THE VALUE OF TRANSITION SUPPORT PROGRAMS FOR NEWLY REGISTERED NURSES AND THE HOSPITALS OFFERING THE PROGRAMS IN NEW SOUTH WALES

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Statement of Sources

This thesis contains no material published elsewhere or extracted 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 tertiary institution.

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Jennifer Evans Date

ABSTRACT

The research reported in this thesis explored the perceived value of transition support programs for newly registered nurses in New South Wales and the health care facilities offering such programs. Although transition support programs have been designed and implemented in various forms since the transfer of nurse education to the tertiary sector, there remains little evaluative evidence of the value of such programs.

Two groups of registered nurses formed the participants in this study. The first were new graduate nurses who completed a transition support program within the past 12 months. The second comprised experienced nurses who worked with new graduate nurses during their transition support program. The study was carried out in seven hospitals in area health services across and around Sydney, representing both small and large facilities with bed numbers ranging from 195 to 530.

Data were collected from four sources including the printed materials made available by sample hospitals. Questionnaires, interviews and observations were used to determine the purposes, outcomes and strengths and weaknesses of transition support programs. The data were analysed using descriptive statistics and theme extraction.

The themes described the ways in which the transition support programs were used to facilitate the transition of the newly registered nurse to confident beginning practitioner. There was widespread belief from the study participants that some aspects of nurse education at university were inadequate. As a result, various structures and policies were required to support the new graduate nurses as they entered the workplace. The transition support programs were used to increase nursing staff for the study hospitals and to provide new learning opportunities for new graduate nurses to enable them to develop the clinical and professional skills required of competent registered nurses. The rotational aspect of the transition support programs were used to provide staff for the less popular areas of the hospital as well as a variety of experiences and skill development opportunities that were considered lacking in the current undergraduate education of nurses. The work environment where the programs operate were described as difficult with nurses exposed to

violence and bullying practices from fellow staff and frequently required to work with a less than ideal number or appropriate skill mix of nursing staff. The hospitals also used the transition support program to exert a controlling influence over the new graduate nurse by way of roster management, assessment of skills and the expectation that each nurse would complete a transition support program before being offered full time work.

The thesis concludes with recommendations and future research avenues. It would be useful for hospitals to conduct formal evaluations of the transition support program they offer to provide the most effective program possible. One source of information could be sought from the new graduate nurses regarding their needs during the first six months of employment. It is also suggested that a study be commenced that investigates the reasons behind the perception that nurse education at universities in New South Wales is inadequate.

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Key to Transcripts

In this thesis, segments of the textual sources, written responses and interviews that were conducted with the research participants will be presented. The interviews were audiotaped at the time of the interview and transcribed soon afterward. These transcripts are presented to illustrate the themes. As spoken English differs from written English the transcripts have been edited so that the reader can make sense of what was said, in context. Where words have been omitted or inserted this has been done in such a way as to retain the meaning of the original. To allow the reader to dialogue with the text these alterations have been indicated in the text in the following ways:

…	An ellipsis is inserted where the speaker paused. If the pause was more than five seconds two ellipses were inserted.
(…)	An ellipsis in brackets was inserted when words were deleted by the researcher either in an attempt to enhance the sense of the script or to edit out irrelevant material.
(words on normal text)	Round brackets around non-italicised text indicate the researcher inserting a definition or complete word where the speaker used an abbreviation.
[words in normal text]	Square brackets around non-italicised text indicate the researcher inserting words either to assist the reader's comprehension or to maintain the participant's anonymity.
<u>words</u>	Words underlined indicate that the speaker gave extreme emphasis at this point.

Chapter 1
Introduction and Background

1.1 Introduction to the Study

This study is concerned with transition support programs for newly registered nurses. Information was sought from both new graduate and experienced registered nurses in New South Wales to help determine what these programs offer the nursing profession.

This chapter presents an historical account of nurse education in Australia and identifies some of the reasons behind the transfer of nurse education from the hospital to the tertiary sector in 1985. This is followed by a statement of the research aim and three research questions posed in order to achieve the aim. The reasons that make this research important are described before an overview of the entire thesis. A brief list of commonly used terms are defined at the end of this chapter to enable readers to have the same understanding of the terms used from the onset.

1.2 Australian Historical Background

Nursing in the colonial period was very much a family matter. The wealthy paid servants to attend to their needs while the poor did whatever was necessary themselves. Australia's first trained nurses arrived from Ireland in 1838. Sister de Lacy was one of the five pioneer Sisters of Charity who visited various hospital settings, to offer advice as well as to nurse the poor at home. Sister de Lacy became the first matron at St Vincents Hospital when it opened at 'Tarmons' at Potts Point in Sydney, New South Wales during 1858 (Woolston, 1988).

Formal nurse education began in Australia in 1868 when Lucy Osburn and five other trained nurses arrived in Sydney from England. Their arrival followed a request from Henry Parkes to Florence Nightingale to send some trained nurses to assist in the Sydney Infirmary. At that time Miss Nightingale ran her own nurse training school at St. Thomas' Hospital in London. She was a well respected authority in nursing and the Nightingale Training School was opened after a gift of money from the British nation in gratitude for her contribution during the Crimean War. The opening of the

school was not supported by the London physicians, however, who saw nurses as maids who could cook and attend to cleanliness (Doheny, Cook and Stopper, 1987). In 1859, Miss Nightingale published a book entitled *Notes on Nursing: What It Is and What It Is Not*, which was a collection of data gathered during her years of nursing experience (Doheny et al, 1987). Her book was enthusiastically received by the public, distributed widely and translated into three languages. It is little wonder that it was to Miss Nightingale that Henry Parkes turned when Sydney needed help with nursing.

Lucy Osburn held her post as Lady Superintendent at the Sydney Infirmary between 1868-1884 during which time she was solely responsible for the female staff of the hospital and the management of the wards. Upon taking up her new position, Lucy Osburn wrote to Miss Nightingale of

> *. . .dirty frowsy old women, slatternly untidy young ones all greasy with their hair down their backs with ragged stiff dresses that required no washing. The doctors habitually stamped and raved at them.*
>
> *In the wards the patients called Betsy and Polly to do the most menial work for them… the noise and pranks in the wards were too dreadful; I was several weeks in understanding it all – weeks simply amazed! Most carefully I weeded out the incorrigible ones, dismissed with my blessing and often a present…*
>
> (Dickey, 1980. p 71)

A Royal Commission into public charities was undertaken in New South Wales during 1873-4. The findings were similar to those described to Miss Nightingale by Lucy Osburn. Along with the nursing care, the buildings, and the hospital administration were critiscised. Middle class notions of respectability were increasingly called for in hospital care. The public demanded and got hospitals which were sewered, watered, made aseptic, nursed, administered and fed to standards reflecting the conception these people had of what was decently proper for the lower orders. As a result, the rate of hospital use in New South Wales grew twice as fast as

the growth in population between 1875 and 1900 (Dickey, 1980). The pressure for respectable hospitals meant that the respectable could use them.

The public push for quality of care received a major boost during a royal visit in 1867-8. Prince Alfred, Duke of Edinburgh was shot in Sydney and nursed back to health at Government House by Lucy Osburn and her newly arrived trained colleagues from the Infirmary. Shortly afterwards, new health facilities emerged in both Sydney, the Prince Alfred Hospital, and Melbourne, the Alfred Hospital. They were built to the best modern specifications of their time complete with aseptic operating theatres and trained nurses. In these hospitals, admission was as much, or more a matter of illness rather than poverty.

Lucy Osburn was also responsible for the establishment of a general nurse training school in New South Wales. This school played an important role in establishing and spreading the Nightingale system of nursing throughout New South Wales and Australia. Nurses trained by Lucy Osburn became matrons of other hospitals and further spread the Nightingale system of nursing. The five other trained nurses who accompanied Miss Osburn to Australia helped her in the Infirmary for a time but eventually became Matrons themselves at other hospitals (Russell, 1990). This system of training was a very successful one and became known as the 'Nightingale System' and was disseminated throughout both New South Wales and Australia. Nurse training programs, with various modifications were still patterned on this system up until the 1980s (Russell, 1981).

In August 1899, the New South Wales Trained Nurses Association was founded by concerned members of the nursing and medical profession. The associations' goals were to standardise and improve general nurse training in New South Wales. The association grew quickly and by December 1899 became known as the Australasian Trained Nurses Association (ATNA) (Martin, 1981). Registers for acceptable nurses were maintained for reference. Membership became an important status symbol among nurses. The aims of the ATNA were to promote the interests of nurses, to establish a minimum standard of education for nurses, to maintain a system of registration of trained nurses, to accredit certain hospitals as training schools from

which hospital certificates were accepted by the ATNA, and to approve the nomination of matrons of hospitals receiving a government subsidy (Reid, 1994 p 4).

A further step in the improvement of general nurse training was the gaining of state registration for nurses in 1924. This was a big step for the nursing profession in their efforts to regulate and standardise their training course. Despite opposition to this proposal, a bill seeking registration for nurses was presented to Parliament in 1909, 1915, 1923 and again in 1924 when it was finally passed and became law (Russell, 1981). The New South Wales Nurse Registration Board was established under this act and took over many of the functions of the ATNA.

From 1924 the Nurses Registration Board assumed responsibility for the training of nurses in New South Wales. The first Nurses Registration Board had several members of the Australasian Trained Nurse Association appointed.

The push for university – based nursing preparation

Nursing and nurse education came under increasing pressure during the time between the Second World War and when the decision was made in 1984 to transfer nurse education to the tertiary sector. Russell (1990) found that there had been nine separate reports published in New South Wales about the problems being experienced in hospitals and matters concerning nurse training. Reid (1994) wrote that the 1943 Kelly Committee found that nurse training was unsatisfactory and needed replacing with a system of training based on sound educational principles. Another committee in 1967 found that trainees were being prepared for ward work without the necessary theoretical instruction. Bowing to this pressure, Senator John Carrick, the then federal Minister for Education, announced that the Commonwealth government would establish a committee of inquiry into the education and training of nurses in 1977. The chairman of the committee was Dr Sidney Sax, Head, Social Welfare Policy Secretariat. The subsequent report *Nurse education and training: report of the Committee of Inquiry into Nurse Education and Training to the Tertiary Education Commission* (Sax Report) remains the only report on the education and training of nurses in all Australian states to date (Russell, 1990). Reid (1994) found that the driving force behind the inquiry was the recurring labour shortages and high attrition

rates that troubled nursing at the time. Low wages, poor working conditions and the professional status of nursing were seen as factors coupled to an inadequate training system (Russell, 1990; McCoppin & Gardner, 1994). There seemed little disagreement about the need for an upgraded training system. There was less agreement, however, on how or where this education should take place.

Some nurses in North America and Britain were beginning to be educated in universities and these new ideas about nurse education were becoming known to Australian nurses. In 1965 the American Nurses' Association declared that the educational standard for professional nursing would be a Bachelor's degree (McCoppin & Gardner, 1994). At the time of this statement, most student nurses were still in hospital training schools. This news, coupled with a series of reports from the World Health Organisation (WHO) recommending that nurse education be comprehensive, provided impetus for the nurses in New South Wales. The WHO reports meant that programs should include mental health, paediatric, maternity and community health nursing. They also recommended that programs provide foundation studies on subjects such as the social and behavioural sciences and that the study should take place away from the service needs of a hospital. Following the patterns set overseas a few experiments with the basic nursing education began in New South Wales from the late 1960s (Dunlop, 1992). The University of New England introduced a combined arts degree-nursing course in conjunction with the Armidale and New England Hospital and the Royal North Shore Hospital in 1967. A similar course offered at the University of New South Wales followed in 1968 (Reid, 1994). A proposal for a shortened nursing program for university graduates along with pilot programs in colleges of advanced education were also considered (Dunlop, 1992). These courses were not seen as an alternative to the hospital training for the majority of registered nurses.

The Sax Committee released their report in 1978 and although many of the criticisms of hospital-based training were noted, it was felt that the problems could largely be addressed within an upgraded hospital training system. Recommendations were to rationalise and upgrade the existing pre-registration courses and it was envisaged that hospitals would forge links with tertiary institutions. The number of places available

in advanced education courses was permitted to extend to 2,200 (less than 10 percent of all trainees) by 1985 (Reid, 1994). The overall objective was to standardise basic nursing education at the diploma level wherever it was to take place. Russell (1990) reported that the majority of the nursing profession was committed to the transfer of training to the tertiary system by this time so were disappointed in the proposed sluggishness of action. A further report in 1970 from the New South Wales Truskett Committee, supported the nursing profession by concluding that it would be beneficial for nurse training to be reoriented towards tertiary education and that institutions move to the control of the Minister for Education (McCoppin & Gardner, 1994). The Australian nursing profession held a national workshop in 1982 to review goals and policies in nurse education. They agreed that the academic award at the completion of pre-registration programs should be the Bachelor of Applied Science (Nursing) but not at the diploma level proposed by Sax. The nurses continued to lobby state and federal governments and gain support from the public and trade unions. It is interesting to note that the NSW medical profession continued to object to educational change for nurses. They were of the opinion that the best nurses were produced through training at the bedside (McCoppin & Gardner, 1994). The changing opinions about nurse education and the emerging assertiveness was set against a backdrop of great social change in Australia.

Social background

The 1960s and 1970s saw the emergence of Feminist theory and the growth of the Women's Liberation Movement. Prior to this time women were largely socialised into viewing marriage and child-rearing as a full-time life-long job. The rise of this movement, then, meant that women were given more opportunity to think about life choices and their future. Bloomfield (1999) found that during this period divorce rates increased and marriage rates fell. Technology and medicine combined to play a role with reliable birth control methods becoming widely available. Women began to delay motherhood in favour of their careers. During the 1970s, the notion of the second class status of women, including their educational deprivation, was being considered. Nurses were able to use this to their advantage in their fight for tertiary education (McCoppin & Gardener, 1994).

When men entered the (general) nursing profession all sorts of 'rules' had to be relaxed. It had been compulsory for a nurse to remain single whilst in training and to 'live-in' at the nurses home attached to the training hospital (Russell, 1981). Since it wasn't thought to be appropriate for men to be accommodated on site the rule gradually weakened and then disappeared from hospitals in New South Wales.

Advances in medical and science technology occurred rapidly in the 1970s and 1980s. The role of the nurse became more complex as she/he became more involved with procedures requiring greater technological skills. Nurses began to use machinery and equipment to assist them to perform clinical skills and acquire knowledge. The implications for nurse education were enormous since student nurses now needed educational opportunities in areas such as computer and communications technology. It was suggested that graduating nurses should be competent in word processing, statistical software packages, computer-based hospital information systems and computerised library databases (Reid, 1994). Clearly, if the nurse understood the technology being discussed for a particular patient then they were in a better position to influence the quality of health care being offered.

In recent years, the ageing of the population in most Western countries has become a significant issue in the provision of health care. The Australian Bureau of Statistics has predicted that the sector of the population over 65 years will rise to be 20% of the total population by the year 2025 (Reid, 1994). This is partly due to the baby boom generation born between 1945 and 1955, and improvements in life expectancy for older people. Many older people require assistance in their activities of daily living and are therefore the recipients of long term care and assistance. There have been predictions that the proportion of older people among those in acute care settings will also increase. This has implications for nurse education curricula with calls for gerontological nursing to become a significant fundamental component of the undergraduate nursing program in New South Wales.

Political background

Even though the case for the transfer of nurse education from hospitals to the tertiary sector was gaining momentum during the 1960s, it would never have been possible

without the endorsement of the Government of the day. The Federal Australian Labor Party came to power in 1972 giving nurses reason to be optimistic. While in opposition, Whitlam and his party had given assurances to support the nursing profession in their push for tertiary education. The Whitlam Government's policy of equity for women was the first government in Australia to set up an office specifically to address women's issues. Even though the transfer of nurse education was seen as a strategy to raise the status of women, there was very slow progress nationally. Of course history shows that the Whitlam Government had many pressing concerns other than nursing before being ousted in 1975.

The State Labor Party led by Wran came to power in 1976. He opened the annual conference of the Nurses Association in 1977 and confirmed his Government's aim of ensuring that nurse education would be gradually integrated into the tertiary education sector. The funds required and the responsibility for nurse education needed to be transferred from health to the education portfolio. The Wran Government did, however, provide $2.7 million for a longer (1000 hour) curriculum to enhance the hospital training system. Later in the same year the State Minister for Education, Eric Bedford, announced that an interdepartmental committee would oversee the gradual transfer of responsibility for nurse education to his portfolio (McCoppin & Gardener, 1994).

Hawke came to federal power in 1983 and announced that his Government intended to set up more college courses as part of a plan for gradual transfer of nurse education in line with the Sax recommendations. It was at this time that nurses in New South Wales forced events more quickly than any other state. Labor had been in power for seven years and had a desire to 'lead the way' and be the first to implement nurse education in tertiary institutions. McCoppin and Gardener (1994) reported that the nurses in New South Wales had other advantages compared to the other states. They had more nurses than any other state and the leader of the New South Wales Nurses Association had an aggressive style (p. 106). The New South Wales Government made the landmark decision in November 1983 to transfer all basic nursing preparation from hospital based schools into Universities and Colleges of Advanced Education. The timing of this announcement was possibly related to a 10.1% swing

to the Liberal Party in a by-election in Sydney and persisting allegations of corruption that had dogged the Premier for some time. Ridgeway (1983) wrote advising nurses to take the word of the Government with caution. The proposal was for a three year diploma course. In response to this, the Federal Government set up an interdepartmental committee between the departments of education and health and made recommendations in favour of the move. Consequently, the Federal Government announced in August 1984 that the transfer of nurse education was to be completed across Australia by 1993.

The State Planning Group for the Transfer of Nurse Education to the Tertiary Sector

The *State Planning Group for the Transfer of Nurse Education* was established in 1983 by the NSW Minister for Education. Mr. Parry was the chairperson of the group that comprised nine members, being representatives from education, health and treasury. They were responsible for the allocation of student numbers to each institution, allocation of hospitals to educational institutions for clinical experience, the transfer of funds from hospital budgets to the educational facilities and identification of the necessary changes in the Nurses Registration Act.

This was an enormous task and one that required much haste. The initial government announcement was made in November 1983 and the first intake of students into the tertiary setting was February 1985. This gave educational institutions less than 15 months to recruit staff, write curricula, gain approval, adapt or build new teaching facilities, and recruit students (Dunlop,1992).

Since this time there have been numerous efforts to tailor the best curriculum for undergraduate nurses to study. There needs to be a balance between academic quality and professional competence. Despite the efforts of many, new graduate nurses continue to struggle to make the transition from student to registered nurse. Hospitals in New South Wales have implemented a number of mechanisms to support new graduate nurses and the focus of this research is the transition support programs designed to assist new graduate nurses upon entering the workplace.

1.3 Statement of Research Aim

The aim of this study is to explore the perceived value of transition support programs for newly registered nurses and the facilities offering such programs.

1.4 Statement of Research Questions

In order to achieve the research aim, a number of questions relating to transition support programs have been posed. These questions are:

1. What are the purposes for conducting new graduate transition support programs in clinical facilities for university educated graduate nurses?

2. What are the outcomes of new graduate transition support programs in preparing new graduate nurses for clinical practice?

3. What are the strengths and weaknesses of new graduate transition support programs in various hospitals in New South Wales?

1.5 Significance of Research

This study is considered important for several reasons. The literature review has revealed that the state of knowledge concerning transition support programs is incomplete. This is particularly the case with regard to thorough evaluation of the programs. Transition support programs affect almost all new graduate nurses as well as large numbers of nurses already working in the hospital setting. The cost of implementing the programs is met by the employing hospitals so justification of expenditure is important. Knowledge gained from this study has implications for the profession and provides an opportunity to prepare and implement programs or services that better meet the needs of new graduates and health care facilities. Each of these reasons will be discussed more fully.

Incomplete knowledge in literature

Transition support programs for new graduate nurses were designed and implemented to support and assist new graduate nurses during their transition from the role of student nurse to that of the registered nurse in the workforce. Although various

programs have been designed and implemented, there is currently little valid and reliable evidence to support them. Clare, Longson, Glover, Schubert & Hofmeyer (1996) found that many of the studies reviewed have either relied on descriptive accounts of graduates to assess the success of the program or provided descriptions of a transition model without evaluation. So what is it that these programs really do for new graduate nurses? Denmead (1999) questioned whether programs are perceived by the new graduate nurse as more assignments and lectures or whether they truly facilitate the professional development of the fledgling nurse (p21). The literature is unable to provide a comprehensive answer to this question at this time.

Transition support programs affect many nurses

New graduate nurses are expected to participate in a transition support program upon completion of the undergraduate nursing qualification. The type of program and the approach taken for the implementation of these programs therefore affects the transition of new graduate nurses from universities to the workplace. Nurses already working in the health care facility offering the program are also affected by the programs, sometimes directly at other times indirectly.

Added to the high number of nurses directly affected by transition support programs is the cost of offering the program. This is borne by the health care facility so it is imperative for them to get value for the time and money that they have invested.

This study may provide answers for other problems

The recruitment and retention of registered nurses is a major concern for health care facilities today. If the transition support programs can be tailored to alleviate the enormous stress and potential for burn-out of new nurses, then the problems of recruitment and retention may be lessened.

While the particular occupational group chosen for inclusion in this study are registered nurses, the findings may guide the evaluation of other transition support programs for groups such as Assistants in Nursing and Enrolled Nurses employed in hospitals and nursing homes in New South Wales.

A more effective approach

The study may provide information that will enable universities and hospitals to better prepare nursing graduates to cope with workplace stressors. With a more efficient transition, nursing staff may be more content and find enhanced satisfaction with their chosen career. Staff turnover may be reduced resulting in a reduction in the training and retraining costs. Monies currently spent on transition support programs may become more focused where a specific need has been identified.

1.6 Overview of Study

To achieve the study aim, Chapter Two examines the literature pertinent to transition support programs for newly registered nurses. This begins with a brief account of nurse education in New South Wales and provides an insight into the difficulties that many new graduate nurses experience when making the transition from student to registered nurse. Transition support programs are one of the measures implemented by hospitals to support newly registered nurses. Even though different models of programs operate in most hospitals around the State the level of evidence supporting them remains unconvincing in the literature.

Based on the Chapter Two findings, Chapter Three develops an appropriate research method for exploring the effects of transition support programs for new graduate nurses and the hospitals offering the programs. The research design and different methods used to facilitate this study are described. Characteristics of the study participants and settings are presented along with the ethical considerations.

Multiple data collection methods were used in this study and the findings from each method were reported in separate chapters. Chapter Four presents the findings from textual sources used to advertise the sample transition support programs and Chapter Five shows the findings from the questionnaires designed and used in this study. Interviews and observations were also conducted and the findings are presented in Chapters Six and Seven respectively.

A discussion of the combined findings is presented in Chapter Eight and conclusions are drawn in Chapter Nine. Following Chapter Nine are the Appendices that provide resource material that helps explain the development of the different methods and the analyses of the study findings.

1.7 Definition of Terms

Registered Nurse

The registered nurse is a first level nurse, educated in a pre-registration degree level course in a university. Nursing courses are broad based and comprehensive and are designed to prepare graduates to work in a wide variety of health care settings. Registered nurses are licensed to practise nursing in the field/s in which they are registered without supervision, and assume accountability and responsibility for all their actions and aspects of care (Australian Nursing Council, Inc, 1993).

New Graduate Nurse

A new graduate nurse or recent graduate nurse is one who is working in their first year after completion of their degree and registration as a registered nurse.

Transition Support Program

A set period of time, usually 12 months, which includes an orientation or induction program, theory/study days, and clinical rotations throughout a number of different clinical areas. The new graduate is employed by the hospital providing the program for the duration of the program. Also known as new graduate programs.

Preceptor

A person who teaches, counsels, inspires, serves as a role model, and supports the growth and development of an individual for a fixed time with the specific purpose of socialising the novice into the new role (O'Malley, Cuncliffe, Hunter, & Breeze, 2000).

Chapter 2
Literature Review

2.1 Introduction

Nurse education and nursing practice has changed dramatically over the past 20 years in Australia. Nurses are now prepared for practice in the tertiary setting prior to taking up positions in the health care system. Upon completion of their Bachelor of Nursing degree, they enter a period of role transition from student to registered nurse. This passage has been described by new graduates as challenging, frightening and wonderful (Renno, 1998; Mitchell, 2000). They need to enter and make sense of the health care system, the culture of the environment and the individuals that help to shape it. They need to find their place in the whole scheme of things. They have their skills, values and beliefs questioned, often by those who they thought would support them. Not surprisingly, many find the transition from university to the workplace challenging.

Most hospitals and health care settings in New South Wales have implemented a number of mechanisms aimed at supporting new graduate nurses and easing their transition into the workplace. These measures commonly include transition support programs for the new graduate nurse. A review of relevant literature has been undertaken to gain a better understanding of the key issues underpinning this study. A brief overview of nurse education in New South Wales will be shown before moving to examine the key issues related to the transition process. The specific difficulties experienced by student nurses making the transition to registered nurses will be explored.

Differing models and structures of transition support programs will be presented to give an accurate picture of the programs currently offered to new graduate nurses in New South Wales today. Evaluation will then be described, first as a concept and then related to transition support programs.

2.2 Nurse Education in New South Wales Today

Nurse education today is based in the university setting with the qualification being an undergraduate degree, the Bachelor of Nursing (BN). There are currently ten tertiary institutions that have a curriculum approved by the Nurses and Midwives Board, New South Wales (NMB) to educate student nurses in New South Wales. Approval is not given lightly and the task of educating nurses is an onerous one. The three year, full time course is required to prepare nurses to work in a variety of institutional and community settings including medical-surgical, mental health and disability facilities. The Nurses and Midwives Board, New South Wales stated that

> *. . . programs of education leading to registration as a nurse must provide a broad and sound foundation in medical – surgical nursing, mental health nursing, maternal and child health nursing, nursing care of children, nursing care of the aged and nursing of the developmentally disabled* (Nurses and Midwives Board, New South Wales, 2004)

The education is required to prepare nurses to undertake a multitude of roles and functions upon registration. The Australian Nursing Council (1993) stated:

> *The role of the registered nurse includes the following integrated components: clinician, care coordinator; counsellor; health teacher; client advocate; change agent; clinical teacher/supervisor. The role of the registered nurse includes the responsibility to examine nursing practice critically and to incorporate the results of personal action research or the research findings of others.*

Upon successful completion of the BN, graduates are eligible to apply for registration with the Nurses and Midwives Board, New South Wales and have their name listed on List A as a registered nurse. Prior to the transfer of nurse education, there had been five basic registers of nurses in New South Wales. These were General, Psychiatric, Mental Retardation, Geriatric, and Mothercraft Nursing registers. Each register was accessible through different hospital training programs with different syllabi. The (then) New South Wales Nurses Registration Board (NSWNRB)

proposed that new graduates should be registered on a single register and allowed to function as beginning practitioners in any of those areas. Consequently, the List A Register replaced the separate registers. Also changed was the requirement of the state licensing examination. Prior to the transfer of nurse education to the tertiary sector the NSWNRB held examinations twice yearly that each student nurse near to completion of their hospital training was required to pass before being accepted as a registered nurse. Today the NMB is content to accept nurses onto the register who have successfully completed an approved program of study at a university or college. This decision bought nursing into line with other professions in Australia.

2.3 The Experience of Role Transition

Transition has been a concept of interest and research to nurse researchers and theorists for some time. Transitions occur at all levels of life and relate to changes occurring in the identities, roles, relationships, abilities, and patterns of behaviour (Schumacher & Meleis, 1994). At the organisational level, it may take the form of structural or functional change. At the family or individual level it may mark the change from childhood to adolescence, the commencement of married life or vocation change. Meleis, Sawyer, Im, Hilfinger & Schumacher (2000) found that even though transitions can be complex and multidimensional, several essential properties exist. These include awareness, engagement, change and difference, time span and critical points and events. When these properties are more closely examined, the impact on individuals in both their personal and professional life can be appreciated. Meleis et al (2000) defined engagement as "the degree to which a person demonstrates involvement in the processes inherent in the transition" (p. 6.) Examples of engagement are actively seeking information and / or role models to cope with the process of change. This might be demonstrated by a person newly diagnosed with diabetes mellitis seeking information about the condition and considering their diet. The passing of time is a characteristic of all transitions even though the onset and cessation boundaries vary considerably. Some transitions have an abrupt beginning, for example the birth of a child even though the new parents have been aware of the impending event for some time. Conversely, Meleis et al (2000) reported that some

immigrants describe their transition experience as an "ongoing, undulating, unending transition" (p. 8).

The earliest studies on transition from student to registered nurse were conducted in the United States. In 1974, Kramer described the experiences of newly qualified nurses during their first few months working in a hospital setting. The term 'reality shock' was coined to describe the shock like reactions to work situations for which new graduate nurses thought they were prepared. More recent research continues to find similar issues arising across different courses and different countries as new graduate nurses struggle with the change in status (Horsburgh, 1989; Jasper, 1996; Kelly, 1996; Gerrish, 2000; Casey, Fink, Krugman, Propst, 2004).

In Australia, transition from student to registered nurse has received most attention since the transfer of nurse education to the tertiary sector. One of the major issues to arise from the national review of undergraduate nurse education in 1994 was to provide the 'best means of facilitating the transition from higher education to work' (Reid, 1994. p4). The national review made a number of recommendations to this end, but as the literature shows, a number of tensions and difficulties continue.

2.4 Difficulties of Transition from Student to Registered Nurse

The difficulties described by new graduates entering the workplace seem to fall into one of two categories. They tend to be either a reality of nursing practice issue or one relating to the socialisation process of becoming a registered nurse. Coming to grips with the reality of nursing practice encompasses working within the confines of the real workplace. For the first time the new graduate nurse experiences the stress of being responsible for a group of patients and many begin to question their own clinical competence. To overcome the difficulties associated with the process of socialisation, the new graduate nurse needs to adapt to a whole new environment.

2.4.1 Reality of Clinical Practice

The reality of practice can surprise many new graduates when they first enter the workplace. One reason for this is that they are confronted with a reality that can be

very different to what they had come to expect during their education (Horsburgh, 1989). The New South Wales Nurses Registration Board commissioned a study to examine the expectations of new graduate registered nurses in the workforce (Madjar, McMillan, Sharkey, Cadd, Elwin, 1997). The project team, led by Dr. Madjar compared and contrasted the expectations of beginning registered nurses with the expectations of more experienced nurses working in the health care system. The research project was conducted between December 1996 and August 1997, and with 493 beginning registered nurse participants, was one of the largest of its type undertaken in recent times. One of the findings of the study indicated that student nurses were given an unrealistic expectation of nursing work. It appeared that their understanding of what nursing entailed was formed far from the workplace.

The unrealistic environment of university

Students are taught the 'ideal nursing practice' in a university environment free from clinical pressures. This can contrast sharply with the real situation where tasks are given a very high priority and need to be accomplished within a given time frame. The literature points to a gap between the theoretical and service aspects of nursing (Madjar et al, 1997). The tension arises due to the mismatch between the educational preparation and the reality that new graduate nurses find in the workplace. On one side, the professional status of nursing is thought to be enhanced by tertiary education away from the demands of the workplace while on the other, the service side of nursing requires that the job be carried out without the emphasis necessarily on quality outcomes for the patient. One of the problems facing the new graduate nurse is that at some stage they must make the transition from the educational ideal to workplace practice reality.

Performance of tasks

Despite much debate over recent years, care is still largely task-centred in many health care settings (Greenwood, 1993). While caring is considered by many to be the essence of nursing, Grbich (1999) argued that it receives little of the recognition, respect and rewards that are accorded to curing. She quoted the formula proposed by James (1992) that care = organisation + physical labour + emotional labour. Even though the components of organisation, physical labour and emotional labour have

equal importance in the equation, Grbich (1999) argued that physical labour was often given priority over the less measurable and tangible aspects of care (such as emotional labour) by both administrators and nurses. Many hospitals still use the physical dependency status of patients to determine staffing needs. It is not surprising that nurses come to equate 'work' with 'doing things' and with physical labour. New graduates are frequently stressed by the emphasis on the physical aspects / tasks in the health care setting. Their education prepared them for continuity of patient care that is often seen as a luxury not afforded in many health care settings. They find themselves in the situation where they are simultaneously subjected to two sets of pressures, one from the idealistic view of the teacher and the other from the ward staff who need the job done as quickly and efficiently as possible (Ramsey, 1982; Bradby, 1990; Philpin, 1999). Feelings of frustration and guilt are expressed because they are unable to provide the level of care they are capable of delivering. Many graduates continue to struggle with the change in focus from patient-centred care to task management.

High work volume

The sheer volume of work during any given shift concerns many new graduates. Hospitals operate with a very fast patient turnover with patients being discharged much sooner than they were a decade ago. The average length of stay for a patient in hospital has shortened significantly. A decade ago a patient who had their gall bladder removed, for example, might have expected to stay in hospital for 7-10 days, today they are discharged after 3 days. Even patients who have undergone major surgery are encouraged to get out of bed and mobilise much earlier than previously thought possible. While these strategies present many benefits for the individual and the community, for the nursing staff it means that there are few patients who are convalescing on the ward and able to care for themselves a little. Rather, the wards are full of very ill patients who require a lot of nursing care. The age-adjusted hospital separation rate in New South Wales increased by 30% over the period 1988-89 to 1998-1999 (Public Health Division, NSW Department of Health, 2002). This figure represents the number of people admitted to hospital, including a day-only admission, and then discharged, transferred to another hospital or dies while in

hospital. Consequently, the workload is more intense and heavier than it was a decade ago.

Technology

The increase in the use and reliance on technology has been one of the forces to change the face of nursing. The role that technology was to play for nursing practice was first mooted in the 1960s and 70s. Sandelowski (1997) reported on the "frontier" spirit shown by nurses as technology allowed nursing practice to take on a more scientific approach. It was during this period that hospitals saw the arrival of automated mattresses and beds, electronic fetal monitors, oxygen tents and suction devices, and numerous monitoring machines. The monitoring machine technology forced nurses to become more knowledgeable about the biophysical, physiological, and engineering sciences, as well as about the mechanical operation and maintenance of the technology. Barnard (1997) said that nurses today are responsible for increasingly machine oriented health care dominated by administrative and bureaucratic structures. Nurses in all specialities are required to care for patients and develop the technical knowledge not only to manipulate machinery but interpret the world around them. This use and reliance on technology in nursing practice today has both benefits and drawbacks. On one hand, technology can save time and allow nurses to concentrate on patients (Calne, 1994), while on the other, it can make nursing practice more time consuming and distracted. Barnard (2000) found that nurses identified technology as one of the primary reasons for spending less time with patients. They complained of being distracted by having to respond to electronic alarms, answering telephones and buzzers. They felt that they attended to noises and equipment before they attended to people.

Staff shortages

When this situation is coupled with wards that often operate with staff shortages, or skill-mix imbalances, the shift is very busy from start to end. Bick (2000) stated that a major contributing factor to new graduates 'reality shock' was the current shortage of registered nurses working in the health care setting. When there was a lack of registered nurses rostered for a shift, new graduates can feel forced into positions of responsibility before they feel competent and comfortable with their own ability to

care for the patients appropriately (del Bueno, 1994). In Charnleys' (1999) study for instance, new graduate nurses expressed anxiety about not being able to give the amount of care that they felt was appropriate because they did not have the time. The care most frequently lacking was the emotional and psychological care. New graduates said that they just did not have the time to sit and talk to patients (Charnley, 1999). This contrasted with their experiences as students because student nurses are supernumerary on the wards so they can find time to sit and talk with patients and attend to their psychological needs.

Shiftwork

Work is not new for new graduate nurses since many support themselves throughout university education. Working full time on rotating shifts, however, is a new experience for many and the difficulties have been well documented in a number of professions. It often requires the person to make major adjustments in their personal lives. The antisocial aspects of shiftwork was cited by nurses in the Sax report in 1978 and continues to be a source of discontent today. Bradby (1990) looked at shiftwork from a different perspective and found that it was a major part of the status passage from student to registered nurse and it seemed to be important in the socialisation process. While some of the new graduates felt that the tiredness and unusual working hours added to their sense of belonging, others experienced a greater concern for themselves and the feeling that the hospital was controlling both their professional and personal lives.

Becoming clinically competent

Holistic patient care, life-long learning and critical thinking skills are emphasised as key principles in most Bachelor of Nursing curricula in westernised democracies (Greenwood, 2000). However being considered clinically competent by both new graduate nurses and experienced nurses, continues to be a problem. While the theoretical basis is covered adequately, the tertiary education system does not allow the day to day practise of skills that make them second nature to the new graduate nurse. A common complaint from the staff in the health care settings is that the new graduates are not proficient at basic nursing tasks (Greenwood, 2000). This has been a major stumbling block in the acceptance of university education. Some experienced

registered nurses feel that the tertiary education programs have too much emphasis on professional theory and not enough on care in practice (Charnley, 1999). There is also criticism about the amount and quality of clinical experiences the students are exposed to during their education (Madjar, et al. 1997). The new graduate nurses in Charnleys' (1999) study felt concerned and expressed anxiety about their lack of skills. This perceived lack of skill led them to feel incompetent in their new role as registered nurses. Other new graduate nurses felt that while they possessed the knowledge, they lacked the experience for confident clinical assessment. This judgement by both new graduate nurses and experienced registered nurses may be overly harsh. It is not the aim of pre-registration nursing courses to produce expert nurse practitioners. Benner (1984) has shown that development of clinical expertise is acquired after years of clinical experience as a registered nurse. These judgements persist in part, because the university nurse graduate continues to have his/her clinical skills compared with those of the 'old' hospital trained nurse graduate. When nurses were trained in the hospital setting, the majority of their time spent on the ward was involved with hands-on practise at specific skills, tasks and procedures. There were a number of role models for the student nurses to emulate, whether they were the more senior student nurses or the registered nurses on the ward. After graduation, it was a relatively easy step to assume the roles and responsibilities of the registered nurses that they had so often observed in their day to day work. This does not mean that these nurses were 'better' or had more knowledge than their university prepared counterparts. It does indicate that they had more exposure to and experience in the workplace prior to taking up positions as registered nurses because they were more practised in skills and time management and thus appeared to be more confident and competent.

Benner (1984) applied the Dreyfus Model of Skills Acquisition to clinical nursing practice. Her research was based on dialogue with nurses that identified five levels of competency in clinical nursing practice. These levels - novice, advanced beginner, competent, proficient and expert have become known and accepted widely in the nursing field. She found that clinical knowledge was gained over time with the clinician often being unaware of the gain. In a more recent study Madjar et al (1997) found that within three months of practicing in the work setting many new graduate

nurses experienced an enormous increase in their level of competence. This led them to feel more confident and to assume their fair share of work within the health care team. New graduate nurses who work in an acute setting, however, reported that it took at least 12 months to feel comfortable and confident in their work (Casey et al, 2004).

In order to be viewed as competent by their peers the new graduate nurse is required to balance learning opportunities with organisational challenges while at the same time, provide care for a number of patients. This means that these nurses have to learn, practise and become competent at a number of skills during the first few weeks of work at a time when everything is new to them. The new graduate becomes aware, perhaps for the first time, that their work is to a large degree task oriented. This view is generally opposed by the profession whose stated intention is to provide person-centred care rather than task-centred care. New graduates learn that a considerable portion of their role is the management of their allocated tasks (Moorhouse, 1992). Since it is important for the new graduate nurse to be seen as 'coping' in the new role, completion of tasks is crucial. Little wonder that beginning registered nurses find the transition from university to the workplace *'very stressful, very demanding, physically and emotionally draining'* (Madjar et al, 1997. p. ix).

The difficulties of undergraduate clinical placements

It is the clinical component of undergraduate nurse education that arguably comes under the most criticism from different sources. One of the aims of the Universities' Schools of Nursing is to prepare nurses who are flexible and able to think critically (Chang & Daly, 2001). Students' clinical experiences now take place off campus and McCoppin and Gardener (1994) warned that each health care setting visited may not be sympathetic to the nurse academics beliefs and teachings. Students frequently return to university after their clinical practicum and make comments such as 'that is not how it is done at such and such hospital'. There seems to be a disparity between what is taught and what is practiced for a multitude of reasons.

Clinical placements have been criticised for giving an unrealistic expectation of the work of the registered nurse. Student nurses are often not allowed access to patient

records for fear of breach of confidentiality, and rarely get the opportunity to be responsible for the care of a number of patients while on clinical placement. The organisation of clinical placements frequently deny the nursing student the true experience of the registered nurses' day. For example, it is common practice at several universities in Sydney for student nurses to work a six hour day on their clinical placement, commencing at 8am. This is in contrast to the registered nurses who usually work an eight hour day and commence their morning shift at 7am. This means that the student nurses start their shift 'late' and finish 'early' and miss the handover report, necessitating them to 'catch up' on the report about their patients' condition before they even start the shift. The experience of working night shift for the student nurse is even more rare.

One of the purposes of undertaking clinical experience as a student nurse is to provide the opportunity to integrate theory and practice under the guidance of an experienced practitioner. To accomplish this it is common practice for the university to provide a nurse educator to accompany the students on clinical experience. This practice is meant to minimise the disruption to the registered nurses on the ward from student nurses keen to ask lots of questions. The nurse educator may or may not be familiar with the clinical setting where they are to supervise the students. This may mean that the nurse educator has to gain an understanding of the setting, the staff, the relevant policies, procedures and the underlying philosophy of an area before nurse education can begin (Schulz, 1992). This process needs to be repeated for each different venue the student nurse visits during their education. Obviously this is a difficult and potentially time wasting exercise. With student nurses expecting to spend between 20-26 weeks on clinical experience during their three year course, such unproductive time is intolerable.

The amount of time spent on clinical experience is also raised as a concern by many. One of the findings by Madjar et al (1977) was that experienced registered nurses did not believe that the current duration of clinical placement experienced during nurse education was sufficient. The amount of time spent on clinical placements can be directly linked to the cost of providing a clinical educator to accompany the students during such placements. The clinical educators are expected to educate the students

in the clinical setting rather than merely supervise them so the number of students that any one educator can be responsible for becomes a balance between cost and quality. The following example illustrates the expensive nature of clinical education.

> *Clinical educator, Emma, accompanies six student nurses to the neighbourhood community hospital for a four week clinical placement. She works six hours per day from Monday to Friday each week. She earns $37.60 per hour, being the current rate of salary for a clinical educator.*
> *Therefore the cost of providing a clinical placement for six students, without any consideration given to administration costs, is:*
> *30 hrs per week ($1128) X 4 weeks = $4512*

Student nurses contribute to the cost of their education under the Higher Education Contribution Scheme (HECS). Contributions to HECS are based on the individual units of study which are divided into three bands. In 2004, the full time full year contributions for each band were as follows:

> *Band 1 - $3768, Band 2 - $5367 and Band 3 - $6283*. (Commonwealth of Australia, 2003)

Nursing units are in Band 1 and attract the least amount of payment possible from the student. The full-time yearly total of $3768 equates to $471 being the amount payable for each of the eight nursing units. If we apply this equation to the example above, we would find that $2826 was received from the six students for their clinical placement unit. This means that any university involved in providing undergraduate nursing degrees has to meet the shortfall in funding between the HECS payment and the cost of the experience, in this case $1686. It must be remembered that this scenario in the above example concerned just six students. The costs are clearly unsustainable when one considers hundreds of nursing students multiplying this negative payment system. As a result, the universities have been forced to consider alternative and shorter types of clinical experiences for their students to save on the cost of the clinical educator.

It is also noted that the placement of nursing in band 1 is inconsistent with all other health degrees. Health science degrees are in band 2 and medicine, medical science, dentistry and veterinary science are in band 3 of the HECS. Additionally, nursing practice units of study are inherently expensive to offer students since they require technical equipment and consumable items as do similar science and medical units. The result is that the cost of maintaining and updating equipment in line with medical and technological advances and replacing consumable items is considerable and is again borne by the university.

