

# CHAPTER ONE

## Introduction

### 1. Introduction

Chapter one introduces the research project and explores the reasons for undertaking a study into the experiences of new graduate nurses making the role transition from student to registered nurse within rural practice settings. The purpose of the research and the research questions are presented, followed by a discussion of the significance of the study. An introduction to the methodology is provided and an outline of the thesis is presented. Definitions adopted by the researcher for the thesis are presented and the limitations of the research are identified.

#### 1.1. Background to the study

This study emerged from my desire to understand the experiences of new graduate nurses making the role transition from student to registered nurse within rural practice settings. My interest in new graduate nurses and their journey of integration into the rural nursing workforce stems primarily from working as a Clinical Coordinator of an undergraduate nursing program within a regional university of NSW. The study also arises from my own interest in rural nursing having been a practising rural nurse for many years.

In my role as Clinical Coordinator I am required to visit and meet with students and staff of rural health care facilities to monitor the progress of student nurses during their clinical preparation and to liaise and support the health facility staff. Over the past few years I have become concerned for new graduates within rural health facilities for three reasons. First, when I visited health

facilities it was not uncommon for new graduate nurses to recognise me as being 'someone from a university' and they would initiate conversations with me regarding their experiences. From my own observations and personal communications with these new graduates, I realised that their experience in rural practice is vastly different from what their initial expectations of beginning practice were, especially when compared to the experience of their peers in metropolitan centres.

Second, student nurses frequently sought advice from me regarding rural graduate nurse programs and they also expressed their admiration for new graduates in rural practice they met during their clinical placements. In an attempt to better inform them, the researcher examined the literature pertaining to new graduate nurses and discovered very little information regarding the role transition in rural practice settings. Third, rural nursing staff frequently expressed concern to the researcher that new graduate nurses were not completing their graduate programs. Additionally staff reported that new graduates were not being offered permanent employment once they had completed the twelve month graduate nurse program and so they were lost from rural nursing.

Thus, this study emerged from the researcher's concerns for new graduates within rural health facilities and she felt that by conducting this study she would be able to identify the specific issues encountered during the transition process. As a result, the researcher anticipated using the findings of this study to more effectively prepare students and inform them of what they could experience within rural practice settings.

The transition process from a student nurse to a registered nurse has been identified by new graduates as an extremely stressful experience, that is, it is both physically and emotionally demanding (Dufault 1990; Green 1988; Madjar 1997).

The successful assimilation of the new graduate nurse into the nursing workforce is largely dependent on the amount and quality of support that the new graduate receives. This is especially true within the first three months of

employment when a rapid and major transformation occurs, both professionally and personally, in the new graduate (Madjar 1997). Problems associated with the transition process are universal for beginning practitioners. To some extent they encounter similar problems to those experienced by any newcomer into any workforce, however, the process is complicated in nursing because of the unpredictability of daily practice and the high level of responsibility that is sometimes placed on new practitioners (Madjar 1997).

For the new graduate in rural practice the role transition is further complicated by the unique role of the rural nurse. Rural nursing has been referred to as a unique specialty, and is described as a specialist-generalist role (Hegney 1996).

For example, rural nurses work in areas where there are limited health services, health care facilities, and medical practitioners. Thus the role of the rural nurse requires a multidimensional approach accompanied by a broad range of skills. Rural nurses frequently do not have ancillary and medical support, which often results in them being the primary care giver and *jack of all trades*, which means working in all areas and sometimes working beyond their legal boundaries (Hegney 1996; Bridgewater 1998).

It is not unexpected then to find that very few new graduate nurses enter the rural workforce and those who do go to large regional health services (Blue 1993; Handley 1998; Hegney 1996). Additionally, beginning nurses enter rural practice which is very different from urban practice and there is a belief (Madjar 1997), that they do so unprepared because they are yet to acquire the broad range of skills which are necessary to practise within rural health settings. Thus the researcher also wished to explore new graduates' perceptions of their preparedness for rural practice once they had entered the rural nursing workforce.

## **1.2. Purpose of the study**

To address the research problem, information was required from new graduates employed as registered nurses in rural health facilities at the time of the study. Thus, the purpose of this study is to explore the experience of transition of newly graduated nurses in rural practice settings.

### **1.2.1. Research questions**

In order to explore new graduates experiences of the transition from student nurse to registered nurse in the rural workforce the following question has been developed.

*What is the lived experience of new graduate nurses making the transition from student to registered nurse in rural practice settings?*

The following research questions were also formulated to assist in exploring the transition process for graduate nurses and to identify issues related specifically to the process.

*What were the reasons the new graduate initially sought employment in a rural area?*

*How do new graduates feel about the adequacy of their educational preparation for registered nursing practice in a rural setting?*

*What type of support was provided to the new graduate nurse to assist the transition process and how effective did the new graduate perceive that support to be?*

*Did the new graduate nurse who chose a rural employment position have regrets about their rural choice and if so why?*

### **1.3. Significance of the study**

This thesis will make both a practical and theoretical contribution. As previously mentioned, a survey of the literature indicates that very few new graduate nurses enter the rural workforce, and those who do go to large regional area health services (Blue 1993; Hegney 1996; Handley 1998). However, little is known about the role transition process experienced by the small number of graduates working in these regional area health services. Even less is known about the transition process of the minority group of graduates who enter small rural health facilities. Thus, this study attempts to address this gap

in the research literature on the transition process, particularly in the rural nursing literature.

Factors impacting on the transition process for graduates working in rural health settings will be identified using Role Theory as the theoretical framework. Identification of these factors will have a twofold effect. First, the research findings will contribute to nursing in the higher education sector by providing an understanding of the specific issues faced by new graduate nurses making the transition into rural practice, and also by providing insight into the graduates' perceptions of their preparedness for rural practice.

Second, the research findings will identify for rural nurse practitioners whether rural graduate nurse programs have a desirable impact on the graduates' transition. This practical contribution has the potential to assist rural nurses with the development and implementation of graduate nurse programs specific to the rural environment.

Finally, this study will assist the researcher to highlight to the nursing profession the current recruitment and retention problems faced by rural health care facilities in Australia. More specifically, it will present the recruitment and retention concerns of new graduate nurses in the rural workforce which will need to be addressed if rural nursing practice is to survive as a viable, rewarding nursing specialty.

#### **1.4. Methodology**

The aim of this study was to explore and provide an understanding of new graduate nurses' experience of transition within rural practice settings. By exploring their experiences the researcher also sought to identify aspects of the role transition that are unique to rural practice settings. Thus the researcher chose a qualitative approach for this study for two reasons. First, many authors have indicated in the literature that quantitative research methods are not appropriate to study experiences that have meaning for people (Hallett 1995; van Manen 1997; Annells 1999; Van der Zalm & Bergum 2000). Second, a qualitative design has been recommended when little is known about a phenomenon (Minichiello, Timewell & Alexander 1999). To this researcher's

knowledge there is little literature which explores the experiences of graduate nurses within rural practice settings, and the views of new graduates were viewed as crucial in discovering in-depth rich data for this study. Individual in-depth interviews were conducted with ten new graduate nurses making the role transition within rural practice settings at the time of the study. This was considered to be an appropriate data collection method by the researcher, as she wanted to explore new graduates' experiences in order to understand their feelings/emotions.

In exploring the new graduate nurses' experience of transition and as previously mentioned, the researcher used Role Theory as the theoretical framework. Role Theory and associated concepts including role modelling, role stress, role strain, plus professional socialisation and reality shock, have been identified in the literature as important underpinning elements of new graduates' experience. Thus the researcher believes Role Theory will provide an appropriate framework from which to view the transition process from student nurse to registered practising nurse within rural practice settings.

### **1.5. Limitations and key assumptions**

This study was conducted in only eight rural towns of northern NSW and therefore is not representative of the new graduate nurse populations in rural areas. However, the researcher was not interested in inferring any statistical conclusions. Rather, the study focused on the lived experience of ten graduate nurses making the role transition in rural practice settings as the researcher sought to obtain rich data regarding their experience.

There is one major assumption on which this study is based. The researcher has an expectation, based on personal experience plus anecdotal evidence, that new graduate nurses working in rural health settings do encounter specific problems during their transition process.

### **1.6. Organisation of the thesis**

This thesis is presented in five chapters. In chapter one the research topic is introduced. A background to the problem is provided followed by the purpose of the study and the research questions. The significance of the study is

discussed and it is identified that the research findings will make both a practical and theoretical contribution. This chapter also identifies the limitations and assumptions related to this study, and a list of definitions is provided to classify terms used throughout the thesis.

Chapter two of this thesis presents an overview of rural nursing practice in Australia and a critical analysis of the literature related to the role transition for new graduate nurses' in metropolitan and rural practice settings. Additionally, Role Theory and associated concepts are presented and discussed.

