further experience.

Some studies concerning rural nursing, found that generally nursing administrators responsible for recruitment had little knowledge about graduates' educational preparedness, or the lifestyle of rural nursing (Molanari et al., 2011). This issue was unfounded in Kimberley nurse managers, but may have been an issue with metropolitan administrators. Kimberley managers were fully aware of the lifestyle of nursing in a remote area and were familiar with the Notre Dame, Broome curricula. They often had connections to the University through tutorials, the advisory board or observation of students during their clinical practicum. Some also based their opinions on their own studies as undergraduates.

From a professional perspective some graduates felt that at the time of graduation they would be better supported in a metropolitan graduate program. Generally, they worried about their abilities and a lack of confidence, which may or may not have been influenced by the workforce nurses. It was suggested that these feelings were a characteristic of the stage of stable internalisation in the professional socialisation process (Davis, 1975). The movement to the city for further clinical experiences could be considered a facet of professional socialisation, which has been described as a lifelong, individual learning process (Messersmith, 2008; Wolf, 2007). Some graduates assumed that they had fewer skills than city graduates, but as one graduate remarked, "I think it's a false tendency to think that in the city you're going to have more opportunities. I don't think that it is necessarily the case."

Graduates who had moved to the city had the opportunity to work in a variety of specialties, but were not always supported and were frustrated at not being allowed to work independently. Significantly, other studies have found that the most potent barrier to the support of graduates was the attitudes of staff (Johnstone, Kanitsaki & Curries, 2008). For example other studies found that the traditional hierarchical nature of nursing and the expectation that the graduate must "hit the ground running", might have deterred graduates from working in a particular environment (Mills et al., 2010, p. 34). Mostly, however, the participants in this study mentioned the friendly nature and a sense of belonging that enticed them to stay, or return to the Kimberley healthcare workforce. This finding concurred with earlier studies concerned with sustaining the rural nursing and midwifery workforce (Mills et al., 2010). Graduates perception that the city graduate programs would be better, changed once they had left the Kimberley. In comparing the Kimberley and city programs, many graduates commented that they could have gained as much experience by staying in a Kimberley hospital.

There are a variety of roles, settings and specialisations for nurses. A criticism noted by the National Review of Nursing Education (2002) was the limited opportunity for nurses practicing in rural areas to specialise. Other studies have also suggested that whilst graduate programs are offered in rural areas, there is limited opportunity for graduates to gain clinical education in area of specialty such as ED, dialysis and operating room (Birks et al., 2010; Lea et al., 2008). These findings

were not supported by studies in rural nursing, which have found that rural nursing was imbued with technical skills equal to their urban counterparts (Sedgwick & Rougeau, 2010).

Significantly, the issue of limited opportunities to specialise was not supported in this study. Whilst the Kimberley hospitals could not offer the same intensive experience in a specialist field of nursing as the city, there was the opportunity for graduates to become generalist specialists consistent with rural and remote nursing. Students in this study experienced diversity in their scope of practice. They had the opportunity in Kimberley hospitals, to work in the OR with visiting surgeons from a variety of specialties and were faced with serious medical and surgical conditions of patients who attended the ED. They also had the opportunity to work with skilled, experienced nurses and medical practitioners in stabilising patients with serious life threatening conditions, prior to their transport via the RFDS to Perth. Stabilisation often meant that patients were managed in a high dependency unit in Broome, which had similar technology to their Perth counterparts. Such technology included telemedicine, which afforded staff a direct line to consultant specialists in the city.

Inhibiting professional factors included workforce issues, particularly the shortage of experienced registered nurses. Whilst this limitation has not been demonstrated specific to nurses working in geographically remote locations, it was particularly important in terms of conducting a graduate program. A number of workforce participants commented that "there is not enough staff to support students and graduates…staff get burnt out and then aren't keen to support". Support was interpreted in terms of encouraging graduates. In other studies the shortage of nurses was associated with graduate attrition (Cowin, Hengstberger-Sims, 2006; Johnstone et al., 2008). Hospitals in the Kimberley have limited opportunities for a skill mix suitable to provide experience and educational advancement for nurses in the first few years post registration.

Nurses completing graduate programs may want to stay after their graduate program, and often want to experience ED, OT or high dependency. Whilst as students they can experience these areas, the opportunity to work as graduates is

limited. The problem is that these areas are typically limited to 2 registered nurses per shift. Thus, allocating a graduate nurse as one of these, may pose a potential risk to the safety of patients. This issue is the same in the smaller hospitals in the region where patient numbers are smaller. In Derby and Broome, however, where the general ward (mix of surgical and medical patients) is large, a minimum of 5 nurses may be rostered. In these areas there is an opportunity for graduates and newly qualified ENs to work with guidance from experienced registered nurses. This is where the point of contention regarding recruitment and retention of Kimberley nurses arises. In other words there are positions for nurses of low levels of experience in the ward areas, but not in the speciality areas, thus limiting experiential progression.

Graduates did not consider the tyranny of distance as influencing their decision to stay, or leave the Kimberley. This was a surprising finding, since anecdotally local people often mentioned the distance from the capital city as a disadvantage and a negative aspect of remote living. Kimberley people, when given the opportunity, tend to move to a cooler less humid climate during the wet season, which extends from September to April. This movement of the population affects hospital bed occupancy, and also affects the number and continuity of staff in the hospitals.

The majority of workforce participants had less than 5 years working in their current place of work. This issue could be interpreted as nurses' flexibility in moving between employment locations. As one graduate commented on her ability to move between workplaces I got to "the city and then I got here and I went away again and then when I got there I realised it was just a hassle". In terms of mobility a Canadian study found that there was a trend for nurses to move away from the rural to urban areas, and that the mobility of nurses was a recognised characteristic of nursing (Baumann, Blythe, Kolotylo, Underwood, 2004; Flum & Blustein, 2000).

Several of the workforce participants in this study commented about the mobility of nurses suggesting, "They tire of working in one place and want to move onto somewhere else…". This statement could be indicative of a preference for a remote health workforce, or the mobility of nurses and their adventurous nature of

working and travelling. Interestingly, in this study a manager felt that Broome students were more likely to be adventurous and remarked that, they "are often quite confident, they want an adventure, it is often a different type of person that applies for a grad program in the Kimberley". This statement may be attributed to career decision-making and the search for further nursing experience in order to gain the most satisfaction from nursing (Ginzberg, 1984). The comment also concurred with other studies, which investigated multigenerational differences in nurses. It was suggested that generation X and millennial nurses have an inherent tendency toward mobility and career enhancement (Duchscher & Cowin, 2004). Graduate participants in this study, reflecting on their experience in the Kimberley as students, agreed that they thought it made them a bit more independent and developed their ability to self-manage. Being an independent learner and having an ability to seek educational opportunities from the workplace are essential in a remote health care environment. The experience of this phenomenon by the researcher enabled self-directed learning to form the basis of the nursing program curricula in the Broome School of Nursing. In particular the concept of using technology for remote access learning is dependent on the student being self-directed.

Whilst graduates did not mention financial incentives for staying in the Kimberley, there were several that suggested that the remuneration for graduate rural nurses was not congruent with their expectations, in terms of the cost of living. Some also mentioned they would follow their partners work before they settled on a graduate program. This comment suggested that a partners' employment was more important in terms of economics and stability. It could also be argued that while nurses were flexible in terms of employment location, their commitments to family and relationships were factors that governed their decision–making. This notion concurs with decision-making theory which suggests that a internal locus of control is relevant to making choices, and that high aspiration for an ideal occupation were more adaptive for the decision–making process (Gadassi, Gati & Dayan, 2012).

Student cohorts are becoming more diverse (Croxon & Maginnis, 2006). In this study half of the participants were in their 20s, with a quarter in their 30s and the remainder over 40. Participants were predominantly women with at least half having a rural and remote background. Each generation has different values and

expectations in terms of characteristics, work ethics, attitudes toward organisation and authority. Generation X and Y perceive themselves as idealistic (Hu et al., 2004). Moreover, unlike the older generation they want short-term employment and a balance between their personal and professional lives (Wieck, Prydun & Walsh, 2002). Likewise, similar studies have determined that the younger generations of nurses want lifestyle choices and are unlikely to work in environments that have limited opportunities for career advancement (Baumann, Zeytinoglu, Akhtar-Danesh, Davies & Kolotylo, 2008).

In recent years there has been a cultural emancipation resulting in more self-absorbed tendencies. These have been characterised by a predominance of self-directed motives and values (Rognstad, Aasland & Granum, 2004). Whilst it was not uncommon for nurses to change the way they view themselves and their practice, it was suggested that these changes are predicated on past experiences, beliefs and values that were promoted during their education (Dinmohammadi, Pevrovi & Mehrdad, 2013). In terms of maturity and life experiences, it was suggested that it was the more mature student who was likely to stay once they had completed a locally based rural program (Gum, 2007). Interestingly, a comment form a graduate suggested that the Kimberley graduate program was more suited to a person who had more life experiences than somebody "straight out of school then uni". Other participants in the study, while not refuting this aspect, did not support this comment.

Graduate programs

One of the limitations of the workplace, and a major influencing factor on graduates to move away from the Kimberley, was the lack of a permanent position once they completed the graduate program. This was a similar finding in studies undertaken in Queensland (Williams, 2012) and NSW (Lea & Cruickshank, 2005). This was a disappointing finding since the majority of workforce participants agreed that Notre Dame, Broome graduates had the required skills and knowledge to work in a hospital in the Kimberley after their graduate year. This finding poses the question about the practice of not recruiting nurses after their graduate year; an idea based on the belief that graduates needed more experience. This notion was demonstrated in WA rural areas by employing registered nurses with five years post registration experience. Given the age of graduates and their lifestyle factors, it could

be argued that promoting more experience in the city had the propensity for graduate attrition from the Kimberley.

In this study, coordination of graduate applications for the Kimberley graduate program was undertaken from a central base south of the State. A nurse manager saw this policy as a key to the marketing success of graduate programs in rural WA. The lack of evidence for this notion suggested that the manager might have been unfamiliar with the factors that influence graduates' decision to undertake graduate programs in remote areas. In reality, the central base marketing strategies were far removed from the context of remote area nursing and may have been why some graduates in this study did not have the correct information about the graduate program in the Kimberley. This disconnect between the city centric view and remote living, concurs with other studies that found rural recruitment when implemented in the city was dissimilar. There seems to be little awareness of the context of nursing practice, in rural and remote areas (Hegney et al., 2002). It was argued that recruitment strategies could be more successful if nurses' perceptions were understood (Molanari et al., 2011; Wieck et al., 2010).

In terms of marketing strategies, this study found there was little attention paid to generational differences or the recognition that individuals balance their personal and professional requirements before making decisions about the location of a graduate program. Whilst there was a choice of graduate programs across Australia it depended on the size and location of a healthcare facility and the nurse leaders past experience that influenced a graduates' decision (Francis & Mills, 2011). In this study, nurse manager's thought that graduates needed more experience following their graduate program. As novice nurses, they were often influenced by those in supervisory roles.

Interestingly, nearly all BN graduates who participated in this study completed a graduate program: eight in a major city, five in the Kimberley and two in other rural areas of WA. This was contrary to another study, which found there was a low percentage of students from a rural background who gained experience in a rural practicum, and who planned to work in a rural location in their graduate year (Hickey & Harrison, 2013). This finding could possibly be associated with the

tendency for young people to move to the city having spent their childhood in a country town, or it might have been related to their understanding that employment opportunities at their level of experience were limited (Bushy, 2002). In this study another factor to consider was the capping of graduate placements in the Kimberley graduate program. Nine graduate placements were offered annually, six rotational (through Broome, Derby and Kununurra) and three based in Broome. These placements were associated with the number of workforce nurses who could precept, or mentor the graduates. Additionally, graduates from Broome were obliged to seek their own accommodation (WACHS, 2011).

There are no graduate programs for the EN workforce. Graduates from the DN program either move away from the Kimberley for a graduate program or remain and work on a casual basis. Interestingly lack of a graduate program did not deter the DNs who wanted to stay in the Kimberley as they considered that working casually or part time suited their family and lifestyle better.

One of the limitations of healthcare agencies is the replacement of competent experienced nurses with graduates (Duchscher, 2008). Several times in the course of this study workforce participants expressed the need for graduates to "gain more experience" yet few explained this concept. In the seminal work of Benner (1984), experience was described as being "gained when theoretical knowledge is refined, challenged, or disconfirmed by actual clinical evidence that enhances, or runs counter to the theoretical understanding" (p. 294). In a separate study, it was noted that graduates were concerned with competence and experience rather than knowledge, whereas more senior staff did not seem to discern the difference (Cowin & Jacobsson, 2003). This notion of experience was identified as nurses placing their technical knowledge over personal knowledge in decision making in order to resist control and intervention (Traynor Boland & Buus, 2010). In relation to rural nursing the generalist specialist role was described as one where the nurse needed to use their scientific knowledge to make sound clinical decisions combined with experiential learning (Hurme, 2009).