Responsibility

New graduates can be overwhelmed by the responsibility with which they find themselves entrusted. Maben & MacLeod Clark (1996) found that new registered nurses in their study reported that the feeling of greater responsibility was described as one of the major differences between being a student and a registered nurse. Overnight new registered nurses were taken from the 'protected student' status where they were free to ask for help and advice from the registered nurses to a position where they were often solely responsible for the care of others and fearful of not doing things correctly and of forgetting something vital (Gray & Smith, 1999). Renno (1998) wrote that she was so nervous during her first handover that she could not remember a thing, while Mitchell, (2000) expressed feelings of 'anticipation, dread, awe, excitement and fear' (p. 44) at the prospect of her first days as a registered nurse. In Charnley's (1999) study, many of the nurses described themselves as being 'shielded' while a student from the full breadth of the registered nurses role. This sometimes meant that they had little experience in some aspects of normal ward routines that had immense implications for team work and time management. New graduates are expected to plan and manage the care of allocated patients often with minimum support. They need to be able to work independently and to give total nursing care to their patients. This expectation comes as a shock to many and causes some degree of stress (Gray & Smith, 1999). During their education it is unlikely that student nurses would have had the opportunity to study or practise time management or organisational skills. Even though these types of skills come with experience over a period of time, Godinez, Schweiger, Gruver & Ryan, (1999) suggest that the formal

teaching of organisational and priority-setting skills may be useful to overcome these experiences in clinical orientation.

2.4.2 Socialisation

There have been numerous attempts to pinpoint the abstract process of socialisation. Bradby (1990) wrote about the process of change from one social status to another. Tradewell (1996), Boyle, Popkess-Vawter & Taunton (1996) and Brown (1999) agreed that socialisation is the process by which persons gain the necessary knowledge, skills, and behaviours to participate in a group.

Abercrombie, Hill & Turner (1994) purported that there are three main stages in the socialisation process. Even though these stages are not viewed as a rigid predetermined course, they do tend to occur at particular times in a person's life. *Primary socialisation* allows an individual to gain the necessary skills, attitudes and knowledge to live and interact as part of the society in which they live. During *secondary socialisation,* the individual learns the knowledge, skills and behaviours that are associated with specific groups and occupations. While the family is considered the key influence in primary socialisation, the peer group and the media tend to have a greater influence during the secondary socialisation stage. The final stage, *tertiary socialisation,* is an ongoing process that occurs throughout adulthood and requires the individual to adopt the values, attitudes and beliefs specific to an occupation. Students and new graduates need to adapt to the new environment and that may require them to question and adjust their previously held view of their career choice to be more in line with those in their intended profession. This view may be somewhat different to those held by the general community. Brown (1999) wrote that the process of socialisation begins during the education program when students learn the accepted norms of the professional group that they are planning to enter. More specific expectations are introduced when the student graduates and enters the workforce. In the hospital setting new graduate nurses are socialised into their expected role within the culture of the hospital.

Hospital culture

In order to work and survive in the hospital setting it is useful to understand the roles of the various groups of people involved and gain knowledge about how and why the hospital operates. The aspects of hospital culture that each nurse will encounter and need to understand are matters relating to power and autonomy, bullying, issues relating to the body, gossip and the roles played by nurses and doctors.

History shows that hospitals have developed with management structures adapted from institutions of social control such as the church and the army where positions of power were held by men. Patriarchal attitudes are maintained in hospitals today with membership to the most powerful decision-making forums, such as hospital boards, medical and ethics committees dominated by men (Clare, Jackson & Walker, 2001). Nurses are placed at the bottom of the hierarchical management system with representation more common to working committees or others with less prestige. Clare, Jackson and Walker (2001) found that in practice this means that nurses are allowed to collect data and present plans of action, but then get sidelined only to watch as their ideas and material gets published as the work of a committee.

With the medicalisation of health care, nursing has been subsumed by medicine which considers all health care as their domain. This institutionally imposed powerlessness has taught nurses not to assert themselves in the workplace, but rather to adopt the behaviours of an oppressed group (Short & Sharman, 1995). DeMarco & Roberts (2003) described the cycle of oppressed group behaviour as *'starting with low self esteem and feelings of powerlessness . . frustrated and unable to assert themselves, these people are unable to support one another, which results in an environment charged with conflict that reinforces each individual's reliance on herself alone'* (p113). The literature describing nurses as an oppressed group and the typical behaviours exhibited by oppressed groups is plentiful. If we accept that even a percentage of nurses are feeling like this, it makes the following sections about power, autonomy and bullying much easier to understand.

Power and autonomy

New graduate nurses most often enter a hospital as their first workplace. Hospitals are part of the national health system that, along with other services have undergone extreme change in the past decade. These changes have been driven by a shift to a more accountable and economic model (Chang & Daly, 2001). Task-oriented behaviours are valued in this model so nurses find themselves valued only for the work that they perform. Treacy (1989) believed that task-orientation treats both patients and nurses as work-objects. This practice only serves to foster the notion that new graduate nurses are not 'up to scratch' even though we know that in time the new graduate will develop clinical skill proficiency (Madjar et al, 1997; Charnley, 1999; Greenwood, 2000). The hierarchical system also encourages the labeling of staff. New graduate nurses are employed as registered nurses though commonly recognised and referred to as 'new grads'. In some hospitals they may be further recognised or 'described' by the number of ward rotations they have progressed through. For example, a nurse who has just started in the hospital and is working on their first ward is known as a 'first rotation' whereas a nurse who has completed two rotations and currently working on their third ward would be known as a 'third rotation'. The new graduates are expected to have more knowledge as they progress through the wards and are afforded less orientation time for each rotation after the first. This practice, also noted by Jasper (1996), negatively affected the confidence of new graduate nurses and denied them the respect to which they were entitled.

New comers to the health care system are keenly aware of their knowledge deficits (Madjar et al, 1997; Charnley, 1999; Casey et al, 2004). This lack of knowledge may not be related to the performance of a specific clinical skill, but rather to the day-to-day functioning of the ward, where knowledge concerning where towels are kept, for instance, can be important. Routine is another factor in the process by which new graduates adapt to their new role. Knowledge becomes equated with power and, in particular, the knowledge that is required to undertake the new status or role within the cultural milieu of the hospital. Its accessibility becomes a crucial component in the transition of new graduate nurses into their new status or social position. New graduates quickly learn to conform to the prevailing norms. Conformity can ensure such rewards as a satisfactory placement and assessment from the preceptor, and

being able to fit in and feel like a nurse (Gray & Smith, 1999). Qualified nurses who act as role models and preceptors therefore could be said to be the gatekeepers to the knowledge and skills required for students and new graduates to exist within the nursing culture. As such, new graduates feel powerless to make changes as newly qualified nurses (Kelly, 1996).

Bullying

Lumby (2000) called for a closer look at the reasons why a decreasing number of women want to enter or remain in a still largely feminised workforce. She stated that although nurse education had changed, the culture of hospitals had not. Nursing skills and expertise in patient care were still undervalued and nurses continued to be treated like second class citizens in the hospital hierarchy. Ironically, much of the negative treatment received by nurses is dished out by other nurses (Alavi & Cattoni, 1995).

This has come to be known as workplace bullying, and although it seems to be widespread, it can be difficult to describe the exact nature or definition of what constitutes bullying. A search of the literature via CINAHL and other Ovid Databases, using 'bullying' and 'workplace violence' as the key words found articles about violence in hospitals perpetrated by patients, but not about the violence that occurs between one nurse to another. Jackson (2003) said that nurses have sanitised bullying by coining the term horizontal violence and when this term was used as the key word, a lot of literature appeared confirming the prevalence of this problem in nursing. The literature reports behaviours such as excessive abuse or criticism, threats, ridicule and humiliation, making excessive demands on any one person, inequitable rostering or any misuse of power to encourage other people to exclude the victim may be considered as bullying (Farrell, 1997; Paterson, McCormish & Aitken, 1997).

Clare, White, Edwards, & van Loon (2002) found that 48% of the respondents in their study made comments about bullying in the workplace, and 100% of those who experienced it on a regular basis considered leaving the nursing profession, a sentiment echoed in this study. Since the victim is viewed as being powerless, it is not surprising to find that bullying is under-reported. McKenna, Smith, Poole &

Coverdale (2003) surveyed a group of new registered nurses to determine the priority for horizontal violence preventative programmes and found that nearly half of the incidents described were not reported. The same study found that of the incidents that were reported only 12 % received any formal debriefing. Perhaps this attitude of apathy towards bullying helps to perpetuate the practice, or perhaps it is not apathy but acceptance of the practice. Dunn (2003) considered that horizontal violence was so common that it became an accepted part of behaviour for many nurses and as such became unnoticeable.

Not only were many new graduates left to feel unsupported in their new role but were badly treated by colleagues who "seemed more intent on asserting their own place within the hierarchy than developing functional professional relationships" (Madjar et al.,1997 pg ix). This phenomenon is not new, horizontal violence has been long recognised in hospital settings. It has been suggested that nurses' dislike of themselves and other nurses is demonstrated by the lack of cohesion in nursing groups (Bent, 1993). Such violence occurs because much of the poor treatment is received from more powerful health professionals, thus making retaliation impossible. Alavi and Cattoni (1995) used Canetti's metaphor of 'stings' to describe these phenomena. It was suggested that when people were given commands and were subjected to embarrassment, punishment or degradation, a 'sting' lodges within them. This sting embeds itself within the person and the only way to be rid of it is to pass it on to someone else. After a short time at work the nurse has an armory of 'stings' to pass on to the new batch of new graduates. And so the cycle continues.

Dealing with the body

George and Davis (2000) considered that the culture shock of contact with death, constant tiredness, conflict with senior staff, the embarrassment of dealing with the human body and its products, and the pain and disfigurement common in acute wards left a lasting impression on health care workers. Lawler (1991) studied how the body and its functions were managed by nurses as they went about their work. The day to day nursing work often encroaches on socially taboo subjects as patients find themselves depending on nurses for the type of care that they would normally perform for themselves. It might be bathing, eating or dressing that a person finds themself

needing assistance to perform. There was often a degree of embarrassment experienced by the person associated with the tasks. For their part nurses find it difficult, if not impossible to talk about their work with anyone other than nurses. Since nurses deal daily with aspects of lives considered personal or dirty, it offends some people and makes them feel uncomfortable (Lawler, 1991). Nurses need the opportunity to debrief after particularly stressful events or shifts and more often than not this takes the form of informal chatting or story telling among one another.

Gossip

Story telling, gossip and rumours are almost inevitable when a group of people meet and have the opportunity to speak. Hospitals provide a tremendous opportunity for such activities. They are full of people working closely together, some of whom have the opportunity to move from ward to ward and spread the word. Due to insufficient time to clarify a story, the information can become distorted quickly as it is passed from one person to another. While the negative aspects of story telling and gossiping are well known some authors argue that they also play a role in the socialisation process for nurses (Davidhizar & Dowd, 1996; Tradewell, 1996; Kelly, 1996). Story telling can be used to communicate specific cultural expectations, indeed, Benner (1991) recommended story telling to explore moral experiences for nurses. Gossip, in the form of 'cadaver stories' showed new graduate nurses how to deal with emotions that can be difficult to handle in the hospital setting. They also allowed nurses to determine what behaviour is appropriate in their professional role and to experience the triumphs or mistakes of their colleagues. Both story telling and gossip help new graduate nurses to learn the professional jargon and language of the hospital while promoting unity and exclusivity.

Nurses and doctors

The nurse-doctor relationship is a hierarchical one and has received a lot of attention in the literature. Stevens (1995) found that despite the transfer of nursing education to universities, oppressive behaviours still flourish and are a feature of nursing education and practice in Australia today. The existing problems between nurse - doctor collaboration is typically blamed on the doctor. It has been argued that the most powerful team members direct the contribution of others. This means that the medical

profession dominates and nurses are generally submissive. This notion supports the view that nurses are 'doers' rather than 'thinkers'. This situation is evident in everyday practice and becomes so much a part of everyday work that some nurses are unaware of it. Short, Sharman and Speedy (1998) wrote about the ritual that is played out between doctors and nurses in relation to the process of clinical decision making. In reality, nurses contribute significantly to the decisions that affect patient care. To play the game, the recommendations offered by the nurse must be communicated to the doctor in such a way that it appears to be the doctors' decision. The negative aspect of this for the nurse is that it undervalues the role that they have played in the clinical assessment and decision making process. This situation is maintained through an effective socialisation process. The nursing profession continues the push for independent practitioners rather than focus on the interdependent role that nurses have to offer. Henneman (1995) believed that in the attempt to promote the uniqueness of nursing, walls have been inadvertently built between nursing and the other health care disciplines. Nurses begin to distrust doctors and have a tendency to believe that they alone are concerned for the patient.

2.5 Gaining Employment as a Registered Nurse

It is useful to describe the process that student nurses undertake in order to secure a position in a transition support program because frequently the program that they are allocated was not their first preference. Most student nurses in New South Wales (NSW) seek employment using the New Graduate Nurse Recruitment Consortium. This equates to between 1800 and 2000 nursing students from 21 different nursing campuses each year.

Prior to 1993, new graduate nurses were recruited independently by hospitals which resulted in over 20,000 applications being lodged around the state. In an effort to curb this uncoordinated approach the five hospitals making up the South Sydney Area Health Service joined together in 1991/92 to recruit at an ‘area health service’ level. The success of this venture grew to include Central Sydney and Central Coast Area Health Services in 1993 and the first consortium approach to new graduate nurse recruitment. Sixteen of the 18 area health services in NSW are members of the New

South Wales Consortium today and collectively offer approximately 1200 new graduate nurse positions each year.

Each student nurse is interviewed by a panel of three experienced nurses. They are asked six questions that utilise the framework of the Australian Nursing Council Inc. (ANCI) Competencies for Registered Nurses. The questions are designed to allow the student to show both their knowledge of clinical nursing practice and the appropriate theoretical knowledge base. Any experiences or personal viewpoint that the student may have may also be included as part of their answer. Following the interview, the student's interview score sheet is scanned, results imported into a database and score ranked. The students who achieved the highest scores are offered a position according to their nominated hospital preference. If the first hospital preference is fully allocated, a position will be offered in the second or third preference and so on, until all positions have been allocated (New South Wales New Graduate Nurse Recruitment Consortium, 2003). It is this recruitment technique that sees many new graduate nurses accepting positions in programs run by hospitals that they did not choose.

2.6 Transition Support Programs

The need for guidance and support for new graduate nurses during their initial employment period has been recognised in the literature over a number of years (Reid 1994, Madjar et al 1997, FitzGerald 2001). Transition support programs have become a popular and formalised way of giving the assistance required. Transition support programs based on various models have been identified in the literature.

Models of transition support programs

In the United States, internship programs are popular. According to Fanelli (1998), the goals of such a program are to provide support for newly graduated nurses, enhance decision-making skills and to promote adaptation to the work place. These programs vary in the amount of time spent in orientation, rotating to different areas and the availability of supervision during clinical placement. Lewison and Gibbons (1980) considered that internship programs could be further classified into three

categories. They felt that a compensatory type of program was designed to make up for deficits in undergraduate nursing education, while an acceleration program was used to prepare new graduate nurses to work in highly specialised areas such as coronary care. An exposure program allowed the new graduate nurse to rotate to several different nursing areas to determine the area that best suited them.

In Australia, Reid (1994) identified two models of transition support programs commonly offered by employing hospitals. The first was the 'deficiency model' based on the belief that the new graduate nurse is deficient in some aspects of nursing practice. The other model, the 'skills consolidation model' accepts that the new graduate nurse has skills but continues to require supervised practice of those skills in the workplace while being exposed to the professional and hospital culture.

One of the major differences in the transition experiences of new graduate nurses in Australia and the United States is the time of registration as a registered nurse. In Australia all transition support program participants are registered with the appropriate Nurses Registration Board before entering the program. This is not the case in the United States where registration is achieved with the passing of the National Council Licensure examination. This may occur during or after the internship program since different states have different requirements.

Transition support programs in New South Wales

Almost all hospitals in New South Wales offer a transition support program in some form and a typical program consists of:

> *. . . an initial orientation or induction program, perhaps some theory classes, and a system of clinical practice in which more experienced nurses play the role of preceptor, mentor or 'buddy'. Clinical practice might be deliberately structured to provide experiences of different nursing work* (Reid, 1994:222)

Even though it is widely believed that one should complete a transition support program before attempting to practise independently, there is no formal compulsion to

do so. The programs are presented in different formats with different ward rotation schedules and different specialty units included according to the criteria set by the hospital offering the program. The programs run most commonly for 12 months duration after which the new graduate nurse may be offered a place as a full time staff member or may leave the hospital and seek employment elsewhere. During the program the new graduate nurse is oriented to the hospital setting by the nurse educator of the hospital and often allocated a preceptor on the ward where they are rostered to work. The orientation period can last up to one week where the new graduate nurse is taught specific skills and introduced to hospital policy and procedure. The theory component of a transition support program is minor with the average theory to practice ratio for most programs of 1:24. The transition support programs are predominantly work programs.

The common component in all of the transition support programs seem to be that they are an organised attempt to give the support required for new graduate nurses. It has been acknowledged that by supporting new graduates, the commonly expressed feelings of anxiety, stress and inadequacy could be lessened (Kramer, 1974; Madjar et al, 1997; McKenzie, 2001a). This support comes from varied sources depending on the resources of the hospital offering the program and many include preceptors, clinical nurse educators, study days, and peer support groups that many of the new graduate nurses find useful.

Preceptorship

Preceptorship programs were introduced as a way of supporting newly qualified nurses during their transition period and may or may not be included as part of a transition support program. Preceptors, mentors, and buddies are terms widely used and often used interchangeably in the literature. There seems to be various interpretations of their exact definition and this can cause confusion for the reader. A definition that seems to have gained consensus is the one by O'Malley, Cuncliffe, Hunter, & Breeze, (2000) who described a *preceptor* as a person who teaches, counsels, inspires, serves as a role model, and supports the growth and development of an individual for a fixed time with the specific purpose of socialising the novice into the new role.

In practice, the preceptor is usually a senior registered nurse who carries out the role of the preceptor as well as their usual clinical and professional duties. They are the nurses responsible for providing orientation to the hospital and ward environment and the supervision and guidance of the new graduate nurse on a one-to-one basis.

The preceptor partnership model has been incorporated into many transition support programs and there is no shortage of literature to support the use of preceptors in the clinical setting. Most new graduates are pleased to be appointed a preceptor to guide them through the first few months until self confidence and skills can be developed (Millburg, 1997; Renno, 1998; Makepeace, 1999; Mitchell, 2000). Oermann & Moffit-Wolf (1997) found that the support that preceptors were able to provide was essential for new graduates to develop confidence in their own clinical practice. Because new experiences may be considered as either stressful or challenging depending on the nurse's own assessment of the situation, it is the preceptor who is well placed to consider the individual needs of each new graduate nurse (Oermann & Moffit-Wolf, 1997).

Many studies have revealed the feelings of stress that continue to be experienced by new graduate nurses during the first six months of practice (Jasper, 1996; Maben & MacLeod Clark, 1996; Charnley, 1999; Buchanan & Considine, 2002). Allanach and Jennings (1990) monitored the changes in hostility, anxiety and depression of new graduate nurses over a 24 week period of time as part of an evaluation of a preceptorship program. A multitude of questionnaires were administered to the new graduate nurses during week 8, 13 and 24 of their placement. Their stress levels did not rise as anticipated and the authors suggested that this may have been due to the preceptor program that included meeting twice weekly when the new graduate nurse had the opportunity to discuss their feelings with others in the same situation.

The benefits of this liaison are not just for the new graduate. Clayton, Broome & Ellis (1989) found that preceptors not only enhance the transition from student to staff nurse, but the experience also served to acknowledge the registered nurses as experts in their role. Since registered nurses gained little formal recognition of their skills, this was seen as beneficial for both parties. In a later study Stevenson, Doorley,

Moddeman & Benson-Landau (1995) supported this finding and added that preceptors gained satisfaction from sharing their knowledge and expertise and watching the preceptee grow.

The preceptorship model also has its critics. Preceptors themselves expressed feelings of frustration at the training process and the often unrecognised increase in workload of precepting a new graduate nurse. The time spent with a new graduate nurse and the resultant increase in stress levels were the chief complaints from preceptors in the Stevenson et al (1995) study.

It seems that the precise role of the preceptor is unclear and varies from area to area and also in relation to the different personalities of both the preceptor and the preceptee. While McKenzie (2001b) considered the best quality of a good preceptor was a friendly face to help them cope with their work, a different person may require that a good preceptor be a registered nurse who is considered an expert in their clinical field. Kelly (1996) found that some preceptors had little understanding of the preceptor role and as a result provided minimal support for new graduate nurses.

Personal as well as professional difficulties may emerge. O'Malley et al (2000) found that due to the very nature of the preceptor relationship conflicting roles of confidante and assessor could emerge. Winter-Collins & McDaniel (2000) considered the impact of morale both personally and on the ward. Not surprisingly, they found that morale was an important issue for the day-to-day functioning of the ward. If the preceptor's morale was low, they questioned the effect this might have on the new graduate nurse.

Sometimes the choice to be a preceptor is not an entirely voluntary one. Experienced registered nurses can be coerced into undertaking the role of preceptor. This may be due to any number of factors including staff shortages and lack of support from nursing management. Considering the current nurse shortages in the New South Wales health system, it may be difficult to find an appropriately experienced role model for the new graduate nurse. Specialist areas, such as operating theatre, mental health and paediatric intensive care units are acutely short of experienced registered

nurses. There may simply be no-one with the necessary qualifications and experience to precept a new graduate nurse who shows an interest in a specialist area.

Preceptor preparation programs have been commenced in many hospitals to encourage and prepare prospective preceptors for the role. Fehm (1990) identified adequate preparation of the preceptor as the single most important factor in the overall success of the preceptor program. While the content of preceptor preparation programs may vary from area to area, the key components have been found to be teaching and learning strategies; principles of adult learning; communication skills; values and role clarification; strategies for resolving conflict; assessment of individual learning needs; and the evaluation of novice performance (Usher, Nolan, Reser, Owens & Tollefson, 1999). With the current stress levels and staff shortages in hospitals in New South Wales it may be difficult to find registered nurses eager to undertake such programs.

2.7 Program Evaluation

To gain an understanding of program evaluation we first need to consider what we mean by these key words 'evaluation' and 'program'. Programs are developed to meet various needs and consequently have different designs and structures. S. Funnell (personal communication, January 17, 2005) described a typology of public sector programs that identified two broad types or families of programs. The first are those whose end result is achieved through influencing behaviour and include advisory, public information and education programs, motivational programs and case management programs. The second are programs for which the end result is the benefit(s) that come through receiving a service or product.

Programs can be designed and implemented at a number of levels. At the mega level, or corporate level program planning is usually directed toward an overall economic or social impact. Divisions of a large company or branches of an organisation are responsible for macro planning, while planning at the micro level falls to the individuals employed within that organisation. Owen (1999) asserted that it is

important to note the level of the program in relation to the evaluation process since the major stakeholders at each different level may have a different priority.

Evaluation is not a new concept. Everyday we make many informal evaluations about such things as what to eat, the best travel route to work and so on. Managers and staff informally assess or evaluate their program's effectiveness by considering such questions as: Are participants benefiting from the program? Are participants satisfied with the services or training? Do the employees have the necessary skills to provide the service or training? These questions and many others are examples of those that may be asked on a routine basis. Formal evaluation addresses these same questions but uses a systematic method for collecting, analysing and reporting the information to answer basic questions about a specific program. Formal program evaluation in the workplace has become more common as management struggle with dwindling resources. Quality control and outcome criteria have become the 'buzz' words of organisations today as they try to find evidence to either defend or refute the usefulness of the programs currently in operation.

There are various reasons given for evaluating programs. An accurate evaluation will provide information about what is and is not working in a program so that future programs may be improved. The availability of funding can sometimes mean whether a program continues or not so a positive evaluation can demonstrate the benefits of a program and be used to justify the existence of the training department (Kirkpatrick, 1998). Posavac and Carey (1980) add that an evaluation may be used to fulfil accreditation requirements and it may also uncover any unintended effects. An evaluation can also be used to improve staff's work by identifying strengths as well as weaknesses and can add to the existing knowledge in the work setting about what does and does not work in that particular type of program with that particular type of participant.

An evaluation of a program can be approached in a number of different ways. Posavac and Carey (1980) divided evaluation into two ways. The first was according to the type of question asked about the program. These questions are classified into four general types: those relating to need, process, outcome, and efficiency. The

second way described by Posavac and Carey (1980) was according to the purpose of the evaluation. They state that the overriding purpose for program evaluation was to 'receive feedback from the environment' (p15.) This general principle can be divided into two main purposes. Formative evaluations are performed to improve the plans and/or delivery of a program, to raise the outcomes or to increase the efficiency of the program. On the other hand, summative evaluations are used to decide whether or not a program should be commenced, continued, or selected from several alternatives.

A different approach was used by Owen (1999) who classified evaluation into five categories: *Proactive Evaluation* whereby the evaluator becomes an adviser who provides the information required about policy development, the format of the program and how the organisation can accommodate the program before the program is designed. The major aim of this type of evaluation is to develop a program before the actual planning stage. *Clarificative Evaluation* whereby the evaluation focuses on clarifying the internal structure and working of a program and is concerned with the causal mechanisms which are known to link potential program activities with program outcomes. *Interactive Evaluation* whereby the evaluation is concerned primarily with the execution of a program. This type of evaluation is particularly useful for programs that are undergoing change. *Monitoring Evaluation* where evaluation is typically performed when programs are established and continuing. This type of evaluation frequently relies on performance indicators of some type that are used as part of a regular monitoring program. *Impact Evaluations* are also performed on programs that are established and settled. This type of evaluation is used to assess the impact of a program. Owen's model of Impact Evaluation has been used in this study and is discussed fully in the Methodology chapter (Section 3.2, p 46).

Process, impact and outcome evaluations have also been described by Hawe, Degeling and Hall (2002) who expressed these types of evaluations in a sequential manner stating that process evaluation should precede impact and outcome evaluation to avoid a premature evaluation. They maintain that it would be useless to obtain an evaluation of the long-term effects of a program before it had been established that the program was operating in the way that it was designed to operate, reaching the target people and having the desired initial effects. For this reason, Hawe et al (2002)

advocated undertaking a process evaluation at the outset by considering such aspects as whether the program is reaching the target group, the degree to which the program is being implemented, the quality of the materials and components of the program and the satisfaction of the program participants. They concluded that it is only after these questions have been answered that evaluation can move to consider the impact and outcome of a program.

Evaluation of transition support programs.

Nursing administrators in hospitals seem to be falling behind with evaluation of programs for although most major teaching hospitals offer transition support programs for new graduate nurses, there is currently little valid and reliable evidence to either support them or refute their benefits. If we adopt the typology of program types described by S. Funnell (personal communication, January 17, 2005) we would describe transition support programs as an educational program since one of the main stated purposes of a transition support program is to support the new graduate nurse while they learn the skills and attitudes necessary to work as a registered nurse. To view the transition support programs as 'educational' is however, inadequate and fails to capture the essence of the programs. Each program operates for a 12 month period and consists of approximately four weeks educational/orientational work while the remaining part is spent working on the wards. Each transition support program is planned and run by individual organisations and as such may be considered to operate at the micro level. The type of program and the level of operation are important considerations in the evaluation process as different programs and different stakeholders may require different program outcomes. It is difficult to determine exactly how transition support programs are evaluated in New South Wales. Problems arise partly because little literature is available and further complicated when one considers that there is no one common transition support program. Rather, each hospital designs, runs and evaluates their own transition support program according to a perception of their needs.

Generally the literature presumes that there are benefits in running transition support programs for new graduate nurses. There is no shortage of literature stating that new graduate nurses need the guidance and support afforded them through participation in

transition support programs (Reid, 1994; Madjar et al 1997; Fitzgerald 2001; Clare & van Loon, 2003). Olson, Nelson, Stuart, Young, Kleinsasser, Schroedermeier, Rose & Newstom (2001) found that benefits could be found for both new graduate nurse and the organisation offering the program. These included improved socialisation and professionalism for the nurse, greater job satisfaction and retention of the new graduate nurse.

Clare, et al (1996) were unconvinced of the benefits in transition support programs since the studies in the published literature have relied mainly on descriptive accounts by graduates to assess the success of the course or provided descriptions of a transition model without evaluation. This approach is commonly used and Jordan (2000) was also dissatisfied with the use of satisfaction questionnaires and 'happiness indices' in course evaluations. She stated that a positive rating on such a questionnaire may be related to light academic workload rather than a positive outcome as a result of the program. Whether the new graduate is the most appropriate person to evaluate a course is also open to debate. It is also obviously very difficult to evaluate any program when there has been no exposure to any other type.

The monetary costs of running transition support programs can be considerable. The main costs are advertising the programs to potential employees; costs associated with interviewing and procuring recent graduates, either via the New South Wales New Graduate Nursing Consortium or privately; personnel associated with the programs, new graduate coordinators, nurse educators, administration; and the costs of the wages paid to participants during periods where they are supernumerary in the workplace such as orientation time and study days. In New South Wales the Department of Health gives financial support to the hospital offering the transition support program with the expectation that the programs will promote support of new general and midwifery graduates. Specifically the aims of transitional support funding are to:

- maximise the employment of new graduates;
- provide a meaningful and supportive period of employment as a new general or midwifery graduate;
- encourage the retention of new graduates in the nursing workforce;

- promote the flow of experienced nurses between the public and private sectors;
- endorse collaboration between the health sectors;
- develop an experienced nursing workforce.
  (Office of Chief Nursing Officer, Department of Health NSW. 2002)

One of the recommendations made by Reid (1994) was to shorten the year-long transition support program. Among the reasons stated to support this recommendation was that the transition support programs were unnecessarily long and therefore expensive and that duplication of parts of the undergraduate program was likely. In spite of this the year-long transition support program continues to be the most commonly offered program with even longer programs available in some hospitals.

2.8 Summary

Nurses have fought for recognition of professional status for several decades. The transfer of nurse education to the tertiary sector was considered by nursing leaders to be a step toward that goal. The preparation of nurses in tertiary institutions also takes them away from the workplace and there are differences of opinion about what can reasonably be expected of a new graduate nurse.

Researchers have studied and reported on the transition passage of the student nurse to new graduate status into the workplace. Many studies have reported the surprises that await the new graduate on commencement of work in the health care system. The enormous workload, the toll of shift work and the disparity between the delivery of optimal and realistic care have all been reported comprehensively.

Even though new graduate nurses have reached the standards of clinical competence prescribed by the Australian Nursing Council, many studies have reported that new graduate nurses desire to have a support network available to them when they first enter the workplace. One of the mechanisms designed and implemented to support new graduate nurses in the workplace are transition support programs. The support

most commonly available is structured study days and educational packages, and the allocation of a preceptor. The programs also provide hospital management the opportunity to recruit and develop future nursing staff.

Although a variety of programs have been implemented, there is currently little valid and reliable evidence to support them. The transition experiences of new graduate nurses from university to the workplace have not changed since the implementation of transition support programs.

Chapter 3
Methodology

3.1 Introduction

This research has been conducted to answer three questions relating to transition support programs for new registered nurses in New South Wales. These questions are:

1. What are the purposes for conducting new graduate transition support programs in clinical facilities for university educated graduate nurses?

2. What are the outcomes of new graduate transition support programs in preparing new graduate nurses for clinical practice?

3. What are the strengths and weaknesses of new graduate transition support programs in various hospitals in New South Wales?

This Chapter describes the research design and framework used to undertake the research. The sample selection and an overview of the methods of data collection and analysis will be described. The limitations of the research design and methodology will also be discussed.

3.2 Research Design

This is an evaluative study designed to gather data about established transition support programs for new graduate nurses working in hospitals in New South Wales. A combination of questionnaires, interviews and observation was chosen to capture both the broad range of responses required for quantitative research and the richness of data gained in qualitative research (Burns & Grove, 2001).

A model of Impact Evaluation was chosen to assess the effect that transition support programs had for both new graduate nurses and the employing hospitals. This model was selected as the most appropriate to answer the questions posed in this study for a number of reasons. For instance; the model fits with the research questions since it presumes some logical end-point analysis of the programs. Owen (1999) outlined the typical issues that concern Impact evaluation. These included:-

- *Has the program been implemented as planned?*
- *Have the stated goals of the program been achieved?*
- *Have the needs of those served by the program been met?*
- *What are the unintended outcomes?*
- *Does the implementation strategy lead to intended outcomes?*
- *How do differences in implementation affect program outcomes?*
- *What are the benefits of the program given the costs?*

(Owen 1999. p 265.)

This clearly shows that Impact evaluations are concerned with finding what aspects of a program work and the reasons for its effectiveness, with the outcomes also being a major consideration. In this study, an outcome is described as a benefit for the participant of the program or the hospital offering the program during or after their involvement in the program. Owen (1999) is of the opinion that Impact evaluation is the most practised form of evaluation and cites five ways to approach it. Two of these approaches were combined for use in this study, namely the objectives-based approach and the process-outcome approach.

Objectives-based evaluation was employed to make a judgement of the degree to which the stated goals of a program were achieved. The goals of the program to be evaluated were accepted and a judgement made regarding how well or completely the stated goals were met based on some standard or level of achievement. Owen (1999) stated that the translation of program goals into valid measures of outcomes can be a major methodological issue. This instrument allowed a judgement to be made that evaluated the stated goals of the transition support programs against the benchmark ANCI Competencies for the Registered Nurse (1993). This also allowed the collection of data concerning the 'real' objectives or goals of the program that may not have been advertised or planned.

Process-outcome studies are concerned with not only outcome determination but also the way in which the program was implemented in order to explain the relationship between process and outcomes. The questionnaires were developed to measure the outcomes of the programs while the interviews were conducted to confirm and clarify the findings. To determine the degree to which the implementation action was consistent with the intentions of the program plan, observations were conducted. Programs that are designed in one location or department are frequently altered at the implementation level for a variety of reasons, often related to local conditions and on the degree of support afforded to the developers of the program. A program evaluation would be lacking if it failed to consider the obstacles or local conditions that affect the implementation of the program at the grass roots level.

Impact evaluations are ideally undertaken on programs that are settled or established (Owen, 1999). The transition support programs have been implemented for more than a decade and although minor changes have occurred in response to managerial constraints and feedback from staff and participants, the structure has changed little and thus may be considered to be a settled program in many hospitals in New South Wales.

The questionnaire was modelled from one published by Owen (1999) who used it to evaluate a teacher education program. That study sought to determine the relative effectiveness of different courses in preparing teaching students for their first years as school teachers. The researcher considered the format of the questionnaire appropriate since the key issue underpinning both evaluations was to uncover the effectiveness of programs that related to the transition of a professional from the status of student to practitioner. The study by Owen (1999) used a set of guidelines that was akin to a policy statement about teacher education in Australia and I believed that these could be replaced with the domains of the ANCI National Competency Standards for the Registered Nurse to provide evaluative criteria that were accepted by the nursing bodies in Australia. Permission to adapt Owens' questionnaire was received by the author (see Appendix 2).

These competencies were developed in 1990 by the Australian Nurse Regulating Authorities Conference (ANRAC) now known as Australian Nursing Council Incorporated (ANCI) after wide consultation with the nursing profession. The competencies have become a benchmark for nursing practice in Australia. The structure of each question was given careful consideration to ensure a logical and ordered flow. Statements a, b and c in the questionnaire related to the first domain of *professional and ethical development*. It is within this domain that the competencies relating to legal and ethical responsibilities could be found. Statements d, e, f, g and h relate to the second domain of *critical thinking and analysis.* The competencies relating to self-appraisal, professional development and research appreciation are within this domain. Being able to reflect on practice, the feelings, beliefs and consequences of these for any given client are considered a yardstick for this domain. The third domain of *management of care* was covered by statements i, j, k, l and m. This domain contains the competencies that relate to the assessment, planning, implementation and evaluation of care for patients under the nurses' care. Statements n, o, p, q, r, s and t relate to the fourth domain of *enabling*. This domain contains the competencies essential for communication and the development of and sustaining the nurse-patient relationship. It also includes the competencies of being able to interact with allied health professionals and safety maintenance.

The research questions were developed to investigate the purposes, outcomes and strengths and weaknesses of transition support programs. In order to answer the research questions a collective approach to evaluation was used since it became necessary to evaluate whether the stated purposes of the transition support programs were the actual purposes. As a result, the summative approach adopted in the study, emphasises the outcomes of the program but also includes an appraisal of the way in which the program was implemented.

The degree and method of implementation was also considered a necessary part of evaluation since there were occasions when programs were not put into practice the way in which they were planned for a variety of reasons. Additionally, it was also considered an important aspect of the methodology that the timing of the evaluation

be commenced as far as possible after individual programs had been delivered in the targeted hospitals.

3.3 Research Plan

The plan for this project linked a number of information sources with a model of impact evaluation and was divided into three phases. Phase one comprised the information sources pertinent to the project which included relevant advertising documents published by the sample hospitals, the Australian Nursing Council Inc (ANCI) National Competency Standards for the Registered Nurse and published literature.

The documents included as a source of information were those published by the hospitals or area health services to give prospective new graduate nurses information about the hospital and the transition support program they offered. Typically the features of the program and the hospital are outlined along with the rotation schedule and study days allowed. The purpose or aim of the program is often stated in these documents. A summary of some of the characteristics of the study settings can be seen in Table 3.3.

The second source of information was the National Competency Standards for the Registered Nurse. Nurses in New South Wales are responsible, in part, for the provision of high quality care to the community and are regulated by the Nurses and Midwives Board, New South Wales. The Board has adopted the national standards developed by the Australian Nursing Council as the framework for professional nursing practice. The competency standards consider the multitude of roles and functions that nurses perform and recognise the attributes that a competent nurse must possess. The competencies that make up the ANCI National Competency Standards for the Registered Nurse are organised into four domains of nursing practice, *Professional and Ethical Practice, Critical Thinking and Analysis, Management of Care*, and *Enabling*. Since there is an expectation that all registered nurses demonstrate these core standards, they provide a useful benchmark for this study.

The way in which competencies from each domain were incorporated into the questionnaire used in this study is discussed in greater detail in Section 3.2.

Published literature was included as the third source of information supporting exploration of the study. Many nurses, in Australia and overseas, have written about the experiences of new graduate nurses as they make the transition from student to registered nurse. This is a rich source of data regarding the transition experiences of nurses and was used in this study by the researcher to gain a clearer understanding of the major issues involved as well as to aid the development of the study questionnaire.

When combined, these sources of information provided a description of the transition support programs available for new graduate nurses, the skills and outcomes common to transition support programs and the issues and problems associated with transition support programs currently offered. This information was vital in gaining an understanding of why it was considered necessary for new graduate nurses to complete a transition support program.

The second phase of the research plan represents the data collection phase. Questionnaires were given to new graduate nurses and experienced nurses to gain an understanding of their experiences working with transition support programs. Interviews and non participant observations were conducted after analysis of the questionnaires. Together the data provided information on the purposes, the outcomes, and the strengths and weaknesses of transition support programs.

The third phase represents the process of impact evaluation. This phase evaluates the purposes, outcomes, and strengths and weaknesses of transition support programs for the impact that they have on the new graduate nurses and their employing hospital. Figure 3.1 shows the research plan diagrammatically.

3.4 Ethical Considerations

This project was approved by the Human Research Ethics Committee at Australian Catholic University and each of the ethics committees representing the sample

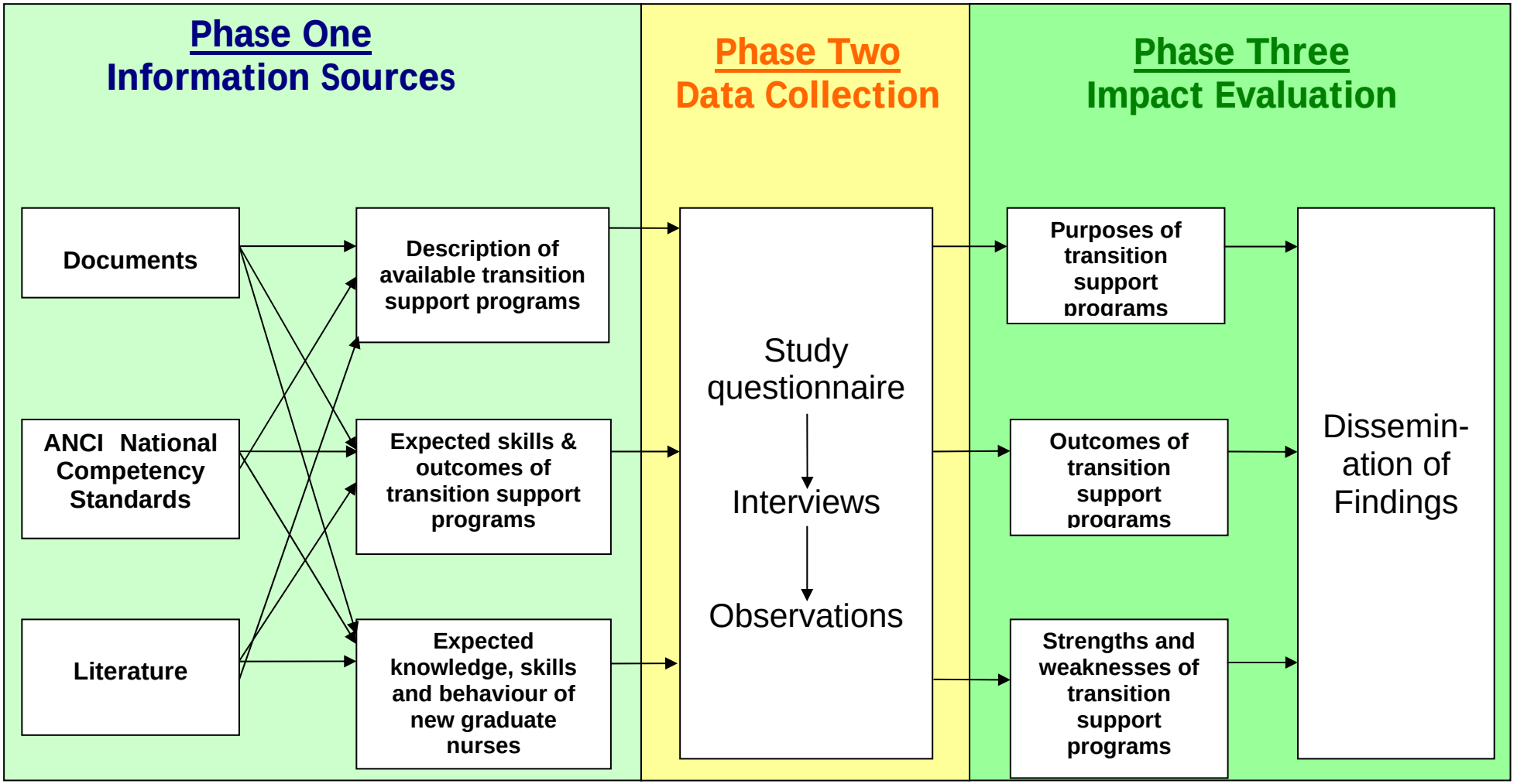
hospitals prior to commencement of contact with potential participants (see Appendix 11). Ethics committees are concerned with the protection of human rights. The major concerns in the conduct of research involving human participants are the rights to self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm (Burns & Grove 2001).

3.4.1 Research Procedure

All participants in this study were provided with an information letter outlining the purpose of the study, the procedures to be conducted within the scope of the study and advice regarding their rights as participants in the study. If the participant returned the questionnaire to the researcher, their consent was implied. Participants who elected to be interviewed were asked to sign a statement of informed consent after having read an information letter and had the opportunity to clarify any questions with the researcher prior to the commencement of the interviews. This process allowed the participants to continue only to a level where they felt comfortable (Burns & Grove, 2001).

The participants' right to anonymity and confidentiality was upheld during all stages of this study. Each participant who returned the questionnaire remained anonymous. The participants who elected to be interviewed chose a pseudonym at the beginning of the interview and this name was used for the purposes of presentation of findings. Each participant was aware that their verbatim responses may be included in the research report and subsequent publications, but their identity would be protected should that occur. All data and completed questionnaires are stored in a locked cabinet in the researcher’s office. Databases remain on disk with restricted computer access. After the required five year retaining period has elapsed the questionnaires and data printouts will be shredded. Disks and audio-tapes will also be destroyed after the time required.

Figure 3.1 The Research Plan



3.4.2 Difficulties in Gaining Ethical Approval

Gaining approval to commence the study proved to be quite time consuming and frustrating with a number of hurdles placed at each potential site. Originally the study was planned to be held solely in one area health service that was popular with graduate nurses applying for work in a transition support program. There are three ethics committees covering this area health service and the appropriate application forms were completed and presented before a scheduled meeting where the applications would be heard. Each Committee requested that the Director of Nursing of each hospital in the area should review the application and, if they considered the project to have sufficient merit, give written support for the Committees consideration. Consequently, each of the (six) Directors of Nursing was presented with a brief four page description of the project and asked to comment on the worth of the project so that their comments could be included with the next application to the Ethics Committee meeting. Of these Directors of Nursing, three gave written support for the study, two declined and one did not reply. The letters of support were subsequently included with the next application to the Ethics Committee meeting and approval was given.