In chapter three the justification for the research design and methodological approach chosen for this study is presented. This chapter provides detailed descriptions of the selection of participants, the method of data collection, as well as a discussion of rigour and trustworthiness required for a qualitative study. Finally ethical issues and methodological limitations relevant to this research study are identified and discussed.

Chapter four presents a detailed account of the data analysis which is presented as a journey of transition consisting of three stages. Themes that emerged from carefully reading and rereading the transcripts of the data are described in each stage of the journey. The themes identify common elements of the participants' experiences and the overall analysis provides the reader with an understanding of role transition in rural practice settings.

The thesis concludes with chapter five, which presents the researcher's interpretations of the findings and major conclusions. Finally, the implications of this research study are addressed and recommendations are made for further research into this field of study.

### **1.7. Definition of terms**

The following terms have been identified for this research study to avoid confusion and to enhance clarity and consistency. A number of these definitions have been drawn from various sources and will be identified as such. Those without a reference are the researcher's understanding of the term.

- Beginning Level Nurse:** 'is one with less than one year's clinical experience in the area of nursing practice in which they are currently working' (Williams 1989 cited in Roberts & Farrell 2003:13).
- Clinical Placement:** The periods of time that student nurses spend in the clinical environment in order to apply the knowledge and skills they have gained in the university setting (University of New England 1996).
- Enrolled Nurse (EN):** A person licensed under an Australian State or Territory Nurses Act to provide nursing care under the supervision of a Registered Nurse (Australian Nursing Council Incorporated 2000:27).
- Graduate Nurse Program (GNP):** A twelve month structured program provided by health care facilities, that aims to assist the transition from undergraduate student to registered nurse by providing extensive clinical orientation and structured support. This may include rotations through clinical areas, plus a range of educational and supportive strategies, for example preceptorship, mentoring, and study days that will assist the new graduates to consolidate skills and gain experience (Jackson, Mannix & Brown 2001; Kluge 2001).
- Preceptor:** A service based nurse with clinical expertise and an interest in student education, who is willing to sponsor a learner in a patient care setting (University of New England 1996:28).
- Registered Nurse (RN):** A person licensed to practise nursing under an Australian State or Territory Nurses Act (Australian Nursing Council Incorporated 2000:27).

**Rural:** For the purpose of this study the Department of Primary Industries and Energy's Rural, Remote and Metropolitan Areas Classification Method 1994 (cited in Handley 1999:2) was adopted. Towns are considered to be rural because their population base is smaller than regional or capital cities. Additionally, *rural* applied to towns whose geographical location, or distance from metropolitan centres is such that they are considered to be rural by the Rural, Remote and Metropolitan Areas Classification Method. This particular classification method states that 'rural usually implies: a geographical area sustained by primary industry; a population with reduced access to medical and other health services when compared to major regional and capital cities; a population with an attitude of self-sufficiency; and, a population particularly susceptible to occupational disease and injury' (Department of Primary Industries and Energy 1994 cited in Handley 1999:2).

**Small rural health care facility:** Located in a rural town with a population base of 10,000–24,000 whose health care facility has a bed capacity of between 30 and 60.

**Large rural care facility:** Located in a rural town whose population base is 25,000 or more and whose health care facility has a bed capacity that ranges between 100 and 150.

## 1.8. Conclusion

In summary, this chapter has laid the foundations for the thesis. The chapter has introduced the research topic and presented a background to the study. Following this the purpose, research questions and significance of the research have been described. Research limitations and assumptions have been identified and definition of terms have been provided. Finally, each chapter of

the thesis has been outlined. The following chapter will present a review of the literature in relation to the research topic.

# CHAPTER TWO

## Literature review

### 2. Introduction

This chapter discusses the literature that pertains to the role transition for new graduate nurses in metropolitan, and rural practice settings within Australia. The aim of this chapter is to first provide an overall review of the issues surrounding the role transition from student to registered nurse and then to examine these issues as they specifically apply to the new graduate making the role transition in rural health care facilities.

In section one, an overview of rural nursing practice in Australia is presented. This section specifically examines the role of the rural nurse, current issues affecting rural nursing, and the issues for new graduates in rural nursing practice.

In section two, Role Theory, which provides the theoretical framework for this study, is presented. This section provides an overview of Role Theory, and how roles are acquired within society. The major focus is on nursing roles, and related concepts such as role stress and role strain will be also discussed, and the impact of these concepts on new graduate nurses in rural areas is explored.

Section three identifies further issues associated with the transition to professional practice for new graduate nurses. The concepts of professional socialisation and reality shock that can occur for new graduate nurses as they enter the nursing workforce are also examined. Associated concepts including undergraduate nursing preparation, the gap between nursing education and nursing service, enculturation of new graduate nurses and horizontal violence

are also discussed. The effectiveness of structured support mechanisms implemented to assist in easing the role transition for the new graduate nurses is reviewed.

## 2.1. Section 1

### 2.1.1. *Rural nursing practice in Australia*

Since the late 1980s, there has been a growing body of knowledge that recognises rural nursing as a separate and unique identity from remote and metropolitan-based nursing (Blue 1993; Hegney 1996; Bridgewater 1998; Handley 1998). Previous literature from Australia which is mainly prescriptive, concentrates on defining rural nursing, investigating the scope of rural nursing practice, identifying the educational and research needs of rural nurses, as well as providing discussions as to the preparedness of new graduate nurses for rural nursing practice. However, whilst much has been written in the past about remote area nursing in Australia, very little empirical literature exists regarding the recruitment and retention issues facing rural health care facilities.

Rural nursing in Australia has been referred to as a unique and separate specialty, with Hegney (1996) describing rural nursing as a specialist-generalist role. For example, rural nurses work in areas where there are limited health services, facilities, and medical practitioners. As a result, the role of the rural nurse is multidimensional and unique, and requires a broad range of skills. Authors such as Blue (1993), Hegney (1996), and Keyzer (1998) have highlighted common elements of rural nursing practice. For example, rural nurses are often the primary care giver and *jack of all trades*, who work in areas which maybe without ancillary or medical support, which sometimes necessitates them working beyond their legal boundaries (Hegney 1996; Bridgewater 1998). Additionally, rural nurses have a high community profile, which often results in a blurring of roles and a lack of anonymity for the rural nurse, as they often have to care for and work closely with people they know professionally, personally and socially.

Taheri-Kennedy (1997) identifies a role diffuseness that occurs for rural nurses, because of the mixing of personal and professional roles in rural practice which

this author terms the *rural culture*. According to Taheri-Kennedy (1997) this diffusion of personal and professional roles is an expectation that *rural cultures* have of rural nurses. Furthermore, Taheri-Kennedy (1997) states that rural people are different from urban people in geographical, occupational and cultural ways that affect health perceptions, behaviours and pathology risks. Therefore, the experience of nursing in rural communities is unique, and nursing care must be appropriate for the rural culture. For example, interactions such as grocery shopping within rural communities are usually thought to be social circumstances, but in rural communities they can involve a professional role. It is not unusual to go shopping and be recognised by people as the nurse who has recently cared for them or their relative, or for the nurse to be consulted in the street regarding a person's health problems. As well, professional roles can involve a personal role if the patient is a friend, neighbour or acquaintance. This can also influence work relationships as work colleagues maybe neighbours, friends, relatives or perhaps acquaintances met through sporting, school or social networks. Role diffuseness results in a lack of anonymity for rural nurses, and Hegney (1996) suggests that the lack of anonymity experienced by rural nurses is difficult for them, especially for those nurses who have grown up in the rural area.

### ***2.1.2. The new graduate nurse in rural practice***

The retention and recruitment of health professionals to rural areas has been acknowledged as a major problem in Australia (Hegney 1996; Bell, Daly & Chang 1997), which has been a long-standing concern. Lack of access to adequate support, education and training are identified as common themes that influence the retention of the rural nursing workforce (Hegney 1996; Bell et al. 1997). In addition, the rural nursing workforce is an ageing one, and numerous reports focus on the recruitment and retention of new graduate nurses as an important issue for rural health care facilities (Hegney 1996; Bridgewater 1998; Mosel Williams 2000; Cowin 2002). Whilst there is a low turnover of nursing staff in rural health care facilities compared to metropolitan and remote areas, this is due to the stability of rural lifestyles and also to the fact that many partners of rural nurses are employed within rural communities, for example, the police force, teaching and farming (Hegney 1996).