Graduates in this study had the impression that they would not gain employment without completing a graduate program. Although most nurse managers

looked favourably on this achievement, it was not essential for future work. Graduates hearing about the limited opportunities of work after completing a graduate program, made decisions to move to the city to gain experience for a few years, rather than opting for a short employment period during their graduate year. This pragmatic decision-making lies within the careership decision-making theory, which suggests that short term decisions may not benefit long term gains (Hodkinson & Sparkes, 1997). Some graduates mentioned that ongoing contracts for employment were not offered following the graduate program, because they were inexperienced. Also the practice of employing nurses with a minimum five years of experience, meant that they had little choice, but to move to the city. This predicament was not specific to this cohort of new graduates. A Queensland study found there was no expectation by rural agencies for graduates to stay on after the 12-month period, but the study did not specify a relationship between policy, levels of experience and expectations. In a further study, however, some rural nurses believed that graduates should seek more experience in larger facilities on completing their twelve month program (Mosel-Williams, 2000).

Limitations

This study was limited in that it did not investigate links between the length of exposure in the remote area and recruitment of graduates into hospitals in the Kimberley. Additionally, there was the chance that some participants may have forgotten events over the five years prior to data collection. Strategies to minimise this potential problem, included ensuring a range of participants were interviewed and that they were afforded time to reflect and think before responding.

The researcher has lived in the North of WA for twenty five years, since graduating. This lifetime of nursing in the Kimberley has created the positive assumption that given support and educational opportunities it is possible for a graduate nurse to grow from a novice to a highly experienced nurse. The researcher wanted to investigate if graduates were making informed choices, or whether they were being influenced by nurses in the workforce who did not necessarily have the long-term experience of nursing in the Kimberley. This closeness to the study could be considered a limitation, however any bias was reduced through journaling and

discussion of finding with the supervisor. The researcher, being mindful of the perceived bias, constantly looked for alternative and rival evidence and displayed this within the findings and the analysis of the study.

Most workforce participants were employed in Broome hospital since it was the largest in the Kimberley. This may have been a limitation of the study since the smaller hospitals may have had a more acute recruitment and retention issue.

Twenty four of the possible 175 graduates responded to invitation to participate. This number was sufficient as data became repetitive after nineteen interviews. Thus, saturation was achieved. As with all qualitative studies there is an assumption that findings from this study cannot be generalized to a larger population. This study used a qualitative case study approach, and as such generalisability of the findings was not the goal. Rather, the focus was on transferability where other interested people could find value. Although the context of the study was unique to the Kimberley region of WA it could resonate with other people in remote regions nationally and internationally.

This thesis was located in the context of professional nursing and the need to provide quality care to people in a remote part of WA. It argues that providing an opportunity for people to learn nursing in their local community, part way meets the problem of nurse shortage in remote areas of Australia.

Conclusion

The rationale for this study was based on the dwindling numbers of rural nurses. The assumption was that graduates from a remote school of nursing would assist in partway resolving the problem in the Kimberley region of WA. To a certain extent Notre Dame, University in Broome provided a considerable number of graduates, but the question remained what were the influences they considered in their decision to remain or leave the area. A satisfactory answer was vital to improving the retention of nurses in the Kimberley.

The issue in deciding whether to stay, or leave the Kimberley at graduation

was based on a number of alternatives that the graduate could act upon, each with a range of possible outcomes based upon facts that the graduate may/may not have controlled. Within this decision making construct graduates displayed self-direction in the face of competing influences, based on their capability to exercise some measure of control. The constraints, compromises and controls were undertaken within the social context of nursing in the Kimberley. It was the interlocking relationships between the disposition of the graduate's inner self, the role they played and the context of the situation that influenced their decision-making. These factors were multidimentional with no clear boundaries between local exposure, personal and professional influences.

Graduates decisions could loosely be divided into enabling and inhibiting factors. Decision-making theories, however, have proposed actions and cannot be evaluated in isolation, but need to be considered within the context of the situation (Maton, 2012). This was evident in the study as often the personal and the professional factors were interrelated. A major underpinning of all influences, however, was local exposure. It was an underlying influence from a personal and professional perspective, in either staying, or leaving the Kimberley.

The role of Notre Dame, Broome cannot be underestimated; it offered a unique experience in remote health and remote nursing. Graduates as students were immersed in the culture and climate of the Kimberley, which included lifestyle and exposure to the community within the context of remote area living. Moreover, workforce nurses acted as tutors, in the University and as mentors and preceptors in the clinical area. The friendly nature and support of the people was also significant in a graduates' decision to stay in a Kimberley hospital.

An overriding inhibiting factor was the notion that graduates would have to leave the Kimberley following their completion of a graduate program, either because they were advised they would need more experience, or because there was limited employment following graduation. The dichotomy between hospital policy and the reality, concerning graduates skills and knowledge, was apparent. It was especially irksome since the students were aware of the shortages of nurses in remote areas, believing they would be welcome in helping to relieve the problem. Inconsistent information coupled with personal and professional conflicts led to

indecisiveness and compromises about decisions to stay, or leave the Kimberley.

Thus, there were numerous interrelated and overlapping factors that can only be interpreted with respect to the context of the study. The push and pull situation had significant implications on the career decision-making process. Ultimately, it was the balance between the demands of reality and the graduates' needs that compelled them in their final choice.

Recommendations

- Continue pre-registration nursing programs in remote regions of Australia to enable the ongoing recruitment of locals into the workforce.
- Continue to provide mechanisms, within the nursing curriculum, to deliver across multi campuses, to enable a focus on rural and remote nursing practices.
- Increase opportunities for locally recruited students to attend clinical placements in the city to provide the experience to quiet the notion of better elsewhere.
- Develop strategies to increase awareness of nursing in remote hospitals and the experience that can be gained, to quell the notion of limited experience in remote areas.
- Develop graduate programs for enrolled nurses in remote hospitals to support them while converting to an RN qualification.
- Review the number of graduate programs offered in remote areas to consider increasing opportunities outside hospital services to include renal dialysis, Aboriginal Health Services and Aged Care.
- Explore a rural pipeline opportunity for nurses with a focus on transition from new professional to career professional in order to improve opportunities for clinical education and further development of knowledge and skills.
- Investigate opportunities and offerings of continuing professional development for nurses in remote areas.

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Appendix A

Clinical Placement Site Sample Agreement

2005

THE BOARDS

AND

**THE EDUCATIONAL INSTITUTION,
THE UNIVERSITY OF NOTRE DAME AUSTRALIA**

**AGREEMENT FOR THE EDUCATIONAL INSTITUTION STAFF AND NURSING
AND MIDWIFERY STUDENTS TO HAVE ACCESS TO THE PREMISES AND
FACILITIES CONTROLLED BY THE BOARDS FOR THE PURPOSES OF THE
CLINICAL PLACEMENTS PROGRAM**

Prepared by:

Legal & Legislative Services Branch
Department of Health
189 Royal Street
EAST PERTH   WA   6004

THIS AGREEMENT is made on the _____ day of _____ 2005

BETWEEN:

THE MINISTER FOR HEALTH in his incorporated capacity as:

a) the board of the hospitals formerly comprised in the Metropolitan Health Service Board;

b) the board of the hospitals formerly comprised in the Peel Health Service;

c) the South West Health Board; and

d) the WA Country Health Service;

under section 7 of the *Hospitals and Services Act 1927* (WA), c/- 189 Royal Street, East Perth in the State of Western Australia

(individually "**Board**" (where the context requires) and collectively "**Boards**")

AND

THE UNIVERSITY OF NOTRE DAME AUSTRALIA, being a body corporate established under section 4 of the *University of Notre Dame Australia Act 1989* (WA) of 19 Mouat Street, Fremantle in the State of Western Australia **(EI)**

RECITALS:

A. The object of this Agreement is to ensure that Students studying at the EI have, as an essential part of their course work, adequate access to clinical and professional facilities, whilst maintaining proper standards of Patient care.

B. Accordingly, the parties have agreed that certain EI Staff and Students may have access to the Facilities situated on the Premises, as part of the CP Program conducted by the EI.

C. The Boards and the EI have now agreed to set out their respective rights and obligations in this Agreement.

D. It is the intention of the parties that entry into this Agreement should not hinder the Boards in their provision of efficient and high quality hospital and health services.

E. The Minister for Health is incorporated as the board of the hospitals formerly comprised in the Metropolitan Health Service Board under s7 of the *Hospitals and Health Services Act 1927* (WA) and has delegated all the powers and duties as such to the Director General of Health.

F. The Minister for Health is incorporated as the board of the hospitals formerly comprised in the Peel Health Service under s7 of the *Hospitals and Health Services Act 1927* (WA) and has delegated all the powers and duties as such to the Director General of Health.

G. The Minister for Health is incorporated as the South West Health Board under s7 of the *Hospitals and Health Services Act 1927* (WA) and has delegated all the powers and duties as such to the Director General of Health.

H. The Minister for Health is incorporated as the WA Country Health Service under s7 of the *Hospitals and Health Services Act 1927* (WA) and has delegated all the powers and duties as such to the Director General of Health.

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THE PARTIES HEREBY AGREE AS FOLLOWS:

1. **DEFINITIONS AND INTERPRETATION**

    1.1.   In this Agreement, unless the contrary intention appears:

        Clinical Co-ordinator means a person designated by the Board to co-ordinate clinical placements and clinical supervision of Students for a Health Service;

        Clinical Instructor means a registered nurse or midwife designated by the EI to provide clinical supervision and assessment of Students;

        Consenting Patients means the Patients who have consented to receive care and treatment from a Student in accordance with clause 9.1;

        CP Program means the clinical placements program conducted by the EI whereby Students are permitted to have access to the Premises and Facilities for the purposes of their course work relating to the Education Program;

        Designated Practice Areas means those areas within the Premises specifically designated by the Board as practice areas;

        Education Program means the undergraduate, postgraduate or re-entry studies in nursing or midwifery at the EI;

        EI Staff means the co-ordinators and supervisors employed or engaged by the EI;

        Facilities means the facilities and resources located within the Premises;

        Health Service means a Hospital and the health centres, schools, clinics and other places staffed by employees of the Board, which are under the management and control of the Board;

        Hospital means a Hospital under the control and management of the Board pursuant to the *Hospitals and Health Services Act 1927 (WA)*;

        Minister means the Minister for Health;

        Patients means the patients (of whatever description or type) currently receiving treatment or care from the Board, and where the context requires, includes Consenting Patients;

        Preceptor means a registered nurse/midwife employed by the Board who provides supervision of a Student during the CP Program;

        Premises means the land and buildings used by the Hospitals and the health centres, schools, clinics and other places staffed by employees of the Board, which are associated with the Hospitals;

        Shift Co-ordinator means a registered nurse or midwife who manages daily operational concerns of a unit or ward of a Health Service;

        State means the State of Western Australia;

Students means the Students enrolled in the Education Program at the EI, and who are also included within the CP Program and placed at the Premises.

1.2. In this Agreement, unless the contrary appears:

(a) words in the singular number include the plural and vice versa;
(b) words importing a gender include any other gender;
(c) where word or phrase is given a particular meaning, other parts of speech and grammatical forms of that word have corresponding meanings.

2. BOARD PERMITS ACCESS BY EI STAFF AND STUDENTS

2.1. The Board permits the EI Staff and Students:

(a) to have access to the Premises; and
(b) to use the Facilities located on the Premises,

provided that such access and use is:

(c) required for, and is part of, the CP Program; and
(d) in accordance with the terms and conditions set out in this Agreement.

2.2. The Board permits the EI Staff and Students, as and when it is necessary, to accompany their Clinical Instructor to places not on the Premises, provided that:

(a) the particular Clinical Instructor is acting in the course of their employment or duties as an agent of the EI;
(b) the particular Clinical Instructor consents thereto;
(c) it is required for, and is part of, the CP Program conducted by the EI; and
(d) it is in accordance with the terms and conditions set out in this Agreement.

2.3. The Board permits the EI Staff and Students access as above in clauses 2.1 and 2.2 provided that all EI Staff and Students individually complete and sign a separate and personal agreement, if required by the Board, in such form as the Board may require to take all reasonable measures to:

(a) maintain Patient confidentiality;
(b) comply with the rules and regulations and protocols of the Board, including the protocols and procedures applicable to the Premises and those relating to visiting Aboriginal communities; and
(c) obey directions and orders of the officers, employees and agents of the Board.

3. ADMINISTRATION OF THIS AGREEMENT

3.1. The Board and the EI shall each nominate representatives to co-ordinate the CP Program at the Premises and each party will provide notice to the other as to who the representatives are.

3.2. For the purposes of this Agreement, the respective representatives of the Board and the EI, nominated under the preceding clause, may:

(a) exercise a power specified in this Agreement as being exercisable by the Board or the EI, other than the power in the preceding clause;

(b) perform an act or do a thing specified in this Agreement as being required or permitted to be done by the Board or the EI;

(c) give an approval specified in this Agreement as being required or permitted to be given by the Board or the EI.

4. ACCESS

4.1. The EI Staff and the Clinical Co-ordinator shall agree on the Student/Patient ratio and on the selection of Consenting Patients for each Health Service.