Since the potential sample of transition support programs was half of the original estimate, the search began in other area health services for access to hospitals offering transition support programs for new graduate nurses. This time the Directors of Nursing were approached before the Ethics Committees in a bid to secure their support for the study to strengthen the case which would be presented to each Ethics Committee. The Directors of Nursing of ten hospitals representing three different area health services in New South Wales were presented with a letter of introduction and the four page description of the study. The Directors of Nursing from two major hospitals declined, saying that the registered nurses were ‘over researched’ already, one replied to advise that the hospital did not have any new graduate nurses that year, four said that they were interested but never sent the promised letter and three did write to support the study. Each Director of Nursing, or in some cases their secretary, was spoken to on the telephone in an effort to secure their support. Of the three letters received, two were presented to the appropriate Ethics Committees and approval was granted. The one letter that was omitted was from the Director of Nursing of a small hospital offering only a few transition support program positions each year. The large amount of time, cost and effort

involved in presenting the ethics application for such a small number of potential participants was not warranted.

Considerable time was taken preparing ethics applications and requests for approval to access nurses from various Directors of Nursing and Ethics Committees and then waiting for their replies. Table 3.1 shows the time taken for approval from different ethics committees.

Table 3.1 Time Taken to Gain Ethics Committee Approval

Hospital/Facility	Submitted	Approved	Time (days)
ACU	21/6/02	01/8/02	40
A	2/7/02	25/10/02	115
B & C	2/7/02	8/11/02	128
D	11/12/02	30/12/02	19
E	11/12/02	18/12/02	17
F	13/11/02	25/2/03	104
G	22/10/02	28/1/03	98

It should be explained that Hospitals D and E fell into a category where formal ethics approval had already been given which meant to gain access to these hospitals, approval was only required by each Director of Nursing.

3.5 Data Collection

Data were collected using four different methods including a collection of textual sources as well as data collected from the field using questionnaire, information gained from interviewing and observation.

3.5.1 Textual Sources

Each area health service and / or hospital provides a description of the transition support program that they offer new graduate nurses and these were used to provide an additional perspective to this study. Documents were collected for analysis in a number of ways. I asked personnel at the sample hospitals to post information to my home address, a visit to the website of the New South Wales New Graduate Nurse Consortium had information about all hospitals using this facility, and many of the new graduate co-ordinators that I

visited supplied me with documents relating to different components of the program they had on offer. Commonly the aims, objectives and purposes of the programs were stated along with any benefits that the hospitals felt that they may have over the other hospitals offering programs. It needs to be remembered that since these documents were used to advertise the programs and procure employment for the hospital, they were written in a positive way to sway the reader to favour that particular hospital over others.

3.5.2 Data from the Field

Data collected from the field included information gained from questionnaire, interviews and observations.

3.5.2.1 Transitional Support Program Evaluation Questionnaires

Because of the two different groups of registered nurses in the study, two variations of the same questionnaire were designed to suit the circumstances of the participants from each group. These differences did not produce any change in the purpose or response sought from the participants. Appendix 6 shows the questionnaire used for the new graduate nurses and Appendix 7 shows the questionnaire used for the experienced nurses. Both questionnaires are divided into three sections: demographic data, a closed scaled response section and a section for written responses.

The questionnaire sought demographic details from participants and information relating to their education, employment and the transition support program offered at their employing hospital. The relationship between demographic variables and other responses was explored. The demographic details obtained in this section have particular significance in this study because of the low response rate. Roberts and Taylor (2002) state that the more a sample is demographically like the population, the more likely the responses are to be typical of the population than if it is unlike the population.

The second section of the questionnaire was a closed scaled response section that asked participants to consider a number of aspects of nursing based on the ANCI National Competency Standards for the Registered Nurse. They were then asked to compare the emphasis each aspect was given during their transition support program with the importance they placed on each aspect during their current practice. The following scale was used to record their responses.

4 High emphasis or very important
3 Moderate emphasis or importance
2 Little emphasis or slightly important
1 No emphasis or not important

The data collected represents the registered nurses' perception of the impact of the transition support program on current clinical practice in the study hospitals in New South Wales.

The final section of the study questionnaire sought a written response from the participants that provided them with the opportunity to answer each question using their own words without any hint or clue given by the researcher. Roberts and Taylor (2002) consider that the words that people choose to express themselves can be very useful to the researcher. A person's choice of word can illustrate the passion felt by the person when discussing a particular topic.

Construction and validation of questionnaire

A questionnaire modified from one used by Owen (1999) was developed to identify the strengths and weaknesses of the research design. The reliability and validity of the questionnaire was then tested before conducting the major study.

The first question on the pilot questionnaire asked the participants to indicate the hospital where they undertook their transition support program. The pilot study was conducted in one hospital and it was envisaged that the major study would include the other hospitals listed on the questionnaire. This did not eventuate due to difficulties gaining ethics approval and the questionnaire used in the major study was altered to exclude the question related to hospital of employment. The remaining questions on the questionnaire were formatted in one of two ways. The first comprised questions that required a short written response by the participant and gave them the opportunity to write a response without receiving any cue from the researcher. The second was a section where the participants were asked to consider a number of aspects of nursing based on the ANCI National Competency Standards for the Registered Nurse. This section of the questionnaire asked each participant to compare the emphasis that a particular aspect of nursing was given during the transition support program with the

importance they placed on that aspect during their current practice. Appendix 3 shows the original questionnaire used in the pilot study.

The setting chosen to test the questionnaire closely resembled the facilities that would be used for continuing data collection. Roberts and Taylor (2002) stated that wherever possible a pilot study should be carried out in the actual setting in which the major study is to be conducted. Consequently, the setting later became one of the hospitals used in the major study. Contamination was avoided since the respondents were drawn from a different cohort of nurses. Approval to conduct the study was sought and gained from the Ethics Committee prior to commencement.

The questionnaire was tested using two groups of registered nurses. The first group was new graduate nurses who had completed a transition support program within the past 12 months. The second group was experienced registered nurses who held positions of nurse unit manager, nurse educator or new graduate co-ordinator in a clinical setting where new graduates regularly work as part of their transition support program. By choosing both new graduate and experienced nurses information was obtained that represented the perspective of both participants and management. The importance of obtaining input from both experienced and new graduate nurses was to ensure a balanced outcome of the testing procedure.

New graduate nurses were identified by the New Graduate Coordinator and sent an information letter, a questionnaire and a stamped envelope for return. The information letter (see Appendix 1) explained the purpose of the study and instructions about how to participate in the research if they so chose. There were no identifying marks on the papers ensuring that the new graduate nurses who returned the questionnaire would remain anonymous. Of the group of 30 new graduate nurses, 10 returned the questionnaire.

Experienced nurses who regularly worked with new graduate nurses during the transition support program were also identified by the New Graduate Coordinator. Access to these nurses was only possible via the New Graduate Coordinator as required by the Ethics Committee. A combination of nurse unit managers and nurse educators made up the ten participants at this facility. These nurses were approached by the researcher and asked to

participate in a semi structured, audio-taped interview. The ten experienced nurses, three males and seven females, who were identified were approached and agreed to be interviewed.

The responses of the questionnaires and interviews were analysed to determine whether changes needed to be made to the instruments. As a result of the analysis it was decided that several modifications were required. For example; By restricting the questionnaire to new graduate nurses only it became evident that only part of the 'story' was being heard. It was decided to widen the use of the questionnaire to include experienced nurses in order to gain data from a number of different sources and strengthen the evidence for the study. Input from the experienced nurses would add the perspective of those working with the new graduate nurses during the program and also give an indication of nursing managements' view of the transition support programs for new graduate nurses. Demographic questions were included to determine the degree to which the total nursing population would be represented by the sample and the format of the questionnaire was changed to appear less daunting and more enticing to potential participants. Appendix 6 shows the information letter and the questionnaire used for the new graduate nurses in the major study.

Interviews with experienced nurses were used in the pilot study to give me practise at interviewing and to test the interview schedule. These interview audio-tapes and transcripts were reviewed by a colleague to assist my learning and improve interviewing technique. Several minor changes and suggestions were made to the interview schedule and process and as with the use of the questionnaire it was thought that the quality of the data would be enhanced if the interviews included new graduate nurses. Following the suggested changes to the interview process subsequent interview transcripts were reviewed and interview technique was monitored for accuracy in the transcripts.

The option to include observations was also considered by the researcher at this time. It was thought that direct observation would allow the collection of data that could either support or refute the data collected from questionnaire and interview. Observation would also allow direct access to the program and provide the opportunity to witness the program in action, rather than relying entirely on participants' accounts.

Reliability of the questionnaire

The reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring. The internal consistency of the questionnaire was measured using the Cronbach's alpha test. The analysis was conducted using the Statistical Program for Social Sciences (SPSS) computer package. The internal consistency approach to establishing an instrument's reliability was chosen because it required only one test administration. The internal reliability of both *emphasis* and *importance* scales were determined. Emphasis scale showed alpha = 0.8993, while the importance scale showed alpha = 0.7630. The normal range of values is between 0.0 and +1.00 with the higher values reflecting a higher degree of internal consistency.

Validity of the questionnaire

In this study, instrument validity described the appropriateness of the questionnaire to gather data on the perceptions of new graduate and experienced nurses related to the competencies acquired as a result of participation in a transition support program. Various approaches were used to ensure validity and a description follows.

The literature and transition support programs were studied to determine the factors that were significant for the new graduate nurse to make the transition from student to professional practice. A number of New Graduate Coordinators from different health care services were consulted in the formulation of the instrument. The instrument incorporated the ANCI National Competency Standards for the Registered Nurse that is widely accepted in the nursing profession as the benchmark for practice. These measures were undertaken to ensure face validity. In order to obtain content and construct validity, the questionnaire was sent to six registered nurses considered experts in the field. These nurses were two professors, two nurse unit managers where new graduates regularly worked and two nurse educators, one from an academic institution and one from the clinical workplace with regular contact with new graduates. They were asked to make comment on the questionnaire in relation to the clarity and appropriateness of the statements, the degree to which it reflected the constructs, and the scope of information likely to be obtained and suggestions for any improvement in the questionnaire (Appendix 5). The responses received were considered and incorporated into the questionnaire as appropriate and content validity of the instrument was based on this judgement.

3.5.2.2 Interviews

Each questionnaire package provided the participant with the opportunity to volunteer for an interview with the researcher. The purpose of conducting interviews was to gain descriptions of the participants' experiences and to clarify any issue raised either in the questionnaire or the literature. A face-to-face semi-structured interview was chosen to provide a rich source of contextual data (LoBiondo-Wood & Haber, 2002). This structure provided myself and the participant with the opportunity to have a conversation within a loosely constructed framework. It is this interactive process that may elicit a response or comment not likely with a written response (Minichiello, Aroni, Timewell & Alexander, 1995). The information letter, consent form and interview schedule used in this study can be viewed in Appendix 9.

3.5.2.3 Observations

Data analysis of the open-ended questions and interviews revealed a need to undertake observation of specific components of the transition support program. Non-structured non-participant observations were chosen in order to keep an open mind and focus on what was actually happening without actual involvement in the setting as a participant.

Observations were made of new graduate nurses involved in their day to day work during the transition support program on four separate occasions over a two week period. Permission from the study hospitals to undertake observation was met with suspicion and resulted in only one site agreeing to allow access. The access was conditional upon being accompanied by the after hours co-ordinator during her visiting rounds of new graduate nurses. This allowed observations to be conducted in general medical and surgical wards, intensive care unit and emergency department.

Attention was given to the where, when, how and why of the situation so that descriptive and comprehensive field notes could be written as soon as possible after the interaction. This included leaving the setting for short periods in an effort to write notes and remain as unobtrusive as possible. The questions that were used as a guide for writing field notes can be seen in Appendix 10. The way the data were collected is shown along with the relationship to the research in Table 3.2.

Table 3.2 Relationship Between the Research Questions and the Data Collection Method

Research Question	Textual Sources	Questionnaires		Interviews	Observations
		Closed Responses	Open ended Questions		
1.	X		X	X	
2.		X	X	X	
3.			X	X	X

3.6 Study Settings

The study was carried out in seven hospitals in area health services across and surrounding Sydney, representing both small and large facilities with bed numbers ranging from 195 to 530. These hospitals were selected, in part, because ethics approval was given at these hospitals within an acceptable timeframe. Gaining ethics approval for access to hospitals proved to be difficult and has been discussed in Section 3.4.2.

Together, the seven hospitals covered the major clinical specialty areas with both public and private hospitals represented. The transition support programs offered to new graduate nurses at these hospitals were considered typical of those offered at other hospitals and included generalist programs as well as specialist strands. Table 3.3 shows some characteristics of each setting used in their advertising material for transition support programs.

Table 3.3 Characteristics of Study Settings

Hospital	Number of Beds	Public / Private	Clinical Areas
A	455	Public	Acute medical and surgical, critical care, mental health, aged care, perioperative, rehabilitation and palliative care.
B	530	Public	Emergency, intensive care, coronary care, operating theatres / recovery, high dependency, general medical and surgical, paediatrics, orthopaedics, psychiatry, respiratory, HIV/AIDS, geriatric assessment and rehabilitation, maternity, day surgery, gastroenterology, neurosurgery/neurology, oncology, haematology, cancer care centre, cardiology, cardiothoracic, renal dialysis, community health services.
C	255	Public	Coronary care, emergency, high dependency unit, intensive care, medical neurology, mental health, oncology, respiratory, operating theatres, orthopaedic surgery, paediatrics, day surgery, rehabilitation, vascular and urology surgery.
D	195	Private	General medical and surgical, orthopaedics, intensive care unit, day surgery, operating theatres, renal unit, cancer care, maternity
E	230	Private	General medical and surgical, cardiac, plastic, orthopaedics, urology, neurology, opthalmology, gynaecology, vascular, thoracic, oncology, bone marrow transplantation, intensive care, operating theatres.
F	457	Public	Emergency, intensive care, cardiac services, geriatric services, operating theatres / anaesthetics / recovery, general medicine and surgery, orthopaedics, psychiatry, maternity, paediatrics, rehabilitation, sexual health and community health services.
G	329	Private	Cardiac surgery and medical, respiratory & vascular, orthopaedics & neurology, oncology & palliative care, day surgery, intensive & coronary care, GIT & general surgery, urology & gynaecology, plastic & reconstructive surgery, opthalmology & ENT, operating theatres / anaesthetics / recovery, renal dialysis.

3.7 Transition Support Programs

Student nurses in their final year of university are given information regarding transition support programs offered by various area health services and hospitals for the following year. Entry into the programs can be attained in a number of ways. Some places were awarded as a result of the new graduate nurses' performance at the New South Wales New Graduate Nurse Consortium interview, some required an application and interview and others used a direct entry approach. Each program has been designed to meet the needs of the hospital offering the program by attracting new graduate nurses for employment. Table 3.4 highlights some of the similarities and differences between the programs offered at the sample hospitals.

Table 3.4 Characteristics of Study Transition Support Programs

	Hospital						
	A	B	C	D	E	F	G
Length of program (months)	12	12	12	12	12	12	12
No. of rotations in program	3	3	3	7	2 or 3	5	3
Specialist strand	CT, PC, renal, MH, OR	MH, OR, Orth	MH	N/A	N/A	CC, MH	N/A
Support available	Prec, CNE	Prec, CNC, CNE	RN, Prec, CNE	Prec.	Prec, CNS	Prec, CNE	Prec, CNE
Supernumerary days	3 Orient 1 Sup	5 Orient 2 Sup 3 St	5 Orient 3 St	5 St	3 Orient 1 Sup	5 Orient 2 St	4 Orient 4 St
Certificate awarded upon completion	Yes	Yes	Yes	Yes	No	No	Yes
Clinical preferences considered	1-2 negotiable	No	negotiable	No	negotiable	No	Choice of final rotation

Key:

Specialist Strand
CT = cardiothoracic
PC = palliative care
MH = mental health
OR = perioperative
Orth = orthopaedics
CC = critical care

Support Available
CNC = Clinical nurse consultant
CNS = Clinical nurse specialist
CNE = Clinical nurse educator
Prec = Preceptor
RN = registered nurse

Supernumerary Days
Orient = orientation
St = study
Sup = working supernumerary

3.8. Participant Identification Process

Prior to the commencement of participant recruitment, ethics approval was gained through the Human Research Ethics Committee of the Australian Catholic University and the health care agency where the registered nurse was employed.

All participants were registered nurses in New South Wales who worked in a number of area health services and settings in and around Sydney. The participants can be further divided into two groups of registered nurses. The first were new graduate nurses who completed a transition support program within the past 12 months. This corresponded with programs offered during the 2001/2002 time-frame. The second group comprised experienced registered nurses who worked with new graduate nurses during their transition support program. Even though the nurses in the second group commonly held

the position of Nurse Unit Manager, Ward Educator or preceptor on the ward, this was not a selection criterion so that the participant may have been a registered nurse on a ward working rotating rosters where new graduate nurses worked.

This particular mix of potential participants was chosen to provide a full and balanced picture of transition support programs. These participants had particular insight and experiences that when combined gave information from the perspective of both new graduate and experienced nurses.

Potential study participants were identified during consultation with the New Graduate Coordinator, or person holding a similar position, in each health care agency. Each nurse identified was sent a letter of introduction and either the Transitional Support Program Evaluation questionnaire for new graduate nurses (see Appendix 6) or the Transitional Support Program Evaluation questionnaire for experienced nurses (see Appendix 7), depending on which was appropriate, and a stamped return addressed envelope. Each nurse was also sent a follow-up reminder note two weeks after the initial contact. A copy of the follow-up letter can be found in Appendix 8.

Along with the questionnaire, each registered nurse was invited to participate in an individual audio-taped interview. If the participant chose to volunteer, they completed the form enclosed with the questionnaire and returned it to the researcher. The observation sessions were carried out in areas where consent was given by the nurses participating. Figure 3.2 on the following page shows the data collection and analysis process.

3.9 Participant Characteristics

Particular characteristics of the participants were sought to assist in describing the sample and to help to determine the representativeness of the sample. Participants were asked to state their age, gender and language spoken at home as well as comment on their nursing experience.

3.9.1 Gender

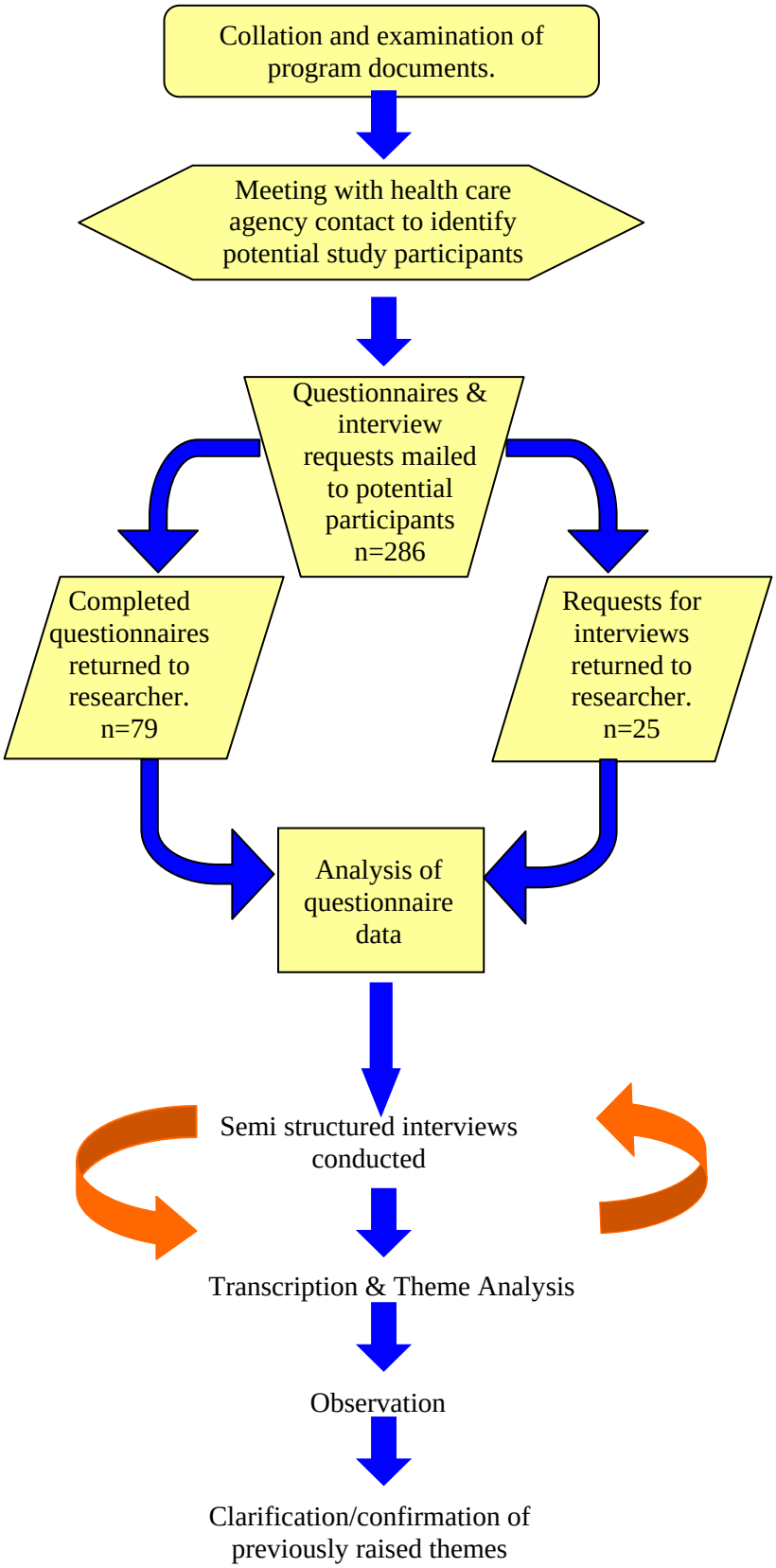
One hundred percent of the new graduate nurses and 96% of the experienced nurses identified their gender on the questionnaire. Eighty nine percent of the respondents were female and 9% male. Two percent chose not to identify their gender. See Table 3.5.

Table 3.5 Gender of Study Participants (n=79)

	New Graduate Nurses %	Experienced Nurses %	Total %
Female	94	86	89
Male	6	10	9
Missing	0	4	2

The percentage of male participants was slightly lower than the total male applicants for that year. There were 14% of male applicants for the 2001 recruitment year through the New South Wales Recruitment Consortium (White, 2002). The gender of the total nurse population working in New South Wales continues to have a high female proportion at 91.7% (Statewide Services Development Branch, 2000).

Figure 3.2 Process of Data Collection and Analysis



3.9.2 Age Group

All of the new graduate nurses and 96% of the experienced nurses provided their age group. The majority of the new graduate nurses, 64%, represented the age groups up to 28years, while 86% of the experienced nurses represented those over 28 years of age. Refer to Tables 3.6 and 3.7.

Table 3.6 Age Groups of New Graduate Nurses (n=31)

	New Graduate Nurses %
21 or under	35
22-28 years	29
29-35 years	10
Over 36 years	26

Table 3.7 Age Groups of Experienced Nurses (n=48)

	Experienced Nurses %
22-28 years	10
29-35 years	31
36-41 years	27
Over 42	29
Missing	4

3.9.3 Language Spoken at Home

English was the language spoken at home by 94% of all respondents. Two percent of the respondents revealed a language other than English and 4% chose not to reveal this information. See Table 3.8.

Table 3.8 Language Spoken at Home by Study Participants (n=79)

	New Graduate Nurses %	Experienced Nurses %	Total %
English	94	96	95
Other	6	0	2.5
Missing	0	4	2.5

Sixteen percent of all new graduate nurses making application for a position through the New South Wales Recruitment Consortium in 2001 stated that they spoke a second language (White 2002), while 15% of the total nurse population working in New South

Wales were born in a country where English is not the native language (Statewide Services Development Branch, 2000).

3.9.4 Nursing Experience Prior to Graduation

Fifty five percent of the new graduate nurses indicated that they worked as assistants in nursing prior to graduation as a registered nurse. A further 6% stated that they were enrolled nurses and 19% indicated that they had other experiences prior to graduation. Nineteen percent of the new graduate nurses did not answer this question. Refer to the following table.

Table 3.9 Nursing Experience of New Graduate Nurses prior to Graduation (n=31)

Nursing Experience	Percent of Sample
Assistant in nursing	55
Enrolled nurse	6
Other	19
Question unanswered	19

The experiences of the new graduate nurses prior to graduation in this study are consistent with all new graduate nurses making application for a position through the New South Wales Recruitment Consortium in 2001. Sixty three percent of those applicants indicated that they had previous nursing experience as an assistant in nursing and 12% as an enrolled nurse (White, 2002).

3.9.5 Years of Nursing Experience since Graduation

Table 3.10 shows the number of years of nursing experience stated by the experienced nurses since graduation. The most frequently selected time frame was between 7 and 12 years of experience with 37% of the experienced nursing selecting this category. The time frames of 13 to 19 years and over 20 years experience were fairly evenly selected with 22 and 29% respectively. Only 6% stated that they had between 1 and 6 years of nursing experience since graduation.

Table 3.10 Years of Nursing Experience since Graduation (n=48)

Nursing Experience (yrs)	Percent of Sample
1-6	6
7-12	37
13-19	22
Over 20	29
Missing	6

3.10 Data Analysis

Before commencing analysis of the data, time was taken to reflect on the original reasons for conducting the research. Roberts and Taylor (2002) believe that this technique refreshes the commitment of the researcher to the project as well as revisiting the stated aims of the research project. Having accepted this suggestion, a clear understanding of what information needed to emerge from the cumulated data from textual sources, questionnaires, interviews and observations was obtained. The way that the data was analysed is shown along with the relationship to the research questions in Table 3.11.

Table 3.11 Relationship Between the Research Questions and the Data Analysis Methods

Research Question	Statistical Analysis	Content Analysis	Theme Extraction	Clarification and verification of themes
1.	X	X	X	
2.	X		X	
3.		X	X	X

3.10.1 Textual Sources

As previously described, documents produced by hospitals to describe and advertise the transition support program offered at their institution were collected as an additional source of qualitative data. The following steps were taken in the process of content analysis of the documents. Coding of the data set began by marking significant words or passages as examples of common representations. After the codes were allocated throughout each of the documents, the data coded to each category were collected together. Since the documents were collected from the sample settings only it could not be claimed that saturation or completeness of codes of all transition support programs

occurred in this study. There was, however, a central core of meaning established and these became the major themes and are discussed in the following chapter.

3.10.2 Study Questionnaire

As previously mentioned the questionnaire was divided into three sections: demographic data, a closed scaled response section and the final section seeking a written response.

Demographic section

Demographic details were sought from participants to describe the characteristics of the group. Descriptive statistics were used to show the frequency of gender, age group and nursing experience of the participants. The demographic variables were used to explore possible relationships in the study and to determine how closely the sample reflected the total group of nurses in New South Wales.

Closed scaled response section

The closed scaled response section required participants to consider a number of aspects of nursing based on the ANCI National Competency Standards for the Registered Nurse. They were asked to compare the 'emphasis' each aspect was given during their transition support program with the 'importance' they now place on each aspect during their current practice.

Frequency distributions were used to organise the data for analysis. Percent distributions were chosen to indicate the percentage of participants that selected each category of emphasis or importance as well as the number of responses allocated to each category. The use of the percentage distribution was particularly useful in this study because it allowed the responses to be compared even though the number of participants in the new graduate and experienced nurses groups differed.

A student t-test was used at the 95% confidence level to compare the means between the two categories of emphasis and importance. This test helped to identify the probability that the gap between the perception of importance and emphasis was not due to a sampling or any other random error. The t-test was useful in this study since it is a robust

test that can be used when participant numbers are small (Burns & Grove 2001, Gillis & Jackson 2002).

Qualitative open ended question section

This section of the questionnaire called for the participants to answer questions using their own words. The answers to each question were transcribed verbatim. The process of theme extraction was selected to analyse the interview data. Roberts and Taylor (2002) describe thematic analysis as a "method of identifying themes, essences or patterns within a text" (p. 426). Text transcripts were read several times before considering what the key elements were the person was trying to communicate. Roberts & Taylor (2002) warn the researcher to be alert for implicit themes as well as explicit ones. This knowledge helped me to consider not just a specific word, but rather to extend the search for a story, a hint or a clue that described the original word. For example; in the present study about transition support programs the participants mentioned the word 'support' frequently. In keeping with Roberts and Taylor's (2002) advice, other words such as 'friendly', 'helpful', 'kind' or similar were considered an extension of the word support. When statements were found in the text the passage was highlighted. There are several ways to manually analyse qualitative data and the method adopted was one described by Roberts and Taylor (2002) as the 'pile on the kitchen table' method (p. 430). This method calls for the researcher to cut out any section of text that has a connection with a theme and arrange them in piles. When there are several piles the researcher tries to reduce them into fewer groups while keeping the meaning intact. When the piles of text represent a group that cannot be subsumed into any of the other categories a word should be found that captures the key idea in each pile. These separate piles of text become the themes. Examples from the verbatim transcripts were selected to support the identified themes.

3.10.3 Interviews

The audio-tapes of the interviews were also transcribed verbatim as soon as possible after they took place. While the data collection occurred during the actual interview, analytical notes were written immediately following the interview while the meeting with the participant remained fresh. In this manner, the subtleties of the interaction were recaptured as well as some of the dialogue that was invariably distorted or a little muffled

in the recording. During transcription note was also taken of the tone of voice and emphasis that different words were given by participants since this sometimes revealed more than the actual words used in the interview.

Once again theme extraction was used to analyse the data using the 'pile on the kitchen table' method. As with the written section of the questionnaire, snippets of interviews were chosen to illustrate and support the themes.

The interviews were conducted over a period of time. During this time transcripts were read and re-read and initial themes identified which were then discussed with a colleague for the purposes of member checking. Transcripts were read a number of times and the themes further developed and refined until agreement was met between the researcher and the colleague. This process provided time for a greater involvement with the data and allowed the incorporation of new questions into subsequent interviews.

3.10.4 Observations

Cormack (1996) stated that the analysis of material collected during observation was dependent upon the quality of the data collected. For this reason field notes were written as descriptively as possible. Additionally, conversations between participants were written as close to verbatim as possible and non-verbal behaviour was also analysed. The questions listed in Appendix 10 were used to assist with the interpretation of the observation and the development of the writing.

Any thoughts or comments made during observation were also written and included as part of the data collection/analysis cycle. All data was subsequently scrutinised and used either as straightforward data that was reported on in this thesis or used to aid an understanding of points raised during interviews.

3.11 Scientific Rigour

Rigour is associated with the worth of the research outcomes, and studies are critiqued as a means of judging rigour (Burns & Grove, 2001. p64). Since this study used a mixed

methods approach the criteria used for evaluating rigour needs to be defined differently since the desired outcome is different.

In quantitative research rigour is reflected in narrowness, conciseness, and objectivity (Lincoln & Guba, 1985; Burns & Grove, 2001). It is the reliability of the instrument that is the major criterion for assessing the quality of the data (Polit & Hungler, 1995). The reliability and validity of the instrument used in this study has been discussed under Section 3.5.2.1.

The issue of rigour, however, in qualitative research is more controversial. Different authors outline alternative measures to assess the rigour of qualitative research (Guba, 1981; Burns & Grove, 2001; Roberts & Taylor, 2002; Gillis & Jackson, 2002). Gillis and Jackson (p.215) outline the categories of "credibility (authenticity), transferability (fittingness), dependability (auditability) and confirmability" as appropriate measures of the rigour of qualitative research. Each of these categories will be discussed as they relate to this study.

3.11.1 Credibility

Several steps were taken to ensure the credibility of the data and conclusions. The first was method triangulation that involved the collection of different forms of data from the same subjects. By using a variety of data collection methods it allowed data to be integrated from these various sources. Cormack (1996 p.336) stated that if the same sort of results are gained using two or more techniques then the conclusions that can be drawn are all the stronger. Combined method in this study involved the use of questionnaires using closed scale and open ended questions, interviews and observations.

Data were collected from participants working in different settings, experiencing different transition support programs, describing their own program and providing examples of the purposes and outcomes of the programs. This use of multiple data sources improves the likelihood that qualitative findings will be found credible.

Credibility was also established by the practice of debriefing with peers as suggested by Lincoln and Guba (1985). Debriefing with a research colleague and nurse who had credibility in the field, or member checking, as stated by Lincoln and Guba (1985), was

performed informally during data collection and more formally after data collection and analysis as a means of providing an external check on the inquiry process. After data collection, themes were identified according to the procedure described in Section 3.10.2. The research colleague and myself discussed and debated the process of theme extraction throughout the analysis of the interviews. The research colleague constantly challenged me to justify the themes that were proposed. During this time the data were condensed from multiple code words, major and minor themes until consensus was reached regarding the final themes.

3.11.2 Transferability

The purpose of this study is not to generalise but to describe the purposes and outcomes of the programs, therefore transferability is not an expected finding.

According to different authors, transferability is concerned with the generalisability or fittingness of study findings to other settings, populations and contexts (Gillis & Jackson, 2002 p. 216). Guba (1981) stated that because social / behavioural phenomena are context bound it is not possible to develop 'truth' statements that have general applicability, rather, one should collect rich descriptive data that will permit comparison of the study context to other possible contexts. Transferability can be assured because this study has been conducted with participants from seven different settings and the findings are a composite of the programs offered at those settings, rather than findings from one specific program. Characteristics of the participants have been presented along with characteristics of the whole cohort of new graduate nurses (in 2001) and the profile of the nursing workforce in New South Wales so that a conclusion about transferability can be made. The settings and processes have been adequately described to allow replication of the study (see Sections 3.5 to 3.10) to enable comparison with other settings or replication of the study by other researchers.

3.11.3 Dependability

Dependability may be judged by the adequacy of information leading the reader from the research questions and raw data through the steps of analysis to the interpretation of findings. Lincoln and Guba (1985) describe the process of enabling someone else logically to follow the process and procedures that the researcher used in the study as an audit trail. In this study it would be possible for an external auditor to examine the

processes of data collection, analysis, including member checking, and interpretation following the steps described.

Triangulation, using questionnaires, interview and observation for data collection was performed to further enhance the dependability of this study. This involved the collection of data from a variety of sources and methods to test and re-test the researcher's assumptions.

3.11.4 Confirmability

Confirmability assures that the findings, conclusions, and recommendations are supported by the data and that there is agreement between the researcher's interpretations and the actual evidence. Confirmability has been established by the use of multiple research methods, consistent sampling procedures from multiple settings, and an audit trail that described each process carried out.

3.12 Limitations of the Research Method

The issue of selecting a sample that represented the whole population under study became a major challenge. Several approaches were considered to provide a system of selection that ensured that the researcher and factors extraneous to the research, had no influence whatsoever on the selection process. This was to ensure a fair representation of the transition support programs currently offered to new graduate nurses in New South Wales.

The first approach was an ambitious one and proposed covering the whole State using cluster sampling. This proposal was abandoned after consideration was given to the time required to contact and obtain approval from the many different ethics committees involved. The second approach considered was to use one area health service in New South Wales as the setting for the study. The area health service chosen was the one most popular and sought after by recently graduated nurses and represented a number of different hospitals and specialist strands. This approach failed when ethics approval was refused from a number of the hospitals within that area health service. The representatives from the Committees felt that the registered nurses employed at their hospitals were being asked to participate in too many research projects at that time and

did not want to burden them with another. Consideration was also given to using the Nurses Registration Board to distribute questionnaires to all recently graduated nurses. Since this approach did not allow for any contact with experienced nurses it was also abandoned.

As demonstrated, even though the selection process was given much thought, it still proved to be difficult and a number of weaknesses resulted in the design of the study that was finally decided upon. The first related to the size of the sample. Burns and Grove (2001) describe power as the 'capacity of the study to detect differences or relationships that actually exist in the population' (p. 377). This study had two key groups of respondents, that is, 31 in one group, 48 in the other. Since the sample size is directly related to the power of the study, the quantitative findings in this study are not generalisable to the wider population.

Two hundred and eighty six questionnaires were distributed to registered nurses employed at eight hospitals in three different area health services in New South Wales. Of these, 183 were sent to new graduate nurses and 103 to experienced nurses. Thirty one new graduate and 48 experienced nurses returned the questionnaire, providing a 16% and 46% response rate respectively. Polit & Hungler (1995) in their work have advised the researcher to check for selection bias by comparing the background characteristics of the groups to determine whether the sample can be likened to the total population. The background characteristics of nurses in this study were checked and found to be comparable with the total population of nurses in New South Wales (see Section 3.9), however, because the study's selection criteria dictated that all new graduate nurses had experienced being a participant in a transition support program and all experienced nurses were closely involved with working with nurses undertaking a transition support program it is reasonable to assume that the participants in this study did have strong feelings about transition support programs, whether they were positive or negative.

Observations were included in an attempt to validate the findings from questionnaire and interview. However, observation as a method is not without difficulties. Maintaining acceptance as a researcher in the clinical setting despite appropriate uniform was always a risk because one could never be sure how conspicuous I was to others and risk

disrupting the usual features of the ward setting. Clinical observation also demanded considerable time in gaining consent and access to the clinical area.

3.13 Advantages of the Research Method

One advantage of using the questionnaire was that it was easy to administer. Since transition support programs are commonly offered throughout all area health services in New South Wales, nurses were selected to represent as many different health services as possible. Because the questionnaires were mailed, the participants could attend to them at a convenient time and place and the anonymity of the questionnaire meant that the respondents were more likely to answer truthfully (Roberts & Taylor, 2002).

The interviews allowed for any matter that appeared vague or unclear after analysis of the questionnaire data to be pursued and clarified. Interviewing is a more flexible technique that allowed me to explore a greater depth of meaning and the study participant's unanticipated responses to the questionnaire.

An advantage of conducting observations was that it allowed me to experience parts of the program at first hand rather than relying on other people's interpretation of the event. Often, small details can be noticed by an observer that may be considered unimportant by someone else relaying the incident, which therefore may be missed by the researcher.

3.14 Summary

In this Chapter, the study method has been described, outlining the process by which the research was conducted. The first phase involved the collection of data from a number of sources who each described the transition support programs available for new graduate nurses. The second phase involved the use of questionnaire, interview and observation to gain data regarding purpose, outcomes and strengths and weaknesses of transition support programs. Data were analysed using descriptive statistics and theme extraction. The findings are presented in the following chapters.

Chapter 4

Findings from Textual Sources

4.1 Introduction

Data were collected from a variety of textual sources and were included in this study for a number of reasons. The first is that the information is a primary source of data since it was prepared and provided by the sample hospitals. The material relating to the aims and objectives of the transition support programs offered by each hospital provides a benchmark from which to gauge the extent that the intended purposes and outcomes resemble the actual purposes and outcomes in this study. Table 4.1 shows the four commonly stated aims of transition support programs derived from the textual sources. The documents were also included to gain a deeper understanding of the transition support programs offered by the sample hospitals and to strengthen the study. It is argued that the use of multiple sources of data improve the reliability and validity of the data and findings.

Table 4.1 Aims of Transition Support Programs derived from the Textual Sources

Provision of a supportive environment to assist new graduate nurses in their transition to the role of the registered nurse.
Allows hospitals to contribute and invest in the nursing profession and care of patients.
Opportunity for new graduate nurses to further develop the ability to analyse and evaluate planning, organisation and delivery of nursing care.
Assists new graduate nurses to integrate and consolidate practical application of theoretical knowledge.

The textual sources used in this study included the pamphlets used to announce and advertise the programs, information from the New South Wales New Graduate Consortium website and other written materials relating to the transition support programs produced by the sample hospitals. These were collected using the process described in the previous chapter in Section 3.5.1 and subjected to content analysis to determine the themes deemed to be important for the new graduate nurse undertaking

such a program. The process of content analysis used in this study has also been described in the previous chapter in Section 3.10.1.

Analysis of the textual sources revealed no indication of the way in which the programs were implemented nor the expected outcomes. The major process for implementation related to a variety of clinical rotations throughout the year and the provision of study days, learning packages and preceptorship. These processes were identified in the textual sources as the strengths of the programs according to individual hospitals.

Three major themes emerged and are presented in Table 4.2 below. Each theme will be discussed and examples or passages from the relevant documents presented to better describe the theme. Even though the documents used in this section are freely available to the public, the hospitals will be referred to as Hospital A to Hospital G in keeping with confidentiality agreements with various Ethics Committees.

Table 4.2 Themes Derived from Textual Data Sources.

Theme 1	New graduate nurses need practise in a supportive clinical environment to learn how to become registered nurses.
Theme 2	Hospitals provide the real environment for new graduate nurses to learn how to perform as a registered nurse.
Theme 3	Hospitals demand that new graduate nurses not be employed as registered nurses without having first completed a transition support program.

4.2 New Graduate Nurses need Practise in a Supportive Clinical Environment to Learn how to Become Registered Nurses.

The belief that new graduate nurses needed to learn how to be a registered nurse was evident in all sample hospital documents. While there was some recognition that new graduate nurses held some theoretical knowledge, it was markedly obvious that there was little confidence in the experiences that the new graduate nurses had gained during their tertiary qualification and their ability to apply this knowledge to practice. The hospitals seemed to believe that it was up to them to help the new graduates to learn how to become a registered nurse. The following passage shows one of the expected outcomes of one hospital's transition support program.

> [Hospital D] *sees the transition support program as a way to prepare new graduate nurses for the clinical, managerial and professional responsibilities they will face as an RN* (registered nurse).

All of the documents reviewed revealed the opinion that the pre-registration programs conducted by universities had not adequately prepared the new graduate nurses to undertake the above roles. A number of measures were put in place by hospitals offering transition support programs for new graduate nurses to facilitate this learning. All programs in this study boasted a supportive learning environment for their new graduate nurses.

A supportive learning environment came to mean that the new graduate nurse could expect an orientation program, both to the hospital and to the specific ward where they were to commence duty, clinical support from preceptors, educators and clinical nurse consultants, rotations to different specialty areas and days allocated as either study days or supernumerary days on the ward. There were slight variances in the number and sequence of these support measures, but they were evident in all program documents. The following example illustrates the way in which the supportive aspects of the program combines with the work on the ward:

> *We'll Support You (. .) the program begins with five days of classroom orientation. We will help to prepare you to work safely and comfortably within our hospital environment, and provide you with the chance to become familiar with the concepts necessary to begin your nursing practice with confidence. During orientation many resource and support people will be available to you when you start on the wards. Clinical supervision and support in clinical areas is provided by experienced RNs, Preceptors, and Nurse Educators. Many areas also have clinically based educators (. .) We'll Help You Learn (. .) A weekly Inservice Program / Debriefing is provided specifically for New Graduate Nurses. New Graduates are issued with clinical objectives, to be used as a guideline and record of ongoing skill development and consolidation. Every clinical area has its own specific set of clinical objectives for new graduates to work towards during the rotation.* [Hospital C]

Upon entry to a transition support program each new graduate nurse participated in an orientation session that included a general hospital orientation and a ward/area specific orientation. This is in keeping with the mandatory requirement for all individuals employed by the New South Wales Department of Health. The documents revealed that the ward orientation was often used as the first supernumerary day for the new graduate nurse. Hospital B had designed a learning package entitled Orientation to the Ward.

This package allowed the new graduate nurse to work at their own pace and answer questions designed to familiarise the nurse to the ward area. The package aimed to:

- *Direct the newly registered nurse to information related to important functional aspects of ward nursing specific to your area.*
- *Familiarise the newly registered nurse with the material and human resources available to them.*
- *Introduce the newly registered nurse to other members of the health care team associated with your area.* [Hospital B].