For the year 2001 there were less than 200 rural graduate nurse positions available within the New South Wales New Graduate Recruitment Consortium as opposed to over 1,000 available in metropolitan areas (NSW New Graduate Nurse Recruitment Consortium 2001 Report). Graduate nurse positions are limited in rural areas because of the reasons previously mentioned and also because of the size of individual health services and the populations they serve, as well as the availability of financial resources to recruit new staff. Rural health agencies vary in the number of graduate nurse positions they have available. Generally, large rural health care facilities can accommodate between four to six graduate nurses whilst smaller rural health care facilities can accommodate only one to two graduate nurses per year. A unique aspect of graduate nurse programs in rural health care facilities is that graduate nurses may be required to rotate for periods of up to three months to smaller satellite health facilities within the region during their graduate program.

Blue (1993), Handley (1998), and Hegney (1996), have indicated that very few new graduate nurses enter the rural workforce, and those who do go to large regional health services. Very few rural health care facilities directly employ staff members, as most come under the umbrella of a larger area health service that recruits for their smaller rural health facilities. For the small group of new graduate nurses who enter rural nursing practice there is often no guarantee of a permanent position once the graduate year is completed. This is because of the low turnover of staff in rural health facilities, as previously mentioned. Hence, most new graduates will leave rural areas upon completion of their 12-month graduate nurse program and seek more permanent employment in metropolitan centres. In addition, anecdotal evidence gathered from new graduate nurses indicates that rural health facilities frequently have problems retaining new graduate nurses for the duration of the graduate nurse program. This is because the prospect of more permanent employment influences new graduates to exit the rural health care facilities part way through their transition program.

New graduate nurses who enter the rural workforce enter a professional practice very different from metropolitan practice and also from what they have experienced as an undergraduate. Hegney (1996) and Bridgewater (1998)

believe that the difference between rural and metropolitan nursing practice may be attributed partly to the scope and diversity of rural nursing practice whereby the level of responsibility and skills differs from that of their metropolitan peers. Thus it is likely that new graduate nurses in a rural practice setting will have to assume workload responsibilities that are vastly different from their metropolitan or regional peers. For example, staff ratios in rural areas can mean that the new graduate may be required to relocate to different clinical areas on a daily basis to provide assistance when other areas within the hospital are short-staffed, when staff are experiencing emergency situations, and when meal relief for other staff members is required. Thus, new graduates in rural practice may be required to move between clinical units fairly constantly throughout one shift. To further highlight this point, it is not uncommon in rural health care facilities for the Accident and Emergency area to be attached to a general ward area. Staff rostered to that ward are expected to also attend to the Accident and Emergency area should the need arise during the course of the shift.

Additionally, the diminishing infrastructure of rural towns and the subsequent restructuring of rural health services have impacted on the staffing ratios and skill mixes within rural health care facilities. This has influenced the educational and support services that can be offered to new graduates in transition programs in rural areas.

Thus this study aims to add to the small body of literature which identifies issues that influence the retention of new graduate nurses in the rural nursing workforce.

## **2.2. Section 2**

### ***2.2.1. Role Theory: A theoretical framework***

Role Theory provides an appropriate framework from which to examine the transition experience of new graduate nurses in rural practice settings, because concepts of Role Theory such as role modelling, role stress and role strain have been identified in the literature as important underpinning elements of the new graduates' experience of entering the nursing workforce. Hardy and Conway (1978:7) state that the concept of Role Theory has frequently been used as a

framework to describe and study the phenomenon of socialisation of individuals for particular roles within society. Socialisation for roles 'is a continuous and cumulative process' (Hardy & Conway 1978:71) whereby expected role behaviours are acquired through interaction with groups in a social context and through learning processes such as role modelling and role observation (Marquis & Huston 1992:191).

Role Theory has its origins in the behavioural and social sciences. Major works regarding Role Theory arise from authors such as Biddle and Thomas (1966), Biddle (1979) and Hardy and Conway (1978). Hardy and Conway define Role Theory as 'representing a collection of concepts and hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behaviours can be expected' (Hardy & Conway 1978:17). Role Theory contends that roles are assigned to individuals in society and each role has recognisable patterns of behaviours and expected behaviours that go with it (Kilstoff & Rochester 2001:79). Additionally, expected patterns of behaviour are also assigned to the individuals with whom the role occupant interacts (Hein & Nicholson 1994:308).

Socialisation for roles begins in infancy where role modelling and the reinforcement of socially relevant behaviours are learned through the influence of family. It continues through to adulthood where individuals develop new behaviours and values associated with adult professional roles.

In this study, Role Theory provides an appropriate theoretical perspective that can be applied to the acquisition of the professional role of nursing. It also provides a theory with which to examine the role changes experienced in the transition from student nurse to professional nurse and the subsequent socialisation into the role of the professional nurse within rural practice settings.

Role Theory is discussed from two different theoretical perspectives, namely, the structural-functional approach and the symbolic-interactionist approach, both of which are applicable to and valid in nursing (Barter, McLaughlin & Thomas 1997:2).

In the structural-functional approach the individual is linked to social structure and the focus is on the division of labour within that social structure (Creasia & Parker 2001:75).

Barter et al. (1997:31) define roles from this perspective as 'homogeneous sets of behaviours that are normatively defined and expected of the occupant of a given social position'. That is, roles are considered functioning units of society and there exists a formal set of expectations or rules about how a person behaves in society. This perspective also contends that norms and values attached to positions in societies are handed down from generation to generation, but as the social structure changes, the norms and values for that position must also adapt and change (Creasia & Parker 2001:75). Roles from this perspective are formal because they have an identifying name and are tightly controlled by our society and generally come to us because of our abilities, education and training (Kilstoff & Rochester 2001:80).

The structural-functional perspective to role theory can be applied to illustrate the formal aspects of nursing roles such as the caregiver and administrative roles. These roles are defined by the context of the setting and designed within the formalised structure of the health care organisation (Creasia & Parker 2001:76), where the role of the registered nurse is regulated by laws, codes of conduct and ethics, and standards of practice (Kilstoff & Rochester 2001:80). This perspective accounts for the primary and secondary role acquisition and socialisation of student nurses as they learn the professional values and standards associated with the discipline of nursing (Kilstoff & Rochester 2001:80). However, the structural-functional perspective alone does not take into account the enormous variations in behaviour that cannot be formalised and which take place in our complex social structures (Hardy & Conway 1978:22; Kilstoff & Rochester 2001:80).

Creasia and Parker (2001:75) explain the symbolic-interaction perspective of Role Theory as focusing on the interaction between people in the social system. The meaning that is given to human behaviours, speech and gestures, forms the basis on which behaviours are selected and roles are constructed (Hardy & Conway 1978:18). That is, for communication to be effective within that social

system these symbols must have the same meaning. Mutual understanding of the meaning of symbols by individuals within a particular social system controls role-related behaviour by either supporting or suppressing behaviours. Roles in this perspective are viewed as a set of interpersonal characteristics inherent in an individual functioning within an organisation, family or group, where the responses of others within that organisation, family or group serve to validate behaviour (Barter et al. 1997:31).

The role in this symbolic-interaction perspective is reciprocal because it is dependent on other individuals who are involved in the interaction. For example, it may involve role modification, where an individual adopts the attitudes or behaviours of others that are involved in an interaction. Or, the interaction with others is structured in such a way as to modify and make explicit certain aspects of the role (Hardy & Conway 1978:24). Specifically, these characteristics are known as role taking and role making, terms that are used to describe the process that takes place when role modification is consciously entered into. By observing the behaviour of individuals within a certain occupational role, another individual who wishes to be in that role can change or model their behaviour to conform to the expectations that others have of the behaviours that go with that specific role.

The symbolic-interaction perspective of Role Theory helps to explain the professional role and the professional socialisation of new graduate nurses who will learn by role taking or role making, by observing, understanding and responding to the meaning of actions of other nurses (Creasia & Parker 2001:75). The nurse's own role expectations and the expectations of other individuals with whom the nurse interacts will also influence behaviour patterns that are specific to the nurse's professional role. Individuals with whom the nurse interacts, for example, doctors, other nurses and healthcare workers, patients and their families, will all have expectations of the nurse's behaviours and will interact to condemn or support the behaviour within the nursing role. Barter et al. (1997:31) state that nurses need to know the function they fulfil, as well as the associated behaviours and expectations concerning the roles of other individuals within the health care organisation so that they can respond accordingly.

Neither of these theoretical perspectives is singularly able to accommodate the range of roles that any one individual can assume in today's society. As our roles are derived from personal, social and occupational domains it is common for individuals to assume roles in all domains simultaneously. Varying degrees of the two theoretical perspectives influences each role, and through a process of socialisation, individuals develop knowledge, skills and values needed to perform certain roles (Oermann 1997:10), across the three domains. However the symbolic-interactionist approach that fits the role acquisition and socialisation of the new graduate nurse provides an appropriate perspective from which this study can examine the role transition of new graduate nurses entering rural practice.