4.2. The Clinical Co-ordinator at the Health Service and the EI shall agree the numbers of, and the times at which, Students may attend in or at the Designated Practice Areas on the Premises.

4.3. In reaching the agreement referred to in 4.1 and 4.2, the Clinical Co-ordinator at the Health Service and the EI shall have regard to the number of Consenting Patients and the effective and efficient operation of the Board, the Heath Care Facility, and the CP Program.

4.4. The EI shall provide appropriately qualified EI Staff to supervise and assess Students, in consultation with the Clinical Co-ordinator at the Health Service, unless otherwise agreed by the parties.

4.5. Access to the Premises by EI Staff and Students will be limited to the Designated Practice Areas, unless otherwise agreed by the parties.

4.6. The EI shall provide the Clinical Co-ordinator at the Health Service with relevant details of Student allocations, including the names of Students, prior to the commencement of each semester.

4.7. Access to Consenting Patients will be dependent upon the discretion of the Clinical Instructor or Shift Coordinator and the Consenting Patient.

4.8. Access by EI Staff and Students to Patient information, including the medical record, is limited to those Consenting Patients for whom the EI Staff and Students are providing clinical care. Where a Student is required to make a notation in a patient's permanent medical record, the entry will be discussed, or a draft checked, by the Clinical Instructor or Preceptor prior to entry unless otherwise permitted by the Clinical Instructor or Preceptor.

4.9. (a) The Clinical Co-ordinator at the Health Service shall inform the EI of any specific infection control policies, including policies relating to access to the Premises by persons with a communicable disease, with which compliance is required in relation to, or affecting, the clinical placements of EI Staff and Students.

(b) EI must take all reasonable measures to ensure that EI Staff and Students comply with any specific infection control policies of the Health Service.

4.10. (a) The Clinical Co-ordinator at the Health Service shall provide EI Staff and Students with access to copies of any policies, regulations, rules, procedure manuals, directions or other similar documents, which relate to or concern the use of the Facilities at the Premises.

(b)   The EI must take all reasonable measures to ensure that EI Staff and Students read, understand and comply with any policies, regulations, rules, procedure manuals, directions or other similar documents.

4.11.   The Board is to provide for the emergency care of EI Staff and Students, according to the facilities available, where they suffer an accident or illness whilst on the Premises, in accordance with the usual conditions relating to such visiting personnel at the Premises.

4.12.   Access by EI Staff or Students to any conference room space, areas for discussion, or areas for interviewing, may be made available by the Clinical Co-ordinator at the Health Service, where possible, according to the Board's usual booking procedures at the Premises.

4.13.   The Board does not permit EI Staff or Students to drive vehicles leased by or under the control of the Board, unless the Board agrees otherwise in writing.

4.14.   The Board will supply Preceptors to precept and supervise Students. The terms and conditions of this supply will be agreed by the parties, but any agreement will be subject to the prior approval of the General Manager and Director of Nursing Services of each Health Service.

4.15.   Where the Board supplies Preceptors to precept and supervise Students, the EI will:

(a)   provide appropriate training for the Preceptors at no additional cost to the Board; and

(b)   reimburse the Board in the time and manner agreed by the parties for any costs, including salary (and on call payments if applicable), district allowance and all other allowances which are incurred by the Board as a result of the Preceptors being unable to perform the usual duties which the Preceptors are required to provide to the Board whilst precepting and supervising Students.

5.   COURSE CONTENT/PROGRAMS/ASSESSMENT

5.1.   The EI shall be responsible for:

(a)   the administration and development of course content;
(b)   clinical and practical programs;
(c)   the format of Student assessment;
(d)   informing the Clinical Co-ordinator at the Health Service of the specific learning objectives for Students;
(e)   the extent and nature of experience of Students which is required; and
(f)   all related matters.

5.2.   The EI shall be responsible for Student assessment, unless it is otherwise agreed by the parties that the content of placements and assessment is to be conducted in collaboration with the Board's staff.

5.3.   The EI will be responsible for compliance with legislative and/or professional organisation's requirements related to Student supervision and clinical placements.

6. **SUPERNUMERARY STATUS OF STUDENTS**

6.1. Students in the CP Program will be supernumerary to the Board's staff at the Premises.

7. **RESOURCE MATERIAL**

7.1. EI Staff and Students may have access to the Board's libraries and any other resource material on the Premises, provided:

   (a) the access is during EI Staff or Student's participation in the CP Program;
   (b) the access is for the purposes of EI Staff or Students' participation in the CP Program; and
   (c) reciprocal access to the EI library is negotiated for Board staff undertaking clinical supervision or preceptoring.

7.2. The terms and conditions on which EI Staff and Students may borrow items or material from the Board's libraries, or from the Board generally, shall be as specified by the Board.

8. **REGISTRATION AND NOTIFICATION TO BOARD**

8.1 The EI must ensure that all EI Staff who provide treatment to Patients must:

   (i) have current, appropriate and adequate medical indemnity insurance or cover with an Australian, or with the prior approval in writing of the Board (which approval must not be unreasonably withheld) overseas, insurer or fund. If required by the Board, evidence of this must be produced to the Board on demand; and

   (ii) be registered with the Nurses Board of Western Australia and, if required by the Board, evidence of that registration must be produced to the Board within 1 month of each annual re-registration or on demand.

8.2 The EI must notify the Board as soon as it becomes aware:

   (a) in the case of the EI Staff who provide medical treatment to Patients, if:

      (1) they are fined or reprimanded by the Nurses Board of Western Australia, give an undertaking to be of good behaviour to the Nurses Board of Western Australia, or his or her Nurse's Board registration being made conditional, suspended, removed or lapsing;

      (2) their indemnity protection is removed or lapses;

      (3) any investigation by a relevant college or professional body is commenced against them;

      (4) any charges or convictions for an offence punishable by imprisonment being made against them;

      (5) any actual or potential conflict of interest involving them which is known to the EI;

      (6) any illness or disease that would interfere with their ability to treat Patients or that is communicable and presents a risk to Patients or other people;

and

(b) in respect of any Patient, any:

    (i)   adverse incident;

    (ii)   serious verbal, or any written complaints received;

    (iii) threats of legal action or any writ, subpoena or summons received;

    (iv) matter which a EI Staff member is obliged to inform his or her indemnity fund, organisation or insurer;

    (v)   referral to the Nurses Board of Western Australia or any such similar bodies in other jurisdictions; or

    (vi) referral to the Office of Health Review.

8.3   The EI must carry out periodic enquiries to investigate whether any of the matters referred to in clause 8.2 have occurred.

8.4   The EI must take all reasonable steps to assist, and use all reasonable endeavours to cause any member of Staff to assist, the Board in inquiring into and resolving any matter arising under or in connection with any matter referred to in clause 8.2.

If requested by the Board, the EI must also provide and cause any member of Staff to provide as soon as reasonably practicable all relevant details of any matters of which the Board is advised under clause 8.2 or otherwise becomes aware.

Nothing however requires any member of Staff to disclose information to the Board where to do so would cause that person to be in breach of his or her obligations to any medical defence organisation, indemnity fund or insurer, or which may significantly prejudice any claim by that person under that indemnity cover or insurance. In any such circumstances the member of Staff must use their best endeavours to obtain the approval of the defence organisation, indemnity fund or insurer to disclosure of the information required by the Board, and must disclose the information to the Board in accordance with any approval given.

9. PATIENT CARE

9.1   At all times it is intended that the Students, under the direct supervision of the Clinical Instructor or Preceptor, with the Consenting Patient's informed consent, will provide:

    9.1.1 assessment of Consenting Patients;
    9.1.2 care of Consenting Patients; and
    9.1.3 professional services,

to the level of their learning.

9.2   The EI shall ensure that EI Staff acquaint the appropriate employees or agents of the Board at the Health Service (which includes the Clinical Co-ordinator) with the Students' levels of learning or curriculum covered, and those aspects of total patient care or professional service for which the Students have not been prepared or are unable to perform.

9.3 The responsibility for Patient care lies with the Board, and the Clinical Co-ordinator of the Health Service can withdraw a Student from the clinical area to maintain Patient safety.

9.4 The EI shall ensure that EI Staff and Students abide by the Board's decisions regarding the needs of, and the care for, Consenting Patients and Patients.

9.5 (a) Unless sub-clause 9.5(b) applies, the EI shall ensure that, at appropriate time intervals, the EI Staff and Students be screened for and vaccinated against the following vaccine preventable diseases – Hepatitis B, Measles, Mumps, Rubella, Varicella, Poliomyelitis, Diphtheria, Tetanus, Influenza, Pertussis, Tuberculosis – and any other disease or condition of health notified in writing by the Clinical Co-ordinator to the EI.

(b) If an EI Staff or Student refuses to be screened and/or vaccinated in accordance with sub-clause 9.5(a) on the basis of conscientious objection, the EI must notify the Clinical Co-ordinator of the name of that EI Staff or Student within 14 days of the refusal, and if the Clinical Co-ordinator forms the view that patient safety may be compromised by that refusal the Clinical Co-ordinator may invoke the provisions of clause 9.3.

9.6 The EI shall provide the Board with evidence that EI Staff and Students have a MRSA clearance if the EI Staff or Student has been a patient or student, or has worked, in any Hospital or residential care facility outside of Western Australia in the last 12 months.

9.7 The EI shall ensure that EI Staff and Students:

9.7.1 comply with the Board's standing orders in relation to Patient confidentiality;

9.7.2 where appropriate, before commencing the CP Program, complete the Board's "Declaration of Confidentiality" documentation, or any revised or updated version of that documentation; and

9.7.3 provide evidence of criminal record clearance to the Board.

9.8 The EI shall enforce the provisions of the "Declaration of Confidentiality" completed by an EI Staff or Student pursuant to clause 9.7.2 (hereafter referred to in this sub-clause as "the Declaration") against that EI Staff or Student where that EI Staff or Student has breached the Declaration.

10. UNIFORMS

10.1 Where the Board determines that uniforms are required for EI Staff or Students, the EI shall be responsible for the selection of those uniforms, unless otherwise agreed by the Board and the EI.

10.2 The Board shall not be responsible for the supply or laundering of the uniforms required under the preceding clause, unless otherwise agreed by the Board and the EI.

10.3 Where uniforms are not required, the EI shall ensure that EI Staff and Students follow the Board's dress standards.

11. RESEARCH PROJECTS

11.1 The EI shall ensure that Students do not undertake any research projects or surveys which involve the Board, or its officers, employees or agents, or Patients, without the prior approval of the Board, and, where relevant, the EI's Human Research Ethics Committee.

11.2 The EI shall ensure that Students do not undertake any research projects or surveys which involve Patients of Aboriginal or Torres Strait Islander descent without the prior approval of the Board and the Western Australian Aboriginal Health Information and Ethics Committee.

12. DISCIPLINE OF STUDENTS

12.1 Unless otherwise agreed by the Clinical Co-ordinator at the Health Service and the EI, whilst Students are on the Premises:

12.1.1 the Students will be under the general direction of EI Staff; and
12.1.2 the EI shall ensure that the Students observe the appropriate by-laws and rules of the Board.

12.2 Any matters of Student discipline within the knowledge of the Board will be referred by the Board to EI Staff and will be dealt with by the EI according to its disciplinary policy and procedures.

12.3 Whilst a Student is on clinical placement, the EI shall enforce its disciplinary policy and procedures pertaining to academic and clinical programs against that Student if that Student breaches any such policy or procedure.

12.4 The Board reserves the right to withdraw or exclude individual Students from the clinical area. Any such exclusion shall be reported by the Clinical Co-ordinator at the Health Service to the EI.

13. ORIENTATION

The Clinical Co-ordinator and the EI shall arrange appropriate orientation for EI Staff and Students.

14. IDENTIFICATION

The EI shall ensure that EI Staff and Students wear identification badges at all times clearly identifying that EI Staff or Students are EI Staff or Students.

15. SECURITY AND FIRE SAFETY

15.1 The Clinical Co-ordinator at the Health Service shall be responsible for the induction of EI Staff and Students with respect to:

15.1.1 security;
15.1.2 emergency; and
15.1.3 safety;
policies and procedures.

15.2 The EI must take all reasonable measures to ensure that EI Staff and Students familiarise themselves with the policies and procedures referred to in this clause.

16. PARKING

The Board and the EI shall negotiate any access by EI Staff and Students to the car parking facilities situated at the Premises, if available. If car parking facilities are available, the usual payment and terms of parking will apply.

17. CATERING

17.1 The meals and refreshments provided by the Board at the Premises will be available to EI Staff and Students.

17.2 The Board may charge EI Staff and Students for the meals and refreshments in accordance with the ruling rate in operation at the time.

18. RESOLUTION OF DISPUTES

18.1 If the two parties are in dispute on any matter under this Agreement, then each party will nominate a senior negotiator who will meet within 5 working days to resolve the problem.

18.2 If the problem cannot be resolved by the persons referred to in-sub-clause 18.1 the dispute shall then be referred to the applicable Chief Executive for the Board and the Vice-Chancellor of the EI.

