Are Graduate Nurses Satisfied with Graduate Nurse Programs?

Submitted
by

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ABSTRACT

The transition from student nurse to Registered Nurse Grade 1 is a difficult journey for many graduates. New graduates experience issues related to reality shock, socialisation, confidence and the theory practice gap. It is well recognised that graduates require extensive support and development throughout this very difficult time. In Victoria graduate nurse programs are a recognised vessel to deliver this support.

Quality graduate programs which meet the satisfaction of graduate nurses are required to provide effective support. The implications of minimal support are enormous and can lead to graduates leaving the profession. There is much in the literature suggesting the importance of each of the varied components of graduate programs however there is minimal comparisons made between various programs. As a result it was difficult to measure the qualities of programs.

The purpose of this study was to explore and compare various graduate nurse programs and identify whether the programs were satisfying the needs of graduate nurses. An exploratory descriptive design was utilised and a written questionnaire was employed to gain data.

The findings of this research indicated that the delivery of graduate nurse programs within this study were not consistent in content and quality. Overall graduates were satisfied with their graduate nurse program although they identified there were areas which required improvement. This project has suggested that the analysis of graduate nurse satisfaction is vital in identifying quality programs that retain graduates. It is essential that ongoing evaluation of programs are completed by graduate nurses to ensure they are satisfying their needs and thus retaining them within the nursing profession.

STATEMENT OF SOURCES

This thesis contains no material published elsewhere in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other institution. All research procedures reported in the thesis received the approval of relevant Ethics Committee.

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1.0   Introduction

The transition from student nurse to registered nurse Grade 1 is a difficult journey for many graduate nurses. Although graduates begin the transition process with a vast amount of theoretical knowledge they require consolidation of their clinical skills to become a skilled practitioner. Graduates need to be supported through this difficult period of transition by a structured Graduate Nurse Program (GNP) that provides an adequate amount of supernumerary time, preceptorship supervision and a coordinator to support graduates as required. This research was undertaken because of the passion the researcher had surrounding graduate programs and that the needs and expectations of the graduate were met. There have been many anecdotal stories recounted about the horrors some graduates face during their transition from student to graduate: minimal support and lack of supernumerary time. Poor support has enormous implications for client safety and can also lead to graduates leaving the profession. This research explored the components of some programs in Victoria and identified if the graduates were satisfied with the program that they completed.

The chapter will provide a background to the topic and identify the purpose, objectives and significance of the study. In addition, a comprehensive review of the literature is presented from both a historical and contemporary perspective.

1.1 Background

1.1.1 Nursing education

Nursing education is continually changing and developing to meet the needs of patient care. Throughout nursing history nursing education has advanced significantly, with many reviews and changes being made. Russell (1990) highlighted that reviews such as Truskett (1969), Ramsey (1970) and Sax (1977) have significantly contributed to the changes in nursing education. These changes have ranged from slight variations in curriculum to moving from hospital based training to nursing education in the university setting. One of the first courses in a university commenced in 1967 by the University of New England in conjunction with the Armidale and Royal North Shore hospital. Students in this course had the opportunity to undertake a combined degree in both nursing and arts or nursing alone (Russell, 1990).

There were many reasons why it was essential for nursing education to move from hospital training to the tertiary sector. According to Russell (1990) many reports reviewed hospital nursing training and highlighted various problems. These ranged from the needs of the hospital taking priority over the education needs of the nursing trainees, to curriculum being outdated and not meeting the professional role of the nurse. Another issue identified relates to budgets. Allocated resources for training were buried within the hospital global funding; resulting in hospital administrators using the funds as they saw appropriate and were not all used for the educational purposes (Commonwealth Department of Human Services and Health, 1994). To ensure the nursing profession moved forward it was critical to move nursing training into the tertiary sector in keeping with the ideology of professional graduates.

Although it was apparent nursing education in Australia was required to move into the university, it was a slow and drawn out process. In 1978 there were 461 nursing students in six advanced education institutions, 1086 at the Newcastle Technical Collage and 22,500 students in hospital training programs (Commonwealth Department of Human Services and Health, 1994). Through various reviews and government changes, in 1984 the decision was made to move from the apprenticeship style of training in hospitals to a tertiary supernumerary model, initially at diploma and then bachelor level. The Health Minister, the Hon. Neal Blewett expressed the benefits of transition to the Australian parliament:

> *First of all, it will provide a better education and more flexible trained profession. Secondly, it will create greater employment opportunities for fully trained nurses. Thirdly, it will bring occupational and vocational benefits, particularly to women. Fourthly, it will certainly help to underwrite the status of nursing as a major profession in the health care field (Commonwealth Department of Human Services and Health, 1994, p 9).*

According to Russell (1990) this decision resulted in ensuring the last intake into hospital training was in 1990 and in 1993 the transfer was complete with all pre-registration nursing courses being conducted by institutions of higher education and by universities.

1.1.2   International Trends in Nursing Education

A similar process occurred in the United Kingdom with Project 2000. Before the introduction of Project 2000 the majority of general nurses were trained in hospital based schools. Students provided a high portion of hands on clinical work and were a significant component of the nursing workforce (Russell, 1990). Stevenson (1996) reported that Project 2000 was launched in 1989, at this time nursing courses were offered at a diploma level, with a curriculum that placed greater emphasis on health education, the prevention of illness and the theories which underpinned

the actions of nursing. Project 2000 redefined both the process and product of nurse education in the United Kingdom, aiming to produce a practitioner who possessed greater knowledge and skills to function in a rapidly changing health care environment (Gerrish, 2000).

The United States of America had a slightly different education process. They did have three levels of qualifications the diploma program, the associate degree program and a baccalaureate (Russell, 1990). The three year diploma programs were conducted by hospitals although according to Day (1997) these programs were phased out in the early 1980's. The associate degree programs were two year courses conducted by colleges; these were introduced in 1952 in an attempt to determine if a two year course was appropriate to prepare beginning bedside nurses. The four year baccalaureate was conducted by universities and led to a Bachelor of Nursing Science or equivalent (Russell, 1990). In both of the two and four year courses students were supernumerary and gained experience in nursing settings (Day, 1997).

1.1.3 The last decade

The move from hospital training to the tertiary sector in Australia brought along issues of its own. A government report entitled the National Review of Nurse Education in the Higher Education Sector- 1994 and Beyond was conducted to assess whether the system of nursing education was meeting the needs of community and if it was educating the nursing profession in the way in which Australia needed (Commonwealth Department of Human Services and Health, 1994). There was much discussion in the report regarding employers being critical of graduates clinical work and organisational skills, which they attributed to the less clinical exposure of graduates in their undergraduate program. Employers also stated at the end of the graduate year graduates had developed a marked improvement in these areas.

The findings of the 1994 report also suggested that higher education was providing a sound foundation for continued learning in the workplace and it should be evaluated for long and short term outcomes. The review further recommended (12.2) that all undergraduate student nurses need to undertake a consolidation period of no less then four weeks prior to finishing the course in a clinical setting (preceptorship). During this period undergraduates should be assessed by both the education and health sector (Commonwealth Department of Human Services and Health, 1994).

Other recommendations from this report included a recommendation regarding mental health. The incidence of mental health issues within the community was increasing due to deinstitutionalisation of mental health facilities. As a result a significant component of mental health education was required to be included within the undergraduate course. This was recommended as the undergraduate mental health course ended and the introduction of the comprehensive curriculum commenced. Recommendation 10.6 outlined the importance of a comprehensive course which included not only mental health components but also basic strands in the areas of medical/surgical and community health nursing for patient/clients across the life span. Nursing education continues to change and adapt to the changing needs of the profession, community and health care sector (Commonwealth Department of Human Services and Health, 1994).

The most recent report into nursing education was completed in 2002 entitled National Review of Nursing Education 2002: Our Duty of Care. It reviewed nursing education across the nation and made many recommendations that reflected the current nursing shortage throughout Australia. This report discussed the undergraduate nursing curriculum and suggested that Australia have a comprehensive program for nurses which

enable them to work in different areas of nursing practice. It reinforced the 1994 review's recommendations about the content pertaining to mental health and aged care. In addition, the report recommended (22) that the minimum level of qualification for entry into nursing should remain a university based bachelor degree with a minimum length of six full time or equivalent semesters (Commonwealth Department of Human Services and Health, 2002).

Interestingly, this report did recommend that the National Nursing Organisations of Australia review the financial benefits of students being employed in hospitals whilst undertaking their nursing course. Recommendation 13 stated:

> *With a view to achieving national consistency, the National Nursing Council of Australia should examine the financial benefits and experience that might accrue to student nurses (and the implications for the workplace) from their employment in health workforce at their level of competence (but not as part of the requirements of their educational program)(Commonwealth Department of Human Services and Health, 2002, p142).*

This recommendation stated that the Australian Nursing Council should address this recommendation, in addition the National Nursing and Nursing Education Taskforce was established by the Commonwealth Department of Education Science and Training (DEST) to implement all recommendations of the 'Our Duty of Care' 2002 report (The National Nursing and Nursing Education Taskforce, 2005). This task force is currently reviewing the possibilities of employing student nurses, along with a number of other issues impacting upon the nursing profession (The National Nursing and Nursing Education Taskforce, 2005).

Both the 1994 and 2002 nursing education reviews highlighted issues relating to graduate programs. The 1994 report recommended that graduates at beginning level and on initial employment, need to have access to more experienced nurses to support them through this time. They also recommended programs which include appropriate induction, orientation, peer support, mentoring and introduction to specific clinical requirements (Commonwealth Department of Human Services and Health, 1994). Recommendation 12.4 of the 1994 report suggested that GNPs should not be 12 months in length as this was unnecessarily long and expensive (Commonwealth Department of Human Services and Health, 1994). The 2002 report made one recommendation on GNPs and was broader in its approach. It suggested that to ensure consistency and quality in the development and delivery of programs, there needed to be a national framework which should provide guidelines and standards for institutions and employing institutions should be responsible for meeting these standards. In addition state and territory nursing boards should accredit these programs (Commonwealth Department of Human Services and Health, 2002).

A senate inquiry entitled 'The Patient Profession: Time for Action, report on the inquiry into nursing' was also conducted in 2002 and was a government initiative in response to the recognised shortage of nurses throughout Australia. It was conducted in an attempt to evaluate why nurses at all levels were leaving the profession and to identify workplace planning for the future. This report highlighted that issues related to the transition of new graduates have a significant influence on recruitment and retention. Data revealed that a significant number of nurses depart nursing within the first year following registration (Senate Community Affairs Committee, 2002). This is echoed by Clare and van Loon (2003) who suggested the quality of graduate's transition had a direct effect on their desire to continue practising as a Registered Nurse. It is therefore vital

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hospitals provide a quality GNP which has effective strategies to support and satisfy the needs of new graduate's during transition to ensure they are retained within the profession.

In addition to the work of the Retention and Recruitment Committee and the Senate Inquiry, the Australian Nurses Federation (Victorian Branch) fought in the Australian Industrial Relations Commission to improve the nurse's award in an attempt to recruit and retain nurses. Many recommendations were approved, such as improved nurse patient ratios, an increase in remuneration and study leave (Industrial Relations Commission, 2004). The change in nurse patient ratios required and will continue to require a large increase in Registered Nurses. It is therefore imperative for the future of the nursing profession that recruitment and retention of nurses is continually addressed.

Along with the various reports and workplace developments there were also changes occurring in the tertiary sector. Clinical placements for students were significantly reduced in order to decrease costs, especially clinical costs. Australian Catholic University for example reduced their clinical placement hours from 1800 hours to 840 hours (Australian Catholic University, 1995). This has resulted in increasing the complexity of the requirements of graduate year programs, as graduates require more time and resources to consolidate their practice.

The importance of providing a GNP which provides structure, support and preceptorship for newly qualified graduates is well recognised (Nurse Policy Branch, 2003; Evens, 2001; Clare and van Loon, 2003; Commonwealth Department of Human Services and Health, 2002; Amos, 2001). Currently in Victoria the Department of Human Services provides funding for public hospitals as part of the Training and Development Grant in the amount of $13,000 per graduate. This funding is given to assist in

providing a quality program which meets the graduates and organizational needs (Nurse Policy Branch, 2003). It is questionable whether hospitals are using this funding for the intended purpose (Senate Community Affairs Committee, 2002). Large public metropolitan hospitals receive a substantial amount of money through this grant. A hospital employing 100 graduates will receive in the vicinity of 1.3 million dollars. If hospitals are not using this money for the GNP, the question then arises where is this money being used? Private hospitals do not receive such funding although they employ a substantial number of newly graduated nurses.

In order for public hospitals in Victoria to receive funding it is expected that they will adhere to the Department of Human Services (DHS) GNP guidelines. The DHS reviewed the GNP guidelines in 2003 as a result of the various reports suggesting a need for consistency and quality in the delivery of GNPs. The guidelines cover the various components of the GNP including the fundamental principles, the requirements of the hospitals culture and the program structure. Various elements such as supernumerary time; orientation; preceptorship and evaluation of the GNP are discussed. The guidelines provide direction for hospitals providing the programs. Although the guidelines are not prescriptive they included a section on how to demonstrate outcomes. This section outlines some examples of markers which can assist in identifying the graduate performance and program effectiveness (Nurse Policy Branch, 2003). These markers are suggestions only and when hospitals have to provide evidence at the end of each year on their GNP the evidence required is minimal. It consists of a section requiring the hospital to broadly outline their revenue, expenditure and the amount of theoretical hours offered in the GNP. There is also a section for employment details (Department of Human Services, 2003). Therefore it is largely left to the hospital conducting the program to outline the structure of the program which will include details of the amount of rotations, supernumerary time and support

provided to the graduates. This has resulted in a broad variation in quality of GNP's and raises the question whether graduates are satisfied with these programs.

1.2 Purpose

The purpose of this study was to explore and compare Graduate Nurse Programs (GNP) in Victoria and identify whether the programs were satisfying the needs of graduate nurses.

1.3 Objectives

The objectives of this research project were to:

1.3.1. Determine the demographical detail of graduates;

1.3.2 Establish graduates place of employment following their GNP, thus identifying hospitals retention rates;

1.3.3 Explore why graduate nurses chose a particular program;

1.3.4 Describe the components of GNP's including;

1. Rotations;
2. Preceptorship;
3. Supernumerary time;
4. Time spent with the GNP coordinator/Clinical Educator;
5. Support;
6. Feeling a part of the team;
7. Theoretical component;
8. Performance appraisals;

1.3.5 Establish the graduates' satisfaction levels;

1.3.6 Determine if graduates were required to complete program evaluation, identifying their satisfaction level;

1.3.7 Identify if graduates believed that they will remain in the nursing profession for the next five years;

1.3.8 Gain an insight into the views of Graduate Nurse Program Coordinators;

1.3.9 Make recommendations to improve Graduate Nurse Programs.

1.4 Definition of Terms

For the purpose of this research the following terms are defined to facilitate understanding of the context in which they are used.

Graduate Nurse (graduate): A person who has completed an undergraduate nursing course and is registered by a Nurse Regulatory Authority.

Graduate Nurse Program: A structured curriculum offered by the work place of usually 12 months duration devised to support the graduate through transition from student to a graduate nurse.

Internship: Refers to a program designed for graduate nurses to facilitate their transition in the USA. They can differ in length from eight weeks to one year.

Preceptor: A preceptor is an experienced and competent registered nurse who acts as a clinical role model and resource person for newly employed registered nurses (Department of Human Services, 1997, p 9).

Preceptorship Program: Educational programs which provide a one-on-one relationship between a graduate and preceptor. The preceptor orientates the graduate to their roles and responsibilities in the unit, and to informal and formal customs and culture of the workplace (Department of Human Services, 1997, p9).

Reality Shock: Reality shock is a term used to describe the phenomenon and the specific shock-like reactions of new workers when they find

themselves in a work situation which they thought they were prepared for and then suddenly discover that they are not (Kramer,1974).

Satisfaction: A feeling of fulfillment and sense of happiness.

Supernumerary time: refers to time where graduates are not considered part of the rostered staff numbers.

Transition: "The transition is the period of learning and adjustment to the requirements of nursing in which the graduate acquires the skills, knowledge and values (additional to those learned during undergraduate study) required to become an effective member of the nursing workforce" (Commonwealth Department of Human Services and Health, 1994, p 215).

1.5 Significance of the Research

There are many issues facing graduate nurses in the first year of practice. They range from reality shock to graduates feeling accepted and part of the team. There have been many reports and initiatives which have highlighted and compounded these issues over the past decade. It has been clearly identified that there is a need for consistency in the delivery of high quality GNP to combat these issues. GNPs need to meet the satisfaction of graduates to ensure graduates have a positive transition and remain working within the nursing profession. It is timely that this research is undertaken, as graduate nurses are the essence of the professions future.

Following an extensive review of the literature including electronic data bases including CNAHL, Proquest, Eric and Medline little comparative data on GNPs was found in particular no study conducted in Victoria. This was also echoed by a review conducted by the Queensland Nursing

Council (2001) which suggested that there was minimal literature comparing various GNP which in turn makes it difficult to measure quality. There was also minimal literature regarding graduate's satisfaction of each component of graduate nurse programs. Therefore this research was timely and will contribute to the body of knowledge in regard to graduate nurse programs and the satisfaction level of newly graduated nurses.

1.6 Literature Review

1.6.1 Transition

There are many international and national research projects, which describe the varied issues associated with the transition from student to graduate (Maben and Clark, 1998; Oermann and Moffitt-Wolf, 1997; Day, 1997; Cobal, 1998; Thomas, Bounds and Brown, 1991; and Winter-Collins and McDaniel, 2000). Maben (1998) outlined various terms which graduates have used to describe their experience of transition. These include; terrifying, distressing, frightening, horrible, stressful, worried and absolute hell. These terms give a very clear picture of how many graduates experience this period. Transition has also been described as an intellectually, emotionally and physically exhausting experience (Clare and van Loon, 2003). It is extremely important to gain an understanding of the issues facing them within this transition to enable a better and informed understanding of how graduates can effectively be supported through this time.

Throughout the literature regarding the transition period the term 'reality shock' is regularly discussed (Clare and van Loon, 2003; Amos, 2001; Evans, 2001; and Maben and Clark, 1996). Reality shock is a term used to describe the phenomenon and the specific shock-like reactions of new workers when they find themselves in a work situation which they thought they were prepared for and then suddenly discover that they are not (Kramer,1974). Many graduates find an intolerable conflict between bureaucratic and professional ideals (Evans, 2001; Gerrish, 2000; Cobal, 1998; and Maben and Clark, 1998). They are caught between the tertiary setting where they have been for the past few years preparing for employment and the new world of employment within a clinical setting.

Clare and van Loon (2003) introduced many issues associated with transition in their paper about the best and worst aspects of transition.

Their study used multiple methods to obtain gain data: Twenty-one focus groups were held throughout Australia. The recurring themes from the focus groups were collated and two questionnaires developed. Three hundred and fifty Directors of Nursing and 550 graduates were surveyed. Some of the positive aspects of transition were that graduates enjoyed consolidating their skills and being able to feel productive as their skills and knowledge was put into worthwhile practice. They enjoyed the thrill of finally becoming independent in their work environment. Some of the worst aspects of the transition were the heightened stress that most graduates experienced. Some of the key feelings graduates expressed was confidence issues and anxiety. Graduates stated that they experienced a lack of confidence in their knowledge and ability. They found difficulties in working full time shift work, tiredness and social isolation. Just under half of the respondents unfortunately also described a lack of professionalism and bullying from other nursing members in the team. Many of these issues identified will now be expanded upon which include; theory practice gap; stress; socialisation; responsibility; confidence; relationships with colleagues; nursing skills; workload; shift work and moving through transition.

1.6.2 Theory Practice Gap

In hospital nurse training, the majority of student experience was within the environment they were working within and theory could be directly related to practice. Both clinical and theory were conducted within the hospital setting. Within the university setting nursing practice and theory is taught within the University surrounds, in lectures or laboratories and some time in the clinical setting. As a result when graduates move from the educational environment to the service environment, they experience conflict associated with changing priorities and pressures (Godinez, Schweiger, Gruver and Ryan, 1999).

Further to this conflict between the learning and working environment, there is also the difficulty of teaching clinical situations in a theoretical context. As Benner (1984, p36) suggests:

> *theory offers what can be made explicit and formalised, but clinical practice is always more complex and presents many more realities than can be captures by theory alone.*

Students of nursing are taught the theory although to become proficient in the clinical environment further clinical experience is required. Benner (1984) undertook research into skill acquisition, when applying the skill of nursing to various clinical settings. This study interviewed 21 peers of new graduates and their preceptors in the orientation period in three different hospitals. The results of this study identified that there are five levels of skill acquisition and development, these include: novice, advanced beginner, competent, proficient and expert. Benners work in this area is considered fundamental and is referred to extensively throughout the literature. The new graduate enters nursing employment according to Benner as a novice or an advanced beginner and with further clinical experience develops into a competent practitioner. In contrast, in Australia based upon Australian Nursing Council competencies all graduates are considered to be competent at a beginning level in order for them to be registered as a nurse.

Some graduates find the theory practice gap significant which may lead to frustration and anxiety during the transition period. Boychuck Duchscher (2001) completed a study using a phenomenological qualitative approach to explore how five graduates experienced the first six months of employment. This research highlighted that graduates experienced disappointment and disillusionment in applying nursing theory to clinical practice. Boychuck Duchscher (2001) stated new graduates attempted to apply context-free concepts to clinical situations and were naturally confused when they discovered that this did not work. These participants

found it very difficult to transfer the theory they had learnt at university to the working world of the nursing profession.

Day (1997) undertook a descriptive survey design study employing a questionnaire to gain data from 35 graduates. This study identified that graduates found the reality of nursing practice differed quite significantly from what they believed they had been prepared for through their university education. The graduate found that the nursing role consisted of management of tasks which were to be completed within a set time frame, rather than being able to provide holistic care for each of their patients (Day, 1997). This study highlighted aspects of both reality shock and stress related to the theory practice gap. Universities educate undergraduate students on the importance of providing holistic care however, in reality the difficulties they faced is that their role is more task orientated. As Godinez et al (1999) suggested graduates must learn how to balance the needs of the individual patient with the needs of the clinical setting. Conflicting expectations lead to further stress and anxiety.

1.6.3 Stress

Ross and Clifford (2002) collected quantitative and qualitative data via questionnaires and interviews to explore the transition from student to Registered Nurse. Data were gathered from participant's pre and post qualification. This study emphasised how the transition period is stressful for newly qualified nurses. This finding is echoed by many other authors (Boychuck Duchscher, 2001; Casey et al, 2004; Clare and van Loon, 2003; Delaney, 2003; Gerrish, 2000; Kelly, 1996; Maben and Clarke, 1998; Oermann and Moffit-Wolf, 1997 and Walker, 1998). Oermann and Moffit-Wolf (1997) highlighted some of the causes of stress experienced by newly qualified nurses. They used a descriptive exploratory design to examine stresses, challenges and threats experienced by 35 graduates. The instruments used in this study were three fold consisting of a

demographic data sheet, a social support instrument and a modified Pagana clinical stress questionnaire. The study identified how during the initial orientation period graduates experience moderate stress. The most frequently identified stressors within the period of orientation, were the lack of experience as a nurse, interactions with physicians, lack of organisational skills and finally new situations and procedures. All these stressors directly relate to reality shock.

Charnley (1999) also studied the stress level of new graduates. This study employed a grounded theory approach and semi-structured interviews were conducted with 18 graduates to explore their perceived stress. This study extended past the orientation period to identify the level of stress during the first six months of the graduate year and their results indicated that is was considered to be a very stressful time. This study identified several factors, which contributed to stress including problems of staff shortages, work pressures and the lack of available support. Another very important stressor, which this study identified, was the impact of the theory practice gap between educational priorities and the reality of clinical practice.

1.6.4 Socialisation

The period of socialisation is stressful as graduates not only need to learn new facts and new skills they are also required to become immersed in a new culture with norms and value expectations (Taylor, Westcott and Bartlett 2001). Graduates want to feel part of this new culture and work environment. Philpin (1999) states for graduates to feel accepted they need to undertake a process of internalising the norms, beliefs and values of the new professional environment. They need to learn the language, the workplace rules and develop different ways of thinking (Clare, White, Edwards and van Loon, 2002). Graduates also need to develop survival skills, from gaining a grasp of the politics to identifying who will be

receptive if asked a question. Moorhouse (1992) suggested that the influence of other nurses in the unit have a significant effect on the socialisation of graduates. Graduates observe other nurses in the work environment and use them as role models and replicate the behavior observed.

Another factor associated with socialisation is the area in which the graduate is working. A study conducted by Philpin (1999) identified that there was a difference between socialisation in acute clinical areas compared to chronic clinical areas. Acute areas were identified as the operating suite and surgical wards where as the chronic environments were represented as medical units or elderly care wards (Philpin, 1999). Philpin (1999) used a grounded theory approach and interviewed 18 nurses working in three Welsh hospitals. The acute areas were identified as harsher in regards to socialisation and were associated with many instances of negative role learning. Socialisation within the chronic areas was considered more satisfactory and it was found that permanent staff in these areas were more accepting and encouraging of newly qualified nurses.

Boyle, Popkess-Vawter and Taunton (1996) studied new graduates in critical care areas. They used a descriptive comparative design and conducted questionnaires about socialisation at 1 to 2 weeks, 3months and 6 months. The results indicated that effective preceptoring and adequate support systems were associated with positive outcomes within the first 6 months of the socialisation period. New graduates who experienced these supportive environments had more self-confidence, less anxiety, less role conflict and ambiguity and had more job satisfaction. These studies highlight the importance of graduates being provided with a supportive environment in ensuring an effective socialisation period.

1.6.5 Responsibility

The change in role responsibility between the student and graduate is dramatic. Students always have a more experienced nurse working with them, assisting them in their decision-making. Graduates have resources available but they have the responsibility of their own workload. Amos (2001) outlined how graduates found the increased responsibility during transition daunting. This study was an exploratory evaluation into transition. Two forms of data collection were utilised, firstly semi-structured interviews with 5 newly qualified graduates who worked in a Gynaecology unit and secondly a focus group of 5 newly qualified graduates who worked on a non-gynaecology unit were conducted. Amos (2001) found that the graduates were worried about 'doing the right thing' and stated it was very difficult to check if delegated tasks had been completed correctly when the unit was so busy. Moorhouse (1992) also highlighted how the accountability of making nursing decisions in spite of whatever advice they may have received from their colleagues weighs heavily on some new graduates shoulders.

Graduates were not only stressed and concerned about responsibility and accountability for their actions, they also felt frustrated that they were expected to be independent in their practice but they had to rely on more experienced nurses for know-how. Casey, Fink, Krugman, and Propst (2004) described this as independence versus dependence. Casey et al (2004) completed a very recent study that identified the stresses and challenges experienced by graduates in six acute hospitals. The researchers used a descriptive comparative design and employed a questionnaire to gather data from a sample size of 270 graduates at various points during the graduate program. Amos (2001) also described a similar phenomenon which is called a double-edged sword where new graduates enjoy being independent but having this autonomy is

considered as a responsibility. One participant stated that i*t is nice to sort out somebody's pain relief yourself* (Amos, 2001, p 5).

Biley and Smith (1998) also identified how graduates find the change in responsibility as a significant issue during transition. This study used an ethnographic approach to discover graduate's perceptions on how Problem Based Learning (PBL) in the undergraduate setting prepared them for the transition into the nursing profession. A sample of 12 graduate nurses were interviewed and the results revealed three significant themes. The first theme was identified as *the buck stops here*; graduates stated that they were very aware of their sole responsibility and accountability for their learning and practice. This differed from what Amos (2001), Casey et al (2004) and Moorhouse (1992) found that graduates were more concerned with the responsibility they had as a Registered Nurse to ensure they rectified any knowledge insufficiency they may have. They *refused to allow their status as novices to be used as an excuse for a lack of knowledge* (Biley and Smith, 1998, p 7). They considered it their responsibility to ensure their skills were appropriate as soon as possible. The second theme identified was *not an unthinking assistant*; this emerged as graduates felt they differed from traditionally trained nurses. They considered themselves far more open-minded, more aware of research and were innovative. The third theme was outlined as *all of a sudden* which describes the graduate's perceptions of their transition from student nurse to all of a sudden being a qualified Registered Nurse. It was highlighted that PBL graduates experienced the same trauma and feelings of inadequacy as the traditionally prepared nurses.