### *2.2.2. Role stress*

Within a defined role there can be multiple associated roles that can be assumed within the same context. For example, the role of the nurse involves a caregiver, plus an education and administrative role and these main roles can have sub-roles that have a similar focus yet differing dimensions. For example, the nurse's educational role is one that can have numerous sub roles. Sub-roles form complex patterns of overlapping social positions and roles, each demanding certain behaviours and relationships, which are unique (Creasia & Parker 2001:77). Thus, the education of patients and their families, clinical education of student nurses and providing in-service education for peers and colleagues, are different dimensions of the nurses' educational role.

However, multiple and sub-roles that an individual assumes, can lead to conditions that make fulfilment of roles difficult or which can adversely affect the role occupant, leading to a phenomenon known as role stress (Hardy & Conway 1978:74). According to Hardy and Conway (1978:73) role stress occurs when 'a social structure creates very difficult, conflicting, or impossible demands for occupants of positions within the structure'. Role obligations may be irritating, unrealistic or vague and can lead to role strain where the individuals experience feelings of frustration, anxiety, irritability or distress because they cannot meet the role obligations (Creasia & Parker 2001:78). An inability to meet role obligations can result in conditions associated with role

stress, which are categorised as: role conflict; role ambiguity; role incongruity; and role overload, which commonly occur within nursing.

Role stress and role strain are prevalent in nursing because of the multiple roles and sub-roles within the professional nursing role. Also, role stress and role strain are generated in nursing because of the changes in the organisation and delivery of health care, the formation of new nursing roles, as well as technological advances and prevailing economic conditions (Hardy & Conway, 1988 cited in Creasia & Parker 2001:78).

Conditions associated with role stress and role strain are role conflict, role ambiguity and role incongruity, and they are encountered in the role transition for the new graduate nurse. They have been identified in the literature as common elements of the new graduate nurse's experience of transition to professional practice (Horsburgh 1989; Moorehouse 1992; Kelly 1996; Winter-Collins & McDaniel 2000; Kilstoff & Rochester 2001).

### **2.2.3. *Role conflict***

Role conflict occurs when role expectations within or among roles are incompatible with one another and when individuals have different perceptions of the role to be enacted (Creasia & Parker 2001:79; Kilstoff & Rochester 2001:86). Role conflict commonly occurs in nursing because of the professional role competing with bureaucratic organisational roles. The organisational role held by nurses can add pressures to comply or act in a way which may be in conflict with the nurses' professional role. Entry to the nursing workforce produces role conflict for new graduate nurses as they struggle with the professional idealised role of the nurse to the actual role as experienced in the working environment (Chang & Daly 2001:5). Kelly (1998) states that new graduates experience severe job stress that is caused by role conflict and role ambiguity. Job stress is directly related to job satisfaction and staff turnover and has implications for the retention of graduate nurses in the nursing workforce (Winter-Collins & McDaniel 2000; Cowin 2002). Thus role stress experienced by graduates in rural practice settings will be further explored in this study.

#### **2.2.4. Role ambiguity**

Role ambiguity arises because individuals may not entirely agree on the normal behaviours or expectations for certain positions. For example, the role may be unclear, vague or ill-defined and there may be a lack of clarity of the role expectations (Hardy & Conway 1978:81). That is, there is a lack of clear consistent information about the behaviour expected in a role (Kahn, Wolfe, Quinn & Snoek cited in Chang & Daly 2001:6). For example, the uncertainty and unpredictability associated with professional nursing practice because of the responsibility and nature of nurses' work can result in a lack of clarity in role expectations, which can contribute to role ambiguity (Creasia & Parker 2001:80). Role ambiguity has been identified as leading to job dissatisfaction and workforce retention problems within nursing (Chang & Daly 2001:6).

Chang and Daly (2001:6) believe that the transition for the new graduate nurse to the professional role is a time of adjustment to the nursing role, which also involves an adaptation to the complex social networks within each health care facility. This also occurs within each ward because, as previously mentioned, the new graduate will have to rotate frequently to different clinical areas during their graduate program. Not only does the new graduate have to adjust to unique nursing roles in each ward but they must also adjust to different personnel and patient management styles in each ward and this can increase the role ambiguity for the new graduate nurse. Thus, the level and type of support provided to new graduates to assist them to adapt to the complex social networks and the nursing role in rural practice are important issues in this study, and will be explored in the data collection stage.

#### **2.2.5. Role incongruity**

Role incongruity results when an individual has difficulty fulfilling role obligations because the expectations for role performance are incompatible with the individual's values, attitudes or self-concept (Hardy & Conway 1978:82; Creasia & Parker 2001:80). Kilstoff and Rochester (2001) state that this type of role stress in nursing is related to the dissonance in values or self-concept between the nurse and the institution where the nurse is employed. The role transition that new graduate nurses' experience in developing and assuming

their new professional role, is an example where role incongruity can be experienced.

When an individual is confronted with excessive demands, where too much work is expected in the allotted time, or the role becomes complex, role overload occurs. Creasia and Parker (2001:80) believe this is a common problem for nurses because of the rapid and frequent changes occurring in the organisation and the delivery of health care which places extra demands on nursing staff. Thus, the new graduate nurse often experiences role overload when they are unable to meet all of their workload responsibilities during their initial entry into the nursing workforce. The workload expectations and workload responsibilities for new graduates within rural practice have implications for this study and will be further explored.

### **2.3. Section 3**

#### ***2.3.1. Role transition for the new graduate nurse***

The transition process into the nursing workforce is fraught with numerous complexities, and transition-based issues have been well documented (Moorehouse 1992; Kelly 1996, 1998; Boyle, Popkess-Vawter & Taunton 1996; Winter-Collins & McDaniel 2000; Chang & Daly 2001; De Bellis, Longson, Glover & Hutton 2001). The literature from Australia and overseas identifies and explores various aspects of the transition process in nursing and the difficulties encountered by beginning registered nurses as they enter the nursing workforce. For example, the reality and culture shock that comes with professional socialisation, the theory practice gap, the new graduates' preparedness for practice and the lack of effective support during the change in role have all been addressed in the literature. As these issues are central to this research study they will now be addressed.

#### ***2.3.2. Professional socialisation and reality shock***

The process of role transition from student to graduate nurse is identified by Chang and Daly (2001:5) as an intense period of socialisation into the workplace culture of the clinical world where beginning registered nurses learn what is expected of them in their new role as a registered nurse. That is:

*A period of learning and adaptation to the requirements of nursing in which the new graduate acquires the skills, knowledge and values required to become an effective member of the nursing workforce*

(Commonwealth Department of Human Services and Health cited in Duffy, Seigloff & Kent 1998:24).

Professional socialisation is a process whereby an individual adult learns the roles and values of a profession with the aim of developing a professional identity. In nursing, professional socialisation is 'a process where a student or nurse acquires the knowledge and skills needed for practice' and also where they 'internalise the norms and values of the nursing profession into their behaviour' (Oermann 1997:10). This socialisation process allows an individual to develop a self-concept associated with a role and then to acquire the role behaviours and expectations needed for carrying out the role in practice. For each new role that is acquired a re-socialisation process or role transition will occur. In nursing, re-socialisation or role transition often occurs with a change in focus of a role. Moving to a nursing management role or moving from community nursing to a more acute setting, are two examples. However, significant to this study is the role transition or re-socialisation that occurs for new graduate nurses entering professional practice where they need to adapt to the workplace nursing role learned in the educational setting. New graduate nurses will also experience frequent re-socialisation because graduate nurse programs in Australia generally require them to rotate to different clinical areas every three months. Thus, the graduate nurse will experience re-socialisation as they learn to adapt to different clinical areas, management styles, patient care practices and staff personalities.

For the student nurse, professional socialisation and subsequent role acquisition occur initially in the educational setting and begin with a recognition of the attributes that make the ideal professional nurse. That is, knowledge of the formal role of nurses and all its dimensions is acquired. This is followed in the practice setting where an awareness of the nursing role, which is only shaped by experience, is developed and the student then attempts to model professional behaviours and attitudes.

Oermann (1997) discusses several models which have been developed to describe this process of professional socialisation within nursing. For example, Cohen's (1981) model, describes professional socialisation in nursing in terms of cognitive development of the student. Cohen believes that the nursing role develops as a result of professional socialisation, which could not be provided by nursing education (Cohen 1981 cited in Green 1988). A model by Hinshaw (1986) describes the socialisation process as the transition of anticipatory role expectations to actual role expectations of the professional, setting the standard for an individual entering the profession.