18.3 If the persons referred to in sub-clause 18.2 within 20 working days of the matter being referred to them are unable to resolve the dispute each party is free to take whatever steps it considers appropriate.

19. REVIEW OF TERMS OF AGREEMENT

19.1 This Agreement may not be varied except in writing signed by both parties.

19.2 The terms of this Agreement will be reviewed every two years or at other times by mutual agreement of the parties.

20. TERM OF AGREEMENT

Subject to Clause 22, this Agreement shall continue in force from the date of execution for such period, as the EI is responsible for operation of the CP Program.

21. TERMINATION

Either party may terminate this agreement by giving the other party no less than six months notice in writing, no later than six months prior to the commencement of the following academic year as published by the EI.

22. NOTICES

22.1 A notice, consent or other communication in connection with this Agreement:

22.1.1 must be in writing;

22.1.2 may be given by an authorised officer or representative of the Board or EI (as the case may be); and

22.1.3 must be:
    (i) sent by prepaid ordinary post to, or left at the address of, the addressee at the following address:

Board Address: The Minister for Health
                     C/O Department of Health, Legal & Legislative Services
                     189 Royal Street
                     EAST PERTH WA 6004

EI Address: Dr Peter Tannock
                Vice Chancellor
                The University of Notre Dame Australia
                19 Mouat Street (PO Box 1225)
                FREMANTLE WA 6959

or

    (ii) sent by facsimile to the following facsimile number:

Board Facsimile: (08) 9222 4038

EI Facsimile: (08) 9433 0855

A notice, consent or other communication takes effect from the time it is received, unless a later time is specified in the notice or communication. For the purposes of this clause (22), a letter or facsimile is taken to be received:

(a)   in the case of a letter sent by post, on the third business day after posting; and

(b)   in the case of a facsimile, on production of a transmission report from the facsimile from which the notice or communication was sent which shows that the entire facsimile was sent to the facsimile number of the addressee set out in this clause.

23.   GOODS AND SERVICE TAX

23.1   Definitions
Unless the contrary intention appears, in this clause:

GST means goods and services tax applicable to any taxable supplies as determined under the GST Act.

GST Act means *A New Tax System (Goods and Services Tax) Act 1999* and where applicable includes the Regulations and the Commissioner of Taxation's Goods and Services Tax Rulings made thereunder and any other written law dealing with GST applying for the time being in the State of Western Australia.

Supply means the supply in any form of a good or service or other thing under this Agreement.

23.2   The EI must pay to the Board the amount of any GST the Board pays or is liable to pay on a Supply.

23.3   The EI must pay to the Board the amount of GST that the Board is liable to pay:

(a) at the same time; and
(b) in the same manner

as the EI are obliged to pay for that Supply.

23.4 The consideration for each Supply does not include GST on that Supply and the EI must pay the amount of GST in addition to the consideration for that Supply determined under this Agreement.

23.5 A written statement given to the EI by the Board of the amount of GST that the Board pays or is liable to pay is conclusive as between the parties except in the case of an obvious error.

24. GENERAL

24.1 This Agreement shall be read and construed according to the laws of the State of Western Australia and the parties hereby submit to the non-exclusive jurisdiction of that State.

24.2 If any provision of this Agreement is held by a court to be unlawful, invalid, unenforceable or in conflict with any rule of law, statute, ordinance or regulation the validity and enforceability of the remaining provisions shall not be thereby affected.

24.3 All stamp duties and governmental charges arising out of or incidental to this Agreement shall be the responsibility of and payable by the EI.

24.4 Nothing in this Agreement shall constitute the relationship or partnership, employment or agency as between the Board and:

(c) The EI; or
(d) EI Staff; or
(e) Students

and it is the express intention of the parties that any such relationships are denied.

24.5 Each party shall execute such agreements, deeds and documents and do or cause to be executed or done, all such acts and things as shall be necessary to give effect to this Agreement.

24.6 The EI may not assign or sub-contract its rights and obligations under this Agreement.

24.7 The Board may assign this Agreement to any entity, which assumes control of a Hospital without the requirement of consent from, or notice to, the EI.

24.8 In the event of a merger of an EI and another EI, the Board's consent to the merger will not be necessary.

SIGNED by DR NEALE FONG,   )
A/DIRECTOR GENERAL OF HEALTH   )
as delegate of each of the Boards)

Signed: _____

Witness: _____

THE OFFICIAL SEAL OF THE UNIVERSITY)
OF NOTRE DAME AUSTRALIA was hereunto)
affixed, in the presence of:)
)

Witness Signature: _____

Witness Name: _____

Witness Address: _____

Witness Occupation: _____

Appendix B

Policy: Nursing Clinical Practicum

POLICY: NURSING CLINICAL PRACTICUM

Clinical practicum forms a fundamental part of the University of Notre Dame, Australia (Notre Dame) nursing programs. Students are required to sign the student declaration acknowledging that they have read and understood the following policy.

Clinical **Placement Scheduling**

The timing of a student's practicum during allocated timetabled practicum period is dependent on the timing and length of placements allocated by agencies to the School of Nursing. This may result in students having their practicum split between different time periods. Students must not book holidays or other commitments until after the final practicum allocation list is released.

Students may be required to travel considerable distances to a clinical practice agency and are responsible for organising their own transport.

Funding

Accommodation for clinical placement is usually provided by the clinical placement site. This can mean there are restrictions on placement numbers. Students may incur some costs for accommodation if free accommodation cannot be secured. Students will be advised of this with confirmation of places. Reimbursement may be provided through the Combined Universities Centre for Rural health (CURCH) or from Notre Dame. These details will be provided to students.

Dress requirements

Students will be expected to wear their uniform in most health agencies, the exception may be when you are on a Community Practicum or working in a Mental Health agency. The uniform consists of specific Notre Dame top and dark blue trousers or long shorts, Notre Dame School of Nursing name badge and black closed toe shoes . Lanyards, for student ID and criminal screening clearance card, can no longer be worn, these must be pinned or students may purchase a retractable card holder.

While on practicum students must present themselves in a neat and professional manner, which includes hair tied back, clean nails and minimal jewellery according to local hospital/facility policy and the World Health Organisation Bare below the

Elbow Policy.

Employment while on practicum

Nursing students will be required to work rostered and rotating shifts while on practicum. This means that they must be available to work any shift (including night shift) across the seven days of the week. The agency with whom they are placed for the practicum will roster the student to work the same shifts as their mentor or to shifts where there is the most support and supervision for the student. Students must give their clinical placement requirements priority over part---time and/or casual employment. Students may continue to work part---time or casually, as long as it does not impact on their rostered clinical placement shifts.

Clinical Practicum Attendance

Bachelor of Nursing students are required to complete a minimum of 1240hours of clinical hours during their course. Bachelor of Nursing students undertaking the conversion program complete 880 hours. Enrolled nursing students (Broome campus only) are required to complete a minimum of 600hours during their course. These hours are divided between semesters with each student completing 160---240 hrs per practicum depending on the particular unit of study.

A student who is absent from clinical placement will need to make up the hours. A medical certificate is required if the student is absent for more than one shift.

Vaccinations/Immunisations

All nursing students are required to be vaccinated against key vaccine preventable diseases (VPDs) before attending clinical practicum. The current schedule of requirements is based on Department of Health immunisation requirements and will be provided by SoN (School of Nursing).

Health Record

On entry into the program all students must complete a health status questionnaire. Students may be required to provide a medical certificate deeming them physically and mentally fit to complete the requirements of clinical practicum during their course of study.

Criminal Clearance

All nursing students are required to complete a Working with Children check, a National Police Screening Certificate and a Department of Health Criminal clearance before attending practicum. Details of the application process will be provided by the

School of Nursing and Midwifery.

Other Requirements

All students must have a Current Senior First Certificate for the duration of the program; this requires annual recertification of the Basic life support component. Students must also maintain the Manual Handling certificate of completion. Evidence of completion must be forwarded to the SoN at the commencement of each academic year. Programs will be available on the Fremantle and Broome campus, with details forwarded to students.

Students must also sign a confidentiality statement prior to attending practicum.

……………………………………………………………………………………………

Student Signature and Declaration

"I declare that I have read and will abide by the above policy during my clinical placements."

Signed_____   Date:_____

Appendix C

Information Sheet for Participants

Information Sheet for Participants

Dear potential participant

My name is Sally Clark. I am a student at The University of Notre Dame Australia and am enrolled in a Doctor of Philosophy degree. As part of my course I need to complete a research project.

Project title:
Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

The purpose of this research is to "Explore and describe the influences on decisions of nursing graduates, from the Broome campus pre-registration programs, to work within remote communities". The findings of this research will have relevance to workforce strategies and policy makers in remote areas of Australia.

I would like to invite you to complete a questionnaire and to meet with me to gain your perspective on the project. It is proposed that the meeting will take place at a mutually convenient time and place. With your permission the meeting will be recorded and will last approximately sixty minutes with the possibility of a follow up meeting should there need to be some clarification and further questions. You will be offered a transcript of the meeting.

If you live in Broome we can meet face to face. However, if you live some distance away we can meet using web-conferencing or teleconferencing. Arrangements can be made once you have agreed to be involved in the study.

I would like to clarify that my role within this project is the lead researcher and PhD

candidate. My working role within the School of Nursing as Assistant Dean has no bearing on the research project and all data collected will be kept confidential and stored within a locked cupboard or in a password protected electronic database separate from School of Nursing resources. Data gathering, storage and analysis will be supervised by Doctor Carol Piercey to ensure confidentiality of materials. Further to this I will be on study leave and away from my role as Assistant Dean during the data collection phase of this study.

The protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the Privacy Act are available at http://www.nhmrc.gov.au/. Information you provide will be stored securely in the University's School of Nursing for five years. No identifying information will be used and the results from the study will be made freely available to you upon request. Unless there are legal requirements, information you provide will be strictly confidential and a code ascribed to you, to minimise the risk of identification.

If you have any queries regarding the research, please contact me directly or Doctor Piercey my supervisor by telephone (08) 943302277 or by email at carol.piercey1@nd.edu.au.

The Human Research Ethics Committee of the University of Notre Dame Australia and the Western Australia Country Health Service (WACHS) Research Ethics Committee have approved the study. If you have any complaints regarding the manner in which this project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943 and/or WACHS Research Ethics Committee, 0417 068 594; or via email wachs.researchethicscommittee@health.wa.gov.au

Your participation in this study is completely voluntary and you are free at any time to withdraw from the project or withdraw any statements made during the interview process. However, should you agree could you please sign the attached consent form, complete the demographic questionnaire and return them in the reply paid envelope

within 2 weeks of receipt.

I thank you for your consideration and hope you will agree to participate in this research project.

Yours sincerely,

Mrs Sally Clark Telephone: 0417184964
Email: sally.clark2@my.nd.edu.au

Appendix D

Participants Consent Form

Consent Form

If you agree to participate please tick the dot points and then sign and date in the area provided below

Project title:
Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

I, (participant's name)hereby freely give my consent to participant in the above research project.

I am over 18 years of age

I understand and accept the nature of the study, which has been explained in the information sheet and Sally Clark has answered any questions to my satisfaction.

I understand that the interview will be audio - taped

I understand that I may withdraw from participating in the project at any time without prejudice or implication.

I understand that all information gathered by the researcher will be treated as strictly confidential, except in instances of legal requirements. I understand that a code will be ascribed to me to ensure that the risk of my identification is minimised.

I understand that the protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the Privacy Act are available at http://www.nhmrc.gov.au/

I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

Participant's name		Email address	
Participant's signature		Date	
Researcher's name	Sally Clark		
Researcher's signature		Date	

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943 and/or WACHS Research Ethics Committee,
0417 068 594; or via email wachs.researchethicscommittee@health.wa.gov.au

Appendix E

Participant Group 1 Demographic Questionnaire

Project title:Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

Dear participant, the researcher of this project, Sally Clark would like to invite you to complete this questionnaire. It will only take a few minutes of your time.

Please circle your response or write your answer in the space provided	CODING
1: Since completing your nursing course at the University of Notre Dame, Australia were you registered with the Nurses Board of Western Australia or more recently with the Nursing and Midwifery Board of Australia? (Please circle) Yes No	☐
2: If yes, are you still registered? Yes No	☐ ☐
3: Since completing your nursing course have you worked in an area outside a capital city? This could be in Australia or Internationally. Yes No	☐☐
4: If yes, can you please identify where this/these place(s) were eg. Karratha Western Australia.	☐
5: If you have worked in an area outside a capital city did you have family members or friends already living there? Yes No	☐☐
6: Prior to studying on the Broome campus had you already lived in an area outside a capital city? Yes No	☐☐
7: If you answered yes to question 6. Where was this?	
8: And how long did you live there for?	
9: Did you attend primary school in an area outside a capital city? Yes No	☐☐

10: If you answered yes to question 9. Where was this?	
11: And how long did you attend?	
12: Did you attend secondary school in an area outside a capital city? Yes No	☐☐
13: If you answered yes to question 12. Where was this?	
14: And how long did you attend?	
15: Did you have family members or friends that lived in Broome when you were studying there? Yes No	☐☐
16: Do you consent to being contacted by the researcher (Sally Clark) for a follow up interview Yes No Please complete the contact details below if you have consented to be interviewed Email Mobile number	☐☐

Thank you for your time and participation in this research project. If you have consented Sally Clark will contact you within 2 weeks of receipt of this questionnaire to arrange a suitable time for an interview.

