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

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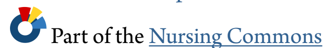
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CHAPTER 5: DISCUSSION

5.1 Introduction

The previous chapter presented the research findings and briefly commented on these in general. This section adopts a detailed approach to these findings to provide deeper insight into contemporary practice in graduate nurse transition within the Western Australian context. The research questions framing this study are:

1. In what ways are novice Registered Nurses' experiences different today from those reported in the 2000 University of Western Australia study?
2. From the Graduate Registered Nurse's perception, how efficacious are graduate nurse programs in helping novice nurses to make the transition to competent practitioner?
3. What perceived effect does the Graduate Nurse Program have on predicted career longevity of newly graduated Registered Nurses?

The first section (5.2) of this chapter presents demographic information giving insight into the cohort. Such data is used to comment on relationships between age groups, gender, prior experience, undergraduate institutions, transitional choices and perceptions of transitional experiences. This was important to consider as the UWA (2000) survey questionnaire did not elicit data related to these elements, and such data has provided broader contrasts in relation to the newly graduated RN's experiences.

The second section (5.3) examines comparative data between the UWA and the present study. This section answers the first research question and considers the types of healthcare sector the respondents were employed in; the specialties within

those organisations that the GRNs were assigned for their GNP rotations; the level of competence, confidence and support the GRNs perceived they had gained from their GNP; the length of supernumerary time the GRN was allocated before being expected to take on a full patient load; their participation in night shifts; and the perceived influence the undergraduate nursing program had upon the GRN's transitional experience.

The third section of the chapter (5.4), the backbone of the study, comments on the efficacy of the graduate nurse program, and as such, answers research question two. Information considered relates to contextual relationships which include program structure, such as specialty rotation length, number, and contracted hours worked for each rotation; support levels from individual designations within the specialty; and descriptions of what the GRNs perceived were benefits, problems and stressors of each specialty rotation. Information gained from the newly graduated nurses was supplemented by that acquired from the graduate nurse coordinators. This section also includes a summative comment on the value of participating versus not participating in the GNP.

The final section (5.5) considers the career pathways that were selected following the transition program and answers research question three. The perceived influences of the GNP on pathway selection are also examined. Findings are significant in the sense that explanations provided may have a bearing on how the GNP is managed to address those areas that are less favoured. This section is followed by a brief chapter summary.

5.2 Demographics

To provide a basis for determining the current status of the Western Australian graduate nurse workforce, it was logical to elicit information related to age and gender in the current research, particularly given the aging and predominately feminine structure of the overall nursing workforce. In addition, prior experience in the health workplace would intuitively suggest that a novice RN may adapt more quickly to their new RN role. Consequently, and to enrich the research data, these elements were incorporated into the newly graduated RN survey questionnaire and, as expected, did provide interesting comparisons and relationships within many of the variables.

5.2.1 Age Groups

A recurrent concern for the future of the nursing workforce is the ageing of its population. There is a general consensus that a focus on recruitment of newly graduated nurses will partially resupply the workforce as older nurses retire. However, in the current study, almost half the respondents (48%) were aged 30-years or older, and of these, more than half were aged 40-years or older, thus casting doubt on the replacement strategy. A large proportion (70%) of the 40-year old-plus cohorts indicated they had previous work experience as an Enrolled Nurse (EN), Assistant in Nursing (AIN) or Patient Care Assistant (PCA), compared with only 19% of the 29-year old or less age brackets. In a review of workforce modelling, Segal and Bolton (2009) found that participation of the older female in the nursing workforce had increased over the past few decades. They attribute this to a reduction in family size, and hence less time taken out for parenting; increased social supports for the working family; and, a greater number of women who were returning to the

workforce following initial child-rearing. These events may be factors contributing to the increasing older age-groups graduating as RNs as found in the current study.

Although the older graduate will have fewer years to give to the nursing profession, they should still be considered a worthwhile source of recruitment, especially considering that GRNs with prior experience as an EN are more likely to have a repository of knowledge and experience to assist in the transition to proficient practice (Gaynor, et al., 2007). An EN's conversion to the degree level of education also consolidates the RN-to-patient ratio to improve patient outcomes.

5.2.2 Gender

The Australian Institute of Health and Welfare (AIHW) recorded the national ratio of female to male nurses for the year 2008 as 90.3% females to 9.7% males, and for Western Australia (WA) as 90.9% females to 9.1% males. These data indicate that WA is marginally behind the national trend of improving the attraction of more males to nursing as a profession (AIHW, 2010b). In the current study, and as expected, females formed the greater majority of the gender mix (93.6% females to 6.4% males), but to a greater degree than is recorded for the State proportion.

In their submission to the National Review of Nursing Education in Australia, one of the recommendations made by the NBWA (2001) was to intensify the promotion of nursing, as a potential career, to males. The intent was to increase the proportion of males within the nursing workforce and to overcome the perception of nursing as a purely feminine profession; with an overall aim behind the strategy to increase the potential pool of nurse recruits and further increase nurse numbers. Duffield, et al. (2006) make the salient point that the reliance on mainly female

recruits to the nursing workforce is not sustainable. These authors warn that if the profession does not increase attempts to sign up more males to nursing as a career, then the industry is essentially halving its potential with regards to enlisting the projected number of nurses required to meet future workforce needs. In its '*Inquiry into nursing'* the Senate Community Affairs Committee (2002) *Recommendation 52* equally urged stronger marketing of nursing to males as a potential career. The fewer number of males in this study suggest that despite these recommendations, minimal gain has occurred in the past decade, and considerable effort is still required to encourage more of their gender into the Western Australian nursing profession.

5.2.3 Prior Experience

Data were collected from the newly graduated nurses to elicit what health related work experience they had prior to becoming a RN. This information gave insight into how this experience may have assisted the respondents in their transition from novice to proficient nurse, and how this might have influenced their career pathways.

Almost half (48%) of the respondents indicated that they had prior health related work experience as an EN or AIN and a further 17% had prior experience as an Orderly or PCA. Of the 58 respondents who indicated that they had prior experience as an EN, 40% did not participate in a formal transition program, and of these, half had returned to the unit that they were previously employed in. Among those respondents who did participate in a GNP, there was a much stronger agreement from those who had prior EN experience that the GNP had helped them feel more confident and competent, and that their undergraduate nursing education had prepared them adequately for their RN role, suggesting that prior healthcare

experience does aid the transition to the RN role. Despite this finding, there was also consensus amongst the EN experienced group that more practical skills training was needed during their undergraduate education prior to graduating. Kilstoff and Rochester (2004) advised against considering the newly graduated RN who had prior EN experience as being more practice ready than their counterparts, due in particular, to the increased complexity and the requisite for much greater critical thought processes in the RN role, a concept that was also supported in later research by Cubit and Leeson (2009). This may suggest that specialty units accepting GRNs who have prior EN experience should take into account the differences between the two roles, and regard the new GRN as they would any novice nurse new to the profession.

Western Australian universities and industry had recently introduced a model whereby nursing students, having successfully completed their second year of studies, were able to apply to register with the NMBWA as an EN. This practice was designed to assist the fledgling nurse, fiscally and in skills development; as well as assisting health care organisations in recruitment of new staff. This may account for the considerable number of graduate nurses with prior experience as an EN. The current study did not distinguish the number of years of previous healthcare experience, so it is feasible that those respondents who reported some transitional issues, despite previous experience, may be those with substantially less years of prior experience than the respondents who reported fewer issues. Since the amalgamation of the Australian States' and Territories' nursing registration boards, this option is no longer offered , as the NMBA now requires a nationally endorsed program of training for all EN registrations. Second-year Student Nurses still have the option to register at the level of an AIN if they desire paid nursing work and additional clinical experience during their undergraduate years.

5.2.4 Undergraduate Nursing Program

As the UWA (2000) survey questionnaire was conducted at a time when only two Western Australian universities offered an undergraduate nursing program, the source of tertiary nursing education was unlikely to be considered a relevant factor in the graduate nurse transitional experience, and was not recorded. Since that time, two more universities have graduated RNs. While each university's curriculum and content must meet minimum requirements to be accredited by the NMBA, there are often some differences in terms of program structure, as well as the duration and nature of clinical practice. Eliciting information from the GRNs in regards to the university they attended for their undergraduate nursing program aided in determining if there were any apparent differences in their transitional experiences, and future career intentions that might be associated with a particular academic institution.

The largest group of respondents indicated that they had attended University B as a nursing undergraduate (n = 99), followed by University A (n = 68); far fewer attended University C (n = 24); with the smallest group from University D (n = 10). The Schools of Nursing at both University B and University A have been established the longest, are consequently larger, and therefore able to offer more undergraduate nursing places, hence the greater proportions are understandable.

5.2.4.1 Participation in a Formal Transition Program Related to University

Of the total survey questionnaire respondents, 82% (n = 168) indicated that they had participated in a formal transitional program. University D had the largest proportion (90%) of nurses graduating from that university, who participated in a GNP; followed by University C (87.5%); University B (84.8%); and, the least

proportion of nurses graduating from a particular university to participate in a GNP was from University A (76.5%). It is possible the lower rates of participation in a GNP by nurses graduating from University A and University B may be due to the larger number of non-participants who had converted from an EN to RN choosing the more established universities for their conversion.

Of the 17.6% (n = 36) RNs who chose not to do a formal program, 64% had prior experience as an EN and a further 16% as an AIN or equivalent. More than half the respondents were aged 40-years and above, and all except one were female. The majority of respondents who did not participate in a GNP returned directly to the unit they had worked in prior to graduating. Other reasons given for not participating in a GNP were to enter into a Midwifery Graduate Program (n = 4) and maternity leave (n = 3). Eleven percent of respondents cited that they did not participate in a GNP because they required part-time work, with three quarters of these from University B. The perception that part-time work should exclude participation in a transitional program is of concern, as most organisations do offer the opportunity for GRNs to work less than full-time hours. This is discussed further in Section 5.4.3.2. Of those 11% requiring part-time work, three respondents recorded their current area of employment as a General Practice. Two respondents indicated the GNP had not appealed to them; one each from University A and University B; both these respondents had prior health care experience as an EN and AIN; one indicated current employment in rural health and the other in community care. The two respondents who indicated they had not continued with nursing as a career were each from University A and University B. Two respondents indicated they had difficulty finding employment as a RN as a result of having not done a GNP, which suggests that participation in a GNP is valued by employing agencies.

5.2.4.2 *Current Employment Sector Related to University*

The greatest proportion of graduates who chose to work in the tertiary sector was from University A (63.5%); and the largest ratio who chose the private sector for employment was from University D (44.4%). As their School of Nursing is located within an area where the closest employing organisation is a private facility, this large proportion of the University D graduates choosing to work in private healthcare is understandable. The remaining three universities have rural campuses that are in addition to their metropolitan sites. While the relationship of rural employment and university site attended is not able to be discerned from the data collected for this research, the data do indicate the largest proportion of respondents choosing the rural sector were from University A, followed by University B. The largest proportion choosing Mental Health was from University C; and the largest proportion of respondents choosing secondary hospitals were from University D. The data do not allow any interpretation of relationships between the individual universities' clinical placements and graduate preference for transitional program, but further exploration into possible links would be interesting.

5.3 Comparative Data

RQ 1: In what ways are novice Registered Nurses' experiences different today from those reported in the 2000 University of Western Australia study?

The comparative data for this research were primarily from the postal survey questionnaire administered to the newly graduated RNs in 2010, and that were based upon those of the UWA (2000) study. In the current research, of the population of 858 nurses who graduated and registered with the NMBWA as a RN for the first time in 2008, 24% (n = 204) responded to the questionnaire. Of that sample, 82% (n =

168) indicated that they had participated in a formal transitional GNP. This was a similar number of respondents to that used in the UWA (2000) study (n = 170). Consequently, in terms of sample size, it has provided a strong comparative base with which to answer the first research question.

The UWA (2000) study was administered to participants in public hospital graduate programs, consequently, new graduate RNs who either did not undertake a formal transitional program, or who transitioned in other areas, such as private, interstate, overseas, or were no longer in nursing, may not have been included in the data collection. As such, the UWA (2000) study might have been limited in the capture of all potential subjects. The current study included *all* nurses graduating from a university and registering with the NMBWA in 2008. This allowed the inclusion of the wider population and enabled greater understandings of those who either chose not to participate in a formal program, or who were no longer in nursing. There is also a larger population of newly graduated nurses in the current study, as recent years have seen more aggressive marketing of both the public and the private health industries in terms of recruiting nurses, and in particular, graduate nurses (N^3ET, 2006). One aspect of improving nurse numbers is to focus on the novice nurse at the commencement of their career. Positive experiences at this early stage of a nurses' career have been shown to encourage longevity within the profession (Reeves, 2007).

5.3.1 Health Sector Employment Type

To elicit the type of organisation chosen for the newly graduated nurse's initial employment, a preliminary question was asked regarding the respondents' employment type at the time of the survey. The number of choices in the UWA

(2000) study was expanded for the current research from four to eight, so that a more clear illustration of where most graduates chose to work would be gained. The fact that the UWA (2000) study did not consider Mental Health, Aged Care or Rural Health as distinct fields of employment may have been a product of how the study instrument was administered, that is, it was distributed to GRNs within current programs at public metropolitan hospitals. However, as these additional sectors are deemed to be in greatest need of suitable nursing workforce recruitment, they were added to the choices depicting the types of employing organisation for the 2010 research instrument. A distinction was made in both studies between the public and private sectors as, due to funding source differences, and in terms of program structure, support personnel, and contract components such as hours worked, the GRN transitional experience is likely to be impacted upon. Other modifications in the current study were to distinguish between the larger, more acute tertiary sector and secondary hospitals, as well as large and small rural, as the resources are often quite different and consequently, so too are the GRN experiences.

Considering the tertiary sector is the largest employer of health professionals within the system, it is logical that the majority of graduates (58.4%) chose to work at a tertiary hospital. Traditionally, the tertiary sector has also been able to offer the greater number of graduate program places, plus a wider variety of specialty rotation experiences. It is conceivable as well, that novice nurses choose to practice for a time within a tertiary institution to gain the acute experience that will stand them in good stead for their future career choices. Conversely, secondary hospitals had the smallest proportion (9.6%) of graduates who indicated this sector as the location for their formal transitional program. Based upon both the GRN and graduate nurse coordinator surveys, comments suggest that diminished resources, in particular

related to support and program structure, may be a significant factor influencing the graduate choosing secondary hospitals for their transitional experience.

A considerable increase in the proportion of respondents employed in the private sector was revealed in the current study (19%) in comparison to those reported in the UWA (2000) survey (5.3%). The catalyst for this may be the more intensive advertising campaigns over the past few years to enhance the recruitment of a greater number of nurses to the private sectors, necessitated by the burgeoning shortage of nurses in the workforce, as well as an increase in the size of the private health sector. Another reason for the discrepancy in the data between the two studies is that the 2000 survey was aimed at GNPs in public hospitals and, as such, was unlikely to have captured the entire graduate nurse population.

In both surveys, Aged Care was an area that few respondents had chosen to work in. Despite the overwhelming evidence pointing toward a growing need for expansion of the Aged Care nursing workforce, the sector is still seen by many as less desirable to other streams of nursing (Belardi, 2012a). Importantly, and as a result of different funding streams between levels of Government, there are continuing disparities in workplace benefits between Aged Care (Federally funded) and public healthcare (State funded), and as such, remuneration, career structure and industrial agreements are not equitable (Smith, 2012). This is despite the Senate Community Affairs Committee (2002) making several recommendations to move towards better parity and improve the image of aged care nursing. Further, there have been numerous reports over the past decade calling for greater attention to these disparate issues and for reform to meet the already critical shortfall of suitably qualified nurses in the sector (Dragon, 2009; Neville, et al., 2008; Pinch, & Della,

2001; Valencia, Hannon, & Stein, 2005). Additionally, due to the Aged Care remuneration inequity, and consequent reduction in RN employment, often the only available undergraduate supervision in these facilities is limited to the subsidiary grades of nurses such as ENs, who lack the academic background to adequately mentor the university nursing student (Neville, Yuginovich, & Boyes, 2008), and hence, suitable undergraduate clinical exposure is often limited. Measures recently announced by the Commonwealth Government will go some way towards addressing the lack of parity between Aged Care resources and general healthcare provision, including the $1.2 billion to attract and retain healthcare workers, and improve recruitment and retention incentives (O'Keefe, 2012). While this is good news for the future of the Aged Care sector, it will take strong leadership in all healthcare sectors to facilitate progress.

5.3.2 Types of Specialty Units Worked In

Within each healthcare sector, and depending on the organisation's size and type, specialty units may range from specific, such as perioperative, to combined, such as medical plus surgical, or multiple, that may include medical, mental health, aged care, community and frequently more, in the one specialty rotation as is often seen in either secondary or rural sites. Although Mental Health, Aged Care, and Community are included in the employment sector type, more often, they form part of an employing agency, such as a unit within, or attached to a tertiary hospital, and consequently, are also included in the components of the specialty rotations.

The UWA (2000) study did not specify specialty choices; rather, the responses to the question were free text and consequently grouped for reporting purposes. Based on these groupings and contemporary literature, respondents in the current

study were given a choice of 12 specialties to indicate the area of nursing to which they were allocated for their GNP specialty rotations. To accommodate the units with combined specialties, the GRNs were able to select multiple options; and, should they have required it, an '*other*' category was also provided, representing specialties not covered in the survey. Ten respondents indicated *other;* however, half of these were able to be reassigned to one of the specified areas, and the remaining five worked in either endoscopy suites, or rehabilitation, which may have included a range of care, including joint replacement, acquired brain injury, spinal, or stroke rehabilitation; consequently reallocation to the specified areas was not appropriate.

The two studies under consideration showed very similar ratios of specialty rotations recorded for surgical and medical units. The UWA (2000) study grouped surgical and medical specialties together (68%), and reported the specialty units only at one point in time. As the current study collected data for each specialty rotation, and distinguished medical and surgical as two separate specialties, the data showed slightly different proportions for each rotation. The current study revealed that 35.3% of respondents who participated in a GNP spent their first specialty rotation in a medical unit, and 35.8% in a surgical unit; and in their second rotation 29.9% were in a medical specialty, and 39.7% a surgical area. These data would suggest that the preferred initial rotation is to a medical or surgical specialty to allow early consolidation of nursing knowledge and skills.