Another model by Kramer (1974) provides one of the best-known models of re-socialisation in nursing which describes the *reality shock* experienced with the transition from the educational setting to the workplace for new graduate nurses. The model describes fears and difficulties new graduate nurses experience in adapting to the work setting. In particular, it identifies the discrepancy between educational preparation and work place expectations, where new graduates in assuming and developing their new roles, experiences role stress, in particular role ambiguity, role conflict and role overload (Clayton, Broome & Ellis 1989:72; Oermann 1997:13; Chang & Daly 2001:5). Winter-Collins and McDaniel (2000:106) discuss four phases of reality shock that are experienced sequentially by newly graduated nurses and which are identified by Kramer's 1974 model. The first stage is *the honeymoon phase*, which is characterised by nurses' excitement and euphoria when obtaining their first nursing job. *The shock phase* constitutes the second stage where graduates discover that their goals may not be able to be met because of their inexperience or because of the organisational nature of the environment. This shock phase is often characterised by feelings of depression, outrage and fatigue. However it is followed by a *recovery phase* where graduates gain a perspective of their job. The final and fourth phase is the *resolution phase* where the graduate gains a nursing self-identity.

Inadequate socialisation and mismanagement of new nurses' early professional experience can lead to job stress for new graduate nurses. Job stress is acknowledged as the strongest predictor of job satisfaction for new graduate nurses (Kramer 1974 cited in Boyle et al. 1996) and often results in the new

graduate nurse experiencing low motivation, unnecessary conflict, and demoralisation that decreases quality of patient care. This is directly related to the turnover and attrition rates of new graduate nurses in the workforce (Boyle et al. 1996:42; Cowin 2002:285). To overcome job stress and to assist in the successful socialisation to the nursing role Kramer (1974), Boyle et al. (1996), and Winter-Collins and McDaniel (2000) have advocated measures to promote a supportive, nurturing environment for new graduates to reduce role stress as they enter the nursing workforce. These measures include; provision of positive preceptor and/or mentoring experiences that promote quality co-worker interactions, clearly defined workload responsibilities to reduce role conflict and role ambiguity and, structured support systems such as continuing education and staff development. These strategies are important to enable the new graduate to develop a sense of belonging, which can assist with a successful socialisation to the registered nursing role.

Thus, the effectiveness and adequacy of support provided to new graduates in easing their role stress and assisting with their professional socialisation to the rural registered nurses role is an important issue in the transition process, which this researcher sought to explore.

### *2.3.3. Theory practice gap*

The transition process from student nurse to registered practising nurse has previously been identified by new graduates as an extremely stressful experience that is physically and emotionally demanding (Dufault 1990; Green 1988; Madjar 1997). Whilst it is appreciated that new graduate nurses face similar problems to those encountered by any new individuals to the workforce, the role transition in nursing is complicated by the unpredictability of daily practice and the level of responsibility and accountability in every day practice (Madjar 1997:3).

There is debate in the literature as to the actual cause of difficulties encountered during the transition process for new graduate nurses, and recommendations made for easing the role transition for them depends on the explanation given for the transition problems. As previously stated, the successful role transition for new graduate nurses is dependent on the level of support they receive in

assisting them to socialise to the professional role of nursing. However, several recent studies (Madjar 1997; Kluge 2001; Pigott 2001; Ramritu & Barnard 2001) suggest that inadequate undergraduate nursing preparation can contribute to problems for the new graduate, especially with regards to a lack of time management skills, an inability to critically and analytically think about appropriate nursing care, and an inability to cope with the workload.

In 1994, the Commonwealth Review of Nursing Education identified that the link between nursing education and the demands of the workforce was a focus for concern. This report highlighted the differing expectations between universities, hospital settings and new graduates as they enter the nursing workforce. The report also indicated that the level of competence of new graduates, the adequacy of undergraduate clinical preparation and the need for employers to provide support during the transition period required attention (Commonwealth of Australia 1994). More recently, transition-based problems encountered by new graduate nurses continue to be linked to the gap between the theory and practice of nursing. That is, the 'academic/hospital' dichotomy constitutes a gap between what is taught in the classroom and what actually happens in the day-to-day practice of nursing (Heslop, McIntyre & Ives 2001:627; Duke, Forbes & Strother 2001:245). Furthermore, there is a belief that the service industry places too high an expectation on the beginning nurse as they enter the nursing workforce, which will now be further discussed.

For example, Pigott (2001:24), states that criticism exists towards tertiary nurse education because it fails to adequately prepare nursing students with the clinical skills required to cope with the 'real' world of practice. The author also acknowledges that this is further complicated because there are differences between experienced nurses, new graduates themselves and the service industry in the performance expectations of new graduates (Pigott 2001:24).

Kluge (2001) concurs with Pigott (2001) and also suggests that tertiary programs may be failing to adequately prepare nursing students for the reality of practice. Kluge states that repeated observations and anecdotal evidence from experienced staff within the health service industry have highlighted the difficulties new graduates have in transferring and integrating theoretical

knowledge to the clinical field. Kluge's qualitative study of new graduates' use of reflective practice during their transitional support program recommended that nurse education needs to utilise reflective practice to bridge the gap between theory and practice.

Amos (2001) suggests that the level of responsibility placed on new graduates is a major issue that causes them extreme stress and nervousness in their graduate year. New graduates also feel that their educational preparation fails to prepare them adequately for the workload and the level of responsibility that they must assume upon entering the nursing workforce as evidenced by a study conducted in North America by Boychuk Duchscher (2001). A phenomenological study of the process of professional socialisation for six graduate nurses in acute care settings, highlighted the overwhelming sense of responsibility new graduates feel upon entering the workforce and their perceived lack of preparation for the level of responsibility which was expected of them. The graduates were concerned that they had never as undergraduate nursing students had to assume the total responsibility for patient care and they felt that there was 'disparity in the lack of preparation by their nursing education' (Boychuk Duchscher 2001:429). However, the graduates also identified a lack of support and guidance from their nursing peers in the workforce, which resulted in low self-confidence. Furthermore, they focused on being accepted by their peers, which influenced their clinical judgment and decision-making because they felt validated or invalidated by the responses to their decisions and clinical judgments from more senior nurses. To ease the transition the researcher made several recommendations that include not rotating new graduates to other clinical units until they have at least a minimum of one year's clinical experience. This recommendation was made because the author found that the rotation of graduates to different clinical units did not serve to adequately orientate new graduates nor did it contribute to new graduates clinical decision-making abilities or self esteem. In addition, the author recommended the introduction of programs that provide supernumerary employment for graduates to allow for integration into the professional role, where formal and informal preceptorship programs can serve to support the new nurse. A final recommendation was that incentives to senior staff need to be considered for their expanded role and commitment that is

required to provide positive preceptoring and a nurturing environment for new graduate nurses.

Within Australia, Ramritu and Barnard (2001) believe that undergraduate nurse preparation needs to be further evaluated and there needs to be 'congruence between entry-level competency standards and the actual understanding and experience of beginning-level new nurse graduates' (2001:54). Ramritu and Barnard (2001) used a phenomenographic approach to explore the conceptions of competence that six graduate nurses have within paediatric settings. New graduates in this study conceptualised and understood competence as management of time and workload, the performance of clinical skills, possessing adequate knowledge, the ability to utilise resources, having an awareness of and application of ethical principles within their practice, and also recognising that their competence would evolve. Findings from this study demonstrated that graduates acknowledged difficulties in organising and prioritising their workload, because they lacked the appropriate knowledge and skills required for provision of care. Graduates also believed learning skills in the educational environment was different from learning in the clinical setting and that it was not possible to learn all the necessary skills during the undergraduate program. Whilst these findings have merit and application, participants may not have had a lot of exposure to specialty paediatric areas during their undergraduate clinical preparation. A major recommendation from this study was that undergraduate clinical skills should be taught utilising the clinical settings. Furthermore, this study also recommended that new graduates require ongoing workplace support in provision of care as well as ongoing educational support in time management, clinical procedures and interactions with other health professionals, patients and their families. Ramritu and Barnard (2001) further assert that health agencies need to factor the teaching role of more experienced nurses into staffing requirements so that effective support can be delivered to assist the new graduate in the provision of care.

In this study, new graduates perceptions of their preparedness for practice, specifically for the reality of the day to day practice of nursing within a rural context, will be explored.

Since the early 1990s, authors such as Dufault (1990) and Del Bueno (1994) have expressed concern for the health service industry expectation of new graduates where staff mix and staff reductions have meant that new graduates are expected to be accountable, responsible and competent as quickly as possible upon becoming a registered nurse.