Please return this questionnaire with your consent form in the prepaid envelope supplied.

Appendix F

Research Data Base

Screen shot of researcher's data base

Analysis	▶	**Analytic memos**	▶
Archive	▶	Coding	▶
Group 1 participants graduates	▶	table of data from all four participants	
Group 2 participants workforce nurses	▶		
Group 3 participants Prominent nurse managers	▶		
Group 4 data	▶		
locked for confidentiality	▶		
NVIVO	▶		
transcription processes	▶		
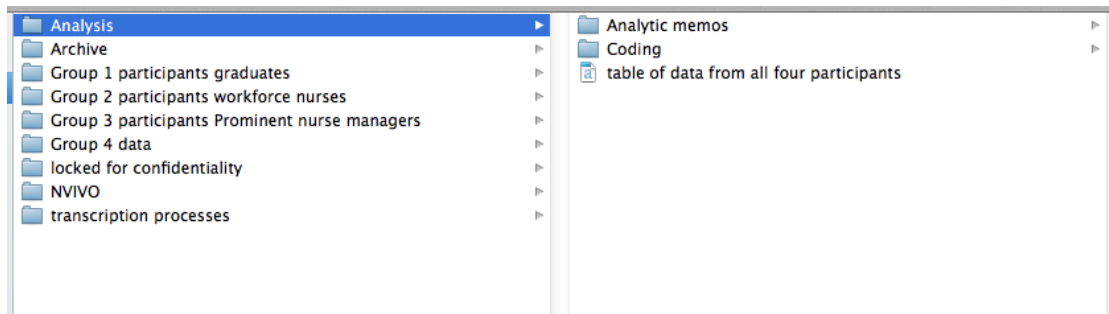
Appendix G

Information Sheet for Workforce Questionnaire

Information Sheet for Participants

Dear potential participant

My name is Sally Clark. I am a student at The University of Notre Dame Australia and am enrolled in a Doctor of Philosophy degree. As part of my course I need to complete a research project.

Project title:
Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

Insufficient numbers of nurses working in geographically isolated regional and remote areas has presented a unique challenge to the provision of health care services. Improving recruitment and retention through the provision of regionally based nurse education, including opportunities for clinical placements, has anecdotally been associated with positively influencing the local nursing workforce.

The purpose of this research is to "Explore and describe the influences on decisions of nursing graduates, from the Broome campus pre-registration programs, to work within remote communities". The findings of this research will have relevance to workforce strategies and policy makers in remote areas of Australia.

I would like to invite you to complete a questionnaire and to meet with me to gain your perspective on the project. It is proposed that the meeting will take place at a mutually convenient time and place. With your permission the meeting will be recorded and will last approximately sixty minutes with the possibility of a follow up meeting should there need to be some clarification and further questions. You will be offered a transcript of the meeting.

If you live in Broome we can meet face to face. However, if you live some distance away we can meet using web-conferencing or teleconferencing. Arrangements can be made once you have agreed to be involved in the study.

I would like to clarify that my role within this project is the lead researcher and PhD candidate. My working role within the School of Nursing as Assistant Dean has no bearing on the research project and all data collected will be kept confidential and stored within a locked cupboard or in a password protected electronic database separate from School of Nursing resources. Data gathering, storage and analysis will be supervised by Doctor Carol Piercey to ensure confidentiality of materials. Further to this I will be on study leave and away from my role as Assistant Dean during the data collection phase of this study.

The protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the Privacy Act are available at http://www.nhmrc.gov.au/. Information you provide will be stored securely in the University's School of Nursing for five years. No identifying information will be used and the results from the study will be made freely available to you upon request. Unless there are legal requirements, information you provide will be strictly confidential and a code ascribed to you, to minimise the risk of identification.

If you have any queries regarding the research, please contact me directly or Doctor Piercey my supervisor by telephone (08) 943302277 or by email at carol.piercey1@nd.edu.au.

The Human Research Ethics Committee of the University of Notre Dame Australia and the Western Australia Country Health Service (WACHS) Research Ethics Committee have approved the study. If you have any complaints regarding the manner in which this project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943 and/or WACHS Research Ethics Committee, 0417 068 594; or via email

wachs.researchethicscommittee@health.wa.gov.au

Your participation in this study is completely voluntary and you are free at any time to withdraw from the project or withdraw any statements made during the interview process. However, should you agree could you please sign the attached consent form, complete the demographic questionnaire and return them in the reply paid envelope within 2 weeks of receipt.

I thank you for your consideration and hope you will agree to participate in this research project.

Yours sincerely,

Mrs Sally Clark Telephone: 0417184964
Email: sally.clark2@my.nd.edu.au

Appendix H

Health Care Agency Personnel Questionnaire

Health Care Agency Personnel Questionnaire

Project title:

Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

Dear participant

I would like to invite you to complete this questionnaire. It has been designed to gain a small amount of information that can be expanded upon at interview to gain your thoughts on the factors that influence nurses decisions to live and work in remote communities. Please return this questionnaire with your consent form in the envelope supplied. Your participation in this project is much appreciated.

Questions. Please circle your answer or provide detail in the area provided	CODING
1: Please name the Health Service you currently work for. eg. Broome hospital	
2: How long have you worked in this Health Service? 0---5 years 6---10 years 11---20 years over 20years	☐ ☐ ☐ ☐
2: Please describe what attracted you to work in this health care service.	☐ ☐

3: Do you consider that nursing graduates from a remote university would have the required skills to work in this health care service? Yes No There is some space here if you would like to expand on your answer.	
4: Do you consider that this health service provides enough professional development and support opportunities to graduates so they can remain working in this remote region after their grad program. Yes No	
5: Do you consent to being contacted by the researcher for a follow up interview	☐

Thank you for your time and participation in this research project. If you have consented Sally Clark will contact you within 2 weeks of receipt of this questionnaire to arrange a suitable time for an interview.

Please return this questionnaire with your consent form in the envelope supplied.

Appendix I

Laminated Poster for Study

!

ARE YOU A NURSE AND DO YOU HAVE A SPARE HOUR FOR AN INTERVIEW?

WHY DO NURSES LIVE AND WORK IN REMOTE AREAS?

Sally Clark is undertaking a research project for PhD studies and would like to invite Registered and Enrolled Nurses to participate in her study.

THIS STUDY ONLY REQUIRES A SMALL AMOUNT OF YOUR TIME AND PARTICIPANT NUMBERS ARE VERY IMPORTANT TO GET A COMPREHENSIVE REPRESENTATION OF OPINIONS

There are information envelopes on the ward and in A&E but if you would like the information emailed to you directly please email **sally.clark2@my.nd.edu.au** or telephone Sally directly on **0417184964**

This study has received UNDA and WACHS ethics approval as well as WACHS director's approval

Appendix J

Synopsis, Background and Literature Review

Nurses decisions to live and work in remote communities: A case study of graduates from a remote school of nursing.

Author: Sally Clark sally.clark2@my.nd.edu.au

Synopsis

Insufficient numbers of nurses working in geographically isolated regional and remote areas has presented a unique challenge to the provision of health care services. Improving recruitment and retention through the provision of regionally based nurse education, including opportunities for clinical placements, has anecdotally been associated with positively influencing the local nursing workforce.

The number of graduates that seek employment and the factors that have influenced their decision to work in the remote nursing workforce has yet to be determined.

The findings of this study will assist policy makers in developing strategies to improve recruitment and retention into the remote health care nursing workforce

Background and literature review

Maldistribution of the health care workforce in regional and remote areas has been identified both in Australia and overseas (Buchan & Aiken, 2008; Bushy, 2002; Duffield & O'Brien-Pallas, 2002; Dussault & Franceschini, 2006). The limited numbers of medical personnel in these areas has led to nurses becoming a principal part of the health care workforce (Australian Government Department of Health and Ageing [DoHA], 2008). As such, a strategy to provide a secure and stable nursing workforce in regional and remote areas has become essential (Lenthall et al. 2011; Preston, 2009). Population growth within regional and remote areas and an ageing workforce are factors that will continue to have an increasing demand on the employment of nurses. Retention and recruitment from outside the area can provide short term relief to these shortages, but there is growing evidence that providing nursing education within regional and remote areas may well provide a more sustainable workforce.

In the mid-1990s, studies demonstrated that providing undergraduate pre-registration nursing students with clinical placements in regional and remote sites, improved the likelihood of students practicing in these areas following graduation (Murphy, McEwan & Hays, 1995). More recent studies by Courtney, Edwards, Smith and Finlayson, (2002), Neill and Taylor (2002), Lea, Cruickshank, Paliadelis, Parmenter, Sanderson and Thornberry (2008), Playford, Larson and Wheatland (2004), confirm these findings.

In the late 1990s and early 2000s, a number of regional and satellite campuses were established to increase access to nursing education for people living in

regional areas of Australia (Bambrick, 2002; Playford et al., 2010). A longitudinal study conducted to determine the type of undergraduate education most related to rural recruitment for nursing graduates was undertaken in Western Australia. The study compared two cohorts, one from an urban nursing program (with an established rural placement program), and one from a rural nursing program. Findings from the study suggested that rural nursing schools that teach all the undergraduate program, are more effective in terms of influencing workforce recruitment than those that provide limited rural clinical placement from an urban based nursing school (Playford et al., 2010).

Clearly, there is some Australian evidence that suggest students who have opportunity to study or attend clinical placement in regional and remote areas, are more likely to work in a regional or remote area after registration. There is, however, limited information on the conversion to employment. Studies located did not differentiate between what was considered a regional or remote campus, clinical placement, or student origin. There is some discussion available from regional/metropolitan providers of pre-registration courses, but little information on remote pre-registration nursing program providers, or their impact on the local community in terms of the health care workforce.

This proposed study would be the first in Western Australia, which focuses on nursing graduates from a remote university school of nursing. Whilst other studies in Australia have focused on the effect of attending clinical placement in a regional area, they have not differentiated between regional, rural and remote settings, or whether students from urban backgrounds attending study or clinical placement, have been recruited into the local nursing workforce. There could be significant implications for health care agencies and their recruitment strategies, in identifying what has influenced graduates from the Broome campus to seek employment in the local areas, following graduation, and how they have impacted on the nursing workforce.

Further, this study has relevance to other remote areas where nursing workforce shortages are evident and remote nursing schools exist, or could exist. Additionally, it will provide relevant information to policy makers for improved funding for existing remote nursing schools and the development of future schools.

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Appendix K

Contact Details Form

Nurses decisions to live and work in remote settings. Contact details.

*1. Please provide me with your first name and last name

First name [   ]

Surname [   ]

*2. Please provide me with the name of the health service that you are currently working in.

[   ]

3. If you would like me to provide information to your mailing address please provide details below

Postal address [   ]

Town [   ]

Postcode [   ]

4. If you would prefer the information to be emailed to you please provide your email address below.

[   ]

5. If you would prefer me to contact you by telephone to discuss the project please provide your telephone number below.

[   ]

6. Your involvement with this project will only require you to complete a very short questionnaire and to be involved with an interview. Your assistance will be greatly appreciated as I value your thoughts on this topic. If you would like to contact me directly please email me at sally.clark2@my.nd.edu.au or telephone 0417184964

◯ Thank you

Appendix L

Workforce Presentation

Slide 1

Nurses decisions to live and work in remote communities:
A case study of graduates from a remote school of nursing.

1

Slide 2

- Insufficient numbers of nurses work in geographically isolated regional and remote areas.
- Recruitment and retention strategies
  – Few have been researched for efficacy
  – Findings suggest that nursing graduates from rural campuses and nursing graduate who have had exposure to rural clinical areas are more likely to seek employment in the rural workforce.
- No evidence to date
  – To show whether they do or the factors that influence their decisions to seek employment in the remote nursing workforce

2

Slide 3

Schools of Nursing

People per sq km
100.0 or more
10.0 to 100.0
1.0 to 10.0
0.1 to 1.0
Less than 0.1

0   1000
Kilometres

Source: Regional Population Growth, Australia (3218.0).

3

Slide 4
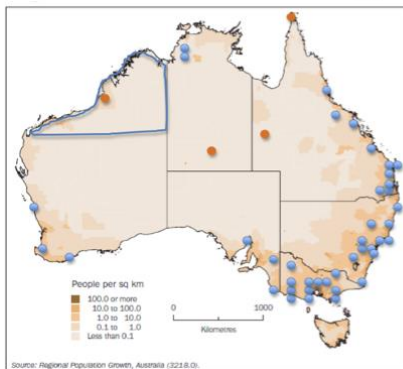
UNDA Broome

- Bachelor of Nursing graduates since 2003 (10 yrs)
- 74 graduates

- Diploma graduates since 2008 (5 yrs)
- 25 graduates

- 29% (29) currently working in the Kimberley
- 35% (35) have worked in the Kimberley since graduating

4

Slide 5

AIM of my study

- To explore and describe the factors that influence remote school of nursing graduates in their decision to work in a remote nursing workforce.