5.3.2.1 Acute Care Specialties

In the comparative data related to the specialty rotations that the respondents worked in during their transition programs, the acute areas of Critical Care and Perioperative demonstrated the greatest change. In comparison to the UWA (2000)

study, the present research showed there was a four-fold and three-fold increase respectively in the number of graduates working in these areas. As these are highly specialised areas, and often require a different skill set to the basics learned in their undergraduate preparation, there is some doubt as to the benefit, both to the graduate and the organisation, of placing novices in these areas at the beginning of their program. It is believed by some (Duchscher, 2009; Woods & Craig, 2005) that it may be of more assistance to allow the GRN to consolidate basic skills and to gain confidence and competence in the more routine areas, and then to take on the challenge of the specialised area as a second year graduate. In response to the smaller, web-based survey, many of the graduate nurse coordinators indicated that where these areas were offered as a specialty rotation, they were usually in addition to the initial 12-month program. This would suggest consensus with the notion of later experience in the more acute areas as the preferred model. The comments from some of the graduates who were allocated to a critical care area within their first 12-months suggests that an added degree of effort was required in comparison to their contemporaries in less acute specialties, and the rotation had the potential to be a more stressful experience. However, most comments also indicated that strong support systems were in place to ensure that the novice was ably assisted in adapting to the novel environment. The following comments illustrate not only the trepidation felt by one GRN, but also the appreciation generated from a supportive unit culture:

> *Weekly updates on new events and policies were great. Kept everyone up to date and issues could be looked at quickly – very approachable management. Loved my work and going to work. Friendly staff with a huge knowledge base. Always someone who could answer your questions using theory and policies to back up what they said. Felt very safe as everyone used the policies – no dodgy practices.* (Paediatric critical care, tertiary.)

> *Facing unknown situation. Patient deceased after resuscitation.*
> (Critical care, tertiary.)
>
> *Excellent education sessions from SDNs* (Staff Development Nurses) *and CNs* (Clinical Nurses). *Great support from other nursing staff.*
> (Critical care, tertiary.)

Due to the specialised nursing care required, these more acute areas of patient care also necessitate additional support systems for the GRNs to ensure that they are appropriately orientated to the specialty, thus impacting upon the unit staff's resources. Despite the heightened intensity of the experience for the GRN, the potential benefits of the positive encounters experienced by them in these specialties is further demonstrated by the large number intending a future career within the critical care areas. Of those responding to the question regarding future career intentions, 13.5% of the GRNs indicated that they were already working within these areas, or were considering specialising in them, with many also intending to undertake future studies within the specialty.

5.3.2.2 Mental Health

In the UWA (2000) study, 9.7% of respondents recorded a specialty rotation in Mental Health nursing. In comparison, the current study demonstrated a reduction by almost half that proportion with only 5.6% denoting a rotation to this specialty. Such an outcome is concerning given that Mental Health is an area of increasing need but seemingly diminishing resources (Procter, et al., 2011). Participants who were allocated to that specialty recorded mixed experiences, with some finding the encounter difficult, referring often to an apparent lack of undergraduate preparation, and others indicating a very positive experience; as is demonstrated in the following comments from the GRN respondents:

Not trained in mental health. Limited support or teaching.

Going to an acute 'lock-up' ward on my first rotation (caused most stress). *As much as it was stressful, it was also a great learning experience.*

Fantastic staff at ward level, sense of learning and achievement, feeling part of the team, lots of feedback from ward staff. A suicide of a patient I was allocated to in my third week (caused most stress).

To improve the number of nursing graduates who choose Mental Health as a viable transitional program specialty, the Sector may benefit from further partnerships with other organisations to develop a more attractive package for graduating nurses, such as the current combined programs already offered that enable a combination of specialties between acute care hospitals and mental health units. Consideration too needs to be given to an increased exposure during the undergraduate clinical placements. Additionally, and to lessen the trepidation felt by the GRN when confronted with the more acute mental health conditions, it would seem a modified introduction to the less acute areas of Mental Health would be beneficial, prior to exposure to the more intense situations.

Happell (2010) draws attention to the number of reports and inquiries that have been undertaken to investigate issues related to the nursing shortfall within Mental Health, particularly since the cessation of the specialist undergraduate program some years ago, and suggests that the mental health component in the current generalist program is insufficient to ensure a suitable number of recruits to the specialty. The proposed introduction of a national undergraduate clinical assessment tool (Crookes, et al., 2010) may go some way to ameliorating this discrepancy as, to enable the student nurse to meet the required competency for registration as a RN with the NMBA, sufficient exposure to the Mental Health specialty would be necessary.

It is also likely that marketing of Mental Health nursing requires review, with a view to encouraging more graduates to consider this area as a specialty experience option. The Nursing and Midwifery Office (NMO) manages the recruitment of GRNs to the Western Australian public GNPs, as well as some private GNPs via the Graduate Nurse Connect (GNC) consortium. The website that student nurses must access to apply for these programs lists available options in the order of generalist urban programs (including public and private); WA Country Health Service (WACHS) generalist programs; and finally, the Mental Health programs (Nursing & Midwifery Office, 2012). An interesting exercise would be to re-arrange the presentation order of these program areas so that the sectors that are most in need of recruits were listed first. Whether or not the number of Mental Health applicants increased could then be determined.

5.3.2.3 Aged Care and Community Health

Other areas that featured minimally in terms of specialty rotations in both the UWA (2000) survey, and the current study, included Aged Care and Community Health. Given the impetus to deliver more health care within the home or community, and the ageing of the population, this is of concern. As discussed, both these areas can be either as a stand-alone sector, or a specialty within a healthcare sector.

Segal and Bolton (2009) suggest that there is a shifting focus on health care into primary and community care and on preventative, rather than reactive medicine, and warn that this change will impact upon the demand for an increase of health professionals within these specialties. The WA metropolitan health services all have *Hospital in the Home* provisions that facilitate earlier patient discharge from hospital

and provide follow up treatment and nursing care within the patient's domicile. The WA Health Department (Department of Health, 2011) describes the Hospital/ Rehabilitation/ Mental Health in the Home programs as the provision of short-term nursing care for patients that do not require constant monitoring or inpatient treatment, within the comfort of their home. The initiatives are a means of reducing the burden on acute care institutes and providing the patients with a greater degree of control over their individual care. WA's Silver Chain service (community healthcare organisation) has also recently launched a Government funded Home Hospital initiative providing nursing care and assessment to a wide range of the metropolitan population (Silver Chain, 2012) and, again, has the potential to offer further opportunity for GRN experiences.

In the current study, most community based specialty rotations appeared to be within the rural sector where, due to the size of the smaller organisations, a mixture of specialties is often required to provide a sufficient level of experience to the novice nurse. Barriers to improving recruitment to these specialties are similar to those within Mental Health and include: resistance within the sectors to take undergraduate nursing student clinical placements that would otherwise allow interest in the specialty to develop; sufficient and suitable supervisory resources to mentor both, students and graduates; lack of defined career paths; and, an image of the specialties that is not congruent with an attractive future career within the profession (Dragon, 2009; Evans, 2005; Health Workforce Australia, 2011a; Nurses Board of WA, 2006; Pinch & Della, 2001). Like Mental Health, it would appear that Aged Care and community nursing are areas that need to be given a far greater focus in nursing workforce and recruitment planning to improve the attraction and retention of a suitable cohort of nurses to these burgeoning specialties.

5.3.2.4 Rural Nursing

Rural Health in WA covers the largest area within Australia, but with only 40% of the State's population residing in its 2.5 million square kilometres (Twigg & Duffield, 2009). Access to remote communities, attracting and retaining suitable healthcare providers, and provision of appropriate resources compound the issues experienced by the rural population, as do the greater health care needs of the predominately Aboriginal populations of the more remote areas (Armstrong, Gillespie, Leeder, Rubin, & Russell, 2009).

Despite the deficiencies described in the previous section, as the transition programs evolve, more diverse programs are being offered, an important step towards recruiting to areas that are under-resourced in terms of nursing staff. One such area is Rural Health where programs are offered either at a singular site or as part of a program, whereby the graduate is able to experience multiple areas throughout the WACHS. The effort involved in this, however, is reflected in the comment from one rural graduate nurse coordinator:

> *Other areas were also considered* (for specialty allocation) *e.g. Mental Health, Remote, Community, and Home Nursing, and Dialysis. These areas were often hard to recruit to because there was little exposure to these areas by staff. This also gave RNs a broader understanding of the facilities available in the community so when discharging patients they had an understanding of where their clients were going to and the problems they may encounter.*

As with other areas, participation in Rural Health as a sector was not measured in the UWA (2000) study; however, it was measured in the specialty rotations. The earlier study showed a greater proportion of GRNs selecting a specialty rotation in Rural than did the current study (3.4% compared to 1.9%). However, when the individual specialty rotations are considered in combination with the organisational

sector, the ratio is far greater in the 2010 study (14.9%). This suggests that the multiple options available via the GNC are an attractive choice for the GRN.

Exposure to rural health nursing during undergraduate clinical placements has been identified as a positive factor in new graduates choosing this sector for their transitional programs (Courtney, Edwards, Smith & Finlayson, 2002), as does personal connection within the area (Nugent, Ogle, Bethune, Walker, & Wellman, 2004). The difficulty with rural placements, however, is the generalist nature of the nursing care required. As Francis and Mills (2011) describe, rural nursing requires a more diverse range of skills, than does urban practice. To provide comprehensive nursing care for the variety of ill-health presentations likely to occur within a rural site, and to enable treatment for the range of specialties likely to be encountered, a broader scope of skills and knowledge are required; hence the RN’s scope of practice needs to be much more extensive. Further complexity is added with the unique social aspects of rural workplaces. A new graduate is likely to be required to work with people known to them socially; however, due to the nature of nursing workplace hierarchical structures, they may find themselves in awkward situations of conflict or professional dissonance, and without suitable avenues to appropriately debrief when required (Lea & Cruickshank, 2007). This would suggest that consideration needs to be given to alternative forms of communication with peers and mentors who are remote to the organisation, such as that offered by electronic networking.

5.3.3 Competence, Confidence and Support

The general intent of transitional programs is to assist the novice nurse gain confidence and competence in their nursing practice along their journey to proficiency. The GNP should enable the GRN to consolidate the skills and learning

gained during their undergraduate program and to apply these to real-life nursing situations (Hayman-White, et al., 2007; Levett-Jones & Fitzgerald, 2005). The provision of appropriate supportive systems to the novice nurse is aimed at ensuring that their transition will be more effectively and efficiently managed. A positive experience is more likely to influence positive perceptions of the organisation as an appealing workplace, and the profession as an attractive choice of career. Johnstone, et al. (2008) found that a supportive environment was strongly associated with more successful integration of novice nurses into a new clinical domain, and greatly assisted their acquisition of confidence and competence within their nursing practice. These authors also suggested, however, that there was little supportive evidence within the nursing literature to corroborate their findings, and encouraged further investigation into the benefits of a supportive clinical environment for new nursing staff. While some organisations within the current study appear to have achieved the goals of providing a favourable setting for new recruits, others seem to struggle with this, often seemingly due to a lack of applicable resources. Such resourcing issues were particularly evident among the secondary and rural sectors, and are further demonstrated in the ensuing discussions.

5.3.3.1 Graduate Program Competence and Confidence

Between the 2000 and the 2010 populations, there was little difference in agreement that the GNP made the GRN feel more *competent* and *confident*. Of the UWA (200) cohort, 90% *agreed* that they felt more *competent* following the program, as did 89% in the current study. There were 89% in the UWA (2000) study and 85% in 2010 who indicated the GNP had improved their *confidence.* However, there were considerable changes in the strength of agreement between the two studies, with almost 10% more of the 2010 study respondents *strongly agreeing* that

the program had made them feel more *confident* and *competent.* These findings suggest that the respondents of the more recent study were more in accord with the notion that the GNP assists the novice nurse to feel more confident and competent with their nursing practice. There were also major differences in the *disagreement* group, but only in relation to *competence;* where the proportion of respondents *disagreeing* that the GNP made them feel more *competent* was halved in the current research in comparison to the UWA (2000) study. The 2010 study inclusion of an option for an *unsure* response, allowing for a more neutral answer, may account for this difference, with 5.8% of respondents choosing this option. The proportions of respondents who *disagreed* that the GNP made them feel more *confident* were almost equal between the two study periods and remained relatively small. There were proportionately more in *disagreement* among the GRNs from the private and rural sectors and relates to findings discussed further throughout the following sections.

5.3.3.2 Preceptor Support

The NMBWA (2009) defined the term ‘preceptor’ thus:

> *Preceptor is the title that is used to describe an expert nursing or medical clinician who is a role model to the learner, demonstrating and personifying a competent nurse. The preceptor models the appropriate professional behaviours and ensures the development of a safe and competent learner (p. 1).*

The predominant model within Western Australian GNPs is one where a nominated preceptor is allocated to the GRN to provide support and guidance to them.

Respondents to both GRN surveys described a mixture of very positive, and some less than desirable experiences, in regards to their preceptors. In the 2010 study, the response options related to preceptor support included a *mixed* choice to allow for a more neutral response alternative, and to provide a more eclectic description of the varying experiences between specialty rotations. As a consequence, a third of the 2010 respondents chose the *mixed* option in relation to preceptor support satisfaction. This resulted in the earlier UWA (2000) study showing a larger proportion of respondents (76.1%) who were *satisfied* with their preceptor support in comparison to the 2010 study (55.3%); but conversely, halved the proportion in the current study (11.2%) who reported *dissatisfaction* with their level of preceptor support compared to the UWA (2000) data (23.9%). The following sample illustrates the diversity of responses as reported by the GRNs in the current study:

> *Very unsatisfied on Medical rotation, very satisfied on Theatre rotation.* (Private.)
>
> *Very supportive and involved preceptor and SDN.* (Tertiary.)
>
> *Without the wonderful support of general nursing staff, the grad year would have been worse. We did not have designated preceptors.* (Secondary.)
>
> *Good clinical preceptor, willing to teach.* (Private.)
> Note: this nurse later made the following comment: *My experience at this particular hospital made me feel less competent as an RN than I felt as a student. My confidence was destroyed, leaving me feeling disheartened by nursing and resigning. The hospital focuses on profits, rather than teaching and patient care. It is evident that staff members are unsupported, over-worked and therefore unwilling to teach.*
>
> *I did not have a preceptor to begin with, which was stressful for the first week as Recovery Room is a very specialised area.* (Tertiary.)
>
> *Nil preceptor support on either rotations and minimal support from SDN on second rotation – presumed we knew everything.* (Private.)

> *The skill-mix during this rotation often meant grads were 'educating' other grads; a severe lack of support. I was assigned a preceptor who worked two days a fortnight, therefore it was sometimes weeks between seeing her, let alone receiving feedback from her.* (Tertiary.)
> Note: this nurse later resigned to study for a non-nursing profession.

From the web-based graduate nurse coordinator data, it was clear that the organisations with a more defined program have stronger support systems in place, with ongoing assessments and feedback utilised to continually refine and improve their programs. A respondent from a tertiary hospital described one such change thus: "*we have implemented preceptor modules for the ward staff to ensure they are prepared for their role as preceptors to the new GRNs*". Based on many of the GRN comments related to their preceptors, this is a commendable innovation and one worthy of consideration at all sites where GNPs take place. Particularly so, given that there were several inferences that the assigned preceptors did not always appear to have a clear concept of the purpose of the transition program, the graduate's level of experience or competence, or indeed, what was required of them, as a preceptor, to support the novice nurse in their beginning practitioner role. In the current study, the tertiary hospitals rated the highest in perceived levels of *satisfaction* (60%) and lowest in *dissatisfaction* (4%) with preceptor support, and rural organisations the converse levels (32% *satisfied* and 21% *dissatisfied*). Such data suggest that the larger organisations are able to provide more suitable preceptor support than those that are less resourced. There was no similar breakdown of the data provided in the UWA (2000) study.

Consistent with the comments provided by the GRNs in the current research, are those from the literature that describe occasions where novice nurses have been paired with a preceptor who is described as too busy, absent, disinterested, or

unaware of the basics of the preceptor role (Johnstone, et al., 2008). Other studies (Adlam, Dotchin, & Hayward, 2009; Charlston & Happell, 2005; Clare, et al., 2003; Cowin & Jacobsson, 2003) described the need to ensure that novice nurse integration to the workplace is supported by experienced and knowledgeable colleagues, and in a process that is deliberate and based upon best practice. These studies also illustrate the positive impact on both the confidence and competence of the neophyte, and importantly, improved patient safety that good support can provide. The preceptor should provide a knowledgeable and exemplary role model to which the GRN can aspire to (Delaney, 2003). In addition, the allocated preceptor needs to be resourced adequately for the role in terms of training and education; and to enable them to sufficiently support the GRN. This could be managed by a reduction in the preceptor's workload responsibilities.

It would appear that in some organisations the preceptor role is not well defined and that the nominated nurse may or may not have received tuition in the role prerequisites, or the graduate's educational requirements. When the preceptor is unsure of what is expected of them in the role, and if they are under-resourced, there is often additional and unrecognised pressure placed upon those adopting the role. This in turn results in a less than satisfactory experience for both the GRN and the preceptor, and sub-optimal learning outcomes. Johnstone, et al. (2008) suggests that inappropriate allocation of preceptors, who were not fully engaged in the role, had a significantly detrimental effect upon the development of confidence, and the perceived competence of the novice nurse. At times the nursing related literature interchanges the term preceptor with 'mentor' and portrays an experienced colleague who is able to supervise and advise a nurse in a new environment (Myall, Levett-Jones, & Lathlean, 2008).

All graduate nurse coordinator respondents indicated the use of the preceptor model in their organisation, with the majority (53%) of the roles performed by Level 1 RNs and only two respondents indicating a Level 2 RN was the preferred level. While the position level of the preceptor is not necessarily important, the level of experience and clinical knowledge is, and as suggested, should be sufficient to be able to provide appropriate advice and constructive direction to the novice GRN.