In a study of the processes by which new graduates learn to fulfil the role of registered nurse, Moorehouse (1992) refers to the dichotomy between anticipated role and actual job descriptions that creates confusion for new graduates. White (1996) also highlighted the dichotomy between the actual and anticipated role in a phenomenological study that investigated the feelings graduate nurses have about clinical practice. Pressure experienced by graduate nurses was a major theme that emerged from the data. The beginning nurses in this study felt that there just wasn't enough time to deliver care the way they would like and indeed the way they had been taught. This resulted in a dichotomy between the educational preparation and the reality of the workplace, However, it could be argued that the *ideals* of the educational institution are merely best practice standards that perhaps are being compromised by the workplace setting, as Hewison and Wildman (1996:754) comment, the environment that nurses are expected to practice in is one that is, 'orientated to throughput, numerical targets and financial constraints. Whilst as a learner nurse they are exhorted to treat patients as individuals, implement nursing theory and advance their own learning'.

More recently, authors such as Kelly (1996), Mosel Williams (2000), and De Bellis et al. (2001) highlight the reality of the practice setting and the expectations of the level at which beginning registered nurses are expected to function, because of the current climate of health service industry. Staff mixes and staff reduction have meant that new graduates are expected to be accountable, responsible and competent as quickly as possible and the health service industry work expectations is that new graduates need to '*hit the decks running*' (J. White pers. comm., Nov. 2000).

Studies by Madjar (1997) and De Bellis et al. (2001) also believe that the present economic rationalisation of health settings is responsible for the difficulties new

graduates experience. However, they also suggest that there is a failure of health care staff to recognise the inexperience of beginning registered nurses, so the provision of adequate support for new graduates is not addressed.

Madjar's study of new graduates within NSW examined the nature of transition to practice, specifically focusing on the expectations that new graduate nurses had of their skill and competence as they entered the workforce. The expectations of these were compared and contrasted with the expectations of more experienced registered nurses. This descriptive-correlation study included well over half of the new graduate nurse population within NSW who began employment in the first three months of 1997. The study sample also included 752 experienced registered nurses alongside whom the new graduates had worked. There were numerous key findings from this study that related to the expectations of competence of new graduates. The study found that most new graduates and experienced Registered Nurses felt that three months after beginning employment the new graduate had acquired and developed adequate knowledge, skills and expected competence to perform safely and adequately in a medical/surgical area within a metropolitan setting (Madjar 1997:vii-ix).

In addition, Madjar's study found that discrepancies existed between clinicians regarding their expectations of beginning registered nurses. The experienced clinicians also believed that the duration of clinical placements for student nurses was not sufficient for them to develop the required competencies and skills for entering the workforce. These findings refute the findings from an earlier study by Battersby and Hemmings (1991) who explored the competence and clinical preparation of new graduate nurses. Battersby and Hemmings (1991) used a self-report survey on a sample of new graduates and nursing unit managers to assess perceived clinical performance of graduates during their first year. The results from this study showed that the amount of pre-registration clinical experience was not as significant in influencing the perception of competence by new graduates and their experienced registered nurse colleagues, as was the quality of the experience and the guidance received during the clinical experience.

However, whilst the new graduates from Madjar's study felt they had acquired the necessary clinical and professional competencies to enter the nursing work force they also believed there was a lack of effective support during their transition to the registered nursing role. The graduates in this study felt poorly treated by colleagues, which resulted in the transition experience being an extremely stressful, draining and challenging one. Furthermore, the graduates perceived that more experienced colleagues were 'more intent on asserting their own place within the hierarchy than developing professional relationships' (Madjar 1997:ix). In addition, experienced registered nurses lacked sensitivity, as well as professional courtesy, and this did not facilitate a supportive learning environment.

It needs to be noted that participants from this study were drawn mostly from one metropolitan health service, with the majority of the participants having completed their undergraduate preparation within metropolitan universities. Caution needs to be taken before generalising these findings to all new graduates within NSW, as the study findings are not representative of new graduates who undertake a graduate nurse program outside metropolitan areas. Whilst the findings provide insight into transition issues which affect new graduates, there are significant differences in workload responsibilities of nurses in rural areas compared to their metropolitan counterparts.

A South Australian study by De Bellis et al. (2001) highlights the unrealistic work expectation by the service industry of new graduates upon their initial entry in the workforce. Using interviews and focus group discussions with 44 new graduate nurses, the authors identified issues and difficulties experienced by new graduates. Findings from this study indicate that health care organisations and more experienced registered nurses expect new graduates to function as registered nurses with a full patient load within a very short period of time. This study also identified an environment of 'doing without thinking' (De Bellis et al. 2001:8) where, because of the new graduates inexperience with the heavy workload and the unpredictability of the work, there was no time for thought, they were just expected to get the work done. The authors of this study argue that rationalisation of the health setting has impacted on the level and type of support that can be offered to the new graduate, and this rather than

undergraduate preparation is responsible for problems associated with graduate nurses. This researcher also believes that a major problem may be an inadequate application of clinical knowledge into the clinical setting rather than inadequate undergraduate preparation. For example, anecdotal evidence gathered from new graduates indicates that it is very hard for them to apply clinical knowledge effectively when they are struggling to manage the workload. Thus this study aimed to explore the issues surrounding workload and responsibility expectations for graduate nurses within rural practice settings.

#### **2.3.4. *Enculturation of new graduate nurses***

As previously stated, several studies have suggested that the difficulties encountered during the transition process may be directly related to the non-supportive environment and culture in which the new graduate is employed (Reddick 1998; Mosel Williams 2000; De Bellis et al. 2001; Thomka 2001). However, new graduate nurses' experiences of the ward enculturation process and how the ward culture affects new graduates upon entering the nursing workforce, has only been briefly mentioned in the literature as a cause for concern with respect to the recruitment and retention of new graduates into the workforce (Jackson, Clare & Mannix 2002). There is very little literature that specifically explores how the workplace culture shapes their experience when they enter the nursing workforce.

Despite this, there is an emerging body of literature that acknowledges the impact that the organisational culture, specifically horizontal violence, has upon the nursing workforce. Numerous studies discuss horizontal violence in the nursing workplace as a major factor that provokes anxiety and extreme work based stress for many nurses (Farrell 1997, 1999, 2001; Taylor, White & Muncer 1999; O'Connell, Young, Brooks, Hutchings & Lofthouse 2000; Freshwater 2000; Taylor 2000; Jackson et al. 2002).

Horizontal violence refers to overt and covert non-physical hostility, and includes workplace conflicts, aggression and bullying. Farrell (1997) states that this type of violence can take many forms, the most common of which include gossiping, infighting, rudeness, criticism, scapegoating, and an unwillingness to

speak up for others. These behaviours by nurses toward other nurses are attributed in the literature (Farrell 1997; Paterson, McComish & Aitken 1997; Taylor et al. 1999; Freshwater 2000; O'Connell et al. 2000; Taylor 2001) to power relations and oppressed group behaviour in nursing, where nurses direct their dissatisfaction inward towards each other. Jackson et al. (2002) report that hostile undercurrents, violence and hostility are part of the day-to-day lives of most nurses.

Kelly (1996) acknowledges that the social climate of the ward which the new graduate enters, is of great significance to their experience, citing studies by Hipwell, Taylor and Wilson (1989) and Nelson and Fells (1989). These studies discuss interactions and interpersonal co-worker relations as being ranked as important elements in nurses' work. They acknowledge that horizontal violence or aggression in the nursing work place is a significant problem that contributes to the level of job satisfaction, the current problems of recruitment and retention of nurses and, significant to this study, the retention of new graduates in the nursing workforce.

In a qualitative study of graduate nurses' recollections of their first year of practice, Kelly (1996) found that the rigid environment, unrealistic management expectations and conflict in attitudes, career aspirations and values makes the new graduate experience traumatic. Furthermore, part of the new graduates' socialisation into health service is the pressure on new graduates by more experienced colleagues to conform to an 'unquestioning conformity to social norms' (Kelly 1996:1067).

Hinds and Harley's (2001) ethnographic study of three new graduates specifically explored the power relations embedded in the new graduate nurses' experience of practice and the socialisation of new graduates into the clinical ward culture. This study identified that the culture within a ward or unit may operate to shape the behaviours and mindset of new graduates and that power relations were pertinent aspects of the new graduates' experience. It was found that senior nurses, influence and shape newcomers' conduct to fit the requirements for maintaining the social and cultural order of the ward environment. Participants from this study identified characteristics which they

thought were required to assist them to be accepted into the ward culture. For example, one characteristic was the knowing that your practice was considered to be 'safe' by more experienced staff. To have senior nurses view your practice as 'unsafe' provided a very persuasive means which influenced the new graduates behaviour because they would be 'spoken about' and be assigned outcast status by senior nurses if their practice was considered to be 'unsafe'. These authors suggest, that whilst unsafe practice poses serious threats to the health of patients, the unsafe practice label assisted to determine who is an 'insider' and who is an 'outsider' in the culture of the ward. Hence new graduates held more importance on acceptance into the ward culture rather than maintaining values and beliefs learned through their undergraduate education.