1.6.6 Confidence

Confidence is another area which newly qualified graduates have difficulties developing within the transition period (Amos, 2003; Casey et al, 2004; and Clare and van Loon, 2003). Amos (2001) suggests that confidence brings a feeling of certainty, which manifests into greater self-reliance and ability to function more autonomously. Therefore issues of confidence can create further stress and anxiety for them. Clare and van Loon (2003) described the problems relating to confidence as a 'crisis in confidence' in their multiple method project. Three themes were identified relating to confidence. The first was the crisis in confidence was largely due to the lack of knowledge and experience within the clinical area. Participants in this study suggested the worst thing about transition was the overwhelming feeling of having inadequate knowledge to enable them to make sound clinical judgments. Secondly graduates felt they did not have enough opportunities to put clinical skills into practice in the undergraduate program to feel confident. This finding was also echoed by Ellerton and Gregor (2003). Clare and van Loon (2003) suggested that confidence issues were compounded by other nursing members voicing their negative attitudes regarding the under preparation of graduates (Clare and van Loon, 2003 and Walker, 1998). Nursing staff were reinforcing the graduates' feelings of self doubt. Lastly graduates were unable to understand the large amount of 'unspoken nursing knowledge' that is only gained through experience. Unspoken knowledge is described as organisational knowledge which is vital to achieve required nursing tasks for example how to get blood picked up to be taken to pathology or how to take a patient to the radiology department. One participant stated *there is so much unsaid stuff to learn about how to get simple things done and not knowing makes me feel dumb and dents my confidence* (Clare and van Loon, 2003, p28). Amos (2003) found that their confidence improves with further experience and increased knowledge.

1.6.7 Relationships with Colleagues

It is vital that there is open communication within a clinical setting to ensure a successful outcome for the patient. Graduates have described both positive and negative experiences with both nursing and medical team members. Boychuck Duchscher (2001) identified that some graduates found nursing members to be nice and helpful but others were not as nice exampled by one respondent stating *they made lists of everything you didn't do or didn't do correctly (p6)*. Others described hostile behavior from colleagues just because they had come from the Project 2000 program (transfer of nursing education into the tertiary sector in the United Kingdom) (Maben and Clark, 1998). Clare and van Loon (2003) found more disappointing results with 41% of their participants describing unprofessional and bullying behaviors. These behaviors included horizontal violence, bitchiness and rudeness. Graduates felt overwhelmed by these attitudes and those who experienced this behavior regularly considered leaving or had left the nursing profession (Clare and van Loon, 2003).

The difficulties graduates experience with other members of the nursing profession may reflect on the amount of support graduates receive. Parker, Plank, and Hegney (2000) suggested that 'senior' nurses are less likely to provide support. This information was identified through a questionnaire given to 2800 Registered Nurses in Queensland with a response rate of 53%. The questionnaire related to whether nurses believed new graduates were supported within the profession. The data indicated that the greater the years of service a nurse has the greater the perception that they are satisfactorily supported. Evens (2001) also proposes that the world for a new graduate is a complex one and is quickly forgotten by more experienced nurses.

Some graduates feel stressed and anxious when having to communicate with doctors (Boychuck Duchscher, 2001; Casey et al, 2004; Delaney, 2003 and Oermann and Moffit-Wolf, 1997). Whilst on a clinical placement an undergraduate student nurse has minimal interactions with physicians as the Registered Nurse they are working with tends to undertake this communication (Casey et al, 2004). Once employed graduates have to learn very quickly how to effectively communicate with interns and residents as well as other members of the health team.

Some graduates explained that they had experienced verbally abusive behavior from medical staff which resulted in new graduates adjusting and manipulating the situation to achieve the outcomes required (Boychuck Duchscher, 2001). Casey et al (2004) also described how graduates felt less confident communicating with doctors within the first six months of the program but between 6 to 12 months they have gained more confidence within this area. Amos (2001) had very different findings which suggested that participants expressed very positive remarks regarding medical staff. They did however state that they lacked the required knowledge to challenge medical orders but they felt confident enough to do so. The study by Casey et al (2004) was an American study, where as the study by Amos (2001) was based in the United Kingdom. The results may reflect the differences in undergraduate education in each of these countries.

1.6.8 Nursing Skills

Ellerton and Gregor (2003) conducted a qualitative study using open-ended interviews to explore various fundamental nursing practices such as planning and priority setting. Eleven graduates were interviewed three months following graduation. They were required to describe their daily work requirements and discuss what they found challenging; graduates identified that they developed a time plan for each shift which included the

requirements for each of the patients they were assigned. Graduates stated that they often were required to re-prioritise this plan before they left the nursing station due to changes in processes or the patient's care which they also found very challenging.

Time management is a significant issue for many newly qualified graduate nurses (Amos, 2003; Casey et al, 2004; Maben and Clark, 1998 and Oermann and Moffit-Wolf, 1997). Being able to organise and manage care within a time limit can be a difficult task. Casey et al (2004) suggested that graduates with less then 6 months experience felt they had a lack of organisational skills, difficulty in prioritising and were not efficient. Graduates experienced many challenges during each shift and are required to manage them in the most efficient way and at all times ensuring their patients are safe and comfortable. The graduates' time management skills are compounded by the varied new skills and knowledge they were required to learn. Working through each shift, the time spent in locating equipment, procedure manuals and consulting others for help in unfamiliar situations left them dashing to complete their work on time (Ellerton and Gregor, 2003). Casey et al (2004) outlined how time management implications were reflected at the end of the shift with many graduates having difficultly leaving work on time as they felt they had not been able to achieve what was required.

Due to the reduction in minimal clinical exposure graduates may not be competent is completing various nursing skills. Maben and Clark (1998) found that initially graduates lacked the ability to perform a range of clinical skills. Amos (2003) found that they have had some exposure to varied clinical tasks but they have not yet had enough time to practice and consolidate these skills. Some of the skills included catheter insertion, aspectic technique and caring for dying patients and their relatives. These are some of the fundamental skills required for daily nursing practice.

Casey et al (2004) also identified other skills which they had difficulty with, including intravenous therapy and caring for patients with patient controlled analgesia (PCA). In addition Casey et al (2004) found that even after one year of practice 41% of participants still felt uncomfortable caring for patients with an epidural catheter.

1.6.9 Work load

There is much in the literature describing how increasing work loads result in graduates feeling overwhelmed with the work requirements (Casey et al, 2004; Maben and Clark, 1998 and Walker, 1998; White, 1996). The increasing workload is further compounded by nursing shortages. Casey et al (2004) illustrated how many graduates described their work environments as being 'understaffed' and expressed concern regarding nursing shortages and retention issues. When there are increased workloads and staff shortages graduates find themselves in a difficult situation, they are attempting to manage their own difficult workload and also require assistance from other nursing staff that is just as busy. Walker (1998) outlined a graduates' statement regarding workload issues and reflects the difficulties and conflict faced with attempting to complete care in a busy environment: i*t's just so busy and you're always understaffed and run off your feet and you can't always do what you want to do and often things are rushed and patients aren't treated as well as they should be* (Walker, 1998, p40).

1.6.10 Shift Work

For many graduate nurses the reality of shift work can be extremely difficult for them to accept. Many student nurses believed that the graduate year will be easier than studying full time and working part time whilst completing the undergraduate course. Unfortunately they soon realise being a novice and working full time shift work is exhausting. Many graduates experience extreme tiredness and it is not uncommon for them

to go home to bed following an early shift (Clare and van Loon, 2003and Maben and Clark, 1998). Feeling tired and working shifts also caused graduates to feel socially isolated (Clare and van Loon, 2003and Maben and Clark, 1998).

1.6.11 Moving Through Transition

Boychuck Duchscher (2001) study about transition outlined some of the stages new graduates work through during transition. Initially graduates stated that they felt an enormous level of frustration due to wanting to deliver quality care, but they did not have the knowledge, focus, time or energy to do so. Also graduates could not achieve independence in their role as they were consistently asking for assistance from other team members. Graduates were focused on 'doing', therefore completing the required tasks on time and not displaying their obvious inexperience. Two to three months into their transition graduates stated that they began to care for their patients more holistically. This occurred when they became more familiar with the tasks and ward routines become a smaller vision of the nursing role. They began advocating for their patients and were able to discuss the patient's progress in relation to their stage of recovery or illness. After five months of transition graduates began to question care or decisions which had been made, as they felt that they had some clinical experience to enable them to rationalise their questions (Boychuck Duchscher, 2001). This explanation of transition would suggest that with time and further experience graduates find the transition period easier. Casey et al (2004) disagreed with these findings and suggested that the most difficult time for graduates is in the 6-12 month period following graduation, as they feel less comfortable and confident in their nursing practice at this point compared to the three and the 12 month point. Casey et al (2004) also found that graduates believed that is takes at least 12 months to feel comfortable and confident practicing within an acute care setting. The differences in these two studies could be contributed to the

difference in methodology, sample size or country of origin. Casey et al (2004) is a descriptive, comparative design with a sample size of 270 graduates and was completed in America, were Boychuck Duchscher (2001) is a Canadian, phenomenological study with a sample size of five.

In summary there is extensive literature describing the issues graduates face in the transition period which impacts upon confidence, stress and anxiety. These issues range from reality shock, stress, confidence and relationship difficulties with colleagues. Nursing shortages and increasing workloads compound the varied difficulties experienced by graduates. As a result of these difficulties graduates can be fragile in their new role (White, 1996). It is evident that graduates require extensive support to get through this very difficult transition and graduate nurse programs are one way in which this support can be achieved.

1.6.12 Graduate Nurse Program

Many studies identify the need for graduates to be nurtured and supported in their first year following graduation (Clare and van Loon, 2004; Cobal, 1998; Moorhouse, 1992; Winter-Collins and McDaniel, 2000). Structured graduate nurse programs are one way to provide this support and are well developed throughout Victoria. These programs are planned, conducted and evaluated by health care agencies, although they differ in content, level of support and evaluation. The following section will discuss the various aspects and components of graduate nurse programs.

There is paucity of literature found on evaluating and comparing programs. There was one study found which is referred to regularly in the literature. It compared an internship program to a hospital orientation in one organisation. The study was conducted by Dear, Celentano, Weisman and Keen (1982) and compared the role transition experienced by graduates in both programs. The internship program was a six month

structured program, where interns had four days in the clinical setting and one theoretical day per week. Interns (new graduates) worked in one surgical ward for six months and they then had the opportunity to undertake an elective in another surgical area. The orientation program was a two week program which aimed to ensure graduates were aware of the routines, policies and procedures of the organisations. The study was conducted over three years and there were 28 participants in the internship groups and 27 graduates in the orientation group. Data were collected by using a variety of data collection tools at various intervals during the course of transition. Variables such as knowledge of medical-surgical nursing, perceived autonomy, job satisfaction and clinical performance were measured. The findings revealed no significant difference between the two groups (internship versus the orientation group). This study had limitations as it only compared an internship to an orientation at one health care agency. It did not evaluate internships and orientations across different health care agencies which may have significantly changed the results. This study is also 22 years old and nursing has changed considerably since this time in Australia.

The following American evaluation studies have merit in discussing aspects of graduate nurse programs. Owens, Turjanica, Scanion, Sanhusen, Willianson, Herbert and Facteau (2001) developed an integrated program which was implemented across five organisations. The program was developed by stake holders throughout the different organisations. Their intention was to focus the program on 'how to' compared to previous foci, which had been conceptually based. The program was eight weeks in length and the structure of the classes were focused on practical knowledge and communication skills. The description of the program highlighted the theoretical aspects and there was some discussion regarding the role of the preceptor and the manger in the area. There was however no discussion regarding clinical education support or

the amount of supernumerary time. The evaluation had four aspects, reaction, learning, behaviors and outcomes. The retention rate was overall 88% which was suggested to be the ultimate goal of the program. The evaluation of the program was very focused on the actual classes provided and there was no data provided about satisfaction levels of participants. Evaluation of support in the clinical areas was also not discussed.

Another program evaluation was completed by Crimlisk, McNulty and Francione (2002) who developed a float Pool program for graduates with the aim of increasing the amount of staff in the float pool (nurse bank). The programs time frame was 4-5 months and there were three rotations, including medical, surgical and a specialty unit, plus time spent in the float pool. The theoretical content of the program was provided once a month for four months. Performance appraisals of the participants were extensive. They completed written evaluations weekly, which were reviewed by the preceptor, educator and nurse manager. Weekly or biweekly meetings were held with the new graduates, preceptor and educator to discuss progress and establish weekly goals. On completion of the each rotation graduates had to complete a written report summarising their progress. The evaluation of the program was conducted by interviews and the results presented by the authors was minimal, only identifying that graduates found the program to be 'terrific'. A follow up questionnaire was also sent to 32 graduates identifying a 96% retention rate. The data revealed that all graduates found the theoretical content to be beneficial. Unfortunately there was no discussion about the amount of supernumerary time graduates received. There was also little mentioned of the support for graduates in the clinical areas or the overall satisfaction level of graduates in this program. This evaluation study does have some interesting information in particular the way in which performance appraisals were managed but it does only describe the

benefits of one program developed in one organisation and did not compare other programs.

Another program evaluation was completed by Rosenfeld, Smith, ervolino and Bower-Ferres (2004) who sent a questionnaire to graduates who had completed a 'Nurse Residency Program' within the past five years. The sample group was 321 and the response rate was 36% with 112 completed questionnaires. As the participants names and addresses were accessed through the health services records only 7% of the sample were not employed within the organization. This excluded many of the participants who had left the organisation which may have added a considerable bias to the results. The aims of the questionnaires was to illicit the opinions, attitudes and overall satisfaction of the graduates who had completed the program at the New York University Hospital. This program was followed by an 8-12 week competency based preceptorship program. One of the aims of the program was to provide a structured first work experience that supports transition. The Nurse Residency Program was described as follows: graduates were employed within one clinical area throughout the program and were supported through a mentoring (The term mentor was interchanged with the term preceptorship regularly) process. There were regular education days which covered unit specific and general topics. 'Key' support was provided through unit managers and assistant unit managers. The type of support provided was not expanded upon.

The Rosenfeld et al (2004) questionnaire requested participants to rank their satisfaction relating to various topics such as experience as an independent nurse; the relationship with senior staff; clinical education days; access to leadership when required and classroom orientation. Participants were also asked to make suggestions on how the program could be improved. Although one of the aims of this study was to identify

the graduates overall satisfaction, unfortunately satisfaction levels were not presented in the paper. A general statement was given suggesting that overall the respondents endorsed the program.

There are similarities between the Rosenfield et al (2004) and the research undertaken in this Masters Thesis. It does however differ as Rosenfield et al (2004) only reviewed one health organisation and the majority of the participants were employed within that organisation. This research project accessed graduates through the university which resulted in data being collected from a variety of organisations and thus bias minimised. Also participants were asked to rate their overall satisfaction level and an overall mean value was provided. Finally Rosenfeld et al (2004) did not describe all the various components of the GNP such as supernumerary time, performance appraisals and time spent with the GNP coordinator/clinical educator for example. By generating this data graduate nurse programs can be compared across institutions and the participants' satisfaction level clearly established.

1.6.13 Preferences for a Particular Graduate Nurse Program

Before the components of a graduate program are discussed it is important to understand what particular elements of these programs appeal to graduates. Heslop, McIntyre and Ives (2001) completed a study that used a descriptive survey design. A questionnaire focusing on what the transition process would mean to 205 third year nursing students and the factors which influenced student nurses to apply to a particular program. Analysis of the data relieved that the location of the hospital was the most important factor. Secondly the reputation of the health organisation and thirdly the clinical rotations offered. Lastly familiarity with the organization was also important.

1.6.14 Orientation

There are several components of the graduate nurse program and one is orientation. This should focus on providing graduates with the tools to effectively function within the clinical area (Department of Human Services, 2003). Within the literature referring to graduate programs there is minimal reference made to orientation. The reason for this could be that the components of an orientation program are similar to that of a graduate nurse program although the time frame for orientation is much less. Orientation can range from one day to 12 weeks (Fey and Miltner, 2000; Kidd and Sturt, 1995; Morin and Ashton, 1998). The various components of orientation include Preceptorship, education concentrating on skills, support and feedback through performance appraisals (Kidd and Sturt, 1995; Fey and Miltner 2000 and Oermann and Moffit-Wolf, 1997).

Nursing skills are discussed as an important aspect in orientation (Currie, Vierke and Greer, 2000 and Kidd and Sturt, 1995; Meyer and Meyer, 2000). Graduates need to rapidly consolidate the skill of medication administration for example as this is a fundamental nursing skill which is used extensively during a given shift. They also need to quickly understand the general routines of the clinical area to assist them with their organisational skills. Some literature refers to the need for graduates to achieve skill checklists to facilitate this process (Currie, Vierke and Greer, 2000 and Meyer and Meyer, 2000).

There is also some discussion about competency assessment which needs to be achieved during orientation. Fey and Miltner (2000) outlined a competency-based orientation program. This orientation evaluation was an extensive orientation process and it could be suggested it has consistent components of a GNP although it was conducted over a 12 week period. The program had a 2 week education period in the classroom and topics were general and unit specific. The education was

focused on the achievement of various competencies. Graduates were assigned a preceptor and Fey and Miltner (2000) suggested the foundation of the success of the program was well prepared preceptors. Once in the clinical areas new graduates commenced caring for two patients and gradually increased their work load to 4 or 5 patients. Feedback meetings were established once a week to discuss progress relating to key aspects of performance and concentrated on competency achievement within a short period of time.

1.6.15 Rotations

A very important component of the structure of a GNP is the clinical rotations. The clinical area and the length of the rotation have a significant impact on the graduate throughout the program. There is minimal literature on which clinical areas are the most valuable for facilitation of graduate learning outcomes. There is also minimal literature on what are the best practice principles for the number of rotations and the appropriate length of these rotations. The Department of Human Services (Victoria) Graduate Nurse Program guidelines (1997) state that the department surveyed 54 hospitals asking them how many rotations are offered in their GNP, the majority of the hospitals suggested that graduates completed 3 to 4 rotations. The methodology of this data collection was not discussed and the satisfaction level of graduates or employers was not addressed. For GNPs to be compared it is essential there is data on the graduates satisfaction of the various components of a graduate nurse program.

Casey et al (2004) found that graduates were rotating to clinical areas such as medical/surgical and specialty areas. Specialty areas included critical care, psychiatry, rehabilitation and women's services. The amount of time spent in each clinical area was not identified except for the medical/surgical placement, although the time differed between not for profit and for profit organisation (12 to 24 weeks to 6 to 10 weeks). This

study did not identify how many rotations graduates complete within neither the program nor the satisfaction of graduates with the rotations that they completed.

Sigsby and Yarrandi (2004) completed an evaluation utilizing an experimental design to determine the difference in undergraduates' knowledge of post operative surgical patients when they rotated to the perioperative environment compared to those who went to a surgical area. The sample consisted of 280 students with 142 students rotating to a perioperative environment and 138 to a surgical unit. The results indicated that the students who rotated to the perioperative area demonstrated greater knowledge regarding the needs and care of surgical patients. Although the participants in this study were at the undergraduate level the findings may have some relevance related to the graduate year and may indicate that graduates develop further knowledge of surgical patient needs if they complete a perioperative rotation.

According to Philpin (1999) socialisation for graduates is harder in an acute clinical area compared to a chronic care environment. The reasons for this are graduates found the relationships with other RNs more difficult and the theory practice gap was more apparent working in an acute setting. Parker, Plank and Hegney (2001) suggested similar findings but they presented their results relating to the amount of support graduates received. These two studies suggest that overall; graduates will find the transition process easier in a chronic area. This is however limiting, as graduates need to consolidate their surgical nursing skills within an acute area, as well. This also conflicts with the rotation preferences undergraduate students want in their graduate nurse program. Heslop, McIntyre and Ives (2001) suggested that students preferred acute care areas such as surgical, pediatrics and emergency.

The best practice principles relating to the amount of rotations within a GNP have not been established. In the GNP guidelines used by the Department of Human Services (2003) it suggests that 2-3 rotations are perceived as valuable however there are no restriction and it is up to the health care facility to design their individual program. The Department of Human Services (1997) asked 61 year three students if they believed that rotations were appropriate within the program and 95% stated that they were. These participants were also asked how many rotations are desirable and 75% said 3 rotations. Boychuk Duchscher (2001) disagreed and proposes that graduates should not rotate to other areas until they have a minimum of a year post graduate experience in a consistent clinical environment. Her rationale is that there is a potential safety issue as graduates are required to enhance confidence, clinical skills, intellectual and emotional attributes and this is best facilitated by consistency of the work environment.

1.6.16 Preceptorship

Preceptorship plays a vital role in the transition period for newly qualified registered nurses and its benefits are extensively discussed within the literature (Anderson, 1998; Boychuk Duchsher, 2001 and Maben, 1998 and O'Malley, Cunliffe, Hunter, and Breeze, 2000) Preceptorships are educational programs which provide one-to-one relationship between a novice and an experienced nurse and are viewed as an effective way to facilitate the preparation of the realities of a work place (Brasler, 1993). This model enables a period of support which facilitates the transition into professional practice and socialisation into a new role and environment (Bain, 1996).

Preceptorship is organised during a graduate program to facilitate acquisition of knowledge and orientates the new graduate into the work environment. The support provided to graduates through this process is

diverse and includes demonstration, instruction, guidance, advice and supervision (Department of Human Services, 2003). Clare, White, Edwards and van Loon (2002) outlines how preceptorship is also a way in which they learn the policies, processes, communication networks and work organisation of the clinical area. The preceptor helps the new nurse understand what they don't know and creates learning opportunities and facilitates learning (Clare et al, 2002). Effective preceptorship enables graduates to be introduced to their role in the clinical environment through a supportive open relationship.

Mostly graduates who participate within a preceptorship program find it extremely beneficial. Day (1997) completed a descriptive study using a sample of 35 graduates who had a minimum of six months experience. This study identified that graduates found the preceptorship program to be successful in easing them into the nursing role, through a supportive learning process. Ellerton and Gregor (2003) found that graduates who were satisfied with the way they were managing in their role had accessible and competent preceptors. Boychuk Duchshcher (2001) found that graduates who were not participating within a strong preceptorship model felt that they had lacked boundaries within their practice and were madly trying to watch other senior staff to gain insight into what was acceptable and non-acceptable practice. The importance of strong supportive preceptorship relationships can not be overemphasized (Boychuk Duchshcher, 2001).

As preceptorship is a significant aspect of the graduate nurse program a preceptor should possess various attributes to facilitate the process. These include effective communication skills, approachability and experience within the clinical field. They should be competent, highly skilled, committed, friendly and enjoy teaching (Clare and van Loon, 2003; O'Malley et al, 2000). The United Kingdom Nursing and Midwifery Council

suggest that preceptors require a minimum of 12 months experience within the clinical area prior to being a preceptor (Nursing and Midwifery Council, 2005). Morton-Cooper and Palmer (2000) expanded on these traits and suggested a preceptor should be empathic, trustworthy, respected and they should inspire confidence. O'Malley et al (2000) recommends that preceptors should be carefully selected in order for the preceptorship program to be successful.

Preceptorship and mentorship approaches are extensively sited in the literature pertaining to graduate nurse and orientation programs. The terms preceptorship and mentorship are also used interchangeably. It is therefore important to clarify the difference between these two terms. Clare et al (2002) suggests a mentor gives wise counsel based on education, experience and good role modeling, they are sensitive, nurturing and provide feedback. From this definition it is difficult to identify a difference between the two terms. Morton-Cooper and Palmer (2000) suggests the difference is preceptorship is clinical socialisation and mentorship is career socialisation. This would suggest that preceptorship programs are short-term compared to mentorship being long term. This identified difference is echoed within the literature (Brasler, 1993; Clare et al, 2002 and O'Malley, et al, 2000).

The structure of a preceptorship program can differ within various clinical areas. O'Malley, Cunliffe, Hunter and Breeze (2000) found that preceptorship within one organisation differed significantly in understanding, documentation and implementation from ward to ward. Clare and van Loon (2003) in their research identified some best practice principles for preceptorship. Based on their research they suggest that the preceptors should be working the same shifts as the graduates for the first two weeks and from then on they should be rostered at least 2-3 shifts with the preceptor. These principles do not however outline an ideal

preceptorship program length. The Department of Human Services GNP developed in 1997 suggest that a preceptorship program should be 4 to 6 weeks in length however the benefits to this suggestion are not identified and it is not referenced. It is clear in the literature that preceptorship is short term although a definition of an appropriate length of time is unclear.

There are various difficulties preceptorship programs need to overcome to achieve success. Some of these include effective preparation for preceptors, appropriate preceptor selection, efficient rostering and lastly support for preceptors. Being a preceptor is a very demanding role. Preceptors need to balance the management of a full patient workload with teaching, supporting, and evaluating a preceptee. Effective preparation for preceptors is also essential. Preceptors require information regarding the program, all facets of the role and the support available for them. O'Malley et al (2000) completed a preceptorship program within one directorate; they developed a preceptorship package consisting of a learning package, group sessions for preceptors and preceptorship guidelines. Case scenarios were used in the group sessions to facilitate the application of the guidelines and to provide an opportunity to discuss effective strategies. This could be an effective and unique way of providing preceptor preparation; unfortunately the reported evaluation of this program was limited suggesting only the intention to undertake further evaluation and changes within the future.

Effective preceptor selection can be a very difficult task as there are many variables which play a role in the selection process. These include access to a preceptor who possesses the appropriate attributes for the role, the availability of the preceptor and the consent of the preceptor to participate. Anderson (1998) identified another aspect which needs to be considered and that is matching learning styles of the preceptor and graduate. The researcher employed the Myers-Briggs Type Indictor to match 51

preceptors to preceptees. The results indicated that the group experienced greater satisfaction when the learning styles of the preceptors and graduate were matched.

Rostering or scheduling is an identified issue as the preceptor first and foremost needs to be working with the designated preceptee for the process to begin. Balcain, Lendrum, Bowler, Docette and Maskell (1997) suggested that it is not uncommon for designated preceptors to work only a few shifts with the preceptee. This may be due to poor roster management or lack of commitment to the preceptorship program. Even though there are many obstacles that need to be overcome to enable the preceptor and preceptee to work the same shifts there also needs to be commitment from management and the particular units to support the model of preceptorship for it to be successful.

Balcain et al (1997) undertook an action research study on preceptorship and found other obstacles in planning and implementing preceptorship. The obstacles identified were preceptor development and workload. The development of preceptors is an important issue as is the support given to them. Balcain et al (1997) identified that preceptors felt they needed support and development when they were faced with professional, personal or social problems experienced by the preceptee. Also preceptors stated that they wanted assistance with setting realistic goals with the preceptee and undertaking performance appraisals. As a result of the difficulties identified through this action research process systematic standard for preceptorship were developed and implemented. These standards addressed workload, scheduling, feedback and the negotiation processes for difficult situations. The evaluation of the process was completed by surveying the preceptors, unit managers and clinical educators. The results identified that all involved found the standards helpful as there were clear communication for all regarding the process

and roles. Unfortunately the evaluation did not include evaluation of the preceptees to identify if they were satisfied with the process.

The workload of the preceptor is an issue which can impede the preceptorship process (Balcain et al 1997 and Meyer and Meyer, 2000, and Stevenson, Doorley, Moddeman and Benson-Landau, 1995). Preceptors found it difficult to care for a full patient workload and be able to effectively preceptor the new graduate. Stevenson et al (1995) completed an exploratory descriptive survey with 30 nurses who had undertaken the preceptor role. The preceptors identified workload and lack of time as a challenge for successful preceptorship. Meyer and Meyer (2000) recommend that the teaching time for preceptors should be increased and the patient workload decreased.

The difficulties preceptors experience in dealing with problems with the allocated preceptee was studied by Hrobsky and Kersbergen (2002). They studied how preceptors perceived the process of assessment for preceptees who demonstrated unsatisfactory clinical performance. The researchers interviewed four preceptors and three themes were identified. The first was how preceptors identified 'red flags' in regards to the students' clinical performance. The identified red flags were that students did not ask questions, were not enthusiastic about their role and had unsatisfactory skill performance. The second theme identified was that preceptors experienced fear and anxiety as they knew by reporting their observations about the student it would probably result in a poor outcome for the future career of the student. The last theme related to the importance of supporting preceptors in this process through the use of a liaison faculty role. The preceptors identified that the important aspects of this role were listening, being supportive and appropriate follow up for the preceptor by management or education. This study recommended that hospitals should implement strategies to support preceptors through the

process of assessing clinical performance. They need to ensure preceptors are effectively prepared and that nurse educators need to share their rich knowledge and experience to facilitate preceptors through these difficult times.

In summary preceptorship can be seen as an important component of the graduate program as it provides support for new graduates during the transition period. Preceptorship enables graduates to be effectively socialised to their role and new clinical environment. Preceptors are required to be competent, have effective communication skills and the ability to inspire confidence. Preceptors also require support and ongoing professional development. Preceptors must work regularly with the preceptee and their patient workload needs to reflect the additional responsibility of a preceptor.

1.6.17 Supernumerary Time

Supernumerary time for graduates is also an important aspect to a graduate program (Clare and van Loon, 2003; Gerrish, 2000 and The Department of Human Services, 2003). There is little mention in the literature about supernumerary time. The Department of Human Services (2003) suggested that there is general agreement that a best practice model for a graduate program includes some supernumerary time. Clare and van Loon (2003) agree and suggest graduates value supernumerary time and this should be available for them to gain confidence in clinical practice. Supernumerary time enables the graduate to shadow experts, locate equipment and discover unit specific processes and protocols (Clare and van Loon, 2003). Without the pressure of a full workload, it enables graduates to consolidate their clinical skills and undertake the socialisation process within the least stressful environment. An acceptable amount of supernumerary time within a program is largely unexplored within the literature.