5.3.4 Full Patient Load

When beginning in an unfamiliar clinical area, a reduction in responsibilities and workload is generally built into the initial period to enable new staff to better acquaint themselves with the environment, unit characteristics, and organisational policies and procedures. The intention of this supernumerary time is to lessen the risk to both the nurse, and the patient (Australian Nursing & Midwifery Council [ANMC], 2006). It is expected that as the graduate becomes more proficient, they are able to draw upon previous experiences and knowledge, and so adapt to a new area more quickly. Consequently, and as their competence and confidence increases, their supernumerary time is generally able to be reduced. This time would not be expected to be eliminated altogether, as each separate unit has varying degrees of clinical diversity, as well as different physical environments. Transitional programs generally stipulate the provision of adequate supernumerary days for the GRN to familiarise themselves with the unique clinical environment and the pertinent unit culture, policies and procedures. When supernumerary time is not available, the nurse is required to adjust very quickly and may be left feeling inadequate and highly stressed which may contribute to errors in patient care, compromise their learning, or prompt them to leave the nursing workforce (Morrow, 2009).

When compared to the UWA (2000) study, the amount of supernumerary time in the current research allocated to the GRN before being assigned a full patient load, showed substantial improvement (Figure 5.1). It is, however, of considerable concern that some novice nurses are still exposed to the stressful experience of being expected to "hit the ground running" (Usher & Mills, 2012, p. 19). In the current study, of the 18 respondents in their first specialty rotation who were required to take a full patient load either on their first day on the ward or unit, or following one day's orientation, seven had no prior experience in healthcare. Eight had previous experience as either an AIN or a PCA; neither roles necessitate anywhere near the degree of responsibility that is required by a RN. Of those with no prior experience, four of the seven were from tertiary hospitals. The impact, and the negative concept the experiences evoke are evidenced in the following GRN comments:

> *Thrown in, everyone too busy – very stressful.* (Secondary hospital, emergency department; full patient load from day 1.)

> *Again, no supernumerary time. The hospital tells you all these wonderful things (supernumerary time, study days, support) to get you to apply to their hospital and once you are employed you are on your own!* (Secondary, medical; full patient load from day 1.)

> *Having one day orientation and no supernumerary days caused a lot of stress as I'd had no surgical experience.* (Tertiary, surgical; second rotation.)

> *Wards were short staffed and you were expected to take full patient loads that were also classified as 'heavy'. Staff were unable to help as they were too busy.* (Large rural, medical/surgical; 1 day orientation, second rotation.)

> *Coming from a neonatal ward to adults – not much support. Feeling not safe to practice due to lack of experience.* (Tertiary, surgical; 1 day orientation, second rotation.)

> *Understaffing and thus given full patient load on first day of work.* (Private, medical; first rotation.)

> *Would have liked to have more supernumerary time – 2 days not enough. Felt I was thrown in the deep end! Did not feel confident, did not know the run of the ward.* (Tertiary, medical; full patient load from day 3.)

In general, the literature does not prescribe specific periods of time for supernumerary practice; however, there is considerable support and evidence of the impact of suitable intervals between commencement in a new work unit and the allocation of a full workload. Reeves (2007) suggested a minimum of four shifts per specialty rotation, while Pinch and Della (2001) advocated that to facilitate integration into the workplace, and to gain familiarity with the related policies and procedures, a new nurse should be provided with at least five days of a reduced workload. It would appear that these periods of time should be at least a minimum in the initial routine specialty rotations, and further allowance made for those with more complexity.

While the Australian Nursing and Midwifery Council (ANMC, 2006) *National Competency Standards for the Registered Nurse* do not specify delineation of a period of time for the beginning practitioner to transition from complete novice to competent practitioner, *Standard 2.5* does require the RN, "Understands and practises within own scope of practice," (p. 12). The difficulty complying with the standard arises when the novice is put into a position of power inequality and fears reprisal if they are seen to 'rock the boat' by voicing any concerns related to inappropriate allocation of assignments (Evans, 2005; Reilly, 2005). This is where the support of a good preceptor or SDN should be able to assist the GRN in negotiating a more suitable supernumerary period of time.

Despite the absence of supernumerary time for some GRNs, the comparative data between the UWA (2000) study and the current research demonstrates that there have been significant improvements to the time allocated before a novice nurse was expected to take on a full patient load. Far fewer in the latter study were expected to adopt a full patient load within the first days and many more were able to assimilate into their new area over the period of a week or more (Figure 5.1).

Figure 5.1. ***Comparison of 2000 and 2010 Days to Full Patient Load***

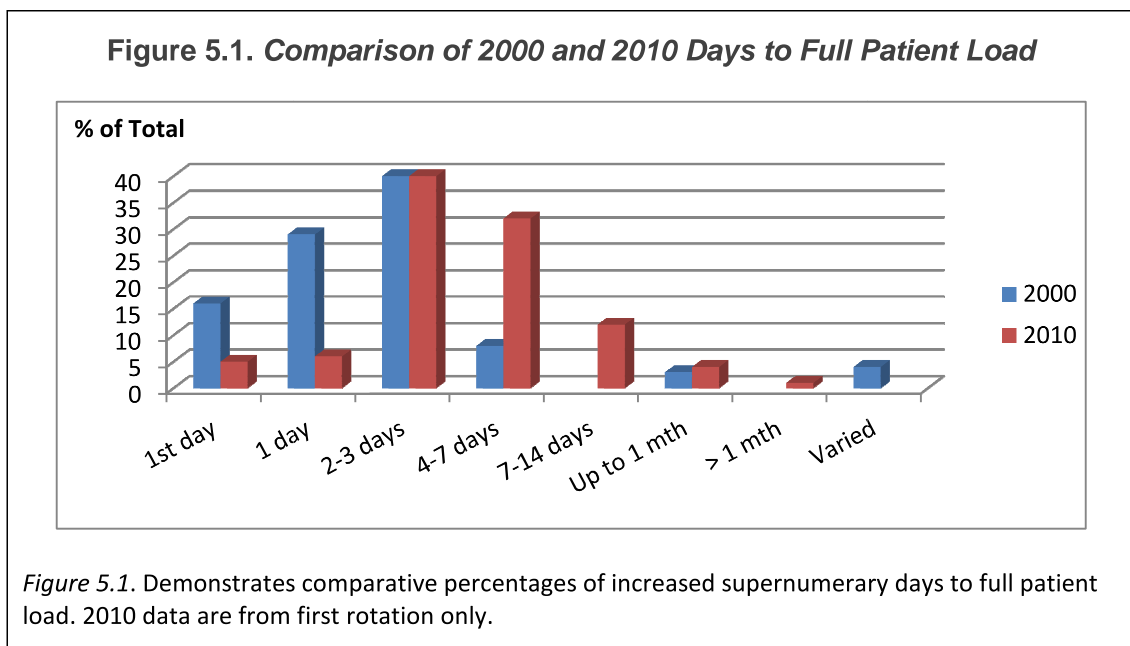

Figure 5.1. Demonstrates comparative percentages of increased supernumerary days to full patient load. 2010 data are from first rotation only.

As the UWA (2000) study did not collect data related to the individual specialty rotations, there is no further comparative data related to supernumerary time. Within the current study, however, for each specialty rotation, there were progressive reductions to the amount of supernumerary time allocated to the GRN. In the GRN's second specialty rotation there was an increase in the number of respondents who were expected to take on a full workload within one-day in their new specialty, and a marked decrease in those who were allowed four to seven, or seven to fourteen days as a supernumerary staff member. The majority of respondents indicating that their supernumerary time for this rotation was up to, or

more than one month was for perioperative rotations, or other specialised areas such as paediatrics, Critical Care or the Emergency Department. Due to the unique and specialised nature of these areas, additional orientation time would be expected for any new staff member and even more so for the novice RN, so it is reassuring to see that this requirement is being acknowledged.

5.3.5 Performance Evaluation

Regular performance evaluation and feedback in any role is important. Constructive appraisal of work performance provides a review of achievements, identifies areas for improvement, presents opportunities for future learning and skills development, and offers an opening to discuss any areas of concern. Additionally, appropriate performance evaluation provides professional structure to an employee and assists in helping them to feel that they are valued, and that their contribution to an organisation is acknowledged (Duchscher, 2009). Research by Reeves (2007) into Victorian graduate nurse experiences found that a greater number of formal and informal performance assessments were directly related to higher satisfaction levels. Duchscher's study of newly graduated Canadian RNs described how graduate nurses looked to feedback from colleagues and supervisors to affirm the progression of their performance to competency (2009).

The majority of respondents (86.4%) in the 2010 study had their performance assessed within the first six months, whereas, the UWA (2000) study reported that 92.7% of the respondents were assessed within their first six-months of commencing the GNP, suggesting that evaluation of the GRN occurred slightly less often in the current research. However, when the 2010 data was separated into those respondents who did and did not participate in a GNP, the proportion of GRNs who were

assessed within the first six-months increased substantially, to 95.2%. In view of the aforementioned research into satisfaction levels related to performance assessment, these data would indicate the current cohort of GRNs would have predominately felt happy with their evaluation schedule.

To ascertain who was most involved in the performance evaluation, a second question was asked of the respondents to indicate the person, or persons responsible for their assessments. The UWA (2000) survey showed that almost three quarters of the assessments were completed predominately by the preceptor whereas, in the 2010 study, the primary person responsible for evaluation was the SDN. This variation is possibly due to organisations directing their GNP Government funding towards employing an increased number of SDNs, with the intent of providing more definitive and skilled support to the GRNs. Both surveys demonstrated a collaborative contribution in the evaluation process, with almost half the respondents revealing that more than one person was involved. The most common combination in the current study was the SDN and the GRN's preceptor. The benefit of a multiparty approach to assessing performance ensures a more objective evaluation of performance, and avoids individuals making purely subjective judgments.

5.3.6 Night Shift Participation and Preparation

To provide comprehensive care to patients within a hospital, some healthcare professionals are required to work a mix of shifts over the 24-hour period of a day. The time between evenings to dawn is generally a phase when minimal services and support are available to those working, and consequently, nurses on the out-of-hours shifts are required to be more independent and self-reliant with regard to knowledge, skills and resources. Research clearly demonstrates a direct link between decreased

RN experience levels and patient “failure to rescue” (Twigg, et al., 2011, p. 543). In the interests of patient safety the newly graduated nurse is therefore, generally given a period of grace prior to being rostered onto shifts at night. “This is especially serious in circumstances where junior medical officers and junior nurses are frequently the only professionals on duty throughout the night to care for patients” (Garling, 2008, p. 9). Expecting them to participate in the night shift roster any earlier may put the novice at risk of finding themselves in situations not only beyond their scope of practice and capabilities, but also without the supports that ought to be available to assist them in patient care (Evans, Boxer, & Sanber, 2008; Reeves, 2007).

In both the UWA (2000) and the current 2010 studies the GRN respondents were asked how long it was from the commencement of their program before they were rostered onto night shifts. In the earlier study the distribution between those who went onto night duty in less than six-months, and those who were given more than six-months before being rostered to these shifts, was almost even. The 2010 survey showed that two thirds of the GRNs had been rostered onto night shift in less than six-months from commencing their transitional program. The rationale for this earlier rostering to night duty is not able to be determined from this study, but would benefit from further inquiry. In the UWA (2000) study 42% of respondents did not do night duty in their graduate year while, whereas of the 2010 group, only 20.8% of nurses indicated they did not do night shift. It is possible that the increase in the latter study may be due to a greater presence of SDNs for the after-hours shifts, aimed at providing more appropriate support to the GRN when it is most needed.

In the current research, and to elicit a more detailed data set, the choices made available to indicate the time period before being rostered onto night duty were expanded from those provided in the UWA (2000) study, and included a *less than three-months* option. It is concerning that so many in the current study (20.6%) were rostered to night duty within their first three months of graduating, and over a quarter of those reporting that they felt they were not well prepared for the role. While it is acknowledged that staffing adequately for the night shift is often the most difficult for unit managers to achieve, it is disquieting that the novice nurse may be rostered to this shift, particularly so when they may not feel confident enough to dispute the decision with the more senior nurses who allocate them (Morrow, 2009).

Despite these concerns, over three quarters of the respondents in the 2010 study felt that they were sufficiently prepared for the responsibility of night duty, which is comparable to the UWA (2000) group, where only slightly fewer indicated that they felt well prepared. The most problematic area for the GRN in regards to night duty in the UWA (2000) survey was cited as lack of experience. In the 2010 study, only 20% of those who did night duty took the opportunity to comment on their preparation and of these, merely two respondents felt that they had insufficient experience for the role. The mix of comments regarding night duty in the 2010 study was comparable between both positive and negative, with many citing good support, or conversely, a lack of support provided while doing night shifts. Prior experience on night duty as an Enrolled or Student Nurse appeared to be a contributory factor in easing the GRN into the night shift. The earlier UWA (2000) study did not look at prior health care experience, so comparisons between the two studies relating to the effect that prior experience may have on the GRNs' perceptions of preparation for night shifts cannot be made.

5.3.7 Undergraduate Nursing Program Influences

The theory-practice gap that relates to deficits in the transfer of undergraduate knowledge and skills to the clinical workplace is well documented (Clare, et al., 2002; Delaney, 2003; Evans, et al., 2008; Fox, et al., 2005; Kelly & Ahern, 2009; N^{3}ET, 2006). A study conducted by Reilly (2005) found that 99% of students who were about to graduate believed they were practice-ready for their imminent role as an RN; however, four-months into their new RN career this perception was reported to have altered considerably, although no quantitative degree of change was given in the study.

Almost three quarters of respondents in the 2010 cohort indicated that they felt they had received sufficient grounding for their role as a RN, contrasting significantly with those from the UWA (2000) study, where only 42.5% of respondents agreed that their undergraduate education had prepared them adequately for their RN role. These findings suggest that the undergraduate education has evolved favourably between the times of the two studies being considered.

Despite the more positive findings, there were still a number of respondents in the 2010 study who believed there were ways their undergraduate education could have been improved. Over half the respondents felt that additional practical experience during their undergraduate program would help them to more adequately prepare them for their role as a RN. This was followed by the view that more clinical information would be of benefit, such as responding appropriately to emergency situations, or the practical skills of dressing wounds or removing wound drains. Other themes were less common but did feature more strongly among respondents of a particular university, for example, those from University C would

have preferred more focus on pharmacology and the reality of the workplace, and both University A and University B believed more emphasis on time management would have been of benefit in easing their transition to practice. A sample of textual responses from the 2010 GRNs demonstrates these concepts. Their place of employment at the time of the survey, and the university attended for their undergraduate nursing program are indicated in the parentheses:

> *In depth learning about the responsibilities that awaits you as a RN so that patients have more confidence in you.* (Tertiary, Uni A.)

> *It has been hard. To be an RN takes guts and hard, hard work. It could be made easier for transition from uni with more skills or a better grad program.* (Secondary, Uni B.)

> *Pharmacology, physical assessments, pathophysiology related to surgeries.* (Private, Uni A.)

> *More hands on clinical skills, some of the basic nursing skills I was 'expected' to know during the first two rotations were not taught at uni for example, insertion of nasogastric tube, or care of colostomy bags, etc.* (Tertiary, Uni A.)

> *Clinical skills preparation – a truer idea of exactly what we are likely to encounter in hospitals, i.e., angry, frustrated patients and staff. Coping with stress and anxiety related to work. Coping with staff who aren't helpful.* (Tertiary, Uni A.)

> *Teaching what variations in blood results mean. More on Allied Health, e.g., speech and dysphagia. More on pharmacology and conditions and diseases.* (Tertiary, Uni C.)

> *Some units weren't really relevant or useful, e.g., communication unit – rambled a whole load of* (stuff) *that had nothing to do with communication within the work place or to patients.* (Tertiary, Uni B.)

> *As a mature aged grad probably had a different perspective on things but feel more support is needed, as well as more practical experience as a student. University did not completely prepare me for the job.* (Secondary, Uni B.)

> *It was very scary and daunting. Because we were new RNs it felt like we were expected to know everything.* (Large rural, Uni A.)

More emphasis should be placed on the real work, not academic (stuff). *Once you learn the formula of what they want to see, it really doesn't matter what you learn as long as you feed them the same rubbish. It was disappointing.* (Small rural, Uni C.)

Give more beneficial units in final year that reinforce knowledge learnt. Not ethics and philosophy units – pathophysiology and pharmacology would have helped. (Tertiary, Uni C.)

Hands on procedures, i.e., IDC (indwelling catheter) *insertion, complex dressings, drain removals. We required more clinical/workshop time and less book education.* (Tertiary, Uni B.)

Knowledge of medications, knowledge of symptoms of disease (medical problems)*, communication skills.* (Tertiary, Uni B.)

There has been protracted debate in the nursing literature in relation to the theory-practice gap, and little that suggests any imminent resolution. Most discussions, however, do recognise the inadequacy of current clinical preparation that is able to be provided to the undergraduate nurse in order to better prepare them for their RN role (Clare, et al., 2002; Dragon, 2009; Evans, 2005; Health Workforce Australia, 2011a; International Council of Nurses, 2009). The ever-increasing complexity of nursing makes it difficult for the content of the undergraduate curriculum to keep pace, or for educators to fit in additional contemporary components of education or clinical practice (Dragon, 2009). While it is recognised that the undergraduate nursing curriculum struggles to incorporate the totality of nursing subjects, and to find sufficient and suitable clinical placements (Belardi, 2012b; Usher & Mills, 2012), broadening the scope of nursing practice to these areas is a topic worthy of further consideration.

Concerned about the inconsistency of pre-registration programs within Australian Schools of Nursing, a team of leading nurse academics and practitioners, supported by a grant from the Australian Learning and Teaching Council, instigated

a project to develop a "...new nationally-agreed competency assessment tool for nursing graduates. The tool applies to Australian universities with nursing programs that lead to eligibility for nurse registration in all states and territories" (Crookes, et al., 2010, p.1). The development of the assessment tool was founded on the *National Competency Standards for the Registered Nurse* (ANMC, 2006) and the project team suggested that these national standards should more clearly define the responsibilities and desired levels of competencies of the beginning practitioner (Crookes, et al., 2010). Additionally, Health Workforce Australia (2011a) has reported findings that university nursing education is no longer contemporary or efficient in producing profession-ready graduates; and that despite intents to move towards competency-based assessments, academia has yet to consistently implement these changes. Despite these very promising reports, there is limited evidence of the assessment tool being finalised or adopted on the scale proposed. A pilot assessment tool is available from the referred web-site, but progress to national implementation of the tool is unknown.

5.3.7.1 Higher Education Contribution Scheme Debt

Just over three-quarters of responders in the UWA (2000) study indicated that they had an ongoing HECS debt, whereas only slightly more than one quarter of the 2010 cohort was still paying off their education liability at the time of the survey. It may be postulated that the newer generations of nurses, in particular those deemed to belong to the Y Generation, have parents who are more willing to provide financial support, in terms of payment of fees, than were those of a decade ago. Another prospect is that some universities may offer a greater number of scholarships for undergraduate studies than was previously available; however, endeavours to confirm this have not been successful. Those universities with the least number of

RNs graduating from them had the highest proportion of respondents with a HECS debt, with 50% from University D (n = 5) and 37% from University C (n = 9) indicating thus.