These findings are similar to the findings from Boychuk Duchscher's (2001) study of the process of socialisation of graduate nurses in acute care settings. Participants in this study believed that to blend into and be accepted in the unit they felt they had to uphold time-honoured traditions of the nursing unit and complete tasks on time so that they would not be exposed as new nurses or perhaps as less capable. These new graduates felt that not knowing something related to practice was a sign of weakness rather than an expected state of their beginning level and because of this they feared not being accepted by nursing staff within the unit.

According to Madjar (1997:2), mastery of the registered nursing role, whereby the new graduate can act safely and competently, depends on several factors. These include the quality and the extent of their educational and clinical preparation, the personal qualities of each beginning registered nurse, as well as the expectations and attitudes of experienced registered nurses with which the new graduate works. The quality of orientation/transition programs and the exigencies of the clinical situation, with respect to staffing levels and other work demands placed on the beginning registered nurse means that it is usually the new graduate who must change and adapt to the 'reality' of the practice world.

Kelly (1998) also believes that it is the new graduate who has to adapt and change to the culture and social group in the real world of nursing. Kelly's grounded theory study on how graduate nurses perceive their adaptation in to the 'real world' of hospital nursing and what they perceived as influences on their moral values and ethical roles, found that many new graduates believe that they are entering a culture they know and understand. This misconception, Kelly states, is the first disillusionment new graduates experience. In addition, Kelly (1998) concluded that self doubt and confusion for the new graduate is the result of intense stress and the desire to fit in to the particular culture on a hospital unit. This author believes that fitting into the culture of the unit is of vital importance in determining the new graduates' experience of their role transition. Furthermore, Kelly believes that new graduates are unprepared to function as members of a team and they need to be better prepared for the social forces that will affect them as they enter the nursing workforce.

These issues of acceptance into the workplace culture for new graduates has important implications for this study because the researcher believes that unprofessional and un-supportive behaviours by more experienced registered nurses will impact on the level and type of support offered to and sought by new graduates nurses. The researcher believes that the culture of rural practices settings will be of significance to the new graduate in rural health care facilities, and also agrees with Kelly that graduate nurses have not been adequately prepared to deal with the social forces within nursing that will influence and shape their beginning year of practice.

### *2.3.5. Graduate nurse programs*

The literature pertaining to the new graduate entering professional practice (Madjar 1997; Kelly 1998) maintains that the successful assimilation of the new graduate nurse into the nursing workforce is dependent largely on the amount and quality of support that the new graduate receives especially within the first three months of employment, as this is when a rapid and major transformation, both professionally and personally occurs in the new graduate.

Graduate Nurse Programs (GNPs) were developed in response to the problems associated with the reality shock of entering the nursing workforce. According

to Glover, Clare and Longson (1998:17), the main aim of GNPs is to provide a 'mediated' entry to the workforce, providing structured support and assistance for graduate nurses in the transition from student to registered nurse. Many authors support the use of structured support systems to provide a nurturing environment, professional role modelling and consolidation of skills to ease the culture shock and assist with the professional socialisation of the new graduate nurse (Boyle et al. 1996; Kelly 1996; Winter Collins & McDaniel 2000; Boychuk Duchscher 2001; De Bellis et al. 2001:8). It is also believed that structured support assists the new graduate with the application of knowledge, and the further development of clinical reasoning and decision-making (Clayton, Broome & Ellis 1989; Nayak 1990; Moorehouse 1992; Jasper 1996; De Bellis et al. 2001).

Structured transition programs vary in nature and duration within health services across Australia. Most health services in NSW have a 12-month transition program for new graduates, which includes rotations, each of three months duration, through medical and surgical areas. Towards the end of the graduate program graduates maybe offered a clinical elective in one or two specialty areas of their choice. The specialty areas may include, Paediatrics, High Dependency nursing such as Coronary Care, Intensive Care, Operating Room and Recovery, as well as Accident and Emergency and Mental Health. A preceptoring model is generally used to support the new graduates and the desirable qualities required of a preceptor include: acting as a role model, having clinical expertise, being able to assist with the application of theory to practice, and having a willingness to provide supervision and teaching (Hardyman & Hickey 2001:59).

There is very little research that specifically focuses on the factors that influence the undergraduate nurse's decision of where to undertake their graduate year. However, recent studies have mentioned factors that influence the new graduate's decision, as part of a broader study. For example, Heslop et al. (2001), in a study of undergraduate students' expectations of their self-reported preparedness for the graduate role, obtained quantitative data regarding the main factors that influenced participants preference for specific graduate year programs. Respondents often had more than one factor that influenced their

decision. However, the majority of responses listed the following factors as influencing their decisions: locality, reputation of the health care facility, rotations offered to specialty areas and familiarity with the health care facility. This study also gathered data related to the clinical rotations favoured by students for their graduate year, the most common choices being Surgical, Paediatrics, Emergency, Medical, Critical and Coronary Care. There was little interest by participants in this study for aged care, community, oncology and palliative care. Whilst the data generated from this study originates from undergraduate students within a metropolitan university, the findings are transferable to undergraduates choosing rural graduate programs. There are no specific studies that focus on why graduate nurses have chosen a graduate year in a rural area, and what influenced their choice for rural graduate nurse programs. Thus this current study aims to explore the reasons behind the new graduates' decision to undertake a rural graduate nurse program.

The effectiveness of graduate nurse transition programs is usually assessed within each health service at a local level and is more in line with a quality control measure. Anecdotal evidence from new graduates regarding their GNPs identifies inconsistencies across health services and individual health care facilities regarding the quality and delivery of support within the graduate nurse programs. To this researcher's knowledge only a small body of research into the new graduate nurses' expectations and experience of graduate nurse programs exists, and this will now be discussed.

According to Heslop et al. (2001), findings from a descriptive survey of third year students about to join a graduate nurse program indicated that there is an expectation from graduating nurses that the GNPs will have a preceptor who will facilitate the transition process and will provide regular feedback on graduates' performance. Students from this study expressed high expectations of preceptor support, however there were inconsistencies regarding the students' expectations of the length of the preceptor support, with some undergraduate students expecting preceptor support to occur for four weeks and others expecting only two weeks of preceptor support. The authors recommended further research into new graduates' expectations of their

graduate year, their actual work experience, and whether their expectations were congruent with that of their workplace.

A study by Hardyman and Hickey (2001) in the United Kingdom used a longitudinal survey to explore the expectations and experience of preceptorship from the views of graduate nurses. Findings showed that there was an overwhelming demand by new graduates for a preceptorship model to ensure a smooth transition. At least half the respondents stated that they expected the preceptorship to continue for six months or more. Participants rated what they perceived as the most important aspects of preceptorship. They were; receiving constructive feedback on their clinical skills, being taught new clinical skills, having someone to help them settle into the clinical environment, and having emotional support. A recent Australian study by De Bellis et al. (2001) identified issues surrounding the enculturation of nursing graduates, and problems encountered with the implementation of preceptorship in graduate nurse programs. These authors assert that graduate nurse programs are run by institutions who are 'focused on outcomes and expenditure' and do not provide an environment that is conducive to ongoing learning. That is, culture of the ward provides an environment that is contrary to the aims of graduate nurse programs and preceptorship. Participants in this study believed that the reality of the workplace and the lack of available experienced staff to act as preceptors, means that new graduates are expected to rapidly become productive members of the nursing team. The study also found that patient loads, inexperience with the workload and the unpredictability of the work meant that the new graduate, as has been previously mentioned in this chapter, was 'doing without thinking' to get the work done with very little support.

Additionally, participants identified a lack of orientation to the ward environment and a 'Clayton's preceptorship', where graduates were often rostered on different shifts to their preceptor, or their preceptor's workload precluded any time to contribute to the graduate and their learning. There was also inappropriate preceptor allocation and inappropriate skill mix rostering which all affected the level of support the new graduate received. Graduates expected more support than they received and also expected the Graduate Support Coordinator attached to the agency to be available to them. However,

because of work and other responsibility constraints within the agency there was very little support from the Graduate Support Coordinator.

A study by Moulinie (2000) explored the effectiveness of a graduate nurse program within a major metropolitan teaching hospital in New South Wales and produced similar findings to that of De Bellis et al. (2001), with respect to a 'Claytons preceptorship'. However, new graduates of this study rated their transition as 'smooth', even though they also cited a lack of time provided by more experienced clinicians for teaching and support. Participants believed the benefits of their graduate program were; increased confidence, increased knowledge, and the development of technical and time management skills. However it is not clear if the 'smooth' transition reported by these participants was the result of them gaining more experience rather than them being part of a graduate nurse program.