The orientation period was also frequently a time for assessment and accreditation of the new graduate nurses' knowledge and skills. Some hospitals used the orientation time to assess mastery of some competencies prior to commencing work on the wards. Though the required competencies varied slightly from hospital to hospital they commonly included cardiopulmonary resuscitation (CPR) and administration of intravenous medications. Hospital A had their new graduate nurses undertake CPR during the orientation period. Documents from Hospital B stated:

> *the graduate is expected to seek supervision and assessment of medication skills (*oral*), SC,(*subcutaneous*) IMI,(*intramuscular injection*) Schedule 8 drugs, giving a bolus dose, loading a drug into a burette, loading a drug into an IV (*intravenous*) infusion. It is the graduates responsibility to organise their assessments/accreditation*. [Hospital B]

In accordance with the requirements of the New South Wales Department of Health, all registered nurses were required to be supervised and assessed for medication administration competency according to their employing hospitals' policy prior to giving medication independently. If a nurse had not been assessed as competent in medication administration they were unable to give medication to the patients in their care and therefore needed to rely on another registered nurse to undertake this task until competency had been achieved. Since the new graduate nurse was unable to fulfil all of the duties expected of a registered nurse until they were assessed and accredited it is easy to understand why this accreditation took on such importance and was sought during the orientation period.

All the hospital programs offered some study days for the new graduate nurse. The study days were generally conducted by the nurse educators away from the ward areas. It was a time when the new graduate nurses met as a group for the purpose of being educated

about various nursing principles and practices. The documentation from one of the study hospitals stated:

> *The study days focus on clinical and professional development issues appropriate for the new graduate nurse with presentations by expert clinical nurses.* [Hospital A]

The content of the study days were determined prior to new graduate nurses commencing in the hospital. Hospital B had the program for each study day documented in the Information Manual that each new graduate nurse received upon entry to the program. This indicates that no provision was made for individual ability and knowledge of the new graduate nurses entering the program. Many of the topics incorporated into the study days at several different hospitals were repetitious of the material covered during the undergraduate program at university.

The use of preceptors was identified in all hospital documents. The preceptor role was seen as multifaceted and valuable for the new graduate nurse. Documents from one hospital stated:

> *Preceptors are asked to support, encourage, socialise, assess performance and give positive and critical formal and informal feedback to the NG* (new graduate nurse) *in their transition to being a safe and independent RN* (registered nurse) *practitioner.* [Hospital G]

Although there are no fixed qualifications or requirements for accepting a role of preceptor, they are ideally experienced registered nurses who express a desire to help new graduate nurses. Preceptors at Hospital A were nurses with a minimum of two years post registration experience who had participated in a workshop specifically developed to equip them with the skills necessary to undertake the preceptor role.

All of the program documents mentioned the opportunity to gain knowledge and experience by working in different specialty areas during the transition support program. The rotation schedules varied in duration and type of specialty area visited among the sample hospitals. Whether the new graduate nurse had any choice of work area was also variable with most documents making a reference to the availability of some specialty areas being dependent on staffing issues. Documents from Hospital G stated:

> *Length of rotations and placements are dependent on rostering opportunities.* [Hospital G].

The documents prepared by Hospital A informed their new graduate nurses that even though consideration was given to their requests for specific clinical placements,

> *factors such as the requirements of particular wards for skill-mix, participant's previous and potential clinical performance and organisational factors* [Hospital A].

also needed to be considered in determining individual placements.

It should be remembered that much of the information in the documents and pamphlets presented in this section were written principally for the intended audience of new graduate nurses to advertise their transition support programs with a view to possible employment. It would obviously be in each agency's favour to highlight the benefits and opportunities available at their transition support program to procure employment.

4.3 Hospitals Provide the Real Environment for New Graduate Nurses to Learn how to Perform as a Registered Nurse.

The second theme described the view that only hospitals were able to provide the environment where new graduate nurses could learn how to perform as a registered nurse. Each hospital had specific policies and procedures in place to guide the learning of the new graduate nurse. This was evidenced in the documents by the desire of the hospitals to educate the new graduate nurses and is characterised by appraisals and assessments of the clinical competence of the new graduate nurses. This was facilitated in a number of ways. Many of the wards offered education packages for the new graduate nurse to complete, some optional, others mandatory. Most rotations had clinical objectives for the nurse to meet during their stay on that ward. Documents from Hospital C stated:

> *New Graduates are issued with clinical objectives, to be used as a guideline and record of ongoing skills development and consolidation. Every clinical area has its own specific set of clinical objectives for new graduates to work towards during the rotation.* [Hospital C].

Most of the hospitals were inclined to record competencies and then cite this record as evidence of proficiency. The records were also used as part of the assessment criteria for ward appraisal.

> *Successful completion of a series of packages/worksheets will be required as part of ward assessment of the NG* (new graduate) *program.* [Hospital G].

The same hospital used a booklet to chart the progress of their new graduate nurses. The booklet was typically given to each new graduate nurse during orientation. It:

> *will contain an ongoing record of the NG* (new graduate nurse) *over the 12 month period. It will be held by the Educator and passed to subsequent Educators. On completion of the program the NG will retain the booklet for personal record.* [Hospital G].

All programs had some requirements for the new graduate nurse to complete. This involved a process of appraisal including a number of assessments or competencies, predominantly in relation to the demonstration of clinical skills. Some of these competencies were assessed and reassessed on each ward, where the new graduate nurse rotated. The following competencies were required for each and every ward visited by new graduate nurses undertaking the program at one hospital:

> *Checking of S4/S8* (Schedule 4 and Schedule 8) *drugs, Checking Emergency Equipment, Correct Documentation (integrated notes, fluid balance charts, clinical pathways), and Gives clear & precise handover.* [Hospital D]

Performance appraisals were also attended regularly with some hospitals distinguishing between formal and informal assessment as shown in the following passage.

> *Formal assessment will occur on a prescribed timetable. Informal assessment should occur on a regular and on-going basis specifically by Educators, Preceptors, NUMs* (nurse unit managers) *to provide support and assist in continual development of skills and integration of theory to practice.* [Hospital G]

Most hospitals opted for an initial appraisal followed by a thorough performance appraisal at the completion of each rotation. The following document illustrates:

> *An appraisal is to be conducted within eight weeks of commencement of the rotation using the performance monitoring tool. . . the complete appraisal is to be conducted at the end of each rotation.* [Hospital B].

4.4 Hospitals Demand that New Graduate Nurses not be Employed as Registered Nurses without having first Completed a Transition Support Program.

Even though new graduate nurses leave university with a bachelors degree and registration from the New South Wales Nurses and Midwives Board it seemed as though there was one last hurdle to jump, the transition support program. The documents indicated that the transition support program was also expected, but something that the new graduate nurse was required to both complete and pass. All sample hospitals offered at least a certificate upon successful completion of the program.

> [Each new graduate nurse is awarded a] *badge and certificate on completion.* [One new graduate from each cohort will be named the] *Graduate of the Year.* [Hospital C]

Some of these hospitals also provided a hospital badge, a tradition dating from hospital training where nurses were acknowledged as having graduated (or registered) from a particular hospital. The documents describe how the certificates and badges were usually awarded at a graduation ceremony which seems to be a misnomer since the nurses had already graduated from university some 12 months prior and had really just completed their first year of employment. It seems that only after completion of a transition support program is the new graduate nurse seen to be properly trained and has earned the right to practise as a registered nurse.

4.5 Summary

This chapter identified three major themes that emerged following analysis of different textual sources used to advertise and describe transition support programs offered by the sample hospitals. One of the research questions sought to determine the purposes of transition support programs. The textual sources identified the opportunity to enhance their clinical skills and practise in a supportive environment.

The first theme, *New Graduate nurses need practise in a supportive clinical environment to learn how to become registered nurses*, described how the health care agencies undertook to teach new graduate nurses what they believed was important for clinical practice. The perceived knowledge deficit was addressed by offering a variety of ongoing educational opportunities for each new graduate nurse. Each program offered support in the form of orientation periods, study days and supernumerary days as well as the use of a preceptor to guide their early days of practice. The opportunity to rotate through various specialty settings was also seen as a way to enhance the knowledge and skills of the new graduate nurse.

The second theme, *Hospitals provide the real environment for new graduate nurses to learn how to perform as a registered nurse*, described how it was important for new graduate nurses to practise in the real environment of a hospital and adhere to each hospitals' specific policies and procedures. Hospitals achieved this by offering a variety of education packages, assessments and competencies that new graduate nurses were required to complete and master during their transition support program. In this way, each hospital exerted a degree of control over the practice of each registered nurse and ensured uniformity in the way nursing skills were performed at that hospital.

The final theme, *Hospitals demand that new graduate nurses not be employed as registered nurses without having first completed a transition support program*, illustrated how the programs had become an extension of nurse education. Documents from the study hospitals implied that the transition support program was a mandatory part of new graduate nurse education and employment. Synthesis of these documents revealed that successful completion of a hospital's transition support program was both expected and compulsory. New graduate nurses were commonly awarded a certificate and hospital badge upon completion of their transition support program which gave the new graduate nurse tangible 'proof' of hospital approval and confirmation of their registered nurse status.

Chapter 5
Findings from Questionnaire

5.1 Introduction

The study questionnaire collected demographic details from nurse participants as well as their responses to a closed response section and qualitative open-ended questions. The demographic details were used to help describe the sample and were therefore reported in Chapter Three (see Section 3.9). This Chapter presents the findings from the closed response questions and the qualitative open-ended questions.

5.2 Closed Response Section

The instrument was designed to elicit the registered nurses' perception of the emphasis and importance of different aspects of nursing and consisted of a series of statements incorporating the ANCI National Competency Standards for the Registered Nurse. The competencies that make up the ANCI National Competency Standards for the Registered Nurse are organised into four domains of nursing practice, *Professional and Ethical Practice, Critical Thinking and Analysis, Management of Care,* and *Enabling.* The instrument included 20 statements of nursing that were chosen to represent all four domains of nursing practice. A score was calculated that represents the discrepancy or gap between the emphasis and importance of each statement. The mean score was calculated using individual ratings. A positive discrepancy reflects an importance score that exceeds the corresponding emphasis score; that is the nurse felt that the particular statement was not emphasised in the transition support program as much as it was considered important to their practice. A negative discrepancy score reflects the opposite. The ideal discrepancy score is zero where the level of emphasis and importance is equivalent.

Initially the findings from each separate statement as they appeared on the research questionnaire will be presented for both groups of participants. The statements will then be distributed to the appropriate domain of nursing as outlined by ANCI to enable the findings to be presented under domain headings.

Thirty one new graduate nurses completed and returned the questionnaire and their responses were as follows.

Table 5.1 Mean Results of ANCI Competency Rankings by New Graduate Nurses (n=31)

Statement	Emphasis	Importance	Discrepancy Score
Professional and Ethical Practice Domain			
a. Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	3.42 (0.80)	3.52 (0.76)	0.09
b. Demonstrate accountability and responsibility for own actions.	3.58 (0.67) *	3.94 (0.25) *	0.35
c. Practice within the limits of own abilities and qualifications.	3.52 (0.72) *	3.87 (0.56) *	0.35
Critical Thinking and Analysis Domain			
d. Actively pursue continuing self education.	3.00 (1.00)	3.39 (0.84)	0.38
e. Provide opportunities to transfer fundamental nursing skills from one situation to another	3.00 (0.81) *	3.65 (0.55) *	0.64
f. Demonstrate ability to integrate and consolidate practical application of theory.	3.13 (0.86)	3.43 (0.72)	0.30
g. Opportunity to develop confidence in clinical practice.	3.42 (0.95)	3.65 (0.66)	0.22
h. Demonstrate proficiency in fundamental clinical skills.	3.48 (0.81)	3.77 (0.61)	0.29
Management of Care Domain			
i. Provide holistic nursing to the patients in your care.	3.13 (0.88) *	3.84 (0.37) *	0.71
j. Undertake all activities in relation to patient care and other assigned duties.	3.19 (0.83) *	3.74 (0.44) *	0.54

Table 5.1 Mean Results of ANCI Competency Rankings by New Graduate Nurses (n=31) Continued

Statement	Emphasis	Importance	Discrepancy Score
k. Provide appropriate education for your patients.	2.87 (1.02) *	3.65 (0.75) *	0.77
l. Consider the needs of your patient's relatives and/or carers.	3.13 (0.99) *	3.74 (0.57) *	0.61
m. Improve time management skills.	3.65 (0.79)	3.58 (0.76)	0.06
Enabling Domain			
n. Co-operate with the nursing units and all other departments within the hospital.	3.06 (1.03) *	3.58 (0.62) *	0.51
o. Actively participate as part of the multidisciplinary team.	3.26 (0.81) *	3.77 (0.42) *	0.51
p. Experience a variety of different areas of nursing specialisation.	3.23 (0.92)	3.23 (0.88)	0.00
q. Understand and adapt to the culture of the hospital.	2.97 (1.11)	3.16 (0.86)	0.19
r. Understand the function of the preceptor as a role model.	2.47 (1.22)	2.73 (1.17)	0.26
s. Provide appropriate education for your patients' relatives.	2.84 (1.06) *	3.52 (0.89) *	0.67
t. Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	3.37 (0.76)	3.67 (0.60)	0.30

Notes:
Means were compared using a student t test at the 95% confidence levels.
(SD) Standard deviation is shown in brackets.
* Statements where emphasis and importance were perceived to be significantly different.

Table 5.1 shows that in the 10 instances where responses for importance and emphasis were significantly different, importance to nursing practice was always rated higher than emphasis in the transitional support program. The highest discrepancy score (0.77) was attributed to statement *k* , the next highest were statements *i* (0.71) and *s* (0.67). The

lowest discrepancy score (0.00) was attributed to statement *p*. Two other statements were attributed low discrepancy scores with *a* given 0.09 and *m* 0.06.

Forty eight experienced nurses completed and returned the questionnaire and their responses, using the same rating scale, were as follows.

Table 5.2 Mean Results of ANCI Competency Rankings by Experienced Nurses (n=48)

Statement	Emphasis	Importance	Discrepancy Score
Professional and Ethical Practice Domain			
a. Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	3.40 (0.87) *	3.83 (0.56) *	0.42
b. Demonstrate accountability and responsibility for own actions.	3.55 (0.74) *	4.00 (0.00) *	0.44
c. Practice within the limits of own abilities and qualifications.	3.51 (0.74) *	3.94 (0.24) *	0.42
Critical Thinking and Analysis Domain			
d. Actively pursue continuing self education.	2.85 (0.95) *	3.57 (0.65) *	0.72
e. Provide opportunities to transfer fundamental nursing skills from one situation to another.	3.24 (0.82) *	3.67 (0.51) *	0.43
f. Demonstrate ability to integrate and consolidate practical application of theory.	3.43 (0.77)	3.70 (0.65)	0.27
g. Opportunity to develop confidence in clinical practice.	3.51 (0.65)	3.66 (0.56)	0.14
h. Demonstrate proficiency in fundamental clinical skills.	3.34 (0.73) *	3.77 (0.47) *	0.42
Management of Care Domain			
i. Provide holistic nursing to the patients in your care.	3.30 (0.95) *	3.83 (0.56) *	0.53

Table 5.2 Mean Results of ANCI Competency Rankings by Experienced Nurses (n=48) Continued

Statement	Emphasis	Importance	Discrepancy Score
j. Undertake all activities in relation to patient care and other assigned duties.	3.35 (0.76) *	3.63 (0.53) *	0.28
k. Provide appropriate education for your patients.	3.00 (0.95) *	3.74 (0.48) *	0.74
l. Consider the needs of your patient's relatives and/or carers.	3.19 (0.92) *	3.74(0.57) *	0.55
m. Improve time management skills.	3.51 (0.74) *	3.74 (0.53) *	0.23
Enabling Domain			
n. Co-operate with the nursing units and all other departments within the hospital.	2.96 (0.91) *	3.50 (0.78) *	0.54
o. Actively participate as part of the multidisciplinary team.	3.34 (0.89) *	3.81 (0.53) *	0.46
p. Experience a variety of different areas of nursing specialisation.	3.47 (0.77)	3.28 (0.80)	-0.19
q. Understand and adapt to the culture of the hospital.	2.89 (0.97) *	3.28 (1.00) *	0.39
r. Understand the function of the preceptor as a role model.	3.23 (0.96) *	3.66 (0.63) *	0.42
s. Provide appropriate education for your patients' relatives.	2.79 (0.99) *	3.36 (0.73) *	0.57
t. Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	3.30 (0.88) *	3.79 (0.58) *	0.48

Notes:
Means were compared using a student t test at the 95% confidence levels.
(SD) Standard deviation is shown in brackets.
* Statements where emphasis and importance were perceived to be significantly different.

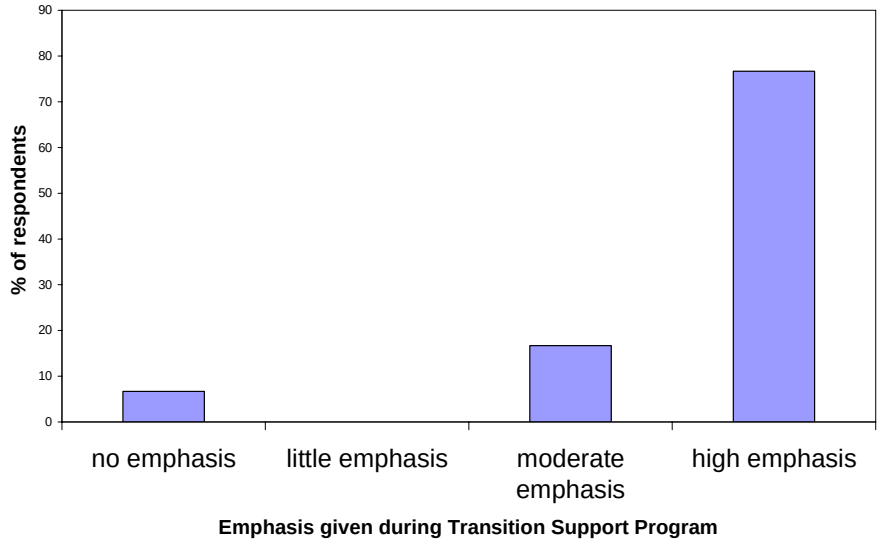
In keeping with the findings from the new graduate nurses, Table 5.2 shows that in the 17 instances where responses for importance and emphasis were significantly different, importance to nursing practice was always rated higher than emphasis in the transitional support program. The highest discrepancy score (0.74) was attributed to the statement *k* and the lowest discrepancy score was attributed to statement *g* (0.14). Statement *p* scored -0.19 which indicates that emphasis was greater than importance. Table 5.3 shows the statements with the highest and lowest discrepancy scores for both groups of nurses.

Table 5.3 Highest and Lowest Mean Discrepancy Scores

ANCI Statements	**New Graduate Nurses**	**Experienced Nurses**
Highest discrepancy	i (0.71), k (0.77), s (0.67)	k (0.74)
Lowest discrepancy	p (0.00), m (0.06), a (0.09)	g (0.14)

Tables displaying the frequency of responses for both the emphasis and importance of all ANCI statements from both new graduate and experienced nurses may be seen in Appendices 12, 13, 14 and 15. This analysis revealed that the emphasis was found to have a mean of 3.65 in one statement by the new graduate nurses which related to management of time. These findings illustrate new graduate nurse's perception that the emphasis of the transition support program is on the work that they are able to perform independently. The frequency of this response is expressed as a percentage and shown in the following figure. The experienced nurses highest ranking statement for emphasis was 3.55 related to accountability and responsibility for own actions.

Fig 5.1 Frequency of Responses by New Graduate Nurses attributed to the Emphasis given to the ANCI statement 'Improve Time Management Skills'



On the other hand, means ranked at 3.0 or less were more common among both experienced and new graduate nurses. The following figures show the frequency of responses for several ANCI statements where the mean was found to be 3.0 or less. The first three figures relate to the emphasis given to educational aspects experienced during the transition support programs.

Fig 5.2 Frequency of Responses by New Graduate Nurses and Experienced Nurses attributed to the Emphasis given to the ANCI statement 'Actively Pursue Continuing Self Education'

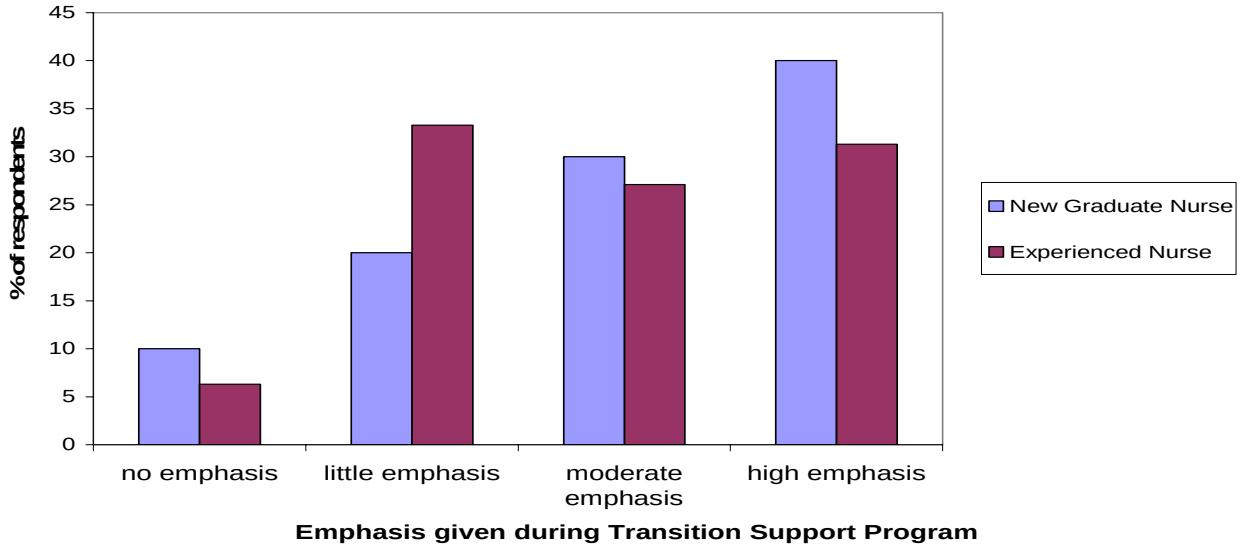


Fig 5.3 Frequency of Responses by New Graduate Nurses and Experienced Nurses attributed to the Emphasis given to the ANCI statement 'Provide Appropriate Education for your Patients'.

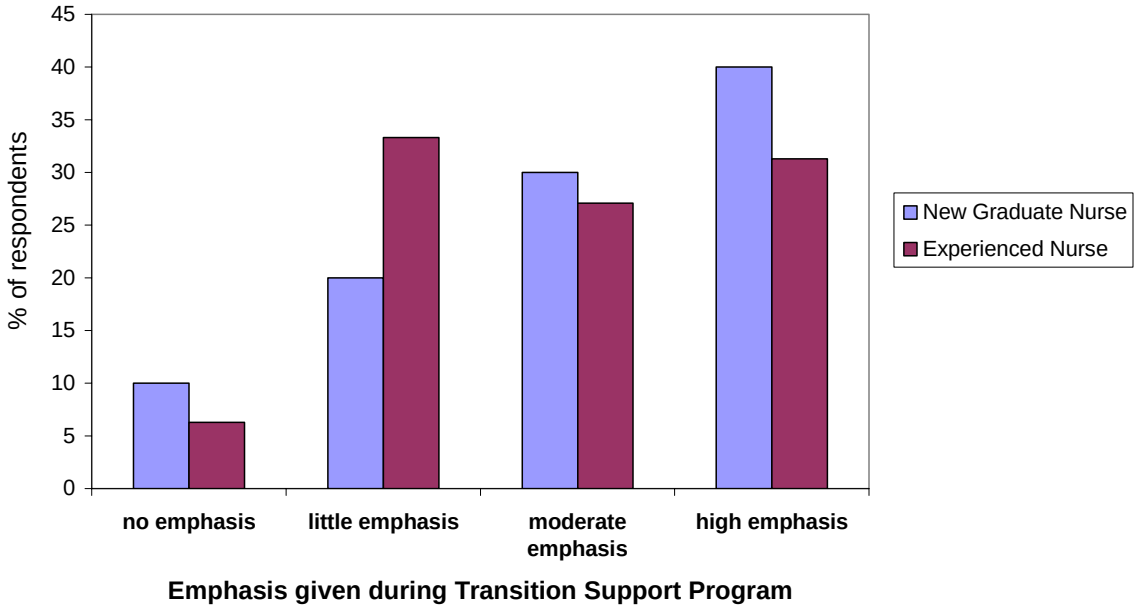
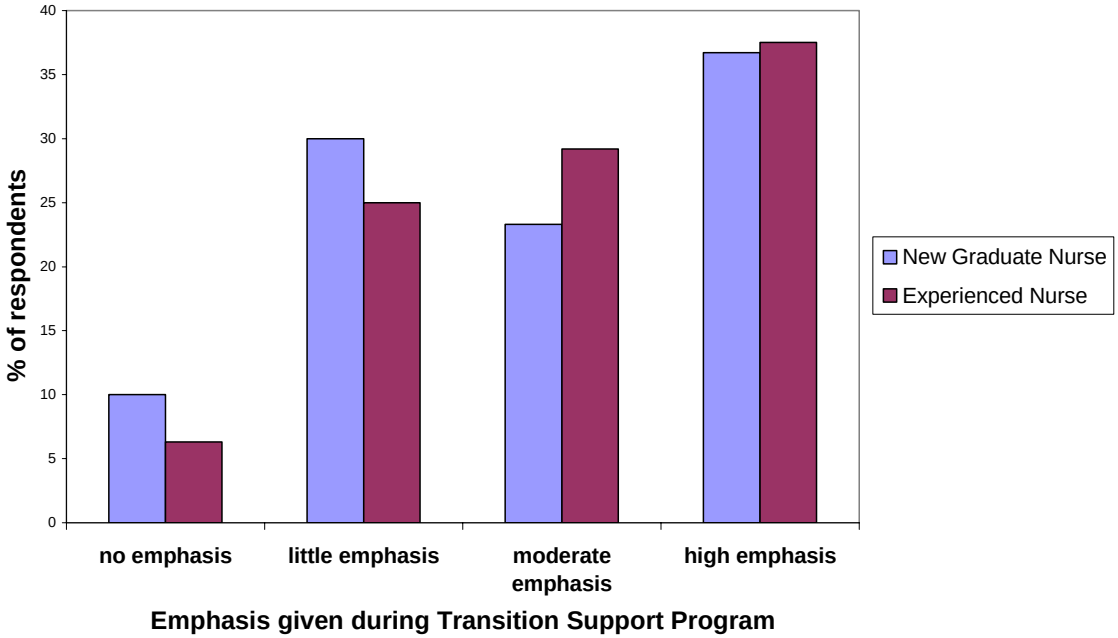


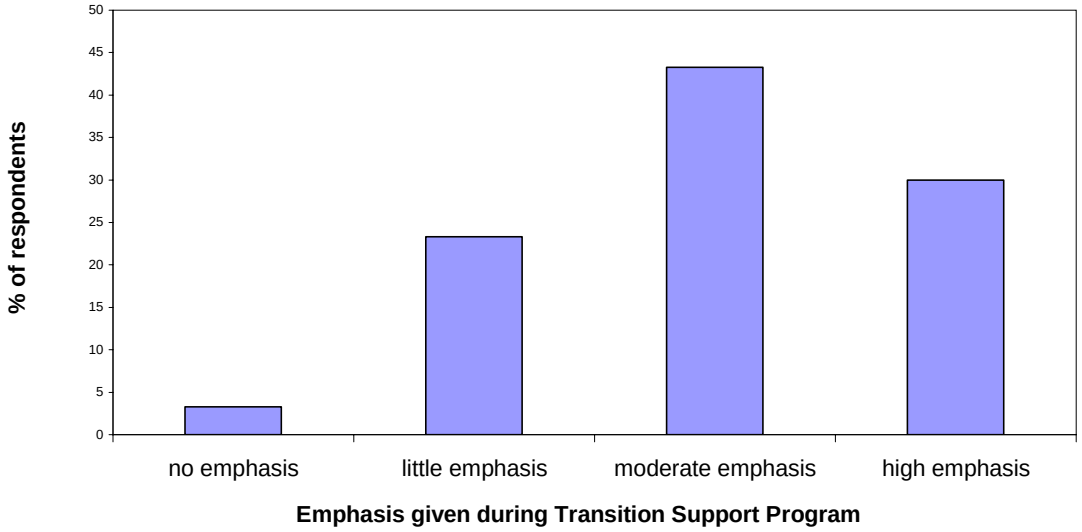
Fig 5.4 Frequency of Responses by New Graduate Nurses and Experienced Nurses attributed to the Emphasis given to the ANCI statement 'Provide Appropriate Education for your Patient's Relatives'



There were a number of statements ranked with a mean of less than 3.0 by the new graduate nurse. Of these statements one was perceived to lack emphasis despite its

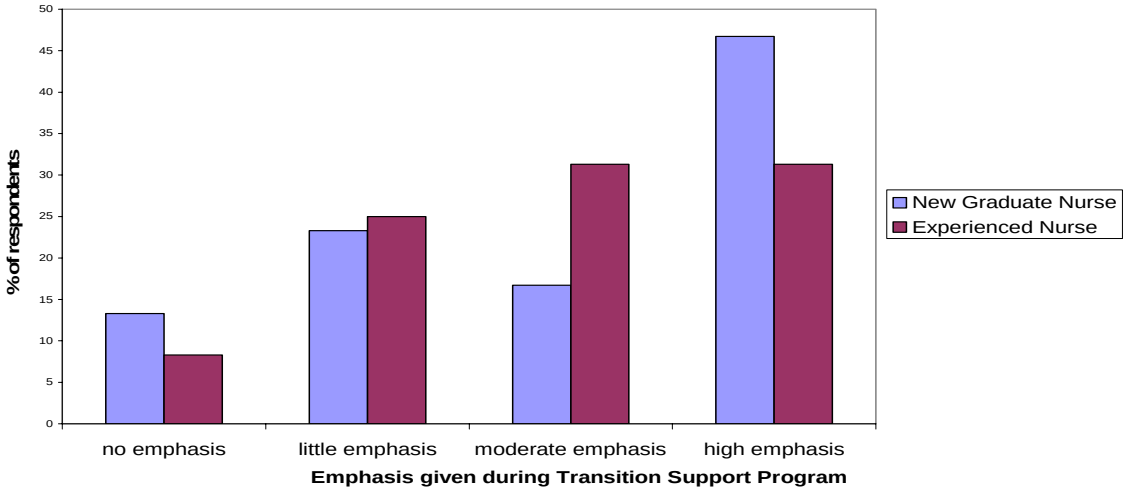
importance and related to providing opportunities to transfer fundamental nursing skills from one situation to another. The experienced nurses ranked this statement with a mean of 3.24. The frequency of responses by new graduate nurses for this statement is shown in figure 5.5.

Fig 5.5 Frequency of Responses by New Graduate Nurses attributed to the Emphasis given to the ANCI statement 'Provide Opportunities to Transfer Fundamental Nursing Skills from One Situation to Another'



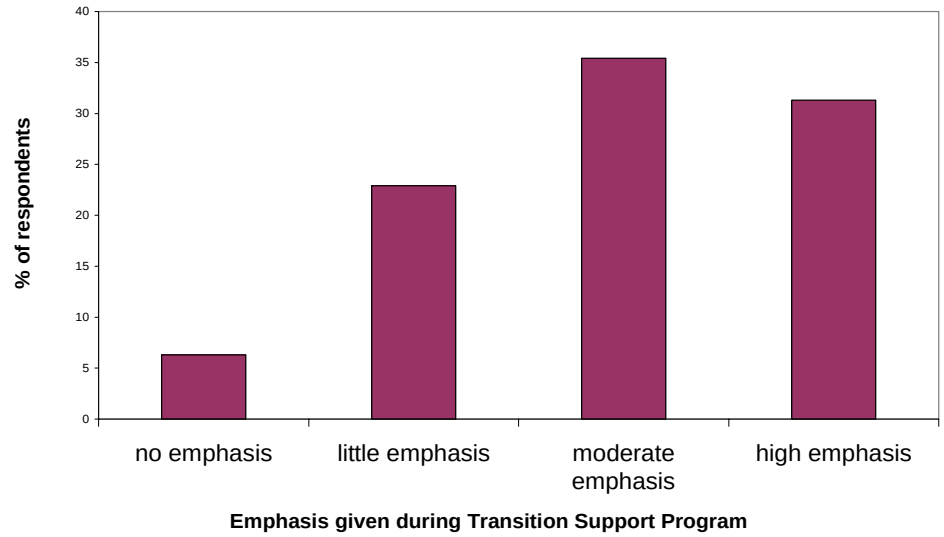
The ability to understand and adapt to the culture of the hospital was rated similarly by new graduate and experienced nurses. Over 30% of responses rated the emphasis to be either 'none' or 'little' in the transition support program. Figure 5.6 shows the frequency of responses for this statement.

Fig 5.6 Frequency of Responses by New Graduate Nurses and Experienced Nurses attributed to the Emphasis given to the ANCI statement 'Understand and Adapt to the Culture of the Hospital'



Co-operation between nursing and other departments of the study hospitals was considered to have a mean emphasis of less than 3.0 by the experienced nurses. The new graduate nurses considered this statement to have slightly higher emphasis with a mean of 3.06. Figure 5.7 shows the frequency of responses by the experienced nurses.

Fig 5.7 Frequency of Responses by Experienced Nurses attributed to the Emphasis given to the ANCI statement 'Co-operate with the Nursing Units and all other Departments within the Hospital'



Study Findings According to ANCI Domains of Nursing

There were different numbers of items in the questionnaire relating to each of the domains so it was important to equate the number of items in each domain to permit a comparison. This was achieved by dividing the sum of each domain score by the numbers of items composed in that score. For example, domain 1 comprised three items. The highest possible score for each item was 4, being considered either very important or highly emphasised by the respondent. Four multiplied by three gave a total possible score for that domain of 12. This score was divided by the number of items in that domain, leaving a final possible score of 4. This process was performed for each of the domains so that their aggregated scores could be compared. Table 5.4 shows this process.

Table 5.4 Process of Achieving Domain Score Uniformity

Domain	Statements relating to domain	Total possible score for domain	Divide by number of items	Final possible score
1 Professional and Ethical Practice	a, b & c	12	3	4
2 Critical Thinking and Analysis	d, e, f, g & h	20	5	4
3 Management of Care	i, j, k, l & m	20	5	4
4 Enabling	n, o, p, q, r, s & t	28	7	4

Table 5.5 shows the mean and standard deviation for the emphasis expressed by the new graduate and the experienced nurses while Table 5.6 displays the findings in relation to the aspect of importance. One of the experienced nurses chose not to complete the emphasis section of the questionnaire which explains the discrepancy in the number of responses between the emphasis and importance categories.

Table 5.5 Emphasis Attributed to each of the ANCI Domains in Transition Support Programs in Study Hospitals.

Domain	Nurse	Emphasis		
		Number of responses	Mean	Standard Deviation
Professional and Ethical Practice	NGN EXN	31 47	3.505 3.489	.589 .625
Critical Thinking and Analysis	NGN EXN	31 47	3.194 3.277	.746 .565
Management of Care	NGN EXN	31 47	3.194 3.272	.699 .623
Enabling	NGN EXN	31 47	3.022 3.133	.739 .640

Table 5.6 shows that there was widespread agreement in the importance of each of the domains. This means that both groups of nurses, the new graduates and the experienced nurses considered each of these aspects to be important to nursing practice. The

emphasis category shown in table 5.5 provided more variation in the responses. This variation probably reflected the various programs offered at different hospitals and the differing experiences of these nurses responding to the questionnaire.

Table 5.6 The Importance Attributed to each of the ANCI Domains to Current Nursing Practice.

Domain	Nurse	Importance		
		Number of responses	Mean	Standard Deviation
Professional and Ethical Practice	NGN EXN	31 48	3.774 3.924	.326 .197
Critical Thinking and Analysis	NGN EXN	31 48	3.581 3.667	.540 .386
Management of Care	NGN EXN	31 48	3.710 3.729	.353 .351
Enabling	NGN EXN	31 48	3.383 3.517	.485 .455

The following four figures display this information graphically. The view that each domain of nursing is considered important is clearly shown along with the variation of perceptions relating to the emphasis given in the various transition support programs.

Fig 5.8 Importance vs. Emphasis Attributed to the Professional and Ethical Practice Domain.

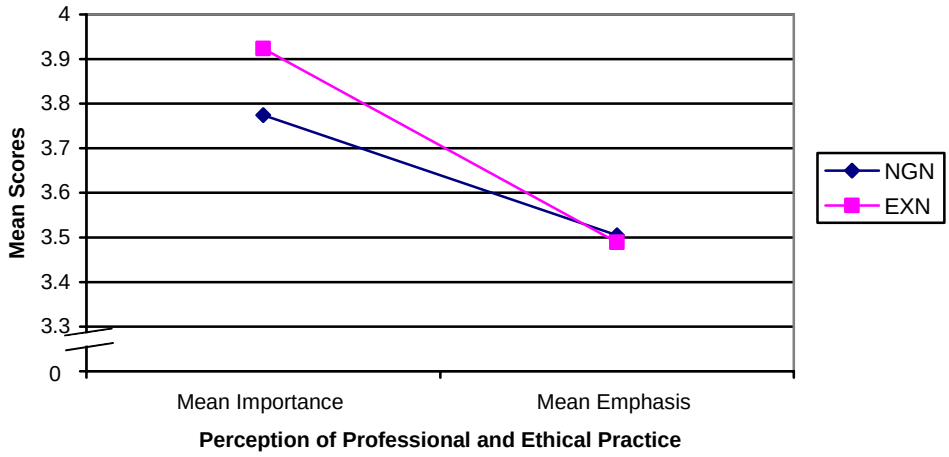
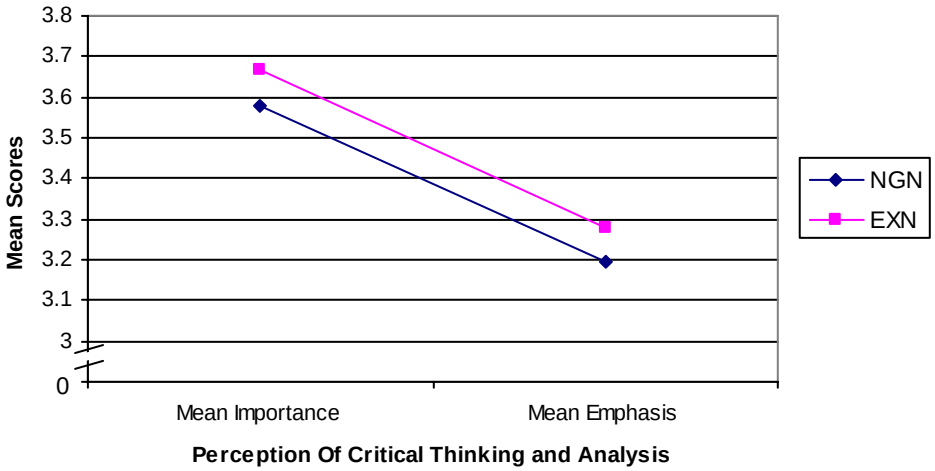


Fig. 5.9 Importance vs. Emphasis Attributed to the Critical Thinking and Analysis Domain.



The domain of *Professional & ethical practice* was the only one where the new graduate nurses perceived that the emphasis was higher than the experienced nurses. In all other domains in both categories of importance and emphasis, the experienced nurses scored a higher mean than the new graduate nurses.

Fig. 5.10: Importance vs. Emphasis Attributed to the Management of Care Domain.

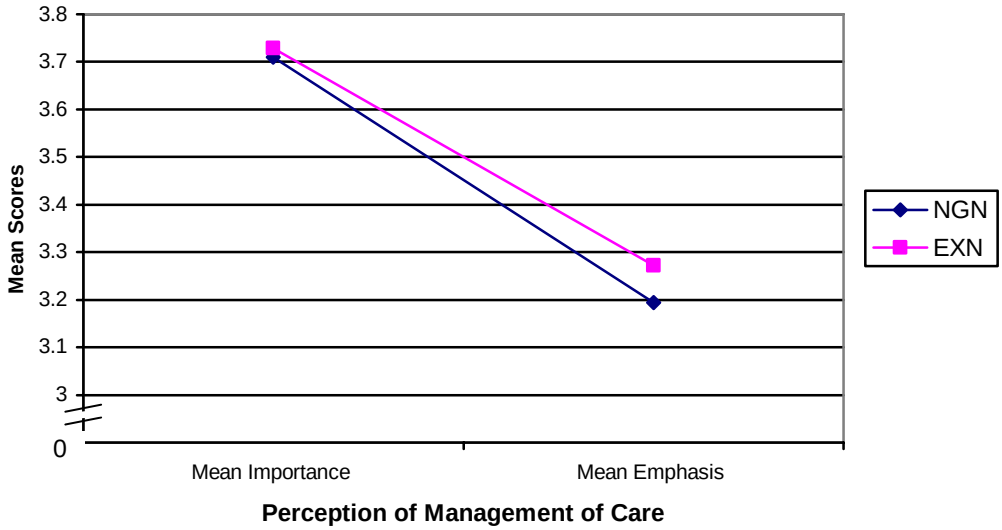
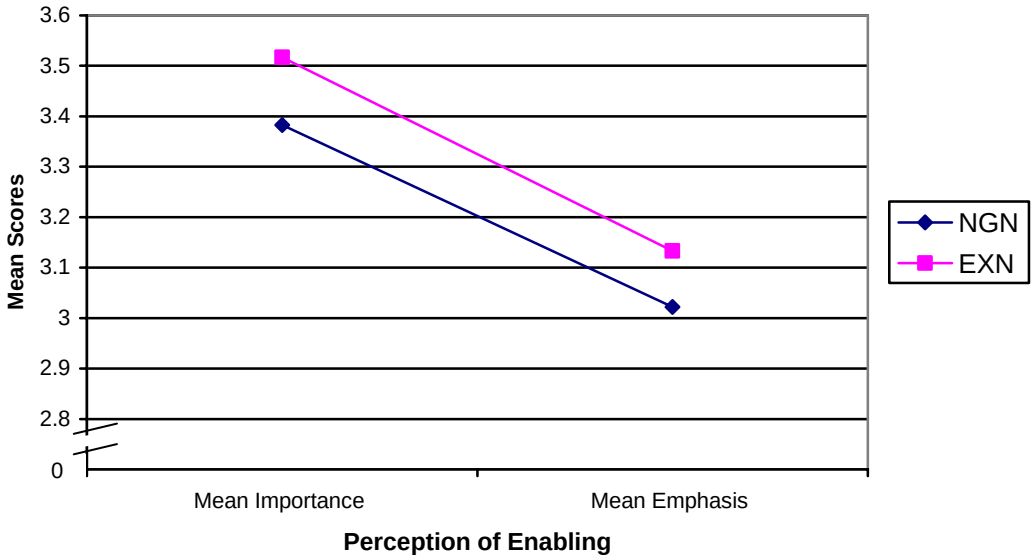


Fig. 5.11: Importance vs. Emphasis Attributed to the Enabling Domain.



The mid point of the scale that the nurses used to record their responses was 2.5, being the mid point between 1 and 4. We can assume that any score below 2.5 indicates that the respondents considered the item to have less emphasis or to be at most, only slightly important. Table 5.7 shows the frequency of the nurses' responses when considering the emphasis and importance of each of the domains of nursing practice.

Table 5.7 Frequency of Responses Less than and More than 2.5.

Domain	Experienced Nurses n=48					New Graduate Nurses n=31			
	Emphasis			Importance		Emphasis		Importance	
	<2.5	>2.6	Missing	<2.5	>2.6	<2.5	>2.6	<2.5	>2.6
Professional and Ethical Practice	3 (6%)	44 (94%)	1	0 (0%)	48 (100%)	2 (6%)	29 (94%)	0 (0%)	31 (100%)
Critical Thinking and Analysis	3 (6%)	44 (94%)	1	1 (2%)	47 (98%)	7 (23%)	24 (77%)	2 (6%)	29 (94%)
Management of Care	6 (13%)	41 (87%)	1	0 (0%)	48 (100%)	7 (23%)	24 (77%)	0 (0%)	31 (100%)
Enabling	6 (13%)	41 (87%)	1	1 (2%)	47 (98%)	8 (26%)	23 (74%)	2 (6%)	29 (94%)

Table 5.7 showed both the experienced nurses and the new graduate nurses indicated a disparity between the emphasis and the importance in all domains of nursing practice.

Domain 1, *Professional and Ethical Practice,* had identical results with 6% of both the experienced nurses and the new graduate nurses stating an emphasis of <2.5 and 94% stating an emphasis greater than 2.6. No responses were given by either experienced nurses or new graduate nurses for an importance rating of less than 2.5, with 100% choosing greater than 2.6.