5.4 Graduate Nurse Program Efficacy

RQ 2: From the Graduate Registered Nurses' perception, how efficacious are graduate nurse programs in helping novice nurses to make the transition to competent practitioner?

The UWA (2000) survey questionnaire was conducted at a time when formal transition programs were still in the provisional stages of being established and, in many cases, unproven. A few programs had regulated rotations, while others were somewhat haphazard and still waiting upon evaluation to determine their feasibility (UWA, 2000). Current programs are predominately well planned and organised, consisting of specific specialties, lengths of individual rotations and designated support personnel. To better understand the differing experiences reported by the graduates, and to capture possible variations in their perceptions of emerging proficiency and industry support, the GRN survey questionnaire individualised the specialty rotations and sought extended, and additional textual responses.

5.4.1 Participation in a Graduate Nurse Program

Of those participating in a transitional program, and at the time of the current survey, 78% of respondents had completed their GNP, 15.5% still had the intention of completing, and 6.5% (n = 11) did not go on to complete their program. There was a variety of reasons cited for not completing their GNP such as an inability to do

shiftwork, bullying, perceptions of unfair workload distribution, and collegial attitudes towards novice nurses, as follows:

> *Having to work up to 10-days in a row at times, and insufficient staff to help with heavy patients, and high-care patients.* (22-29 year-old, Uni B, Tertiary hospital, surgical, first rotation.)
>
> *Feeling of losing basics learnt at uni, support staff not at this hospital, even though part of the program; fast pace, babies dying. Realised I didn't want to pursue nursing at this time in my life, so I am working in retail while I am back at uni, still studying in a health profession.* (22-29 year-old, Uni A, Tertiary, paediatrics, first rotation.)
>
> *I was being bullied by an older nurse and management did nothing about it and would not allow a transfer to another ward.* (50 or over year-old, Uni B, Tertiary, medical/surgical, first rotation.)

Bullying in the workplace has been associated with increased turnover of nursing staff, and has also been linked with poorer quality of nursing care provision (Duffield, et al., 2010). Reports of bullying in nursing are common and, according to Dunn (2003), nurses eventually accept the practice in order to cognitively minimise the degree of stress caused, thus facilitating an ingrained culture. Supporting this view, Evans (2005) reported that some GRNs chose not to work in their preferred specialty due to the unit's reputation of a bullying culture. Comments related to bullying throughout the current study indicate that it remains enough of an issue in the workplace to negatively influence the novice nurse's tenure in the nursing workforce, and is discussed further in subsequent sections of this chapter.

The inability to work shiftwork was found to be an issue for some newly graduated nurses, predominately for reasons of child-care responsibilities and an associated lack of suitable social supports:

> *Was unable to do shift work during week due to being a sole parent with no other family.* (30-39 year-old, Uni B, tertiary, medical, first rotation.)

I will most likely be doing casual shifts, 1-2 per week as I have started a family. I do want to maintain my skills and update my knowledge however. (20-29 year-old, Uni B, tertiary.)
Note: did not do GNP due to pregnancy.

Shifts versus family friendly (caused most stress). (30-39 year-old, Uni C, small rural, medical, first rotation.)

Dorion, et al. (2008) urged greater consideration and acceptance of nurses with family responsibilities, and found that the majority who left the workforce for child care commitments returned at a time when they were more able to. Reeves (2007) similarly called for greater flexibility in scheduling for nurses who rely on paid child care due to the majority of child care centres having operating hours that weren't congruent with nursing shifts. While it is not possible to cede to all requests for employees work-life balance and simultaneously provide comprehensive nursing resources, it is imperative that flexibility be considered within organisational planning of the nursing workforce (Department of Health, n.d.). This is particularly pertinent given that more than 90% of the nursing workforce is female, and of those, a large proportion is responsible for parenting. Further, with nurses being employed from other countries, many are without extended family support to enable them to commit to more work time.

A further two participants did not complete their program as they were accepted into other programs before their GNP had finished (Post Graduate Diploma of Midwifery and Graduate Diploma of Perioperative Nursing). Another two had resigned from the organisation and four had moved to different organisations where they believed their needs were better able to be met. Such data suggest that nurses are more likely seek workplace experiences that are cognitively harmonious, rather than tolerate discordant environs.

5.4.2 Graduate Nurse Program Length

Formal transition program length is determined by the employing organisation. Of the 86 records with complete data enabling the estimation of GNP length, 72 respondents (83.7%) signified participation in a 12-month program. Eleven participants (12.8%) indicated a 24-month program with nine of these at tertiary hospitals and the remaining two within private organisations. Three respondents reported an 18-month program, two in tertiary hospitals and one in a large rural establishment. The program lengths indicated by the GRNs corresponded with the data from the graduate nurse coordinators. Only graduate nurse coordinator respondents from the tertiary sector indicated that they offered a 24-month program. The 24-month program indicated by the GRN respondents from the private sector may have been from a site that was not a participant in the GNC consortium, and therefore, not included in the graduate nurse coordinator population. A 12-month program was nominated by the graduate nurse coordinators from all secondary and small rural sectors; and in one private and two large rural organisations an 18-month program was available. While the most appropriate program length is difficult to recommend from this study, many of the GRN comments related to the topic do indicate a preference that, in addition to the 12-month program, the option to participate in further specialty rotations would be desirable, as is depicted in the following GRN comments:

> *Possibly an extra rotation, to try a different area and broaden my scope.* (Tertiary, medical and surgical rotations, 6-months each.)

> *Possibly have 2 x 6-month rotations instead of 4 x 3. In my case I did 2 x 3-month and 1 x 6-month – not by choice either.* (Tertiary, surgical, medical and surgical rotations.)

Although it may be difficult for some GRNs with family commitments to consider additional specialty rotations at an alternative site, the option to gain further experience by way of an extended program at a larger organisation is worthy of consideration, and would enable a broader scope of practice, particularly for those GRNs at secondary or small rural sites.

5.4.3 Specialty Rotation Characteristics

For each specialty rotation of the GNP the GRNs were asked a series of questions that included the type of specialty; the length of stay in the specialty; the average hours they were contracted to work; the degree of support experienced from various unit personnel; and a final set of questions designed to gain an understanding of what they perceived were the most beneficial, or problematic issues during the rotation.

Of the 168 respondents indicating participation in a transitional program, the majority were allocated to either a medical or surgical unit or a combination of these two areas. Mental Health was also an area where a combination of specialties were worked, with half the respondents indicating thus, most commonly those from rural centres, secondary hospitals and some private organisations, where individual units may not be large enough to provide sufficient experience in a single specialty. While the multiple specialty allocation may enable the graduate to gain a wider variety of experience and exposure to more disease profiles, it is possible that there may be too many issues for them to attempt to master at once, and consequently, it does have the potential to overwhelm them, as is suggested in the following comments related to what areas the GRN found were problematic in that particular rotation:

Paediatrics, medical, surgical, mental health and high care patients all on one ward. (Large rural hospital.)

Lack of knowledge. Ward with medical, surgical, paediatrics, mental health patients in one location. (Large rural hospital.)
In the 'further comments' section this GRN stated: *It was a scary process, I hope it improves. I would not want other grads to have to go through it.*

Added to the complexity of dealing with multiple specialties within the one rotation, the GRN is also required to adjust to the unique social pattern and personalities of the new unit, thus potentially compounding the anxiety of the novice (Chang & Hancock, 2003). Where there is little alternative but to have multiple specialties within the rotation in some areas, it may benefit both the nurse and the organisation to ensure that appropriate levels of support were always available to the GRN to provide advice and direction.

5.4.3.1 Specialty Rotation Length of Stay

The majority of respondents (43.5%) indicated that their first rotation was of 13 to 25 weeks in length, closely followed by a period of 26 to 39 weeks for an initial rotation (34.5%). The data from the graduate nurse coordinators suggested that all tertiary hospital programs consisted of six-month rotations; the majority of the rural sector have multiples of two, three and four month rotations; and secondary hospitals generally indicated that a combination of two three-month, plus one six-month specialty rotation were the norm.

The length of stay for each specialty rotation is sometimes a contentious issue. While some studies suggest shorter, more regular rotations to be of benefit, others believe a longer length of time gives the graduate a greater opportunity to consolidate their learning and acquisition of competencies (Chang & Hancock, 2003; McKenna

& Newton, 2008). From the graduates' comments in relation to the rotation, it is feasible that both views hold merit. It appeared that if a rotation was in an area where there was little variety or challenge, a graduate was likely to become frustrated with not having more opportunities to put theory into practice, and so became bored or complacent with learning. Conversely, if there was much to learn in a specialty, and the novice was given only a limited time to consolidate this learning, they were more likely to become frustrated with missed opportunities to progress their development. This was more evident in the second rotation where there appeared to be an increasing number of graduates who felt the rotation was either boring, repetitive, or that they were not wholly utilising their undergraduate education. These views are depicted in the following comments related to what the GRNs found problematic during a specialty rotation:

> *Specific nursing care, not as much opportunity to practise general nursing skills.* (Medical unit, tertiary hospital.)
>
> *Nursing duties very minimal, more on administrative duties, i.e., checking notes and calling in patients, answering phone calls.* (Community, tertiary hospital.)
>
> *Boring in DOSA* (Day of Surgery Admission) *was boring and felt I did not learn anything.* (Surgical unit, tertiary hospital.)
>
> *In-patient rate was a bit low. Did not have enough chance to practice a lot of aspects of paediatric nursing care.* (Paediatric unit, large rural.)
>
> *Got bored!* (Surgical unit, large rural.)
>
> *Longer length in each rotation. As soon as you got the routine you were shifted.* (Surgical, midwifery, medical/surgical, medical rotations, 3-months each, private sector.)

It would seem that, in areas where the level of opportunity during a rotation may be limited in terms of learning and applying theory to practice, consideration

should be given to the inclusion of more stimulating experiences for the GRN to ensure that their enthusiasm is maintained. Conversely, in specialties that appear to be very intense for the graduate, support resources need to be at a sufficiently high level to assist the nurse at the first indication of them becoming overwhelmed, and to facilitate them in recognising appropriate learning opportunities. Johnstone, et al. (2008) suggested that at least three to four-month specialty rotations were preferred, as the GRN was then more likely to have time to familiarise themselves with the unit routine, and specific specialty skills prior to moving on to the next experience. Further, increased satisfaction levels have been found amongst nurses who were offered more than one specialty rotation, with the GRNs preferring a rotation length of approximately six-months (Reeves, 2007).

One reason for favouring longer, but fewer specialty rotations within a program, is that of the GRN returning to ‘new’ status at the beginning of each rotation, and thus being subjected to feelings of inadequacy once again. Additionally, there is a recognised period of ‘down time’ while the GRN is supernumerary, including the time taken from the preceptor’s workload to support the GRN into the idiosyncrasies of the new unit. Reeves (2007) upholds the notion that this negative aspect of multiple rotations is clearly balanced by the benefits to the GRN, as they experience a broader range of clinical learning, and are exposed to more exemplars of professional leadership and role models, that in turn, provide a greater repertoire of knowledge upon which to base their critical decision making. Therefore, it would appear that specialty rotations should be at least four-months in length, and, in the initial year of transition, no more than six-months each.

5.4.3.2 Average Contracted Hours per Week

The number of those working fewer than full-time hours increased during their second rotation, indicating that following their initial commencement, some chose to decrease their average weekly hours to part-time. It is possible that to allow the novice to consolidate theory to practice, an initial period of full-time hours is required by most organisations before a GRN is able to reduce to part-time, however, no data from the graduate nurse coordinators indicated such. Hours that the graduates were contracted to work in their third rotation were similar to those indicated in the first and second rotations, with a further decrease in the percentage working full-time hours, and a corresponding moderate increase in the 20 to 29-hour bracket. Programs agreeing to part-time positions have recently become more common in an effort to accommodate both, those parents with child-rearing responsibilities, and the different work modalities of the younger generations who may prefer to work fewer hours than has traditionally been considered to be full-time (Jorgensen, 2003; Leiter, Jackson & Shaugnessy, 2009).

The responses from the graduate nurse coordinators indicated that most contracted hours for the GRNs were 40-hours per week. Two metropolitan hospitals (one tertiary and one secondary) indicated that GRNs' were contracted to 37-hours per week, and this was considered full-time. One private organisation's graduate nurse coordinator considered full-time as 35-hours per week. It would appear from the data that the equivalent of half of full-time (20-hours per week) is the minimum the GRNs were allowed to work. It is unclear from either the primary survey questionnaire, or the secondary web-based survey, whether those graduates working at half of full-time were required to lengthen their GNP in order to gain the basics of the transitional experience. Some organisations are reluctant to offer part-time GNPs

as they believe any extension to the time it would take for the novice to be deemed competent may discourage the GRN from continuing in the program, particularly when they witness their peers advancing at a more rapid pace (personal communication with SDN).

Considering the above, it is of some concern that of those graduates who did not participate in a GNP, the reason given by four respondents was a lack of part-time options. Individual organisations develop their own policies in this regard, and there is no overarching authority to deem otherwise. It is possible that those new graduates were not made aware of the organisations that do offer part-time positions in their transitional programs to enable them to make a more informed choice in regards to participating in a GNP. While it is imperative that contemporary nurse leaders consider the changing needs of newer generations of nurses, the impact that the increasing number of nurses who choose to work part time, and the effect that this will have on final Full Time Equivalent (FTE) numbers of nurses, must also be factored into future workforce planning.

5.4.4 Levels of Support

A sufficient level of support from colleagues, supervisors and mentors enables the new graduate to more easily translate theory into practice, and to develop the confidence and competence required for their new RN role (Johnstone, et al., 2008; Morrow, 2009; Myall, et al., 2008).

Lack of support has often been cited as a problem in transitional programs (Bartram, et al., 2004; Levett-Jones & Fitzgerald, 2005; Morrow, 2009) so it is encouraging to see that the overall levels of support, as perceived by the GRNs in the

current study, was portrayed primarily as *Very Good* to *Extensive*. Between the first and consequent specialty rotations, the data depicting the degree of perceived support of the GRNs from the Program Coordinator and the Clinical Nurse Manager/ Specialist/ Consultant showed some improvement, most often in the rural and private sectors. This general improvement over time may be attributable to the GRN becoming increasingly confident within their role, and in contributing more to the unit as a productive member of staff. Conversely, the perception of support from the SDN appears to have diminished in consequent rotations, more often within the secondary and private sectors. It is likely that at the commencement of their first rotation, the initial SDN support given to the GRNs is quite intensive, but able to be tapered off as the GRN's confidence and competency increases. Additionally, there are often new intakes of GRNs who, at the beginning of their term, would require the same concerted levels of support from the SDN as did their predecessors. This would account for the reduction in the perceived levels of support from the SDN in consequent rotations. The following comments are indicative of how appreciative the GRN is when provided with appropriate levels of support:

> *Excellent education sessions from SDNs and CNs. Great support from other nursing staff.* (Critical care unit, tertiary hospital.)

> *Excellent staff assistance when required; exposure to medical, surgical, paeds* (paediatrics) *and midwifery on the private ward.* (Medical, surgical, paediatrics, private hospital.)

> *Great staff, very supportive, good skill mix, plenty of experienced, senior staff.* (Medical ward, private hospital.)

> *The CN and ward coordinators were very good, patient and helpful. Staff very helpful and supportive.* (Surgical ward, tertiary hospital.)

> *All staff were extremely welcoming and supportive, working in a rural hospital gave a broad overview of many nursing scenarios.* (Surgical, community, rural, emergency, perioperative; large rural hospital.)

By the third rotation, the incidence of reported *occasional* or *negligible support* shows a marked increase across all categories. The surmised rationale for this, as previously referred to, suggests that the support personnel may be focusing the majority of their attention on new intakes of graduate nurses. It is also likely that an assumption has been made by the ward or unit staff that by the third rotation, the GRN will have gained a moderate level of proficiency and therefore, not require as intense support as that needed in the initial stages of transition. This concept is supported by comments related to the GRNs' perceptions of growing competence and confidence and that is discussed in the following sections.

5.4.4.1 Staff Development Nurse Support

The SDN role is one that has responsibility for the clinical training and education of nurses within a specified area of an organisation, in particular, those new to the organisation or profession. A dedicated resource to support the GRN is obviously important to GRNs. This is demonstrated within their comments below, in response to how GRNs believed their transition program could be improved, and suggesting that SDN support should be increased:

> *An increased SDN role on ward at first when beginning rotation – then there is always someone to point you in the right direction.* (Secondary hospital.)
>
> *More SDNs.* (Tertiary hospital.)
>
> *I was employed during a transitional time at the hospital where there were no staff development people employed. At the time this impeded my experience and education.* (Private hospital.)
>
> *Having extra support and encouraging SDNs to be more available and willing to help their graduates.* (Secondary hospital.)
>
> *More active SDNs who are actually on the ward, not just in their office.* (Secondary hospital.)

Senior staff may be perceived by junior nurses as not always being present in a clinical capacity. When nurses take on roles that carry more responsibility, the position obligation increases, as does the accountability and associated administrative tasks. This time taken away from clinical duties may lead others, who are unfamiliar with the role requirements, to perceive an incumbent is not fully engaging in the workload and is often expressed as in the comment above.

An option of *other* was included in the choices to indicate the source of support proffered to the GRNs was, and when chosen by them, was shown to be mainly from fellow graduate nurses; these were either as part of the ward staff, or via graduate nurse networks, suggesting that peer support was highly valued by the GRN.

5.4.4.2 Clinical Coach

Among the tertiary hospital GRN respondents, *clinical coach* featured strongly within the comments related to *other* designated sources of support. Graduate nurse coordinator respondents from two tertiary hospitals described deploying a *clinical coach*, a relatively new role that is still in the process of being developed and formalised, and consequently, one for which there is a dearth of literature available. The clinical coach is described as a trained mentor and available exclusively to new graduates within the first few weeks of their transition. The clinical coach does not have patient responsibilities, is paid at the level of a second tier RN (Level-2), and assists the SDN role in supporting the graduates, and in guiding them to attain the core competencies necessary to enable them to be deemed to have achieved the program requirements. Formal review of the role has shown that GRNs experience lower levels of anxiety and stress and integrate into the workplace more quickly when there is a clinical coach presence (Webb, 2011). Once the graduate has

assimilated into their first unit, the attention of the clinical coach is able to be reduced. The clinical coach role would appear to fulfil a good deal of the initial support needs of the novice nurse, suggesting that for those organisations offering transition programs, implementation of the role would be a worthwhile concept. The position is a temporary role so it has fewer financial implications, and as such, would benefit sites that are less well resourced. Additionally, as appointment to the role is temporary, the competitive recruitment process to it would ensure the position applicants remained cognisant with contemporary transition practices.