5

Slide 6

Case study

Study question: What influences graduates from a remote nursing school to seek employment in a remote community?

- Graduates from UNDA Broome
- Nursing workforce throughout the Kimberley
- UNDA Broome SoNM

6

Appendix M

Cover for Hard Copy Packs

WHY DO NURSES LIVE AND WORK IN REMOTE
AREAS?

Sally Clark is undertaking a research project for PhD studies and would like to invite
Registered and Enrolled Nurses to participate in her study.

THIS STUDY ONLY REQUIRES A SMALL AMOUNT OF YOUR TIME
AND PARTICIPANT NUMBERS ARE VERY IMPORTANT TO GET A
COMPREHENSIVE
REPRESENTATION OF OPINIONS
Please complete the enclosed contact details sheet and using the enclosed pre---paid
envelope post directly to Sally Clark
Alternatively you can email sally.clark2@my.nd.edu.au with your contact details or
telephone Sally directly on 0417184964

This study has received UNDA and WACHS ethics approval as well as WACHS
director's approval

Appendix N

Sample Data Spreadsheets for Graduates and Workforce

Code	coded	Gender	Age at time of course	Nurse prior to course	full course in Bme	part course in Broome	family and friends in Bme at time of study	lived outside city pior to studying on Bme campus	place ? Remote score	primary school outside city	secondary schooling outside city	registered	Grad program outside city	Grad program in city	worked outside city	where outside	family or friends there	worked in Kimberley	nur the
BN1	rnd 1		30s			yes	yes	yes	Derby	no	no	yes		RPH				no	yes
BN2	rnd 1		20s			yes	no	yes	Lake Clifton	yes	yes	yes		Armadale				no	yes
BN3	rnd 1		30s		yes		yes	yes	Broome and fitzroy	no	no	yes	kimberley		yes	knx bme	no	yes	yes
BN4	rnd 1		20s			yes	no	no		no	no	yes		Murdoch SJ				no	yes
BN5	rnd 1		20s			yes	yes	yes	Essex and Lancashire, Ka	yes	no	yes		Osborne Pk				no	yes
BN6	rnd 1	Male	30s	yes	yes		no	yes	kalbarri	no	no	yes		RPH Graylands				no	yes
BN7	rnd 1		30s			yes	yes	yes	Derby	yes	yes	yes	Kimberley		yes	bme	yes	yes	yes
BN8	rnd 2 review		20s			yes	no	no		no	no	yes		PMH				no	yes
BN9			20s		yes		no	yes	albany	yes	yes	yes	manjimup		yes	alb bun bsl manji	yes albany	no	
BN10	rnd 1		30s		yes		yes	no	major city and inner reg	yes IR	yes IR	yes		Tugan Qsl GC	no			no	yes
BN11	no interview		20s	no	No	Yes	no	no		no	no	yes	no	SCGH	yes kalg	kalgoorlie	no	no	yes
BNWF1	rnd 1		40s	yes	yes		yes	yes	Broome and Bunbury	yes	yes	yes	Bunbury		yes	brm bunbury	yes	yes	yes
BNWF2			20s			yes	no	yes	Mansfield	no	yes	yes	kimberley		yes	bme dr knx	no	yes	
BNWF3	rnd 1		20s			yes	no	yes	Esperence, Tonga, Blackstone remote community in WA??	yes	no	yes	Kimberley		yes	dby knx bme	yes	yes	no
BNWF4	no interview		40s	yes	yes		yes	yes	geelong vic	yes	yes	yes	no grad pr		yes	bme	yes	yes	no
BNWF5	no interview		20s	no	yes		yes	yes	broome/knx	yes	yes	yes	no grad pr		yes	bme	yes	yes	no
BNWF6	no interview		20s	No	No	Yes	yes	yes	esp wogan hills, sth cross	yes	no	yes	yes		yes	bme dby	yes	yes	no
EN1	rnd 2 review	Male	40s		yes		yes	yes	Ellenbray, Fitzroy Crossing, Hue Vietnam and Tete Mozambique	no	no	yes	no grad pr	no grad pr	yes	broome	yes	yes	no
EN 2			40s			yes	Yes	no		no	no	yes	no grad pr		no			no	yes
ENWF1	rnd 2 review		40s		yes		yes	yes	Meckering	yes	yes	yes	no grad pr		yes	bme	yes	yes	no
ENWF2	rnd 2 review		30s		yes		Yes	Yes	Geraldton	yes	yes	yes	no grad pr		yes	bme	yes	yes	no
ENWF3	rnd 2 review		40s		Yes		Yes	yes	Broome/Karratha	yes	no	yes	no grad pr		yes	bme	yes	yes	no
ENWF4	rnd 2 review		20s		Yes		Yes	Yes	Broome	yes	yes	yes	no grad pr		yes	bme	yes	yes	no
ENWF5	no interview	Male	40s	no PCA	yes		yes	yes	derby	yes	yes	yes	no grad pr		yes	dby	yes	yes	no

	10	1st round coding	
	6	2nd round review	
24 surveys	5	no interview	2 were not transcribed
	3	Interviewd but not transcribed	

Workforce data	Date of first registration with AHPRA	Year since rego	male	female	Length of time in work place 0--5	6 to 10	11 to 20	over 20	UNDA grads have skills yes	no	PD enough for grads yes	no	Transcribed
WFRN1	1990	23	x	x	x				x			x	Yes
WFRN2	1978	35	x	x	x				x		x		
WFRN3	1991	22	x				x		x			x	c
WFRN4	2010	13	x	x	x					x		x	C
WFRN5	1987	26	x	x	x				x		x		
WF RN6	1994	19	x	x	x				x		x		yes
WF RN7	2006	7	x	x	x					x	x		yes
WFRN8	2010	3	x	x	x					x		x	c
WF DG1	2010	3	x		x				x		x		yes
WF FD2	1998	15		x			x		x		x		yes
WF DG3	2007	6		x	x				x			x	yes
WF FD4	1990	23	x		x				x		x		yes
WF FD5	1983	30	x		x				x		x		yes
WFC1	1981	32	x					x	x			x	yes
Interviewed													
not interviewed													
WFRN9	1987	26	x	x	x				x		x		
WFRN10	1986	27	x	x	x				x			x	
WFRN11	1976	37	x				x		?		?		
WFRN12	2005	8	x	x	x				x		x		
WFRN13	1976	37	x					x	x		x		
WFRN14	2009	4	x					x		x		x	

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Appendix O

Transcription Confidentiality Agreement

CONFIDENTIALITY   AGREEMENT

It is understood and agreed that Sally Clark may disclose confidential information to Carol Mastick that is and must be kept confidential. To ensure the protection of such information, Carol Mastick agrees not to disclose the confidential information obtained from Sally Clark to anyone unless required to do so by law. All files received and created for the transcription process will be digitally destroyed or shredded by Carol Mastick upon successful receipt and notification by Sally Clark.

Carol Mastick

Carol Mastick

153 Park Place Drive Petaluma, CA USA 94954 707-290-4737

Date

11/15/2012

Appendix P

First Round Codes

First round codes

Name	Sources	References	Created On
a lot of support for remote grads when needed	5	9	3/3/2013 11:32 AM
accommodation	6	12	1/28/2013 8:08 PM
availability of rental properties	2	2	1/28/2013 8:18 PM
cost of real estate	3	3	1/28/2013 8:17 PM
provision by workplace	2	2	1/28/2013 8:18 PM
adventure	0	0	1/28/2013 8:17 PM
attracted to studying remote to get to country	2	2	2/13/2013 8:29 PM
being able to study remotely influenced decision to stay nursing	2	4	4/7/2013 10:07 AM
broome was home	6	8	3/3/2013 10:01 AM
childrens needs not met in remote	4	6	2/3/2013 1:31 PM
chose broad CP in degree to be prepared for country	2	4	2/12/2013 8:26 PM
city experience is important especially if wanting to go back remote	5	6	2/13/2013 8:14 PM
Cocooned in Perth as a student	5	11	2/3/2013 12:09 PM
coherced to do a full course in Broome	2	2	2/13/2013 8:30 PM
convenience to stay in the city	2	2	3/3/2013 10:54 AM
convenience to stay remote	2	2	3/3/2013 10:01 AM
Didn't complete course in Broome	2	4	2/3/2013 1:25 PM
family reasons for moving	2	2	2/3/2013 1:26 PM
didn't like nursing in city	2	2	2/12/2013 8:23 PM
didn't need to know anyone to move to Broome to study	3	3	3/3/2013 10:46 AM
different opportunities in remote health	2	4	2/12/2013 8:07 PM
easy to get nursing jobs in remote	2	2	3/3/2013 11:21 AM
enjoyed nursing in remote	3	3	2/13/2013 8:15 PM
enjoys the remoteness	3	3	3/3/2013 2:46 PM
exploration from a safe base broome campus	4	4	3/3/2013 10:46 AM
Family health needed to leave countre	1	1	4/7/2013 9:57 AM
found a place in the city that was like country	2	2	2/12/2013 8:23 PM
friend had done remote grad and recommended it	1	1	4/7/2013 10:44 AM
got hooked in city	12	50	1/28/2013 8:52 PM
extended family	8	12	1/28/2013 8:53 PM
friends	2	2	2/2/2013 3:23 PM
partner	4	12	1/28/2013 8:53 PM
study opportunities in the city	4	4	2/3/2013 1:43 PM
work	6	14	1/28/2013 8:52 PM
greater opportunities to travel throughout aust with national rego	2	2	3/3/2013 11:04 AM
had to be a self directed and motivated learner	2	8	3/3/2013 10:05 AM
having a local University for people to study nursing in the region	1	1	4/7/2013 10:09 AM
having remote clinical experience helped	1	1	4/7/2013 10:48 AM
lack of information on remote grad programs	2	2	2/2/2013 3:25 PM
lack of information on remote worksites	2	6	2/12/2013 8:03 PM
lack of staff in remote increased work load	2	2	3/3/2013 11:31 AM
lack of support on metro grad programs	2	4	3/3/2013 11:17 AM
learnt self reliance	4	8	3/3/2013 11:04 AM
lifestyle	7	14	2/13/2013 8:12 PM
limited access to healthcare in remote	2	16	2/5/2013 5:24 AM
reliance on telehealth	2	6	2/5/2013 5:29 AM
travel to city for healthcare expensive	2	2	2/5/2013 5:30 AM
limited opportunity in remote towns for different job opportunities	2	2	3/3/2013 10:41 AM
limited staff development nurses in remote	2	2	3/3/2013 10:06 AM
limited support in very remote	4	14	3/3/2013 9:47 AM
loved clinical in remote	3	4	3/3/2013 10:52 AM
medical situation caused change of plans	4	14	2/3/2013 1:33 PM
more exp required for RFDS	2	2	3/3/2013 9:45 AM
more opportunity for clinical experience in remote	16	60	2/2/2013 3:26 PM
more opportunity in remote	4	4	3/3/2013 11:02 AM
more support in the country	1	1	3/4/2013 2:42 PM
need opportunities to upskill	4	4	3/3/2013 9:54 AM
need opportunity to gain experience in other areas	3	3	3/3/2013 10:39 AM
need to develop educational opportunities and support for those who stay remote	3	11	3/3/2013 11:59 AM

needed exposure outside of the Kimberley	3	7	3/4/2013 11:57 AM
needed to transition from EN to RN somewhere different	1	2	4/7/2013 9:41 AM
not experienced enough to stay remote	3	5	3/3/2013 11:32 AM
nurses in remote enjoyed their jobs	1	1	3/4/2013 2:41 PM
nursing in remote is more personal you get to know pts its not so fast paced	1	1	4/7/2013 10:42 AM
opportunity for indigenous stuff in NT	2	2	3/3/2013 10:53 AM
opportuntiy to extend scope of practice in remote	2	2	3/3/2013 11:24 AM
partner	1	1	1/28/2013 8:09 PM
history of remote living	2	4	1/28/2013 8:13 PM
influence on where to live	11	29	1/28/2013 8:16 PM
work availability	8	11	1/28/2013 8:14 PM
perception of more experience in city grad programs	5	5	3/3/2013 11:20 AM
perception of more support in the city	2	2	3/3/2013 11:29 AM
percieved lack of support staff development nurses	2	2	3/3/2013 10:55 AM
personal history of living remote	6	6	2/13/2013 8:26 PM
previous clinical exposure	5	8	3/3/2013 9:51 AM
Reasons for studying in Broome (not used as a code)	3	5	2/2/2013 3:22 PM
remote education would increase opportunity for job after graduation	2	2	3/3/2013 11:22 AM
remote grads need to be mature, life exerienced	2	4	3/3/2013 12:11 PM
remote people are friendly	4	4	2/5/2013 5:22 AM
remote work place conditions	2	4	3/3/2013 9:53 AM
remote workplaces required more experienced staff	1	5	4/7/2013 10:57 AM
seachange	1	1	4/7/2013 9:40 AM
sense of belonging	1	2	4/7/2013 10:09 AM
sink or swim in remote grad program	2	6	3/3/2013 11:27 AM
speciality area not offered in Kimberley	9	21	1/28/2013 8:49 PM
Studying remote prepared you for nursing	4	24	2/3/2013 12:06 PM
being resourceful	6	10	2/4/2013 8:42 PM
cultural training	6	12	2/4/2013 8:42 PM
learnt extra skills for clinical	4	12	2/4/2013 8:43 PM
the country is in you	2	4	2/12/2013 8:15 PM
no entry next to this code			
wanted to get out of the city	4	4	2/12/2013 7:56 PM
wanted to see mainstream health, city	2	4	3/4/2013 11:54 AM
wanted to work in indigenous health	2	4	3/4/2013 2:43 PM
wants to work overseas	1	1	4/7/2013 11:00 AM
workplace benefits in remote	4	10	2/12/2013 8:01 PM
would need a good opportunity to go remote	4	6	3/3/2013 12:21 PM