There were wider differences between the experienced and new graduate nurses' responses in the other domains, especially in the emphasis category. In Domain 2, *Critical Thinking and Analysis,* 6% of the experienced nurses considered the emphasis to be less than 2.5 while 23% of the new graduate nurses made the same selection. The importance to clinical practice was strongly supported by both of the groups of nurses, 98% of the experienced nurses and 94% of the new graduate nurses.

This trend continued in the remaining domains of nursing practice. In domain 3, *Management of Care*, 13% of experienced nurses chose the emphasis to be less than 2.5 while 23% of the new graduate nurses made the same rating. The importance of this domain was fully supported with 100% of responses from both groups of nurses. Domain 4, *Enabling*, showed that 13% of the experienced nurses and 26% of the new

graduate nurses chose the emphasis to be less than 2.5. The importance was again supported with 98% of the experienced nurses and 94% of the new graduate nurses selecting the scale greater than 2.6.

5.3 Qualitative Open-ended Questions

In this section data collected from the open-ended questions is presented. The study questionnaire asked about the purposes of the transition program, the way in which the program was implemented on the ward, the use of preceptors and aspects of the program that were considered most useful and least useful. (The questionnaires used for the new graduate nurses and experienced nurses is provided in Appendices 6 & 7). In order for the reader to identify more closely with the data the source of each example will be identified. Since the identity of all of the nurses remains anonymous, each nurse will be referred to as either experienced nurse (EXN) or new graduate nurse (NGN) and a number that identifies the questionnaire.

Following analysis of the data, two themes emerged regarding transition support programs. These themes are presented in Table 5.8 below and described more fully in the following passages. Examples are included to further describe each theme.

Table 5.8 Themes Related to Transition Support Programs

Theme 1	Opportunity is provided for role transition from student to registered nurse by work experiences in different nursing specialties.
Theme 2	Support for new graduate nurses during role transition is available through program structures and processes.

5.4 Opportunity is provided for role transition from student to registered nurse by work experiences in different nursing specialties.

Perhaps not surprisingly, many nurses viewed the transition support program as a period of time where the new graduate nurse could ease into the role of what was expected of the registered nurse. The following example describes this commonly held view of the purpose of the transition support program.

> [to] a*llow new qualified nurses to find their feet, develop their skills & relate the theory they have learnt at uni to practice in the hospital environment, whilst having support around them by all members of the health care team.* EXN6

Neither the new graduate nurses themselves, nor the experienced nurses, considered new graduate nurses as truly functioning registered nurses, but rather something in between a student and a registered nurse. This presented a gap between the role of the student nurse and the registered nurse. The transition support programs were viewed as an aid to assist them bridge the gap and to develop the confidence required of the registered nurse. The following examples illustrate this idea.

> *It is a safety net. Putting new nurses in the program ensures they are not put in over their head. It is well known you are straight out of uni and haven't worked in a hospital environment full time* NGN24

and

> [The transition support program allows the new graduate nurse to] *gain knowledge and experience which has not been provided by the current university course.* EXN15

The following examples show that it is not just clinical skills that are considered lacking but also management skills and development of the professional responsibilities associated with the role of the registered nurse.

> *I see the transition support program as a stepping stone from being a student with no responsibilities in regards to patient care, to one where you are responsible for all aspects of care.* NGN24

and

> *Easy assimilation into a nurses day - shift work / responsibilities . . . learning hospital policy / methods. Becoming part of a team* EXN32

Essentially, the transition support program was seen as an opportunity for the new graduate nurse to transfer the theoretical aspects of nursing learned at university to the practical setting. All new graduate nurses have completed a bachelor degree at university that has comparatively little hands-on practice opportunities for student nurses. One new graduate nurse explained:

> *The purpose of the transition support program is to allow the new grads the opportunity to practice what they have learned at university. This is hands on practice.* NGN2

Not only did the program give the new graduate nurse the opportunity to practice, repeatedly, the skills they had learned, but also the opportunity to practice in the real workplace where skills such as time management, communication and team work take on a new significance. The following example confirms the notion that new graduate nurses are not considered to be registered nurses by the use of the word student when referring to a new graduate nurse and also highlights the need for the development of a whole gamut of skills.

> [the purpose of the transitional support program is] *to provide assistance for the transitional 'student' from the 'academic' role to the fully integrated, confident* [registered nurse] *and develop 'people skills'.* EXN40

It seems that the question as to where to educate nurses, be it hospital or tertiary institution, has never been totally resolved. The following example clearly shows that the participant has little confidence that universities adequately prepared new graduates for their role as a registered nurse in hospital, let alone that they were competent to practice.

> *. . Surely it's up to the universities to ensure that their students <u>REALLY</u> meet eligibility to register in NSW.* EXN3

The rotational system of the transitional support programs allowed the new graduate nurse to experience a variety of different clinical situations. The number of rotations and length of time spent in any one ward varied considerably from hospital to hospital. The first example illustrates the fixed nature of some programs.

> *Rotational program of 12 months - rotations are orthopaedics (12/52), gen. surg* [general surgical ward] *& oncology 16/52, OS* [operating suite] *(either scrub, anaes. or rec*.[working as either scrub nurse, on anaesthesia or in recovery room]) *12/52, ICU* [intensive care unit] *4/52, renal 1/52, day surgery 4/52, maternity 2/7, 5 study days".* EXN6

Another program allowed the new graduate nurse a limited variety in placements, though was much more flexible in considering the new graduate's clinical preferences.

> *A 12 month program. 5 months in one area/ward - then 2 weeks holiday - then 6 months in another ward/area. 1st week is orientation then one week supernumerary on the ward of choice. For the second rotation you get two days supernumerary.* EXN33

From analysis, there seems little agreement as to the best schedule of rotations with each having advantages and disadvantages. If the placements were of shorter duration, there were more rotations available within the 12 month period. While this approach is typically taken to provide the nurse an overview of the hospital and the different specialities available, it seems difficult for the new graduate nurse to settle in any one ward. The following illustrate the advantages and disadvantages of having many rotations.

> *Having 6 rotations – it was great to get an overview of different parts of the hospital & also great if you were located in a spot you didn't like – you weren't there for too long.* NGN24

Whereas another new graduate nurse explained:

> *Always moving wards meant I never fitted in and never was respected because I was 'just a new grad'.* NGN22

The situation was just as undecided for those programs offering fewer rotations. While one nurse explained that:

> *3 rotations gave sufficient diversity & time to accomplish skills and confidence.* NGN19

another felt:

> *I believe there should be at least six* [rotations] *to different areas. The staff* [new graduate nurses] *don't have enough experience to make decisions about permanent work places*. EXN12

Placement of new graduate nurses in various types of clinical areas was also considered. Some programs allowed the new graduate a choice of where they would like to work, others did not. Some specialty clinical areas were favoured by new graduate nurses as

potential permanent workplaces while other clinical areas held little appeal. Obviously everyone cannot go to the same ward at the same time so placement of new graduate nurses becomes a delicate balancing act if one is to consider the needs of the hospital and the new graduate nurse. One option is to give each new graduate nurse a short amount of time in popular specialty areas so that a greater number of new graduates can experience what the area has to offer. The specialty clinical areas that seem to be most popular with new graduate nurses are those involving high patient turn-around and the use of technology in the everyday care of patients, like intensive care units, accident and emergency and paediatric units. Less popular areas are medical wards, aged care and rehabilitation. New graduate nurses seem to equate being busy and constantly learning new clinical skills with a successful or enjoyable rotation. The following examples describe the relationship between different lengths of time spent in different clinical areas and the new graduates' perceived advancement of their clinical skills.

> *Some places didn't offer enough to warrant the amount of time spent there, others, there wasn't enough time to spend on them to learn enough. NGN12*

And another new graduate nurse pointed out:

> *wards such as aged care and rehab might need to be reconsidered. I know that both are within the realm of nursing but would not allow finer skills and advancement of clinical knowledge to occur*. NGN23

As already stated, the degree to which the new graduate nurse had any choice about their rotations varied from program to program and availability within the employing hospital. Some new graduate nurses were rostered to work in areas that held little or no interest for them as one new graduate nurse wrote:

> *We were unable to choose where we wanted to go – and given areas (ie. mental health) that I didn't even like*. NGN20

This theme painted a picture of how the new graduate nurse was not really seen to be, or expected to be for the most part, a truly functioning registered nurse. It described how the new graduate was afforded time to find their feet in the workplace and gently assume the mantle of the registered nurse; how the new graduate nurse was rotated through various specialty wards to enable them to find their niche, and how they can practice their clinical skills under the watchful eye of key ward staff. As idealistic as this situation may

be, the responses to the questionnaire also referred to the times when new graduate nurses were expected to function as competent registered nurses regardless of whether they had been on the ward for two days or two months. It seems that it was acceptable for a new graduate nurse to work as a registered nurse if there is no-one else available. These times usually occurred when the ward was short staffed or at times when clinical nurse educators were unavailable to help. The following example highlights this issue:

> *There is an expectation that the NG will contribute equal value to the ward as an experienced RN irrespective of their stage in the program.* EXN26

The stress that this situation can cause is considerable for everyone on the ward. One new graduate nurse wrote:

> *New grads* [are] *expected to be in charge at times! NOT acceptable! New grads having to take an increase in workload when short staffed. I've had 12 patients one afternoon shift.* ☹ NGN11

The inclusion of the drawing of the sad face shows how this situation made the nurse feel. And even though they wrote that the staffing situation was unacceptable, very few nurses actually refused to shoulder the extra responsibility. The effect of this situation can be far reaching as portrayed in the next example.

> [The situation occurs] *particularly on PM shift, excessive patient loads (always 7-8 patients <u>each</u>) for newer nurses to cope with <u>+</u> medications. Unable to prioritise and time manage. . . <u>too many</u> junior (new grads) on same shift. No support - compromise patient care & undermines their* [new graduate nurse] *confidence, especially when things go wrong, nobody to prompt, direct, reassure them. Even when educators are working, there is only ever <u>one</u> on for the <u>entire hospital.</u> Clinical nurse specialists (like myself) have a full patient load too, and there is inadequate time to spend doing some much needed education with such new staff.* EXN27

5.5 Support for New Graduate Nurses during Role Transition is available through Program Structures and Processes.

The second theme encompasses one of the major purposes cited for the offering of the transition support programs, that of support for the new graduate nurses. Support, or at least the word support, was raised by almost everyone. Often it was conveyed in vague ambiguous statements like:

> [the purpose of the program is to] *provide a structured, supportive environment to facilitate integration . .* EXN8

Less often, examples of what support might constitute were described. Supportive measures could be divided into two distinct groups, those relating to the structure of the transition support program, including study days, supernumerary days and education packages, and those relating to the people who offered support, like preceptors and nurse educators.

Each transition support program offered at the sample hospitals had a set structure. Some of the components of the program were designed to support the new graduate nurse during their tenure in the program. The aspects of the programs' structure that were considered supportive by the nurses were the study days, the supernumerary days and the education packages.

Study days were included in all of the sample transition support programs. The number varied between different programs, with most offering 3-5 paid study days. Sometimes the topics/materials were pre-set by nurse educators, while at other times there was room for input from the new graduate nurses. The following example describes how the study days meshed with the other aspects of the transition support program.

> [The] *Program co-ordinator organises rotations for all participants to cover a wide range of clinical experiences. These are supported by regular study days facilitated by the program co-ordinator.* EXN8

Supernumerary days were spent by the new graduate nurse working on the ward where they were rostered with the benefit of not being counted in the working numbers of the ward. Even though these days were few, usually one at the beginning of each rotation, they are seen as supporting the new graduate nurse by enabling them to ease into the ward area without the immediate responsibility of patient care. The following example shows how the supernumerary day precedes the more routine support offered by the preceptor and other ward staff.

> *When first on the ward, supernumerary day with preceptor then support by preceptor / mentor or senior staff on shift that day.* EXN32

Some of the work areas offered work packages that the new graduate nurse was expected to complete during their stay on the ward. These packages were seen as a way of helping

the new graduate nurse to cope with all the new information and experiences they were now being exposed to. The following example shows this.

> *Education packages given to BPs* (beginning practitioners) *to help with understanding.* EXN24

The education packages varied from containing brief orientation information considered to be useful about the work area to an exhaustive list of competencies that the new graduate nurse was required to master during the placement. Some of the education packages were collected by the New Graduate Program Coordinator (or similar person) when completed so that the new graduate nurse could have their competencies recorded. At some hospitals a booklet stating each skill or competency that the nurse had mastered during the transition support program was awarded, along with a certificate, to the new graduate nurse upon completion of the transition support program. Even though this practice of education packages was viewed as being positive, in reality it meant that the new graduate nurse was given extra, often compulsory, work which was often completed in their own time. One nurse wrote:

> [I] *encountered difficulty completing ward packages due to lack of time and privacy to work on without interruption. Some were completed at home, but certain questions required ward specific information only.* NGN19

There was an expectation that all ward nursing staff would support the new graduate nurses working on the wards. The following example goes further to include non-nursing staff.

> *Support from all - from top down. All staff look forward to new grads starting, Drs & allied health made aware.* EXN6

Even though all staff are expected to support new graduate nurses informally, two groups of registered nurses have been identified as having a special role. These nurses are preceptors and clinical nurse educators. The role of the preceptor was seen to be multidimensional, from that of a role model and resource person to someone who would lookout for the new graduate nurse, both clinically and professionally. It should be stressed that to be useful at all, the preceptor needs to be rostered with the new graduate for at least the initial weeks of the rotation. This was not always the case in this study and was reported as being one of the least useful aspects of the program. The preceptor also needs to choose whether or not to be a preceptor if they are to function effectively in

the role. Nurses in this study have written about the increase in workload while precepting a new graduate nurse so it is important that the preceptor choose the role rather than have it imposed by the Nurse Unit Manager or some other person in the hierarchy of the hospital as is sometimes the case.

As a role model and contact person the preceptors have knowledge of how the ward and hospital works, how things ought to be done, and how best to go about getting things done. This type of practical knowledge is not to be found in procedure manuals, but comes with experience. The support of this person can be invaluable to the new graduate nurse as the next example shows.

> *There is a role model person to ask questions of, resource of information, link between yourself and other staff members you don't know.* EXN33

There seems to be some opinion that one of the roles of the preceptor is to be a sentinel for safe (or otherwise) practices of the new graduate nurse. One nurse wrote:

> *They help give the confidence needed whilst installing* (sic) *a safe practice environment.* NGN6

another

> *I think preceptors were used to detect any unsafe new graduates and act on that.* NGN7

This implies that the preceptor becomes an unofficial nurse trainer. They have both a supervisory role and also a teaching role. They are often responsible for setting goals and educational objectives for new graduate nurses to master during the rotation. The influence that they may have for the new graduate nurse is great. The next example shows the assessment aspect of the preceptor role as well as showing how the preceptor is seen as being the only resource required for the new graduate nurse.

> [The] *Preceptor works first four weeks on an identical roster to preceptee to facilitate* [the role of] *a dedicated resource clinician for preceptee. This is useful in assessing level of competence, identifying knowledge / practice deficits in a consistent approach which can then be easily addressed. Also provides stability for preceptee.* EXN8

The role of sentinel was more than assessing and correcting any unsafe practices conducted by new graduate nurses. It was also seen that the preceptor had a role as advocate for the new graduate nurse. One new graduate nurse explained:

> [the preceptor] *was someone to go through procedures with, and to debrief with, and someone that stands up for you, represent you*. NGN3

The next example shows how the preceptor can link the new graduate nurse with other staff members. It seems that by being introduced by an experienced nurse somehow gains the new graduate nurse acceptance into some inner circle or culture.

> *You also had someone there who was introducing you to everyone else, which made it easier to befriend other staff members.* NGN28

The other group of nurses that were found to be supportive were the clinical nurse educators. The type of support that they offered was supervision of the new graduate nurses. The following example illustrates that it is seen as important to have expert assistance available for the new graduate nurse.

> [the new graduate nurse rotates to] *3 areas, all have CNC,*[clinical nurse consultant] *CNE* [clinical nurse educator] *cover.* EXN21

The use of the word cover implies that the new graduate nurse is not totally responsible for their own actions in the workplace.

The role of the clinical nurse educator varied from ward to ward. Some wards had their own nurse educators and these nurses spent a lot of time with the new graduate nurses who were rostered to their ward. These nurses, however, usually only worked Monday to Friday, eight am to five pm. If the new graduate nurse was working times other than these hours they were reliant on other nurses for support. Some hospitals provided a roving nurse educator specifically to help new graduate nurses. The on-call nature of the nurse educators was appreciated by many of the new graduate nurses. The following examples illustrate:

> *The after-hours TSP co-ordinator at our hospital was GREAT - made such a difference to have that extra resource (& smiling face) there when you needed it.* NGN10

and

> *Knowing that there was support there available - I could ask the new grad support person and have her come to the ward to demonstrate ng* [nasogastric tube] *insertion etc.* NGN9

The responses on the questionnaire displayed how the new graduate nurses were identified or labelled during their transition support program and how they were treated as a result of this label. The majority of experienced nurses referred to the transition support program being available for new grads (new graduate nurses). Several nurses spoke of BPs (beginning practitioners), while only a few experienced nurses spoke of the new nurses as being registered nurses. It seems that even though all of the new graduate nurses are registered nurses, they have an identity of being something less than that. The following example illustrates this concept and implies that the new graduate nurses are unsafe and need constant supervision in the clinical area.

> *To support the 'apprentice' RN in a new role providing backup for safe nursing practice* EXN4

Interestingly, being identified as new graduate nurses was, for the most part, seen as being advantageous by most of the new graduate nurses. They felt that the label allowed others in the health care system to know that they were new graduates and so were expected to have limited knowledge and experience. It also meant that other health care workers might take the time to demonstrate procedures and/or let the new graduate nurse share the experience with them. The following example explains:

> *The 'new graduate' title allowed other staff to realise my level of experience and prompted them to explain concepts / procedures (ie: not being thrown in the deep end).* NGN19

When the data elicited from the questionnaires were analysed it became apparent that a considerable amount of the data related to the current state of the health care system, in particular, the shortage of nurses. Since the focus of this study is transition support programs for new graduate nurses it was not anticipated that themes would emerge about deficits in the New South Wales health care system. However, the impact of working consistently with staff shortages, budget restrictions, violence, directed at both staff and patients cannot be overlooked. It seems obvious now that the context of working and

coping in hospitals in New South Wales is essential to understanding how and why some situations and practices occur.

Both new graduate and experienced nurses identified occasions when new graduate nurses were not supported in their work and these descriptions are included in this theme. These times did not occur due to insensitivity to the new graduate nurses' needs, but rather reflected the current shortage of nurses working in the hospital system. When asked how the purpose of the transition support program was reinforced in the workplace, one experienced nurse wrote:

> *Don't believe it is reinforced* - [new graduate nurses are] *often left to their own devices, rely on minimal educators & often inexperienced ward staff.* EXN39

Another nurse wrote about the stress on all staff members when support was not available on the ward.

> *. . . educators are available though NOT everyday, NOR every shift, even when these staff are rostered to work. There is NO lesser workload for these staff to adjust to the demands of 'everyday' nursing, & I see a lot of staff stuck in the 'sink or swim', which is very stressful for many & ultimately stresses the entire team, who have to pick up the pieces, after these staff. There's no time to follow up & inform how badly/or how good they're doing & it's less than satisfying vicious cycle!* EXN27

Another cited some stressors that have an impact on the delivery of the transition support program.

> *While we have every intention of supporting our students there are many practical situations which lead to failure. Lack of permanent staff, lack of educators on some wards.* EXN18

The use of the word students when referring to new graduate nurses is interesting. It may imply a protective and nurturing aspect to this experienced nurse's comment, or it may be evidence of her non acceptance of the new graduate nurses' registered nurse status. Whatever the case, the frustration of not being able to provide the level and type of support considered necessary is evident.

Transition support programs are organised at a hospital level, however, individual ward areas are responsible for the rostering of their own staff. The following examples

highlight the difficulties experienced by ward areas in trying to fulfill obligations to hospital, new graduate nurse and ward staffing requirements.

> [the program] *does allow for some preferences, but usually placements are at the discretion of rostering.* EXN39

and

> *These days it is not unusual for 2 new grad RN, and the TEN* [trainee enrolled nurse] *to be rostered on the same shift, with (eg: of a recent shift), 1 core EN* [enrolled nurse] *and the in-charge RN (myself) on an afternoon shift. . . So many junior staff should NOT be rostered on at the same time, because it is impossible to provide appropriate allocations / skill mix, because there is no skill / no experience!* EXN27

During the period of the study, hospitals in New South Wales were experiencing a shortage of nursing staff. This had a direct effect on the role of the preceptor as the following experienced nurses explain:

> *The idea of preceptors is only adequate when it can be implemented properly. . . At the moment we have more TSP* [transition support program] *nurses than permanent staff! New grads value preceptors,* [but] *rostering often difficult.* EXN17

and

> *Given the current workloads being a preceptor can place extra demands on a senior nurse that can be difficult to maintain.* EXN26

As the nurse shortage deepens, more and more is being expected of the senior nursing staff. Senior nurses are tired and barely able to cope with their workload on a busy day so it is not surprising that many do not relish the thought of precepting a new graduate nurse or feel that they have much enthusiasm or passion left to offer them. The following example shows that there are limited preceptors available to new graduate nurses and that the role is not viewed with the status deserving of such a position.

> *If they* [preceptors] *were available they would be a vital part of the transition program. If nurses were made to feel that their knowledge and experience is vital it increases the prestige and encourages the preceptors to become more knowledgeable. The new grads can only benefit from someone who feels they have something to share.* EXN18

5.6 Summary

This Chapter presented the findings obtained after analysis of the responses obtained from the questionnaire. The questionnaire sought information from participants about their demographic details as well as answers to closed response questions and open ended questions.

The closed response section elicited the participants' perceptions of the emphasis and importance of different aspects of nursing using the ANCI National Competency Standards for the Registered Nurse. The findings from both the new graduate and experienced nurses, showed that the importance of the statements was always ranked higher than the emphasis given in the transition support programs. There was widespread agreement between the participants regarding the importance of each nursing statement. More variation was found in the emphasis category and this is possibly due to the collection of data from participants who had experiences from a variety of transition support programs offered by the different sample hospitals.

Thematic analysis was conducted on the short answer responses and two major themes emerged. The first, *opportunity is provided for role transition from student to registered nurse by work experiences in different nursing specialties,* describes how the transition support programs are used to facilitate the transition of the new graduate nurse from the role of student to registered nurse. Accounts are given to describe how the new graduate nurse is not really considered to be a registered nurse and not really expected to behave like one. The transition support programs are used to provide learning opportunities for new graduate nurses to develop the clinical and professional skills required of the competent registered nurse. The theme also describes the way in which rotations to different nursing specialties are made available with the intention of providing experiences and skill development opportunities lacking in the current undergraduate education for nurses.

The second theme, s*upport for new graduate nurses during role transition available through program structures and processes,* described the various structures and policies put in place by the health care agencies with the view to support their new graduate nurses. These commonly included study days and education packages as well as preceptors and clinical nurse educators. Analysis uncovered the effect that an inadequate

staffing level has on the implementation of the transition support program. Nurses told of the stresses of working with inadequate staffing levels and an inadequate skill mix. These difficulties frequently resulted in new graduate nurses being left without support, sometimes in charge of the ward. Both of these themes corroborate the aims of the programs identified in the textual sources and may be considered strengths of the programs.

Chapter 6

Findings from Interview Analysis

6.1 Introduction

Thirty three registered nurses volunteered to be interviewed by returning their contact details to the researcher after being mailed the questionnaire. Twenty two semi structured interviews were conducted with nine new graduate nurses and 13 experienced nurses representing all of the sample hospitals except one. However, the majority of interviewees arose by chance from two sample hospitals. The following table shows the employing hospital of each of the interviewees.

Table 6.1 Employing Hospital of Interviewees

Hospital	Number of Experienced Nurses	Number of New Graduate Nurses
A	7	4
B	0	1
C	0	0
D	1	1
E	1	0
F	3	2
G	1	1
Total	**13**	**9**

A semi-structured approach was taken for the interviews and an interview schedule was developed (see Appendix 9). The format of the questions allowed the researcher to focus on the crucial issues of the study and request the interviewee to describe the experience, person or event. Short prompts, such as 'I see' and 'Hmm' as well as non-verbal communication techniques such as eye contact and head nods were used to encourage the interviewee to continue throughout the interview. In keeping with the confidentiality requirements of the research the nurses are referred to by the pseudonym of their choosing followed by either the abbreviation EXN meaning experienced nurse, or NGN to denote the status of a new graduate nurse. From the analysis, three themes emerged and are shown in Table 6.2. Quotes from the study participants are presented to describe each theme.

Table 6.2 Themes Derived after Interview Analysis

Theme 1	Programs operate in a clinical environment which results in unsupportive behaviour towards new graduate nurses.
Theme 2	Nurse unit managers influence the experiences of new graduate nurses in their workplace.
Theme 3	Transition support programs are provided to redress the perceived inadequacy of university preparation for registered nurses.

6.2 Programs operate in a clinical environment which results in unsupportive behaviour towards new graduate nurses.

The challenging and difficult hospital work environment was identified by many study participants and was usually cited as a weakness of the transition support program. The working environment was considered important by the participants since they believed that their sense of identity and self esteem was influenced by the way they were viewed and subsequently treated in the workplace. Thus the negative impact of the working environment could have far reaching effects on their professional and personal lives. Several factors contributed to the view that the hospital is a difficult and harsh place to work. Each of these will now be described and presented with examples used to further illustrate each.

A workplace that included 'bitches' and 'bullies' was the first feature of the hospital work environment described by the interviewees. Most of the nurses interviewed spoke of bullying or horizontal violence among their peers and knew of the wards in each of the hospitals where bullying was known to regularly occur. This seemed to be well known and at least partially accepted as the status quo as the following example suggest.

> *Every hospital is known to have the bitchy ward. I know at* [hospital name] *there was one ward that everyone hated.* Hayley NGN.

The following example illustrates the fear experienced by some nurses related to both their own clinical performance and the reluctance to approach ward staff for assistance.

> *There were so many nurses working there who were scared, scared of their own safety* [nursing competence] *and scared of the staff as well.* Kathy NGN.

At a different hospital, a similar story was told.

> *The thing about nursing unfortunately is, although we are a very caring profession, we are not very caring for each other. The saying that nurses eat their young is absolutely true, absolutely true.* Lisa EXN.

New graduate nurses were not the only nurses to experience bullying in the workplace with trainee enrolled nurses and agency staff also frequent recipients. It seemed that anyone seen as having a lower status in the hierarchy, or more commonly, someone not permanently rostered to the ward was somehow 'not up to scratch' in the eyes of the bully and thus became a likely target. It was difficult for new graduate nurses to be viewed as permanent staff members on any ward due to the rotating nature of the transition support program. They were more likely to be allocated the role of a 'visitor' and subsequently lack a sense of belonging and acceptance as part of the team. The following example suggests how this practice is not restricted to new graduate nurses but to all staff perceived as outsiders to the permanent ward staff. It could be interpreted as a mind set of 'us and them' between the permanent staff rostered to the ward and the staff who work on a less permanent basis. This concept is exemplified by the following:

> [Even when you finish your program if you go to] *work in an area where you have never worked, they'll treat you just as badly as a BP (*beginning practitioner) *until they get to know you.* Marianne NGN.

The sense of belonging was also raised by another registered nurse who felt the transition support program did offer this feeling of belonging, though it was to the program, not to the ward where the new graduate nurse was rostered. This reinforced the identity of the new graduate nurse undertaking a program rather than a new graduate nurse working as a member of the ward staff. The following highlights this issue:

> *I think the fact that they belong to a program that has an infrastructure involved and formal support in itself offers them support in the sense of belonging and having avenues . . to access should they need help.* Maureen EXN.

Although workplace bullying seemed to be widespread the exact nature or definition of what constituted bullying remained difficult to determine. The following example shows not everyone had the same experience in the same ward with the same personalities present.

> *Some people had a bad time at wards where I had been and had a good time. . so I don't know.* Helen NGN.

The concept of bullying was difficult to pinpoint. Consideration was given to whether it was confined to a particular type of person who after experiencing some type of difficulty on the ward would then claim to be a victim of bullying, or whether the majority of bullying complaints arose from a particular ward. The difficulties of explaining the concept are highlighted by the following example.

> *I don't know. One or two have actually been through all rotations and not just grads but trainee enrolled nurses as well and said that this occurred in each rotation. Now if it occurs once, then it could be the ward, but if it occurs twice or three times you start to wonder about the definition or is it because they're told that patient care is not appropriate, and they see that as bullying. They might be overly sensitive, I don't know.* Penny EXN.

Despite the problems of definition, the consequences of bullying can be far reaching. Two of the interviewees stated that they did not work in their chosen specialty area due directly to the bullying of the staff already working there. Both nurses had been rostered to their area of choice as part of their transition support program, but when considering permanent work, opted for other work areas as the following exchange explains.

> Q. Did you know what area you wanted to work in when you left university?
> *A. Yes I wanted to work in palliative care.*
> Q. Is that where you work now?
> *A. No I'm not and that's only because of umm different personalities in the palliative care ward.*
> Q. You said that you had your first rotation there.
> *A. Yes I did and I loved it, absolutely loved it.* Lyn NGN.

In this case, even though the new graduate nurse said that she loved working in that nursing specialty, full time work in that ward was impossible for her due to the practices demonstrated by some of the staff that amounted to subtle bullying behaviours. This new graduate nurse used the phrase 'different personalities' to describe nurses who were nasty and unsupportive of new graduate nurses on the ward. Another nurse spoke at length about the difficulties she had with the acting nurse unit manager of one particular ward where she wanted to work upon completion of her transition support program.

> *I didn't know she* [the nurse unit manager] *was acting, I didn't know she was bad to other nurses . . so anyway, I just lost interest. I really <u>really</u>*

> *lost interest there. Maybe later. I just couldn't work there* [at the moment] Dora NGN.

These two examples show how bullying can prevent nurses from working in their chosen specialty area. The following example shows how it could prompt a nurse to consider leaving the profession altogether.

> *Sometimes you just want to throw it away and become a street cleaner or something because that would be better. And that is just from attitude, peoples attitude, and not once, not once has a patient said anything derogatory about nurses. . .it's always your fellow staff, doctors and nurses.* Antony NGN

Sometimes it is not what is said but the way that it is said that can be hurtful to new graduate nurses. Even the innocent statement "Oh you're a new grad!" can be perceived as welcoming and accepting or derogatory depending on the way that it is delivered. Similarly, comments need not be directed at the person receiving them to be an effective weapon. The following example reveals this concern.

> *Sometimes people can be cruel, they might say "the new grads are just terrible" or something like that and you hear it and it makes you feel terrible because you are a new grad so you feel it too. If they say it about others, they can say it about you too.* Dora NGN.

The problems associated with working shiftwork and seven day rotating rosters were raised predominantly by the new graduate nurses. In this study the experienced nurses frequently held positions of nurse educators or nurse unit managers. These positions most usually had standard employment hours from Monday to Friday so it was not surprising that it was the new graduate nurses who highlighted the difficulties of working on rosters and shiftwork.

The new graduate nurses were less concerned about working shiftwork than they were about the inequity of the shiftwork roster. The new graduate nurses believed that they were unfairly treated with the rosters in that they ended up working more weekends and 'unpopular' shifts, afternoons and night shifts, than other registered nurses on the ward.

> *Invariably you end up doing all of the weekends. Invariably. I think everybody would say that*
> Q. Why is that?

> *A. Oh because they have this wonderful rostering system, or the pecking order, or whatever it is.* Marianne NGN.

Another said,

> *I don't mind working weekends, in emergency I got pretty much every weekend. I didn't mind, I didn't have any kids, I didn't have a boyfriend at the time. So I guess that is why I didn't care about the roster.* Hayley NGN.

Staff rosters were managed at a ward level usually by the nurse unit manager. There were usually provisions for nursing staff to request days that they would like to have off prior to the roster being written and also to swap shifts on the roster that had already commenced. Although this sounds a satisfactory method the new graduate nurses explain that you can only swap with another new graduate nurse, and since there may be only one other rostered to the ward, there is usually little chance of that occurring. The following example tells of an experience of requesting certain days off prior to the commencement of a roster.

> *When I arrived at the hospital I had to request for my first roster off because I had a wedding to attend which was like five weeks away so, so it was definitely outside of the next roster, the next roster hadn't even been done. I gave the dates, I went in and visited the NUM, gave the dates, gave them my number da de da and everything. When I got on the ward, guess what I was rostered on? I said what happened? They said we lost the piece of paper!* [laugh] Marianne NGN.

This was not an unusual occurrence and the same new graduate nurse had the 'unofficial' way of coping with inadequate rosters explained to her by her peers.

> *Don't ask for the day off, just be sick!* Marianne NGN.

She recounted this story.

> *I was* [working as a] *casual* [nurse] *once and somebody said "do you want to be back here tomorrow?" I said "Why?" and she said "I'm going to be sick tomorrow" and this was about 8 o'clock in the morning* [laugh]. *I said "Oh you're not feeling well?" she said "No, I'm going shopping with my daughter tomorrow, so, you know, you'll probably be back here tomorrow so don't throw your handover sheet away". That's what they do!* Marianne NGN.

There was widespread agreement from both groups of registered nurses that a major purpose of offering transition support programs was to provide the hospital with nursing

staff. The staffing requirements of the hospital seem to be paramount with the number of positions available in transition support programs growing each year to meet the demands of the hospital. The following example states this purpose.

> *The transition program provides staff for the hospital . . we have large numbers of pretty junior staff.* Penny EXN.

The following example highlights the ever increasing need for nursing staff and the way in which the transition support program can be used to address the shortage of nurses.

> *We call them fodder* [laugh] *and there is never enough. It's like if you have a bucket with a hole in the bottom, no matter how many or how much you put in the top, the bucket never gets full.* Penny EXN.

The process of placing large numbers of new graduate nurses through the program may put the new graduate nurse at risk or create other difficulties as described by one of the experienced nurses.

> *I think there are too many new graduates going through the program. I think they don't get the support they are entitled to . . I think the program itself hasn't been fully evaluated.* Penny EXN.

Wards often have to rely on large numbers of junior nurses to staff the shifts. Even though the number of staff rostered may be adequate, there is a dearth of experience that means the age old system of asking a question or gaining a second opinion from a more experienced staff member as the need arises, no longer exists for new graduate nurses. Sometimes when a more experienced nurse is rostered to work with large numbers of less experienced nurses, they become the sounding board for all of the new graduates, and find it difficult to get their own work completed. The stress involved for both new graduate and experienced nurses when working under these conditions day after day are described in the following example:

> [the nursing shortage makes it] *more difficult for everybody. I think it is more difficult for new graduates and it is more difficult for the* [other] *staff because. . um . . say for example here now at this hospital we have a lot of acting clinical nurse educators who are relatively inexperienced in their role. We have a lot of casual staff and we are employing third year nursing students as AINs,* (assistants in nursing) *so the skill mix is dramatically different from ten years ago. Ten years ago I think that there were lots and lots of people with a lot of experience that a new graduate could go and ask questions and there were lots of people around to act as preceptors and I*

> *suppose share the load . . a lot more people that a new graduate nurse could feel confident to go and ask, but these days there may be only one permanent staff member and four agency on the shift. And that is really hard then because the new graduate has to keep going back to the team leader.* Cathy EXN.

There was a view that the absence of enough or suitable role models for new graduate nurses to emulate deprived the new nurses of valuable learning opportunities. There was a concern that with the nurse shortage suitable preceptors were not always available and the people that new graduate nurses learn from may not necessarily be the best person to teach them.

> *I am a firm believer with new grads* [that] *it is monkey see, monkey do. . the nursing shortage makes it very difficult if you haven't got a skilled nurse or* [have] *one whose technique may not be adequate . . that is a shame to put* [that person] *with a new grad.* Lisa EXN.

Another issue raised resulted from lack of staff continuity. Many nurses were acting in positions, so were less likely to become fully involved and take ownership of the program and were more likely than their permanent counterparts to be transient. This is evident in Kay's example:

> *It has been a bit of a battle for me because unfortunately we* [previously] *had a clinical nurse educator leave, so anytime I get it going right with a nurse educator they leave me.* Kay EXN.

Yet another challenge caused by the shortage of nurses is that sometimes relatively new and inexperienced registered nurses are expected to take greater responsibility than they would like. The following example explains:

> *The really scary thing is, now on my ward, I'm a really senior nurse. I am two years out* [of university] *and usually in-charge* [of the ward] *and considered a senior nurse. People ask me things that I'm not sure if I really know* [laugh]. Helen NGN.

The workplace can also pose difficulties for new graduate nurses because there seems to be little uniformity in the management of the program throughout the hospital. Each ward the new graduate visits as part of the transition support program operates independently and this has implications for the interpretation and management of the program as well as the day-to-day operation of the clinical setting. The lack of

uniformity between the wards can cause confusion for the new graduate nurse as they rotate from one area to the next. The following example highlights the independent nature of each ward.

> *The hospital structure isn't what it used to be, in the hospital* [training] *system you had a matron or a supervisor or someone who was always available to call. These days it is a bit more higgledy piggledy and people aren't sure who is available to help.* Lisa EXN.

Because each ward is responsible for its' own day to day management, it is inevitable that differences will occur. These differences are evident in some key areas that have a direct effect on the transitional support program for new graduate nurses. The following example explains some of the different approaches taken in regard to education packages available for new graduate nurses during their work rotation.

> *It depends on the areas and how they do* [manage] *their BPs* (beginning practitioners). *Because some areas are really well set up and some of the packages are really really good. Other areas you ask for the packages and they say "What package – no we don't have that here". And they don't have anything there you just do the work – just work, work, work.* Marianne NGN.

The support available to new graduate nurses also differed from ward to ward. One ward in the study chose not to provide preceptors for the new graduate nurses because the nurse unit manager did not believe it was in the best interest of her ward to do so. The support available from the clinical nurse educators also varied from ward to ward and this left the new graduate nurse unsure of what was expected from them. The following example shows how the role of the clinical nurse educator varied from ward to ward.

> *Two of the three wards that I worked on the educator had a patient load. Every ward has a different standard I think.* Kathy NGN

New graduate nurses had their clinical skills and performance appraised on each ward that they visited as part of their transition support program, but even this evaluation/appraisal form varied according to different wards' own preferred systems and needs.

> *Each area, like medical or surgical, or critical care or mental health had their own written evaluation system.* Marianne NGN.

For the new graduate nurse, this meant that they were unsure about how they were going to be assessed since the criteria could change from one ward to the next.

The workplace also exerted some degree of control over new graduate nurses in that they almost demanded that each new graduate nurse complete a transition support program before a permanent offer of employment would be made. Although some nurses knew of people who had pulled out of a program for various reasons, every one of the new graduate nurses interviewed in this study completed the transition support program they had commenced. Many nurses spoke of the program as being a professional year and thus it became an expected extension of their tertiary education. Having completed a hospital transition support program was seen as mandatory employing criteria by many hospitals. The following nurse stated that one of the strengths of completing a transition support program was:

> *Guaranteed work, you'll get accepted by another hospital.* Marianne NGN.

The hospital hierarchy discouraged any thoughts by new graduate nurses about leaving the program as the following example demonstrates.

> Q. So if a person say on their second rotation, said "No, this is it, this is where I want to stay", would they be able to stay and not do their third rotation?
>
> *A. No. Not on the program because they are on quarantined positions . .one of the things is that there are certain numbers of positions reserved for new graduates in staffing numbers on every ward so . . if that person stays on it means that there is already someone planned to go there afterwards, that person misses out on the experience or the person who should have moved on is leaving a gap somewhere else. So the . arrangement at this hospital is that no one jumps off the program.* Cathy EXN

Completion of the program was usually celebrated with the awarding of certificates and hospital badges to the successful nurses. The following example shows the new graduate's relief upon completing the program.

> *when you're at uni* (university) *and you're finished uni, you think thank God that's over with. And now four months after I finished my new grad*

program I got a job at another hospital and I think I'm free I can do what I like. And that's what it is all about

Q. So you don't see yourself as being free after you finish university?

A. No because you've got a 12 month contract I guess. Antony NGN.

6.3 Nurse unit managers influence the experiences of new graduate nurses in their workplace.

The nurse unit manager was depicted as being a very powerful character in the ward setting by nurses in this study. This person had responsibility for the budget, rosters, the general feeling or character of the ward and for staff appraisal. The data for this theme were derived mainly from the questions asking about the strengths and weaknesses of the program. While it was acknowledged that the role of the nurse unit manager is multifaceted, the impact that these people had on the ward is worth further mention. Bitchiness and bullying has already been raised in the previous section, however it is worth mentioning that the nurses in this study felt that the responsibility for this phenomenon is placed at the feet of the nurse unit manager. One new graduate nurse said that each ward had its own particular milieu, and it was the responsibility of the nurse unit manager to influence the milieu. She said:

> *The NUM* (nurse unit manager), *and whoever the main ones are in charge set the tone*[of the ward]. *So it is very important that they set a nice tone.* Marianne NGN

One new graduate nurse spoke of going to work, finally as a registered nurse only to be confronted by another nurse during shift hand-over venting some of her personal views about the ward and nursing in general. The lack of enthusiasm for the job was considered a significant determinant of the ward character.

> *I've sat through hand-over where people say I hate the patients, I hate the ward, I hate the staff, I hate this, I hate that and I say "Well why do you want to be here?" It is really great because we come here enthusiastic, and she said "Oh well, you'll learn better – how long have you been nursing for?"* Marianne NGN

Nurse unit managers appeared distant for many new graduate nurses, often busy with matters that kept them away from the ward and away from the day to day working staff. For the most part it seemed that new graduate nurses were not really acknowledged by the nurse unit manager as a team member or were even worth speaking to. New graduate

nurses were very sensitive to this, possibly because they were unsure where they wanted to work upon completing the program and so were keen to make a good impression with all of the managers. Several new graduate nurses said that some of the nurse unit managers didn't even say good morning to them. This was not an uncommon complaint. Penny explained:

> *I bet there are few new grads who ever get a thank you at the end of the day, very few nurses really, but even less new grads. Or even a <u>good morning</u>!* Penny EXN.

It was also noted that most nurse unit managers did not get to know the new graduate nurses rostered to their wards. It seemed that the new graduate nurse was not considered to be part of the ward and consequently had less status. When appraisal time came around they had to rely on others to inform them about the nurse they were to appraise. This is most disconcerting to the new graduate nurse who is having an appraisal written about them by someone who has little if any first hand knowledge about them.

> *Why can't they* [nurse unit manager] *spend like 15 minutes, once a week and say "Well how are you getting on? Sit down and have a chat with me da da da" Then at least you would feel part of the ward. And then you come to the interview with the NUM and the NUM says "I really don't know you"* [laugh]. *You could say "Well I've been here for three months"* [laugh] *They are there on the ward. They are there at handover, they are there all day doing bits and pieces, they're always around. . .Why can't the NUM, after one month, go and speak to the person you are working with and ask how you are getting on? That's a manager's job. She is a manager, you should know your staff.* Marianne NGN.

6.4 Transition support programs are provided to redress the perceived inadequacy of university preparation for registered nurses.

The nurses interviewed believed that the transitional period was a time where new graduate nurses learnt a lot very quickly, both professionally and personally. This was necessary to survive when the new nurses found themselves in a hostile workplace for which they were ill prepared. Both new graduate and experienced nurses expressed dissatisfaction with the preparation of nurses by universities. Preparation for the role of the registered nurse was found to be lacking in several different ways. Concern was expressed about the relevance of some aspects of the course material presented during the university course and also the degree to which new graduate nurses are able to function

as a registered nurse upon graduation. Some of the course content of the undergraduate nursing degree was seen as irrelevant, being too theoretical for the practical skills required of the nurse. The following opinion was offered by one new graduate nurse.

> *There were some subjects that we were taught simply because we had to have them done because it is a degree. Which I think is a load of bollocks.* Antony NGN.

There has been no shortage of debate about the theoretical and clinical components of the undergraduate degree and the way nurses are prepared since the transfer of nurse education to the tertiary sector. The following example shows that some people have little belief that university can be realistically expected to prepare nurses to work without some form of practice.

> *It* [content of undergraduate degree] *doesn't make much difference when they come out as an RN (*registered nurse) *because they've never actually practiced in the role of a registered nurse. They've never actually looked after six patients, they've never had to cope with the whole shift, or the whole days work.* Jane EXN.