> *Clinical coach used at* [xxxx]. *A senior nurse was assigned to all grads and did not have a patient load.* (Medical ward, tertiary hospital.)

> *We had a clinical coach and graduate support people who touched base; extra people just for our rotation.* (Surgical ward, tertiary hospital.)

A recent concept in the literature related to support, particularly in connection to Mental Health nursing, is that of *clinical supervision* (Brunero & Stein-Parbury, 2008; Taylor & Harrison, 2010), and appears to be a similar role to that of the clinical coach. Clinical supervision is described as a method of assisting the novice nurse to develop their competence and confidence through a process of reflective practice, whereby time with an accomplished colleague is made available to discuss recent clinical experiences in a supportive and non-threatening environment (Taylor & Harrison, 2010). While the notion has merit, the recurrent theme of insufficient resources within the nursing workplace for even rudimentary mentorship may pose a dilemma for industry. As such, the clinical coach may be a more appealing option.

5.4.4.3 Graduate Nurse Program Coordinators

The GNP Coordinator is responsible for bringing together the components of a transition program. This generally involves marketing of the program to

undergraduate nurses within the universities; recruitment of potential graduate nurses via the GNC consortium; liaising with specialty units for GRN placements; development of program guidelines; and negotiating for appropriate supports to be in situ for all the elements of the program. The role may also include organising study days for the GRNs, training for preceptors, and assuming the role of mentor to the GRNs within their organisation. In their discussion of graduate nurse residency programs Poynton, Madden, Bowers, and Keefe (2007) describe the role of the program coordinator in relation to providing knowledgeable guidance and support, while also presenting as a role model and confidante to the novice nurse. Research by Cubit and Ryan (2011) found that the consistent presence of a graduate nurse coordinator was able to modify the stress and anxieties of new GRNs by enabling more timely debriefing sessions within a safe, non-threatening environment. These researchers suggested that the graduate nurse coordinator was able to take on the role of a mentor, and in doing so, allowed the preceptor to take on a more supervisory role and to provide clinical direction and constructive advice when required.

While the majority of graduate nurse coordinators appeared to be at a SRN level, some of the secondary and rural graduate nurse coordinator respondents indicated the position was held by an incumbent on a lesser level. It is postulated that the more senior level of coordinator or educator would be better placed to determine program deficits and initiate change. The following graduate nurse coordinator comments indicate some of the issues that are faced by the less resourced sectors in relation to managing graduate nurse transition programs, and how a more senior level of nurse may be better placed to manage these:

> *First year I have acted as GNR* (Graduate Nurse Recruiter) *so I am learning as I go.* (Small rural.)

> *Our program will be under review at the end of this year. Our difficulty for our program is having a dedicated person, being in the (*semi-remote area*) if staff resign it takes awhile to recruit. This has led to some difficult times in the past.* (Large rural.)

> *We are hoping to have fulltime GNP Coordinator that can travel to smaller hospitals.* (Large rural.)

> (In response to guidelines governing GNP) *I can't answer this as the program is run from* (distant hospital over 1,000 kilometres away)*; we are allocated grads at* XX *as part of their rotation. They work only on our general ward and are allocated a preceptor. We work through their* (the GRN) *WACHS* (Western Australian Country Health Service) *transition to practice workbook, and follow the ANMC* (Australian Nursing & Midwifery Council) *Competency Standards.* (Small rural.)

These comments would appear to support the notion that a more appropriate level of senior nurse would be in a stronger position to negotiate resources and adherence to program guidelines. Health Workforce Australia (2011b) call for reform in the way health leaders and managers are educated, suggesting that while most are clinically knowledgeable and skilled, many may lack the essential leadership qualities that will ensure appropriate structures are established, and innovate solutions applied to emerging problems. A graduate nurse coordinator with strong leadership characteristics will be more able to provide appropriate direction and education, as well as acquire the resources necessary to ensure the GRNs' transition is strongly supported.

The tyranny of distance within the WACHS is seen through multiple aspects of delivering an appropriate healthcare service, from attracting suitable and sufficient medical, nursing and allied health staff, to being able to provide specific clinical expertise to the smaller populations when required. The advent of video conferencing and other electronic means of communication have assisted in reducing the void somewhat, however, its use assumes the technology and access is readily

available, but in some of the more remote areas of the state, this is not always the case (Newman, Martin, McGarry, & Cashin, 2009). Consequently, regular contact and support with senior staff may, at times, be ad hoc and somewhat less than is desirable (Lea & Cruickshank, 2007). As implied by the above comments, many of the programs in the smaller rural sites are governed by larger organisations, and often from a considerable distance away. In terms of the best use of resources, this would appear to be an efficient concept. However, it behoves these organisations to ensure that their communication facilities and support structures are used optimally, and that the GRN is provided with the best possible opportunity to develop into a competent and confident practitioner. Similar resource limitations are apparent in some of the metropolitan secondary hospitals.

5.4.4.4 Aspects of Support

Supportive comments also featured strongly in areas that the GRNs perceived were *benefits* of the specialty rotations and demonstrate that the *support* was proffered from a variety of sources:

> *Very high acuity, quick turnover, excellent support, great communication with allied health staff and between medical team.* (Medical ward, tertiary hospital.)
>
> *Extensive preceptor support.* (Perioperative, private hospital.)

The importance of adequate support to the transitioning graduate nurse cannot be underestimated. Critical thought affecting clinical judgement can only be developed through knowledge acquisition and exposure to clinical experiences (Fero, Witsberger, Wesmiller, Zullo, & Hoffman, 2009; Reilly, 2005). Subjecting novice nurses to unsupported clinical situations beyond their scope of practice has been shown to diminish patient safety (Garling, 2008; Johnstone, et al., 2008; Morrow,

2009), and influence a nurse's decision to maintain tenure within the nursing workforce (Heath, 2002; Takase, 2010). These issues and their ensuing effects are clearly demonstrated in the following GRN comments:

> *I would have learnt a lot more about critical thinking with some support.* (Medical, tertiary.)
> Note: in her consequent rotations, this nurse wrote: *fantastic education enhanced learning experience.*
>
> (Support) *varied from poor to excellent, depending on staff/SDN/CNS on the ward/department.* (Medical, aged care, mental health, secondary hospital.)
> Note*:* this nurse commented in 5-year vision as: *not sure if I will still be nursing.*
>
> *Management was unsupportive, huge patient loads, unfair rostering; grads not welcome at staff in-services.* (Medical/palliative, secondary hospital.)
> Note: this nurse commented in 5-year vision as: *working - ? where. Bit over nursing already.*
>
> *Acuity of patients relative to my experience. Inadequate staffing. Not knowing what I was doing and not having other staff who were willing to help. The skill mix during this rotation often meant grads were 'educating' other grads – a severe lack of support.* (Surgical, tertiary.)
> Note: This nurse chose to remain in his next rotation: *I have stayed in the Unit because it was an easier workplace than the first rotation. It is a better supported unit; they have catered to my time availability as I have returned to university to study in a different field. I always knew that I wouldn't be a nurse on the wards forever, but I envisaged doing it for approximately a decade. I now feel that as soon as I can find another profession within my field of study, I will leave nursing and probably not return to the job.*
>
> *High work load, very complex patient histories, no support, staff too busy, too many ENs and not enough RNs in Regional areas. Felt like you were dropped into nursing and you had to sink or swim. Unsafe for patient's care.* (Medical/surgical, large rural hospital.)
> Note: this nurse commented in her third rotation: *only myself on shift dealing with A&E* (Accident and Emergency) *patients with limited knowledge.* Following completion of her GNP she chose to work in a different organisation and a specialty where she had previously felt supported.

These comments clearly demonstrate the importance of strong and consistent support systems; the effect it has on the GRN, their perceived delivery of safe patient care, their overall concept of the nursing profession, and their intention to remain within it. It is imperative that the nursing profession ensures that all newly graduated nurses are proffered adequate and appropriate support and, more importantly, that areas known to be lacking in sufficient resources, such as the rural sector, are provided with the means to provision these. As depicted in the following graduate nurse coordinators' responses, it would appear that procuring resources to provide suitable support to the novice nurse is a difficult and ongoing challenge in a number of the rural and secondary sectors.

> *Would prefer my only job was GNP coordinator so I could find the time to introduce more innovations and changes.* (Metropolitan secondary.)

> *Our difficulty for our program is having a dedicated person. Being in the* (location)*, if staff resign, it takes a while to recruit. This has led to some difficult times in the past.* (Large rural.)

GRN respondents from tertiary hospitals provided more positive responses in regards to overall support systems and program structure. This outcome correlates with the more structured systems that were described by the graduate nurse coordinators from this sector. Data from the graduate nurse coordinators indicated that all tertiary hospitals had a combination of senior level graduate nurse coordinators and educators (SRN), supported by staff development nurses, and in many cases, clinical coaches at a midway seniority grade (Level-2). Some of the graduate nurse coordinator respondents from secondary and smaller rural organisations indicated only a mid-grade nurse was available as the senior coordinator and/or educator. Given that support and guidance of the graduate, and the unit staff working with them has been shown to have a positive impact upon the

transitional experience of the novice nurse (Cubit & Ryan, 2011), it is important to consider the benefits that a more senior nurse may have in facilitating this. Organisations need also to ensure recruitment and retention of suitable nurses as support resources.

5.4.5 Benefits of Specialty Rotations

Following the set of closed questions related to each rotation, open-ended questions were asked to elicit what the GRNs perceived were the benefits, problems and stressors that they had encountered within that particular specialty, with a view to gaining some insight into their experiences, and how they felt these had impacted upon their transition. Comments regarding the perceived *benefits* of the GRNs' first rotation related predominately to the *learning* of new knowledge; and the acquisition of *clinical* skills; followed by the *support* received; and the development of *time management* skills, as is demonstrated in their textual responses:

> *Great opportunity to develop time management skills and improve on basic nursing skills, i.e., IVABs* (Intravenous Antibiotics). (Medical unit, tertiary hospital.)
>
> *Fantastic staff at ward level, sense of learning and achievement, feeling part of the team, lots of feedback from ward staff.* (Mental health, tertiary organisation.)
>
> *Practicing basic care, confidence building with medications and communication.* (Rehabilitation unit, tertiary organisation.)
>
> *Good grounding, managed good time management skills. Became competent with narcotic administration post surgery.* (Surgical unit, secondary hospital.)
>
> *Looking after technology dependant patients, basic respiratory assessment skills improved.* (Paediatric medical unit, tertiary hospital.)
>
> *Learnt to deal with stress, learnt small bits about lots of things.* (Aged care, rural.)

> *Gaining surgical knowledge, for example, PCAs* (patient controlled analgesia pumps)*, epidurals, drains, dressings.* (Surgical unit, tertiary hospital.)

> *Lots of dressings, IVABs, basic nursing care* (skills increase)*, team nursing – good when partnered with experienced nurse not when with a non-medication competent EN with 10 patients on IVABs.* (Medical unit, private organisation.)

In the second rotation, the majority of graduates (56.5%) again indicated that the process of *learning* was the greatest *benefit*; followed by comments that were themed as *clinical* (41.3%), *support* (34.8%) and *time management* (8.7%). While the ranking of the most common responses in the second rotation were the same as the first, the percentage of the whole number of responses increased for all, with the exception of *time management,* which decreased by more than half from that of the first rotation proportion. This suggests that, by the second rotation, the novice nurse has begun to overcome the challenge of managing, and more effectively prioritising, a full patient workload, hence the reduced focus upon *time management*. Textual responses from their second rotation experiences demonstrate that acquiring further knowledge and clinical skills were perceived as important to the GRN:

> *First-hand view of challenges in community. Very flexible time management needed.* (Community health, large rural.)

> *Learnt a lot of clinical skills such as insertion of NGT* (naso-gastric tube)*, IDCs* (indwelling catheters)*, plenty of opportunities on surgical ward* (Surgical ward, private hospital.)

> *Another busy ward exposed to everything quickly, makes you learn quickly. The staff development nurse was very proactive and hands on. She spent time with each of us discussing our patients each shift and suggested learning opportunities to develop our skills and knowledge.* (Surgical ward, tertiary hospital.)

> *Types of patients, complex co-morbidities, care of dying patient, oncological / haematological malignancies.* (Medical ward, tertiary hospital.)

> *Great support from ward staff. Well structured and outlined. Provided with education plus, plus, plus.* (Surgical ward, tertiary hospital.)

Third rotation respondents once more, found *learning* to be of the greatest benefit, with an equivalent proportion of related responses as for the second rotation. *Support* moved to the second most common theme (29.7%) and *clinical* shifted to a lesser ranking (21.9%) with *time management* remaining the same (8.7%) as shown in the respondents' comments:

> *It required me to develop a set of nursing skills that was normally neglected in a medical setting.* (Mental health unit, secondary hospital.)

> *Acute setting mental health learning to identify patients that may go unnoticed on wards.* (Mental health, tertiary hospital.)

> *Getting a good grounding in all cardiac, metabolic and other medical conditions. Knowledge of commonly used drugs.* (Medical ward, secondary hospital.)

> *Builds nursing skills very well, ability to work independently.* (Perioperative unit, tertiary hospital.)

By the third rotation an additional theme of *confidence* had become evident with 7.8% of respondents indicating it to be a *benefit* of that rotation. This finding supports the theory that for the novice nurse to develop self-assurance in their nursing practice, the path to proficiency requires sufficient time to build upon basic knowledge and skills, as is revealed in the following GRN textual data:

> *Increasing confidence, learning to manage surgical lists.* (Perioperative unit, tertiary hospital.)

> *Getting to be more confident in dealing with sick cardiac patients. Working independently, very good environment.* (Critical care unit, tertiary hospital.)

> *Great staff! Always willing to help if available. Improved my time management skills and self criticism* (critique). (Medical unit, large rural hospital.)

These comments clearly suggest that growing levels of confidence and nursing skills are achieved with each new rotation, a concept supported by similar research (Evans, et al., 2008; Reilly, 2005; Reeves, 2007). Whether the same levels and rates of confidence and competence would be gained by those who chose not to participate in a GNP is not able to be determined from this study, but is worthy of further research.

5.4.6 Problems and Stressors of Specialty Rotations

To enable registration as a RN with the NMBA, the newly graduated nurse must possess the basic knowledge and competencies relative to the profession. However, and as discussed previously in relation to the theory-practice gap, the dichotomy of thought between academia and industry can result in expectations that do not match reality. This often results in the novice nurse encountering issues and confronting experiences that are not found in most other professions. For many GRNs the transition from the relative safety of the theoretical arena to practice is a highly stressful experience, and many fear they lack the knowledge or skills to safely deliver appropriate nursing care (Goh & Watt, 2003; Levett-Jones & Fitzgerald, 2005). Furthermore, expectations by unit staff that GRNs should be fully practice-ready may be unrealistic. Such expectations add not only to the degree of anxiety experienced by the novice, but may reflect poorly on the organisation as a supportive environment (Morrow, 2009; Reilly, 2005). Adequate and timely support, particularly in the initial stages of transition to practice, have been found to directly impact on the sense of confidence and developing competence of the newly graduated nurse (Johnstone, et al., 2008).

5.4.6.1 Perceived Problems

In their initial specialty rotation, GRN responders who were in a secondary level hospital were more likely to indicate that a *lack of support* was considered a *problem,* with 26.7% denoting thus. Respondents from tertiary hospitals were the least likely to report a *lack of support* as a *problem*. Further breakdown showed that more than half of those who depicted *lack of support* as a *problem* (57.6%) were aged less than 30 years, and almost half of these (48.5%) had not indicated any prior employment in a health related occupation. Such data suggests that those GRNs who are older, and those with prior health care experience may perceive support levels in a more positive light than those who are younger, and without the benefit of previous exposure to the healthcare environment. Those who had attended University D as an undergraduate nursing student showed a slightly higher proportion of respondents (22.2%) who indicated problems related to a lack of *support* than did those from other universities, with University A showing 21.2%, University B 20.2%, and University C the least (14.3%). These differing levels of perceived support may also be related to the health sector the GRNs were employed in, as the greater proportion of University D graduates indicated employment in the private sector and those from University C were predominately within the tertiary sector. Conversely, University D also had the greatest proportion of respondents indicating that they had *no problems* in their first rotation and University C showed the lesser proportion of graduates (9.5%) indicating they had *no problems* during their first rotation. It needs to be noted however, that these two universities had the least number of nurses in the total graduate nurse research population, and therefore, any conclusions drawn from the data need to be viewed with caution. The following statements of perceived

problems seem to suggest, once more, that appropriate support was an important factor in shaping the GRNs' perceptions of their transitional experiences.

> *Assigned preceptor was part-time, then went on holidays so no set preceptor - was an issue in terms of support which is crucial in this first rotation.* (Surgical ward, secondary hospital.)
>
> *Staff not always supportive and grads often given most difficult patients.* (Medical unit, secondary hospital.)
>
> *Having little or no support from program coordinator and no staff development at times.* (Medical unit, private organisation.)
>
> *Nurse manager very critical, occasionally abusive. Other staff too busy to help. Usually the only feedback you get was when you did something wrong.* (Surgical ward, private hospital.)
>
> *High numbers of graduate nurses, ward staff not very helpful, negative staff morale.* (Surgical unit, tertiary hospital.)
>
> *Lack of 1 or 2 support people that were dedicated to transition period and assessments.* (Surgical, community, emergency, periop, large rural hospital.)

Research by Bartram, et al. (2004) found that job satisfaction increased and stress decreased when there was positive support given to the GRN from nursing colleagues and supervisors, a finding that was supported by Tervo-Heikkinen, et al. (2008), who also discussed the concept that an increase in nursing practice standards corresponded with a reduction in adverse patient events.