1.6.18 Support from the Education Department

The program coordinator and hospital educators provide support and ongoing development for graduates through transition. Each hospital generally has a coordinator and clinical educator to support the graduate nurse program. In smaller organisations this role may be combined. The Department of Human Services guidelines (1997 and 2003) recommended a coordinator should be employed to manage the planning, structure, content and evaluation of the program. The coordinator also needs to ensure that programs meet the expectations of new graduates (Department of Human Services, 2003). Clare and van Loon (2003) suggested that an educator is required to be accessible for new graduates to supervise and assist them with new procedures, by doing so this takes pressure off the preceptor. With the support of an educator they are able to complete the required teaching task or procedure with less time pressure as the educator does not have a patient workload. Another essential part of the clinical educator's role is to provide support for preceptors to ensure they are assisted with role development (Day, 1997).

A role which has been recently developed in the nursing education team of organisations is that of Clinical Support Nurse (CSN). The title of this role differs between organisations although the roles are similar. The difference between an educators and CSN is they are usually paid at a lower rate and their role is focused more on developing graduates within the clinical environment. This CSN role has become popular and has been included within the latest nursing award (Industrial relations commission, 2004) and is titled clinical support nurse.

Kelly, Simpson and Brown (2002) completed an action research project on the implementation of a Clinical Practice Facilitator (CPF). The aim of this newly developed role was to support graduates and enhance their

competence and clinical skills as a supernumerary team member. The results of this research suggested that the role was valid and it had a positive influence on clinical learning and staff moral. One staff member commented on how the role reduced stress and stopped them feeling guilty in regards to having to teach and support graduates (Kelly, Simpson and Brown, 2002).

There are various studies that investigated what learners believe are the most important characteristics of a clinical educators. Benor and Leviyof (1997) used a tool entitled the Nursing Clinical Teachers Effectiveness Inventory (NCTEI) to gain data from 123 student nurses in three Universities. The most important characteristic of a clinical educator was that they were competent practitioners, followed by being able to effectively conduct student evaluation. The third most important aspect was the educator's ability to impart instruction and lastly interpersonal characteristics. Violeta and Bernard (2001) also completed a study on this topic although the data collection tool was the Clinical Teacher Characteristics Instrument. The sample size in this research was also higher with 189 undergraduate nurses. The results for this study were similar to Benor and Leviyof (1997) outlining that items related to professional competence were the most important characteristic of a clinical educator for students. The second and third characteristic identified was interpersonal relationships and personal attributes.

There is literature suggesting that the characteristics of educators are the most important to learners and there is also much discussion regarding the importance of educators providing support for the GNs and preceptors. There is however little literature outlining how much time an educator should spend with graduates. Cobal (1998) found that educators spent minimal time with graduates and that they were very disappointed with this level of support. The amount of time spent with graduates in this study

was described as 'maybe two minutes in the first week' and 'never'. The characteristics of educators and the quality of support provided are important aspects of a program. Therefore it is important to describe how much time educators are actually spending with graduates and to identify if this is to the satisfaction of new graduates.

1.6.19 Support

Support of new graduates is extensively discussed in the literature and is widely acknowledged as very important for new nurses during the transition period (Amos, 2001; Clare et al 2002; Clare and van Loon. 2003; Clark, Maben and Jones, 1997 and Parker, Plank and Hegney, 2003). Graduates face many challenges within the first year of practice support from preceptors, educators, managers and other staff members is essential as *having the confidence to practice is inextricably linked to the amount and quality of support a nurse receives* (Amos, 2001, p41). According to Clare et al (2002) a supportive environment is an important part of a positive transition as it enables them to improve and consolidate their clinical skills and time management in a nurturing setting. Therefore effective support facilitates new graduates transition to the work environment.

Oermann and Moffit-Wolf (1997) completed a descriptive design study. The aim of the study was to describe the stresses, challenges and threats experienced by new graduates during initial orientation and to examine the relationship of social support. They employed a social support instrument and a modified Pagana clinical stress questionnaire to collect data from 35 graduates (3 hospitals). The modified Pagana clinical stress questionnaire contained a list of 20 emotions participants may experience within the orientation period and new graduates were asked to rate them from 0 (none) to 4 (a great deal). The findings suggested that during the orientation period most of the graduates felt that they had an adequate

support system and reported experiencing predominately positive emotions. There were many terms used to describe the positive and negative emotions within this study such as stimulated; excited; overwhelmed and angry. There were many terms used within the literature describing transition for graduates that were not covered within this research such as feelings of being encouraged, helped; valued; frustrated or inadequate (Casey et al, 2004; Clare and van Loon, 2003; Cobal, 1998 and Ellerton and Gregor, 2003). This study does have a small sample size and graduates are only asked to describe there feelings of stress and support during the initial period of orientation.

1.6.20 Feeling that you belonged

It is suggested that when graduates feel they belong to the clinical area then this has a positive effect on transition and job satisfaction (Casey et al 2004; Clare et al 2002 and Winter-Collins and McDaniel, 2000). Winter-Collins and McDaniel (2000) completed a study of 107 graduates selected at random who completed a Mueller-McClaskey satisfaction scale (identifies job satisfaction) and a modified Hagerty-Patusky sense of belonging instrument. This study concluded that if a graduate feels a strong sense of belonging then this is associated with the satisfaction of their nursing role. The length of orientation did not significantly correlate with graduates feeling they belonged but there was some suggestion that quality interactions with other staff members may influence the graduate's sense of belonging (Winter-Collins and McDaniel, 2000). The study identified the importance of ensuring graduates are supported, nurtured and welcomed into the team, it did not however identify how long they felt it takes for them to feel they belonged to the clinical area.

1.6.21 Theoretical Component

The theoretical component of a GNP program can be presented in many different ways including study days, learning packages or competency

assessment. The Department of Human Services (1997) recommended that programs include a minimum of 40 hours of theory and that graduates wanted theory relating to the practical aspects of nursing care. Rosenfeld et al (2004) expanded on this and suggested that participants want topics which are directly related to the clinical area in which they are working. This can be a difficult task as graduates rotate to a variety of areas therefore the coordinator needs to ensure the topics are relevant to all participants of the program. There is limited material in the literature which addresses satisfaction compared to the amount of theory hours included in the program.

1.6.22 Performance Appraisals

Positive feedback has an enormous impact on the confidence and job satisfaction of graduates and it is therefore essential they have ongoing assessment both formal and informal (Clare et al 2002; Clare and van Loon, 2003; Cobal, 1998 and Day, 1997). Feedback can be formalised through a performance appraisal which involves appraising via a series of performance documentation. Informal feedback can be given through many different avenues such as after a procedure, at the end of a shift or through a weekly meeting with the graduate, preceptor and clinical educator. Whatever form feedback takes it is an essential aspect of personal and professional development (Day, 1997). Clare et al, (2002) suggested that graduates want constructive feedback; to know how they are progressing towards achieving competence.

Day (1997) found that 62% of graduates felt they did not receive enough feedback and this made them feel unsure and insecure about their performance. Casey et al (2004) also found that graduates experienced a lack of feedback from preceptors and peers and they wanted more. It is important that they receive regular verbal feedback and planned performance appraisals (Clare et al 2002 and Clare and van Loon, 2003).

The literature is consistent in identifying the importance of ensuring graduates receive feedback regarding their performance it is however unclear on how often this should occur. Day (1997) identified that participants within her study had all received a performance appraisal within the first four months of employment. There was however no further explanation on the total number of appraisals graduates received and at what time they were completed. The literature also does not identify if graduates were satisfied with the performance appraisal process.

1.6.23 Graduate Nurse Program Evaluation

The evaluation of the program is essential to identify if the program is meeting the needs of the graduate, patient, staff and organisation. The Department of Human Services (1997 and 2003) advised that organisations are required to complete formal evaluations of the program and that the recommendations of the evaluation are implemented in the following year. Graduates need to be asked if they were satisfied with the program, what they thought worked well and what could be improved.

The transition from student to graduate nurse is a difficult and stressful time. New graduates experience issues related to reality shock, socialisation and the theory practice gap. It is well recognised that they require support during this difficult time. Effective programs which meet the satisfaction of graduates are one way that this support can be delivered. The components include orientation; preceptorship; supernumerary time; clinical rotations; clinical educators; theoretical component and performance appraisals. There is much in the literature suggesting the importance of each of these components although there is minimal in the Australian literature. Comparisons between various programs and the level to which graduate nurses are satisfied is largely unexplored. Based upon the literature and personal experience a conceptual model for this research was developed.

1.7 Conceptual Model

Satisfaction with the Experience of the Graduate Nurse Program

Based upon the literature review the following conceptual model immerged.

```
┌────────────────────────┐      Program Components      ┌────────────────────────┐
│   Negative Experience  │                              │   Positive Experience  │
└────────────────────────┘   ┌──────────────────────┐   └────────────────────────┘
                             │ Graduate Nurse Program│
                             │       Support         │
                             └──────────────────────┘
                             ┌──────────────────────┐
                             │    Preceptorship     │
                             ├──────────────────────┤
                             │  Supernumerary Time  │
                             ├──────────────────────┤
                             │   Clinical Educator  │
                             ├──────────────────────┤
                             │ Being Part of the Team│
                             ├──────────────────────┤
                             │      Rotations       │
                             ├──────────────────────┤
                             │ Theoretical Competent │
                             ├──────────────────────┤
                             │     Evaluation       │
                             └──────────────────────┘

┌────────────────────────┐                              ┌────────────────────────┐
│ •Unsatisfied           │                              │  • Satisfied           │
│ •Loss to the organisation│                            │  • Retained within the │
│ •Loss to the profession│                              │    organisation        │
│                        │                              │  • Retained within the │
│                        │                              │    profession          │
└────────────────────────┘                              └────────────────────────┘
```
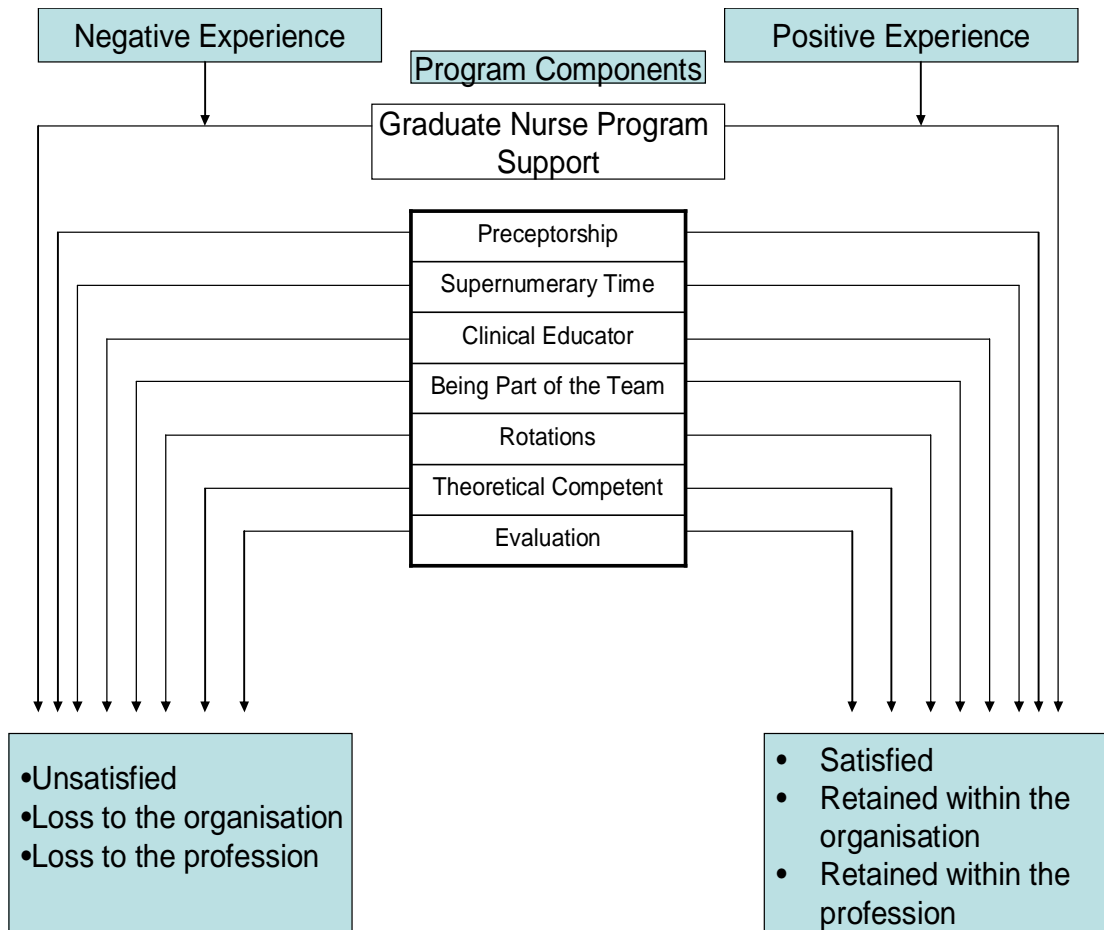
A graduate nurse program is composed of support; preceptorship; supernumerary time; time spent with the GNP coordinator/Clinical Educator; feeling a part of the team; rotations; theoretical component; performance appraisals and evaluation. If a participant of a graduate nurse program has a negative experience they may be unsatisfied and less likely to be retained within the organisation. Whereas if a participant has a positive supportive experience

they are more likely to be satisfied with the graduate nurse program and retained within the organisation.

Chapter Two Methodology

2.0   Introduction

This chapter outlines the processes undertaken during this research and will address the research design; sample selection; the data collection tool; validity and reliability; the procedure for collecting the data; ethical considerations and finally data analysis. The purpose of this research was to explore and compare various graduate nurse programs and identify whether the programs met the needs and expectations of a sample of graduate nurses from Australian Catholic University (ACU National).

2.1   Research Design

For the purpose of this research an exploratory descriptive design was employed, both quantitative and qualitative data were gathered, to obtain a comprehensive picture of graduate nurse programs and the satisfaction level of newly graduated ACU National nurses. An exploratory descriptive design is used when there is little or no literature existing on a particular topic (Beanland, Schneider, LoBiondo-Wood and Haber, 1999). According to Polit, Beck and Hungler (2001) a researcher undertaking quantitative descriptive research design, observes, investigates, counts, describes and classifies a particular phenomenon. In this research the phenomena being investigated are graduate nurse programs and graduate satisfaction levels.   Beanland et al (1999) suggests that exploratory descriptive research collects detailed data describing existing variables. The information is then used to explain and assess the current conditions and practices and to make informed plans for improving future practices. As the literature review clearly identified there is much literature discussing the transition from student to first year registered nurse although the Australian literature is lacking in the area of evaluating

graduate programs. The literature identifying graduate satisfaction with programs is limited. As there is an identified gap within the literature an exploratory descriptive design was employed. The results of this research may inform future planning and development of graduate programs in Victoria and may also provide valuable material for national and international developers of graduate nurse programs.

A mailed questionnaire was utilised to gather data. Questionnaires have many advantages and are used frequently in nursing and midwifery research. Research participants who complete a mailed questionnaire are more likely to express themselves freely as their responses are anonymous. They are inexpensive compared to other data collection tools and data can be gathered from a large diverse population of participants (Roberts and Taylor, 1998). In addition they can obtain a large amount of information from the target sample. A disadvantage of mailed questionnaires is that they have a tendency to have poor response rates. Polit et al (2001) compared interviews to questionnaires and suggested the response rate is higher in face-to-face interviews as people are less likely to refuse to talk to an interviewer compared to discarding a questionnaire. Other advantages of interviews according to LoBindo-Wood and Haber (1990) are that interviews have a number of inbuilt safeguards for example if a respondent does not understand the question being asked the interviewer can address the misunderstanding immediately this cannot occur with a mailed questionnaire. Interviews are however very labor intensive and time consuming and less participants are generally involved. In contrast a major benefit to mailed questionnaires is that they take less time to complete and the administration time is less then conducting an interview. Both methods of data collection have advantages and disadvantages the choice to use either of these data collection methods needs to be based upon the purpose and objectives of the research, economic considerations and time constraints. A mailed questionnaire

was chosen as the most appropriate tool to gain data in this research as it allowed a large amount of data to be collected in the set time frame. Also as the sample group lived in a large geographical area the questionnaires facilitated easier access to the research participants. Interviewing this sample group would have been extremely time consuming and not cost effective. Data were gathered from two groups of participant's (newly graduate nurses and program coordinators).

2.2   Sample Selection

2.2.1 Graduate Nurses

All nursing graduates from Australian Catholic University (ACU National), St Patrick's and Aquinas campus graduating in 2000 were asked to participate in this study.. Out of the 145 graduates sent a questionnaire, 52 responded and agreed to participate. There were 97 graduates from the St Patrick's campus Melbourne who were sent a questionnaire and 32 participants returned the questionnaire. Therefore the St Patrick's campus response rate was 33%. The response rate from the Aquinas campus Ballarat was higher at 42%, with 20 participates out of 48 possible returning questionnaires. Therefore the overall response rate was 36%. Minichello, Sullivan, Greenwood and Axford (2004) suggest a reasonable response rate to mailed questionnaires is 35%. The response rate for this study is therefore considered acceptable.

Although the response rate was acceptable at 36%, it may have been inhibited by the fact that the postal addresses for the graduates were gained from ACU National in 2000 and the questionnaires were sent in 2001. This may have resulted in some of the participants not receiving the questionnaire due to changes in addresses. There were 14 (26.9%) questionnaires returned stating the addresses were in correct.

2.2.2 Graduate Nurse Program Coordinators

Once the completed questionnaires were returned from graduates a quota sample of ten coordinators were approached to participate. *A quota sample is one in which elements that meet the criteria are chosen until the subsections of the sample are full* (Roberts and Taylor, 1998, p144). The sample of ten were those whose programs had at least 2 graduates who elected to be involved in the research. The purpose of gathering data from the coordinators was two fold, firstly to gather data about the program they conducted and secondly to identify how they believed the program could be improved.

In the year 2000 there were 109 programs participating in the process of the Nursing Computer Match (Victorian Medical Postgraduate Foundation, 1999). Of these 109 programs ACU National graduate participants in this study participated in 24 programs. A quota sample of coordinators were drawn from the 24 programs, 10 (41.6%) were approached and 6 returned the questionnaire (response rate 60%). The ten hospitals included in this sample were both public and private. The size and location of hospitals varied from major metropolitan to regional hospitals.

There were many strategies implemented to improve the response rate. Minichello et al (2004) suggest that it is vital that the study brief or cover letter is simple and business like when administrating postal questionnaires. They concluded that the cover letter is the only way in which participants can understand the details of the study. The letter also needs to convince the participant of the studies benefits. It needs to highlight that the time that participants spend completing the questionnaire is worthwhile. The cover letter sent to participants was clear and concise (Appendix A). It outlined what the study aimed to achieve and how it will benefit graduates in the future. It also assured participates of

confidentiality and anonymity. A stamped self addressed envelope was also included to ensure returning the questionnaire required less effort for the participants, thus possibly enhancing the return rate.

2.3 Pilot

The questionnaire was given to five Registered Nurses who had graduated from their nursing degree and completed a graduate program within one year of the data collection. These nurses completed their undergraduate studies at other universities excluding ACU National. The coordinator questionnaire was also piloted. The questionnaires were sent to three coordinators who are considered experts in the field as they have gained many years of experience and education in the field. Roberts and Taylor (1998) outlined that a pilot study will allow the researcher to assess the adequacy of the data collected and adjust any instrumentation appropriately. The aim of piloting the questionnaires was to identify if the questions were clear and concise. To assess if the data gathered was consist with the objective of each question. It was also completed to clarify if the ranking scale used was effective and if the spacing of the questions were appropriate.

The pilot study proved to be very beneficial as it identified various areas were the questionnaire could be improved to gain the data required. Simple changes were made such as allowing more space between questions to major restructuring of a few items. For example item nine, which discusses rotations, originally did not ask participants to identify the length of each rotation. Item 21 was changed considerably as this question in the pilot study asked graduates to identify terms which describe the support they received or did not receive. Unfortunately the data gathered was difficult to analysis. By giving GNs terms used to describe support in the literature and asking them to rank how often they

experienced the feelings described was more effective in gaining data and easier to analyse. The likert scale used for the satisfaction level was also changed from a scale using very satisfactory to very dissatisfied to a scale where participants had to rank their satisfaction level from 1 to 10. Number one was identified as the lowest level of satisfaction and 10 at the highest level of satisfaction. This enabled the analysis of the satisfaction levels to be conducted more effectively and a mean score be calculated.

2.4   Data Collection Tool

2.4.1 The Tool

Following an extensive literature review a questionnaire was developed. A questionnaire suitable to achieve the purpose and objectives of this research was not found in the existing literature. The literature review identified various questionnaires relating to the performance of graduates for example, but it did not however discover a questionnaire covering each aspect of a program nor satisfaction levels of participants.   The items on the questionnaires were developed specifically to answer the research questions. The aim of the questionnaire was to gather data relating to each aspect of the program and to identify the graduate's satisfaction with each component. The questionnaire was divided into 13 sections using both qualitative and quantitative items (appendix C). The items consisted of yes/no answers and a mixture of both open ended and closed-ended questions. Likert and rating scales were also used. These items were all designed to illicit data pertaining to the following 13 sections of the questionnaire: 1) the demographic profile of the participant; 2) the graduate nurse program details (for graduates only) 3) the clinical rotations; 4) preceptorship program; 5) supernumerary time; 6) Coordinator/Clinical Educator; 7) support given to graduates; 8) being apart of the team; 9) the theoretical component; 10) performance

appraisals; 11) the evaluation of the program; 12) the overall satisfaction of graduates and 13) future planning for graduate nurse programs.

2.4.2 Section 1: Demographic Profile of the Participant

Item 1-4 is demographics.

Item 1 is essential in describing and comparing GNPs. This item determines which hospital the GN completed their GNP. This enabled GNPs to be grouped and compared for analysis purposes.

Item 2 and 3 were designed to determine if age and gender has any influence on GNP satisfaction. This information also gives some insight into the demographics of the participants.

Item 4 was included to ascertain if GNP satisfaction differed between the two campuses of the same University who completed the same course of undergraduate study.

2.4.3 Section 2: The GNP Details

Item 5 identified if participants completed the GNP. If the answer is no GNs are requested to explain why they did not complete the program to determine any recurring themes.

Item 6 was included in the study to establish when participants completed their GNP.

Item 7 was intended to identify how many GNs are retained after there GNP. Retention of nursing staff in health services is imperative as

recruitment is difficult and costly. This data will enable retention rates for various programs to be considered. A comparison between satisfaction levels and retention was also established.

Item 8 was designed to clarify why GNs actually choose to apply to a particular hospital. This will assist in understanding important recruitment characteristics of a GNP and hospital to GNs. The assumption being that the quality of the program may have an impact upon recruitment.

2.4.4 Section 3: The Clinical Rotations

Item 9 related to rotations of the GNP. The literature is silent regarding rotations and this item was determined to identify how many rotations a program has, the length and where the GNs felt the rotations were the most to least valuable. This item was also designed to support or refute the discussion relating GNs rotating to a general or specialised area. It may also discover which clinical areas are the most valuable to GNs.

Item 10 was designed to ascertain the overall satisfaction level of the rotations completed. This item also enabled the comparison between overall program satisfaction with the satisfaction of the rotations experienced.

2.4.5 Section 4: The Preceptorship Program

Item 11 enabled data to be collected on whether the GN actually participated in a preceptorship program during the GNP. As the literature review identified preceptorship is an essential part of a program it cannot

however be presumed that preceptorship programs are a part of all GNPs. If the participant answered no then they were asked to move onto item 15.

Item 12 was designed to gather data on the time that graduates participated in a preceptorship program in the first rotation. As the literature review identified there is minimal research describing the appropriate time frame for a preceptorship program.

Item 13 was included to gain insight into how many shifts graduates worked with their preceptors. There was some discussion in the literature describing one of the difficulties encountered in preceptorship programs are rostering issues (Balcain et al, 1997). Preceptees are not being rostered with the preceptor, which is an obviously fundamental flaw in providing an effective preceptorship program. This item allowed data to be collected and analysed on the amount of shifts preceptors and preceptees worked together to support or refute the concept of rostering difficulties.

Item 14 was designed to ascertain the overall satisfaction level of the experience of preceptorship. This item allowed the comparison between preceptorship length and preceptorship satisfaction, to identify what the mean preceptorship time graduates were satisfied with. This item also enabled the comparison between overall program satisfaction with the satisfaction of preceptorship.

2.4.6 Section 5: Supernumerary Time

Item 15 was designed to gain information on how many supernumerary shifts GNs worked on the first rotation. As the literature review identified there is little literature discussing supernumerary time. This data will enable the amount of supernumerary time to be described outlining the

range and the mean supernumerary time for graduates on the first rotation. As supernumerary time is the most costly expense in a program, this item was included to identify if the amount of supernumerary time given to GNs is consistent with governmental funding.

Item 16 was included to identify the amount of supernumerary time graduates received on the second rotation and to identify if the amount of supernumerary time changed on the second rotation.

Item 17 was designed to ascertain the overall satisfaction level with the amount of supernumerary time. This item allowed the comparison between the amount of supernumerary time received and supernumerary satisfaction levels.

2.4.7 Section 6: The GNP Coordinator/Clinical Educator

Item 18 was designed to discover how many hours per week in the first three months the GNP Coordinator/Clinical Educators spent with graduates. The literature discussing how much time a GNP Coordinator/Clinical Educator should ideally spend with a graduate in the first three months of employment is limited. Support provided by the GNP Coordinator/Clinical Educator is an essential part of the graduate support package.

Item 19 identified if the hours the GNP Coordinator/Clinical Educator spent with GNs changed following the first three months of the program. There is some anecdotal evidence suggesting that employers believe the support provided by GNP Coordinator/Clinical Educator is more extensive in the first three months and the following nine months less support is required. This is reflected in some employment contracts of GNP

Coordinator/Clinical Educator which decreases their employment hours after the first three months.

Item 20 was designed to ascertain the overall satisfaction level of graduates with the time spent with the GNP Coordinator/Clinical Educator. Identifying the amount of time spent with the GNP Coordinator/Clinical Educator is one aspect of the support provided but it is also important to establish if GNs were satisfied with the quality of support the GNP Coordinator/Clinical Educator provided.

2.4.8 Section 7: Support Given to GNs

Item 21 was intended to gain data on how graduates felt supported during the GNP. Terms were outlined for graduates to describe to what extent they experienced the feelings described. The scale used ranged from 1- being not at all to 4- a great deal. The terms used were gathered from the literature describing the feelings graduates felt when they were supported and when they were not supported (Casey et al, 2004; Clare and van Loon, 2003; Cobal, 1998; Ellerton and Gregor, 2003 and Oermann and Moffit-Wolf, 1997).

Item 22 was included to determine the overall satisfaction level of the support experienced by graduates during the GNP.

2.4.9 Section 8: Being Apart of the Team

Item 23 is related to the study completed by Winter-Collins and McDaniel (2000) that discovered a strong link between a sense of belonging and job

satisfaction. This item will allow data to be gathered on the amount of weeks they felt it took to feel they belonged to the work environment.

2.4.10 Section 9: The Theoretical Component

Item 24 relates to the number of hours graduates spent undertaking the theoretical component of the GNP. Therefore the amount of time graduates spent in structured study sessions, which were organised by the GNP Coordinator. The DHS guidelines for GNP (1997) require there to be 40 hours theoretical time in GNPs. This item permitted data to be collected on the amount of hours of structured study sessions. The amount of hours was then compared to the requirements of DHS to discover if they were consistent.

Item 25 was intended to identify the overall satisfaction level of GNs with the theoretical component of the GNP.

2.4.11 Section 10: Performance Appraisals

Item 26 identified the number and stage GNs participated in performance appraisals. This item enabled comparison between GNPs and a mean identified.

Item 27 There is much discussion in the literature suggesting the importance of self appraisal in evaluating performance and future development. This item allowed data to be collected on whether or not self appraisal is part of graduates' performance appraisals.

Item 28 was designed to ascertain the overall satisfaction level of GNs in regards to formal performance appraisals.

2.4.12 Section 11: The Evaluation of the GNP

Item 29 allowed data to be collected about program evaluation. This is an important item as it identified if GNP Coordinators asked for graduates opinions on how they thought the program was conducted and where they believed it could be improved.

Item 30 was designed to identify if graduates were asked if they were satisfied with the GNP.

2.4.13 Section 12: Overall satisfaction of the GNP

Item 31 was intended to gain data on how graduates scored their overall satisfaction level of the completed GNP.

2.4.14 Section 13: Future planning for GNPs

Item 32 was designed to gather qualitative data on how GNs believed GNPs can be improved for future graduates. This is a significant item as it gained insight into how programs can be improved and better meet the needs of a newly graduated nurse working in a stressful work environment.