Thought re benefits or negatives for study in remote and continuing on with grad pr	6	10	2/3/2013 1:03 PM

Appendix Q

Code of Conduct for Research

POLICY:

CODE OF CONDUCT FOR RESEARCH

Purpose:	This policy outlines the Code of Conduct which binds all staff, students and researchers at the University.
Responsible Executive:	Provost
Responsible Office:	Research Office
Contact Officer:	Manager, Research Administration
Effective Date:	March 2006
Modification History:	Originally issued March 2006; reformatted July 2006/May 2007; VC approved 25 Oct 2007
Last edited:	25.10.07 (MF)
Campus Applicability:	All Campuses

Rationale

The University of Notre Dame Australia is committed to the highest standard of integrity in research. The responsibility for research quality and integrity is shared by the University – its Academic Council and Ethics Committees (and their sub-committees), Research Management Office, the School Research Committees, research supervisors, principal researchers/project directors and research students.

The Code of Conduct ("the Code") binds all staff, students and researchers at the University and failure to comply with the Code may be a ground for disciplinary action.

Principles

The Code is based on the following general principles:
1. the fundamental goal of all research is the pursuit of truth.
2. in the pursuit of such truth all researchers at the University should:
   - maintain high ethical standards and comply with the University's procedures and policies for ethical clearance;
   - maintain high standards of professional conduct and ensure that their work enhances their profession and the good name and Mission and Goals of the University;
   - respect people, their privacy and ensure the safety of those associated with the research;
3. respect non-human participants in research;
4. only participate in research which conforms to the ethical standards approved by the University and which they are competent to perform;
5. ensure validity and accuracy in the collection and reporting of data;
6. make research methods and results open to scrutiny and debate by colleagues and the profession at large;
7. ensure confidentiality;
8. guarantee that research data is not used for their personal advantage or that of a third party; and
9. disclose any situation that could lead to real or apparent conflict of interest.

CODE OF CONDUCT FOR RESEARCH[1]

This code of conduct for research addresses the following issues:

1. DATA STORAGE AND RETENTION
2. AUTHORSHIP
3. PUBLICATIONS
4. CONFLICT OF INTEREST
5. ETHICS CLEARANCE
6. RESEARCH MISCONDUCT

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[1] The following Code of Conduct for Research is adapted from the Joint NHMRC/AVCC Statement and Guidelines on Research Practice[1], the University of Melbourne Code of Conduct for Research[2] and Edith Cowan University's Guidelines on the Responsible Conduct of Research and Scholarship[3].

Data storage and retention

1. Research data and records obtained by staff, students and researchers in research projects conducted under the auspices of the University must be held in a durable, secure and registered place in the School in which they were generated.

2. Stored data must be appropriately referenced and kept for sufficient time to allow claims made in publications to be verified and to honour any confidentiality and intellectual property agreements. The minimum period for retention is at least five years from the date of publication, but for specific types of research, such as clinical research, fifteen years is required. [Research data refers to primary data obtained through observations, measurements, interviews, surveys and tests. Clinical research means research obtained through clinical trials which are pre-planned, usually controlled, clinical studies of the safety, efficacy, or optimum dosage schedule (if appropriate) of one or more diagnostic, therapeutic, or prophylactic drugs, devices, or interventions in humans selected according to predetermined criteria of eligibility and observed for predefined evidence of favourable and unfavourable effects]

3. Each School or research unit must establish procedures for retention of data. Data management should comply with relevant privacy protocols, such as the Australian Federal Privacy Legislation and associated National Privacy Principles[4]. Researchers must comply with these retention procedures.

4. Individual researchers may hold copies of the data for their own use. Retention solely by the individual researcher provides little protection to the researcher or the University in the event of an allegation of falsification of data.

5. Data related to publications must be available for discussion with other researchers. Where confidentiality provisions apply (for example, where the researchers or the University have given undertakings to third parties, such as the participants of the research), it is desirable for data to be kept in a way that reference to them by third parties can occur without breaching such confidentiality.

6. Confidentiality agreements to protect intellectual property rights may be agreed between the University, the researcher and a sponsor of the research. Where such agreements limit free publication and discussion, limitations and restrictions must be explicitly agreed.

7. The Dean of the School should inform researchers of their obligations with respect to these provisions. All confidentiality agreements should be made known at an early stage to the Research Administration Office.

8. The location of all research data must be recorded on the relevant Ethics Clearance form which contains information on ownership of data, location of data, access to data, right of access to data and confidentiality agreements. It is the researcher's responsibility to ensure any changes to the location and/or status of research data is notified to the Ethics Committee.

9. Only persons specified in the original ethics application should have access to confidential data. Should others wish to have access to the data, this will be subject to an application to the Research Administration Office.

10. When data are obtained from limited access databases, or via contractual arrangements, written indication of the location of the original data, or key information regarding the database from which it was collected, must be retained by the researcher or research unit.

11. Where a copy of the data is stored in a researcher's office or otherwise, researchers are responsible for ensuring appropriate security for any confidential material, including that held in computing systems.

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12. Where Schools have established computing systems holding research data which are accessible through networks, particular attention to security of confidential data is required. Security and confidentiality must be assured in a way that takes account of multiple researchers and the departure of individual researchers.

13. Where the research entails the use of name-identified data, said data must not be removed from a secure location on campus. Please also refer to the guidelines document *Code of practice for name-identified data*.

14. In an event a researcher leaves the University, and the researcher continues to use the material, the original data must remain at the University in a secure, registered place in the School in which they were generated, the researcher taking a copy only of the data. Any subsequent research publications and other outcomes must acknowledge the University. Similarly if any University researchers wish to continue with the data generated at the University, any subsequent research publications and other outcomes must acknowledge the original researcher.

Authorship

1. The minimum requirement for a person to be attributed as an author of a publication should accord with the 'Vancouver Protocol'[5]. For a person to be attributed as author, he or she must have substantially participated in the creation of a publication and must satisfy all of the following conditions:
    a. participation in the conception and design, or analysis and interpretation, of data;
    b. drafting the article or revising it critically for important intellectual content; and
    c. giving final approval of the version to be published.

2. Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is not sufficient for authorship. Any part of an article critical to its main conclusion must be the responsibility of at least one author. An author's role in a research output must be sufficient for that person to take public responsibility for at least that part of the output in that person's area of expertise. No person who is an author, consistent with this definition, must be excluded as an author without his or her permission in writing.

3. "Honorary authorship" (i.e. inclusion based on status, seniority or credentials) is an unacceptable practice.

4. Where a student is the primary author of research, his/her name must be recognised as the senior author in any publication.

5. Authorship of a research output should be discussed between researchers at an early stage in a project, and reviewed whenever there are changes in participation. Any disputes about authorship should be referred to the Provost, who will decide on a course of action.

6. When there is more than one co-author of a research output, one co-author (by agreement amongst the authors) should be nominated as executive author for the whole research output, and should take responsibility for record-keeping regarding the research output.

7. Where there is more than one co-author, the order of authorship should be a joint decision of the co-authors.

8. A publication must contain appropriate acknowledgment of the contributions made by all participants in the relevant research, including the work of research students, research assistants and technical officers who have made a contribution to the research. Courtesy demands that individuals and organisations providing facilities should also be acknowledged.

Publications

1. Publication of multiple papers based on the same set(s) or subset(s) of data is not acceptable, except where there is full cross-referencing within the papers (for example, in a series of closely related work, or where a complete work grew out of a preliminary publication and this is fully acknowledged).

2. Author(s) who submits the same or substantially similar work to more than one publisher should disclose that fact to the publishers at the time of submission.

3. As a general principle, research findings should not be reported in the public media before they have been reported to a research audience of experts in the field of research - preferably by publication in a peer-reviewed journal, except where there is a contractual arrangement. However, where there is public interest in research findings, occasionally reporting to the media before peer reviewing of findings may be justified but the unreported status of the findings must be disclosed at the time.

4. Where there is private reporting of research that has not yet been exposed to open peer-review scrutiny, especially when it is reported to prospective financial supporters, researchers have an obligation to explain fully the status of the work and the peer-review mechanisms to which it will be subjected.

5. Publications must include information on the sources of financial support for the research. Financial sponsorship that carries an embargo on such naming of a sponsor should be avoided

6. Deliberate inclusion of inaccurate or misleading information relating to research activity in curriculum vitae, grant applications, job applications or public statements or the failure to provide relevant information, is a form of research misconduct. Accuracy is essential in describing the state of publication (in preparation, submitted, accepted), research funding (applied for, granted, funding period), and awards conferred, and where any of these relate to more than one researcher.

7. All reasonable steps must be taken to ensure that published reports, statistics and public statements about research activities and performance are complete, accurate and unambiguous.

Conflict of interest

1. A conflict of interest arises in circumstances where that person has a real, perceived or potential opportunity to prefer their own interests, or those of any other person or organisation, to the interests of the University such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise. A conflict of interest depends on the situation, and not on the character or actions of the individual.

2. Examples of conflicts of interest in research include-
   a. Where the research is sponsored by a related body;
   b. Where the researcher or a related body may benefit, directly or indirectly, from any inappropriate dissemination of research results (including any delay in or restriction upon publication of such results);
   c. Where the researcher or a related body may benefit, directly or indirectly, from the use of University resources; and
   d. Where the researcher conducts a clinical trial which is sponsored by any person or organisation with a significant interest in the results of the trial.

3. A related body is any person or body with which the researcher has an affiliation or a financial involvement.

4. A financial involvement includes a direct or indirect financial interest, provision of benefits (such as travel and accommodation) and provision of materials or facilities.

5. An indirect financial interest is a financial interest or benefit derived by the researcher's relatives, personal or business associates, or research students.

6. A researcher must make a full disclosure of a conflict of interest as soon as reasonably practicable to the Dean of the School, except that where the researcher is a Dean of a School, the disclosure must be made to the Provost.

7. The officer in receipt of the disclosure referred in paragraph (b) above must discuss the matter with the staff member concerned and determine a procedure for the management or elimination of the conflict of interest. The procedure must be documented and the researcher advised in writing.

8. Researchers must disclose any conflict of interest to editors or journals, to the readers of published work and to external bodies from which funds are sought.

Ethics Clearance

Researchers must ensure that they have gained ethics clearance from the appropriate ethics committee of the University before commencing the research.

Research Misconduct

1 Definition of research misconduct

   (a) "Misconduct" or "scientific misconduct" is taken here to mean fabrication, falsification, plagiarism, or other practices that seriously deviate from those that are commonly accepted within the scientific community for proposing, conducting, or reporting research. It includes the misleading ascription of authorship including the listing of authors without their permission, attributing work to others who have not in fact contributed to the research, and the lack of appropriate acknowledgment of work primarily produced by a research student/trainee or associate. It does not include honest errors or honest differences in interpretation or judgements of data.

   Examples of research misconduct include, but are not limited to, the following:

   (i) Misappropriation: A researcher or reviewer shall not intentionally or recklessly plagiarise (which shall be understood to mean the presentation of the documented words or ideas of another as his or her own, without attribution appropriate for the medium of presentation), make use of any information in breach of any duty of confidentiality associated with the review of any manuscript or grant application, or intentionally omit reference to the relevant published work of others for the purpose of inferring personal discovery of new information.

   (ii) Interference: A researcher or reviewer shall not intentionally and without authorisation take or sequester or materially damage any research-related property of another, including without limitation the apparatus, reagents, biological materials, writings, data, hardware, software, or any other substance or device used or produced in the conduct of research.

(iii)   Misrepresentation: A researcher or reviewer shall not with intent to deceive, or in reckless disregard for the truth, state or present a material or significant falsehood, or omit a fact so that what is stated or presented as a whole states or presents a material or significant falsehood.

7.2   Procedures for dealing with allegations of misconduct

(a) Protection of interested parties

(i)   Protection of interested parties is essential when handling allegations of research misconduct. Adequate protection of the person(s) bringing the allegation and the person(s) against whom the allegation is made must include absolute confidentiality and reasonable speed in the conduct of any investigation.