Three respondents cited they had felt they were not wholly using their knowledge and skills gained during their undergraduate education. All three had indicated their undergraduate nursing program was at University A; were in the 20 to 29 year-old age bracket; female; and had not specified prior health care experience before graduating. The age group and lack of prior health care experience may be relevant in terms of contributing to the theory-practice gap and consequently feeling

that there was dissonance between the knowledge they had acquired in university, and their ability to apply it to the workplace. The specialties they were assigned to for their first rotation were paediatrics, rehabilitation and mental health, all of which are somewhat more challenging than most specialties, and therefore, may not have received sufficient exposure to them during their undergraduate years. Two of the three GRNs indicated future careers in nursing, however, the third had resigned during her graduate program to pursue a non-nursing degree:

> *Feeling of losing basics learnt at uni, support staff not at this hospital, even though part of program.* (Paediatrics, tertiary.)
> Note: this nurse indicated a future career plan *'not in nursing'*.
>
> *Felt that I didn't consolidate knowledge learnt at uni as that was more focused on medical and surgical nursing.* (Mental health.)
>
> *It was boring, no use of uni knowledge; lack of some education for looking after 'ward outlier' patients* (Patients who do not fit the unit specialty profile). (Rehabilitation.)

In subsequent rotations, there were greater proportions of respondents notating that they had *not* experienced *problematic* areas. The primary theme depicted by those respondents who did report areas they felt were *problematic* was again *lack of support,* and was more commonly reported in their second rotation than in their first. As discussed previously, this may have been as a consequence of support staff considering the GRN required less support than in their earlier rotation, and the initial level of support shifting to new intakes of graduate nurses. *Busyness, lack of competence, poor skill-mix* and *bullying and harassment* continued to be reported by the graduates as perceived problems, and at a similar rate to that of the first rotation. Additionally, themes of *poor communication* (6.5%) and *unprofessional behaviour* (5.6%) emerged in this rotation, which may indicate an emerging awareness of the less favourable aspects of some organisational cultures. Again, those who believed

they were *not using skills* learned in their undergraduate nursing program (2.8%), or where the work was *repetitive or boring* (4.7%) were apparent. The issue of *program structure* began to feature in this rotation with 4.7% (n = 5) indicating thus, as depicted in the following comments:

> *Complex assignments while trying to learn a completely new area.* (Perioperative, private hospital.)
>
> *Not enough study days.* (Medical unit, large rural hospital.)
>
> *Lack of supernumerary time.* (Surgical unit, tertiary hospital.)
>
> *Lack of adequate supernumerary time.* (Medical / surgical unit, large rural.)

In their second rotation, those GRNs who had attended University B as an undergraduate nursing student indicated the highest proportion (32.4%) of problems related to *support* in comparison to the other universities; University A attendees indicated 22.4% had *support* related problems, University D demonstrated no change from the first rotation (22.2%), and University C again, showed the least, but with somewhat more (21%) than that reported in the first rotation (14.3%). The University B cohort indicated the greatest (35.1%) and University C the least (10.5%) proportion of their graduates denoting that they had *no problems* during their second rotation. Some the issues the GRNs felt were a problem during their second specialty rotation are depicted in the following comments:

> *Lots of GRNs but not always enough senior staff.* (Surgical ward, tertiary organisation.)
>
> *Some staff members expecting and pressuring graduates to do more work than they can handle*. (Medical unit, secondary hospital.)
>
> *Not trained in mental health. Limited support or teaching.* (Community mental health, large rural hospital.)

> *No clinical coach available due to budget restrictions.* (Surgical unit, tertiary hospital.)

> *Adjusting from the way RNs worked in the country as opposed to the city, as in communication with colleagues and issues regarding clients.* (Domiciliary, small rural hospital.)

> *Ward very heavy and busy, sometimes no actual support staff, so you had to rely on ward staff and they were busy too.* (Surgical ward, tertiary hospital.)

Further exploration into the number of undergraduate clinical placements, and their type and duration may reveal plausible associations between them and the resultant transitional perceptions of the novice nurse.

While possibly indicative of an evolution in graduate confidence and assertiveness with colleagues, plus a greater awareness of what is, and is not, acceptable behaviour in the workplace, the increase in comments related to *poor communication*, *unprofessional behaviour* and *bullying* is of concern:

> *The ward was a basket case, poorly run. Many practice issues on this ward. I could feel myself becoming increasingly depressed and deskilled.* (Medical / surgical unit, private hospital.)
> Note: this nurse transferred to a different private hospital to complete a second GNP year but was clearly affected by the negative experience in her second rotation.

> *Some of the staff were unprofessional and unwelcoming in our first month.* (Medical unit, tertiary hospital.)

> *Bitchiness between staff, arrogant surgeons to deal with.* (Medical/ surgical unit, private hospital.)

> *Nurse Manager was difficult to approach, did not respect rostering requests and personal needs.* (Medical/ surgical unit, tertiary hospital.)

> *Some doctors are very rude to nurses and you constantly had to chase them up to do things.* (Medical and surgical unit, tertiary hospital.)

It is possible that those charged with managing difficult behaviours in the workplace are not sufficiently skilled in negotiating this difficult process, and consequently, the negative culture remains unchanged, as is suggested in the above GRN comments.

Only a few respondents (n = 8) indicated that they had participated in a fifth specialty rotation. Although the cohort was small, a new theme emerged related to *problems* and was coded as *lack of respect*:

> *Some staff not prepared to accept my judgement, treated like a student.* (Emergency, large rural.)
>
> *Lack of respect from younger staff.* (Medical, surgical and emergency, large rural.)

As both these respondents were of the 50-plus age category, it is conceivable that their perceptions could suggest that the graduates were beginning to develop a sense of identity and competence as they became more proficient in their RN role, or alternatively, may stem from a generational gap. Leiter, et al., (2009) suggest that the differing values held between the generations have the potential to generate conflict within the workplace and that the older graduate nurse may find it confronting to take direction from a possibly much younger, albeit more clinically experienced, colleague.

5.4.6.2 Perceived Stress

As well as seeking information related to what the GRNs had perceived as problematic areas within a specialty, a second question asked 'what caused the most *stress* for you in this rotation?' The rationale for including a separate question in relation to the difficulties encountered by the GRNs was based upon research by Evans (2005) suggesting that some experiences may be perceived as a problem but

are not always considered a stressor, and vice versa. This notion was evident in the current research where *workload* emerged as the leading cause of perceived *stress* as reported by the GRNs; as opposed to *lack of support* that was the more prevailing theme of perceived *problems*. Notwithstanding this, *lack of support* still featured strongly amongst the *stressor* themes.

While in the first and second rotations comments related to *workload* and *lack of support* formed the majority of the *stressor* themes, in the third specialty, the more common theme emerged as *lack of support*. It is feasible that as the GRN became more proficient, and was able to manage assignments more effectively, the perception of heavy workloads eased. The secondary hospitals had the greatest ratio of respondents citing a perception that their *workload* was a major *stressor*, and respondents from the tertiary organisations had the least. It is possible these disparities reflect inadequate nurse-to-patient ratios in the smaller sites. Concepts of *workload* causing *stress* are described in the following GRN comments:

> *Work routine. Caring for critically ill patients. All machine settings, ECG monitor, ventilator, blood test reading, all requiring a lot of study.* (Critical care, tertiary hospital.)

> *Poor skill mix on ward. Stress amongst staff and manager, pressure from manager on staff.* (Surgical ward, private hospital.)

> *Patients going septic quickly, palliative patients and their family.* (Surgical ward, tertiary hospital.)

> *The heavy workload and greater expectations on my inexperience caused my health to suffer.* (Medical unit, secondary hospital.)

> *Physical demands of lifting, rolling patients often without enough staff to assist.* (Medical ward, private hospital.)

> *Thrown in – everyone too busy – very stressful.* (Emergency unit, secondary hospital.)

The rural sector had the largest proportion of respondents who perceived that *lack of support* was a major *stressor* and is consistent with previous discussions related to areas perceived by the GRN as *problems*. As was found in the section that related to perceived *problems*, the smallest proportion of respondents where *lack of support* was considered a cause of *stress* was from the tertiary hospitals.

In the consequent rotations, and unlike the first rotation, the second most commonly mentioned source of *stress* was a *lack of knowledge*. When tabulated against the type of organisation that the respondent worked in, both the tertiary and the secondary sectors demonstrated the largest proportion of respondents reporting a *lack of knowledge* had contributed to *stress*. This emerging perception may be related to a growing self-awareness within the GRNs as they begin to develop basic skills in critical thinking and, as a consequence, recognise the enormity of the knowledge scope that the profession of nursing encompasses. Their undergraduate education is aimed at providing the foundation upon which the novice nurse will build their clinical knowledge and skills, and that will lead them to ongoing competence and proficiency. Consequently, the learning acquired in the undergraduate nursing education is often of a different nature than that experienced in an ongoing industry setting (McKenna & Newton, 2008). The following GRN comments are indicative of the stress experienced in attempting to apply their skills and knowledge to rapidly changing clinical situations:

> *Learning how to deal with machine alarms and dealing with 'crashing' patients.* (Medical unit, tertiary hospital.)
>
> *Patients' conditions can change so quickly and critical thinking* (needed) *plus, plus, plus. Have to be fully alert and knowing what to do.* (Critical care, tertiary hospital.)

Lack of experience, feeling unsafe to practice. (Surgical unit, tertiary hospital.)

The novice is required to quickly and consistently develop new skills and learn to be assertive in communicating with not only the patient, but with colleagues as well, including those who may appear less than receptive to a junior member of staff (Delaney, 2003). On several occasions, poor *communication* was cited as an issue causing *stress* and related mostly to colleagues and, on two occasions, to medical staff. Such occurred predominately in the tertiary sector (n = 6), with four respondents working in surgical and one each in medical and perioperative units:

The staff being hard to communicate with. (Same day unit, tertiary hospital.)

Strong personalities amongst staff; conflicting advice. (Perioperative unit, tertiary hospital.)

Lack of staff, increased workload. Destruction of confidence by other staff. (Surgical ward, private hospital.)

Being excluded from ward meetings because 'I'm a grad'. Lack of support by ward staff. (Surgical ward, tertiary hospital.)

Novice nurses often struggle with coming to terms with the demands of their new RN role. Such a stressor may be compounded when senior, and apparently more experienced nurses demonstrate hostile or dominant behaviours (Duchscher, 2009). Most people have a natural desire to want to feel part of a group and socialisation forms part of adaptation to a new environment (Turner, 2009). Occasions of unfair allocation of workload and/or unsociable shifts (weekends and evenings) were cited by the GRNs in the current research and are issues that have also been reported in other studies of graduate nurse transition (Evans, 2005; Lea & Cruickshank, 2007). When there are perceptions of unfair work allocation, or

communications, GRNs are generally reluctant to speak up due to a desire to be part of the unit culture; for fear of ridicule; or being made to feel incompetent (Duchscher, 2009; Evans, et al., 2008). Additionally, older, non-university educated nurses are often likely to be implicated in issues related to poor communication (Kelly & Ahern, 2009; Leiter, et al., 2009). Conversely, the experienced, knowledgeable nurse is in a prime position to mentor and support the novice nurse through these experiences and many of the comments in other sections clearly demonstrate this to be the case. It is feasible that these occurrences of seemingly poor communication and workload allocation may have been ameliorated if a suitable mentor was available to intervene on the GRN's behalf.

The importance of an appropriate mentor with whom the GRN is able to debrief and perhaps, improve their experiences during their GNP is highlighted in some of the responses reflecting the graduates' stressful situations. The following comments rather succinctly demonstrate the variety of issues the GRN may experience transitioning from novice to competent nurse.

> *Drug errors I made!* (Surgical unit, tertiary hospital.)
>
> *Struggling with whether or not nursing was for me.* (Day procedure unit, tertiary hospital.)
> Note: this nurse left the profession to study a different, health related career.
>
> *Nature of the ward, very distressing and sad sometimes.* (Medical ward, tertiary hospital.)
>
> *Not having someone to talk to when needed.* (Medical unit, secondary hospital.)
>
> *The seriousness of some situations.* (Emergency department, tertiary hospital.)

Difficult events experienced in the workplace create stress and anxiety. Open disclosure and frank discussion are important tools to reduce the emotional impact of these experiences and to monitor that coping strategies are appropriate. Informal opportunities to debrief are often unavailable to healthcare workers due to the increasing busyness of their workloads, but alternatives, generally in the form of counselling, such as Employee Assistance Programs, are usually made available. In the current study, many GRNs found that the study days were an opportunity to network with fellow graduates and rated this opportunity highly, particularly in terms of being able to discuss their experiences. It may be of benefit to the novice nurse to ensure adequate provision of regular, informal networking opportunities, where they are able to share their experiences in a more relaxed and supportive environment (Welding, 2011); or alternatively, make certain that they are fully cognisant of how to source support systems should these be required. In an effort to facilitate an informal communication network for GRNs, the NMO has recently explored the option of developing a facebook page to enable discourse between nursing peers. This is still to be finalised (R. Newton, Marketing & Events, NMO, WA Health Department, personal communication, May 28, 2012).

Formal debriefing is particularly important for staff involved in sentinel events where a patient has experienced either serious outcomes from the provision of medical care, or indeed, has deceased. The emergent theme of patient death as a stress inducer came primarily from the GRNs who were working in the tertiary sector. Many of the associated specialty rotations were in either medical wards or critical care units, locations where there are a higher likelihood of such events occurring. Witnessing a person's end of life of is always confronting and is an

experience that is difficult to prepare for, particularly when the patient has yet to experience life to any real extent.

> *Emotionally coming to terms as a young nurse that children get sick and die.* (Paediatrics unit, private hospital.)

> *In my first week on my own, 3 patients that I had* (looked after) *passed away, there was no form of debriefing for me.* (Medical unit, tertiary hospital.)

> *On a very busy ward with very sick patients and many deaths.* (Medical unit, tertiary hospital.)

> *Learning about nursing management for stroke patients as it wasn't something I had come across. Plus it was my first time I had nursed a palliative patient who then died during my shift.* (Medical unit, secondary hospital.)

In a US study of transition experiences, similar distress was experienced by graduate nurses when they were first confronted with the issue of death and dying (Delaney, 2003). The author of that study concluded that death and dying, and developing strategies to cope with the event, was a topic that required more attention and further discussion in the undergraduate curriculum. An education package would seem a valuable option and was described by Thompson (2007) as including formal clinical experience within a hospice facility that involved pre and post briefing within a protective environment. Debriefing following a patient's death enables those who have been involved in the patient's care to explore coping strategies, and to help manage the emotional distress that is part of witnessing such an event. It would appear that appropriate measures for assisting the GRN to deal with such stressful situations may be lacking in some organisations.

The third specialty rotation data demonstrated an increase in comments related to a sense of lacking *competency* and may be indicative of the GRN developing their

ability to self reflect and to better understand the complexity of the role of the RN. Deficits in understanding the needs of the novice nurse in some sectors were also apparent, as is demonstrated in the following GRN comments:

> *Sense of a lack of training to be prepared for the area of mental health nursing*. (Mental health unit, secondary hospital.)
>
> *Initially working out drug dosages much smaller than before.* (Paediatric unit, private hospital.)
>
> *With limited critical care experience; looking after critical patients can be stressful at times.* (Critical care, tertiary hospital.)
>
> *Only myself on shift. Dealing with A&E* (Accident and Emergency [Department]) *patients with limited knowledge.* (Third rotation, large rural hospital.)

The final comment is of concern. The graduate nurse coordinator from a large rural organisation indicated that towards the latter stage of their program the graduate was the only RN on a shift. As the graduate would still be consolidating knowledge and skills at this stage, this poses a significant risk to the organisation in terms of safe patient care, as well as placing considerable stress upon the nurse as is demonstrated by the following comment.

> *Not having enough experience to work in accident and emergency.* (Emergency Department, first rotation, large rural.)
> Note: in relation to night duty, this nurse also commented – *I did not believe I had enough experience to have the responsibility of working night duty as I, being the RN, was working with mainly* (only) *ENs.*

Graduate nurse coordinators from both a metropolitan secondary and a small rural hospital indicated that their graduates often worked with only one other RN. This is likely to create situations where the graduate has the entire responsibility for a unit, for example, in times of meal breaks, or short leave taken by the other RN, and is forced to exceed their scope of practice (Duchscher, 2009; Lea & Cruickshank,

2007). Morrow (2009) states that "patient safety must be at the fore when planning and implementing nursing human resource allocation, including the support of fledgling nurses into the staff mix" (p. 283). When there is a deficit in nurse staffing levels, expecting an inexperienced nurse to take on additional responsibilities only exacerbates the hazardous situation (Cowin & Hengstberger-Sims, 2006; Evans, et al., 2008; Garling, 2008); and has already had dire consequences within the Australian healthcare context where this has occurred (Death caused by unsafe staffing levels, 2008; Record of Investigation of Death, Ref No: 12/12, 2012).

In subsequent rotations, the proportion of responses in relation to *stress* comments recorded as *nil* increased to 31.5%. The *patients/ clients* originating perceptions of *stress* were seen as a concern. It is feasible that, as the graduate becomes more competent and confident, they are allocated more complex patients to care for, including those who have little respect for the 'zero tolerance to abuse' directives. The WA Health Department has long advocated a policy of no tolerance to abuse of staff by patients and/or their relatives. Their policy and guidelines stipulate the necessary regulatory requirements to ensure that training and controls are in place to manage and minimise workplace aggression and violence, and to ensure staff are safe in their workplace (Department of Health, WA, 2004). The following comments suggest that despite these measures, such experiences are still stressful to the nurse involved:

> *The unpredictability and volatility of patient mix upon the ward.* (Mental health, secondary hospital.)
>
> *To deal with difficult families of the patient.* (Surgical unit, tertiary hospital.)
>
> *Difficult patients and learning how to manage them effectively.* (Medical unit, tertiary hospital.)

Overall, and throughout the consequent rotations, the GRN responses have demonstrated a maturing professional, a concept that could be interpreted as an indication of a successful transition from novice to proficient nurse.

5.4.7 Additional Perceptions from Specialty Rotations

At the end of the section for each specialty rotation, a final open-ended question asked for any further comment that the graduates wished to make in regards to their rotation. For ease of grouping, these comments were coded on a five-point Likert-type scale from *very positive,* to *very negative*. First rotation responses were predominately *positive* (61%), implying that the GRNs overall outlook related to their first transitional experiences is optimistic and conducive to affirmative experiences.