Item 33 relates to where graduates believe they will be professionally in five years. This item was intended to firstly identify if they believed that they will still be a part of the nursing profession. Secondly to establish where graduates believe they will be employed, in which clinical area and what career development do they believe they will have achieved.

Item 34 was included so that participants could add anything they felt was appropriate.

The GNP coordinators questionnaire also has 34 items. The demographic details included information on the coordinators initial nursing education and their qualifications. The questionnaire also requests data on the number of hours the coordinator is employed to coordinate the program and if this time changes. These items were included to identify if the hours of coordination change throughout the program (please refer to appendix C – GNP Coordinators questionnaire).

2.5 Procedure/ Method

All graduates who were asked to participate in this study were recruited through ACU National. Names and addresses of all registered nurses who graduated from ACU at both St Patrick's and Aquinas campuses in 2000 were accessed through the School of Nursing (Victoria). A quota sample of ten coordinators were then identified from the top ten respondents with the highest number of ACU National graduates. Coordinators of the top ten programs were asked to participate in this study. The names and addresses of the ten coordinators were accessed through the computer match booklet.

All participates were sent a copy of the study brief (cover letter), a questionnaire and two consent forms. Participants were asked to return one consent form with the questionnaire the other to retain for their personal records. A stamped self-addressed envelope was also sent in an attempt to improve the response rate. When the questionnaires were returned to the St Patrick's Campus School of Nursing the completed

consent forms were detached and separated from the questionnaires to ensure anonymity.

2.6   Ethical Considerations

An application for ethical approval was made to the University Human Research Ethics Committee at the Australian Catholic University. All required documentation explaining the study were completed and sent with the application. The committee granted approval for this study to proceed. With approval participant details were accessed and contact was made.

2.7   Security of Data

Data collected was kept in a locked filling cabinet and in a computer secured by a password in the researcher's home. All information will be kept at ACU St Patrick's campus, School of Nursing in a locked cabinet for five years following any publication. After this period the paper data will be shredded and all electronic data will be erased.

2.8 Confidentiality

When a participant consented to take part in a study the researcher assures them that confidentiality will be maintained. This pledge ensures the information a participant contributes will not be publicly reported or made available to anyone unrelated to the research (Polit, Beck and Hungler, 2001). Confidentiality was maintained within this research as only the researcher had access to the data collected. The supervisor only had access to the coded data; therefore there were not any identifiable participant characteristics.

2.9   Anonymity

Anonymity exists when the identity of the participant cannot be linked to the responses (Beanland et al 1999). When the questionnaires were returned the consent forms were separated from the questionnaire to ensure anonymity. The questionnaires do not have any personal identifying characteristics, which could link the participant's identity to their responses. The hospitals where the programs were conducted were coded therefore identifying hospitals as 1, 2, 3 etc to also ensure anonymity.

2.10   Informed Consent

Informed consent was gained from all participates in this study. Roberts and Taylor (1998) suggest informed consent is when the participant agrees to take part in the research after being comprehensively briefed about the project and its possible outcomes. The study brief sent to the participants outlined the studies aims and how the data collected will be used. It was made clear that the studies results will be submitted as a thesis for the requirements of the researcher's Masters of Nursing (Research) and could be published, at a later stage in a referred journal. The brief also identified that participation in the study was voluntary and participants could withdraw from the study at any given time without giving a reason. If participants had any questions regarding the study, contact details of the researcher and the supervisor were presented for uncomplicated contact to be made. Two consent forms were sent with the studies brief and questionnaire (please refer to appendix B). Participants were asked to sign and return one with the completed questionnaire via Australia post. The second consent form was for the participant to retain in their personal records. Completion and return of the questionnaire may be considered as implied consent although the ethics committee required a consent form.

2.11 Reliability

Beanland et al (1999) suggest that an instrument is considered reliable when it is used on more than one occasion to measure relatively constant behavior and similar results are obtained. The reliability of the questionnaire used in this research was demonstrated through the use of the pilot study and the data collected from 52 participants. The data collected on two separate occasions were consistent. Therefore data collected at both times showed repeated responses highlighting the reliability of the questionnaire.

2.12 Validity

Validity refers to the extent to which the method used in the research to collect and analyse data actually measure what it purports to measure (Roberts and Taylor, 1998). Reviewing and analysing the data collected outlines the validity of this research. The responses collected via the questionnaire were consistent with the purpose and objectives of the study. The questionnaire gained the data it was designed to achieve. The data identified each aspect of a graduate program and the graduate's satisfaction level. The responses also demonstrated that the questions were interpreted correctly. Minichiello et al (2004) suggest for content validity to be claimed the research needs to be sure that all content areas of importance are represented in the instrument. The data collected and analysed in this study represent all documented components of a graduate nurse program. These areas were identified from the literature and personal experience of the researcher as a coordinator. The coordinators who completed the pilot study also confirmed the areas covered within the questionnaire as being a true representation of the

various components of a program. The experts who completed the questionnaire confirmed that all areas of importance were addressed.

2.13 Limitations to this study:

- Participants (n=52) in this study were drawn from a population of 145 graduates of nursing (response rate 36%) educated at ACU National, therefore only giving the perspective of one University.

- A quota sample of graduate coordinators was employed rather then a random sample.

- The sample of 10 coordinators was less then 10% of the total population of coordinators involved with computer matched programs and only 6 participated. Although, this sample of 6 represented 25% of the coordinators who had ACU National graduates in their graduate year.

- Even though the tools were developed from the literature and the pilot test conducted was beneficial, it was conducted with small sample sizes which may present an issue with the validity of the tool. The tools did however achieve the data required to meet the objectives of the research.

Although there were some limitations in this work the data gathered provided valuable insights into the organisation and structure of graduate nurse programs in the state of Victoria. In addition the satisfaction of graduates will significantly contribute to the body of Australian literature on this topic.

2.14 Data Analysis

Quantitative data was entered into and analysed using the Statistical Package for the Social Sciences (SPSS) Version 10. Descriptive statistics

were generated through SPSS. Content analysis is the process of organising and integrating, information according to emerging themes and concepts (Polit, Beck and Hungler, 2001). Content analysis was used to categorise the qualitative data gained from the questionnaires. Themes and keywords in the data were identified and further details of analyses are explored in the following result chapter.

Chapter Three Findings of the study

Introduction

This chapter contains a discussion on the findings of both the quantitative and qualitative aspects on the study. The quantitative data collected was entered into SPSS and descriptive statistics were generated. The qualitative data was analysised through content analysis and various themes were identified. The results are presented according to the objectives of this project: these include demographic and the various components of a graduate nurse program and thus follow the conceptual framework.

3.0   Data Analysis of the Graduate Nurses Questionnaires

3.1   Demographics

Fifty two nursing graduates from Australian Catholic University (ACU National), St Patrick's and Aquinas campus participated in this study. There were 31 (59.6%) participants who completed their undergraduate program at Mercy/St Patrick's campus and 21 (40.4%) who attended Aquinas campus. The participant's age ranged from 21-44 years with an average age of 24 years. There were 48 (92.3%) females and four (7.7%) males. According to the Nurses Board of Victoria (2000) there were 3,496 registrations approved in 2000, this study had a total of 52 participants, therefore this group represents 1.05% of those who were registered for the first time in Victoria.

Participants in this study completed their graduate program at many hospitals across Victoria. There were a total of 24 hospitals involved in the study with 18 (75%) being public and six (25%) private. There were 10 (41.7%) metropolitan public hospitals and three (12.5%) metropolitan private hospitals. Nine (37.5%) rural hospitals were public and two (8.3%) were private. There were four (19%) of the Aquinas campus participants

who worked in private hospitals and 17 (81%) who worked in a public hospital. The number of St Patrick's campus participants had lower employment in the private sector with only two (6%) and 29 (94%) in public hospital.

Thirteen (54.2%) hospitals were in metropolitan Melbourne and 11 (45.8%) rural hospitals. There were 34 (65.4%) participants who worked in a metropolitan hospitals and 18 (34.6%) in a rural hospitals. There were six (29%) participants from Aquinas campus who worked within a metropolitan hospital compared to 28 (90%) from the St Patrick's campus. There were 15 (71%) participants from Aquinas campus who worked in a rural hospital and only three (10%) from St Patrick's campus. Therefore the majority of Aquinas campus participants worked within the rural setting and the majority of St Patrick's campus participants worked within the metropolitan setting.

In answer to the first objective the demographic details of the graduates revealed that the mean age of the 52 respondents was 24 years and over 92% of participants were female. There were 24 hospitals in the study and therefore 24 graduate programs.

3.2   Employment following Graduate Nurse Program

Only one participant did not complete the Graduate Nurse Program. The graduate who did not finish resigned from her position as *she was told she was not functioning at the pace she should have been*. This participant indicated that she was subsequently employed through a nursing agency.

At the time of the data collection 38 (73%) participants were currently employed in the hospital where they completed their graduate program. Consequently the retention rate for this group of graduates was 73%. The remaining 14 (27%) graduates found alternative employment in other

organisations. Three (5.8%) graduates were employed through an agency and one (1.9%) graduate was completing a Graduate Diploma of Midwifery. One (1.9%) participant moved into community nursing and the remaining nine were employed by a hospital. A total of 51 (98.1%) participants at the time of data collection were working within the hospital system. All graduates at the time of data collection remained employed within the nursing profession.

The second objective for this study was to identify the graduate retention rates for hospitals, the statistics revealed retention to be 73%. It was pleasing to note that all participants at the time the data was collected remained working within the nursing profession.

3.3 Selection of Graduate Nurse Program

When participants were asked why they chose to apply to a particular hospital for the graduate program, the highest ranked reason for doing so was because of the proposed level of support offered to graduates. This was closely followed by the hospital having a good reputation. The third most important reason was the rotations the hospital offered. Personal reasons were identified as the next important reason for choosing a particular hospital and lastly the least popular reason was because it was a large metropolitan hospital.

When participants were asked to identify if there were any other reasons why they chose the hospital to complete their graduate program two main themes were identified. The first was the hospital was located close to home and therefore the travelling distance from work to home was small. The second theme was having a previous clinical placement within the hospital.

The third objective was to identify why graduates choose to work at a particular hospital for the graduate program and the data revealed that the two most important reasons were because of the proposed support offered and that the hospital had a good reputation.

3.4 Graduate Nurse Programs

3.4.1 The Clinical Rotations

There were 10 (19.2%) participants who did not rotate to more than one area in their graduate year. Twelve (23.1%) completed two rotations within the graduate year and nine (17.3%) participants undertook three rotations. Fourteen (26.9%) rotated to four different clinical areas and three (5.8%) of the participants rotated to five clinical areas. The maximum number of rotations completed by the participants within this study was six and only four (7.7%) participants completed six rotations. The mean number of rotations was 3.01.

The 10 participants that did not rotate were employed in one of three (12.5%) hospitals and therefore there were three programs where graduates do not rotate within the graduate year.

There were four (14.2%) hospitals which had a mixed number of rotations which ranged from one to six rotations. Hospital number three had graduates not rotating as well as graduates having one rotation. Hospital number six had graduates rotating four and six times. Hospital eight and 16 had graduates rotating three or four times.

Three (10.7%) hospitals had two rotations and eight (28.5%) had three rotations. Nine (32.1%) had four rotations within the graduate program and two (7.1%) have five rotations. Only three (10.7%) had six rotations (please refer to table 1).

Table 1: Number of rotations per hospital

Rotations	Number of Hospitals
1	3
2	3
3	8
4	9
5	2
6	3
Mean: 3.01	Total: 28

Interestingly the 10 participants who did not rotate undertook their program in either general or speciality clinical areas. Seven graduates completed their rotations in a Medical/Surgical unit, the other three graduates worked within a speciality area which included the Operating Suite, Neonatology and Paediatrics.

There were 157 rotations to various clinical areas. When general clinical area rotations were compared to speciality rotations it was clear that the general rotations significantly prevailed over the speciality rotations with a total of 106 (67.5%) general to 51 (32.5%) speciality rotations. Twenty nine (55.8%) participants completed both a general and speciality rotation. There were 19 (36.5%) graduates who only completed a general rotation and the participants who only worked within a speciality area were four (7.7%).

Participants were asked to rank the rotations they completed from the most to the least valuable. The six rotations are broken down as follows:

- Rotation One: The first rotation length ranged from 5 weeks to 52 weeks with a mean of 23.96 and a SD of 15.18 There were 37 (71.1%) participants who believed that a general rotation was the most valuable and the remaining 15 (28.9%) outlined that a speciality clinical area as the most valuable. Interestingly when the 10 participants who stayed within one clinical area

were removed from the analysis the length ranged from 5 weeks to 36 weeks and the mean was 17.29 weeks.

- Rotation Two: The second rotation had a mean of 17.31 weeks, with a SD of 6.61 and ranged from 2 weeks to 30 weeks. There were 33 general and 9 speciality rotations.

- Rotation Three: The third rotation ranged from 1 to 26 weeks with a 11.32 mean and SD of 5.00. Within the third rotation there were 19 general rotations and 12 speciality rotations.

- Rotation four: The fourth rotation lasted from 1 to 14 weeks with a mean of 8.71 and the SD was 4.10. The general rotations to the speciality rotations were very similar with the general rotations having one more rotation, 12 to 9.

- Rotation five: The fifth rotation ranged from 1 to 10 weeks with a mean of 5.43 weeks and a SD of 3.36. The fifth rotation has a higher number of speciality rotations with only 2 general and 5 speciality rotations.

- Rotation Six: Lastly the sixth rotation range was between 1 to 12 weeks with a mean value of 4.5 and a SD of 5.07. There were 3 general rotations with 1 speciality rotation.

When the 10 participants who did not rotate were removed from the data, the mean length of rotation one and two was very similar 17.29 (rotation 1) and 17.31 weeks (rotation 2). Interestingly after this point the data showed the longer the rotation the more valuable it was for participants (please refer to table 2). Therefore overall graduates believe the longer the rotation the more valuable it was. The overall mean length of the clinical rotations was 11.87 weeks.

Table 2: Most valuable to least valuable rotation compared to mean length of rotation.

Ranking	Mean Rotation Length	SD
1	17.29 weeks	15.18
2	17.31 weeks	6.61
3	11.32 weeks	5.00
4	8.71 weeks	4.10
5	5.43 weeks	3.36
6	4.50 weeks	5.07

The length of rotations to different clinical areas varied between hospitals. The surgical area was identified as having a mean length of 18.27 weeks. There were a total of 51 rotations to a surgical area within the graduate program, making it the most common area for participant rotation. There were 19 rotations to a medical area with a mean length of 18.68 weeks. Table 3 outlines all rotations describing how many rotations there were to different clinical areas. It also highlights the range of weeks per rotation and mean length of these rotations.

Table 3: Clinical rotations

Clinical Area	Number of rotations to this clinical area	Length of rotation in weeks and mean length.
Surgical	51	4-52 (18.27)
Medical	19	1-52 (18.68)
Operating Suite	17	2-52 (12.76)
Medical/Surgical	11	8-52 (16.90)
Emergency	9	1-36 (16.22)
Oncology/ Haematology	9	8-52 (21.77)
ICC/CCU	7	2-26 (9.57)
Aged Care	6	10-16 (13.33)
Community Nursing	6	2-16 (7.33)
Palliative Care	3	12-52 (24.40)
Paediatrics	6	8-16 (12.00)
Rehabilitation	4	12-16 (13.00)
Day Procedure Unit	3	1-12 (5.00)
Allied Health	1	1 (1.00)
Medical Imaging	1	26 (26.00)
Midwifery	1	7 (7.00)
Neonatal	1	52 (52.00)
Renal Dialysis	1	5 (5.00)
Reproductive Medicine	1	12 (12.00)

When graduates were asked to rate their overall satisfaction level about the rotations, the satisfaction range was from 1 to 10, one being the lowest level of satisfaction to 10 being the highest level of satisfaction. The mean satisfaction level was 7.97. Fourteen (26.9%) participants ranked the rotation satisfaction at seven and 34 (65.3%) participants rated the rotation satisfaction between 8 and 10. When rotation satisfaction level was compared to the number of rotations the most significant trend was that 11 (91.6%) of the 12 participants who had completed 2 rotations rated their satisfaction level at 8 or above (Please refer to

table 4) and the mean satisfaction level for two rotations was the highest at 8.58. Of the 10 participants who did not complete a rotation six ranked satisfaction of the rotation as 8.. Participants who rotated within the program were more satisfied with a mean satisfaction of 8.10 compared to a mean satisfaction level of 7.6 for those participants who did not rotate.

Table 4: Rotation Satisfaction Compared to the Number of Clinical Rotations

Rotation Satisfaction Level

	1	2	3	4	5	6	7	8	9	10	Total	Mean
Number of rotations												
1	1						3	1	4	1	10	7.60
2							1	5	4	2	12	8.58
3							5	1	1	2	9	8.00
4			1	1		1	3	3	2	3	14	7.57
5							1	2			3	7.60
6							1		2	1	4	8.75
Total				1		1	14	12	13	9	52	

The fourth objective of this study is to describe the components of graduate nurse programs. In summary the data from the rotation component of a graduate program identified that there were 10 participants who did not rotate and stayed within the same clinical area for the length of the program. Twelve graduates completed two rotations and 14 participants completed four rotations. There were a total of 157 separate rotations with 106 of these rotations were within a general clinical area and the remaining 51 were within a speciality area. The length of rotations ranged from 1 - 52 weeks, with a mean rotation length of 11.87 weeks. There were 51 separate rotations to a surgical and the mean length for this area was 18.27 weeks. This was followed by 19 separate rotations to a medical area with a mean length of 18.68 weeks. A trend emerged from the data which

suggested that graduates believe the longer the rotation the more valuable it becomes. Overall participants were satisfied with the rotations they completed in the graduate nurse program with a mean value of 7.97.

3.4.2 The Preceptorship Program

Forty eight (92.3%) graduates participated in a preceptorship program during the graduate year. Only four (7.7%) participants were not orientated and supported through a preceptorship program. It was fascinating that the length of the preceptorship programs had an extremely broad range from 1 to 52 weeks in length. The mean preceptorship length was 9.76 weeks. There were 17 (36.9%) participants who stated that preceptorship lasted one week. Four (8.6%) participants believed the preceptorship program ran for the whole year. There were 32 (69.5%) graduates who stated the length of the preceptorship program ranged from between 1 to 6 (mean: 1.93) weeks (Please refer to Graph 1).
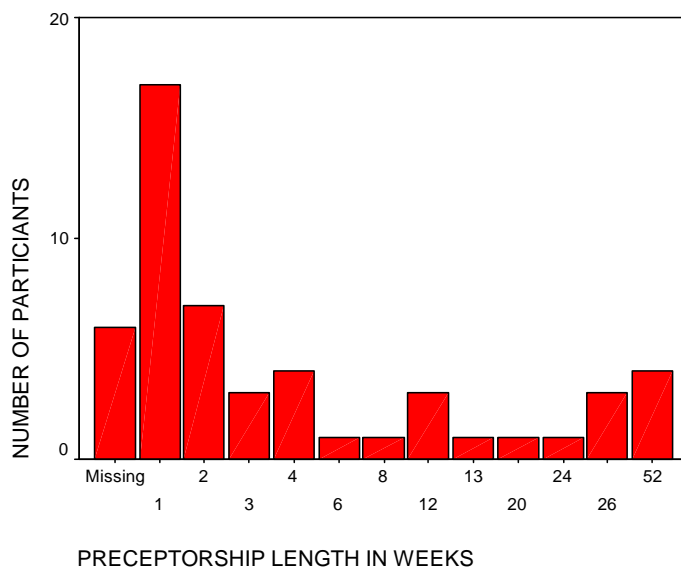
Graph 1: Length of Preceptorship

The number of shifts that participants stated they worked with a preceptor within the first six weeks of employment ranged from no shifts to 40 shifts. The mean number of shifts was 14.86 with a missing value of 4. The most frequent number of shifts worked with the preceptor was 10 shifts.

The preceptorship satisfaction level for the 48 graduates who participated within a program ranged from 1 representing the lowest level of satisfaction to 10 the highest level of satisfaction. The identified mean of preceptorship satisfaction level was 6.75. When preceptorship length was compared to the satisfaction level of graduates the only significant length identified in the data was a total of 12 (26%) participants scored their preceptorship satisfaction level as 7 with their preceptorship length ranging from 1 to 4 weeks. The mean satisfaction score of the 17 participants who completed a one week program was 5.88 this increased to 6.85 when participants completed a two week program (please refer to table 5). Satisfaction levels from 7 to 10 ranged from 2 to 40 shifts worked with the preceptor.

Table 5: Preceptorship length compared to preceptorship satisfaction

Preceptorship Length	Preceptorship Satisfaction										Total
	1	2	3	4	5	6	7	8	9	10	
1	1	2	2			2	7	1	1	1	17(m=5.88)
2		1				1	3		1	1	7 (m=6.85)
3							1		2		3 (m=8.33)
4				1	1	1	1				4 (m=5.5)
6										1	1 (m=10)
8							1				1 (m=7)
12								2	1		3 (m=8.33)
13								1			1 (m=8)
20										1	1 (m=10)
24									1		1 (m=9)
26				1	1				1		3 (m=6.6)
52							1		1	2	4 (m=9)
Total	1	3	2	1	2	5	14	4	8	6	46

*m-mean

In summary the preceptorship component of this study identified that the majority of graduates participated in a preceptorship program during the graduate program. The length of the program ranged from 1-52 weeks and 31 participants stated that the program was conducted over 1-6 weeks. The number of shifts graduates worked with a preceptor ranged from no shifts to 40 with a mean value of 14.86. Preceptorship satisfaction levels ranged from 1-10 and the overall mean was 6.75.

3.4.3 Supernumerary time

The amount of supernumerary shifts during the first rotation ranged from no shifts to 16 shifts and the mean was 5.49. The most frequent number of supernumerary shifts identified from 12 (23.5%) participants was 2. This was closely followed by 11 (21.5%) participants who said they had 3 shifts (please refer to graph 2). Forty two participants who completed a second rotation stated the number of supernumerary shifts ranged from none to 10 and the mean value was 2.17. Eleven (26%) participants from this group had no supernumerary shifts during their second rotation (please refer to graph 3).

Graph 2: Supernumerary shifts on the first rotation	***Graph 3: Supernumerary shifts on the second rotation***

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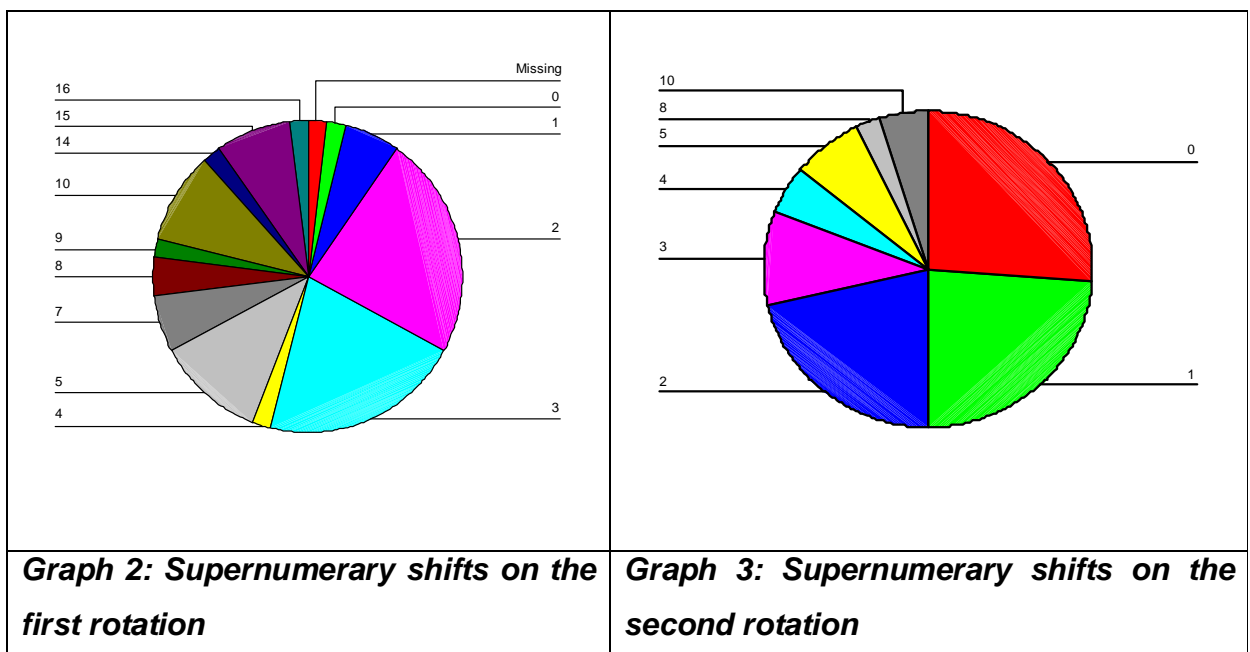
The satisfaction level for supernumerary time ranged from 1 – 10 and the mean was 7.10. It was difficult to identify if there was a relationship between shifts and satisfaction levels (please refer to table 6). This may be because of the limitations posed by a small sample size. When examining supernumerary shifts during the second rotation and comparing those to satisfaction levels it appears the more supernumerary shifts undertaken the more satisfied graduates were. For example when the participant had no supernumerary shifts their mean satisfaction was 6.18 compared to five shifts with a mean satisfaction level of 8. Although this maybe the case it may not be statistically significant due to the small numbers in the cell. When comparing the figures supernumerary shifts in rotations one and satisfaction levels no pattern emerges.

Table 6: Satisfaction level compared to the number of supernumerary shifts

Supernumerary Shifts	Rotation one: mean supernumerary satisfaction	Rotation two: mean supernumerary satisfaction
0	5.00 (n-1)	6.18 (n-11)
1	2.50 (n-3)	6.50 (n-10)
2	7.08 (n-12)	7.30 (n-9)
3	6.54 (n-11)	7.00 (n-4)
4	4.00 (n-1)	7.50 (n-2)
5	8.33 (n-6)	8.00 (n-3)
7	8.60 (n-3)	-
8	8.00 (n-2)	7.00 (n-1)
9	5.00 (n-1)	-
10	8.60 (n-5)	8.00 (n-2)
14	9.00 (n-1)	-
15	9.25 (n-4)	-
16	6.00 (n-1)	-

*n-number of participates

In summary the supernumerary time identified by this study was low with a mean of 5.49 on the first rotation and 2.17 on the second. There were 11 (26%) participants who did not have any supernumerary time allocated to them on the second rotation. The overall supernumerary satisfaction level ranged from one-10 and the mean was 7.10.

3.4.4 Time Spent with the GNP Coordinator/Clinical Educator

When asked to identify how much time participants spent with the Coordinator/Clinical Educator in the first three months of the program and the remaining nine months some participants answered these questions suggesting they only saw the Coordinator/Clinical Educator in their study sessions which was unable to be quantified in hours and are identified in table 7 as during study days. Also some participants identified the time as no time to 30 minutes or no time to one hour both these descriptions were collated into the category of no time to one hour.

Of the 50 participants who answered the question related to the amount of time the Coordinator/Clinical Educator spent with them in the first three months, the minimum time was no time (n=2) at all compared to the maximum of 20 (n=2) hours per week (please refer to table 7). The most frequent amount of time spent with the Coordinator/Clinical Educator was a no time to one hour (n-18, 36%). The SD was 3.26. Eleven (22%) participants outlined that the Coordinator/Clinical Educator spent between one to two hours with them. Two (4%) graduates identified that they did not spend anytime with the Coordinator/Clinical Educator. A total of six (12%) participants suggested that they only spent time with the Coordinator/Clinical Educator during their structured study sessions.

When graduates described the amount of time the Coordinator/Clinical Educator spent with them in the following nine months of the program, the time ranged from no time to eight hours per week, with a SD of 1.88. Twenty four (48%)

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participants suggested the Coordinator/Clinical Educator spent no time to one hour per week with them. Eight (16%) participants explained they spent no time at all with the Coordinator/Clinical Educator and six stated that they only spent time with them in the structured study sessions.

Table 7: Time spent with the GNP Coordinator/Clinical Educator

Hours	Within the first three months	After 3 months
0	2	8
0- 1	18	24
1-2	11	4
2-3	3	5
4-5	3	2
8	2	1
9	1	0
10	1	0
16	1	0
20	2	0
Study sessions	6	6
Total	50	50

When graduates were asked to rate the level of satisfaction with the time the Coordinator/Clinical Educator spent with them, it ranged from one the most dissatisfied to 10 the most satisfied. The mean was 7.13. There were 31 (68.6%) participants who rated their satisfaction level at 8 and above. When comparing the mean satisfaction level for each category of hours spent with the Coordinator/Clinical Educator in the first three months it is difficult to

identify a relationship due to small numbers in some cells. It could be suggested that even with these smaller cell numbers the more time a Coordinator/Clinical Educator spends with the graduate the more satisfied they will be as the mean satisfaction level starts with 6.00 and increases to 9.5 with 8 hours (please refer to table 8). This is also reflected in the mean satisfaction level in the 4-12 month period in the graduate year. The mean begins at 5.60 with no time spent with the Coordinator/Clinical Educator and increases to 9.60 with 2-3 hours (please refer to table 8).