(ii)   Other interested parties in an allegation of misconduct might include:
- Staff, students and trainees working with persons making the allegation, or with persons against whom the allegation is made.
- Journals and other media reporting research subject to suspected, alleged, or found research misconduct.
- Funding bodies that have contributed to the research.
- The public.

(iii)   Protection of other interested parties should not violate the confidentiality of the complainant or the accused in a case of alleged misconduct. Where disclosure is deemed necessary, the Vice-Chancellor should make the decision.

(b) Complaint

(i)   An allegation of research misconduct is to be made to the Dean of the School within which the research is taking place or to the Provost.

(ii)   A Dean who has received a complaint must inform the Provost of the complaint as soon as practicable, and provide the Provost with all available information relevant to the complaint.

(iii)   On receipt of an allegation, the Provost shall inform the Vice-Chancellor of the nature of the allegation.

(iv)   Should the Provost receive a complaint under this section, the Provost must inform immediately the person against whom the complaint is made.

(v)   There will be a preliminary investigation of cases in which a charge of research misconduct has been made and it will be conducted under the direction of the Provost. Such preliminary investigation will make provision for a written statement of any allegations to be provided to the person(s) against whom such allegations are directed, and for a written response from that person to be received and considered. A preliminary investigation will be limited to determining whether a prima facie case exists that research misconduct may have occurred.

(vi)   If a person about whom allegations of research misconduct have been made ceases to be an employee or student of the University, the investigation shall continue, in order to establish the facts of the matter.

(vii)   If a case for consideration of research misconduct is found to exist in the preliminary investigation, a formal investigation shall proceed.

(viii)   Where the Provost is satisfied that a complaint cannot be sustained, the Provost must advise the Vice-Chancellor to dismiss the complaint and inform the person making the complaint accordingly.

(ix)   Where the Provost is satisfied that there is no reasonable basis for a complaint, the Provost must advise the Vice Chancellor to determine if it is appropriate to take disciplinary action against the person making the complaint.

(c)   Formal Investigation

(i)   An enquiry established under the Code must be completed as expeditiously, and with such confidentiality, as the circumstances of the complaint permit.

(ii)   The Vice-Chancellor must inform the person who is the subject of the complaint in writing of the terms of the complaint, the decision to undertake an enquiry, and the person or persons appointed to undertake the enquiry.

(iii)   The Vice-Chancellor must also provide the person who is the subject of the complaint with (1) an opportunity to respond in writing to the complaint within thirty days of notification, and (2) an opportunity to make oral submissions to the person or persons appointed to undertake the enquiry during the hearing of the complaint.

(iv)   The person or persons appointed to undertake an enquiry must provide the Vice-Chancellor with a report of the enquiry and advise the Vice-Chancellor whether, in their opinion, the person who is the subject of the complaint is guilty of misconduct.

(v)   The Vice-Chancellor must inform the person who is the subject of the complaint and the person making the complaint of the finding of the person or persons appointed to undertake the enquiry.

(vi)   Where the person or persons appointed to undertake an enquiry is or are satisfied that the person who is the subject of the complaint is guilty of misconduct, the Vice-Chancellor must determine whether it is appropriate to take disciplinary action against that person.

(vii)   Findings of research misconduct must be reported to any funding agency that supported work in respect of which such misconduct occurred, or which is currently supporting the person found to have engaged in research misconduct, and to journals and other media through which the research in question was reported. Distortions of the research record must be rectified, whether or not the persons involved remain in the institution.

(viii)   Where the person or persons appointed to undertake an enquiry is or are satisfied that there is no basis for a complaint, the Vice-Chancellor must determine whether it is appropriate to take disciplinary action against the person making the complaint.

FOOTNOTES AND LINKS TO SUPPORTING DOCUMENTATION

1. Joint <u>NHRMC/AVCC Statement and Guidelines on Research practice (1997)</u> available at http://www7.health.gov.au/nhmrc/research/general/nhmrcavc.htm last accessed 11/4/05

2. University of Melbourne <u>Code of Conduct for Research</u> available at http://www.unimelb.edu.au/ExecServ/Statutes/r171r8.htm last accessed 25/5/05

3. Edith Cowan University <u>Guidelines on the Responsible Conduct of Research and Scholarship</u> available at http://www/ecu.edu.au/GPPS/ethics/ last accessed 11/4/05

4. Privacy Act (1988) and Privacy Amendment Act (October 2001). Available at: http://www.privacy.gov.au/act/ National Privacy Principles (part of Privacy Act 1988). Available at: http://www.privacy.gov.au/publications/npps01.html

5. Uniform Requirement for Manuscripts Submitted to Biomedical Journals 1997. Available at http://www.ro.mq.edu.au/policy/procedures/Vancouver/Vancouver.pdf

Appendix R

Cultural Awareness

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BROOME CAMPUS

Extract for purpose of Appendix only

NSP 101 AND CLINICAL PRACTICUM 1
UNIT OUTLINE, SEMESTER 1, 2012

SCHOOL OF NURSING AND MIDWIFERY
BROOME CAMPUS

UNIT DESCRIPTION

This unit will give students an overview of the clinical learning expectations to be achieved whilst on practicum. The unit will explore strategies for the students to utilise that will enhance communication within the multidisciplinary team. There will also be a focus on building reflective practice skills that will enable the students to maximise opportunities to develop the skills and knowledge that underpin quality practice. The aim is to prepare students to appreciate the clinical environment and the learning experience that this provides.

The unit will also offer an opportunity for students to consolidate the skills, knowledge and clinical competencies learnt in previous nursing skills units.

OUTCOMES OF THE UNIT

At the completion of this unit, a student will:
- Identify their own learning objectives for the practicum context they will be undertaking;
- Describe and demonstrate the strategies they will utilise to meet their learning objectives for the practicum they are undertaking;
- Self appraise how well they have been able to achieve their learning objectives during their clinical practicum experience;
- Demonstrate competency in each of the 45 ANMAC competency elements of the core competency standards as described by the ANMAC National Competency Standards for Registered Nurses (RNs) http://www.anmc.org.au;
- Be able to utilise the Nurses and Midwives Board of Australia Scope of Practice when implementing a nursing intervention.

Scope of Nursing Practice: Decision Making Framework

This unit is informed by or contains where appropriate the concepts outlined in the Scope of Nursing Practice – Decision Making Framework (SONP-DMF). *Please go to* http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx

LECTURE AND TUTORIAL TIMES FOR THE UNIT

Lecture:	Week One (1 hour) 1330-1430	Attend all Lecture sessions
	Week Five (4 hours) 0830-1230	
Tutorial	Week Two (1 hour) 1330-1430	Optional attendance
Laboratory	Week Eight (4 hours) TBC	Attendance compulsory
Practicum:	14th May 2012 to 22nd July 2012	Attend 200 hours clinical practicum

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Fax: (08) 9192 1247 • Email: enquiries@broome.nd.edu.au • www.broome.nd.edu.au • ABN: 69 330 643 210 • CRICOS PROVIDER CODE: 01032F

Clinical Practicum Attendance
The total clinical placement hours for this unit = 200 hours. At no time is a student to organise their own clinical placement. All placements are coordinated through the clinical coordinator. Placement details will be available on Blackboard. All students are required to complete a clinical practicum request form (available on Blackboard) or they will be placed at the discretion of the clinical coordinator. See Clinical placement priorities later in this unit outline.

UNIT PROGRAM OUTLINE

WEEK	Date	LECTURE TOPIC	TUTORIAL/WORKSHOP/LAB TOPIC
1.	27th February 2012	• Introduction to clinical practicum unit • Review unit outline • Review pre practicum requirements and unit assessment	
2.	5th March 2012		Q&A regarding prac packs
3.	16th March 2012	Complete CUCHR cultural awareness package	See Blackboard for details
4.	23rd March 2012	Complete the hand hygiene SDLP	See Blackboard for details
5.	30th March 2012	• Clinical Practicum Assessment Tool [CPAT] • Reflective practice & objective setting • Scope of nursing practice: Decision making framework • Working in the aged care context • Maximising learning opportunities • Introduction to emergency procedures & online quiz	
8	Week beginning 16th April	• Manutension workshop	

ASSESSMENT DETAILS

Item 1:	Complete CUCHR cultural awareness package	Pass/Fail

• Students are asked to review the Interactive Ochre learning tool (available in Blackboard) and then complete the CUCHR cultural awareness package. Once complete please follow the prompts to download your certificate, attach it to an assignment coversheet and submit to the School of Nursing in the assessment box downstairs in the academic program centre. Students can also upload this to the digital dropbox prior to the end of week.

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Extract for purpose of appendix only

NSP 102 Clinical Practicum 2
Unit Outline, Semester 2, 2011

School of Nursing and Midwifery
Broome Campus

Unit Description

This unit will give students an overview of the clinical learning expectations to be achieved whilst on practicum. The unit will explore strategies for the students to utilise that will enhance communication within the multidisciplinary team. There will also be a focus on building reflective practice skills that will enable the students to maximise opportunities to develop the skills and knowledge that underpin quality practice. The aim is to prepare students to appreciate the clinical environment and the learning experience that this provides.

The unit will also offer an opportunity for students to consolidate the skills, knowledge and clinical competencies learnt in previous nursing skills units.

Outcomes of the Unit

At the completion of this unit, a student will:
- Identify their own learning objectives for the practicum context they will be undertaking;
- Describe and demonstrate the strategies they will utilise to meet their learning objectives for the practicum they are undertaking;
- Self appraise how well they have been able to achieve their learning objectives during their clinical practicum experience;
- Demonstrate competency in each of the 45 ANMAC competency elements of the core competency standards as described by the ANMAC National Competency Standards for Registered Nurses (RNs) http://www.anmc.org.au;
- Be able to utilise the Nurses and Midwives Board of Western Australia Scope of Practice when implementing a nursing intervention http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

Scope of Nursing Practice: Decision Making Framework

This unit is informed by or contains where appropriate the concepts outlined in the Nursing Practice Decision-Making Summary Guide. *Please go to* http://www.nursingmidwiferyboard.gov.au/Codes-and-Guidelines.aspx

Lecture and tutorial times for the Unit

Lecture: Fridays	Week One 0830-1030	Attend all lectures
	Week Five 0830-1030	
	Week Seven 0830-1230	
Practicum:	Hours dependent upon allocation	Total 160 - 240 hours

Attendance

Clinical Practicum Attendance
The total clinical placement hours for this unit will be between 160 and 240 hours depending upon allocation and clinical requirements. A student who is absent from clinical placement will need to

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School of Nursing and Midwifery, Broome Campus
UNIT OUTLINE

NSP301

Clinical Practicum 5

2013
Semester One

1. **Unit Description**

This Nursing Practice Unit is the first in the series of 6 clinical practice units that introduces the student to the essential nursing skills of the profession. This practicum complements the first year curriculum of a patient-centred, wellness model. The focus of this practicum is the application of essential nursing skills, beginning communication skills as a health professional, and the essentials of documentation within the aged care setting. To prepare students for this initial placement 8 hours of lecture content are provided. This will focus on building reflective practice skills that will enable the students to maximise opportunities to develop the skills and knowledge that underpin quality practice. Students are guided in their learning by both work place mentors and a university clinical facilitator. Student assessment for this unit is through the completion of the Clinical Practicum Assessment Tool (CPAT) and both a pre and post reflective paper. A total of 200 clinical hours is required, this occurs over a variety of nursing shifts throughout the week to provide a reality of practice to the nursing profession.

4.2 Clinical Practicum Attendance

The total clinical placement hours for this unit = 200 hours. All placements are coordinated through the clinical placements coordinator sally.clark@nd.edu.au and placement details will be available to students at least 4 weeks prior to the placement. Students have opportunity to request clinical placements and further details will be provided in NSP classes, in the Student Clinical Handbook (2013) and on Blackboard.

2. **Unit Program**

Week	Session topics	Times
1	Post NSP202 clinical feedback Introduction to clinical practicum unit	Wednesday 1330-1530 (all students)
4	Complete Interactive Ochre online cultural awareness	Available through Blackboard
5	Manutension practical	Monday 1330-1530 (on campus students)
5	CPR updates for students with a Snr First Aid from 2012 or before	Wednesday 1330-1530
6	Cultural awareness workshop and reflective exercises	Wednesday 1330-1530

Item 3:	Complete cultural awareness program	Pass/Fail

"There are consistent and complementary themes identified in the literature to working effectively as Mental Health practitioners with Aboriginal and Torres Strait Islander people, such as adopting a community development approach and using primary care models, and the crucial role of cultural competence. A case is made for the importance of practitioners providing cultural safety and care (as well as culturally responsive and appropriate services) for Aboriginal and Torres Strait Islander clients, their families and communities. Equally important is the need to develop strategies for self care and support such as mentoring, journaling, peer support and counseling and engaging in self reflective, transformative practice."

Walker, R,. & Sonn, C. (2010) in Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice p 157.

Students will attend a workshop with guest speakers and then complete reflective practices exercises.