> *I thoroughly enjoyed my first placement of my graduate program.* (Medical ward, private hospital.)
>
> *Loved it. Chose to continue on this ward after grad program.* (Surgical unit, secondary hospital.)
>
> *I was made very welcome and supported well by the SDN and other staff during this time.* (Surgical ward, secondary hospital.)
>
> *Excellent support, good rapport amongst staff, all very supportive.* (Domiciliary placement, community health.)
>
> *It was a great ward and I now work there full-time.* (Surgical ward, tertiary hospital.)
>
> *It had been a very positive, productive and beneficial start of my career.* (Perioperative unit, tertiary hospital.)

These comments clearly show that positive experiences are conducive to retention within the workforce, and in particular, to those areas where the encounter has occurred (Johnstone, et al., 2008; Morrow, 2009). Much of the literature related

to graduate nursing transition tends to focus on the negative viewpoint. The current research has shown that the greater majority of transitional experiences are, on the whole, much more positive than other studies imply (Chang & Hancock, 2003; Evans, 2005; Kelly & Ahern, 2009), and as such, these aspects should be the focal point of future planning and the development of guidelines for transition programs within WA.

Only five responses of the *additional* comments were coded as *very negative* with a further 22 as mostly negative (37% total negative). Of the *very negative*, the spread of designated workplace was from across all organisational categories, which would suggest that the experience was more likely related to the individual, rather than the sector.

> *Our ward was very understaffed and nurses expected to pick up the slack. I had workers comp injury here.* (Medical unit, private hospital.)
>
> *Felt like you were dropped into nursing. You had to sink or swim, unsafe for patients care.* (Medical / surgical, rural.)
>
> *Was not preceptored, made to feel a nuisance. Staff were not friendly.* (Medical unit, small rural.)

A small proportion of the responses that indicted the GRNs had encountered both *positive* and *negative* aspects of their specialty rotation were themed as a *mixed* experience, as is shown in the following:

> *I've enjoyed this rotation and have learnt a lot of skills. Need more support from senior staff.* (Medical ward, tertiary hospital.)
>
> *Very supportive SDN. Not rostered on with Preceptor – it is a waste of time being assigned one.* (Medical and surgical, tertiary hospital.)
>
> *High acuity and turnover = increased stress. Often dreaded going to work. Often staying back. Great, friendly staff, excellent graduate program support – would come and help when called.* (Medical unit, secondary hospital.)

It provided a good entry point to nursing, however staffing shortages and management decisions proved a dangerous combination. (Medical unit, secondary hospital.)

For their second specialty rotation, 74 respondents took the opportunity to provide *further information;* 12 of these were themed as *very positive* and an additional 28 as *mostly positive.* While this was slightly less than that recorded for the previous rotation, there were also moderately fewer coded as *very negative* or *mostly negative*. Between the specialty rotations, the GRN responses from the tertiary and private sectors showed minimal change in the proportions, however, there was a considerable increase in the *positive* responses from the rural sector and a small decrease in those from the secondary hospitals. Without additional data it is difficult to speculate as to why this has occurred. It is possible that in the initial stages of their program the GRNs in rural areas may have felt more isolated from their peers, and as they progressed in their transition, assimilated more easily into the team. Again, the responses demonstrate the favourable impact that positive experiences have upon the GRN's concept of their nursing role:

Fantastic education enhanced learning experience. (Surgical ward, tertiary hospital.)

I thoroughly enjoyed my second rotation and would be interested in returning to this area in the future. (Surgical unit, tertiary hospital.)

Weekly updates on new events and policies were great. Kept everyone up to date and issues could be looked at quickly – very approachable management. Loved my work and going to work. Friendly staff with a huge knowledge base. Always someone who could answer your questions using theory and policies to back up what they said. Felt very safe as everyone used the policies – no dodgy practices. (Paediatric critical care, tertiary hospital.)

This was a fantastic ward to develop nursing skills. My preceptor would check my observations were complete, my drugs were correct and offer help in any patient deterioration. (Surgical ward, tertiary hospital.)

> *Fantastic rotation. Great introduction to busy post-operative ward, great team.* (Surgical ward, small rural hospital.)

> *I loved it. I like mental health.* (Mental health unit, private hospital.)

> *Loved it, and it's where I'm staying.* (Perioperative unit, tertiary hospital.)

Conversely, some experiences were not so conducive to a constructive experience and led a few to thinking about leaving the program. Takase (2010) found that thoughts, and verbalisation of intent to leave, were early signs of nursing staff turnover, and that such incidents are often exacerbated by work overload and even workplace injury. Ongoing issues with insufficient human and material resources, that are a necessity for any nurse to effectively and safely provide optimum patient care, are depicted in the GRNs' comments:

> *I couldn't wait for it to end!* (Surgical ward, tertiary hospital.)

> *Highly stressful rotation.* (Medical ward, tertiary hospital.)

> *Very bad SDN. I got sent to another ward my second week I was there and got another back injury – not the right equipment for heavy patients.* (Medical / surgical, private hospital.)

> *The most un-enjoyable rotation. Worst experience leading to thoughts of quitting nursing for good.* (Surgical ward, tertiary hospital.)
> Note: this nurse continued, enjoyed the next rotation, and did not resign.

Of the 73 GRNs who completed a third specialty rotation, only slightly more than half took the opportunity to provide *further comment.* Of these, 16 were themed as either *very positive* or *mostly positive,* and 13 as *very negative* or *mostly negative;* the remaining texts were considered to contain *mixed* responses. The responses continued to demonstrate the influence that the GRN's experiences had on their perception of the specialty rotation relative to the magnitude of that experience:

I really enjoyed this rotation and would like to specialise in nephrology nursing. (Dialysis unit, large rural hospital.)

Have only been here about 3 weeks – the 2 SDNs have been amazing and very supportive and thorough. (Medical unit, tertiary hospital.)
Enjoyed this rotation. (Surgical unit, private hospital.)

The staff in the critical care area are much more supportive than on the wards. (Critical care, tertiary hospital.)

I really enjoyed this rotation and feel it helped me so much in my next rotation. (Perioperative, tertiary hospital.)

Absolutely impossible to get study days to the point where I considered transfer to another hospital! Even though we are entitled to them. (Medical unit, secondary hospital.)

A very negative experience so far, permanent staff very 'clicky' and exclude grads. (Surgical ward, tertiary hospital.)

My preceptor left in my second week. I paged my SDN four times over my next two shifts, I went to her office and her pager was off. I was given a new preceptor who worked nights and was an RN I had gone through uni with but who had chosen not to do a grad program! (Surgical unit, tertiary hospital.)

The absence of the SDN related in the above comment is of concern and, as discussed in Cubit and Ryan (2011), deprives the GRN of an important resource in terms of support and assistance to integrate into the unit. Additionally, the experience level of the newly assigned preceptor appears to be inadequate. Many respondents cited that units were often too busy for the GRNs to be released from them in order to attend scheduled study days. This restriction is obviously disadvantageous to the novice's further development of clinical knowledge, and also reduces their opportunity to network with fellow graduates; a concept that has been discussed as important to the novice's successful integration and psychological wellbeing (Adlam, et al., 2009). Inability to share their experiences with their peers

is also likely to detrimentally influence their opinion of the unit as being supportive to them.

5.4.8 Benefits of the Graduate Nurse Program

The GRN survey questionnaire respondents were asked to briefly describe what components of their graduate program they believed were the most *beneficial* and facilitated their transition to the role of proficient RN. Of those responding to this question the largest group (45.3%) stated that *study days* were the most *beneficial*, followed by *support* (35.8%) and then *educators* (20.9%). This combination of themes suggests that a robust program structure that includes appropriate guidance, ongoing and relevant learning opportunities, and professional exemplars is appreciated by the graduate nurse and is seen to be helpful to them progressing during their transition to proficiency. The related responses also indicate the importance of suitable and strong support systems to demonstrate that the organisation genuinely desires the novice to develop into a confident, competent and compassionate practitioner. As previously alluded to, these positive components of the current GNP should be emphasized and developed to further enhance future programs.

In addition to the positive elements, respondents were also asked if they believed there were any components of the graduate program that they felt were *not beneficial* in facilitating their transition to the role of RN. The greater majority (70%) of respondents indicated that there were no components of the GNP that they felt were *non-beneficial.* While these results are very heartening, the *non-beneficial* components identified by the respondents still need to be considered; with an aim to develop strategies to overcome the issues, and to continually improve processes and

graduate experiences; as well as to maximise the retention of nurses within the workforce.

The majority of *negative* response themes were related, once more, to a *lack of support*, followed by (too many or unrelated) *assignments* and included comments questioning the relevancy of clinical governance as a subject at a novice level of learning. The data does not allow any indication if, by clinical governance, the graduates are referring to quality improvement, as in reality, the terms relate to similar, but different aspects of improving practice. A knowledge of quality improvement principles is usually a criterion in nursing job descriptions for selection purposes, and hence, should be included in the GNP curriculum; whereas, knowledge of clinical governance principles would be generally considered a requisite for more senior levels of nursing. Of the total *negative* responses to beneficial components of the GNP, there was a mixture of *irrelevant* or *repetitive study days*, *staffing*, *workload* and *rotations* all with similar ratios of responses, as follows:

> *Spending so much time in the day procedure unit. Too many assignments for the program – only added to the stress.* (Large rural.)
>
> *Inflexibility, unreasonable working hours.* (Private.)
>
> *Very poor course coordination never saw our supervisor, had to chase for information, emails, phone, etc., very frustrating.* (Small rural.)
>
> *There were a lot of study days that covered the same material over and over again, which became quite tedious.* (Tertiary.)
>
> *The stuff about clinical governance in first year. Also the ancient books and performance evaluation – identical to work done as students.* (Private.)
>
> *The fact that this particular hospital takes on too many graduates and then no jobs at the end of program. Too much of a workload with assignments – too stressful in first year out.* (Secondary.)

The transition to nursing was a waste of time. Clinical governance highly irrelevant to a grad nurse trying to learn. (Secondary.)

Lack of support and direction on site. Withdrawal of program rotations vital to all round care in the rural setting. (Large rural.)

Overall, there was a greater proportion of *negative* responses from the non-tertiary sector, and in particular, the rural and private sectors. It needs to be noted however, that when considering these findings, data related to the private sector are inclusive of private tertiary, secondary and rural organisations, and may consequently suffer from similar resource issues as public sector organisations of similar size.

5.4.8.1 Graduate Nurse Program Improvements

When asked for suggestions of how they believed the GNP could be improved, almost half the respondents indicated that either *no* improvement to the GNP was required, or did not give a response. The most common theme for improvement was (more) *support* which included general, clinical and SDN support; this was followed by *program structure*, with some suggesting fewer rotations, and as many proposing additional rotations; and several respondents advocating an increase to the program length to enable additional rotations to the more specialised areas.

Train grad nurses with skills – don't put grad nurses under so much pressure to do something to fill criteria if there is not funding to provide support. (Secondary.)

Improve communication between staff and staff development – what they need to do as a preceptor. (Tertiary.)

More supernumerary shifts. A graduate program that can continue for 2 years and a chance to work in the critical care areas. (Tertiary.)

More support for those graduates located at different hospitals - as we tended to be forgotten about. (Tertiary.)

Clear guidelines prior to grad program would have helped me understand work-load, as this was very stressful. More education for staff members (preceptors, etc) *to help increase communication between grads and staff, e.g., staff unaware of requirements.* (Secondary.)

Definitely need full-time staff development/preceptor/go-to person. Supernumerary time for new work areas needs to be complied with. (Large rural.)

Do what they say they offer: more support, more development, supernumerary days, zero-tolerance to bullying and action it. Better skill-mix and better rostering – it was a relief to finish the grad year – you feel you are not part of the team (only there temporarily) and therefore get all the (worst) *patients and* (worst) *loads.* (Secondary.)

Increase staff development nurse role on ward at first when beginning rotation – then there is always someone to point you in the right direction. All graduate nurses should be invited to presentations by other graduate nurses to learn from each other. (Secondary.)

Offer the option for a 3rd rotation. The feedback we get feels very generic – for example, we passed competencies, followed protocols – it would be nice to have an interview or review session to talk about the plusses and minuses and how to work on the things that need more attention. I feel senior staff are quick to blame but rarely give feedback. (Tertiary.)

I believe there should be more clinical supports when graduates first start. Someone to be there to answer any little questions, so as to not make coordinators' and other nurses' workloads huge! (Small rural.)

More staff development nurses; more of an introduction into the hospital systems; nurse who coordinated program was too busy – wore too many hats. (Tertiary.)

More study days to complete ward competencies, i.e., ALS (Advanced Life Support)*, epidural, IVI* (intravenous infusion)*, and catheter competencies – all had to be done in our own time!* (Large rural.)

More in-depth analysis and teaching of pathophysiology of disease processes - enables nurses to think 'outside of the box' when planning interventions. (Tertiary.)

Once more, respondents from the non-tertiary areas were the predominate group to advocate improvements, with 79% from the private sector believing that there were ways the program could be improved, and 60 and 65% respectively, of the

secondary and rural sector respondents suggesting ways that they believed their transitional experience could have been enhanced. Further *improvement* themes included:

- appropriate training of preceptors, with clear guidelines of the expectations and limitations of the GRNs who were allocated to them;
- better compliance with supernumerary time;
- patient allocation, workload and rostering that is more appropriate to the GRN's level of experience;
- improved feedback and review sessions; and
- an option of additional program time to allow rotations to the more specialised areas.

Interestingly, many are reflective of the UWA (2000) study recommendations that are summarised in section 1.3 of the first chapter. If these components that the GRN believe are conducive to a supportive and beneficial transitional program were clearly articulated, they would provide a sound framework for a constructive guide to those who are charged with managing such programs, and for facilitating the progression of the novice nurse to a skilled and knowledgeable practitioner.

5.4.8.2 Program Evaluation

Feedback in relation to transition programs is generally sought from the GRNs via formal evaluations, either during and/or at the end of a program. This feedback is important for organisations to enable them to determine the effectiveness of their program, and to allow identification of areas requiring improvement. Further, measurable evidence of program efficacy tends to substantiate program funding.

Sites most likely to have formal evaluation processes in place were from tertiary (88%) and secondary (86%) organisations. Those less likely to have provided evaluation of their GNP were respondents from the private and rural sectors, with 70 and 73% of respondents respectively indicating thus. Reeves (2007) research into Victorian graduate nurse transition programs reported the majority of GRN respondents had evaluated their programs highly and that this related to higher levels of satisfaction.

5.4.8.3 Graduate Program Guidelines

The graduate nurse coordinators who participated in the web-based survey were asked to provide a brief outline of the guidelines that they used to govern the administration of their graduate nurse transitional programs (Appendix F).

There is little doubt from their responses that the graduate nurse coordinators intend to provide a positive experience for the nurses transitioning from novice to proficient practitioner within their organisations. However, it would appear from the feedback of both the graduate nurse survey questionnaire, and the graduate nurse coordinator web-based survey, that comprehensive and objective guidelines relating purely to the aspects of graduate nurse program structure, management and assessment are lacking. This is a considerable oversight by organisations in ensuring their transitional programs are well executed and that they wholly facilitate the development of a competent and professional nursing workforce that is available to provide optimal health care to the population of WA. It is also of concern in the current financial environment that suitable measures of fiscal accountability, in relation to the Government funding for GNPs, are not readily apparent.

5.4.8.4 Transition Programs Innovations

To determine what innovations or strategies may have contributed to the further development of their respective transitional programs, the graduate nurse coordinators were asked to describe what changes have either been made, or are planned to improve their graduate programs. The responses were generally comprehensive and insightful, with the majority of information from the tertiary sectors, and are presented in Appendix F. Some of the metropolitan secondary hospitals appeared to have a less structured approach to their transition programs, and fewer resources than the larger tertiary sites, but did give the impression that they were committed to support the graduate nurse where they were able to. The small sample, and limited information from the private organisations reduced the ability to draw any definitive conclusions, however, both graduate nurse coordinator respondents indicated a partnership with a university that enabled their GRNs to gain the Graduate Certificate in Clinical Nursing at the completion of their transition program. The feedback from the rural sites was the most informative in relation to the tyranny of distance and the resultant lack of support for the graduate nurse coordinators to implement the changes that they would have liked to.

The breadth and detail of the innovations, as described by the tertiary hospital graduate nurse coordinators, and in comparison to the more seemingly reactive changes put forward by the secondary and rural sectors, would appear to demonstrate how an evidence-based approach is able to provide a more robust and structured framework with which to design a successful transition program. It is obvious that the greater the graduate nurse coordinator and staff development input there is into the GNP, the more positive the experiences the nurses have in their transition phase.

The following comments show the different experiences of GRNs who did, and did not have supportive SDNs and graduate nurse coordinators:

> *Staff on the ward gave you great support and easier patient loads to begin with; clinical coaches and supernumerary days, lots of in-services, encouragement and positive feedback from staff.* (Metro tertiary.)

> *Level of support I received at* xxx *Hospital was excellent. Staff development nurses were extremely helpful as were my mentors/ preceptors.* (Metro tertiary.)

> *Monthly seminars organised by grad coordinators, presence of clinical coaches during 1-2 weeks post orientation, self directed learning packages and ward based assessments* (were benefits of GNP). (Metro tertiary.)

> *PDNs* (Professional Development Nurses)*, CNMs* (Clinical Nurse Managers) *and some staff did not offer adequate support on 2 of my rotations.* (Metro secondary.)

> *Not beneficial at the time, but the lack of a program coordinator encouraged self direction and motivation.* (Large rural.)

> *Lack of support, full patient loads from day-1 on each ward* (told we had 2-days supernumerary on each ward)*, so no orientation. Lazy and unapproachable staff development nurses.* (Metro secondary.)

> *Program coordinator and staff development had little input.* (Large rural.)

Once more, these comments clarify how important the support of program coordinators, SDNs and preceptors are to the GRN, and how they appear to appreciate the ability to assimilate into a new environment when suitable supernumerary time and appropriate learning opportunities are provided.