Table 8: *Amount of time spent with the Coordinator/Clinical Educator compared to satisfaction.*

Hours	Within first 3 months Mean satisfaction	After 3 months Mean satisfaction
0	6.00 (n-2)	5.60 (n-8)
0- 1	5.77 (n-18)	6.41(n-24)
1-2	6.90 (n-11)	9.00 (n-4)
2-3	8.30 (n-3)	9.60 (n-5)
4-5	9.33 (n-3)	10.0 (n-1)
8	9.50 (n-2)	8.00 (n-1)
9	10.0 (n-1)	-
10	10.0 (n-1)	-
16	8.00 (n-1)	-
20	8.00 (n-2)	-
Study sessions	7.33 (n-6)	7.50 (n-6)

*n-number of participates

In the first three months of the graduate nurse program the time graduates spent with the Coordinator/Clinical Educator ranged from no time to 20 hours per week. The range of time per week was significantly lower in the last nine months of the program with no time to eight hours. Eight (16%) of the participants stated that they did not spend any time with the Coordinator/Clinical Educator during this period. The range of satisfaction levels regarding the amount of time spent with the Coordinator/Clinical Educator was 0 -10 and the mean score was 7.13. The data identified that the mean satisfaction level was low with no time to one hour with a level of five to six but increased as the hours spent with graduates increased.

3.4.5 Support Given to Graduates

Participants were given words describing feelings they may have experienced during the year and asked to rank them on a scale between 1 (not at all) and 4 (a great deal). The terms used to describe their feeling were: encouraged; friendliness; valued; approachability; helped; overwhelmed; inadequate; frustrated; angry and stressed. Each word is presented below with the analysis of each rating and its influence on the overall satisfaction of the support a graduate experienced. Fifty one (98%) participants ranked each word.

Table 9: Mean feelings

Feeling	1- Not at All	2- Very Little	3-Moderate Amount	4- A Great Deal	Mean	SD
Encouragement	0	10	21	20	3.20	0.75
Friendliness	0	3	23	25	3.43	0.60
Valued	2	10	27	12	2.96	0.77
Approachability	5	26	20	21	3.29	0.64
Helped	0	4	26	21	3.33	0.62
Inadequate	9	24	13	5	2.27	0.87
Frustrated	3	27	13	8	2.51	0.83
Angry	12	31	7	1	1.94	0.68
Stressed	1	16	23	11	2.86	0.78
Overwhelmed	5	23	15	8	2.51	0.88

Encouragement

Graduates rated the feeling of being encouraged as a frequent experience. The range was between two being very little to four a great deal, with a mean of 3.20 (please refer to table 9). Forty one (80.3%) graduates stated they experienced the feeling of being encouraged a moderate amount or a great deal. All graduates felt they were encouraged to some extent during the graduate program with no graduate identifying that they did not experience feelings of encouragement.

Friendliness

The mean score for friendliness was the highest and therefore the most experienced feeling with 3.43. The range was two to four. All graduates experienced friendless to some extent during the year and 48 (94.1%) participants rated friendless between three and four.

Valued

The feeling of being valued ranged from two to four with a mean of 2.96. Twenty-seven (52.9%) participants believed they felt valued in the program a moderate amount. Twelve (23.5%) graduates felt valued a great deal during the year. Of the positive terms of feeling valued was experienced the least.

Approachability

Overall participant's experiences of approachability were high with a mean score of 3.29 and a range of two to four. Forty six (88.4%) graduates experienced approachability either a moderate amount or a great deal. All graduates experienced approachability to some extent.

Helped

The mean score for graduates experiencing feelings of being helped was 3.33 and the range was two to four. All participants felt helped to some extent with no graduate rating the feeling of being helped at one (not at all).

Overwhelmed

Overall participant's felt overwhelmed a moderate amount during the program with a mean score of 2.51. The range was from one to four. There were a high number of participants (n-22, 45.1%) who scored the feeling of being overwhelmed at two (very little).

Inadequate

Overall graduates experienced the feeling of being inadequate a moderate amount with a mean score of 2.27 and a range of one to four. Fewer than half the graduates (n-24, 47.1%) experienced very little feelings of being inadequate in the graduate year. Nine (17.6%) graduates felt that they did not feel inadequate at all.

Frustrated

Participants rated frustration similar to feeling inadequate with a mean score of 2.51 and a range of 1 to 4. There were 27 (52.9%) graduates who experienced very little frustration and 13 (25.4%) experienced a moderate amount of frustration.

Angry

The range for the amount of time graduates felt angry was one to four with a mean score of 1.94. There were a vast number of participants (n-31, 60.8%) who experienced very little anger during the graduate year. Seven participants felt angry a moderate amount of time and only one experienced anger a great deal of the time.

Stressed

Graduates felt they experienced stress more than anger with a mean score of 2.86 and a range of one to four. As the mean score identifies there were a higher number (n-23, 45.1%) of participants who rated the feeling of being stressed at three (a moderate amount). Eleven (21.5%) participants stated they felt stressed a great deal of the time during the graduate year.

Support Satisfaction

When graduates were asked to rate their overall satisfaction level with the support they received in the graduate nurse program the mean was 7.73 and the satisfaction levels ranged from 5 to 10 being the most satisfied. Forty (78.4%) participants scored the support satisfaction level above 7.

Support Satisfaction Compared to Feelings of Support
Encouragement

Twelve (23.5%) of the 20 (39.2%) participants who suggested they received a great deal of encouragement ranked the support satisfaction at the highest level of 10. Of the 20 participants who stated they experienced a moderate amount of

encouragement 16 (31.3%) participants ranked the satisfaction level between seven and nine. The mean support satisfaction compared to feelings of being encouraged showed a correlation between feelings of encouragement and satisfaction (please refer to table 10). The support satisfaction mean for graduates who stated they did not feel encouraged was 5.70 but the satisfaction for graduates who experienced encouragement a moderate amount was 7.38. This increased further for graduates who felt encouraged a great deal to 9.25. This data may suggest the more encouraged a graduate feels the more supported they feel.

Friendliness

Twenty-one (41.1%) of the 25 graduates who experienced a great deal of friendliness scored the support satisfaction level at eight and above. The mean satisfaction score for friendliness showed an increase in satisfaction when feelings of friendliness increased therefore suggesting the more a graduate experienced friendliness in the work place the more supported they felt (please refer to table 10).

Valued

Seventeen (33.3%) of 27 (52.9%) graduates who experienced the feeling of being valued a moderate amount scored the support satisfaction at eight and above. The mean satisfaction related to feelings of being valued did not identify a strong correlation compared to feelings of encouragement or friendliness (please refer to table 10). The reason for this maybe due to the low cell numbers in the 'not at all' category with only two participants. Although it is clear if a graduate feels valued a great deal then their support satisfaction is high with a mean score of 9.41.

Approachability

Of the 20 (39.2%) participants who experienced a great deal of approachability 19 (37.2%) of these participants scored their support satisfaction level at above 8. The support satisfaction mean increases when graduates feel more approachability therefore as with the other positive feelings of support the more a graduate experiences approachability the more satisfied they are with the support they received (please refer to table 10).

Helped

Of the 21 participants who stated they experienced being helped a great deal, 11 (21.5%) of these participants scored the support satisfaction level a perfect 10, therefore the highest level of support satisfaction. Feelings of being helped also impact positively of the support satisfaction with the more helped a graduate felt the more supported they were as there is a correlation between the mean satisfaction support and feeling helped within the graduate year (please refer to table 10).

Overwhelmed

When a graduate did not experience feelings of being overwhelmed the mean support satisfaction was high at 8.60. Graduates who experienced feeling overwhelmed a great deal scored their support satisfaction at 6.87 (please refer to table 10). Interestingly the support satisfaction for graduates who experienced feelings of being overwhelmed very little or a moderate amount was the same at 7.86. Both of these cell sizes also had higher numbers of participants with 23 and 15.

Inadequate

The nine (17.6%) graduates who felt that they did not feel inadequate scored the support satisfaction level between 9 and 10. Four (7.8%) of the five graduates who stated they felt inadequate a great deal of the time during the program scored the support satisfaction level below 5. Sixteen (31.3%) of the 24

participants, who identified that they experienced feelings of inadequacy very little, scored the satisfaction level above 8. The mean support satisfaction for experiencing feelings of inadequacy decreases from 9.60 for not at all to 4.60 for a great deal. Therefore a correlation was identified when the feelings of being inadequate were compared to the support satisfaction mean suggesting the less a graduate feels inadequate the more supported they felt (please refer to table 10).

Frustrated

There were 27 (52.9%) graduates who experienced very little frustration. Twenty (39.2%) rated the support satisfaction level at 8 or above. A strong correlation was identified between support satisfaction and feeling frustrated (please refer to table 10). It is clear that a graduate feels more supported if they experienced less frustration.

Angry

There were a vast number of participants (n-31, 60.8%) who experienced very little anger during the graduate year. Nineteen (37.2%) scored the support satisfaction level at 8 and above. A weaker correlation was identified between feeling angry and support satisfaction (please refer to table 10). This may be due to a low cell number of one participant in the category of 'a great deal'. A correlation was identified within the other categories showing a decrease in support satisfaction with an increase in feelings of anger.

Stressed

Twenty-three (45.1%) participants rated the feeling of being stressed at three (a moderate amount). Eighteen (35.2%) still rated the support satisfaction level above seven. A strong correlation was not identified between feeling stressed and support satisfaction (please refer to table 10).

Table 10: Feelings compared to the support satisfaction mean

Feeling	Not at All (satisfaction mean) 1	Very Little (satisfaction mean) 2	Moderate Amount (satisfaction mean) 3	A Great Deal (satisfaction mean) 4	Total Mean
Encouragement	5.70 (n-10)	-	7.38 (n-21)	9.25 (n-20)	7.44
Friendliness	-	5.30 (n-3)	7.26 (n-23)	8.56 (n-25)	7.04
Valued	6.50 (n-2)	5.90 (n-10)	7.85 (n-27)	9.41 (n-12)	7.34
Approachability	-	5.00 (n-5)	7.26 (n-26)	9.15 (n-20)	7.13
Helped	-	5.25 (n-4)	7.07 (n-26)	9.14 (n-21)	7.15
Inadequate	9.60 (n-9)	7.83 (n-24)	7.61 (n-13)	4.60 (n-5)	7.41
Frustrated	9.33 (n-3)	8.37 (n-27)	7.07 (n-13)	6.37 (n-8)	7.78
Angry	8.75 (n-12)	7.70 (n-31)	6.28 (n-7)	7.00 (n-1)	7.43
Stressed	8.00 (n-1)	8.43 (n-16)	8.17 (n-23)	6.00 (n-11)	7.65
Overwhelmed	8.60 (n-5)	7.86 (n-23)	7.86 (n-15)	6.87 (n-8)	7.79

*n-number of participates

When reviewing the support section of this study a large percentage (78.4%) of the graduates felt they were supported in the graduate nurse program. When participants were asked to rate how often they experienced feelings of being supported compared to feelings of being unsupported the positive terms overall scored higher. The overall mean score for the positive terms was 3.24 and the negative terms mean score was 2.41. When support satisfaction was compared to each term it could be suggested that the more positive feelings of support experienced by graduates the more satisfied they felt. This was the opposite for the negative terms experienced with the less these feelings were experienced the higher the support satisfaction level.

3.4.6 Being a Part of the Team

Fifty-one (98%) participants responded to the question asking graduates at what point they felt they belonged in the clinical area and thus a member of the team. One participant felt that they did not belong at all to the clinical area. Fourteen participants highlighted that it took 4 weeks for them to feel apart of the team. The mean length graduates felt it took to feel a part of the team was 5.92 weeks, with a standard deviation of 3.97 and a range of 0 weeks to 20 weeks (Please refer to Graph 4). The median was 10 weeks and the mode was 4 weeks. It would appear then that graduates felt they belonged to the clinical area after 10 weeks into a rotation.
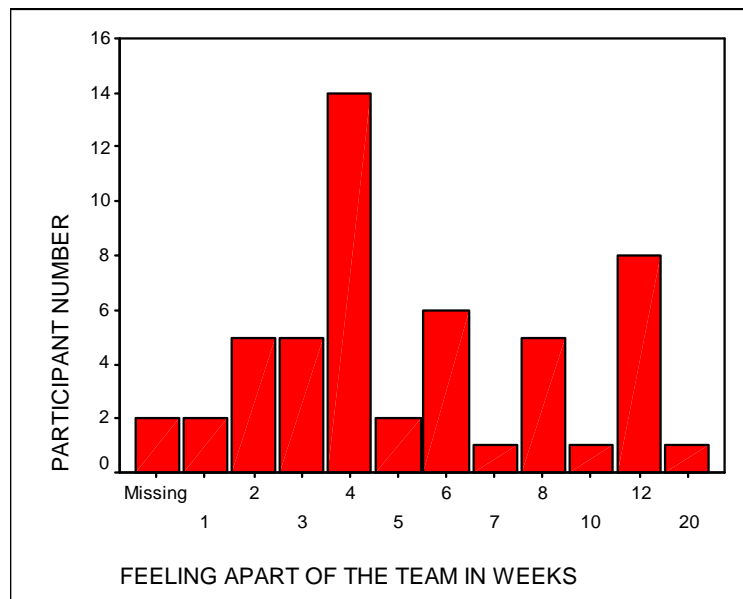
Graph 4: ***Length in weeks for graduates to feel they belonged in the clinical area.***

3.4.7 The Theoretical Component

The data relating to the theoretical component or structured study sessions revealed that the range of hours was varied from 1 hour to 234 hours with a mean of 59.79 hours. The most frequent number of theoretical hours was highlighted by 7 (13.4%) participants with 80 hours (please refer to graph 5). There were 21 (40.3%) participants who participated in less then 34 hours of structured study sessions.
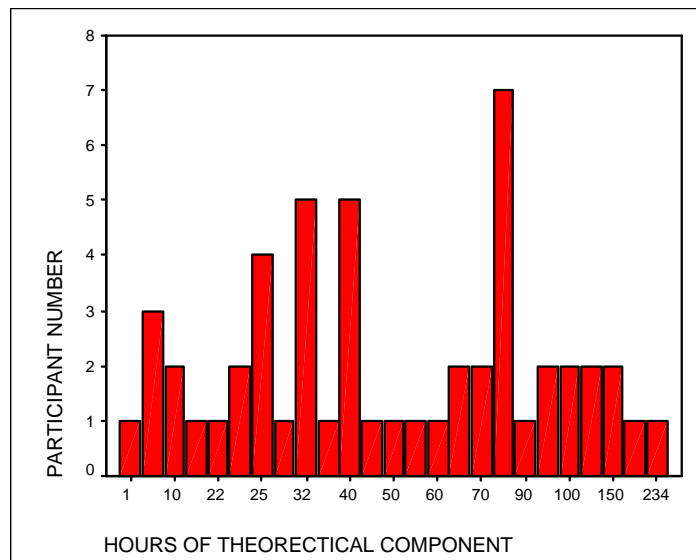
Graph 5: Hours of the Theoretical Component of the GNP

The satisfaction level regarding the theoretical component of the graduate nurse program ranged from 3 to 10 with a mean of 7.17. The highest number of participants (n-7, 14.46%) scored a satisfaction level of 7 and above and had participated in 80 hours of theoretical time. Eighteen (35.2%) participants who had at least 70 theoretical hours ranked their satisfaction level greater than seven.

In summary the amount of theoretical hours ranged from 1 to 234 hours with a mean score of 59.79 hours. Participant's satisfaction level ranged from 3 to 10 and the mean satisfaction level was 7.17.

3.4.8 Performance Appraisals

Of the 48 (92.3%) participants who answered this item, two (3.8%) did not receive a performance appraisal throughout the whole program. The mean number of performance appraisals per graduate was 3.5. The number of appraisals and the point in time in which these appraisals were completed will be expanded below:

- *First Performance Appraisal*

  Twenty three (47.9%) graduates stated that they completed their first appraisal at three months. Forty-five (97.2%) graduates completed their first appraisal within the first 4 months of the year. The mean time for the first appraisal was at 2.62 months.

- **Second Performance Appraisal**

  A second appraisal was completed by 43 (82.6%) participants between 1 to 9 months with a mean time of 5.51 months. Twenty four (55.8%) graduates identified that they completed their second appraisal at six months.

- **Third Performance Appraisal**

  The mean time for the third performance appraisal was 8.56 months and was calculated with the data from 39 (75%) participants who completed a third appraisal. The range was 3 to 13 months. Fourteen (35.8%) participants identified that the third appraisal was completed at nine months.

- **Fourth Performance Appraisal**

  There were 24 (46%) graduates who completed a fourth appraisal and the mean time of this appraisal was 10.83 months. Participants received this appraisal in the second half of the program from 6 to 12 months. Fifteen participants identified that their fourth appraisal was at the 12 month or at the completion of the program.

- **Fifth Performance Appraisal**

  Eight (15.3%) graduates had a fifth appraisal between 10 to 12 months and the mean time was 11.5 months. Six participants identified that they also received these appraisals at the end of the program (12 months).

- **Sixth Performance Appraisal**

  There was only one (1.9%) participant who had six appraisals in the program and this was completed at the 12-month mark.

Self-Assessment

Of the 52 (100%) participants 48 (92.3%) completed a formal self-appraisal and four (7.7%) did not. Two (3.85%) of these participants identified that they had not completed a performance appraisal during the program. Therefore only two (3.85%) participants who completed an appraisal throughout the graduate program did not complete a self-assessment.

The mean score for overall satisfaction with performance appraisals was 7.04, with a range of 1 to 10. Twenty-three (47.9%) participants scored their satisfaction level above 8. A correlation was identified between the mean performance appraisal satisfaction compared to the number of appraisals received per graduate (please refer to table 11). The mean satisfaction increases from 2 to 4 appraisals and then decreases after four appraisals suggesting that participants who received four appraisals were the most satisfied. The mean satisfaction for the 17 (33.3%) participants who received four performance appraisals was the highest satisfaction score at eight.

Table 11: *Compares the number of appraisals with the performance appraisal satisfaction.*

Number of appraisals	Performance Appraisal Satisfaction										Total	Mean
	1	2	3	4	5	6	7	8	9	10		
0	1			1							2	2.50
1				2				1			3	5.33
2		1			1		1	1			4	5.50
3				1		1	5	4	2	2	15	7.66
4				1		2	3	3	5	3	17	8.00
5				2	1		1		2		6	6.33
6							1				1	7.00
Total	1	1	0	7	2	3	11	9	9	5	48	

*n-number of participates

Therefore the total number of performance appraisals completed for this group of graduates totalled six appraisals. Performance appraisal one was completed on average in the second month of the program and the second appraisal was completed in the fifth month. The third and fourth appraisals were completed in the eighth and tenth month. The fifth appraisal was done in the eleventh month and one participant completed a sixth appraisal in the twelfth month. Two participants did not complete an appraisal throughout the transition year. Forty-six (92.3%) graduates did participate in a self-appraisal and the overall mean for the performance appraisals satisfaction was 7.04. The satisfaction range was 1-

10. When the mean performance appraisals satisfaction was compared to the number of appraisals, four appraisals was identified as having the highest mean of 8 from 17 (33.3%) participants.

3.5 The Evaluation of the Graduate Nurse Program

Forty five (86.5%) participants identified that they completed a formal evaluation of the program. Therefore there were seven (13.5%) graduates who were not formally asked to evaluate the program they were completing. Fifty (96.2%) participants responded to the next question asking if they were asked by their employer to provide their overall graduate nurse program satisfaction level on an evaluation tool. Forty two (84%) participants stated they were requested to provide this information and eight (16%) were not. When the participants who did not complete an evaluation of the graduate program but responded to this question were removed the number decreased. Leaving three (6%) participants who completed an evaluation but were not asked to identify their overall satisfaction.

3.6 Participants Overall Satisfaction with the Graduate Nurse Program

When participants were asked to rate their overall satisfaction with the graduate nurse program, the mean score was 8.15. The range of satisfaction was from 3 to 10. Thirty six (69%) participants scored their satisfaction at 9 or 10 (Please refer to graph 6).
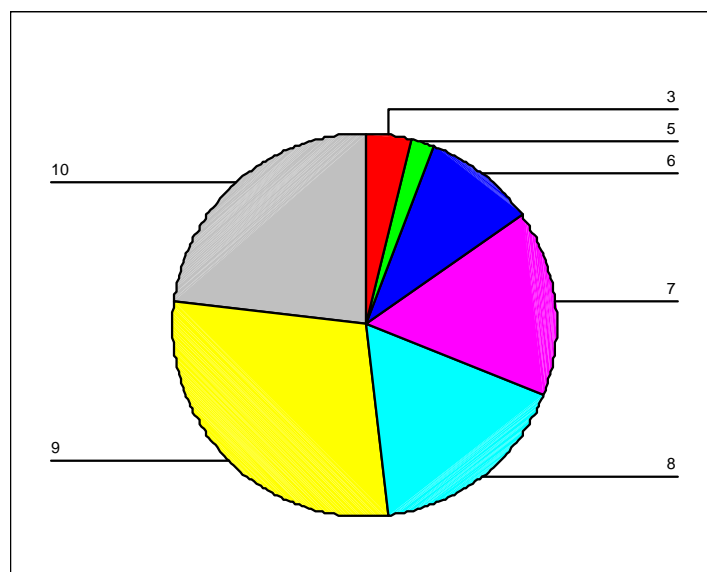
Graph 6: Overall Graduate Nurse Program Satisfaction

When retention rates were compared to the overall satisfaction it was evident that graduates who were re-employed within the same organisation after the graduate year had a higher mean program satisfaction level. The mean satisfaction value for graduates who remained within the same organisation was 8.42, compared to graduates who moved organisations with a mean of 7.42 and the standard deviation was 0.06 (please refer to table 12). Therefore the greater the satisfaction level the more likely graduates will be retained in the organisation.

Table 12: Overall Graduate Nurse Program Satisfaction Compared to Hospital Retention.

Retention	Overall Graduate Nurse Program Satisfaction										Total	Mean Satisfaction
	1	2	3	4	5	6	7	8	9	10		
Yes	0	0	0	0	1	3	6	7	11	10	38	8.42
No	0	0	2	0	0	2	2	2	4	2	14	7.42
												SD: 0.06

Interestingly when the graduate nurse program satisfaction level of participants working in the same hospital was compared it became evident that the satisfaction levels may not be similar. There were eight (15.3%) participants who completed a graduate program at hospital 11. These graduates rated the overall program satisfaction at varying levels ranging from 5 to 9 (Please refer to table 13). Hospital number ten with five participants had an overall satisfaction ranging from 7 to 10. Hospital number three was the most consistent with all graduates rating the overall program satisfaction between 8 -10.

Table 13: ***Overall Graduate Nurse Program Satisfaction Compared to Hospitals.*** **Overall Graduate Nurse Program Satisfaction**

	3	5	6	7	8	9	10	Mean	Retention rates
Hospital 1 (R,Pu)							1	10.00 (n-1)	0%
2 (M,Pr)			1		1			7.00 (n-2)	50%
3 (M,Pu)					1	4	4	9.33 (n-9)	100%
4 (R,Pu)				1	1			7.50 (n-2)	0%
5 (M,Pu)				1		2		8.33 (n-3)	66.6%
6 (M,Pu)						1	1	9.50 (n-2)	100%
7 (R,Pu)					1	1		8.50 (n-2)	100%
8 (R,Pu)					1	1		8.50 (n-2)	50%
9 (R,Pu)				1				7.00 (n-1)	0%
10 (R,Pu)				2		1	2	8.60 (n-5)	100%
11 (M,Pu)		1	2	1	2	2		7.25 (n-8)	87.5%
12 (R,Pu)				1				7.00 (n-1)	100%
13 (M,Pr)						1		9.00 (n-1)	100%
14 (M,Pu)							1	10.00 (n-1)	100%
15 (M,Pr)	1 (resigned)							3.00 (n-1)	0%
16 (R,Pr)	1				1			5.50 (n-2)	50%
17 (M,Pu)			1					6.00 (n-1)	0%
18 (M,Pu)							2	10.00 (n-2)	100%
19 (R,Pr)			1					6.00 (n-1)	0%
20(R,Pu)							1	10.00 (n-1)	0%
21(M,Pu)						1		9.00 (n-1)	0%
22(M,Pu)				1				7.00 (n-1)	100%
23 (R,Pu)					1			8.00 (n-1)	100%
24(M,Pu)						1		9.00 (n-1)	0%

M: Metropolitan hospital; R: Rural hospital; Pu: Public hospital; Pr: Private hospital

When the program satisfaction was compared to age (please refer to table 14) and gender (please refer to table 15) no significant correlation was identified.

Table 14: Age compared to program Satisfaction.

Age	Mean
21	8.83 (n-6)
22	8.20 (n-20)
23	7.75 (n-8)
24	8.50 (n-8)
25	9.00 (n-1)
26	7.50 (n-2)
27	9.50 (n-2)
28	8.00 (n-2)
35	3.00 (n-1)
43	9.00 (n-1)
44	6.00 (n-1)

*n-number of participates

Table 15: Gender compared To overall satisfaction.

Gender	Mean
Female	8.14 (n-48)
Male	8.33 (n-4)

When comparing the mean satisfaction score between the participants who graduated from the Aquinas campus with the St Patrick's campus they were very similar. The mean satisfaction values for the St Patrick's campus graduates were 8.29 and Aquinas campus graduates 8.23.

When the hospital location was compared to the overall satisfaction level, graduates who completed the graduate program in metropolitan Melbourne were slightly more satisfied with a mean satisfaction level of 8.23 compared to a mean of 8.00 from graduates working in a rural hospital (please refer to table 16). The retention rates for these programs were particularly different with the metropolitan hospitals having a 27% higher retention rate than the rural program.

When comparing each component of the graduate nurse program between the average metropolitan and rural program it became evident that there were some significant differences between the programs which may have impacted on the overall program satisfaction. Firstly the number of clinical rotations was slightly more in a rural program and the rotation satisfaction was significantly less. Graduates participation in preceptorship programs was slightly less in the rural program but the length of a preceptorship program was significantly less by 11.4 weeks. Preceptorship satisfaction was also considerably less with 7.25 in the metropolitan program and 5.5 in the rural program.

The number of supernumerary shifts was less in the rural program on the first rotation but slightly higher on the second rotation. The rotation satisfaction was similar between the two programs. The amount of time spent with the coordinator/educator was less in the rural program by one hour per week and the satisfaction with this time was also less in the rural program. The support component of the program showed that the positive terms of support were similar although there was a large difference between feelings of being angry with the rural graduates suggesting they experienced more anger. Graduates in the rural program felt they belonged to the team more quickly than their counterpart. Also the amount of theoretical hours was higher in the rural program but the satisfaction level was lower (please refer to table 16).

Table 16: *Comparison of Metropolitan GNP to a Rural GNP.*

Graduate Nurse Program Component	Metropolitan GNP	Rural GNP
1. Clinical Rotations		
Number of rotations	3.36	3.87
General Rotation	65.9%	69.1%
Speciality Rotation	34.1%	34.1%
Rotation satisfaction	8.17	7.61
2. Preceptorship		
Participated in a Preceptorship program	94.1%	88.8%
Length of preceptorship program	13.7 weeks	2.3 weeks
Amount of shifts worked with the preceptor	15.5 shifts	13.6 shifts
Preceptorship satisfaction	7.25	5.5
3. Supernumerary Time		
Supernumerary time in the first rotation	6.18 shifts	4.22 shifts
Supernumerary time in the second rotation	2.08 shifts	2.29 shifts
Supernumerary time satisfaction	7.02	7.22
4. Time spent with the GNP Coordinator/Clinical Educator		
Within the first 3 months	3.25 hours	2.10 hours
In the following 9 months	1.20 hours	1.3 hours
Satisfaction with the time spent with the GNP Coordinator/ Clinical Educator	7.44	6.55
5. Support		
Encouragement	3.20	3.16
Friendliness	3.48	3.33
Valued	2.90	3.00
Approachability	3.30	3.27
Helped	3.30	3.38
Overwhelmed	2.51	2.50
Inadequate	2.27	2.27
Frustrated	2.52	2.44
Angry	1.87	2.94
Stressful	2.81	2.94
Support satisfaction	7.88	7.44
6. Being apart of the team	6.81 weeks	4.52 weeks
7. Theoretical component		
Number of hours	54.32	70.44
Theoretical component satisfaction	7.29	6.94
8. Performance Appraisal		
Number of appraisals	3.36	3.75
Performance appraisal satisfaction	6.85	7.50
9. Overall GNP satisfaction	8.23	8.00
10. Retention rate	82%	55%

Participants who were employed during the graduate year in a public hospital were significantly more satisfied with the program than those who worked within a private hospital. The mean satisfaction level for the graduates who worked within the public sector was 8.41 compared to the private sector satisfaction mean of 6.16 (please refer to table 17). There were 33 (71.7%) participants that scored greater then eight in the overall satisfaction within the public hospitals compared to three (50%) graduates in private hospitals. The retention rate was also drastically less in the private sector with a retention rate of 50% to 76% in the public sector.