As a result there was a perception by both new graduate nurses and experienced nurses that new graduate nurses were ill prepared to assume the role of the registered nurse straight from university. Only one of the new graduate nurses in this study felt confident to work as a registered nurse upon graduation from university. More commonly nurses expressed feelings of being vulnerable in the workplace as the following example illustrates.

> *The first four months was pretty bad, feeling unsafe um and you just didn't like going to work* [laugh]. *I think most nurses are like that.* Kathy NGN.

One of the responses by the hospitals to this perception of inadequate preparation or lack of confidence by the new graduate nurses is the preparation of various education packages for the new graduate nurse to complete. When asked whether more education was required, one new graduate nurse said

> *I don't think they do* [need more education]. *I think, I think we need to understand what we are doing.* Lyn NGN.

This alluded to the idea that new graduate nurses have difficulty in applying the knowledge that they have to everyday situations. It seems that the nurse must make a major leap to advance from knowing how to do tasks to understanding why they were doing them for the patient now under their care. Some new graduate nurses were able to relate this more easily than others. The following example is recounted by an experienced nurse explaining the difficulties that one new graduate nurse had in relating and understanding her nursing activities to patient care.

> *She's got a patient who has had an intercranial haemorrhage,* (ICH) and *she would say "Oh the patient is complaining of a headache". So I said "What did you do?" "Oh I gave him a Panadol" "Well is that all?" . . "Do you understand what is going on with their head? Shouldn't you be thinking about investigating a little bit more?" But, you know, she doesn't know what the abbreviation ICH* [given on the handover sheet] *stands for, doesn't think to investigate, doesn't realise what an intercranial haemorrhage is . . it means nothing . . therefore all of these things could be missed as the person goes about their tasks rather than thinking ICH.* Cathy EXN.

At other times it is not just the application of knowledge that needs to be nurtured, there are clear shortfalls in the knowledge that has been acquired. Although the transition support program has not been designed to assist or address these problems, it becomes the hospital problem once the nurse is employed.

> *We can't fix up all of the problems that people come out of university with. Um for example we had people with huge knowledge deficits, absolutely huge. Don't know the basics like haven't looked at cell formation, don't know what a red blood cell and platelets and things like this are, um, don't know how to take a radial pulse, don't know about using sphygmomanometers, don't know like what the pancreas does and all of these things, you know they have got through the exam at uni in first year and they have never revisited that* Cathy EXN.

Once identified, these nurses are usually given extra materials and learning contracts to address their learning needs. It is a mutual arrangement to work together between the nurse and a nurse educator. It can be a fine line to walk as the following example shows.

> *It is really hard because you think this person is registered, they are already registered. You look at the ANCI competencies of the beginning practitioner and they are no where near, no where near it. Some people* [new graduates] *are willing to work with you to get over the hurdle, I think, but others say "No, this is too hard and I feel like you're putting too*

> *much pressure on me so I'll leave and go and work somewhere else". And they do.* Cathy EXN.

New graduate nurses who required extra help from the workplace were unfortunately well represented.

> *Out of the 55 we've got now, we've had about five people who um have been extremely difficult from that point of view.* Cathy EXN.

The vulnerability evident in some of the new graduate nurses seems to evoke some type of nurturing response by some of the experienced nurses. These nurses expressed some strong protective overtones when speaking about new graduate nurses on their ward.

> *When we are introducing our little graddies for the first few weeks (. .)* Kay EXN.

> *I do their appraisals on them, so really they are my babies, I get to look after them.* Lisa EXN.

Perhaps the perception of inadequate university preparation is the reason why all nurses interviewed expressed a strong need for the transition support programs. Some of the nurses spoke of it as a professional year and all inferred that it was a requirement before seeking full time permanent employment. It was seen as a period where the new graduate nurse was offered time to get used to the role and responsibilities of the registered nurse, hone their skills and find the nursing specialty area that suited them best. The following examples illustrate this view.

> *I think it* [the transition support program] *has consolidated a lot of knowledge and I think I've learnt a lot more knowledge. . I think the stuff I know now is very practical and related to what I'm doing.* Emily NGN.

And,

> *I think the BP year is good and it should be there because it teaches people, it gives them a chance to make the mistakes or get the experience, not being expected to have, you know, to be totally responsible for every single thing and know everything immediately.* Marianne NGN.

The transition period coincides with other changes occurring in the lives of many of the new graduates. For many of the new graduate nurses if was their first experiences away

from school or university, they were independent and working. With the independence came mixed feelings of both freedom and new responsibilities. The following example explained this mixed emotional time:

> [there was] *so much to deal with at once, you know, you weren't only dealing with learning new things, dealing with shift work, you were dealing with whatever else was going on at home. . a lot of the people I was working with were moving out of home. Working full time was pretty much new to all of us and that was difficult in itself.* Emily NGN

6.5 Summary

This chapter presented the three major themes to emerge after analysis of the interview data. In many ways these findings reflected and enhanced those found from the other sources previously presented.

The interviewees confirmed that the work environment was a harsh and difficult place to work. In the first theme, *Programs operate in a clinical environment which results in unsupportive behaviour towards new graduate nurses,* the nurses spoke of being exposed to violence and bullying practices from fellow staff and it was widely accepted that there were difficult wards in almost every hospital setting. These wards were those where a group of nurses banded together and made life very difficult for those staff not in this inner circle. The unfair rostering practices resulting in new graduate nurses gaining an unequal distribution of the unpopular shifts have been raised as well as the shortage of staff. The staff shortages did not just relate to a lack of nurse numbers but also to the lack of suitable role models and mentors for new graduate nurses to emulate. Many interviewees considered that transition support programs had more to do with supporting total nursing numbers than offering any service to the new graduate nurses employed.

The differing approaches taken by staff from different areas towards the implementation of the transition support programs have also been raised. The experienced nurses tended to stay in one area and therefore did not notice the differences experienced by new graduate nurses as they rotated through different settings. The expectation by the hospitals that new graduate nurses would complete a transition support program was also noted as a way of controlling new graduate nurses. Program completion also meant that the hospitals had 'stamped' each new graduate nurse as being 'one of theirs' which meant

they had passed some kind of test and were now employable by that hospital or any other hospital.

The stress of the transition year also encroached on the private lives of many of the new graduate nurses. Some described how the first year of nursing was difficult not only at work where everything was new but also because of the changes occurring concurrently in their private life. Many were leaving their family home for the first time and taking total responsibility for themselves. While this was a choice by each individual, it added to the stress of their transition year.

The second theme, *Nurse unit managers influence the experiences of new graduate nurses in the workplace,* described the role that the nurse unit manager played on the ward. The interviewees felt that this person was responsible for the character of the staff working on the ward. The new graduate nurses found that often the nurse unit manager was unavailable to them and busy with other matters not pertaining to them. This frequently resulted in the nurse unit manager having little first hand knowledge of the new graduate nurse causing them to rely on other people's opinion when time came to complete performance appraisals.

The final theme, *Transition support programs are provided to redress the perceived inadequacy of university preparation for registered nurses,* related to the perception of inadequate preparation by universities for the role of the registered nurse. This resulted in a sharp learning curve for the new graduate nurse during the transition program and the university undergraduate nursing curriculum was questioned regarding the appropriateness of some of the content. Some interviewees thought that deficits in knowledge were a problem for some new graduate nurses while others believed that the difficulties experienced by new graduate nurses had more to do with the application of theory to the practical situation. The inadequate preparation meant that many nurses felt a strong need for a program to help bridge the gap between university and the workplace and some of the experienced nurses adopted an overly protective relationship with the new graduate nurses.

The following chapter presents the findings from the observation sessions where it was hoped that the researcher would witness some of these insights first hand.

Chapter 7
Findings from Observation

7.1 Introduction

Non-participant observation was undertaken in this study to help to clarify points or themes raised in either the questionnaire or interviews previously conducted. Observations were conducted at one of the sample hospitals during four separate sessions over a two week period. The hospital is a major teaching hospital that comprises medical and surgical wards as well as a number of very highly specialised units. New graduate nurses regularly work in any of these areas as part of their transition support program and the researcher was allowed to observe consenting new graduate nurses as they went about their usual work. The work included direct patient care, documentation, communication with team members and discharge planning. At this particular hospital, a registered nurse is employed specifically as an after hours co-ordinator to help and assist the new graduate nurses as they work on afternoon shift in different areas of the hospital. The observation sessions took the form of accompanying this co-ordinator as she went around the hospital working with an average of 10-12 new graduate nurses on each shift. This approach was beneficial for the researcher because being directly involved with the program meant that this particular component could be actually witnessed in operation as opposed to merely observing a nurse go about their daily work in any one ward.

Debriefing meetings are conducted routinely as part of the transition support program between the new graduate nurses and the new graduate coordinator to allow a time for everyone to vent any problem or issue that may have arisen in their work. Coincidentally a debriefing meeting was scheduled during one of the observation visits to the hospital and permission was sought and given to enable the researcher to attend this meeting as well. During this meeting the researcher was introduced to the group but took no further active role, choosing to jot down any point raised on paper to provide a prompt for later description.

In this Chapter the findings from the observation sessions are presented as either straightforward data or passages of conversation to enhance the understanding of issues and themes raised in previous chapters and are displayed in Table 7.1.

Table 7.1 Summary of Major Observation Findings

Major Finding	Observations
Supportive practices	· Presence of an after hours co-ordinator · Belonging to a program - Debriefing sessions, newsletters. · Initial rostering excluded afternoon and night shifts · Role modelling and advocacy by experienced staff
Less supportive practices	· No allocated preceptor · Support from educators only during morning shift · Sole responsibility for patient care · Working in isolation from other staff
The program's use in rectifying gaps in nurses knowledge, skills and confidence	· Study days and educational packages · Identification of new graduates who are experiencing difficulty with practice · Repeated assessment/appraisal · Period of time for development of confidence · The reality of differences between theory and practice
Programs operate under difficult work conditions	· Large numbers of inexperienced nurses · Shortages of nursing staff led to inadequate support for new graduate nurses · New graduate nurses used to supply staff for less popular work areas

7.2 Description of the Program Observed

In this hospital, approximately 65 new graduate nurses are employed for the first 12 months of their practice via what is referred to as a transitional support program. During these 12 months the new graduate nurse works as a clinician taking an active role in all aspects of patient care and management. The transition support program was developed to provide a supportive environment for development of confidence and competence in practice by allocating preceptors; rotation to different three or four clinical areas for skills development; and theoretical consolidation via study days. The study days provide a revision of theoretical aspects of nursing studied during undergraduate programs without consideration of the new graduate's learning needs or current clinical environment. One

focus of the study days is to reinforce the hospital's policies and procedures related to the material presented. Academic assessment is not a feature of this program however, the process of performance appraisal occurs twice during each clinical rotation. The performance appraisal includes assessment of clinical skills and professional behaviour. Clinical rotations are offered in all wards and specialty units including medical/surgical nursing, mental health, community, rehabilitation and critical care.

7.3 Supportive Practices

Support afforded to the new graduate nurses was evident during observation sessions and took various forms. The observation sessions coincided by chance with a time when the new graduate nurses were changing, or rotating to another ward. This can be a time when the new graduate nurses become more anxious and uncertain of themself and their ability as they are entering a new ward environment with new rules and ways of doing things. It was also a time when some of the concessions or supportive measures afforded to new graduate nurses became more apparent. The most obvious way of supporting new graduate nurses related to the rostering practices by the nurse unit managers. The majority of the wards in this sample hospital did not allow new graduate nurses who had just been rotated to the ward to be placed on afternoon or night duty for two weeks. The time spent on morning duty gave the new graduate nurse time to work with the clinical educator attached to the ward and generally get a feel for the ward amid more experienced staff before working the evening and night shift where they were expected to work more independently.

For the program to claim to offer support is one thing, but the new graduate nurses at this hospital stated that they actually felt supported. The topic of support was raised during the debriefing session for new graduate nurses attended by the researcher. The new graduate nurses also acknowledged between themselves that there were times when the program failed and they worked without educators and preceptors and other support mechanisms advertised by the hospital and these are discussed in Section 7.3. It seemed as though each new graduate nurse could report a tale of another new graduate nurse at a different hospital who had a terrible story to reveal about the support or lack thereof at their hospital. The following example was typical of the stories told by the new graduate nurses.

> *A girl that I was at uni with went to* [name] *hospital and she says that no-one helps the grads there at all. They had a little orientation to the hospital but then they just went to the ward -–no preceptors, educator, nothing!*

Perhaps it was a case of 'better the devil you know' but the new graduate nurses in this study said that they were satisfied with the level of support offered by the staff and program at their hospital.

The hospital where the observations took place employed a person as the 'after hours new graduate co-ordinator'. This was the only hospital in the sample settings in this study that employed a person in this designated position. The support that this person gave to the new graduate nurses cannot be over-emphasised. The after hours new graduate co-ordinator worked four afternoons per week and met with each new graduate nurse rostered on duty on the evenings that they worked. This person became familiar with each new graduate nurse, knowing them by name and came to recognise each nurse's strengths and weaknesses as an individual. The observation sessions revealed to the researcher how each new graduate nurse looked forward to the visit by the after hours new graduate co-ordinator and the benefits that they received after speaking with her.

Coordinator : Hi. How are you?
New graduate : Good, pretty good.
Coordinator : Busy tonight?
New graduate : I've got a few patients post op – nothing special.
Coordinator : What did they have?
New graduate : TURPs. [transurethral resection prostatectomy]
Coordinator : You OK with that?
New graduate : Yeah. Done it before. Usual obs, watch for bleeding.
Coordinator : You're right with this then?
New graduate : Yep fine.
Coordinator : How did the man go with the PCA [patient controlled analgesia] yesterday?
New graduate : He was OK. Once he understood what was happening he was good.

The after hours new graduate co-ordinator encouraged the new graduate nurses to think about the care that they were offering their patients, offered advice regarding that care as well as tips about managing their time in order to deliver the appropriate amount of care to each patient. This person was 'on call' for each new graduate nurse should they need or like to discuss the care they were delivering to their patients. Just the knowledge that

this person was available was reassuring to the new graduate nurses even if they didn't actually require any assistance or advice.

The way that learning occurred incidentally by having experienced staff around to model appropriate behaviour for new graduate nurses was also observed. On one occasion the after-hours new graduate coordinator was working with a new graduate nurse on the ward because the nurse was busy and becoming stressed because of the amount of work to be done. The coordinator helped the new graduate nurse to organise the necessary tasks so that they could be performed in a methodical manner. Without the help and direction of the coordinator, the new graduate nurse was unable to prioritise tasks and was kept very busy mainly due to disorganisation. This example demonstrated that time and task management can be just as important as the expertise required to be able to perform specific nursing skills and requires a role model to help develop those skills.

A debriefing meeting specifically for new graduate nurses was held during one of the observation sessions. This meeting demonstrated the high level of rapport that had been built between each of the new graduate nurses and the new graduate co-ordinator. It was held during the change-over period between morning and afternoon shift and the high attendance of new graduate nurses indicated their support and enthusiasm for such a meeting. Concerns about matters relating to housekeeping and any grievances raised by the new graduate nurses were considered by the group, but it was the recognition of the new graduates as a group that was most impressive. A newsletter written specifically for the new graduate nurses outlined optional in-service lectures and other articles that may have been of interest to them was discussed and was another example of the way that these nurses were supported in the workplace. The nurses who had worked the morning shift were able to go home but instead chose to be at this meeting thus demonstrating the importance and support it offered them.

Advocacy was also demonstrated as a means of support for new graduate nurses. That an experienced nurse would act as an advocate could be reasonably expected as part of the role of a preceptor or nurse unit manager, however the experience witnessed was not from such a person, merely by a registered nurse who worked on the ward.

A conversation was overheard between the program coordinator and a registered nurse on the ward. The registered nurse reported that a new graduate nurse on her ward had been rostered for two full rosters of working weekends. She said that the new graduate nurse did not want to formally complain but was finding the allocation of shifts unfair and difficult.

The registered nurse bringing the issue of the unfair roster to the attention of the coordinator displayed the role of advocate on behalf of the new graduate nurse.

7.4 Less Supportive Practices

Paradoxically, the lack of support available for new graduate nurses was also evident from the observation field notes.

One of the most outstanding observations was the lack of preceptors on the wards. All transition support programs in the study advertised and stated that they valued the use of preceptors for the new graduate nurses, so the failure to provide this type of help and support was surprising. The new graduate-preceptor relationship was seen to fail in a number of ways. Sometimes the new graduate nurse was simply not allocated a preceptor. At other times a preceptor was allocated but they were too busy, often being in-charge of the shift or taking other roles as well, to provide an adequate amount of time to sufficiently support the new graduate nurse. In this situation the preceptor was continually drawn away from the new graduate nurse to attend to other responsibilities.

At other times when a new graduate nurse was allocated a preceptor they frequently found that either they were working a different roster to their preceptor, or their preceptor was on leave when they arrived on the ward. Frequently a preceptor was not allocated because there were not enough experienced nurses to take on the role. This all resulted in the new graduate nurses having to work alone and rely on the skills that they had learned either at university or in other wards, which may or may not have been appropriate in their current ward. The after hours new graduate co-ordinator helped to fill this gap to the best of her ability, though as already mentioned, no other hospital in this study's sample had anyone in this role for the new graduate nurses. The shortage of preceptors and educators was raised during the debriefing session and the topic drew the following response from one of the new graduate nurses:

"what's an educator?"

It seems that the new graduate nurses use humour and camaraderie tactics to help them through the more difficult aspects of their chosen career.

The workplace was noted to be very busy and all nurses were expected to work independently and get on with the many tasks at hand. Being solely responsible for a group of patients does have advantages for both nurse and patient but it also gives little opportunity for nurses to mingle and get to know one another during the day to day work. The observations revealed that when a new graduate nurse had a query about an aspect of patient care, rather than go and ask for an opinion from another nurse, they accessed the required information from the ward computer. While the computer certainly has a role in health care it did help to keep the nurses working in isolation for long periods of time. This situation was the same for all nurses, not just the new graduate nurses, but it does mean that many nurses receive little support and comradeship in the workplace. Indeed the most frequent time that nurses conversed with one another during the shift was when they required another registered nurse to check the medication they were going to give one of their patients. This independent practice deprived the new graduate nurses of good role models and the opportunity to share their experiences and gain from the experiences of other nurses. It also focused attention on individual effort rather than those of a team.

7.5 The Program's Use in Rectifying Gaps in Nurses Knowledge, Skills and Confidence

As part of the transition support program each new graduate nurse underwent an orientation period and various study days and educational packages as routine and accepted components of the program. The observation sessions allowed the researcher the opportunity to witness some of the ways in which the transition support programs were used to identify and rectify deficits in new graduate nurses' knowledge and skills.

Assessments and appraisals played a large role in the transition support program. The new graduate nurse had their clinical skills assessed and reassessed on every ward that they rotated through as part of the program. This seemed to be partly because each ward

needed to check that fundamental skills were of a satisfactory level, but also because some of the wards required the nurse to be able to perform skills specific to the specialty that the nurse may not have encountered previously. The progress of each new graduate nurse through each rotation was recorded as part of their employment record which became available to the new graduate co-ordinator after each ward rotation. The progress of each new graduate nurse was discussed during the hand-over briefing report between the new graduate coordinator and the after-hours new graduate coordinator at the commencement of the afternoon shift. Since the observation sessions occurred at a time of new ward rotation, the reports from each ward regarding the new graduate nurses were discussed during the hand-over. If it was found that a new graduate nurse was performing at a level less than that expected from a new graduate nurse, the new graduate co-ordinator was required to instigate a plan of remedial instruction for the new graduate nurse. Three nurses were observed who had been identified as requiring extra education and attention by the hospital as they went about their work. The after-hours co-ordinator paid particular attention to the needs of this group of nurses to ensure that they were able to perform the tasks assigned to them and cope with what was required of them for the shift.

The program also allowed the new graduate nurses the opportunity to grow in confidence and take on full responsibility for their patients. The following example was part of a conversation that was overheard between an experienced nurse and a new graduate nurse and illustrates that even though taking on more responsibility for patient care can be frightening for a new graduate nurse, sometimes it can turn out to be a positive experience. The new graduate nurse was retelling her experiences of the previous day to the experienced nurse. She spoke of being very busy, scared and unsure of her ability to manage her allocated patients for the day. As the story unfolded it became apparent that the new graduate nurse did manage to cope independently even though the day presented many challenges. On reflection, the new graduate nurse was proud of her competence and felt that she had benefited from the experience.

Not all nurses' experiences were positive. The following situation showed the inconsistency of patient care and the powerlessness experienced by new graduate nurses as they worked on the wards with experienced nurses. A new graduate nurse was expecting patients to return from operating theatre during her shift. She made their beds

in preparation for their return and told one of the experienced nurses her plans to wash each patient upon arrival to the ward to make them comfortable. She was told by the experienced nurse that there was no need to wash the patients since they would be able to wash themselves the following morning independently. The new graduate nurse complied with the advice given by the experienced nurse and altered her plan of care accordingly. Later in the shift when the after-hours coordinator visited the ward and asked how she had managed with the post operative patients the new graduate nurse explained the reasons for not having washed her patients upon arrival to the ward and relayed the story to the coordinator. The coordinator agreed with the new graduate nurses' original plan to wash the patients post-operatively as a comfort measure. Clearly the new graduate nurse had been taught and was aware of the proper procedures involved in receiving a patient from theatre and settling them back into the ward but with the experienced nurses' advice on her mind she chose to do what was expected of her rather than what she thought was correct. The new graduate nurse may have felt powerless in this situation as she needed to comply with the experienced nurses' advice to be accepted on the ward and exhibit the skills that reflected those of the other nurses on the ward.

7.6 Programs Operate under Difficult Work Conditions.

The shortages of nursing staff working in hospitals has been a popular topic and widely reported in the press over the past few years. It was impossible to observe the functioning of any of the wards at the sample hospital without noticing the shortages of nursing staff. The skill-mix of the roster seemed imbalanced on some of the wards where observations took place. These wards had disproportionately large numbers of new graduate nurses on the roster compared with experienced nurses. It seemed likely that the number of new graduate nurses accepted into program intakes each year were more dependent on the number of nurses required by the hospital than the number of new graduate nurses that each facility can adequately facilitate through the program.

On some wards the number of nurses rostered to work the shift seemed satisfactory. On closer examination it became apparent that the composition of nurses included assistants in nursing and large numbers of agency staff, both registered and enrolled nurses. This resulted in the experienced nurse, often only one, being unable to spend adequate time working directly with the new graduate nurse because they were continuing being called

away by the other staff who were unfamiliar with the running of the ward and their role in patient care.

The shortage of nursing staff had enormous implications for the quality of the transition support program that was offered. There was a high number of relatively inexperienced staff available on any given shift and appropriate preceptors and clinical educators were hard to find. The experienced nurses that were available were very busy and unable to provide the level of support that was necessary. This situation caused stress for the new graduate and the experienced nurses.

In order to alleviate the shortage of nurses in some wards, it seemed that transition support programs were used to support nursing numbers and to provide nurses for less popular work places in the hospital. During the observation sessions it was apparent that one particular new graduate nurse had recently been rotated to the third and final placement of her transition support program. This nurse had a history of experiencing difficulty working as a registered nurse since her first placement and had required special learning contracts to be written and undertaken that focused on correcting knowledge deficits and developing nursing skills. After settling into the second placement she grew to like that particular type of nursing and was offered a full time position on the ward upon completion of the transition support program. To complete the program she was required to rotate to the third placement where she was again reported as experiencing difficulty adapting to a new environment and different area of nursing. Even though she stated that she did not want to stay on the ward and her nursing practice was considered to be unsafe by experienced nurses working with her, in order to complete the transition support program, she was required to complete the placement. This example shows that transition support programs can be used both to recruit new graduate nurses during the program and also to enhance staff numbers on other wards such as the third rotation ward in this instance.

7.7 Summary

This Chapter presented some of the data derived from the observation sessions which, for the most part, supported questionnaire and interview findings. The way in which different work settings went about offering support to their new graduate nurses was

observed and recorded. The way that rosters were tailored to give new graduate nurses time to adjust to the new ward setting was described as well as the roles that various experienced nurses adopted to support the novice nurses. Perhaps more importantly, these new graduate nurses spoke of feeling supported as they progressed through their first year of practice as a registered nurse.

The observation sessions also provided insights into the times when new graduate nurses were left unsupported in the workplace. The way that most nurses were expected to work independently and received little support and back-up from their peers and managers was described. Some of the difficulties incurred with the development of the new graduate-preceptor relationship were also uncovered. It was found that many new graduate nurses did not have the benefit of being allocated a preceptor for varying reasons.

The identification and rectification of the gaps in new graduate nurse's knowledge, skills and confidence was also raised. Examples were given regarding the practices of giving remedial educational packages for those new graduate nurses deemed to have insufficient skills and knowledge for safe work practices. Substantial power differences in the relationships between new graduate nurses and experienced nurses on the ward were also highlighted.

The way in which transition support programs use the rotations to different ward areas to provide nursing staff and the possibility of permanent employment upon completion of the program was raised. Recruitment and retention of nursing staff are not a stated goal or aim of transition support programs.

Chapter eight discusses the findings from this Chapter together with those from the textual sources, questionnaire and interviews.

Chapter 8
Discussion of Findings

8.1 Introduction

A summary of the combined findings from the study are shown in Table 8.1 on the following page. From these findings it can be seen that the transition support programs provided the opportunity for new graduate nurses to make the transition from student to registered nurse. Statements from each of the ANCI domains of nursing practice were consistently ranked as being important to nursing practice by the participants. The programs provided a time when new graduate nurses could practise in a supportive environment and refine the skills required to work independently and to adjust to both the role of the registered nurse and the unique culture of the hospital. This year long program was seen as a valuable opportunity for new graduate nurses to consolidate the knowledge they had gained at University and apply this knowledge to their practice. One of the aspects of the transition support program new graduate nurses found to be valuable was the feeling of belonging they gained for the duration of the program.

The various measures adopted by the hospitals to support the new graduate nurses were raised by almost everyone in this study. The participants described how the structure of the transition support program, including study and supernumerary days was beneficial for new graduate nurses. Clinical nurse educators and preceptors were valued and seen as being supportive, as was being identified as a new graduate nurse.

The findings also highlighted how the transition support programs were used to address a perception of inadequate university preparation. Such practices included the use of educational packages and assessment and reassessment of the clinical skills of the new graduate nurse.

Table 8.1 Summary of Combined Findings and Key Points for Discussion

Study Data Collection Method	Research Question Responses	Findings	Key Points for Discussion
Textual Sources	Research Question 1	*Themes Derived* ▪ New graduate nurses need real life experiences to learn how to become a registered nurse. ▪ Only hospitals can provide the environment for new graduate nurses to learn the right way to perform as a registered nurse. ▪ Hospitals demand that new graduate nurses not be employed without having first completed a transition support program.	▪ The identified gap between the perception of Importance and Emphasis of the ANCI Competency Statements. ▪ A time of role transition from student to registered nurse. ▪ Hospitals are a difficult workplace. ▪ The role played by transition support programs for recruitment and retention of nurses.
Questionnaire	Research Questions 1, 2 & 3	*Closed Response Section* ▪ Both new graduate and experienced nurses considered the ANCI competency statements to be important in their current clinical practice. ▪ More variation occurred in the perception of the emphasis that each of the ANCI competency statements were given during the transition support program. *Short Answer Responses* ▪ Opportunity is provided for role transition from student to registered nurse by work experiences in different nursing specialties. ▪ Support for new graduate nurses during role transition available through program structures and processes.	
Interview	Research Questions 1, 2 & 3	*Themes Derived* ▪ Support was available for new graduate nurses in various forms. ▪ Programs operate in a clinical environment which results in unsupportive behaviour towards new graduate nurses. ▪ Nurse unit managers influence the experiences of new graduate nurses in the workplace. ▪ Transition support programs are provided to redress the perceived inadequacy of university preparation for registered nurses.	
Observation	Research Question 3	▪ Support was available for new graduate nurses in various forms. ▪ Lack of support for new graduate nurses was also evident. ▪ Transition support programs are used to identify and rectify gaps in knowledge, skill & confidence of new graduate nurses. ▪ Transition support programs operate under difficult work conditions.	

Lack of support resulted from a number of sources, not the least of which was working in a difficult and challenging work environment. The nurses had to cope with a chronic staff shortage and fellow nurses who were frequently unsupportive of one another. The problems resulting from working shift-work and rotating rosters were also highlighted.

The process of recruitment of new graduate nurses was also raised by the participants and occurred in two ways. First, there was a belief that the programs were used to recruit new graduate nurses to the hospital offering the program often without regard to the resources available to support the new nurse. Some of the nurses believed that the program was used to boost the number of registered nurses employed by the hospital. The rotational aspect of the program gave the new graduate nurse exposure to several nursing specialties and the nurse unit manager from each of those areas was able to assess the suitability of each new graduate nurse for the possibility of full time employment upon completion of the program. In this way the program provided recruitment opportunities for the different areas of the hospital and was seen as one significant value for the continuation of these programs.

This Chapter discusses the four key issues that emerged from the combined findings. Conclusions will be drawn in the following chapter.

8.2 The Identified Discrepancy Between the Perception of Importance and Emphasis of the ANCI Competency Statements

Registered nurses are required to demonstrate competence of the ANCI National Competency Standards for the Registered Nurse. They may be used as a standard or benchmark against which to judge clinical practice, used for workplace performance review and to identify the appropriate knowledge, skills and attitudes required by nurses. It is for these reasons that hospitals incorporate the competencies into their transition support programs. There was a small uniform difference between the mean scores for the emphasis and the importance of each domain of the ANCI competencies in the transitional support programs that was shown by both groups of participants. The participants were asked to judge the emphasis that each ANCI statement was given in the

transition support program offered at their employing hospital and compare it with the importance that each statement had in their current nursing practice. The importance was always perceived to be higher than the emphasis of the statements and one possible explanation may be that the mean score was derived from the composite experiences of the participants from seven different transition support programs. Variations between the study sample programs may be in part responsible for the difference in the mean scores.

The highest and lowest mean discrepancy scores were displayed in Table 5.3. The greatest discrepancy related to the management of care domain, specifically the statements, *Provide holistic nursing to the patients in your care*, and *Provide appropriate education for your patients*. New graduate and experienced nurses concurred about patient education having a very low emphasis in the programs. This is to be expected as it would not be a priority for inexperienced nurses to focus on patient education during this type of program. The focus for new graduates in this study was to develop clinical skills and confidence in basic patient care. University preparation of nurses endorses the practice of holistic patient care, however, in practice new graduate nurses realise that management of nursing tasks takes priority over more holistic patient care issues. The statement related to holistic patient care rated by new graduate nurses illustrates this disparity between theory and practice. The other statement with a high discrepancy was from the enabling domain, *Provide appropriate education for your patients' relatives* and can be explained as for patient education above.

Low mean discrepancy scores were distributed more widely across the four domains of nursing practice. The lowest score for both experienced and new graduate nurses was *Improve time management skills*. This is not surprising as the completion of work in a timely manner is stressed throughout nursing practice. The other statement where both experienced and new graduate nurses agreed on the discrepancy was the *Opportunity to develop confidence in clinical practice.* Again this is not a surprising finding because one of the purposes of the programs is to provide a time of transition that allows the development of confidence in nursing practice.

The statement *Understand the function of the preceptor as a role model* received the lowest score for both emphasis and importance by new graduate nurses. This is supported by findings from the questionnaires, interviews and observations and directly contradicts the advertisements for transition support programs which state the benefits of preceptors for support and guidance during the program.

There was one negative discrepancy score for the statement *Experience a variety of different areas of nursing specialisation* (-0.20) by experienced nurses. They felt that the transition support program placed greater emphasis on the opportunity to work in a variety of different areas of nursing specialisation than was important to their current practice. This conflicts with findings from the questionnaires and interviews where nurses indicated that the rotational aspect was a strength of the program.

The textual data analysis from program materials revealed that one purpose of the programs was to provide an opportunity to consolidate clinical skills and develop confidence in practice. However, the emphasis in the programs was on the development of knowledge (by providing study days, learning packages etc) which reinforces other findings of this study that transition support programs are used to redress educational deficiencies in the undergraduate nursing programs.

Nursing practice is valued for the physical work and completion of tasks which may account for the higher rating of the importance of the statements to new graduate's practice (Ramsey, 1982; Bradby, 1990; Greenwood, 1993; Grbich, 1999; Philpin, 1999). The emphasis of the statements in the programs may not have been obvious because of the focus on ensuring the new graduate nurses performed and practiced within hospital based guidelines, rather than drawing on generic skills and experience gained during the undergraduate program.

8.3 A Time of Role Transition from Student to Registered Nurse

Much has been written which suggests that the new graduate's transition to the workplace continues to be stressful and difficult both in Australia and overseas (Clare 1993; Brighid 1998; Charnley 1999; Clare, et al 2002). New graduate nurses not only have to learn how to function satisfactorily at work, but also make significant changes in their personal lives. It is this time that Tradewell (1996) described as a rite of passage where the new graduate nurse is allowed to wear the registered nurse uniform and is required to master the stresses of shift work and be integrated into the hospital culture. Greenwood (2000) considered that the transition period was crucial in not only determining the new graduate nurse's commitment to nursing but also gaining the technical, clinical and patient management skills necessary to function as a professional registered nurse.

Adjustment to the new role

The participants in this study said that the transition support program allowed new graduate nurses a period of time to make the adjustment from student to registered nurse. They identified this time of transition as important particularly as it was a time when support was available to them and they felt a degree of protection or shelter by being part of the program. Even with the aid of the program some of the new graduate nurses in this study stated that they felt scared and apprehensive and lacked the confidence to carry out the job required. Only one new graduate nurse in this study said that she felt confident to work as a registered nurse upon graduation from university. The possibility that feeling apprehensive was a normal and expected response to starting any new job did not seem to be considered. The study participants described the transition as being a time for the new graduate nurse to find their feet and assimilate into the workplace. How smoothly this transition occurred depended on various factors such as different personalities on the wards, the actual wards that the new graduate nurse worked on and the degree to which the new graduate nurse was accepted into the ward environment.

The nurses in this study identified several issues involved with a successful transition period, such as the acquisition and performance of clinical skills while others related more to the socialisation process and a new language, new workplace rules and

regulations and different ways of thinking and doing things. According to Madjar et al (1997)

How well and how quickly newly graduated nurses are able to demonstrate mastery of their new role, acting in a safe, competent, sensitive, and confident manner, depends on a range of factors. In broad terms these may include:

- *personal qualities of each beginning registered nurse, including age, maturity, previous work experiences, motivation, aspirations, and availability of personal supports;*
- *the quality and extent of the educational preparation, including the nature and duration of structured clinical experiences during the pre-registration course, and the quality and rigour of formative and summative assessments within the course;*
- *the quality and duration of orientation/transition programs for new graduates provided by employing institutions;*
- *the expectations, attitudes, reactions, and behaviour of more experienced clinical nurses, nurse managers and other staff toward new graduates, the role modeling of expected behaviour by more senior nurses, and the prevailing ethos of the situation;*
- *the exigencies of clinical situations, staffing levels, and other demands placed on the registered nurse* (p.3)

All these factors were identified by participants in this study as influencing the quality of their transition program and the ease with which they assimilated into the workforce.

Acquisition and performance of clinical skills

This study revealed a perception that new graduate nurses entering a transition support program were inadequately prepared for clinical work as a registered nurse. The reasons given for this perception arose from the amount of time spent on clinical practice as a nursing student, the ability to apply theory to practice and the real or perceived deficits in knowledge. The ward staff wanted a nurse who could take a full patient load and the responsibility for patient care in a very short time after commencing work. This was

referred to by experienced nurses as “hitting the floor running” and many of the experienced nurses expressed disappointment at the lack of ability of the new graduate nurses to do this.

One of the major challenges for the nursing profession is the inconsistency between the preparation of nurses by universities compared to the requirements of the workplace. There has also been considerable disagreement about the pre-registration course since the transfer of nurse education to the tertiary sector (Reid, 1994) and tensions between the old and new forms of nurse education persist today. University nurse education combines both vocational and education aspects in their pre-registration course. The nursing curriculum in New South Wales is subject to accreditation by the Nurses and Midwives Board and unlike some other allied health professionals there is no internship or extended practice component. Universities are required to produce graduates who have achieved the Australian Nursing Council Inc. (ANCI) competencies as beginning practitioners. “The education sector sees itself as preparing graduates capable of lifelong learning, not only with vocational skills and minimum competence but also with broad generic skills and a grounding in academic learning and systems of knowledge” (Reid, 1994.p.*xviii*). On the other hand, nursing is a practice discipline and the workplace expects graduates to be able to practice as skilled registered nurses. The conflict between the goals of undergraduate education and the expectations of the workplace has caused experienced nurses to consider the reintroduction of a State registration examination upon completion of university education. Nelson (2005) asserted that it is the responsibility of the registering authorities to ensure that new graduate nurses are safe to practice and have acquired the necessary knowledge to maintain professional standards. This proposed practice would place Australian nurses on equal footing with their colleagues from the United States and Canada who are required to pass an examination prior to licensing. A State examination may confirm for other nurses that new graduates have acquired an acceptable level of knowledge and skill, however, it would not meet the need for the period of transition required to develop the attitudes and confidence necessary for practice.

Faculties and Departments of Nursing in New South Wales have responded to the suggestion of being unable to produce competent nurses with a number of changes in curricula and format. One of the main issues has been the content and quality of clinical placements experienced by students in their pre-registration course. This issue has been raised in major reports for several years (Madjar et al, 1997; Clare et al, 2002). New graduate nurses commence work as registered nurses with relatively little practical experience of the real nursing environment. The practical component of the undergraduate degree can give an unrealistic expectation of the work of a registered nurse since the student nurse works without the stress of responsibility for total patient care. Longer lengths of time on the ward have been recommended, along with realistic patient loads and opportunities for students to experience afternoon and night shifts. Faculties and Schools of Nursing teaching undergraduate programs require comprehensive feedback on the knowledge and performance of new graduate nurses from hospital staff. This would allow universities to evaluate their programs to meet the changing needs of the clinical environment which may reduce the perception that new graduates are ill prepared for the role of the registered nurse.

The inability of many new graduate nurses to work as competent registered nurses immediately upon entry to the workplace has caused some to consider whether the nurse has deficits in their knowledge base or whether they have difficulty applying the knowledge that they do have to the current situation. It seems that new nurses must make a major leap to advance from knowing how to do tasks to understanding why they are doing them for the patient now under their care. This has become known as the theory-practice gap and gives rise to issues of competence. The difference in the expectations of what can reasonably be expected from new graduate nurses seems to be at the root of this issue. The final report of the Federal Government Review of Higher Education Financing Policy – Learning for Life document identified the attributes society should expect from a graduate at the completion of their first degree. These attributes include:

- *the capacity for critical, conceptual and reflective thinking in all aspects of intellectual and practical activity;*

- *technical competence and understanding of broad conceptual and theoretical elements of the field of specialisation;*
- *intellectual openness and curiosity and appreciation of the interconnectedness and areas of uncertainty in current human knowledge*
- *effective communication skills in all domains (reading, writing, speaking and listening);*
- *research, discovery and information retrieval skills, and a general capacity to use information;*
- *multifaceted problem-solving skills and a capacity for teamwork; and*
- *high ethical standards in personal and professional life, underpinned by a capacity for self-directed activity* (Department of Employment, Education, Training and Youth Affairs, 1998).

Despite these attributes being defined for graduates, there continues to be confusion about the expected performance of new graduate nurses. The differences in the perception of their performance by different members of the health care team further complicates the issue of clinical competence and is unhelpful for the new graduate. Madjar et al (1997) found that new graduate nurses held a higher expectation of being able to perform competently than did the experienced nurses. Heslop, McIntyre & Ives (2001) found that most new graduate nurses felt adequately prepared by their pre-registration course in relation to knowledge, clinical experience, skill level, time management and decision making. While there are positive aspects to this level of confidence, it is a view not often shared by other nursing staff. Roberts and Farrell's (2003) study indicated different levels of nurses could not agree on the level of performance of new graduate nurses. With this sort of discrepancy among the registered nurses it is little wonder that the support offered in this study varied widely from ward to ward as new graduate nurses rotated through the transition support programs. This also explains to some extent, the reasons the experienced nurses felt as though they needed to assess and reassess the competency of each new graduate nurse for themselves.

The nurses in this study spoke of the relationship between knowledge and experience and recognised that they had knowledge from their university course but felt they needed time to consolidate their skills through practice. Kolb (1984) asserted that even though new graduate nurses had accumulated a body of knowledge, such knowledge was awaiting transformation through clinical experience. If we also consider the landmark work of Benner (1984) a clearer understanding of how nurses develop skills can be gained. Benner applied the work of Dreyfus and Dreyfus in their study of skill development of airline pilots and chess players to develop five levels of skill acquisition for nurses. The skill levels she identified were: Novice, Advanced Beginner, Competent, Proficient and Expert. If we are to accept this model, we must conclude that university can only do part of the job of preparing confident and competent practitioners since competence is built layer upon layer over time. It is therefore an unrealistic expectation of the profession and the workplace that new graduate nurses straight from university can perform as independent experienced registered nurses. New graduates may be able to perform a single clinical skill competently, but to be viewed as a competent practitioner requires many clinical experiences to be culminated, as opposed to its component skills.

Generally the literature showed that new graduate nurses felt there were unrealistic expectations to perform immediately as a competent and confident registered nurse (Brown & Olshansky 1997, Oermann & Garvin 2002, Roberts & Farrell 2003). Inadvertently, this caused new graduate nurses to experience ‘a pervasive feeling of needing to prove they were good nurses to themselves and their colleagues to gain professional acceptance’ (Goh & Watt, 2003, p17). The new graduate nurses in this study found it difficult to refuse requests from experienced nurses for fear of ridicule or not fitting in even if they thought the request was unreasonable.

At other times it was not just the application of knowledge that needed to be nurtured, there were clear shortfalls in the knowledge that had been acquired at university. Examples of this type were not new and are widely canvassed in the literature (Greenwood, 2000; Clare, et al, 2002). Clinicians and academics have long debated about the clinical preparation of graduate nurses and there seems little consensus apart

from the view that universities cannot produce expert practitioners in isolation from the actual workplace (Chang & Daly, 2001; Roberts & Farrell, 2003; Goh & Watt, 2003). It is expected that upon graduation from university new graduate nurses are able to function at the beginning practitioner level which is the equivalent to the advanced beginner in Benner's (1984) work. There were times in this study, however, when this was not the case.

When nurses with a knowledge deficit were identified at one of the study hospitals, they were given extra materials and learning contracts to address their learning needs. The program coordinator and the new graduate nurse determined by mutual arrangement to work together to increase the knowledge and skills required. This approach drew heavily on resources of time and money, and the collective efforts of the new graduate nurse and the program coordinator. The ward area where the new graduate nurse worked was also denied the full working capacity of the staff member because even though they were on the roster as a registered nurse, they were unable to work effectively in that role. The repercussions for other nursing staff on the ward were that they were required to cover the resulting gap in appropriate nursing care as well as maintain their other nursing responsibilities on the ward.

As a result of this perception that new graduate nurses were insufficiently prepared to work as registered nurses, the transition support programs have developed along the lines of either deficiency or skills consolidation models. Reid (1994) first defined these two models in 1994. The 'deficiency model' is based on the premise that university preparation of new graduate nurses is inadequate and transition support programs are needed to rectify this deficiency. Alternatively, the 'skills consolidation' model was based on the premise that a period of supervised practice was necessary to consolidate clinical and decision making skills and help the new graduate nurse to orientate to the workplace and culture of the nursing profession. The transition support programs in this study combined aspects of both of these models and provided the nurse with what Reid (1994) had earlier described as a period of learning and adjustment to the requirements of nursing in which the graduate acquired the skills, knowledge and values (additional to

those learned during undergraduate study) required to become an effective member of the nursing workforce.