5.4.9 Final Registered Nurse Integration Comments

The final open-ended question of the newly graduated nurses invited further comments from the respondents to assist in identifying how they felt about their

integration into the workforce as a RN. Equivalent proportions of those who had participated in a GNP, and those who had not chosen this option to transition, responded to the invitation to comment. The responses were once more coded on a five-point Likert-type scale of *very positive* to *very negative* to determine trends. While the greater proportion of responses (37.2%) was deemed *positive*, only slightly fewer were considered *negative*. However, when separated into the groups of GNP participants and non-participants, the comparisons where quite distinct. Of those respondents who had participated in a GNP, 41% of their responses were deemed *positive*, and 28% *negative*; the remainder where coded as *mixed* as the responses were felt to contain both positive and negative elements. Of those respondents who did not participate in a GNP, only 21% of their responses were *positive*, while 36% were themed as *negative*, with the remainder considered to be *mixed*. A small portion of comments were related to staffing, work-life balance and a single comment recounted bullying. The following sample demonstrates how difficult it was for some of the newly graduated RNs to transition from novice nurse to competent practitioner:

> *Hard work! Enjoyable at times, stressful at times. Underpaid! Feel I definitely would have been more confident and felt more able to deal with the pressure if I had spent more time on the ward and less in the classroom (as an undergraduate).* (Tertiary hospital, Uni B for undergraduate program.)

> *Thank you for doing this survey! It feels great to be heard for once. It has been a scary bumpy and unsupportive time. If I didn't have a passion for nursing, I probably would have changed professions.* (Private organisation, Uni C for undergraduate program.)

> *First 6-weeks of first rotation quite stressful in getting used to everything – a bit freaked out with the responsibility of someone's life and how poorly written some med* (medication) *charts are.* (Tertiary hospital, Uni B for undergraduate program.)

> *Coming back into Australia looking for work having not done a graduate program, I found it very hard to find work.* (GP, Uni A for undergraduate program – non-GNP.)

> *Some ward/units welcome graduates and support them well, while others fail to see that without graduates the profession will die. There are still quite a few RNs, CNs and CNSs that 'eat their young' - who do not want to support graduates, and if you are placed with these, you will see that the retention rate falls.* (Tertiary hospital, Uni B for undergraduate program.)

> *Found it quite a harrowing experience at times knowing a patient's life was in my hands.* (Tertiary hospital, Uni A for undergraduate program.)

> *As I had prior experience as an EN I was fortunate – I believe I would have left the profession otherwise as* (there was) *no educator/preceptor.* (Private organisation, Uni D for undergraduate program – non-GNP.)

> *The work is much harder than I ever thought. It's very tiring and shift work makes it difficult to get into a routine.* (Private organisation, Uni C for undergraduate program.)

> *The staff in the wards are generally helpful and wonderful, but I have seen what bullying has done to friends and myself. I noticed that some of these bullies really have no idea how badly they criticize others. There should be an intervention program or something to help these people to recognise and change their behaviour. While they are fantastic at managing a ward, they lack skills to manage people.* (Tertiary hospital, Uni A for undergraduate program.)

> *The grad year was a bit brutal for me. I only survived due to the effort put into the study with babies at home. Recognise, and always did, the crucial importance of experience. Currently, I feel much more part of a team, able to assist and equally able to ask for help as needed, without damage to identity as an RN. This is partly due to my experience but also very good morale on the ward.* (Tertiary hospital, Uni A for undergraduate program.)

Conversely, the positive comments related to the novice nurse's integration into the workforce provide strong evidence that when commencing in their new role of responsibility and professional development, good program structure and support are greatly appreciated by them; and endorses the effort and resources invested in transitioning them to the profession of nursing:

The graduate program is a great concept as it provides you with a helping hand and more support and education throughout your first year. I also believe it is beneficial to incorporate a medical and surgical rotation into the graduate program to diversify the graduates' learning experience. (Tertiary hospital, Uni B for undergraduate program.)

The grad program has made me a much better nurse by increasing my exposure to different hospital settings. (Tertiary hospital, Uni A for undergraduate program.)

I am very proud of the profession I have chosen, and would recommend it to anyone if they have a desire to learn, but it is an ongoing life-long commitment to learning. Graduate programs need to be in a place to allow new nurses to grow and learn before leaping into an area of choice. Get the basics down first. (Tertiary hospital, Uni A for undergraduate program.)

I have enjoyed the transition from student to graduate to Registered Nurse. It has been stressful at times, but overall very rewarding and challenging. I now preceptor students and it is enjoyable to help them through their practical experience and offer advice for their own transition. (Private organisation, Uni A for undergraduate program.)

Thank you for this further study into the experiences of my peers of their graduate programs. I feel that this contributes to a perception of nursing as a profession. (Tertiary, Uni C for undergraduate program.)

It is lovely to have so much support from most of the staff within my hospital, which made my transition from student to Registered Nurse a lot easier and less pressured. (Secondary organisation, Uni B for undergraduate program.)

I am happy that my grad year was completed in a large public tertiary hospital, as talking to fellow students it appears that much more support has been offered than in private hospitals, or smaller hospitals. (Tertiary hospital, Uni B for undergraduate program.)

It was lovely to hide under the title of 'graduate' – felt protected and not really judged. It was a good grad program with a lot of support on the first rotation from staff and SDNs. Now I'm glad I've lost the grad bit from my name badge! (Private organisation, Uni C for undergraduate program.)

These comments clearly demonstrate the maturing of the novice nurse into a confident practitioner. In addition, it is plainly apparent that the notion of the newly

graduated nurse being assisted by a structured program, and supportive organisation throughout their interim transition is a worthwhile investment in achieving proficiency in their nursing skills, and ongoing education.

5.5 Career Pathway Following Transition

RQ 3: What perceived effect does the Graduate Nurse Program have on predicted career longevity of newly graduated registered nurses?

The general intent of a GNP is to provide suitable supports to the newly graduated nurse and facilitate their transition to becoming a proficient member of the nursing workforce. The transition period is an opportune time to nurture the novice nurse and to encourage their retention within the profession. To answer the final research question, two sections of the GRN survey questionnaire elicited information from the respondents to determine what influence the graduates' transitional experience may have had on their choices related to their current or intended career pathways, and to their five-year professional vision.

5.5.1 Career Pathway Intention / Choices

In response to the question pertaining to their intended pathway following the GNP, 56% of the GRN respondents indicated that they had stayed in either the last specialty rotation of their program, or returned to one that they had experienced earlier in the program; and a further 17.6% had stayed within the organisation, but chose to work in a unit different to those they had experienced in their GNP. Only 13.9% of those responding to the question had moved to a different organisation; suggesting that a formal GNP has a positive influence upon a novice nurses' intention to continue tenure with the transitional organisation. Of those who had

moved to a different organisation, the greatest proportion was from the private (28% of all private respondents) and rural (30%) sectors. The least likely to move to a different organisation were from the tertiary (6% of all tertiary respondents) and secondary (13%) sectors. Many of those who changed organisations had reported issues pertaining to a lack of support, work overload, and poor attitudes that had been demonstrated to them by colleagues and senior staff. This would suggest that these types of issues, already discussed extensively in the previous sections and further depicted in the comments below, are indeed a significant factor in influencing the retention of nurses within a workplace.

When asked to comment on how they perceived their graduate experiences had influenced their choice of career path following their program, the majority of GRN respondents, particularly those from the rural sector, gave a response that was generally positive. There were some, however, who described suboptimal experiences and how these had resulted in them choosing a less preferred option. The parentheses contain the GRN's chosen pathway, or intended pathway following their transitional program:

> *Gave me a chance to discover what area of nursing I enjoyed. Gave me an opportunity to experience different areas of nursing.* (Same organisation, earlier rotation, private.)

> *Being able to experience the different areas of work meant being able to discover which areas I enjoy working in, and which units would work in well with my family life.* (Same organisation, earlier rotation, tertiary.)

> *I am determined to continue with paediatric nursing. I loved my graduate program and think it's a great way to introduce new nurses to the profession. In the next year I am looking into a course to further my knowledge in NICU* (neonatal intensive care unit) *nursing. I don't know if I'd still be in nursing without the support and ability to experience different wards in my graduate years.* (Unemployed – travelling, tertiary.)

Widened my vision; enhanced my knowledge; gained more confidence; ability to deal with different situations; realised how hard (it is) *to be a nurse.* (Last rotation, tertiary.)

Graduate year has cemented together my training and made me more confident and competent in my work practices. (Last rotation, secondary.)

No choice – we were given a position where there were vacancies and we had experience in. (Last rotation, secondary.)
Having a good grad program with wonderful support from the coordinators helped me decide where my future in health care was. Experiencing all aspects of hospital care in a location close to my residence also helped. (Same organisation, earlier rotation, secondary.)

I found it very beneficial as it has given me the confidence and competence to work in other tertiary hospitals. (Different organisation, similar unit, tertiary.)

Had no choice, was all that was offered or would otherwise have been unemployed. Was out of work for 3-months. (Same organisation, different unit, tertiary.)

My graduate year has driven me toward moving into the public sector post this rotation. I have been unable to leave sooner due to lack of jobs and so have had to remain in a 3-year grad program to retain a job. My time in this program has not allowed me to rotate into the areas of nursing I had requested, so I am still unsure of the career pathway I am yet to take. I have not been supported through this decision process either and have been forced to double up on areas I have already gained experience in. (Different organisation, different unit, private hospital.)

No influence at all. I have gained a grad certificate which is good – what I learned from the program was little. I had no support at all from L&D (learning and development). *This program is not set up to help nurses – it is money for L&D and* (university). *No support or compassion at all to people as nurses – would never recommend it.* (Different organisation, different unit, secondary hospital.)

My graduate experience influenced my choice of ward, because I feel I did not get the experience of a surgical ward. Also the staff on the medical ward were helpful and easy to get along with. I felt confident enough to give my best on the medical ward. When I was given the DPU (Day Procedure Unit) *as my surgical rotation I did ask if I could split it to 3-months DPU, 3-months surgical – this was not possible, I was told that there were a lot of graduates to place. I still feel I missed out.* (Same organisation, earlier rotation, tertiary hospital.)

> *Did not enjoy A&E* (accident and emergency) *as I had limited knowledge and sometimes complex patients, no support. Loved aged care before I started my RN and I did not want to keep disliking my job, so I went back to Aged Care as a RN, which I enjoy.* (Different org, different unit, large rural.)
>
> *I would have loved to have stayed on in theatres or my last rotation; however, I had to move state. I will look for a job in similar areas to my last rotation. I confidently worked in a fast paced surgical ward in a tertiary hospital; I can work anywhere and be confident in my skills.* (Unemployed, tertiary.)
>
> *My final surgical rotation made me want to leave the profession. I received very high grades in my grad program and was offered a job in PACU* (post anaesthesia care unit) *which usually requires a longer nursing history. I was very concerned about my skill development on my final rotation, and realised in situations I was placed in I was the only RN working, therefore, I was responsible for all of the patients should there be any patient events.* (Same organisation, earlier rotation, tertiary.)

It is evident from the feedback that, overall, transition programs do allow the graduate nurse to consolidate their learning; experience different aspects of nursing; and determine their preferred areas of practice. The majority of those nurses who indicated a preference for returning to a prior specialty rotation, or to remain in their current area had described positive experiences during their GNP. Of the seven GRN respondents who participated in Mental Health, Aged Care and Community specialty rotations, all remained within those areas, strongly suggesting there is merit in encouraging graduates to experience these specialties, with a view to ultimately improving recruitment of nurses to them. As such, it would be reasonable to suggest that a good program does have an affirming influence upon the novice nurse in retaining them within the workforce; in their developing into confident and proficient RNs; and in positively shaping their nursing career path.

It was disappointing to see that 6% of the GRN respondents to this section were no longer in nursing, with 1.3% (n = 2) in non-nursing employment and 4.7%

(n = 7) unemployed. Extrapolating these proportions to the whole newly Registered Nurse population for 2008, these figures account for a total of 51 novice RNs no longer in the nursing workforce. While the majority of attrition is explicable, some reasons may be industry related:

> *No job available due to health budget cuts.* (Secondary hospital.)
>
> *Travelling this year.* (Tertiary hospital.)
>
> *Currently on maternity leave.* (Tertiary hospital.)
>
> *Spent 5-months volunteer work overseas after my grad program.* (Private sector.)
>
> *Moving interstate and looking for work.* (Tertiary hospital.)

The Health Workforce Australia's (2012) report *Health Workforce 2025*, forecasts that WA will experience a shortfall of at least 12,000 nurses by the year 2025. While in this study the number of novice RNs opting out of the workforce early in their career equate to only a small proportion of this target, it is still an opportunity lost if the profession fails to do all it can to optimise their retention. Added to this is the concern that not all nurses graduating as a RN from Australian universities are able to find suitable positions. At a '*Health Australia Forum'* in Adelaide, Head of the University of South Australia's School of Nursing, Professor Helen McCutcheon, expressed concern that in some Australian states there were a lack of sufficient positions available for newly graduated nurses, and that this situation indicated a substantial lack of foresight and planning between the Federal and State governments, as well as national nursing workforce bodies (Health Workforce Australia, 2011a). This would suggest that while the nursing industry is aware that there is an issue in regards to suitable employment options for transitioning novice nurses, there may be more that can be done by the industry in

terms of provision of sustainable opportunities to ensure longevity of these nurses within the nursing profession.

5.5.2 Permanent Contract Influence on Choice of Employer

Organisations differ with regards to offering a permanent contract of employment to a newly graduated nurse. In the past, some employers offered contracts only for the term of a transitional program, whereas others saw the offer of a permanent position as an additional marketing tool. In recent years, however, and as a result of the GFC, some organisations have reduced the number of novice nurses that they employ. The number of graduate positions available has consequently decreased, and as such, permanent contracts are sometimes no longer an option (Nursing & Midwifery Office, 2009). This change in circumstances is reflected in some of the respondents' feedback given in relation to position availability following their program. Eighty percent of respondents were offered a permanent contract at the beginning of their program, and half of these were positively influenced by the offer when choosing the organisation for their transition. A further 53.4% indicated that the offer of a permanent contract had no influence upon their choices:

> *Only able to get part-time contract, not full-time.* (Tertiary.)
>
> *No graduates were offered permanent contracts following grad program due to rumoured jobs freeze. One grad out of the 6 took a permanent position at the hospital prior to the program finishing.* (Private.)
>
> *My grad program has a guaranteed permanent position at the end – very important in the current* (jobs) *climate.* (Tertiary.)
>
> *No permanent jobs available due to: increase of English nurses being brought over for recruitment; health budget cuts have affected* (hospital) *being able to employ more staff. 1 out of 6 grads got a job.* (Secondary.)
>
> *I was not offered a permanent contract because I was on a temporary visa.* (Tertiary.)

> *Although at the end of my student* (midwife) *role there were no positions, had to continue for 3-months on an extended student contract until a position became available. Stressful for that time waiting for confirmation. Now I have position.* (Secondary.)
>
> *Offered only if I gained permanent resident status.* (Private.)

It would seem that the offer of a permanent contract is an important factor to many nurses when seeking employment. The current financial climate pressures organisations to further reduce establishment budgets and, as such, may influence the numbers of nurses who would seek the security of guaranteed employment.

It is evident from the GRN comments that there are a number of graduate nurses employed from overseas on a temporary visa status, which implies the need to recruit nurses from further afield. It appears a waste of resources when nurses from abroad incur the expense and emotions associated with moving to a new country and then find the need to search for alternative employment. This is a matter requiring further investigation, especially considering the personal and the organisational investment in their education and development to the point of novice practitioner. Their novice status may also restrict their opportunities of applying for alternative nursing positions, as, before committing to further visa nominations, many organisations prefer new nursing recruits to be able to demonstrate a reasonable degree of prior nursing experience.

5.5.3 Future Professional Pathway

When asked to indicate where they saw themselves professionally in five years time, several respondents envisioned themselves in a promotional position, with 27.5% indicating a preferred post as a Level-2 RN, and 3.6% as a Senior Registered Nurse (Level-3 and above) or a Nurse Practitioner (SRN Level-7). In a study of

newly qualified nurses in Canada, Dearmun (2000) found that thoughts of promotion or changing to a new, more challenging position commonly occurred in the latter part of the graduate's first year. With almost a third of the GRN respondents looking to higher level positions in the current research, the data would seem to concur with this observation. Additional findings indicated that many GRNs (21.2%) planned further study, and another 2.1% intended future study in a medical degree. Almost 10% of the respondents aimed to pursue midwifery, and 6.7% of respondents planned to nurse in rural areas. Many of these latter respondents indicated their current employment in non-rural areas, so it would appear that this is a future intention and, as such, will improve the numbers who have already chosen this sector in which to work. Equivalent proportions of respondents proposed to continue in their current specialties of either perioperative nursing or critical care areas of ICU, coronary care, or emergency medicine (3.6% each). Disappointingly, only small numbers indicated their preference for Mental Health (2.6%) and Aged Care (2.1%). It is possible the reason so few have chosen these areas for their ongoing career is, as previously discussed, an initial lack of marketing to student nurses and exposure to the specialties during clinical practice; and a consequent reduction in exposure during their RN transitional program.

To promote areas of need as suitable options for nursing career choices a feasible strategy would be the provision of vocational guidance. This could occur during both the undergraduate nursing program as well as the GNP. There are a multitude of career options within the profession that are available to nurses, but many nurses may not be aware of these. The NMO is responsible for promotion of nursing as a profession, and has made considerable progress in advancing the image of nursing, as well as in developing some excellent pathways for nurses with which

to enhance their professional experience and further develop their proficiency. While most universities invite the NMO to inform student nurses of the available options pending graduation, some student nurses remain unaware of these resources, presumably due to non-attendance at such presentations (personal communication, student nurse, 29 May 2012).

5.6 Summary

This chapter has discussed the findings of the research into graduate nurse transition programs in WA in response to the research questions. Establishing the basic demographics of the graduate RN has enriched components of the research data by providing demonstrable links between age-groups, and prior healthcare experience. The research has compared the contemporary novice RN's transitional experiences with findings of the UWA (2000) study upon which this study has been based. In addition, the perceived efficacy of the GNP in facilitating the GRN's transition to competent practitioner, and consideration of how the GNP might influence the GRN's future career pathway has been discussed.

In general, transitional programs for newly Registered Nurses within WA appear to have improved considerably in the last decade or so in regards to the available supports, the range of specialty experiences available, and the benefits perceived from participation in a formal program. It is clear that a positive transitional experience has a valuable influence on the professional future of the novice RN and their retention within the nursing workforce. The study has also revealed opportunities to further improve the graduate nurse transition pathway, and to provide a benchmark for successful and safe progression for the nurse from a

novice to a proficient and dependable practitioner. It is of vital importance that novice nurses are aided in their transition to proficiency in the most sustainable way.

The following chapter draws conclusions from this discussion and, proffers recommendations for future graduate nurse transition programs within WA.