When comparing the clinical rotations the private sector graduates had over two more rotations then the public sector graduates and the rotation satisfaction was less in the private sector. Overall preceptorship had less participation; less time for the preceptorship program and graduates worked less with their preceptors in the private sector. The supernumerary shifts were also less in the private sector compared to the public sector. The amount of time spent with the coordinator/educator was also less than the public sector. As a result of the significantly less support graduates received in the private sector through preceptorship, supernumerary time and educator time the positive feels on support were all experienced less than in the public sector and the negative feelings of support were experienced more in the private sector. Which resulted in graduates in the public sector being more satisfied with the support they received compared to the private sector.

Table 17:   Comparison between Public GNP to a Private GNP.

Graduate Nurse Program Component	Public GNP	Private GNP
1. Clinical Rotations		
Number of rotations	2.84	4.16
General Rotation	66.7%	72%
Speciality Rotation	33.3%	28%
Rotation satisfaction	7.69	6.67
2. Preceptorship		
Participated in a Preceptorship program	93%	83%
Length of preceptorship program	9.97 weeks	7.5 weeks
Amount of shifts worked with the preceptor	15.3 shifts	11.4 shifts
Preceptorship satisfaction	6.81	6.2
3. Supernumerary Time		
Supernumerary time in the first rotation	6.86 shifts	3.83 shifts
Supernumerary time in the second rotation	2.59 shifts	1.3 shifts
Supernumerary time satisfaction	7.15	6.16
4. Time spent with the GNP Coordinator/Clinical Educator		
Within the first 3 months	3.57 hours	1.5 hours
In the following 9 months	1.36 hours	<1 hour
Satisfaction with the time spent with the GNP Coordinator/ Clinical Educator	7.28	6
5. Support		
Encouragement	3.24	2.80
Friendliness	3.44	3.00
Valued	3.00	2.33
Approachability	3.35	2.50
Helped	3.40	2.83
Overwhelmed	2.46	2.83
Inadequate	2.20	2.83
Frustrated	2.42	3.16
Angry	1.68	2.16
Stressful	2.80	3.33
Support satisfaction	7.95	6.00
6. Being apart of the team	6.18 weeks	5 weeks
7. Theoretical component		
Number of hours	35	63
Theoretical component satisfaction	7.413	5.33
8. Performance Appraisal		
Number of appraisals	3.5	3.5
Performance appraisal satisfaction	7.32	5.16
9. Overall GNP satisfaction	8.41	6.16
10. Retention rate	76%	50%

Table 18 provides a tabular summary of the data collected within this study relating to the components of a graduate nurse program, therefore highlighting the identified mean program from this data.

Table 18: Graduate Nurse Program Results

Graduate Nurse Program Component	Value	SD
1. Clinical Rotations		
• Number of rotations	3.01 rotations	1.49
• General Rotation	68%	
• Speciality Rotation	32%	
• Rotation satisfaction	7.97	1.75
2. Preceptorship		
• Participated in a Preceptorship program	92.3%	
• Length of preceptorship program	9.76 weeks	15.11
• Amount of shifts worked with the preceptor	14.86 shifts	8.03
• Preceptorship satisfaction	6.75	2.51
3. Supernumerary Time		
• Supernumerary time in the first rotation	5.49 shifts	4.44
• Supernumerary time in the second rotation	2.17 shifts	2.50
• Supernumerary time satisfaction	7.10	2.13
4. Time spent with the GNP Coordinator/Clinical Educator		
• Within the first 3 months	3.3 hours	3.26
• In the following 9 months	1.2 hours	1.88
• Satisfaction with the time spent with the GNP Coordinator/Clinical Educator	7.13	2.62
5. Support		
• Encouragement	3.20	0.75
• Friendliness	3.43	0.60
• Valued	2.96	0.77
• Approachability	3.29	0.64
• Helped	3.33	0.62
• Overwhelmed	2.51	0.88
• Inadequate	2.27	0.87
• Frustrated	2.51	0.83
• Angry	1.94	0.68
• Stressful	2.86	0.78
• Support satisfaction	7.73	1.95
6. Being apart of the team	5.92 weeks	3.98
7. Theoretical component		
• Number of hours	59.79 hours	46.14
• Theoretical component satisfaction	7.17	1.80
8. Performance Appraisal		
• Number of appraisals	3.5	1.31
• Performance appraisal satisfaction	7.08	2.14
9. Overall GNP satisfaction	8.15	1.70
10. Retention rate	73%	

3.7 Future Planning

When graduates were asked to identify any area of a graduate nurse program that could be changed to improve future programs the themes identified from the qualitative data include; preceptorship; the theoretical component; Clinical Education; supernumerary time; rotations; rostering; issues with other staff members; workload and feedback.

3.7.1 Preceptorship

The most frequent theme identified was related to preceptorship. There were many issues graduates highlighted regarding preceptorship and how it may be improved. Firstly, graduates believe that there should be a preceptorship program being conducted in each rotation. This is consistent with the statistical data identified in this research with 92.3% of participants stating they participated within a preceptorship program. Secondly, effective rostering or scheduling was also highlighted as an area, which could be improved for future nurses. Participants outlined how preceptors need to be working regularly with graduates. There were instances outlined where graduates had not met the preceptor until two weeks after commencing in the clinical area. One graduate nurse commented on this issue suggesting that hospitals need to *make sure all the units have preceptorship arrangements. In my hospital we were supposed to have preceptors in our 4 units however somehow some preceptor's were on holidays etc when they were meant to be preceptoring.*

One graduate suggested that preceptors and preceptees should be working together at least 2 to 3 shifts per week in the first 6 weeks after commencing. There should be *more time at the start of the program (spent) with (the) preceptor to encourage a healthy relationship.* Other graduates believed that preceptors should be working more frequently

with the preceptees throughout the whole year and not just at the beginning.

More feedback was a frequent theme suggested by graduates to improve graduate programs. Participants recommended that more feedback from the preceptors was necessary and there should be meetings held between the preceptor and preceptee once a week.

Other areas where participants felt preceptorship could be improved were related to the preparation of the preceptor and their willingness to be involved. Graduates felt the preceptor needs to be aware of the roles and responsibilities of a preceptor and when a preceptor is chosen to ensure the preceptor actually wishes to participate in the role of preceptor.

3.7.2 Theoretical Component

The theoretical component of the program was also an area that participants believed could be improved. The most common theme in this section outlined was that some graduates want more study days within the program. One graduate suggested that there should be more study days at the start of the program. Other participants highlighted that the topics being covered in the study days need to be relevant to the clinical area they are currently working within. One graduate nurse said, *because I was in paediatrics a lot of the study days had nothing to do with paeds (paediatrics), so it was hard.* Another theme identified was that graduates want to be taught new skills in the theoretical component of the program for example an epidural course or an intravenous cannulation course. Lastly another graduate recommended that there should be weekly debriefing sessions with the coordinator.

3.7.3 Clinical Education

The next theme identified in the qualitative data was clinical education. The most consistent theme relating to clinical education was that the graduate nurse coordinator or clinical educator should spend more time with graduates and provide more support. This is consistent with the quantitative data, which suggested the satisfaction with the time spent with the GNP Coordinator/clinical educator ranged from 0-10 with a mean satisfaction of 7.13 and a SD of 2.62, outlining that some graduates were dissatisfied with the time spent with the GNP coordinator/clinical educator. Another recommendation suggested that there should be regular meetings held between the graduate nurse and educator. One graduate nurse identified that the introduction of a clinical support and development nurse in speciality area is of great benefit in specialised areas.

3.7.4 Supernumerary Time

Participants also discussed supernumerary time as an aspect of the program which could be enhanced. All comments in this theme were related to the desire to have more supernumerary time. One participant stated *"more supernumerary days (are required) to enable graduates to settle in to the area"*. Another graduate nurse suggested there should be at least two to four supernumerary shifts *"just to get the hang of it"*. Various graduates identified that there should be an increase in the supernumerary shifts particularly in the second rotation. This is constant with the quantitative data which identified that 26% of participants did not receive any supernumerary time on their second rotation with a mean supernumerary satisfaction level of 6.18. One participant commented on her experience and stated *"I felt I needed at least one supernumerary day on (the) 2nd rotation I was unfortunately rostered on night duty at the commencement of the 2nd rotation and found it a bit difficult."*

3.7.5 Clinical Rotations

Another theme recognised is clinical rotations. There were various comments related to the location and the number of rotations. Some participants who commented on this area believed there should be fewer rotations within the program. One graduate stated there should be *fewer rotations (and) longer rotations on the ward.* Another participant said *I would make the rotations more structured (as) I had to move around a lot.* The participants who made the above comments participated in at least four rotations with a maximum of five rotations. Other comments regarding rotations were related to the location of these rotations. Some graduates believe there should be rotations to specialty areas such as the emergency department, intensive care or in the midwifery area.

3.7.6 Rostering

Rostering is an area that five participants believe could be improved. The themes identified in this area were that participants believe they were working too many weekends and too much night duty. One graduate commented on how there should be *better rosters for graduates; some graduates (are) working three out of four weekends. Not encouraging graduates to continue in (the) profession.* An additional theme outlined was that rostering should be more appropriate as graduates were put straight onto night duty when they commenced in a new clinical area. One participant stated that graduates should *not commence (on) night duty in the first week of (the) second rotation.* Another believed that the rostering is inflexible and made the following comment: *as nurses we are also Mothers, daughters or carers for others. I find the inflexibility of nurses' hours a big discouraging factor for nurses to remain in acute hospital setting. I have recently been appointed a position earning 2-3 times as much as I would in the hospital setting and I can work my own hours, still nursing which enables me as a single mother of 3 to live and work and be a sole parent. Good bye hospital work.*

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3.7.7 Issues with Other Staff Members

A variety of graduates suggested that they experienced difficulties with other nursing staff within the profession. Some graduates felt that there were nurses who did not respect them. A number of participants believed that some of nurses did not support or encourage the graduates. *Some members of team are resistant to graduates nurses and don't help graduates to feel comfortable. Some can be very unsupportive.* One graduate believed the way this could be facilitated would be to *improve the level of ward staffs understanding of the scope of practice of the graduates.* There were also graduates who experienced horizontal violence and bullying. *The only thing that was hard was the horizontal violence graduate nurses experienced from some senior nurses* stated one participant. Another participant suggested that *it would be nice to have older nurses who stood up for the younger ones and supported them rather than ignoring the bullying and allowing that culture to continue.*

3.7.8 Workload

Patient workload is another area graduates believe could be improved to facilitate a superior graduate nurse program. Some participants stated that the maximum workload for a graduate nurse should be four patients and the graduate looking after those four patients should have the skills and knowledge to care for them appropriately. *Work load –was a major issue for me as a graduate nurse. With the current staffing issues especially in a private hospital I was often the only RN for 11 patients with the help of a RN division 2 on a busy medical ward* stated one participant.

3.7.9 Feedback

The last theme identified in this category was feedback. Some graduates felt there should be regular feedback for graduates to inform them of how they are progressing in the program. The feedback should come from both the preceptors and senior nursing staff. One participant made the following comment about her experience *it's too late to tell a graduate their problems at the end of a rotation –there's no time to fix it- so communicate.* Feedback given frequently would prevent this problem from being repeated.

In reviewing the suggestions graduates made to improve graduate nurse programs for future nurses there were nine themes identified. Issues related to preceptorship were mentioned more frequently than any other theme. Graduates suggested that there should be a preceptorship program in place for each rotation and the rostering should reflect the importance of preceptees and preceptors working together. There should be regular meetings held between the two parties to ensure regular feedback. Participants also believe it is important for the preceptor to be prepared effectively and clearly understand their role. Lastly the preceptor chosen should want to participate in the role of a preceptor. Graduates also believe there should be more study days and they should study relevant topics to the area they are working within. When participants discussed clinical education some suggested that the educators should spend more time with graduates and there should be a regular meeting held with the educator and graduate nurse to enhance feedback.

Graduates also believe there should be more supernumerary days allocated particularly in the second rotation. Some participants outlined

that there may be too many rotations in some programs and others suggested there should be more specialty rotations. There were various comments relating to rostering. Participants suggested that graduates should not be working three out of four weekends and there should be less night duty. It was also highlighted that being rostered onto night duty at the commencement of the rotation was not beneficial. Another area recognised related to bullying and horizontal violence. Various participants outlined the importance of such behavior being prevented for future graduates. Workload was discussed and participants proposed that graduates should not care for more than four patients per shift. Graduates should also have the appropriate knowledge and skills to be able to care for their patients effectively. Lastly participants believe there should be more feedback given. Participants believe it is essential for graduates to have regular feedback from preceptors, senior staff and educators.

3.8   Future Employment

Question 33 asked participants to identify where they believed they would be professionally in the next five years. The themes include; further study; working towards a promotion; working in a specialty area; undecided; changing professions and travel.

3.8.1 Further Study

Twenty two (42.3%) participants commented on how they believed they would like to partake in further study in the next five years. Some graduates were already studying, other participants identified the possible areas they would like to study and some graduates suggested they wanted to complete two courses in the next five years. There were six (27.2%) participants who stated they would like to complete a Graduate Diploma but were unsure in what particular area. Five (22.7%) participants

stated they were interested in studying Midwifery. Four (18.1%) participants are interested in studying nursing education. There were three (13.6%) participants who highlighted that they wanted to complete qualifications in the Perioperative environment. Two (9%) were intending to complete further studies in paediatrics. Other areas of interest include neonatal, peadiatric and adult intensive care and oncology. Three (13.6%) graduates had already commenced studying when the data was collected. Two (9%) participants identified that they want to complete a master's degree, one in nursing education and the other in Midwifery.

3.8.2 Working Towards a Promotion

When looking at the theme promotion it is evident that participants believe promotion in the nursing profession is closely linked with further study. Many graduates who outlined their intention to be working in a higher position within the profession stated they would complete study to facilitate the move. Twelve (23%) participants suggested they are planning to achieve a promotion in the profession over the next five years. Seven (58.3%) participants identified that they would like to be in a Clinical Nurse Specialist (CNS) role within the next five years. Four (8.3%) participants were not sure if they wanted to move into either a CNS role or an Associate Nurse Unit Manager (ANUM) role. Other areas of interest included management and nursing education.

3.8.3 Working in a Specialty Area

Working within a specialty area is another theme identified in the data. The data related to participants studying or planning to complete further study in a specialised area was not included from this area as it has already been discussed in further study. Only the graduates who stated they would like to specialise in a particular area and have not discussed further study were included within this theme. There were seven (13.4%) participants who identified they would like to be working within a

specialised area. Each of these participants identified a different clinical area. The areas of interest include; paediatrics; paediatric intensive care; the emergency department; health promotion or the mobile support and treatment team. One graduate was not sure if she would like to work in either intensive care or the operating suite. Another participant suggested that they would like to specialise but at the time of data collection was not sure of the clinical area.

3.8.4 Changing Professions

Overall there were six (11.5%) participants who identified that they were considering changing professions. Two (33.3%) of these participants suggested that they would like to be in a different career but still doing a few agency shifts to maintain their nursing registration. Professions that graduates would like to move into include a paramedic, a high school teacher and Veterinary Science. One (16.6%) graduate intends to complete two graduate diplomas in nursing and then leave the profession.

3.8.5 Travel

There were five (9.6%) participants who suggested they were going to travel within the next five years. Three (60%) of these participants want to work within nursing and travel. The remaining two stated they just wanted to travel.

3.8.6 Consolidating

Three (5.7%) graduates outlined how they wanted to continue to consolidate in nursing and were unsure of what they would like to be doing in the next five years. One stated *hopefully still nursing, perhaps abroad but really who can tell at this stage. I feel after 12 months that I have just started to comprehend the complexity of the ward.*

In summary a large number of graduates believe they will be studying in the next five years particularly a graduate diploma. Some of the most frequently highlighted areas of study include midwifery, paedatrics, nursing education, preoperative and intensive care. Just under one fourth of participants are planning to achieve a promotion in the nursing profession. The most sort after position being the CNS role. Other graduates believe they would like to specialise in a particular clinical area and did not discuss any plans for further study within this specialty. Six (11.5%) participants suggested that they were considering leaving the profession. The remaining participants outlined how they were planning on either travelling or continuing to consolidate their clinical skills.

3.9   Data Analysis of the Graduate Nurse Program Coordinator Questionnaires.

3.9.1 Demographics

Of the six coordinators who returned the questionnaires all programs were conducted within a public hospital. Three (50%) were in the Melbourne metropolitan area and three (50%) are in a rural setting. The age of coordinators ranged from 39 to 55 years, with a mean of 45 years. All participants were female and completed their initial nursing education through hospital training. Four (66.6%) participants have completed a Graduate Diploma or Bachelor in Nursing Education or Education. One (16.6%) coordinator completed a certificate in workplace training and assessment. One participant did not highlight any qualifications in education. This participant does however have extensive qualifications in various other nursing fields. Only one (16.6%) participant has a master qualification in education.

Participants had at least three years experience coordinating graduate nurse programs and the maximum number of years was 15. The mean number of years participants have coordinated a program was 8.4 years.

One participant did not give a value and stated she has been coordinating graduate nurse programs since the inception of the programs.

When participants were asked to identify the amount of hours they are employed to coordinate the program the range of hours was between 10 – 38 hours per week with a mean of 27.7 hours. Three (50%) participants stated that the hours of employment for the program coordination do not change throughout the year. Three (50%) suggested that the hours do change. One (16.6%) did not describe how the hours changed. Another coordinator suggested the change *depends where the graduates are at in their program.* The final participant suggested that as the graduates get more experienced the hours change from 32 hours to just a few.

In review of the demographics for the coordinators, half the hospitals where the participants are employed are in Melbourne and the other half are in rural hospitals. Majority of coordinators had completed some qualifications in education but only one participant had a master's degree. Participants were experienced in coordinating graduate nurse programs with a mean of 8.4 years and a SD of 4.93. The mean hours of employment for coordinating are 27.7 hours and half the participant's hour's change as the program progresses.

3.9.2 The Clinical Rotations

When coordinators were asked to identify how many rotations graduates complete in their program the range of rotations were from no rotations to five, with a mean of 3.25 rotations. This is similar to the graduate nurse's data which identified a mean rotation of 3.01. Two (33.3%) organisations conducted five rotations and one (16.7%) has three rotations. There are also two (33.3%) organisations who conducted two rotations and finally the last participant does not allocate any rotations.

Coordinators in this study identified that the most beneficial rotation for graduates was in a surgical or medical unit. Two (33.3%) participants identified that a surgical area is the most beneficial and two (33.3%) suggested a medical area was the most beneficial. One participant (16.6%) suggested that a combined Medical/Surgical rotation was the most beneficial. Therefore the majority of participants believed that a general rotation is the most beneficial. This is consistent with the graduate nurse data with the majority (71.1%) of graduates also believing that a general rotation was the most beneficial. One (16.6%) GNP coordinator did not comment on rotation areas as the program she coordinators does not have any rotations.

Participants were asked to rate their satisfaction level with the rotations within the programs they coordinate. The satisfaction level ranged from 7 - 10 and the mean level was 8.5.

Therefore the number of rotations in these coordinators programs range from 0 to 5 with a mean of 3.25 rotations. Overall participants believe the most beneficial rotation is a surgical or medical unit and the mean satisfaction level was 8.5.

3.9.3 The Preceptorship Program

All six (100%) participants suggested they have a preceptorship program in place within the graduate nurse program. The preceptorship length ranged from three days to 12 weeks with a mean of 5.9 weeks. The number of shifts preceptors work with preceptees range from 1 to 20 shifts and the mean value is 12.67 shifts. When coordinators were asked to rate the preceptorship satisfaction level it ranged from 3 to 10 and the mean score was 6.33.

The graduate nurse preceptorship data was different to the coordinators in the mean length at 9.76 weeks and the mean number of shifts was slightly higher at 14.86. The mean preceptorship satisfaction was similar between the two groups with the graduates satisfaction at 6.75 compared to the coordinators 6.33.

3.9.4 Supernumerary time

The number of supernumerary shifts allocated to graduate nurses as identified by the coordinators ranges from 3 to 16 shifts with a mean value of 7.5 shifts on the first rotation. This is higher than the graduates' data which identified the mean number of shifts at 5.49. 0n the second rotation the coordinators data indicated a mean value of 1.8 shifts with a range of 0 to 3 shifts. The coordinators satisfaction level ranged from 3 -9 and the mean was 6.8.

3.9.5 GNP Coordinator/Clinical Educator

Participants outlined that the mean value for the coordinator/clinical educator spending time with graduates in the first three months of the program was 11.8 hours per week. The range of hours per week was from two to 30 hours. The data showed that the following nine months of the program saw the graduates having less time with the coordinator/clinical educator. The range of hours was from one to 20 and a mean value of 8.8 hours per week. The satisfaction levels for the amount of time spent with the coordinator/clinical educator ranged from 4 to 10 with a mean of 7.17.

3.9.6 Support Given to Graduate Nurses

Coordinators were asked to rate terms describing feelings of support and identify how often they believed graduates in their program would experience these feelings.

Overall the positive terms of support ranged from 3 to 4 with a mean score of 3.6. The feeling of graduates being encouraged, friendlessness and approachability were rated from 3 to 4 and the mean value was 3.67. Coordinators perception of graduates feeling valued and helped also ranged from 3-4 although the mean for these terms was 3.5.

Overall the negative terms of support were less. The coordinators perception of graduates feelings of inadequacy ranged from 1-3 and the mean was 2.17. Both frustration and anger ranged from 2-3 with a mean of 2.17. Feeling overwhelmed ranged from 2-4 and the mean value was 2.67. Lastly feelings of being stressed were highlighted as the most common feeling that coordinators believe graduates experience of the negative terms.

The mean support satisfaction for these participants was 7.83 and ranged from 6-10. Three (50%) participants scored the support satisfaction at eight, with a total of four (66.6%) participants believing the support provided in their program was eight or above.

3.9.7 Being Apart of the Team

When participants were asked how long they believed it takes for graduates to feel they belong to the clinical area in which they are working it ranged from three to 12 weeks. The mean value is 6.83 weeks. All participants identified a different number of weeks.

3.9.8 The Theoretical Component

The range of hours for the theoretical component of the program given by these participants ranged from 40 to 112 hours. The mean was 62.83 hours. Two (33.3%) participants identified that their program conducts 40 hours of theory. Theoretical satisfaction ranged from 8-10 and the mean satisfaction was 9.33.

3.9.9 Performance Appraisals

Coordinators identified that all graduates receive a performance appraisal. The first appraisal will be completed within the first four months of the program, with the mean time being 3.17 months. The second appraisal will be completed at 6-12 months with a mean score of 7.5 months. A third appraisal was outlined by five (83.3%) participants and will be completed from 9-12 months and the mean time is at 10 months. A fourth appraisal is completed in three (50%) of the participants programs and it will be completed at 12 months. The overall satisfaction level for performance appraisal ranged from 7-9 with a mean value of 7.83. Six (100%) participants outlined that the performance appraisal included self assessment.

3.9.10 The Evaluation of the Graduate Nurse Program

All six (100%) participants suggested they ask graduates to complete a program evaluation which contains a section requesting them to provide their overall satisfaction.

3.9.11 The Overall Graduate Nurse Program Satisfaction

When participants were asked to rate their overall GNP satisfaction the mean score was high with a score of 8.5. The range was from 8-10. Four (66.6%) coordinators scored their program at eight.

3.9.12 Future Planning for GNPs

When coordinators were asked if they had the opportunity to alter the program without having any management or resource limitations how would they change the program the themes identified were consistent with many of the themes the graduate nurses suggested. These include; preceptorship; the theoretical component; clinical education; supernumerary time; rotations; issues with other staff members; and lastly feedback.

Preceptorship

There were three sub themes identified in this section where participants believed the program could be improved. The first improvement relating to the preceptor, one participant suggested that the preceptor should be a *quality preceptor*. Another participant wanted preceptorship acknowledged and promoted by nursing management to facilitate its processes. The last theme identified was that preceptors should work more shifts with the graduates.

Theoretical Component

Three (50%) participants suggested that they would like to have more hours allocated to theory. One coordinator suggested that there should be one study day per month.

Clinical Education

There were four (66.6%) participants who would like more clinical education time allocated to spend with graduates. This was suggested to occur in different ways; one coordinator suggested the time should be after hours and on weekends. Another participant outlined how a clinical support educator should spend more time with graduates and lastly that there should be more clinical education time for the graduates who are struggling.

Supernumerary Time

Four (66.6%) participants outlined how they would like to increase the amount of supernumerary time given to graduates. One (16.6%) participant suggested there should be one week allocated per rotation and another suggested that more supernumerary time should be available for struggling graduates.

Clinical Rotations

Two (33.3%) participants recommended that there should be community placements in the program. One participant said *more community placements so that they have a greater understanding of other nursing roles within the profession.*

Issues with other staff members

One (16.6%) coordinator would like to provide education to Nurse Unit Managers (NUM) and senior staff about graduates and their needs. This participant suggested that this may assist in moving past *in my day...*

Feedback

One (16.6%) participant would like to have more time at the end of the shift to provide feedback to graduates. One (16.6%) coordinator would like graduates to page the educator more frequently for further development.

In summary overall coordinators believed that to improve the program they would like to give more time to the graduate nurse. Coordinators would like to enable graduates to spend more shifts with a quality preceptor. To have more hours spent in the theoretical component of the program. They would also like to spend more time with graduates and increase the amount of supernumerary time.

Chapter Four Discussion; Recommendations and Conclusion

4.0 Introduction

The results outlined in the previous chapter addressed the purpose and objectives of the study. This chapter will discuss these results, compare them to the available literature and make recommendations.

4.1 Demographics

The demographic details of the participants of this study showed that the average age for a graduate nurse was 24 years old and there were significantly more female graduates then male. The majority of Aquinas campus participants were employed within the rural setting for the graduate nurse program as one of the aims of having a rural campus is that graduates staff rural hospitals.

4.2 Graduate Nurse Program details

Of the 52 participants only one (1.9%) participant did not complete the graduate program. The Senate report (2002) suggested that a large number of new graduates are leaving the profession within the first year of practice. The findings of this study were not consistent with this statement, this maybe due to the small sample size of this research and the sample being from one university. Even though the numbers are limited it should be acknowledged that this is a very difficult time for the graduate nurse. The participant stated that she *made it to a Grade2 year 1 on her own* suggesting a great personal achievement.

The retention rate was 73%; this is lower than the retention rate Owens et al (2001) identified of 88%. It is to be expected that there is going to be a

percentage of graduates who want to change organisations due to a variety of reasons. It could be because of the desire of the graduate to specialise or because the traveling distance to work is too extensive. It may even be because the organisation does not have any vacant position so the graduate has no option but to find employment else where.

Ideally employers are aiming for graduate nurses to be retained within their organisation as recruitment is expensive and difficult in times of nursing shortages. Graduate nurse programs must provide a supportive environment which meets the satisfaction of graduates and thus encourage them to remain in the same hospital service. The data clearly indicated that the mean satisfaction level for graduates who changed organisations was lower than those who were retained. This suggests that the more satisfied graduates are with the program the more likely they are to remain within the organisation.

Another aspect related to retention is the importance of retaining graduates not just within an organisation but within the nursing profession. As Clare and van Loon (2003) suggest the quality of graduates' transition has a direct effect on their desire to continue practicing as a registered nurse. Graduate nurse programs are responsible for providing a supportive introduction into the organisation of employment and to the profession. At the time of data collection 100% of graduate nurses remained working in the nursing profession.

The highest ranked reason why graduates chose to apply to a particular hospital and graduate program was because of the proposed support offered to graduates. Therefore participants within this study believe that support during the transition period was an influential aspect when considering employment. This is contrary to Heslop et al (2001) study where the locality of the hospital was the most influential reason. The

location of the hospital was also identified as a reason contributing to a graduate choosing a graduate program. There were further commonalties between this study and Heslop et al (2001) where participants believed the reputation of the hospital, the rotations offered and familiarity with the hospital were important.

4.3   The Clinical Rotations

There were 19.2% of participants who remained in the same clinical environment for the duration of the program. There are arguments for and against rotating within the graduate year. Boychuk Duchscher (2001) recommends that graduates should not rotate until they have completed 12 months experience as there are potential safety issues. Graduates have so much to deal with in the transition process and including another clinical environment may not be beneficial. This is also consistent with what Casey et al (2004) found that it takes graduates 12 months to feel comfortable and confident which suggests it maybe beneficial not to rotate. This would also be beneficial for hospitals financially as fewer resources are required. Graduates would not require further supernumerary time, preceptorship programs and support from educators. Of the 10 graduates who completed one rotation within this study 60% scored the rotation satisfaction level greater then eight and the mean satisfaction level was 7.60.