Supportive measures

The importance of support was indicated throughout all data sources. Examples of supportive measures that were raised by this study's participants could be divided into two distinct areas, those relating to the structure of the transition support program, including study days, supernumerary days and education packages, and those relating to the health professionals who offered support, who were frequently the preceptors and nurse educators. All of the transition programs in the study purported to have a supportive learning environment. These supportive measures included orientation for the new graduate nurse into the hospital and to the ward environment, study and supernumerary days, preceptors to assist the new graduate nurse and the opportunity to rotate to a number of different specialty areas during the transition support program. There is no shortage of literature to vouch for the supportive value of each and every one of these measures for the new graduate nurse (Reid, 1994; Stevenson et al, 1995; Walker, 1998; Gerrish, 2000) but several issues require further discussion. For instance; the orientation period was provided to give information to new employees about their place of employment. The documents showed that the orientation for new graduate nurses was split into a general orientation to the hospital, where they would possibly join all new hospital employees and learn about the hospital generally, and a ward specific orientation, where they would go to the ward where they were to be rostered for their first rotation. It is the ward specific orientation that has come under scrutiny. A number of hospitals use this time for new graduate nurses to be assessed on some of the competency requirements of the hospital. It is only after the successful completion of the competency requirements that the nurse can work independently. Assessment of the required tasks during the orientation period was seen as being a supportive measure because then the new nurse was able to work independently without being forced to rely on another nurse to attend those tasks in which the nurse was not accredited.

There was, however, another way to view these practices. It seems the whole notion of support is bound up in re-education of the new graduate nurse. The learning packages and study day schedules give no indication of applying adult learning principles to the content or any recognition that the new graduate nurse might be able to identify what they need to learn or experience themselves. It could be argued that the assessment practices reinforce the nurses' perceptions that new graduate nurses are ill prepared by the undergraduate university course and are unable to function independently. When new graduate nurses rotated to a new ward area they were frequently bombarded with a large amount of new information in a short period of time which many found overwhelming. There were also clinical skills to be mastered and assessed, many specific to each individual specialty area. This practice helped to foster a learned helplessness and dependence on others.

In the context of the present study it is suggested that a less stressful approach might be to accomplish the required competencies when the new graduate nurse was working closely with a preceptor during the initial shifts on the ward. In this way, the new graduate nurse could develop the competence required for the new role while being supported by the preceptor and concentrate solely on the new tasks at hand.

Preceptorship

While each of the transition support programs advertised the use of preceptors, the study participants reported that it was more common for new graduate nurses not to work with one. It was considered that some of the problems in the development of the preceptor-new graduate nurse relationship were caused by staff shortages and rostering. Sometimes, a new graduate nurse was allocated a preceptor only to find that they were rarely rostered to work the same shifts or the preceptor went on holidays while they were rostered to that clinical area. Irrespective of the reason, preceptors were often unavailable for new graduate nurses on each rotation. The effect that this had on new graduate nurses was that they were expected to work independently. Even though other registered nurses sometimes offered to help them, the registered nurses' heavy workloads frequently

prevented them from being with the new nurse and assisting them as they would have liked.

However, when a preceptor was allocated by the hospital, they usually fulfilled several roles, one being that of a role model in both clinical and professional areas. Many of the interviewees believed that new graduate nurses learnt much from experienced preceptors and that they could influence the process of transition in a positive way. Their concern was that with the nurse shortage suitable preceptors were not always available and the people that new graduate nurses learnt from may not necessarily be the best person to teach them. Myrick & Yonge (2002) outlined the importance that role modeling had for teaching professional attitudes and behaviours, so the lack of experienced nurses on the ward deprived the new graduate nurses of this valuable resource. As a role model and contact person the preceptors had knowledge of how the ward and hospital worked, how practice ought to be accomplished, and how best to go about achieving patient goals. This type of knowledge was developed from experience and was often not written anywhere or available in procedure manuals.

When new graduate nurses had an experienced nurse working along side them, they were able to ask questions as they arose from someone whom they knew to be an approachable experienced practitioner. In this situation the new graduate nurse could also observe the experienced nurse working competently with patients and co-workers during the day and was likely to model their own behaviour on that of the experienced preceptor. Conversely, during observation it was noted that not all experienced nurses modelled professional behaviours and practices. This resulted in new graduate nurses sometimes modelling nursing practice in the desire to be accepted by the team rather than from evidence based practice or previously acquired knowledge.

The preceptor also fulfilled the role of assessor which included correction of any unsafe practices of the new graduate nurse and it also included the role of advocate should the new nurse be the recipient of any unfair treatment. It seemed that by being introduced by an experienced nurse somehow gained the new graduate nurse acceptance into some

inner circle or culture. This socialisation aspect was very important for the new graduate nurse because it forged a link with other registered nurses enabling the new nurse to develop friendships and professional relationships. These professional relationships provided the new graduate nurse with opportunities to share their experiences and gain from the experiences of others. The preceptor could make the transition from one clinical area to another less stressful for the new nurse as the preceptor facilitated the acceptance of the new graduate nurse into the new team.

The nurses in this study, though they did highlight the clinical expertise aspects and the assessment role of the preceptor, they regarded the accessibility of the person as the most important supportive quality. They spoke of friendly faces and people who would advocate for them if the need arose, and the benefits of being introduced to other nurses by their preceptor in gaining acceptance into the workplace. Madjar et al (1997) also found that effective support for beginning practitioners came from nurses who were approachable, willing to explain and demonstrate, willing to help but not to take over, and who provided frequent, realistic and positive feedback as well as correcting mistakes. This type of support could be provided by a very experienced nurse or from a second year registered nurse, the degree of experience did not seem to be the key factor. The role of advocate is essential to new graduate nurses to make them feel less powerless and excluded from the workplace. Being labelled a new graduate, the multiple educational packages and rotating through various workplaces all combined to reinforce the view that new graduate nurses had a second class status compared to the other registered nurses. Without an advocate to support them, the new graduate nurse may not cope with the challenging complexity of contemporary Australian health care and could in some way explain the poor retention rate of nurses in hospitals in New South Wales today (Buchanan & Considine, 2002).

The preceptor / new graduate relationship had potential benefits for both parties. The preceptor benefited by having their expertise acknowledged and experiencing the satisfaction of watching the new graduate nurse gain skills and confidence. Although the new graduate nurses in this study recognised the usefulness of being appointed a

preceptor, there were no responses from the experienced nurses endorsing the role of preceptor from their point of view. Nurses have written about the increase in workload while precepting a new graduate nurse, consequently, it is important that the preceptor choose the role rather than have it imposed upon them by the Nurse Unit Manager or some other person in the hierarchy of the hospital, as is sometimes the case. To this end, it is essential for the workplace to acknowledge some of the challenges of being a preceptor and reward them appropriately. Madjar et al (1997) recommended that employing bodies need to develop ways of selecting and rewarding experienced clinical nurses who can act as preceptors for beginning registered nurses, and that they be facilitated to attend workshops, conferences or other learning situations to enhance their role development. Currently, preceptors receive no incentive or reward from either the hospital or Department of Health to act in the role which means they take on the role of preceptor in addition to their other responsibilities as a registered nurse.

Clinical nurse educators and program co-ordinators were also found to be supportive of new graduate nurses during the process of transition. The way that the nurses operated within these roles varied across hospitals and sometimes between wards in the same hospital. These nurses could assist new graduate nurses to develop their skills and apply theoretical knowledge to their practice in the absence of preceptors but were usually only available during regular office hours. Two of the study settings offered this type of support for other shifts. The only negative aspect identified about any of the coordinators was that they were very busy, often with paperwork that kept them off the wards and away from the new graduate nurses.

Being identified as a new graduate nurse

Being identified as new graduate nurses was seen as having both advantages and disadvantages by the new graduate nurses. The major benefit was that they felt that the label allowed others in the health care system to know that they were new graduates and as such, were expected to have limited knowledge and experience. It was also hoped that other health care workers might take the time to demonstrate procedures and/or let the new graduate nurse share the procedure or experience with them. This process allowed

the new graduate nurse to practise in a supported environment which helped them develop confidence in their practice.

Learning packages and assessments

Another component of the transition support program was the completion of learning packages, performance review and assessment, the attendance at study days and the experience of a variety of clinical rotations. Learning packages were structured in two ways, either as orientation or learning materials related to each ward. The perceived advantages of these packages were that the new graduate nurse gained valuable knowledge about the ward routine, where to find things, and common questions or matters that arose in the running of such a ward which meant they did not have to rely constantly on others for information and direction. A major disadvantage was that the new graduate nurse spent the first day on the ward predominantly alone which meant that they had to negotiate their own introductions, tea and lunch breaks, and since they didn't know anyone, these would probably be spent alone which could make them feel quite isolated. This was not the warm welcome that Madjar et al (1997) found to be beneficial for a new graduate nurse who hoped to feel accepted and valued upon entering the workplace. The hospitals opted for a uniform or blanket approach to the education since the new graduate nurses were not assessed to determine the skills or knowledge that they already had prior to the presentation of the educational packages. This practice not only stripped the new graduate nurses of confidence but resulted in the new graduate nurse being required to complete an assessment package about a specialty area in which they had little or no interest. Similarly, Clare et al (2002) reported that new graduates were tired and did not want any written assignments that many felt were pointless. The completion of packages and written material reinforces the notion that these new nurses were inadequately prepared by university programs.

What was found to be more useful than the performance appraisal for the new graduate nurse was feedback from the experienced nurses on a regular basis (Lofmark & Wikblad, 2001; Oermann & Garvin, 2002). Unfortunately it seemed that new graduate nurses were quick to be told if they are doing something incorrectly and ignored if everything was

satisfactory. Heslop, et al (2001) found that nearly half of the new graduate nurses in their study expected some feedback from their preceptor, nurse unit manager and other nurses they worked with. The new graduate nurses in this study indicated a strong desire for support, reassurance and guidance to be offered on a regular basis and they preferred continual and immediate feedback rather than having to wait for the formal evaluation at the end of their rotation.

Ward rotations

Participants in this study were unanimous in their belief that the rotational aspect of the programs was beneficial. Some hospitals adopted a fixed approach to the delivery of transition support programs which meant the structure of the program, including both the placement and the length of time spent in each specialty area was set before the new graduate nurse accepted the position. Other programs allowed the new graduate nurse a very limited variety of placements, though were much more flexible in considering the new graduate nurse's clinical preferences. Though there seems to be little consensus about the optimal number, type or duration of rotations some of the advantages and disadvantages raised by the nurses are worthy of further discussion.

For those programs that offered fewer longer rotations, the new graduate nurse could expect to become very familiar and comfortable with the type of nursing care frequently required in that ward and the day-to-day running of the ward. They became confident with the skills commonly used on the ward and felt comfortable performing them and were able to anticipate the care that would be required in a given situation. Because they were rostered to the ward for a longer period of time, they were less likely to be known as the 'new grad' and more likely to be accepted as part of the team by other nursing staff. The major disadvantage according to the new graduate nurses was that they would experience fewer specialty nursing areas. The new graduate nurses in this study valued the opportunity to work in specialty areas though the reason underlying this remains unknown.

The nurses outlined two main advantages of transition support programs with more, shortened rotations. The first was they experienced many different nursing specialties and that was seen as helpful with their final selection of where to work. The second was that if they found that they did not enjoy working in one particular area they knew that they would not have to stay in that area for very long. This rotation schedule balanced the advantages for the new graduate nurse in gaining an overview of the hospital and the different nursing specialities available, with the difficulty many have in settling in one place and feeling part of a team.

The effect that rotating through a number of different wards in a 12 month period has on the nursing practice of new graduate nurses is also unclear. Benner (1984) suggested that new graduate nurses were functioning at the advanced beginner level and consequently believed that few would advance to the competent level with less than approximately 18 months experience in any one specialty area. She was of the view that if a nurse was transferred to a different specialty their skill level would revert to that of the advanced beginner even if they were competent in another specialty area. As all transition support programs offer a number of rotations within the 12 month period, the nurse's level of confidence in their skill and knowledge would decrease from their previous level of functioning at the beginning of each rotation.

Some specialty clinical areas were favoured by new graduate nurses as potential permanent workplaces while other clinical areas held little appeal. The new graduate nurses in this study stated a preference for working in acute care settings over less technical areas such as aged care and rehabilitation. This concurred with Heslop, et al (2001) who found that the three clinical rotations preferred by new graduate nurses were surgical, paediatrics and emergency nursing. The new graduate nurses seemed to believe that nursing skills were only consolidated in an acute care setting. As one new graduate nurse explained "some placements – like mental health – while being interesting, took time away from experience on the clinical side" (McKenzie, 2001c. pg14). The view that consolidation of skills can only occur in an acute care setting reinforces the perception that the focus of transition support programs is on skill development rather than the

development of a registered nurse able to provide wholistic care to patients in a variety of settings.

Hospitals have a vested interest in recruiting new graduate nurses to their facilities as they attempt to fill chronic staff shortages in all clinical areas. Because most new graduate nurses believe they are required to work in an acute healthcare setting to acquire the appropriate experience as a registered nurse it makes the relationship between new graduate nurse placement and staffing a complex one. Obviously not all new graduate nurses undertaking a transition support program are able to work in their choice of nursing specialty area, especially when a lot of nurses continually seek experiences in areas that have a limited number of vacancies (such as paediatric units). The programs offered by all of the hospitals in this study had positions especially reserved for rotations by the new graduate nurses in all clinical areas suggesting that hospital management uses the nurses undertaking the transition support program to provide the nursing numbers in all areas of the hospital whether the new graduate nurse has a preference for that specialty or not.

Undertaking a transition support program

The transition support program today has evolved into another year of nurse education that new graduate nurses feel compelled to both complete and pass. It is only after the successful completion of such a program that new graduate nurses feel able to move forward professionally and personally. Transition support programs are not compulsory before proceeding to independent practice, however, the hospitals exert a powerful influence over new graduate nurses by not employing anyone who has not completed a transition support program. The human resource departments from each of the sample hospitals verified that they would not employ a first year registered nurse straight from university unless it was through a transition support program. The New South Wales Nurses and Midwives Board expect that new graduate nurses will have access to and direction from experienced registered nurses at the commencement of their working career (Nurses and Midwives Board, 2004) however there was no mention of transition support programs being either necessary or compulsory. None-the-less, new graduate

nurses are left in a situation where they are unlikely to be able to secure employment without having completed one.

Although some nurses knew of people who had resigned from a program for various reasons, every one of the new graduate nurses interviewed in this study completed the transition support program they had commenced. Many nurses spoke of the program as being a professional year and thus it became an expected extension of their tertiary education. Although the hospitals stated that one of the reasons for the transition support program was for new graduate nurses to find their niche, all of the new graduate nurses interviewed said that if a nurse expressed a desire to leave the program, preferring to stay in a ward where they were working happily, it was discouraged in some hospitals and forbidden in others. This suggested that nurses in the transition support program were used to boost the total staff numbers for the year's duration and help provide staff for less popular areas of the hospital.

8.4 Hospitals are a Difficult Workplace

The workplace common to nurses in this study was described as a tough place to survive, where the demands of shift-work and staff shortages were compounded by bullying, bitchiness and harassment. These conditions often resulted in a lack of support for new graduate nurses. The management of the transition support program at the ward level, the control exerted by the nurse unit managers and the need to complete the transition support program were also considered to contribute to the difficulty of work.

Bullying practices

The concept of bullying in the workplace is not new, nor is it unique to nursing. Most of the nurses interviewed spoke of bullying or horizontal violence among their peers and would readily describe the wards in each of the hospitals where bullying was known to regularly occur. It seemed that every hospital had a 'bad' ward and even though this was not condoned, it did seem to be accepted as the 'way it is'.

In this study new graduate nurses identified behaviours as either welcoming and accepting, or derogatory depending on what was said and the way in which it was delivered. If a group of nurses were speaking in a negative way about one particular new graduate nurse, then all other new graduate nurses felt identified in the same way and reported feeling belittled by this experience. Two of the interviewees in this study stated that they did not work in their chosen specialty area due directly to the bullying of the staff already working there. Both nurses had been rostered to their area of choice as part of their transition support program, but when considering permanent work, opted for other work areas. Obviously this has implications for recruitment and retention of nursing staff.

The ability to understand and adapt to the culture of the hospital was raised in one of the closed scaled response questions. The nurses were asked to consider the emphasis this aspect of nursing was given in the transition support program and the importance they felt it had in subsequent nursing practice. The perceived lack of importance of this phenomenon was, on the surface surprising, though if one considers the behaviour of oppressed groups of people it becomes more understandable. DeMarco and Roberts (2003) described a silencing behaviour whereby an oppressed person learns to suppress feelings and needs in an effort to cope with powerlessness. This behaviour usually applies to women and since the majority of nurses are women, outspokenness is not encouraged. Women, it seems, would choose silence to avoid negativity and conflict. The new graduate nurses in this study did not complain about their work conditions to the nurse unit manager even when they believed that they were being unfairly treated.

New graduate nurses were not the only nurses to experience bullying in the workplace. FitzGerald & Amadio (2001) stated that bullies usually picked on people who were perceived to have little or no power within the hierarchy. The nurses in this study felt that trainee enrolled nurses, agency staff and some of the staff from hospital casual pools were also the target of bullying tactics so it seemed that any nurse not permanently rostered, or belonging to the ward could be seen as vulnerable and become a likely target. It was difficult for new graduate nurses to be viewed as permanent staff members on any

ward due to the rotating nature of the transition support program. They were more likely to assume the role of a visitor and subsequently lack a sense of belonging to any one ward which made the nurse more vulnerable to bullying, regardless of their status. The implications for the rotational aspects of the transition support programs is clear as a reduction in the number of rotations would allow new graduate nurses to work for longer periods of time in one ward, become an accepted member of that ward and thereby reduce the chance of bullying.

Nursing staff shortages

Nurses in this study spoke of working without the benefit of having experienced nurses who were rostered to a particular ward to guide their practice or act as role models. These nurses suggested that having nurses who regularly worked on the wards was important because they possessed knowledge pertinent to that ward that other staff from other wards or nursing employment agencies did not have. Without a clear understanding of the way that a particular ward operated the imported nurses, at times, needed to seek constant clarification and information that interrupted the team leader repeatedly during the shift. It was further suggested that the inexperience of these nurses made them slower in their practice so that performance of basic nursing became a challenge. As a result these nurses were seen as not suitable role models for new graduate nurses and the participants in this study expressed concern about the effect on patient care and the increase in stress levels for all staff working frequently under such conditions.

The effect of nurses working in relief or non-permanent positions was also raised by nurses interviewed in this study. As experienced nurses left the hospital system, other nurses, often those with less experience were asked to relieve in the vacant position until a permanent replacement could be found. The nurses who filled these positions were often inexperienced in the role, gained little job satisfaction and suffered feelings of stress due to being over committed (McGibbon, 1997). The practice of acting in a role frequently took another clinical nurse off the floor to fill a management position which ironically exacerbated the shortage of experienced clinical nurses and role models readily accessible to the other staff on the ward.

Each ward that the new graduate nurse rotated through functioned independently and frequently interpreted and managed the transition support program differently. These differences meant that new graduate nurses had to constantly adapt to the changes between wards. There were also variances in the expectation of what new graduate nurses could and couldn't be reasonably expected to do, and in the evaluation forms used to appraise the performance of new graduate nurses. Because of these inconsistencies it was difficult for the new graduate nurses to understand and maintain practices common to each ward and impossible to generalise skills learnt from one ward to another. This disempowered the new graduate nurses because they were always seen as new, always having to ask what should be done and how it should be done even though they may have been able to comfortably accomplish the same task while working on their previous ward.

Unsupportive practices

The ways in which support was offered to new graduate nurses has already been discussed, but there were also times when support was unavailable. Unsupportive practices at work included the times when new graduate nurses were left to work alone and assume the full responsibility of the registered nurse.

The current nurse shortage in New South Wales hospitals was cited as the reason for new graduate nurses being left to work alone in this study. This was a major downfall of the rotational aspect of the programs since the ward areas had a continual reduction in the number of skilled nurses due to constantly rotating inexperienced nurses. Alternatively, if the wards were allowed to recruit directly or keep the new graduate nurses for a longer period of time, they would have a more experienced and settled worker after approximately three months continual experience on the same ward.

This study found that the occasions when new graduate nurses were left unsupported most frequently were weekends, afternoon and night shifts when nurse educators and managers were less available and is reinforced by Horsburgh's (1989) study. As a result new graduate nurses felt stressed and confused about their role on the transition support

program. On one hand they were expected to perform without supervision and take extra responsibility for ward management, while on the other hand, they were considered to be part of a controlled and supported program that highlighted their lack of preparation for ward work.

Given that the hospital system has no written or identifiable component of practice specifically for new graduate nurses, it seemed that the demands of the ward dictated what responsibilities the new graduate would have on any given day (Horsburgh, 1989). Additionally it seemed on the study that it was acceptable for a new graduate nurse to work as a registered nurse if there was no-one else available. These times usually occurred when the ward was short staffed, at times when clinical nurse educators were unavailable to help or to fill rosters that senior staff chose not to do. This translated to a situation on morning shifts, when staff were more plentiful, where support and dependence were fostered while on afternoon and night shift, new graduate nurses were frequently left with the sole responsibility for a group of patients. The inconsistent expectation of new graduate nurses' ability was confusing for the new nurse and delayed their professional development.

If a new graduate nurse was placed in charge of a shift, as was frequently the case in this study, this increased responsibility further compounded the new graduate nurses' sense of confusion.

New graduate nurses in this study reported being in-charge of shifts during their transition support program. This meant that they were not only responsible for their own actions but also for the actions of other levels of staff. Horsburgh (1989) stated that no other professional group expects their practitioners in first positions to take this role. Although the new graduate nurses in this study indicated that the staffing situation was unacceptable, very few actually refused to shoulder the extra responsibility. This situation also reflects the perceived powerlessness of the new graduate nurses since none of them indicated that they could or would refuse to take the in-charge shift.

The positive or supportive aspects of being identified as a new graduate nurse has been discussed in the previous section but there were also disadvantages cited by the new graduate nurses in this study. They described how they never really felt accepted as part of any ward where they worked and felt they were only the new grad, the visitor. Feeling accepted as a team member on the ward could be difficult for new graduate nurses, in part, due to short rotations, but the problems were intensified when they were identified as being something other than a registered nurse. Madjar et al (1997) and Clare and van Loon (2003) found that a friendly welcome to the ward and being addressed by name rather than just the label ('the new BP' [beginning practitioner]) created important initial impressions. Duke, Forbes & Strother (2001) also considered that one of the shortcomings associated with transition support programs was that some of the staff would see new graduate nurses as a student of the program rather than as a colleague.

This lack of belonging may also explain how and why new graduate nurses felt left out of social events happening on the ward. They reported that they were sometimes not invited to dinners and other social events held for ward staff and how they felt they were given inequitable rosters compared to the other registered nurses on the ward. These situations resulted in the new graduate nurses often feeling undervalued for their role in the team and unhappy in the work environment. Nurse unit managers may have considered it more beneficial for the long-term management of the ward to keep permanent staff happy with rostering requests rather than worry too much about a visiting new graduate nurse. The lack of acceptance as a team member is further exacerbated by the rotational nature of transition support programs as the new graduate nurse is continually viewed as the visitor to the ward.

Another disadvantage raised by the new graduate nurses related to the rostering system used on the wards. Each ward roster was written in a hierarchical format with new graduate nurses close to the bottom of the list. Since the roster may have been written before the new graduate nurse rotated to the ward, they become known as the 'new grad' rather than by name. This habit became difficult to break after the actual person went to the ward and new graduate nurses were often addressed as the 'BP' (beginning

practitioner) rather than by their name. The identification process sometimes became further discriminatory with new graduate nurses being identified either as a 'first rotation' or 'second rotation' nurse, or being identified as part of their intake group. For example, they may be identified as part of the 'January group' or 'February group' depending on their commencement date. If this were the case the January group nurses would be expected to know more and cope better than the February group nurses. The more rotations the new graduate nurse had completed in the program, the less support was deemed necessary, which meant these nurses may commence work on a rotating roster from the beginning of the rotation. These nurses were subsequently deemed to be more experienced than those with less rotations and depicts the way in which the hospital pecking order is established according to nurses' clinical experience on the ward.

Shiftwork

The challenges presented by shiftwork have been well reported in the literature and are not restricted to nursing (Wallace, 2003). Buchanan & Considine (2002) found typically, that nurses felt that shiftwork was detrimental to their health, inflexible and antisocial. Some of the new graduate nurses in this study said that while they were young with few commitments or family responsibilities it was manageable, but felt that later they would probably look for a management or education position with more regular hours. The shiftwork was not the problem per se because it was an expected part of nursing but the inequity that many new graduate nurses experienced with the rostering system was not acceptable. The new graduate nurses believed that they were unfairly treated with the rosters in that they ended up working more of the unpopular shifts such as weekends, afternoons and night shifts, than other registered nurses on the ward. The unfairness demonstrated toward the new graduate nurses indicated a disregard for them as new health professionals that could lead to general disenchantment with the profession. Another consequence of this rostering distribution related directly to safe practice and patient care as new graduate nurses were rostered to work the less popular shifts, when experienced nurses were not available to support them. It seems that little has changed since Horsburgh (1989) found that new graduate nurses had total responsibility for a group of patients without appropriate supervision and support.

8.5 The Role Played by Transition Support Programs for Recruitment and Retention of Nurses

There was widespread agreement from both groups of registered nurses that one of the major purposes of offering transition support programs was to provide the hospital with nursing staff. With the current shortage of registered nurses, hospitals are left to fill nursing vacancies the best way they can so recruitment of new graduate nurses is crucial. Some of the sample hospitals now employ nursing students as assistants in nursing and offer scholarships to nursing students to assist with the cost of their education in return for accepting a position in the transition program at that hospital following completion of their university degree.

The relationship between transition support programs and recruitment was shown in the study to occur in two ways. The first was recruitment of newly graduated nurses into the transition support program offered by the hospital and the second was the recruitment of the nurses while they were participating in the program to take up positions in specific ward areas upon completion of the program.

The second type of recruitment differs from retention in that each ward, operating independently, seeks staff to complement their own nursing teams and often find themselves competing with nursing teams from other wards. Regardless of the ward area where the nurse chose to work after the transition support program, the hospital would report that the nurse had been retained at the hospital. Anecdotal evidence from one of the transition support program coordinators suggested that up to 60% of new graduate nurses were retained by the hospital offering the program for approximately six months after program completion. It seems that new graduate nurses consider their work options after completion of their program and then move to an area that suits them whether at the original hospital or another.

Even though it was widely believed that transition support programs were used to entice new graduate nurses to the hospital, the literature shows that the actual transition support program is not among the first considerations by new graduate nurses when seeking employment. Heslop et al (2001) found that locality was the major factor to influence the

choice of program. This finding was confirmed the following year by White (2002) who reported that of the 13 factors previously known to influence the employment choices of new graduates, the most influential factor was the proximity of the hospital to their place of residence. Other factors rated by the new graduate nurses as having a high influence, in descending order, were the experiences and treatment by hospital staff whilst on clinical placement, the type of transitional support program offered – length of program, number of study days, number and type of clinical rotations, access to specialty areas such as operating suite / intensive care unit / emergency departments, and the services provided by the hospitals (White, 2002). If this is the case then the hospital's continued emphasis on length of program and number of rotations to different clinical specialties during the program must be based on their need to recruit staff not the needs of the new graduate nurses.

Several experienced nurses from different settings in this study stated that the number of new graduate nurses being accepted into transition support programs was rising each year. They considered that the hospital administration constantly filled vacant nursing positions with new graduate nurses regardless of the ability to provide adequate support for them. This practice, though it may alleviate nurse shortages is a two edged sword as the more inexperienced people are recruited, the less the support that can be offered.

The diminishing number of experienced nurses meant that there were fewer people available to help and support new graduate nurses on a day to day basis. Even though the number of staff rostered may have appeared adequate, there was a dearth of experience that meant the new graduate nurse was unable to seek clarification and a second opinion from a more experienced staff member as the need arose. This practice was perceived as a lack of support and sometimes left the new graduate nurse floundering.

The rotational aspect of the transition support programs was also raised in connection with recruitment and retention. The opportunity to experience a variety of different areas of nursing specialisation was raised in one of the closed scaled response questions on the questionnaire (see Section 5.2). The opportunity to rotate through different nursing areas

was both emphasised as a valuable component of the program and considered important to subsequent nursing practice by the nurses in this study. The reasons underpinning this are unclear. It seems as though there is an expectation that new graduate nurses will make a permanent career choice straight after leaving university.

This study further found that as part of the application process to the New South Wales New Graduate Nurse Recruitment Consortium new graduate nurses were asked to nominate their first clinical area preference. From 54 clinical areas, the most popular were emergency, medical / surgical, paediatrics, midwifery, operating theatre and intensive care units. Least popular areas were developmental disability, psychogeriatrics, rehabilitation and Aboriginal health (White, 2002). This is a worrying trend for the nursing profession since the single largest specialty or principal area of nursing practice for registered nurses in 2000 was geriatrics / gerontology with 17.2% working in that specialty (Statewide Services Development Branch, 2000). Nurses in this study reiterated these findings and were quite definite about the perceived lack of value of working in aged care, rehabilitation and other less acute areas. These areas of nursing lack the apparent glamour of emergency or intensive care departments and may be influencing the new graduate nurse's perceptions. Short, Sharman and Speedy (1998) suggested that nurses chose to work in high technology areas such as intensive care units, operating theatre and acute surgical wards because they could demonstrate competence similar to medical personnel. Whatever the reason, the nursing profession will need to seriously consider the implications of attracting nurses to work in the growth areas of geriatric, mental health and other less acute areas of nursing.

There are a number of long standing features of nursing work that continue to cause both recruitment and retention problems, some of which have been identified in this study. These include shiftwork, the heavy nature of nursing work, limited opportunities for career progress and poor recognition for nursing work (Buchanan & Considine, 2002). These factors take a huge toll on the nurse in both their personal and professional lives. One nurse wrote about her work "for the time being I enjoy it. But I do worry about the future. I simply can't imagine myself working in a clinical position and raising a family"

(McKenzie, 2001b p.13). So it seems that nurses leave their career of choice even though they enjoy the work because the working conditions do not fit with other aspects of their life.

8.6 Summary

Although nurses continue to be prepared at Bachelors level through university programs there is a commonly held view that these programs do not prepare neophyte nurses for real life practice as a registered nurse. As a result, transition support programs have proliferated to redress this perceived inadequacy and new graduate nurses have little choice but to enter the workforce through such a program.

Hospitals provided tangible support for new nurses via the structure of the programs, through study and supernumerary days and education packages and by providing clinical nurse educators and preceptors. The role of the new graduate nurse while employed on the program was considered supportive because they were identified as a new practitioner and it was assumed that they would be treated accordingly.

While these programs may have had the best intentions of providing a supportive learning environment for new graduate nurses to begin their professional practice, they had a number of short comings. The lack of experienced ward staff, the large number of nursing vacancies, the culture of the nursing environment and the pressure on new graduate nurses to take extra management responsibilities were all aspects that influenced the degree of support provided by the programs. The times when new graduate nurses were left to work unsupported occurred most frequently during the less popular shifts of weekends, afternoons and nights. Working without support was taken further when new graduates accepted the responsibility of being in-charge of the shift.

The rotational aspect of the program was thought to be beneficial however the true benefits of rotations were unclear. The new graduate nurses appreciated the variety of experiences in different work areas, but experienced loss of confidence and competence

at the beginning of each new rotation. There was no clear benefit to the ward as each time a nurse rotated to a new ward they were considered to be inexperienced and needed to be trained all over again regardless of the length of time they had spent on the program.

The transition support programs were implicated in the recruitment and retention strategies of the hospitals as there was evidence to suggest that the programs were used to boost total nursing staff numbers. This practice meant that increasing numbers of new graduate nurses were offered a place in a program, sometimes without the commensurate support mechanisms being available. Given the proposed purpose of transition support programs the lack of support provided at different times throughout the program raises concerns regarding their credibility.

Chapter 9

Conclusion and Recommendations

9.1 Introduction

This thesis reported study findings concerning registered nurses who had first hand experiences of transition support programs. The aim of the study was to explore the perceived value that transition support programs designed for university educated new graduate nurses had on the nurses involved and the hospitals that offered them. This Chapter draws together the findings as they relate to each of the following research questions.

1. What are the purposes for conducting new graduate transition support programs in clinical facilities for university educated graduate nurses?
2. What are the outcomes of new graduate transition support programs in preparing new graduate nurses for clinical practice?
3. What are the strengths and weaknesses of new graduate transition support programs in various hospitals in New South Wales?

9.2 Purposes of Conducting New Graduate Transition Support Programs in Clinical Facilities for University Educated Graduate Nurses in New South Wales.

In this study, the majority of experienced and new graduate nurses believed that the transition support programs were implemented to give support to the new graduate nurse during their transition from student to the workplace. The way in which support was offered was fairly consistent throughout the different settings and included the use of preceptors, clinical educators and work packages written to assist the new graduate nurses as they encountered new workplaces and practices. There was little evidence to suggest that the support offered was in any way tailored to meet the needs of individual nurses or that the new graduate nurses had any input into the program.

Recruitment of nurses was also seen as a key purpose of the programs. New graduate nurses are unable to procure work without first having completed a program, so as hospitals strive to attract more nurses to their workplace, there is increased pressure to increase the number of positions available in the transition support programs. Unfortunately the need for nursing staff sometimes drives the number of positions rather than the amount of resources available to assist the new graduate nurse as intended. Recruitment also occurs as the new graduate nurse rotates through various wards in the hospital as both the new nurse and the ward staff get to know one another with the view to an offer of permanent employment upon completion of the program. There was evidence to suggest that the transition support programs were used as a strategy to provide staff to less popular clinical areas such as rehabilitation and gerontology.

There was also widespread agreement that the transition support programs were used to redress inadequate university preparation. Concerns were raised regarding university preparation, ranging from the appropriateness of some of the theoretical units to the clinical experiences of the nursing students. Most of the nurses believed that there was no substitute for the real life experiences and repeated practice opportunities that were lacking in university preparation. Many felt that is was left to the transition support program to bridge the void left after completion of university education.

9.3 Outcomes of New Graduate Transition Support Programs in Preparing New Graduate Nurses for Clinical Practice.

Even though the study nurses acknowledged that there were times when new graduate nurses worked independently without the assistance and support of more experienced registered nurses, the general consensus was that the programs were supportive. New graduate nurses felt supported by being identified as a new graduate and belonging to a structured program and a peer group. Experienced registered nurses who were approachable on the ward were also seen as being most helpful and supportive.

The transition support programs played a role in the recruitment and retention of nursing staff for the hospital. As described in the previous section, the programs were used to entice new graduates to the hospital to provide registered nurses for rotating rosters. They also gave the new graduate nurses the opportunity to experience different ward settings in an effort to broaden their experiences and enable them to find their niche. In some of the sample hospitals, the programs were used to provide nursing staff for areas where vacancies had occurred unexpectedly. On those occasions a new graduate nurse was withdrawn from the rostered area on the transition support program and reallocated to the area where a nurse was required. Most of the sample hospitals used nurses in the transition support program to fill positions in less popular wards.

Even though new graduate nurses are expected to be competent to the level of beginning practitioners upon registration, there are wide differences in the experiences and practices of graduates during their university education. The program therefore provides the new graduate nurse with the opportunity to become familiar with the hospital protocols and procedures. The transition support program also allows the hospital to identify deficits in knowledge and skills and rectify any shortcomings. These practices give the new graduate nurse a clear indication of the expected work of the nurse in that particular hospital.

9.4 Strengths and Weaknesses of New Graduate Transition Support Programs in the Study Hospitals in New South Wales.

Strengths

The support afforded and experienced by the new graduate nurses was an obvious strength of the programs. This was beneficial for the new graduate nurse embarking on a career who needed to feel accepted and be able to work as a valued member of the team. When the nurse felt accepted and valued, the workplace stood to benefit by having more satisfied workers who were less likely to leave their place of work.

The transition support program also gave the new graduate nurse a period of time to adapt to the role of the registered nurse and develop the necessary confidence to perform in that

role. Student nurses are protected in various ways from the full responsibilities of the registered nurse even in their final year of university so it is not surprising that when new graduate nurses suddenly find themselves in a position of authority, they require a period of time to adapt.

The role of the preceptor was also considered to be a strength of the programs when it was implemented in the intended manner. Preceptors were valued by the new graduate nurses when they were rostered to the same shifts and able to work side by side, when the preceptor had a choice in whether to accept the role and when the personalities of the preceptor and the new graduate nurse were compatible. The new graduate nurses welcomed frequent constructive feedback from their preceptors rather than waiting for formal evaluations. Unfortunately the preceptors gained little recognition or reduction of workload in exchange for assisting the new graduate nurses in this way.

Weaknesses

The times that new graduate nurses spent working without support remained a weakness of these programs. These times frequently reflected the difficult workplaces where the programs operate. The aspects that made working in hospitals difficult included coping with the chronic nursing staff shortages, the challenges of shiftwork and bullying practices that persisted amongst some of the nursing staff. Another aspect was the necessity for new graduate nurses to be in-charge of a ward before they felt comfortable with the responsibility of the role.

The unrealistically high expectation of what can reasonably be anticipated from a new graduate nurse may also be considered a weakness of the program. The New South Wales Nurses and Midwives Board expects new graduate nurses to function at the level of beginning practitioners though during the transition support program they could be rotated to as many as seven different ward areas during the 12 month period, frequently to areas that required highly specialised nursing skills and were expected to be able to work as competent registered nurses. Each new graduate nurse required a period of time to develop the confidence to carry a fair share of the workload in any given area and this

often coincided with the time that the nurse was to be rotated to their next ward area. Even though the new graduate nurses indicated that they enjoyed the rotational aspect of the programs, it seemed as though it ensured a continual supply of new graduate nurses to the wards who needed to continually relearn how to work in each particular specialty area. This undermined the confidence of the new graduate nurse and reinforced the notion that new graduate nurses were unable to cope with the work on the wards.

9.5 Recommendations

- Alternative transition support models need to be proposed, developed, implemented and evaluated in a rigorous manner. A comparison of the cost of the programs against the outcomes should form part of the evaluation.

- Schools and Faculties of Nursing need to provide student nurses with more clinical experiences in real work place environments where they have some responsibility for patient care to gain a realistic understanding of the role of the registered nurse.

- Employers need to seriously consider methods for attracting and recruiting new graduate nurses to rehabilitation, aged care and mental health nursing as these are the growth areas in health care.

- If hospitals advertise preceptors as a key component of transition support programs then they need to examine the process of allocation to ensure new graduate nurses are not left unsupported during afternoon and weekend shifts.

- Identify a process for providing a channel of communication between hospitals and Schools and Faculties of Nursing regarding the perceptions of undergraduate university courses.

- Hospitals need to develop and implement realistic and practical ways to educate, support and reward registered nurses who accept the role of preceptor.

APPENDICES

Appendix 1

Pilot Study Information Letter

Jennifer Evans
C/O Australian Catholic University
MacKillop Campus
PO Box 968. North Sydney
NSW 2059
Telephone: 9739 2076

I am currently seeking participants for a research project that will examine transition support programs for new registered nurses. This project will form part of my thesis for the Doctor of Education degree. In order to obtain specific information a questionnaire has been designed which is to be completed by new graduate nurses within one year of completing their transition support program. Experienced registered nurses who hold the position of Nurse Unit Manager are also sought for interviews to gain further information regarding transition support programs operating on their unit.

If you agree to participate in this project you should complete the attached questionnaire and return to the researcher using the envelope provided. Please do not identify yourself in any way. If you require more information regarding this project please telephone me on 9739 2076.

This study has been approved by the Australian Catholic University Research Projects Committee and the [hospital name] Research Ethics Committee.

Yours sincerely,

Jennifer Evans

Appendix 2

Permission from Dr John Owen

John Owen <j.owen@edfac.unimelb.edu.au> on 19/04/2001 09:52:06 AM

Dr Owen,
I am a student enrolled in the Doctor of Education degree at Australian Catholic University in New South Wales. I am writing to seek your permission to use a questionnaire format used as an example in your book "Program
Evaluation. Forms and Approaches. 2nd Edition. 1999."

The questionnaire is Figure 13.3 "Diploma in Education Course Evaluation" pages 293-295 from chapter 13 Impact Evaluation. I believe that this format would be useful in my evaluation of a nursing program. The questions would be changed to suit the content of the nursing program.

Thank you for your consideration of this matter. I look forward to hearing from you.

Jennifer Evans
J.Evans@mackillop.acu.edu.au
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
School of Nursing (NSW), ACU
40 Edward Street, North Sydney NSW 2059
Australia
PO Box 968, North Sydney NSW 2060

jennifer, go for it. just do the usual acknowledgement if appropriate and send me a copy of your final survey at some stage.
regards johno
--
John M Owen (Dr)
Director, Centre for Program Evaluation
The University of Melbourne
Parkville, Australia, 3052
http://www.edfac.unimelb.edu.au/cpe/

tel 613 9344 8371
fax 613 9344 8490
j.owen@edfac.unimelb.edu.au
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Appendix 3

Pilot Study Questionnaire

Transitional Support Program Evaluation

1. Where did you undertake your transitional support program? (Tick one)

□ A	□ B	□ C	□ D	□ E	□ F	□ G
St Vincent's Health Care Campus	Royal North Shore	Children's Hospital Westmead	Westmead	Gosford	St. George	Other

2. What do you believe was the purpose of the transitional support program that you completed?

_____
_____
_____
_____

3. Listed below are a series of statements that describe aspects of nursing. On the left-hand side indicate the emphasis each was given during your transitional support program. On the right-hand side we would like you to evaluate each aspect according to its current importance to you *in your present practice.*

PLEASE RESPOND TO EVERY QUESTION

Emphasis in my transitional support program (tick one)			Importance to my present position (tick one)	
Little/None	□	Provide quality nursing to the patients in your care, placing emphasis on the medical/psychosocial/spiritual needs of the patients, and to be mindful of the needs of the relatives and/or carers.	□	Not important
Small	□		□	Slightly important
Moderate	□		□	Moderately important
High	□		□	Very important
Little/None	□	Co-operate with the nursing units and all other departments within the hospital.	□	Not important
Small	□		□	Slightly important
Moderate	□		□	Moderately important
High	□		□	Very important
Little/None	□	Undertake all activities in relation to patient care and other assigned duties.	□	Not important
Small	□		□	Slightly important
Moderate	□		□	Moderately important
High	□		□	Very important
Little/None	□	Actively participate as part of the multidisciplinary team.	□	Not important
Small	□		□	Slightly important
Moderate	□		□	Moderately important
High	□		□	Very important

Little/None Small Moderate High	□ □ □ □	Actively pursue continuing self education.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Provide appropriate education for the patients and relatives.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Participate in the delivery of clinical care based on best practice principles, outlined by the 'Australian Nursing Council Inc. (ANCI) - National Nursing Competencies for Registered and enrolled nurses'.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Provide opportunities to transfer fundamental nursing skills from one situation to another	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Demonstrate ability to integrate and consolidate practical application of theory.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Experience a variety of different areas of nursing specialisation.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Improve level of confidence.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Show proficiency in basic clinical skills.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Identify and utilise support systems available in the facilitation of role transition from student to registered nurse status.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Improve time management skills and ability to prioritise as part of the process of advancing clinical proficiency.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Demonstrate accountability and responsibility for own actions.	□ □ □ □	Not important Slightly important Moderately important Very important

Little/None Small Moderate High	□ □ □ □	Practice within the limits of own abilities and qualifications.	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Appreciate the nuances of the hospital culture	□ □ □ □	Not important Slightly important Moderately important Very important
Little/None Small Moderate High	□ □ □ □	Understand the function of the preceptor as a role model.	□ □ □ □	Not important Slightly important Moderately important Very important

4. Please use the space provided below to make any comments on your transition support program, in the light of your subsequent experiences.

Please be as specific as possible.

i) Strengths:

_____
_____
_____
_____
_____
_____
_____

ii) Weaknesses:

_____
_____
_____
_____
_____
_____
_____

iii) What changes would you recommend to the transitional support program you completed?

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire.

Appendix 4

Pilot Study Interview Schedule

Interview Schedule

Thank you for agreeing to this interview about transitional support programs. As you are aware, the interview will be audiotaped and transcribed verbatim.

- Are you familiar with the transitional support program in this institution?
- How are you involved in the implementation and evaluation of the transitional support program?
- What do you believe is the purpose of this program?
- What is your understanding of the role of the preceptor within the transitional support program?
- Can you explain how effective the program is preparing new graduates for practice?
- Can you give examples of how you believe the program has helped a new graduate in their first year?
- What do you believe are the strengths of the program?
- What do you believe are the weaknesses of the program?
- What changes would you recommend to the transitional support program?