On the other hand the Department of Human Services (1997 and 2003) outlined that including rotations within a graduate nurse program is valuable as they provide variety and increased experience. Rotations introduce graduates to differing patient acuity, diseases and procedures. They also enable graduates to be exposed to various nursing experts within each clinical area, varying management styles which can result in extensive changes within the professional and clinical environment. Rotations can build on the graduates' clinical knowledge and skills that

can be transferred between clinical environments. Sigsby and Yarrandi (2004) discovered students who rotated to the perioperative environment demonstrated greater knowledge regarding surgical patients. If this is transferred into the graduate year, graduates who rotate to the perioperative environment and then to a surgical rotation will begin the rotation with greater knowledge regarding the care of a surgical patient.

The results of this study found that there was only two (8.4%) hospitals where graduates did not rotate which may suggest that majority (91.6%) of hospitals believe that rotations are an essential part of the program. The overall mean amount of rotations for graduates was three. Twelve (50%) hospitals conducted either three or four rotations and 44.2% of graduates completed 3-4 rotations. 40% of participants completed 2-3 rotations which suggests that just under half of graduates completed the amount of rotations recommended by the Department of Human Services (2003). The remaining participants did not rotate or completed 4-6 rotations.

When comparing rotation satisfaction graduates were more satisfied if they completed a rotation. The mean satisfaction for graduates who rotated was 8.10 compared to participants who did not rotate at 7.60. When the rotation satisfaction was compared to the number of rotations graduates completed it was identified that 11 of the 12 participants who completed two rotations scored their satisfaction greater then eight. The mean satisfaction score for two rotations was 8.58 but for six rotations the score was 8.75.

The length of rotations is closely linked to the number of rotations within a graduate program as the length of the rotation will determine how many rotations can be conducted within the time frame of the program. If a program (52 weeks) has five rotations for example then the rotation length would be 10.4 weeks if the year was divided equally. Six weeks annual

leave for graduates also needs to be included which would decrease them further. This research identified that overall most graduates believed the longer the rotation the more valuable it is. The most valuable rotation for these participants had a mean length of 23.96 weeks. This research suggests that the ideal amount of rotations within a graduate nurse program is two.

It is evident that rotating to a different clinical area is a stressful experience for many graduates. Although two rotations within a program of equal length is a reasonable compromise as it allows enough time for the graduates to settle into the clinical area and become a contributing member of the nursing team before they need to move onto the second rotation. Two rotations facilitate the graduate in gaining valuable experience of being exposed to differing clinical areas without applying extensive pressure with many rotations. A theme was also identified from the graduates' comments regarding rotations suggesting that some graduates wanted fewer rotations within the program. During the second rotation graduates still wanted supernumerary time, preceptorship and support to facilitate transition between clinical areas. According to the literature (Department of Human Services, 1997 and 2003) and the results of this study it is recommended that at least two rotations are beneficial.

There is very little literature discussing the clinical areas where graduates should consolidate their nursing knowledge and skills within the graduate nurse program. The clinical areas where graduates rotated to in this research were vast and included general surgical/medical units and very specialized areas. Casey et al (2004) also found that graduates were rotating to medical/surgical and specialty areas including critical care, psychiatry, rehabilitation and women's health services. The Department of Human Services (1997) outlined that it is important for graduates to rotate to a specialty area as they may not have been exposed to these areas in

the undergraduate course and it is important for recruitment for these specialty areas. Twenty nine (55.8%) participants within this study completed both a general and specialty rotation. It could be suggested that this is an ideal situation as graduate nurses are able to consolidate their skills within a general clinical area and also be exposed to a specialty area. There were 36.5% of graduates who only completed rotations within a general clinical area and 7.7% remained within a specialty area. Therefore a total of 92.3% of participants worked within a general surgical or medical unit within the program. This may suggest that hospitals believed it was important for graduates to complete a general rotation within the transition period.

Of the 52 graduates 71.1% believed that a general rotation was the most valuable and the remaining 28.9% outlined that a specialty clinical area as the most valuable. If the 10 participants who did not rotate within the program were removed from the analysis as they automatically placed their only rotation in the position of most value, 71.5% of graduates believe a general rotation is the most valuable and 28.5% believe a specialty rotation is most valuable. The coordinators agreed with the majority of graduates and suggested that a general medical/ surgical placement was most beneficial for graduates within the first year of practice.

There are other aspects regarding rotations which also need to be highlighted. One aspect is the clinical area the graduate may want to continue in after the graduate program. There were many graduates within this study that believed they wanted to complete further study within a specialised field in the future. If a graduate has decided that they want to specialise within neonatology for example is a rotation within in the operating suite going to be beneficial for this graduate or would a rotation within a midwifery area be of more value. It could be argued that in any

rotation graduates are going to develop transferable skills but if graduates have decided on their preferred future nursing area should the graduate program facilitate this by providing relevant clinical exposure? The other aspect is knowledge and skill acquisition. The time it takes for a graduate to develop competence within a clinical rotation has an effect on the appropriate clinical rotations and the length it should be conducted.

Recommendation 1
- Rotations within a graduate nurse program should be kept to a minimum. The ideal being two rotations of equal length.
- Graduate nurses should rotate to a general medical/surgical clinical area within the graduate nurse program.

4.4　The Preceptorship Program

There were 92.3% of graduates who participated within a preceptorship program and there were 7.7% who did not. It is remarkable that there were four graduates who were not orientated through a preceptorship as a model of supervision. Through reviewing the literature preceptorship is considered an essential component of the orientation process (Anderson, 1998; Boychuk Duchsher, 2001; DHS, 1997 and 2003; Maben, 1998 and O'Malley, Cunliffe, Hunter, and Breeze, 2000). It is disappointing that there are still graduate programs where a preceptorship program is not an essential component. Graduates in this study confirmed this and made comment on the need to have a working preceptorship program for future graduate nurses.

The length of the preceptorship program identified by graduates was from 1 to 52 weeks. This is a very large range from the beginning of the program to the end. The literature suggests that the difference between preceptorship and mentorship is that preceptorships are short-term compared to mentorship's being long term (Brasler, 1993; Clare et al 2002; Morton-Cooper and Palmer, 2000; and O'Malley, et.al 2000). It may

be suggested that some graduates actually participated within a mentorship program. It is also possible that some may not have a clear understanding of preceptorship and believed that throughout the graduate nurse program they were being preceptored.

The mean length of the preceptorship program for graduates was 9.76 weeks. A large majority of graduates (36.9%) suggested that the program lasted one week and 63.7% of participants outlined that the program was conducted between one to six weeks. 22.9% of graduates who participated within a program conducted over one to four weeks scored the preceptorship satisfaction at seven. The Department of Human Services (1997) suggested that a preceptorship program should be from four to six weeks in length. Only 10.9% of graduates participated within a preceptorship program of this length which highlights that many programs are not following the recommendations of the DHS relating to preceptorship. Clare and van Loon (2003) suggest that a four week program works well. After reviewing the data from this study and the related literature, it is recommended that a preceptorship program be conducted over four-six weeks. This will facilitate enough time for effective orientation and support. Although this is the recommended length this may vary and need to be flexible according to the graduate's entry behavior, their ability to learn, the acuity of the area and the competence of the graduate.

The range of shifts graduates worked with their preceptors within the first six weeks was also broad from 0-40 with a mean score of 14.86 shifts. Clare and van Loon (2003) suggests that preceptors should work every shift with the graduate for the first two weeks and then at least 2-3 shifts each week from then onwards. If a graduate works full time then within the first six weeks of employment Clare and van Loon (2003) suggested that a preceptor should work a minimum of 18 shifts with the graduate. The data

from this study is lower than 18 shifts for many graduates. Seventeen (38.6%) participants only worked less then ten shifts with their dedicated preceptor. This may have contributed to the low satisfaction levels articulated by this group.

Balcain et al (1997) implied that it was not uncommon for designated preceptors to work only a few shifts with the preceptee. This was also found in this study with some graduates suggesting they did not work any shifts or minimal shifts with their preceptor. The benefits of a preceptorship program can not be achieved until the graduate and preceptor are actually working with one another. Graduates also commented that preceptors need to be working regularly with preceptors and there needs to be structure in place to ensure this happens. One participant suggested that the preceptor should work at least two to three shifts together within the first six weeks.

According to the results gathered in this study the number of shifts worked with preceptors had minimal effect on the graduate's satisfaction. This is an interesting finding as it could be suggested that the more shifts worked together would enable a more effective program. These results may have been due to the smaller sample size of the study or it could suggest that graduates base their satisfaction on other aspects of the preceptorship program. The questionnaire did not however ask preceptors how important working the same shifts with the preceptee was. This is an important component of the preceptorship program as the preceptor may be more frustrated if they are not working with their preceptee to identify and monitor their progress.

The data in this study clearly showed that the structure of preceptorship programs differ considerably between various clinical areas. This is consistent with O'Malley et al (2000) findings. It is apparent that there are

many factors, which can contribute to positive or negative preceptorship, such as the preparation of the preceptor, appropriate selection of a preceptor and the relationship between the two parties. Before these aspects can impact on the preceptorship process the preceptor needs to actually work regularly with the graduate nurse and the logistics of the program need to be structured effectively. Balcain et al (1997) implemented clear systematic expectations within their action research to enable preceptorship programs to be more effective and have a standard approach. The standards included expectations regarding effective scheduling. The participants within Balcain et al (1997) study found the expectations helpful as there was clear communication for all regarding the process.

Overall preceptorship satisfaction for graduates ranged from 1 to 10 and the mean score was 6.75. The mean satisfaction level is the lowest of all program component satisfaction, which Implies preceptorship programs could considerably be improved for the benefit of future graduate nurses. The following recommendations have been developed using both the data from this research and the available literature to improve the way preceptorship programs are delivered.

Recommendation 2
- Preceptorship is one of the most effective methods of supporting graduates and it is recommended that:
  - Preceptors work with graduates for a minimum of the first two weeks of each rotation and then 2-3 shifts per week for the following 2-4 weeks.
- Organisations need to ensure the logistics of preceptorship planning are an essential priority when developing rosters.

4.5 Supernumerary Time

Supernumerary time is an important part of a supportive graduate nurse program (Clare and van Loon, 2003; The Department of Human Services, 2003 and Gerrish, 2000). On the first rotation the amount of supernumerary time graduates received ranged from 0 to 16 shifts with a mean number of 5.49 shifts. It is disappointing that some graduates are not given any supernumerary time or only one shift in there first rotation. The issues that graduates face in transition from student nurse to graduate nurse are vast and it is clear in the literature that they require support to get through this time. Supernumerary time is an effective way of providing support to ensure the transition is positive for the graduate, safe for patients and enhances the retention of nurses within the profession. Yet there are some graduates who report very little supernumerary time. Twelve (23.5%) participants only had two supernumerary days.

It is also disappointing that the mean supernumerary time for the second rotation was 2.17 shifts, with 11 participants having no supernumerary time. It could be suggested that the supernumerary time in the second rotation could be low as graduates have already worked in one clinical area for a period of time therefore they shouldn't need supernumerary time. It could also be argued that the second rotation can be a difficult time for graduates as in a new rotation they have to 'start over'. Towards the end of their first rotation graduates are feeling more competent and confident and they are feeling like an important team member. They are moved from this safe environment into a new and different setting. They have to get to know the new environment, the routines of that particular area and the people who work there. This can be overwhelming and reduce the graduates' confidence. Casey et al (2004) found that the most difficult time for graduates in relation to feeling comfortable and confident was between 6 to 12 months. This finding could suggest that the reason for this is that graduates begin to rotate during this time. One

supernumerary shift gives graduates minimal support but at least some time to "find their feet" and get to know some of the routines of the ward and meet some of the other nurses before she or he assumes a patient load.

Supernumerary time is one of the most costly aspects of conducting a graduate nurse program from purely a budgetary perspective during this time graduates' wages are being paid for minimal outcome. The sooner the graduate is caring for a full patient load then the more productive and cost effective they become. When graduate nurse program coordinators were asked how they would change their programs without any budgetary restraints 66.6% of participants outlined that they would like to increase the amount of supernumerary time allocated to graduates. The grant public hospitals receive from the DHS is supposed to assist in providing hospitals relief from these costs. So the question has to be asked why are hospitals not providing more supernumerary time for graduate nurses? The Senate Community Affairs Committee (2002) also found this and stated that it is questionable whether hospitals are using this funding for the intended purpose.

Some graduates agreed with the coordinators and suggested that there needs to be more supernumerary time allocated to graduates. One participant stated *more supernumerary days (are required) to enable graduates to settle in to the area*. Another graduate suggested there should be at least 2-4 supernumerary shifts *just to get the hang of it*. One coordinator suggested that there should be one week allocated for supernumerary time. Various graduates identified that there should be an increase in the supernumerary shifts particularly in the second rotation. One participant commented as her experience and stated *I felt I needed at least one supernumerary day on (the) 2nd rotation I was unfortunately rostered on night duty at the commencement of the 2nd rotation and found*

it a bit difficult. The wisdom of not giving any supernumerary time to a graduate nurse on the second rotation and particularly rostering them initially onto night duty needs to be questioned. It is recognised from antidotal evidence that there is less support on night duty with less staff working and for the majority of organisations no clinical education support.

With the minimal amount of supernumerary time many graduates received within the program it is interesting that the overall satisfaction of supernumerary time identified by graduates was not low the data indicating a mean satisfaction level of seven. The range of satisfaction was 1-10. This may suggest overall graduates were satisfied with the supernumerary time but interestingly a strong theme was identified in the graduate's comments, which suggested that there should be more supernumerary time for future graduates. It may also suggest that some participants are not aware that they were entitled to significant supernumerary time.

The data however within this study identified that there were higher satisfaction levels when participants had increased supernumerary time. Therefore the more supernumerary time graduates receive the more satisfied they were.

A satisfactory amount of supernumerary time identified would be a minimum of at least four supernumerary shifts per rotation. At the absolute minimum four days enables graduates to experience various clinical situations, type of patient needs and the clinical environment of the new rotation. Working with a preceptor the first day would facilitate the graduate to begin to learn the routines, with the second and third day taking on 2-3 patients and on day four, 4 patients. From this point

graduates should continue to have a reduced patient load of four patients until further knowledge and skill acquisition can be achieved. As with preceptorship the recommended four days also needs to be flexible to incorporate the individual requirements of each graduate nurse. Some graduates may be working safely with this supernumerary time but there will also be graduates who require more to achieve the same outcome.

Recommendation 3
- Graduates should be given a minimum of four days supernumerary in each rotation and be flexible to meet the individual needs of the graduate.

4.6   GNP Coordinator/Clinical Educator

The GNP coordinator and clinical educators provide support and development for graduates through transition. Although there is literature identifying the importance of the GNP coordinator/clinical educator (Clare and van Loon, 2003; Day, 1997 and The Department of Human Services GNP guidelines, 1997 and 2003) there is very little literature describing how much time a coordinator/clinical educator should spend with graduates. Cobal (1998) identified that educators spent minimal time with graduates and who were disappointed with the level of support, however the amount of time actually spent with the graduates was described using comments from graduates suggesting 'maybe two minutes in the first week' or never. There was also no mean value given in this paper.

This current research identified that in the first three months of the program graduates suggested that the amount of time spent with the coordinator/clinical educator ranged from 0-20 hours per week with a mean value of 3.3 hours. This is significantly higher then what Cobal (1998) found. The majority (60%) of participants stated that the time they spent with the educators was between .50 – 2 hours per week. In contrast

the coordinators stated a significantly higher value of 11.8 hours. The difference between these two values may be due to the significantly smaller sample size of the coordinators compared to the graduates or it may suggest that coordinators believe they are providing more support than they are delivering.

The time spent was considerably lower in the following nine months with a mean of 1.2 hours with a range of 0-8 hours. The coordinators mean value was 8.8 hours with a range of one to 20hours. This suggests that as time goes on graduates are given significantly less time from the coordinator/clinical educator. It was very disappointing to discover that 20% of graduates indicated the coordinator/Clinical Educator did not spend any time with them during the last nine months of the program. It is recognised in the literature that the coordinator/clinical educator need to provide support and development for graduates. Coordinators need to ensure the program is meeting the graduates' individual needs and this is not possible if they are not actually spending any time with graduates.

The other issue that needs to be discussed is that there is the assumption that after three months graduates requires less support in the program as the mean time spent with the educators dropped from 3.3 hours to 1.2 hours. As highlighted earlier Casey et al (2004) found that the most difficult time for graduates was between 6 to 12 months. The data from this study suggests that many graduates are given less support through this difficult time from the coordinator/clinical educator. Half of the coordinators surveyed suggested that their employment hours reduced as the program progressed. Therefore there is less resources made available for graduates in some hospitals throughout the program, which may also explain why the amount of time spent with graduates significantly reduces after the first three months. Through reviewing the data and literature regarding this topic it is recommended that resources remain consistent

throughout the whole program and that the individual needs of each graduate nurse are taking into consideration.

Overall graduates were satisfied with the amount of time the coordinator/ clinical educators spent with them throughout the program with a mean score of 7.13 although there is obvious room for improvement. Although the satisfaction level is above seven both the graduates and the coordinators comments indicated that the coordinator/clinical educator should spend more time with graduates. Some graduates stated that they wanted more support from the coordinator/clinical educator by spending more time with them. One graduate and coordinator identified that the introduction of a clinical support nurse to the clinical area was of great benefit. One coordinator also suggested that there should be more support for graduates out of hours.

It was clear when reviewing the mean satisfaction regarding the time spent with the coordinator/clinical educator that the more time spent with a graduate then the more satisfied they were. Graduates who identified no time to one hour per week had a mean satisfaction of 5.77. This increased as the hours increased with participants who spent 4-5 hours with the coordinator/clinical educator scoring a mean of 9.33. It could be suggested that a satisfaction level above seven is reasonable; two hours of contact per week will achieve this satisfaction level. The introduction of a Clinical Support Nurse into the nursing profession will also enable more time to be spent with graduates in the clinical environment.

Recommendation 4
- The graduate nurse program coordinator/clinical educator or the Clinical Support Nurse should spend a minimum of two hours with graduates per week throughout the graduate program to ensure the program is meeting the individual needs of graduates.

4.7 Support Given to GNs

It is widely acknowledged that support for graduates is an essential component of a graduate nurse program (Amos, 2001; Clare et al 2002; Clare and van Loon, 2003; Clark, Maben and Jones, 1997 and Parker, Plank and Hegney, 2003;). The support satisfaction levels for participants in this study ranged from 5-10 with a mean score of 7.73 that suggests overall graduates felt they were supported to some extent.

Feeling encouraged, helped, valued, friendliness and approachability all correlated with support satisfaction. The more graduates felt these feelings the more supported they were. When graduates experienced encouragement, valued approachability and helped a great deal they scored their support satisfaction above nine which suggested these graduates really felt supported. This data clearly highlights that it is essential that coordinators of graduate nurse programs provide a program which facilitates these feelings. It is also essential for organisations to encourage a culture of positive feelings of support to support their learners effectively.

Overall the negative terms of support were experienced less by graduates. It is disappointing that some graduates still felt inadequate within the graduate program. An example of when a graduate may be made to feel inadequate was identified in the comments in this study when staff members suggested that the undergraduate course that these graduates have just completed has not prepared them effectively.

Feeling stressed was experienced the most out of the negative terms with a mean score of 2.86. This has been well documented within the literature suggesting that graduates find the first year of practice stressful (Boychuck Duchscher, 2001; Casey et al, 2004; Clare and van Loon's, 2003; Delaney, 2003; Gerrish, 2000; Kelly, 1996; Maben and Clarke,

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1998; Oermann and Moffit-Wolf, 1997; Ross and Clifford, 2002 and Walker, 1998). Majority of participants experienced stress at a moderate level during the program. Graduates who experienced a moderate amount of stress identified their mean support satisfaction at 8.17. This may suggest that graduates feel stress although they are supported and is unavoidable in the transition period.

Feelings of being angry were experienced the least with a mean score of 1.94. Oermann and Moffit-Wolf (1997) asked new graduates in their study to rate both feelings of being overwhelmed and angry using a scale 0-none and 4 a great deal. Overwhelmed had a mean score of 2.41 and feeling angry scored 0.71. Therefore feelings of being overwhelmed were similar in this study but feeling angry was significantly higher in this study.

The majority of graduates' experienced positive feelings in terms of support more than they experienced the negatives. Although with an overall support satisfaction mean value of 7.73 from the graduates there is still room for some organisations to improve the support they provide. The data in this study identified a correlation between positive and negative terms of support that are very helpful in providing practical terms for preceptors, mangers and other staff members. There are many terms used to describe support although the terms identified in this research suggested that the more graduates feel encouraged; helped; friendliness; valued and approachability the more supported they will feel. This is the opposite when discussing negative terms the less inadequate; frustrated; angry and overwhelmed a graduate feels the more supported they will feel.

Recommendation 5
- Health care environments cultivate a culture of support and inclusion so that new graduate's feel welcomed and a part of the team.

4.8 Feeling That You Belonged

It has been identified that when graduates feel they belong to the clinical area this has a positive effect on transition and job satisfaction (Clare et al, 2002; Casey et al 2004 and Winter-Collins and McDaniel, 2000). Winter-Collins and McDaniel (2000) found that when graduate nurses feel a strong sense of belonging then this is association with the satisfaction of their nursing role. The majority (98%) of graduates in this research felt they belonged to the clinical area on their first rotation. The time it took for graduates to feel they belonged ranged from 1 to 20 weeks with a mean score of 6.04 weeks. The mean value identified from the coordinators data suggested that it takes graduates 6.83 weeks to feel a part of the team.

Interestingly the two graduates who stated that they felt they belonged to the clinical area within one week scored the overall program satisfaction at 10. Eight (16%) participants who believed that it took them two to three weeks to feel they belonged scored their program satisfaction at 8-10.

Recommendation 6
- Graduate nurse program evaluation should include an item to establish when graduates felt a part of the team.

4.9 The Theoretical Component

The range of theory hours included in the data was vast. Seven (13.4%) participants completed 80 hours of theory. The range was from 1 -234 and the mean was 59.79 hours. The Department of Human Services (1997) recommended that graduate nurse programs include a minimum of 40 hours of theory. Therefore the mean amount of theory hours is considerably higher than the amount recommended from the DHS. Although 40.3% of graduates within this study only participated in 1-34

hours of theory suggesting that there are many programs which do not fulfill the recommendations of the DHS.

The satisfaction level regarding the theoretical component of the program ranged from three to 10 with a mean of 7.17. Apart from the amount of hours, other aspects which could effect satisfaction could be the quality of the sessions, the topics and the relevance to the graduate's clinical environment. Although there may be various aspects related to satisfaction of the theoretical program time to access theory sessions is an essential first step in establishing an effective theory component of the program. It is recommended that further research be completed to establish an ideal number of theory hours to be conducted within a graduate nurse program with a larger cohort of graduates.

In both the graduate and coordinator comments a theme was identified that recommended there should be more study days within the program. One coordinator suggested one day per month that means a total of 96 hours over a year program. Some graduates recommended that the topics in the theoretical component are relevant to the clinical area that they are working within, this is consistent with what Rosenfeld et al (2004) found. Another theme identified was that graduates wanted to learn new skills in this time such as intravenous cannulation and caring for epidural anaethesia. It is therefore recommended that the topics covered within the theoretical component of the graduate nurse program are relevant to the clinical areas in which the graduates are working within.

Recommendation 7
- Due to the size and sample of this research it is recommended that future research be undertaken to further understand the interactive issues of the graduate year, in particular the theoretical content needs.

4.10 Performance Appraisals

The importance and benefits of feedback to graduates is clearly identified within the literature (Clare et al 2002; Clare and van Loon, 2003; Cobal, 1998 and Day, 1997). Graduates want to know how they are progressing and how they can further develop within their practice. The data from this study identified that there were two (4.17%) participants who did not receive a performance appraisal throughout the program. This is very difficult to comprehend as the graduate program is known to be a steep learning curve for graduates yet there were two participants who did not receive any formal feedback on their performance and progress. If these participants were not given regular informal feedback it must have been very difficult for them to attempt to understand how they were progressing. As Clare et al (2002) outlined graduates want constructive feedback as they want to achieve competence and these two programs did not achieve the graduates' requirements. The mean performance appraisal satisfaction for these two participants was the lowest at 2.50.

Forty-six (95.83%) participants received at least one-performance appraisal within the program. Forty-five (93.83%) of these participants received a performance appraisal within the first four months of the program. This is very similar to what Day (1997) found with all participants in her study having completed a performance appraisal within the first four months of the program.

There were five (10.4%) participants who only received one performance appraisal. This is unacceptable for graduates in their first year of practice as they are facing many issues of transition. They require regular formal and informal feedback for ongoing professional development. These five participants were not satisfied with the amount of performance appraisals they completed during the program as the mean satisfaction value was 5.33. A mean of 5.33 is higher than those participants who received no

appraisals (2.50), which suggest the more appraisals conducted may increase the satisfaction of the graduate.

There were four (8.3%) participants who completed two appraisals. The mean performance appraisal satisfaction level for these participants was 5.50. This mean value is only slightly higher then the participants who received one appraisal suggesting that there is no significant difference between receiving one or two appraisals in regards to satisfaction. Although a larger sample size may have produced a different result.

A larger (n-15; 31.25%) number of participants completed three appraisals. The mean satisfaction for three appraisals increased significantly from one and two appraisals with a value of 7.66. The mean performance appraisal satisfaction level for the 16 (33.3%) participants who received four appraisals was higher again at a value of 8.06. The mean satisfaction then decreases from the participants who completed 5 and 6 appraisals with a value of 6.43 and 7. This data outlines that the largest number of participants completed four appraisals and they were the most satisfied with the number of performance appraisals completed. Therefore it is recommended that graduates complete four appraisals within the graduate program.

The data describing the times performance appraisals were conducted for this cohort of participants suggests the mean time the first appraisal was completed was at 2.62 months and the second appraisal was 5.51. The third mean time performance appraisals were completed at 8.56 months and lastly the fourth appraisal was completed at 10.83 months. Therefore it is recommended that the four performance appraisals completed within the program should be completed at the following times throughout the year: 2-3 months; 5-6 months; 8-9 months and 10-11 months.

The timing for the appraisals allows the graduate to settle into the role and start developing before they should be formally assessed. Two months gives the graduate enough time to undertake the processes of orientation and be exposed to many varying clinical experiences. Two months also gives the preceptor, nursing staff and the educator's time to identify the learning needs for each individual graduate. Repeating the appraisal at 5-6 months gives the graduate time to continue to develop and work towards achieving their personal learning needs. The third appraisal being completed at 8-9 months enables graduates time to have consolidated further and be given that incentive to continue to develop. If the graduates complete two rotations of equal length then this would also be a very appropriate time to review the graduate's progress and learning needs within the new clinical environment. If the fourth appraisal is completed at 10-11 months this allows the final formal review to be completed in enough time to reflect on the review before the program is complete. It also enables the graduate to have a final appraisal completed during the time they are applying for a Grade 2 year 1 nursing positions.

Feedback was discussed extensively in the comments from the participants suggesting the need for more formal and informal feedback from the preceptors, senior staff and educators. This theme was also identified in the data from other studies suggesting that graduates felt they did not receive enough feedback during the program and they wanted more (Casey et al 2004 and Day, 1997).

One participant suggested that one way to facilitate more feedback is to have regular meetings between the graduate, preceptor and the educator. This is an excellent suggestion as it enables time for the facilitators and the graduate to reflect on the progress, to identify any learning needs and strategies to achieve them. Ideally a member of the nursing management team should also be involved within these meetings although the logistics

of getting four compared to three nursing members from the clinical environment may be very difficult. If it is too difficult to achieve this it is essential that the educator gains feedback from the nurse unit manager and associate unit managers on the graduate's performance to ensure the feedback is relevant and from varying nursing levels. This feedback should be relayed back to graduate identifying where the feedback has come from to ensure all information is transparent.

Preceptors and nursing staff should also be educated on how to give appropriate feedback and how important it is for graduates to receive this information. Graduates should also be reminded on the need to ask for regular feedback to ensure all involved in the learning process are working towards the same goal.

As both the data and literature suggests graduates want more feedback therefore it is recommended that:

Recommendation 8
- Graduates should receive four performance appraisals throughout the graduate nurse program.
- Regular feedback sessions should be conducted with the graduate, preceptor and educator to ensure regular feedback is given on the graduates performance and to discuss further learning requirements.

4.11 The Evaluation of the GNP

There were seven (13.5%) participants who were not requested to formally evaluate the graduate nurse program they were completing or had completed. One would question the method of evaluating a program if the participants of the program are not formally requested to give their evaluation. It is not possible to effectively evaluate a program without asking the participants views. The DHS (2003) recommended that

organisations are required to complete formal evaluations of their graduate nurse programs, although DHS did not state who should contribute to the evaluation. The majority (n-45; 86.5%) of participants did however complete an evaluation. Also all six (100%) of the coordinators outlined that graduates are requested to complete a formal evaluation of the program.

Of the participants who completed an evaluation there were only three (6%) who were not asked to indicate their satisfaction. It could be suggested that it is essential in the process of evaluating the program that participants are asked to identify their overall satisfaction. It is recommended that organisations request graduates to complete at least two evaluations of the program throughout the length of the program and that they are asked to identify their satisfaction level.

Recommendation 9
- Organisations request graduates to complete at least two formal evaluations of the graduate nurse program throughout the year and that they are asked to indicate their satisfaction level.

4.12 Overall Satisfaction of the GNP

The overall satisfaction mean was high at 8.15 with 69% of participants scoring their satisfaction at 9 or 10. This significantly high rate suggests that on reflection of the overall experience of the graduate year the majority of graduates were satisfied with the program that they completed. This is a positive result that may have contributed to 100% of participants remaining in the nursing profession at the time of data collection.

As highlighted earlier although 100% of graduates in this sample group were retained within the profession 73% were retained within the organisation where they completed the graduate program. When the

overall satisfaction was compared to retention rates it was identified that the mean program satisfaction for graduates who were retained was 8.42 compared to 7.42. This reinforces the need to ensure graduate nurse programs are providing a supportive environment that meets the needs of graduates.

Interestingly when comparing satisfaction of graduates who completed the program at the same organisation there were some organisations where the satisfaction levels were different. It could be suggested that there may be a small difference in satisfaction levels within the same program due to different personal expectations. However one hospital had a program satisfaction of five compared to nine, which is significantly different. This particular program had the same number of rotations and all graduates participated in a preceptorship program. The supernumerary shifts were different ranging from one to three on the first rotation and no shifts to three shifts one the second rotation. The time spent the coordinator/clinical educator was also different ranging from no time to one hour. This data suggests that the program being delivered to graduates needs to be consistent and ensure the individual needs of each graduate are addressed.

There was a marginal difference between the mean program satisfaction of the metropolitan hospitals and rural hospitals with 8.23 compared to 8.00. When the programs were compared it was evident that overall the graduates in a rural hospital received fewer support resources. They had less participation in preceptorship and for those who were preceptored, worked less with their preceptors and the program length were significantly less. The supernumerary time on the first rotation was two shifts less than the graduates who worked in a metropolitan hospital and the time spent with the coordinator was less.

The retention rates for the metropolitan hospitals were significantly higher at 82% compared to 55% in rural. Although there was only a slight difference in the mean program satisfaction it may have contributed to this difference in retention. Overall the graduates working in metropolitan Melbourne received more resources for support which may have contributed to the significant difference in retention rates. It could be suggested that another reason for the reduced retention rate in the rural hospital is because some graduates working within the rural setting may want to 'spread their wings' after completing a graduate year and move to Melbourne to gain more experience. This is not the case in this study as the data identified that the majority of graduates who were not retained in the rural organisation moved to another rural organisation.

There was a significant difference between the mean program satisfaction of the public programs (8.41) compared to private programs (6.16). When the programs are compared the private hospital had a higher mean by two rotations which is a considerable difference between programs. The resources provided for the graduates in a private hospital may be less. There is less preceptorship participation, considerably less supernumerary time on both the first and second rotation and a lot less time with the coordinator/clinical educator. Graduates working in the private hospital also experienced less positive terms of support and more negative terms of support. The retention rates for the private hospitals were 50% compared to 76% in the public hospitals.

It could be suggested that it is unfair to compare public and private programs as public hospitals receive over $13,000 in grants per graduate to support them through transition where private organisations receive nothing. This maybe the case however they are still employing graduates and therefore see the benefits, so they are just as accountable as public organisations to ensure graduate programs are meeting the requirements

of graduates and retaining them within the organisation and the nursing profession.

4.13 Future Planning for GNPs

There were various themes identified from the participant's comments. The first one relates to rostering, some graduates believed that rostering needs to be improved. One graduate identified that he/she was working three out of four weekends and commented on how this was not encouraging him/her to remain in the profession. This is a difficult issue to resolve as ideally graduates should work less weekends so they have more support from educators who generally work Monday to Friday. However it is also part of the nursing roster to work weekends and if graduates are working less then that requires other more experienced staff members to be working more which may be a retention issue for them. It has also been identified that working shift work causes graduates to feel socially isolated (Clare and Van Loon, 2003 and Maben and Clark, 1998). Therefore graduates working three out of four weekends are going to feel socially isolated and more likely to experience less support.

Another graduate commented on the inflexible of nursing shift work in the acute hospital setting stating *as nurses we are also Mothers, daughters or cares for others. I find the inflexibility of nurses' hours a big discouraging factor for nurses to remain in acute hospital setting. I have recently been appointed a position earning 2-3 times as much as I would in the hospital setting and I can work my own hours, still nursing which enables me as a single mother of 3 to live and work and be a sole parent. Good bye hospital work.* This graduate left acute care because of inflexibility. Shift work can be flexible as nurses are able to work various shifts although it is inflexible as the commencement times for a particular shift in majority of hospitals is not negotiable. Some childcare centres don't even open until after 0700hrs but we expect Mothers to be at work at 0700hrs on a

morning shift. This issue of flexible hours is a concern all organisations are facing and a solution has yet to be found. There needs to be some flexibility between both the organisation and the nurse to enable an amicable outcome.

The next issue which was identified by both the graduates and the coordinators was the relationship with other staff members. Some graduates identified that some staff members did not make them feel comfortable, supported or encouraged. Another graduate suggested that *'older' nurses should stick up for 'younger' nurses.* This is consistent with what Parker, Plank and Hegney (2000) found that senior nurses are less likely to provide support for graduates. Evens (2001) suggested that the world for graduates is complex and is soon forgotten by more experienced nurses. Both the graduates and coordinators data indicated that one way support could be improved for graduates is to remind staff members about the difficulties and challenges graduates face so they are more understanding and supportive.

Experiences of horizontal violence and bullying were also discussed by graduates in this study. Clare and van Loon (2003) also found an astonishing 41% of graduates experiencing this unprofessional behaviour. Graduates who experienced this felt overwhelmed and regularly considered leaving or had let the profession (Clare and van Loon, 2003). This behaviour is unacceptable and the culture of organisations should be one that outlaws such behaviour. It needs to be spelt out to staff that bullying and horizontal violence is not tolerated. Coordinators, educators and managers also need to ensure that they are proactive on dealing with such behaviour. It is also essential that graduates are empowered to not accept such behaviour. Achieving this can be difficult but it needs to be reinforced to graduates that this behaviour under any circumstances is

unacceptable and hospital polices reinforce the outcome for any staff member acting in this manner.

The last issue in this section is related to workload. The literature clearly identifies the problem graduates have with increasing workloads and suggested that graduates feel overwhelmed (Casey et al 2004; Maben and Clark, 1998 and Walker, 1998 and White, 1996). One graduate in this study stated that she was the only registered nurse for 11 patients with the help of a Registered Nurse Division Two. This is an extremely difficult workload for a graduate to manage. Another suggested that graduates should have four patients and have the skills and knowledge to care for them appropriately. This is a very reasonable suggestion as the patient ratios in Victoria are generally one to four or five patients on a morning shift for most acute care wards. However the acuity of the patients also needs to be considered to ensure graduates don't have four patients of high acuity.

When graduates were asked where they would be professional in five years there was answers such as studying, consolidating or leaving the professional. It was very encouraging that 42.3% of participates would like to have completed a graduate diploma. The clinical areas were varied and included midwifery, perioperative, peadiatrics and intensive care. Only 9% of participants suggested that they wanted to complete their masters one graduate said education and other was midwifery. Interestingly there were 13.4% of participants who believed they wanted to specialise within a clinical area but did not discuss the need for further study.

Participants within this study were very aware of the career structure in nursing and had given thought to where they would like to be in the future. Twelve participants believed that they wanted to achieve a promotion in nursing within the next five years. Encouragingly the majority of these

participants were also planning to complete some form of study as this was going to facilitate them achieving a promotion. Some graduates want to achieve a clinical nurse specialist (CNS) and others can not decide between a CNS and Associate Nurse Unit Manager (ANUM).

Six (11.5%) of participants stated they were considered leaving the profession. Two graduates identified that they would like to change professions but would still like to do a few agency shifts. One participant stated they wanted to complete two graduate diplomas and then leave the profession. Other professions that were identified remained 'caring' professions such as a paramedic, veterinary science and high school teacher. Overall the nursing profession may loose four of these graduates as two will still work agency.

This discussion chapter has identified the many issues graduates are facing within the graduate year and how a graduate nurse program can support or hinder participants. A theme that is reoccurring in this chapter is that graduate nurse programs need to meet the needs of the graduate as low satisfaction can result in lower retention rates. Another theme which is also clear is that the 24 programs that were evaluated within this study were not consistent; they provide differing levels of support, clinical exposure and theoretical content and some were not consistent with DHS recommendations for graduate nurse programs. If the profession is serious about retaining graduate nurses within the profession there needs to be a concerted effort to ensure quality and consistency in graduate nurse programs across Victoria. Recommendation 14 of the National Review of Nursing Education (2002) suggests that a national framework should be developed to provide guidelines and standards for institutions and that these programs should be accredited programs. It would be extremely beneficial to have clearer expectations for organisations that are based on evidence to ensure quality programs are being conducted. This

would result in supportive programs that meet the needs of graduate nurses.

It is also essential that organisations are held accountable for maintaining these quality programs. Recommendation 14 of the National Review of Nursing Education (2002) also stated that employing institutions should be responsible for meeting the required standards. One way this can be achieved is firstly for the program to be accredited on a regular basis and for the Department of Human Services to request extensive data on how organisations are achieving the standards and how they are meeting the needs of graduate nurses. Another aspect which needs to be seriously considered is the need for the nursing branch of the Department of Human Services to develop an evaluation tool relating to the developed standards. This tool should be sent to all graduate nurses to ensure graduate nurses have a strong focus in the evaluation and future development process. The data gathered in this tool would also significantly contribute to the body of nursing knowledge relating to the transition year and graduate nurse programs.

Recommendation 10
- Development and implementation of evidence based standards to guide quality graduate nurse programs that meet the needs of graduate nurses.
- Organisations are responsible and accountable for maintaining the developed standards. Accountability may be monitored by:
  - Graduate nurse programs being accredited.
  - The Department of Human Services requesting extensive data on how organisations are achieving the standards and how they are meeting the needs of graduate nurses before reconciliation occurred. Development of an evaluation tool which reflects the standards to be sent to all graduate nurses in Victoria.

Conclusion

The transition from student to registered nurse remains to be a difficult and stressful experience for graduate nurses. New graduates experience issues related to reality shock, socialisation, confidence and the theory practice gap. It is well recognised that graduates require extensive support and development throughout this very difficult time. In Victoria graduate nurse programs are a recognised vessel to deliver this support. The components of a graduate program include orientation; preceptorship; supernumerary time; clinical rotations; clinical education; a theoretical component and performance appraisals.

Quality graduate programs which meet the satisfaction of graduate nurses are required to provide effective support and retain graduates within the profession. There is much in the literature suggesting the importance of each of the varied components of graduate programs however there is limited comparisons made between programs. As a result it is difficult to measure the quality of all available programs. The level to which graduate nurses are satisfied with these programs is also largely unexplored. There was an identified gap in the literature and thus the purpose of the study was to explore and compare various graduate nurse programs and identify whether the programs were satisfying the needs of graduate nurses.

In order to explore and compare these programs an exploratory descriptive design was utilised. The findings of this research indicated that the delivery of graduate nurse programs within this study was not consistent in content and quality. Overall graduates were satisfied with their graduate nurse program although they identified there were areas which required improvement. A strong correlation was recognised between support and satisfaction, suggesting when the support improved the graduates satisfaction increased. There was also a correlation identified which suggested that the more satisfied a graduate nurse was with the graduate program the higher the retention rate.

Based on the results of this study and the literature a number of recommendations were made. These include:

1. The ideal number of clinical rotations is two of equal length.

2. Preceptorship programs should be implemented with organisations ensuring priority is given to the preceptor and preceptee working the same shifts.

3. Graduates should have a minimum of four days supernumerary time in each rotation.

4. The coordinator/clinical educator should spend a minimum of two hours per week with graduates.

5. Effective support is provided to graduates ensuring they experience positive feelings of support.

6. Further research should be conducted with a larger sample size to establish an ideal amount of theoretical hours.

7. Graduates should receive four performance appraisals throughout the program with regular feedback sessions.

8. Graduates complete at least two formal evaluations of the program.

9. Organisations are held accountable by the Department of Human Services in providing quality graduate nurse programs.

Despite the limitations, this study has achieved the purpose and objectives of the project. This research has further explored graduate nurse programs and thus given us an insight into particularly the Australian context of graduate nurse programs. On reflection of this research project, I believe it has been a significant learning curve and identify that a larger sample size may have contributed to building stronger correlations and recommendations. To date there has been no research of this nature and I would like to continue evaluating GNP's as they are the most significant year of the ongoing development of a professional nurse. In light of the necessity of graduate nurse programs facilitating the transition from student to Registered Nurse ongoing evaluation and development of these programs must continue. An essential part of this ongoing evaluation must

include evaluation completed by graduate nurses to ensure the program is satisfying the needs of participants and thus retaining them within the nursing profession.

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Appendix A

Letter to the Graduate Nurses

Information Letter to the Participant

Title of Project: *Are Graduate Nurses Satisfied with Graduate Nurse Program?*

Research Supervisors: RICHARD TAYLOR AND MARIA MILLER

Student Researcher: JULIE REEVES

Dear Colleague,

My name is Julie Reeves and I am currently undertaking my Masters in Nursing Research. I am also a Graduate Nurse Program Coordinator at a Melbourne hospital. In this position I see the many difficulties graduate nurses' experience in their graduate nurse program. These difficulties are further impacted by the current problems of nursing shortages. It is imperative graduate nurses are provided with a quality program which satisfies their needs to encourage them to remain working within the profession.

The following study aims to explore graduate nurse programs, to identify and compare various aspects of each program. It also aims to identify the level to which graduates of these programs were actually satisfied. Data will be collected through written questionnaires to one hundred and twenty graduates and a quota sample of ten Graduate Nurse Program Coordinators. Once all data has been explored and analysed recommendations will be made to identify characteristics of a quality Graduate Nurse Program.

By completing the attached questionnaire you will provide invaluable information on how you experienced your graduate year and how you believe graduate nurse programs can be improved. This information will contribute to the improvement of graduate nurse programs, and ultimately improve the way future first year Registered Nurses experience their graduate nurse program.

The questionnaire attached will take less than fifteen minutes to complete. There are also two consents forms attached. Please sign one and return it with the questionnaire. The second copy is for your own records. Please return the completed questionnaire and consent form in the provided self addressed envelope via Australia Post.

Your participation in this study is voluntary and you are free to withdraw consent and to discontinue participation in the study at any time without giving a reason. Confidentiality and anonymity will be maintained at all times. When your questionnaire is returned, the consent form will be separated from the questionnaire to maintain anonymity. Hospitals in the study will be identified as Hospital A,B,C,D etc.

The results of the study will be submitted as a thesis for the requirement of my Masters of Nursing Research. It is also anticipated the results and recommendations will be published. They will also be available to you at your request.

If you have any questions regarding this project please direct them to myself the student researcher: Julie Reeves on telephone number: (03) 9270 2511
and/or to the Supervisor, Maria Miller on telephone number (03) 9953 3179
in the Department of: School of Nursing Victoria. Australian Catholic University.
St.Patrick's Campus, 115 Victoria Parade, Fitzroy.

The University Human Research Ethics Committee at the Australian Catholic University has approved this study. If you have any complaints about the way you have been treated during the study, or a query that the Researcher or Supervisor have not been able to satisfy, you may write care of the nearest branch of the Office of Research

Chair, University Human Research Ethics Committee
C/o Office of Research
Australian Catholic University
115 Victoria Parade
Fitzroy VIC 3065
Tel: 03 9953 3157
Fax: 03 9953 3315

Any complaint made will be treated in confidence, investigated fully and the will be participant informed of the outcome.

Thank you for your invaluable contribution.
Regards,

Julie Reeves.

Letter to the Graduate Nurse Program Coordinator

Information Letter to the Participant

Title of Project: *Are Graduate Nurses Satisfied with Graduate Nurse Program?*

Research Supervisors: RICHARD TAYLOR AND MARIA MILLER

Student Researcher: JULIE REEVES

Dear Colleague,

My name is Julie Reeves and I am currently undertaking my Masters in Nursing Research. I am also a Graduate Nurse Program Coordinator at a Melbourne hospital. In this position as I am sure you too see the many difficulties graduate nurses experience in their graduate nurse program. These difficulties are further impacted by the current problems of nursing shortages. It is imperative graduate nurses are provided with a quality program which satisfies their needs to encourage them to remain working within the profession.

The following study aims to explore graduate nurse programs, to identify and compare various aspects of each program. It also aims to identify the level to which graduates of these programs were actually satisfied. Data will be collected through written questionnaires to one hundred and twenty graduates who completed their program in 2001/2002 and a quota sample of ten Graduate Nurse Program Coordinators. Once all data has been explored and analysed recommendations will be made to identify characteristics of a quality Graduate Nurse Program.

By completing the attached questionnaire you will provide invaluable information on your 2001 graduate nurse program and how you believe graduate nurse programs can be improved. This information will contribute to the improvement of graduate nurse programs, and ultimately improve the way future first year Registered Nurse experience their graduate nurse program.

The questionnaire attached will take less than fifteen minutes to complete. There are also two consents forms attached. Please sign one and return it with the questionnaire. The second copy is for your own records. Please return the completed questionnaire and consent form in the provided self addressed envelope via Australia Post.

Your participation in this study is voluntary and you are free to withdraw consent and to discontinue participation in the study at any time without giving a reason. Confidentiality and anonymity will be maintained at all times. When your questionnaire is returned, the consent form will be separated from the questionnaire to maintain anonymity. Hospitals in the study will be identified as Hospital A,B,C,D etc.

The results of the study will be submitted as a thesis for the requirement of my Masters of Nursing Research. It is also anticipated the results and recommendations will be published. They will also be available to you at your request.

If you have any questions regarding this project please direct them to myself the student researcher: Julie Reeves on telephone number: (03) 9270 2511
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> *C/o Office of Research*
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> *115 Victoria Parade*
> *Fitzroy VIC 3065*
> *Tel: 03 9953 3157*
> *Fax: 03 9953 3315*

Any complaint made will be treated in confidence, investigated fully and the will be participant informed of the outcome.

Thank you for your invaluable contribution.

Regards,

Julie Reeves.

Appendix B

Consent Form

Are Graduate Nurses Satisfied with Graduate Nurse Program?

Research Supervisors: RICHARD TAYLOR AND MARIA MILLER

Student Researcher: JULIE REEVES

I .... (the participant) have read (or, where appropriate, *have had read to me) and understood the information provided in the Letter to the Participants and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I can withdraw at any* time (or stipulate the deadline by when the participant may withdraw).
I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT   ....
(block letters)
SIGNATURE ....DATE.......................................

NAME OF RESEARCH SUPERVISORS: RICHARD TAYLOR AND MARIA MILLER

NAME OF STUDENT RESEARCHER: JULIE REEVES

SIGNATURE ....DATE.......................................

Please return this copy with your completed questionnaire.

Appendix C

Questionnaire
Graduate Nurse

Demographics

1. In which hospital did you begin your Graduate Nurse Program?

    _____

2. Age**: _____**

3. **Gender:** ⬜ **Female**   ⬜ **Male**

4. At which campus of ACU did you complete your Bachelor of Nursing?

    _____

5. Did you complete your Graduate Nurse Program?

    <u>Please circle:</u>   Yes   No

    *If no please comment on why you **did not** complete your program.*

    _____

    _____

    _____

    _____

6. When did you finish your Graduate Nurse Program?   ___/___/___

7. If currently employed please identify the name of your workplace:

    _____

8. Please rank the following statements from 1-4, using the scale below

Not at all **1** Very Little **2** Moderate Amount **3** A Great Deal **4**

I choose to apply to the hospital where I started my graduate nurse program because:

O   The hospital has a good reputation.

O   The rotations offered were what I wanted

O   The level of graduate nurse support proposed

O   Large metropolitan hospital

O   Personal reasons

Please comment if there are any **other reasons**

_____

Rotations

9. Please state your rotations throughout the Graduate Nurse Program, ranking them from the most to the least valuable. i.e.
    1 = most valuable   8 = least valuable

Area	Length
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	

10. Please indicate your level of overall satisfaction with the rotations of your Graduate Nurse Program.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Lowest level of
satisfaction

Highest level of
satisfaction

Preceptorship

11. Did you participate in a preceptorship program during the Graduate Nurse Program?

☐ Yes   ☐ No *(if no please got to 15)*

12. During your first rotation, what was the average length of time you were preceptored?

_____weeks

13. Approximately how many shifts did you work with your preceptor in the first six weeks during of your first rotation?

_____shifts

14. Please indicate your overall level of satisfaction with your experience of preceptorship.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Lowest level of
satisfaction

Highest level of
satisfaction

Supernumerary Time

15. On the first rotation of the Graduate Nurse Program how many supernumerary shifts did you work?

_____shifts

16. On the second rotation how many supernumerary shifts did you have?

_____shifts

17. Please indicate your overall level of satisfaction with your experience of your supernumerary time.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of satisfaction

Highest level of satisfaction

Graduate Nurse Program Coordinator / Clinical Educator

18. In the first three months of your graduate nurse program how many hours on average per week did you spend with your Graduate Nurse Program Coordinator / Clinical Educator?

_____hours per week

19. In the following nine months of your Graduate Nurse Program on average how many hours per week did you spend with your Graduate Nurse Program Coordinator / Clinical Educator?

_____hours per week

20. Please indicate your overall level of satisfaction with the amount of time your Graduate Nurse Program Coordinator/ Clinical Educator spent with you.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of satisfaction

Highest level of satisfaction

Support

21. In your overall evaluation of your graduate nurse program please use the scale below ranking each word from 1 to 4 to best describe how often you experienced the feelings described.

    Scale: Not at all- **1**   Very Little -**2**   Moderate Amount-**3**   A Great Deal-**4**

    O   Encouraged   O   Valued   O   Stressed

    O   Inadequate   O   Approachability   O   Helped

    O   Frustrated   O   Angry   O   Overwhelmed

    O   Friendliness

22. Please indicate your level of overall satisfaction with the support you received in your graduate nurse program.

1	2	3	4	**5**	6	7	8	9	**10**

    Lowest level of   Highest level of
    satisfaction   satisfaction

Being a part of the team

23. In your first rotation how long was it before you felt you belonged to the area you were working within?

    _____ weeks

Theoretical Component

24. What was the total number of hours you spent undertaking the theoretical component (structured study sessions organised by the coordinator) of the graduate nurse program?

    _____hours

25. Please indicate your overall satisfaction level of the theoretical component (structured study sessions organised by the coordinator) of the Graduate Nurse Program.

| **1** | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | **10** |

Lowest level of
satisfaction

Highest level of
satisfaction

Performance Appraisals

26. Please highlight when you received formal written appraisal/s during your program?

1st		months
2nd		months
3rd		months
4th		months
5th		months
6th		months

27. Did you complete any formal written self-appraisal at either of these times? Please circle

Yes   No

28. Please indicate your overall satisfaction level of the formal appraisals you received.

| **1** | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | **10** |

Lowest level of
satisfaction

Highest level of
satisfaction

Evaluations

29. Did you undertake any formal evaluation of the Graduate Nurse Program? Please circle

Yes   No

30. Did the evaluations ask you to provide your overall satisfaction level with the program? Please circle

    Yes   No

Overall satisfaction

31. Please indicate your overall satisfaction level of the Graduate Nurse Program.

    1   2   3   4   **5**   6   7   8   9   **10**

    Lowest level of   Highest level of
    satisfaction   satisfaction

32. If you were given the opportunity to change anything about the graduate nurse program to improve it for future graduate nurses, how would you change it? .

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

33. Where do you see yourself professionally in next five years?

_____

_____

_____

_____

_____

_____

34. Any further comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire and please remember to sign the consent form attached.

Questionnaire

Graduate Nurse Program Coordinator

1. Please state the hospital in which you coordinate the Graduate Nurse Program?

   _____

2. Age**:** _____

3. Gender*:* ☐ ***Female***   ☐ ***Male***

4. What university/hospital did you complete your initial qualifications in nursing?

   _____

3. Please state any post graduate studies you have completed?

   _____

   _____

   _____

   _____

4. How long have you been coordinating Graduate Nurse Programs?
   _____years

5. How many hours per week are you employed to coordinate the Graduate Nurse Program?
   _____hours

6. Does the amount of coordinating hours change as the year progresses?
    Please circle:

    Yes   No

    If you have answered yes please describe the change to coordinating hours.

    _____

    _____

    _____

Rotations

7. How many rotations do graduate nurses undertake in their graduate nurse program?

    _____ Rotations

8. Please state the clinical areas graduate nurses can rotate within the Graduate Nurse Program, ranking them from what you believe to be the most to the least valuable to graduate nurses.

Area	Length
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

9. Please indicate your overall satisfaction with the rotations incorporated within the Graduate Nurse Program.

1   2   3   4   **5**   6   7   8   9   **10**

Lowest level of
satisfaction

Highest level of
satisfaction

Preceptorship

12. Do all graduates participate in preceptorship during the Graduate Nurse Program? Please circle

               Yes   No *(if no please go to 16)*

13. What is the average length of the preceptorship program during the graduates' first rotation?

               _____weeks

14. On average in the first six weeks of a graduate's first rotation how many shifts per week do they work with their preceptor?

               _____ Shifts

15. Please indicate your overall satisfaction level of the preceptorship program for graduates.

1   2   3   4   **5**   6   7   8   9   **10**

Lowest level of
satisfaction

Highest level of
satisfaction

Supernumerary Time

16. On the graduate's first rotation how many supernumerary shifts does the graduate undertake?
               _____shifts

17. On the graduates second rotation how many supernumerary shifts do graduates undertake?
               _____shifts

18. Please indicate your overall satisfaction of the amount of supernumerary time graduates receive.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of
satisfaction

Highest level of
satisfaction

Graduate Nurse Program Coordinator / Clinical Educator

19. In the first three months of the Graduate Nurse Program how many hours per week do graduates spend with the Graduate Nurse Program Coordinator / Clinical Educator?

_____hours

20. In the subsequent nine months of the Graduate Nurse Program how many hours per week do graduates spend with the Graduate Nurse Program Coordinator / Clinical Educator?

_____hours

21. Please indicate your overall satisfaction with the time Graduate Nurse Program Coordinator/ Clinical Educator spend with each graduate.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of
satisfaction

Highest level of
satisfaction

Support

21. In your overall evaluation of the graduate nurse program in 2001 please use the scale below ranking each word from 1 to 4 to best describe on average how often you believe your graduates would have experienced the following feelings described.

Scale: Not at all- **1**   Very Little- **2** Moderate Amount-**3**   A Great Deal-**4**

O   Encouraged   O Angry   O Helped

O   Inadequate   O Valued   O Overwhelmed

O   Frustrated   O Approachability O Friendliness

O   Stressed

22. Please indicate your overall satisfaction level with the support graduates receive in their graduate nurse program.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of
satisfaction

Highest level of
satisfaction

Being a part of team

23. On average in a graduate's first rotation how long does it take before a graduate feels they belong to the area they are working within?

_____weeks

Theoretical Component

24. What is the total number of hours graduate nurses spend undertaking their theoretical component (structured study sessions organised by the coordinator)?

_____hours

25. Please indicate your overall satisfaction level of the theoretical component (structured study sessions organised by the coordinator)of the graduate nurse program.

1	2	3	4	**5**	6	7	8	9	**10**

Lowest level of
satisfaction

Highest level of
satisfaction

Performance Appraisals

26. Please highlight when graduates receive their formal written appraisal/s during their program?

1st		month
2nd		month
3rd		month
4th		month
5th		month
6th		month

27. Do graduates complete formal written self-appraisal at any of these times?
     Please circle

                     Yes   No

28. Please indicate your overall satisfaction level of the formal appraisals
     graduates receive.

     1   2   3   4   **5**   6   7   8   9   **10**

Lowest level of   Highest level of
satisfaction   satisfaction

Evaluations

29. Do graduates undertake formal evaluation of their Gradate Nurse Program?
     Please circle
                     Yes   No

30. Does the evaluation ask graduates to provide their overall satisfaction level
     of the program?
     Please circle
                     Yes   No

Overall satisfaction

31. Please indicate your overall satisfaction level with the Graduate Nurse
     Program you coordinated in 2001.

     1   2   3   4   **5**   6   7   8   9   **10**

     Lowest level of   Highest level of
     satisfaction   satisfaction

32. If you had the opportunity to alter the graduate nurse program without having any management or resource limitations can you describe how you would alter it?

_____
_____
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33. Any further comments:

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Thank you for taking the time to complete this questionnaire and please remember to sign the consent form attached.