Appendix 5

Letter to Nursing Experts

Australian Catholic University
40 Edward Street. North Sydney.
NSW. 2059
26/10/01

Dear

Re: Transition Support Program Questionnaire Evaluation

Thank you for agreeing to act as a panel member in the validation of the enclosed questionnaire for my EdD project. The project seeks to describe the impact of new graduate transition support programs in the preparation of new graduate nurses for their role of registered nurse. The study is guided by the following research questions:

> *What are the purposes for conducting new graduate transition support programs in clinical facilities for university educated graduate nurses? and*
> *How effective are new graduate transition support programs in preparing new graduate nurses for clinical practice?*

This questionnaire was adapted from one published by Owen to evaluate a teacher education program in 1999. The format of this questionnaire was considered appropriate and adapted using the domains of the Australian Nursing Council National Competency Standards for the Registered Nurse.

As part of the validation process I would like you to assess the questionnaire using the following criteria.

- Are there sufficient and appropriate statements under each domain?
- Are the statements clear and precise?
- Will the statements provide sufficient information regarding the impact of the transition support program on subsequent practice as a registered nurse?
- Do the questions in section 4 provide sufficient scope to allow the subjects to evaluate the program?
- Are there any suggestions that you would make about the format or the structure of the questionnaire?

I would appreciate if your comments could be returned to me by 16th November 2001 in the envelope provided. Alternatively you may email your comments to me at J.Evans@mackillop.acu.edu.au

Yours faithfully,

Jennifer Evans
Lecturer in Nursing
Australian Catholic University.

Appendix 6

New Graduate Nurse Information Letter and Questionnaire

[Letterhead from each sample hospital]

New Graduate Nurse Information Letter

TITLE OF PROJECT:	TRANSITION SUPPORT PROGRAMS FOR NEW GRADUATE NURSES – HOW EFFECTIVE ARE THEY?
NAME OF INVESTIGATOR:	JENNIFER EVANS
NAME OF PROGRAMME IN WHICH ENROLLED:	DOCTOR OF EDUCATION, Australian Catholic University (NSW)

You are invited to participate in a project that aims to describe the purpose and importance of new graduate support programs in the preparation of new graduate nurses for the role of registered nurse. Data will be sought via anonymous questionnaire, interview and possibly observation. When combined these data will give a clear indication of the role and importance of new graduate transition support programs to new graduates and their employing hospital. You have been selected as a possible participant in this study because you have unique experiences with transition support programs.

If you choose to participate in this study I do not believe that you will be exposed to any risk or inconvenience. You will complete the attached questionnaire that will take approximately 30 minutes and return using the stamped return addressed envelope. If you wish to participate in an interview at a later date you should complete that section and return in a separate envelope to ensure anonymity.

I hope that by participating in this study you will benefit from the opportunity to reflect on the transitional support program for new graduate nurses offered by your employing hospital. The literature shows little evidence of program evaluation so your input is very valuable. Your participation in the project will contribute to the understanding of the relationship between new graduates and their employers.

Your responses will remain confidential. The individual responses will be combined for analyses and the findings may be published in an academic journal or thesis.

If you have any questions regarding this study, they can be directed to the principal supervisor:
Dr Shukri Sanber
School of Education (NSW)
25a Baker Rd. Strathfield. NSW. 2135.
Telephone: 9701 4194

New Graduate Nurse Information Letter(CONTINUED)

(Transition Support Programs for New Graduate Nurses – How Effective Are They?)

The findings of this study will be made available to your hospital. A report will be given to your education department upon completion.

This study has been approved by the [name] Research Ethics Committee. If you have any complaint about the way you have been treated in the study or have a query not addressed by the researcher, please write to:

The Executive Officer, [name and contact details].

Your decision whether or not to participate will not prejudice any future relations with [name] Area Health Service. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you agree to participate in this study, you should complete the attached questionnaire and return to researcher in envelope supplied. The return of your questionnaire will imply consent.

Thank you for your time and consideration.

Supervisor :_____Student Researcher :_____

Transitional Support Program Evaluation

Demographic Data
Please tick the correct response

1 Gender

- Female ☐
- Male ☐

2 Age at graduation

- 21 or under ☐
- 22-28 ☐
- 29-35 ☐
- Over 36 ☐

3 Nursing experience prior to graduation

- AIN ☐
- EN ☐
- Other (specify) ☐ _____

4 State where you completed your secondary schooling. (city, town, overseas etc.)

_____

5 In which hospital did you undertake your transitional support program?

_____

6 What language(s) do you speak at home?

_____

7 Give a brief summary of the transitional support program that you completed.

_____

_____

_____

_____

_____

_____

8 In your own words, describe the purpose of the transitional support program that you have just completed. (eg: integration of knowledge and practice, rotation etc)

_____

_____

_____

_____

9 How was the stated purpose of the program reinforced in the workplace?

_____

_____

_____

_____

10 In your own words, describe what you believe to be the purpose of transitional support programs for the hospital or workplace and the wider community. (eg: integration of knowledge and practice, employment opportunities, retention of nurses etc)

Workplace

_____

_____

_____

_____

Community

_____

_____

_____

_____

11 Explain the role of the preceptor in the transitional support program that you completed. What aspects made them useful or useless?

_____

_____

_____

_____

_____

_____

_____

12 Listed below are a series of statements that describe aspects of nursing grouped according to the domains of the ANCI competencies. On the left-hand side indicate the emphasis each was actually given during *your transitional support program*. On the right-hand side evaluate the importance of each aspect to you *in your present practice.*

Emphasis in my transitional support program (circle one) 4 High emphasis 3 Moderate emphasis 2 Little emphasis 1 No emphasis		**Importance to my present position (circle one)** Very important 4 Moderately important 3 Slightly important 2 Not important 1
4 3 2 1	**a.** Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	4 3 2 1

4 3 2 1	**b.** Demonstrate accountability and responsibility for own actions.	4 3 2 1
4 3 2 1	**c.** Practice within the limits of own abilities and qualifications.	4 3 2 1
4 3 2 1	**d.** Actively pursue continuing self education.	4 3 2 1
4 3 2 1	**e.** Provide opportunities to transfer fundamental nursing skills from one situation to another	4 3 2 1
4 3 2 1	**f.** Demonstrate ability to integrate and consolidate practical application of theory.	4 3 2 1
4 3 2 1	**g.** Opportunity to develop confidence in clinical practice.	4 3 2 1
4 3 2 1	**h**. Demonstrate proficiency in fundamental clinical skills.	4 3 2 1
4 3 2 1	**i**. Provide holistic nursing to the patients in your care.	4 3 2 1
4 3 2 1	**j.** Undertake all activities in relation to patient care and other assigned duties.	4 3 2 1
4 3 2 1	**k.** Provide appropriate education for your patients.	4 3 2 1
4 3 2 1	**l.** Consider the needs of your patient's relatives and/or carers.	4 3 2 1
4 3 2 1	**m.** Improve time management skills.	4 3 2 1
4 3 2 1	**n.** Co-operate with the nursing units and all other departments within the hospital.	4 3 2 1
4 3 2 1	**o.** Actively participate as part of the multidisciplinary team.	4 3 2 1
4 3 2 1	**p.** Experience a variety of different areas of nursing specialisation.	4 3 2 1
4 3 2 1	**q.** Understand and adapt to the culture of the hospital.	4 3 2 1
4 3 2 1	**r**. Understand the function of the preceptor as a role model.	4 3 2 1

4 3 2 1	**s.** Provide appropriate education for your patients' relatives.	4 3 2 1
4 3 2 1	**t.** Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	4 3 2 1

13. Reflect on your transition support program and comment on your experiences using the prompts below. You might like to consider such aspects as length, diversity, rotations, type of support offered, educational opportunities etc.

Please be as specific as possible.

iv) What were the most useful aspects of the program?

_____

_____

_____

_____

_____

v) What were the least useful aspects of the program?

_____

_____

_____

_____

_____

vi) What changes would you recommend to the transitional support program you completed?

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

If you wish to volunteer for an interview, please complete the information on the following sheet and return to researcher in separate envelope. Thank you

New Graduate Interview

Contact Details : Name _____

Address _____

_____

_____

Telephone _____

Email _____

Hospital where Transition Support Program completed

_____

Currently employed at

_____

Appendix 7

Experienced Nurse Information Letter and Questionnaire

[Letterhead from each sample hospital]

Experienced Nurses Information Letter

TITLE OF PROJECT:	TRANSITION SUPPORT PROGRAMS FOR NEW GRADUATE NURSES – HOW EFFECTIVE ARE THEY?
NAME OF INVESTIGATOR:	JENNIFER EVANS
NAME OF PROGRAMME IN WHICH ENROLLED:	DOCTOR OF EDUCATION, Australian Catholic University (NSW)

You are invited to participate in a project that aims to describe the purpose and importance of new graduate support programs in the preparation of new graduate nurses for the role of registered nurse. Data will be sought via anonymous questionnaire, interview and possibly observation. When combined these data will give a clear indication of the role and importance of new graduate transition support programs to new graduates and their employing hospital. You have been selected as a possible participant in this study because you have unique experiences with transition support programs.

If you choose to participate in this study I do not believe that you will be exposed to any risk or inconvenience. You will complete the attached questionnaire that will take approximately 30 minutes and return using the stamped return addressed envelope. If you wish to participate in an interview at a later date you should complete that section and return in a separate envelope to ensure anonymity.

I hope that by participating in this study you will benefit from the opportunity to reflect on the transitional support program for new graduate nurses offered by your employing hospital. The literature shows little evidence of program evaluation so your input is very valuable. Your participation in the project will contribute to the understanding of the relationship between new graduates and their employers.

Your responses will remain confidential. The individual responses will be combined for analyses and the findings may be published in an academic journal or thesis.

If you have any questions regarding this study, they can be directed to the principal supervisor:

Dr Shukri Sanber
School of Education (NSW)
25a Baker Rd. Strathfield. NSW. 2135.
Telephone: 9701 4194

The findings of this study will be made available to your hospital. A report will be given to your education department upon completion.

This study has been approved by [name] Research Ethics Committee. If you have any complaint about the way you have been treated in the study or have a query not addressed by the researcher, please write to:

The Executive Officer, [name and contact details].

Your decision whether or not to participate will not prejudice any future relations with [name] Area Health Service. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you agree to participate in this study, you should complete the attached questionnaire and return to researcher in envelope supplied. The return of your questionnaire will imply consent.

Thank you for your time and consideration.

Supervisor :_____Student Researcher :_____

Transitional Support Program Evaluation

Demographic Data
Please tick the correct response

1 Gender		**2** Age		**3** Nursing experience since registration	
Female	☐	22-28	☐	1-6 years	☐
Male	☐	29-35	☐	7-12 years	☐
		35-41	☐	13-19 years	☐
		Over 42	☐	over 20 years	☐

4 State where you completed your secondary schooling. (city, town, overseas etc.)

_____

5 What are your nursing qualifications?

_____

6 What language(s) do you speak at home?

_____

7 Give a brief summary of the transitional support program that is offered by your employing hospital.

_____

_____

_____

_____

_____

_____

_____

8 In your own words, describe the purpose of this transitional support program.
(eg: integration of knowledge and practice, rotation etc)

_____

_____

_____

_____

9 How is the stated purpose of the program reinforced in the workplace?

_____

_____

_____

_____

10 In your own words, describe what you believe to be the purpose of transitional support programs for the hospital or workplace and the wider community. (eg: integration of knowledge and practice, employment opportunities, retention of nurses etc)

Workplace

_____

_____

_____

_____

Community

_____

_____

_____

_____

11 Explain the role of the preceptor in the transitional support program offered at your workplace. What aspects do you believe makes them useful or useless?

_____

_____

_____

_____

_____

_____

_____

12 Listed below are a series of statements that describe aspects of nursing grouped according to the domains of the ANCI competencies. On the left-hand side indicate the emphasis each is actually given during the *transitional support program* offered at your workplace On the right-hand side evaluate the importance of each aspect to *nursing practice.*

Emphasis in the transitional support program (circle one) 4 High emphasis 3 Moderate emphasis 2 Little emphasis 1 No emphasis		**Importance to nursing practice (circle one)** Very important 4 Moderately important 3 Slightly important 2 Not important 1
4 3 2 1	**a.** Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	4 3 2 1

4 3 2 1	**b.** Demonstrate accountability and responsibility for own actions.	4 3 2 1
4 3 2 1	**c.** Practice within the limits of own abilities and qualifications.	4 3 2 1
4 3 2 1	**d.** Actively pursue continuing self education.	4 3 2 1
4 3 2 1	**e.** Provide opportunities to transfer fundamental nursing skills from one situation to another	4 3 2 1
4 3 2 1	**f.** Demonstrate ability to integrate and consolidate practical application of theory.	4 3 2 1
4 3 2 1	**g.** Opportunity to develop confidence in clinical practice.	4 3 2 1
4 3 2 1	**h**. Demonstrate proficiency in fundamental clinical skills.	4 3 2 1
4 3 2 1	**i**. Provide holistic nursing to the patients in your care.	4 3 2 1
4 3 2 1	**j.** Undertake all activities in relation to patient care and other assigned duties.	4 3 2 1
4 3 2 1	**k.** Provide appropriate education for your patients.	4 3 2 1
4 3 2 1	**l.** Consider the needs of your patient's relatives and/or carers.	4 3 2 1
4 3 2 1	**m.** Improve time management skills.	4 3 2 1
4 3 2 1	**n.** Co-operate with the nursing units and all other departments within the hospital.	4 3 2 1
4 3 2 1	**o.** Actively participate as part of the multidisciplinary team.	4 3 2 1
4 3 2 1	**p.** Experience a variety of different areas of nursing specialisation.	4 3 2 1
4 3 2 1	**q.** Understand and adapt to the culture of the hospital.	4 3 2 1
4 3 2 1	**r**. Understand the function of the preceptor as a role model.	4 3 2 1

4 3 2 1	**s.** Provide appropriate education for your patients' relatives.	4 3 2 1
4 3 2 1	**t.** Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	4 3 2 1

13. Reflect on the transition support program offered by your workplace and comment using the prompts below. You might like to consider such aspects as length, diversity, rotations, type of support offered, educational opportunities etc.

Please be as specific as possible.

i) What are the most useful aspects of the program?

_____

_____

_____

_____

_____

_____

ii) What are the least useful aspects of the program?

_____

_____

_____

_____

_____

_____

iii) What changes would you recommend to the current transitional support program ?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire.

If you wish to volunteer for an interview, please complete the information on the following sheet and return to researcher in separate envelope. Thank you

Experienced Nurse Interview

Contact Details : Name _____

Address _____

_____

_____

Telephone _____

Email _____

Currently employed at

_____

Appendix 8

Follow-Up Letter

23 Tomah Street
Carlingford, 2118.
14/1/03

Dear Registered Nurse,

You may remember being sent a questionnaire in the mail recently inviting your comments on the transition support program for new graduate nurses offered at your hospital. I believe that this project is vital for the nursing profession. It has implications for new nurses' initial employment, retention and ongoing professional development as well as the allocation of scarce resources from your hospital budget.

Since participation in the project is confidential I have no way of knowing who has returned the questionnaire already. This letter is simply to thank those of you who have and to remind everyone else to return their questionnaire and have their voice heard.

If you have misplaced your questionnaire and would like another sent to you please contact me either at the postal address above or by email J.Evans@mackillop.acu.edu.au

Regards,

Jennifer Evans

Appendix 9

Study Interview Schedule, Information Letter and Consent

[Letterhead Paper]

Information Letter and Consent for Interviews

TITLE OF PROJECT:	TRANSITION SUPPORT PROGRAMS FOR NEW GRADUATE NURSES – HOW EFFECTIVE ARE THEY?
NAME OF INVESTIGATOR:	JENNIFER EVANS
NAME OF PROGRAMME IN WHICH ENROLLED:	DOCTOR OF EDUCATION, Australian Catholic University (NSW)

You are invited to participate in a project that aims to describe the purpose and importance of new graduate support programs in the preparation of new graduate nurses for the role of registered nurse. Data will be sought via anonymous questionnaire, interview and possibly observation. When combined these data will give a clear indication of the role and importance of new graduate transition support programs to new graduates and their employing hospital. You have been selected as a possible participant in this study because you have unique experiences with transition support programs.

If you choose to participate in this study I do not believe that you will be exposed to any risk or inconvenience. You will complete the attached questionnaire that will take approximately 30 minutes and return using the stamped return addressed envelope. If you wish to participate in an interview at a later date you should complete that section and return in a separate envelope to ensure anonymity.

I hope that by participating in this study you will benefit from the opportunity to reflect on the transitional support program for new graduate nurses offered by your employing hospital. The literature shows little evidence of program evaluation so your input is very valuable. Your participation in the project will contribute to the understanding of the relationship between new graduates and their employers.

Your responses will remain confidential. The individual responses will be combined for analyses and the findings may be published in an academic journal or thesis.

If you have any questions regarding this study, they can be directed to the principal supervisor:
Dr Shukri Sanber
School of Education (NSW)
25a Baker Rd. Strathfield. NSW. 2135.
Telephone: 9701 4194

Information Letter and Consent for Interview (continued)

The findings of this study will be made available to your hospital. A report will be given to your education department upon completion.

This study has been approved by the [name] Research Ethics Committee. If you have any complaint about the way you have been treated in the study or have a query not addressed by the researcher, please write to:

The Executive Officer, [name and contact details].

Your decision whether or not to participate will not prejudice any future relations with [name] Area Health Service. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

You are making a decision whether or not to participate. Your signature indicates that you have decided to participate having read the information provided.

_____	_____
Signature of subject	Signature of witness
_____	_____
Please PRINT name	Please PRINT name
_____	_____
Date	Nature of Witness

_____
Signature of investigator

_____
Please PRINT name

REVOCATION OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardize any treatment or my relationship with my employing hospital.

_____	_____
Signature	Date

_____
Please PRINT name

Possible Interview Schedule

Thank you for agreeing to this interview about transitional support programs. As you are aware, the interview will be audiotaped and transcribed verbatim.

- How are you involved in the implementation and evaluation of the transitional support program?
- According to hospital policy, what is the purpose of this program?
- How is this transferred to the ward? Is this a true picture of what actually happens?
- What is your understanding of the role of the preceptor within the transitional support program?
- Can you explain how effective the program is preparing new graduates for practice?
- Can you give examples of how you believe the program has helped a new graduate in their first year?
- What do you believe are the strengths of the program?
- What do you believe are the weaknesses of the program?
- What changes would you recommend to the transitional support program?

Appendix 10

Field Note Guidelines

Questions used by researcher to prompt the writing of field notes.

- What happened?
- When did it happen?
- Why did it happen?
- Who was involved?
- What was the nature of the interaction?
- What was the background of the situation?
- What were the sights, sounds, and smells?
- What effect did this interaction have?

Appendix 11

Ethics Committees Approvals

ACU National

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Dr Shukri Sanber Sydney Campus

Co-Investigators: Ms Elaine Boxer Sydney Campus

Student Researcher: Ms Jennifer Evans Nth Sydney Campus

Ethics approval has been granted for the following project:
Transition support programs - how effective are they?

for the period: June - December 2001

Human Research Ethics Committee (HREC) Register Number: N2000/01-28

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

(i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
- security of records
- compliance with approved consent procedures and documentation
- compliance with special conditions, and

(ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
- proposed changes to the protocol
- unforeseen circumstances or events
- adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: ..... Date: 2 February 2005
(Research Services Officer, Strathfield Campus)

PS: This is a re-issued approval form for the above ethics application ML.

[redacted]

January 10th 2003

Ms Jennifer Evans
23 Tomah Street
Carlingford 2118

Dear Jennifer

Re: Transition support programs for new graduate nurses - How effective are they?
[redacted]

Thank you for your letter dated November 22 2002 to the Human Research Ethics Committee informing of your intention to include the [redacted] Hospitals in the above study.

The HREC is happy to approve the inclusion of the other sites however, you must formally approach both hospitals DON to proceed with the study. You will also need to organise appropriate letterhead for the consents ie [redacted] will need to be on their letterhead as will the [redacted] consent.

Thank you for organising the enclosed study report.

If you have any queries please contact me on [redacted].

Yours sincerely,

[redacted]

[redacted]

18 December 2002

Jennifer Evans
23 Tomah Street
Carlingford, NSW 2118

Dear Jennifer,

Thank you for your correspondence of 11 December 2002. I have read your proposal and have spoken to [redacted] Hospital Research Ethics Committee. I understand from [redacted] that you will be required to put your consent forms on to [redacted] Hospital letterhead. This can be easily facilitated.

I suggest that you liaise regarding timing and access to staff etc through [redacted], the Senior Nurse Educator. [redacted] can be contacted through the hospital switchboard. If you are able to bring your consent form to the hospital on disk we will arrange to have it copied on to hospital letterhead.

I wish you every success with your project and also take this opportunity to wish you a happy Christmas.

Yours sincerely,

[redacted]
Director of Nursing

[redacted]

[redacted].com.au>
30/12/02 08:52

To: "'J.Evans@mackillop.acu.edu.au'"
<J.Evans@mackillop.acu.edu.au>
[redacted]
Subject: Project

Dear Ms Evans

I refer to your letter of 11 December regarding your project "Transition support programs for new graduate nurses - How effective are they?".

[redacted] Manager Staff Development, would be delighted to assist you in any way regarding the above. Could you please contact her direct on [redacted]

I look forward to your findings, in due course!

Yours sincerely
[redacted]
Director of Nursing
[redacted]

CAUTION: This message may contain both confidential and privileged information intended only for the addressee named above. If you are not the intended recipient you are hereby notified that any dissemination, distribution or reproduction of this message is prohibited. If you have received this message in error please notifiy the sender immediately, then destroy the original message. Any views expressed in this message are solely
those of the individual sender, except where the sender is specifically authorised by The [redacted] Hospital to state that they are the views of [redacted]

[redacted]

20th November, 2002.

Dr S. Sanber
Australian Catholic University
25a Baker St
Strathfield NSW 2135

Dear Dr Sanber,

RE: Transition support programs for new Graduate Nurses – How effective are they? (02/75 Sanber)

Thank you for your letter dated 8/11/02. As you have now fulfilled all necessary conditions I hereby notify you, that at its meeting held 30th July 2002, the [redacted] Ethics Committee - [redacted] agreed to approve:-

Transition support programs for new Graduate Nurses - How effective are they? (02/75 Sanber) to be conducted at [redacted] and [redacted] Hospital.

The Committee requires a brief six month progress report on research it has approved and yearly reports thereafter. (Estimated duration of the project two years).

These reports should:-

Be accompanied by abstracts of any articles or publications (if any) arising out of the study.

Confirm security of records.

Confirm compliance with approved consent procedures and documentation.

The investigator should also report immediately to the Ethics Committee anything which might affect ethical acceptance of the protocol, including:-

Adverse events on subjects.

Proposed changes in the protocol.

Unforseen events that might affect continued ethical acceptability of the project.

I look forward to placing your first report before the Committee and wish you well in this study.

Yours sincerely,

[redacted]

Chairperson

[redacted]

cc: Ms J. Evans
23 Tomah Street
Carlingford NSW 2118

[redacted]

[redacted]

[redacted]

21 January 2003

Ms Jennifer Evans
23 Tomah Street
CARLINGFORD. NSW 2118

Dear Ms Evans,

TRANSISTION SUPPORT PROGRAMS FOR NEW GRADUATE NURSES – HOW EFFECTIVE ARE THEY?

I apologise for the delay in processing your application to our Ethics Committee. The Committee has been in an extended recess.

Your research project now has been assessed carefully and given full approval to be conducted at [redacted] Hospital. We do request that you will submit a full report at the conclusion of the study, and that the Committee is informed of any significant changes to the protocol, or any significant complaints or problems encountered.

I know that [redacted] Manager of our Nursing Education is ready to assist you in implementing your research, and we trust it goes well.

With best wishes

Sincerely

[redacted]

Secretary, Hospital Ethics Committee

[redacted]

[redacted]

3P 1202

[redacted]

25 February 2003

Dr Shukri Sanber
25a Baker Street
STRATHFIELD, NSW 2135

Dear Dr Sanber

RE: 02/55 Transition Support Programs for New Graduate Nurses - How effective are they?

At the Ethics Committee meeting held on 13 November 2002 the above study was considered and given conditional approval.

Your revised consent form, including a space for the name and contact details of the witness, has been received and I now enclose the signed documentation to allow your study to commence.

The Committee wishes you well with your project.

Yours sincerely

[redacted]

Secretary, Ethics Committee

[redacted]

[redacted] HEALTH SERVICE
ETHICS COMMITTEE

APPROVAL FOR RESEARCH - NON CLINICAL TRIAL

TITLE OF PROJECT:
02/55 Transition Support Programs for new graduate nurses – How effective are they?

PRINCIPAL CO-ORDINATOR / INVESTIGATOR:

Dr Shukri Sanber, Senior Lecturer, Australian Catholic University, Strathfield

NH & MRC COMPLIANCE:
It is the committees opinion that this project complies with the provisions contained in the NH & MRC document 'Statement on Human Experimentation and Supplementary Notes'.

COMMENTS, PROVISOS OR RESERVATIONS:

With any reported adverse reactions, the local investigator should also provide an opinion.

Your attention is drawn to the fact that insurance for this project is your responsibility.

REPORTS DUE TO THE ETHICS COMMITTEE:

Reports are due on a six monthly basis being the end of June and December. A copy of the final report is also requested.

Name of Ethics Committee Representative: [redacted]

AUTHORISED BY: [redacted] Secretary, Ethics Committee

Signature: [redacted]

Date: 2 Dec 02

Form Endorsed by Ethics Committee
13 September, 1995

[redacted]

Appendix 12

Mean and Frequency Results for Emphasis given to ANCI Competency Rankings by New Graduate Nurses.

Nursing Aspect	Frequency		Percent	Cumul-ative Percent	Mean	Standard Deviat-ion
Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	No emphasis Little emphasis Moderate emphasis High emphasis Total	1 3 9 17 30	3.3 10.0 30.0 56.7 100.0	3.3 13.3 43.3 100.0	3.4	0.814
Demonstrates accountability and responsibility for own actions.	No emphasis Little emphasis Moderate emphasis High emphasis Total	1 0 10 19 30	3.3 3.3 33.3 63.3 100.0	3.3 3.3 36.7 100.0	3.6	0.679
Practice within the limits of own abilities and qualifications.	No emphasis Little emphasis Moderate emphasis High emphasis Total	 4 7 19 30	 13.3 23.3 63.3 100.0	 13.3 36.7 100.0	3.5	0.731
Actively pursue continuing self education.	No emphasis Little emphasis Moderate emphasis High emphasis Total	3 6 9 12 30	10.0 20.0 30.0 40.0 100.0	10.0 30.0 60.0 100.0	3.0	1.017
Provide opportunities to transfer fundamental nursing skills from one situation to another.	No emphasis Little emphasis Moderate emphasis High emphasis Total	1 7 13 9 30	3.3 23.3 43.3 30.0 100.0	3.3 26.7 70.0 100.0	3.0	0.830
Demonstrate ability to integrate and consolidate practical application of theory.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 6 10 12 29 1	3.3 20.0 33.3 40.0 96.7 3.3	3.4 24.1 58.6 100.0	3.14	0.875
Opportunity to develop confidence in clinical practice.	No emphasis Little emphasis Moderate emphasis High emphasis Total	2 4 4 20 30	6.7 13.3 13.3 66.7 100.0	6.7 20.0 33.3 100.0	3.4	0.968
Demonstrate proficiency in fundamental clinical skills.	No emphasis Little emphasis Moderate emphasis High emphasis Total	1 3 7 19 30	3.3 10.0 23.3 63.3 100.0	3.3 13.3 36.7 100.0	3.47	0.819
Provide holistic nursing to the patients in your care.	No emphasis Little emphasis Moderate emphasis High emphasis Total	1 7 10 12 30	3.3 23.3 33.3 40.0 100.0	3.3 26.7 60.0 100.0	3.1	0.885
Undertake all activities in relation to patient care and other assigned duties.	No emphasis Little emphasis Moderate emphasis	1 5 12	3.3 16.7 40.0	3.3 30.0 60,0	3.17	0.834

	High emphasis	12	40.0	100.0		
	Total	30	100.0			
Provide appropriate education for your patients.	No emphasis	3	10.0	10.0		
	Little emphasis	9	30.0	40.0	2.87	1.042
	Moderate emphasis	7	23.3	63.3		
	High emphasis	11	36.7	100.0		
	Total	30	100.0			
Consider the needs of the patient's relatives and / or carers.	No emphasis	3	10.0	10.0		
	Little emphasis	4	13.3	23.3	3.10	0.995
	Moderate emphasis	10	33.3	56.7		
	High emphasis	13	43.3	100.0		
	Total	30	100.0			
Improve time management skills.	No emphasis	2	6.7	6.7		
	Little emphasis	0	0	6.7	3.63	0.809
	Moderate emphasis	5	16.7	16.7		
	High emphasis	23	76.7	76.7		
	Total	30	100.0	100.0		
Co-operate with the nursing units and all other departments within the hospital.	No emphasis	3	10.0	10.0		
	Little emphasis	6	20.0	30.0	3.03	1.033
	Moderate emphasis	8	26.7	56.7		
	High emphasis	13	43.3	100.0		
	Total	30	100.0			
Actively participate as part of the multidisciplinary team.	No emphasis	1	3.3	3.3		
	Little emphasis	4	13.3	16.7	3.23	0.817
	Moderate emphasis	12	40.0	56.7		
	High emphasis	13	43.3	100.0		
	Total	30	100.0			
Experience a variety of different areas of nursing specialisation.	No emphasis	1	3.3	3.3		
	Little emphasis	6	20.0	23.3	3.27	0.907
	Moderate emphasis	7	23.3	46.7		
	High emphasis	16	53.3	100.0		
	Total	30	100.0			
Understand and adapt to the culture of the hospital.	No emphasis	4	13.3	13.3		
	Little emphasis	7	23.3	36.7	2.97	1.129
	Moderate emphasis	5	16.7	53.3		
	High emphasis	14	46.7	100.0		
	Total	30	100.0			
Understand the function of the preceptor as a role model.	No emphasis	10	33.3	34.5		
	Little emphasis	4	13.3	48.3	2.45	1.242
	Moderate emphasis	7	23.3	72.4		
	High emphasis	8	26.7	100.0		
	Total	29	96.7			
	Missing	1	3.3			
Provide appropriate education for your patient's relatives.	No emphasis	5	16.7	16.7		
	Little emphasis	5	16.7	33.3	2.83	1.085
	Moderate emphasis	10	33.3	66.7		
	High emphasis	10	33.3	100.0		
	Total	30	100.0			
Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	No emphasis	1	3.3	3.4		
	Little emphasis	2	6.7	10.3	3.34	0.769
	Moderate emphasis	12	40.0	51.7		
	High emphasis	14	46.7	100.0		
	Total	29	96.7			
	Missing	1	3.3			

Appendix 13

Mean and Frequency Results for Importance given to ANCI Competency Rankings by New Graduate Nurses.

Nursing Aspect	Frequency		Percent	Cumul-ative Percent	Mean	Standard Deviat-ion
Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	Not important Slightly important Moderately important Very important Total	1 2 8 19 30	3.3 6.7 26.7 63.3 100.0	3.3 10.0 36.7 100.0	3.5	0.777
Demonstrates accountability and responsibility for own actions.	Not important Slightly important Moderately important Very important Total	0 0 2 28 30	0 0 6.7 93.3 100.0	0 0 6.7 100.0	3.93	0.254
Practice within the limits of own abilities and qualifications.	Not important Slightly important Moderately important Very important Total	1 0 1 28 30	3.3 0 3.3 93.3 100.0	3.3 3.3 6.7 100.0	3.87	0.571
Actively pursue continuing self education.	Not important Slightly important Moderately important Very important Total	1 4 8 17 30	3.3 13.3 26.7 56.7 100.0	3.3 16.7 43.3 100.0	3.37	0.850
Provide opportunities to transfer fundamental nursing skills from one situation to another.	Not important Slightly important Moderately important Very important Total	0 1 9 20 30	0 3.3 30.0 66.7 100.0	0 3.3 33.3 100.0	3.63	0.556
Demonstrate ability to integrate and consolidate practical application of theory.	Not important Slightly important Moderately important Very important Total Missing	1 1 12 15 29 1	3.3 3.3 40.0 50.0 96.7 3.3	3.4 6.9 48.3 100.0	3.41	0.733
Opportunity to develop confidence in clinical practice.	Not important Slightly important Moderately important Very important Total	0 3 5 22 30	0 10.0 16.7 73.3 100.0	0 10.0 26.7 100.0	3.63	0.669
Demonstrate proficiency in fundamental clinical skills.	Not important Slightly important Moderately important Very important Total	0 3 1 26 30	0 10.0 3.3 86.7 100.0	0 10.0 13.3 100.0	3.77	0.626
Provide holistic nursing to the patients in your care.	Not important Slightly important Moderately important Very important Total	0 0 5 25 30	0 0 16.7 83.3 100.0	0 0 16.7 100.0	3.83	0.379
Undertake all activities in relation to patient care and other assigned duties.	Not important Slightly important Moderately important	0 0 8	0 0 26.7	0 0 26.7	3.73	0.450

	Very important	22	73.3	100.0		
	Total	30	100.0			
Provide appropriate education for your patients.	Not important	1	3.3	3.3		
	Slightly important	2	6.7	10.0	3.63	0.765
	Moderately important	4	13.3	23.3		
	Very important	23	76.7	100.0		
	Total	30	100.0			
Consider the needs of the patient's relatives and / or carers.	Not important	0	0	0		
	Slightly important	2	6.7	6.7	3.73	0.583
	Moderately important	4	13.3	20.0		
	Very important	24	80.0	100.0		
	Total	30	100.0			
Improve time management skills.	Not important	1	3.3	3.3		
	Slightly important	2	6.7	10.0	3.57	0.774
	Moderately important	6	20.0	30.0		
	Very important	21	70.0	100.0		
	Total	30	100.0			
Co-operate with the nursing units and all other departments within the hospital.	Not important	0	0	0		
	Slightly important	2	6.7	6.7	3.57	0.626
	Moderately important	9	30.0	36.7		
	Very important	19	63.3	100.0		
	Total	30	100.0			
Actively participate as part of the multidisciplinary team.	Not important	0	0	0		
	Slightly important	0	0	0	3.77	0.430
	Moderately important	7	23.3	23.3		
	Very important	23	76.7	100.0		
	Total	30	100.0			
Experience a variety of different areas of nursing specialisation.	Not important	1	3.3	3.3		
	Slightly important	6	20.0	23.3	3.23	0.898
	Moderately important	8	26.7	50.0		
	Very important	15	50.0	100.0		
	Total	30	100.0			
Understand and adapt to the culture of the hospital.	Not important	1	3.3	3.3		
	Slightly important	6	20.0	23.3	3.17	0.874
	Moderately important	10	33.3	56.7		
	Very important	13	43.3	100.0		
	Total	30	100.0			
Understand the function of the preceptor as a role model.	Not important	7	23.3	24.1		
	Slightly important	4	13.3	37.9	2.72	1.192
	Moderately important	8	26.7	65.5		
	Very important	10	33.3	100.0		
	Total	29	96.7			
	Missing	1	3.3			
Provide appropriate education for your patient's relatives.	Not important	2	6.7	6.7		
	Slightly important	2	6.7	13.3	3.50	0.900
	Moderately important	5	16.7	30.0		
	Very important	21	70.0	100.0		
	Total	30	100.0			
Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	Not important	0	0	0		
	Slightly important	2	6.7	6.7	3.67	0.606
	Moderately important	6	20.0	26.7		
	Very important	22	73.3	100.0		
	Total	30	100.0			

Appendix 14

Mean and Frequency Results for Emphasis given to ANCI Competency Rankings by Experienced Nurses.

Nursing Aspect	Frequency		Percent	Cumul-ative Percent	Mean	Standard Deviat-ion
Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	2 6 10 29 47 1	4.2 12.5 20.8 60.4 97.9 2.1	4.3 17.0 38.3 100.0	3.40	0.876
Demonstrates accountability and responsibility for own actions.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 4 10 32 47 1	2.1 8.3 20.8 66.7 97.9 2.1	2.1 10.6 31.9 100.0	3.55	0.746
Practice within the limits of own abilities and qualifications.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 4 12 30 47 1	2.1 8.3 25.0 62.5 97.9 2.1	2.1 10.6 36.2 100.0	3.51	0.748
Actively pursue continuing self education.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	3 16 13 15 47 1	6.3 33.3 27.1 31.3 97.9 2.1	6.4 40.4 68.1 100.0	2.85	0.96
Provide opportunities to transfer fundamental nursing skills from one situation to another.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 8 16 21 46 2	2.2 17.4 34.8 45.7 100.0 4.2	2.2 19.6 54.3 100.0	3.24	0.82
Demonstrate ability to integrate and consolidate practical application of theory.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 5 14 27 47 1	2.1 10.4 29.2 56.3 97.9 2.1	2.1 19.6 54.3 100.0	3.43	0.77
Opportunity to develop confidence in clinical practice.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	0 4 15 28 47 1	0 8.3 31.3 58.3 97.9 2.1	0 8.5 40.4 100.0	3.51	0.66
Demonstrate proficiency in fundamental clinical skills.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	0 7 17 23 47 1	0 14.6 35.4 47.9 97.9 2.1	0 14.9 51.1 100.0	3.34	0.73
Provide holistic nursing to	No emphasis	3	6.3	6.4		

the patients in your care.	Little emphasis Moderate emphasis High emphasis Total Missing	7 10 27 47 1	14.6 20.8 56.3 97.9 2.1	21.3 42.6 100.0	3.30	0.95
Undertake all activities in relation to patient care and other assigned duties.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 5 17 23 46 2	2.1 10.4 35.4 47.9 95.8 4.2	2.2 13.0 50.0 100.0	3.35	0.77
Provide appropriate education for your patients.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	3 12 14 18 47 1	6.3 25.0 29.2 37.5 97.9 2.1	6.4 25.5 51.1 100.0	3.00	0.96
Consider the needs of the patient's relatives and / or carers.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	2 10 12 23 47 1	4.2 20.8 25.0 47.9 97.9 2.1	4.3 25.5 51.1 100.0	3.19	0.92
Improve time management skills.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	0 7 9 31 47 1	0 14.6 18.8 64.6 97.9 2.1	0 14.9 34.0 100.0	3.51	0.75
Co-operate with the nursing units and all other departments within the hospital.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	3 11 17 15 46 2	6.3 22.9 35.4 31.3 95.8 4.2	6.5 30.4 67.4 100.0	2.96	0.92
Actively participate as part of the multidisciplinary team.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	2 7 11 27 47 1	4.2 14.6 22.9 56.3 97.9 2.1	4.3 19.1 42.6 100.0	3.34	0.89
Experience a variety of different areas of nursing specialisation.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	1 5 12 29 47 1	2.1 10.4 25.0 60.4 97.9 2.1	2.1 12.8 38.3 100.0	3.47	0.78
Understand and adapt to the culture of the hospital.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	4 12 15 15 46 2	8.3 25.0 31.3 31.3 95.8 4.2	8.7 34.8 67.4 100.0	2.89	0.97
Understand the function of the preceptor as a role	No emphasis Little emphasis	4 5	8.3 10.4	8.5 44.7	3.23	0.96

model.	Moderate emphasis High emphasis Total Missing	14 24 47 1	29.2 50.0 97.9 2.1	68.1 100.0		
Provide appropriate education for your patient's relatives.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	4 17 11 15 47 1	8.3 35.4 22.9 31.3 97.9 2.1	8.5 44.7 68.1 100.0	2.79	1.00
Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	No emphasis Little emphasis Moderate emphasis High emphasis Total Missing	2 7 13 25 47 1	4.2 14.6 27.1 52.1 97.9 2.1	4.3 19.1 46.8 100.0	3.30	0.88

Appendix 15

Mean and Frequency Results for Importance given to ANCI Competency Rankings by Experienced Nurses.

Nursing Aspect	Frequency		Percent	Cumul-ative Percent	Mean	Standard Deviat-ion
Utilise available support / resources in the facilitation of role transition from student to registered nurse status.	Not important Slightly important Moderately important Very important Total	1 1 3 43 48	2.1 2.1 6.3 89.6 100.0	2.1 4.2 10.4 100.0	3.83	0.56
Demonstrates accountability and responsibility for own actions.	Not important Slightly important Moderately important Very important Total	0 0 0 48 48	0 0 0 100.0	0 0 0 100	4.00	0.0
Practice within the limits of own abilities and qualifications.	Not important Slightly important Moderately important Very important Total	0 0 3 45 48	0 0 6.3 93.8 100.0	0 0 6.3 100.0	3.94	0.24
Actively pursue continuing self education.	Not important Slightly important Moderately important Very important Total	1 1 16 30 48	2.1 2.1 33.3 62.5 100.0	2.1 4.2 37.5 100.0	3.56	0.65
Provide opportunities to transfer fundamental nursing skills from one situation to another.	Not important Slightly important Moderately important Very important Total Missing	0 1 14 32 47 1	0 2.1 29.2 66.7 97.9 2.1	0 2.1 31.9 100.0	3.66	0.52
Demonstrate ability to integrate and consolidate practical application of theory.	Not important Slightly important Moderately important Very important Total	1 3 7 37 48	2.1 6.3 14.6 77.1 100.0	2.1 8.3 22.9 100.0	3.67	0.69
Opportunity to develop confidence in clinical practice.	Not important Slightly important Moderately important Very important Total	0 2 12 34 48	0 4.2 25.0 70.8 100.0	0 4.2 29.2 100.0	3.67	0.56
Demonstrate proficiency in fundamental clinical skills.	Not important Slightly important Moderately important Very important Total	0 1 9 38 48	0 2.1 18.8 79.2 100.0	0 2.1 20.8 100.0	3.77	0.47
Provide holistic nursing to the patients in your care.	Not important Slightly important Moderately important Very important Total	1 1 4 42 48	2.1 2.1 8.3 87.5 100.0		3.81	0.57
Undertake all activities in relation to patient care and other assigned duties.	Not important Slightly important Moderately important	0 1 16	0 2.1 33.3	0 2.1 36.2	3.62	0.53

	Very important Total Missing	30 47 1	62.5 97.9 2.1	100.0		
Provide appropriate education for your patients.	Not important Slightly important Moderately important Very important Total	0 1 10 37 48	0 2.1 20.8 77.1 100.0	0 2.1 22.9 100.0	3.75	0.48
Consider the needs of the patient's relatives and / or carers.	Not important Slightly important Moderately important Very important Total	0 3 7 38 48	0 6.3 14.6 79.2 100.0	0 6.2 20.9 100.0	3.73	0.57
Improve time management skills.	Not important Slightly important Moderately important Very important Total	0 2 9 37 48	0 4.2 18.8 77.1 100.0	0 4.2 22.9 100.0	3.73	0.54
Co-operate with the nursing units and all other departments within the hospital.	Not important Slightly important Moderately important Very important Total	1 5 12 30 48	2.1 10.4 25.0 2.5 100.0	2.1 12.5 37.5 100.0	3.48	0.77
Actively participate as part of the multidisciplinary team.	Not important Slightly important Moderately important Very important Total	1 0 6 41 48	2.1 0 12.5 85.4 100.0	2.1 2.1 14.6 100.0	3.81	0.53
Experience a variety of different areas of nursing specialisation.	Not important Slightly important Moderately important Very important Total	0 11 14 23 48	0 22.9 29.2 47.9 100.0	0 22.9 52.1 100.0	3.25	0.81
Understand and adapt to the culture of the hospital.	Not important Slightly important Moderately important Very important Total Missing	4 6 10 27 47 1	8.3 12.5 20.8 56.3 97.9 2.1	8.5 21.3 42.6 100.0	3.28	0.99
Understand the function of the preceptor as a role model.	Not important Slightly important Moderately important Very important Total	1 1 11 35 48	2.1 2.1 22.9 72.9 100.0	2.1 4.2 27.1 100.0	3.67	0.63
Provide appropriate education for your patient's relatives.	Not important Slightly important Moderately important Very important Total	1 4 20 23 48	2.1 8.3 41.7 47.9 100.0	2.1 10.4 52.1 100.0	3.35	0.73
Demonstrate ability to prioritise tasks as part of the process of advancing clinical proficiency.	Not important Slightly important Moderately important Very important Total	1 1 6 40 48	2.1 2.1 12.5 83.3 100.0	2.1 4.2 16.7 100.0	3.77	0.59

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