Madjar (1997), in an earlier study, also found that the level and type of support provided to the new graduates was a major issue and new graduates differed in the level of support they thought they needed. In addition, graduate programs differed in the timing and delivery of that support. New graduates in this study felt that the level of support they received only served to highlight their inadequacies and could have been provided in a manner that was 'looking out for' and 'acting with', rather than just 'telling' and 'supervising'.

Anecdotal evidence collected by this researcher as a clinical coordinator indicates that the expectations of graduate nurse programs by graduating nursing students about to enter the nursing workforce is not congruent with the actual graduate nurse program. New graduates report inconsistencies between health services and individual wards as to the content structure and delivery of the GNP. For example they identify a low level of support and assistance, and a lack of clinical rotations. Thus, new graduates' perceptions of the provision of adequate and timely support and the effectiveness of graduate programs in rural areas in easing the transition experience will be further explored in this study.

### *2.3.6. The transition process for graduate nurses in the rural workforce*

A search of the literature pertaining specifically to the transition process for new graduate nurses in the rural workforce revealed very little published literature. Authors such as Mosel Williams (2000) highlight the lack of evaluative studies which focus on the new graduate in rural practice settings or the experience of employing new graduates in rural health care facilities within Australia.

However, there is concern within the literature in Australia (Madjar 1997) that new graduates who enter rural nursing practice, feel they are unprepared because they are yet to acquire the broad range of skills that are required of rural nurses. There is a lack of support for the employment of new graduates in rural settings because of the belief that undergraduate education currently does not provide sufficient clinical practice in nursing programs to prepare students for rural nursing practice (Huntley 1991 cited in Mosel Williams 2000:100). In addition, the workplace culture in rural areas is a significant issue for new graduates, and several authors including Bridgewater (1998), Reddick (1998), and Mosel Williams (2000), have identified common areas of concern that are unique to rural nursing practice.

For example, Reddick (1998) suggests that the clinical environment of rural agencies and the impact of work practices, stress levels and staffing issues have impacted on the support programs offered to rural graduate nurses and this has meant that the new graduate is often 'plunged into a hostile environment'. Reddick (1998) also identifies workplace barriers such as; unprofessional behaviour by more experienced colleagues, competence measured by an ability to cope rather than application of knowledge and skills, and an underestimation of the abilities of new graduates in rural practice. Furthermore, Reddick believes that new graduates have to prove themselves as valuable members of the team by being able to succeed with the workload without assistance. Because of the power relations still inherent within nursing, the new graduate must be mindful of communication with other registered nurses, as they maybe labelled as too 'cocky' if they contribute to discussions, forgetting their place as 'just a new grad' (Reddick 1998:4). The difficulties graduates in

this study encountered perhaps may be attributable to the fact that staff have developed social cliques which the new graduate must try and assimilate into.

However, Madjar 1997, found that experienced registered nurses who participated in her study felt that the new graduate is not adequately prepared to fulfil the registered nursing role within a rural setting. However this finding must be treated with caution because only a small sample of rural nurses was included in the study. Furthermore, many new graduates in the study did not feel sure of their competence outside a metropolitan or large regional setting due to the perceived lack of exposure to rural placements during their pre-registration programs. Interestingly, graduates from regional universities, who were more likely to have experienced rural clinical education experiences, expressed less self-confidence in their readiness for rural practice than did graduates from metropolitan universities.

However as previously discussed, Madjar's study was centred on large metropolitan teaching hospitals, with the majority of the participants being drawn from one metropolitan health service. Although there were a small number of beginning registered nurses from rural areas in the sample, the study does not specifically address the competencies of the beginning registered nurse within rural practice settings or the experience of new graduate nurses in rural practice settings. Perhaps the reported lack of self-confidence by rural graduates in this study can be attributed to the new graduate who is already in rural practice and has a better understanding of the realities of rural practice than their metropolitan counterparts.

Mosel Williams' (2000) qualitative study of new graduates in rural practice in Queensland identified supportive factors and barriers, which existed for new nursing graduates in their first job. Using informal interviews with five new graduate nurses the study found that there are numerous environmental barriers that impact on the level of support, the level of responsibility, and the level of competence of which the new graduate is forced and expected to practise at within rural practice settings. The study also found that competence is often perceived as an ability to cope with the workload rather than the application of knowledge and skills in practice. Barriers existed for the new

graduate with respect to their socialisation into rural agencies. Mosel Williams (2000) likens the experiences of the new graduates in her study to moving through portals or doorways into effective practice. For example, there were supportive doorways that represented a genuine welcoming to the agency and community, effective support and guidance from experienced clinicians, and being able to meet clinical challenges positively. However, there were also challenging portals that involved barriers to effective transition, such as tests to prove themselves capable of the workload. For example, tests included being able to cope when understaffed, and conforming to workplace practices. Also, not *rocking the boat*, having to do things the way of the more experienced registered nurses and having to tolerate disturbance to their self-esteem because of unprofessional behaviours from experienced staff. For example, being referred to as 'the new grad' and having to tolerate passive aggressive behaviours from enrolled nurses. Another example was not being allowed to work to the extent of their professional licence, and having to work at an enrolled nurse level. The most significant barrier encountered was the lack of identifiable cohesion within the professional team, where the new graduate felt that the nursing team closed ranks against the new graduate. The participants in this study also identified coping strategies that were necessary to survive in the environment. Some examples are, learning when to conform and when to challenge the work ethic and practices of other staff and also how to 'arm' themselves by reverting back to textbooks and asking the appropriate questions.

Conversely, the responses of the experienced clinicians who took part in Mosel Williams' study were likened to having a genie in a bottle, where the clinicians did not know if the genie [new graduate] was good or evil. Mosel Williams (2000) describes concepts such as: 'controlling the genie, restraining the genie, walking the genie and freeing the genie'. For example; 'controlling' was related to graduates being well skilled but unprepared for practice, as well as a belief that exposure to the clinical area and not their university education was responsible for the graduate being skilled with technology. Another strategy for controlling the genie was not referring to new graduates as registered nurses in their own right and reluctance to acknowledge their increasing competence. 'Restraining the genie' was characterised by passive/aggressive and

unprofessional behaviours and attitudes demonstrated by more experienced colleagues towards new graduates. 'Walking the genie' related to the fact that the workplace is a hostile environment and new graduates needed to work it out for themselves indicating that support or advice was not freely offered but rather the new graduate had to ask. Competency was measured by proficiency with bedside tasks, that is, an ability to get the work done efficiently. 'Freeing the genie' was characterised by acknowledging that the new graduate needed collegial support, accepting the graduate as a colleague and accepting responsibility for fostering the development of the new graduate.

The study highlighted the finding that clinicians believe and support the idea that new graduates should seek more experiences in larger facilities upon completion of the twelve-month program. According to Mosel Williams, the new graduate undertook a 'defacto training' where their experience 'was characterised by trials and tests that bore little relationship to the pre-registration preparation or experiences' (Mosel Williams 2000:103). This author further asserts that the new graduates are often 'discarded' after their initial twelve months; they are not encouraged to stay on in rural facilities and are in fact encouraged to seek further experience in larger facilities. As a result, Mosel Williams believes health agencies in rural areas have virtually wasted their investment, as new graduates are not encouraged to continue their career in rural nursing.

Furthermore, findings from this study did not support the notion that graduate nurses are not suitably skilled for rural hospital environments. This is an important finding and Mosel Williams argues that undergraduate nursing programs aim to develop practitioners who are able to practise within a wide variety of environments and across specialities at a beginning level. Additionally, Mosel Williams states new graduates are inexperienced rather than clinically unskilled for rural practice. Furthermore, Mosel Williams believes that undergraduate education cannot teach years of experience and development as experienced professionals, qualities that are desirable for rural practitioners (2000:101-104). Hegney (1996) also believes that the nature and scope of rural nursing practice is one for which new graduates cannot be

adequately prepared, because the rural nurse is multi-skilled and has years of experience.

From anecdotal evidence and personal communication with new graduates in rural practice this researcher believes that most new graduates feel that they have been well prepared, but as a beginning registered nurse they lack confidence and experience in their practice.

This researcher agrees with Mosel Williams (2000), that new graduates do not have the experience to cope with the workload and level of responsibility that comes with professional nursing practice and as such should not be expected to enter rural nursing practice with the skills required of their more experienced rural nursing peers. From my own observation and personal communication with new graduates during the course of employment at a rural university, their experience of rural practice is vastly different from their initial expectations of beginning practice. Their experience in rural agencies was also very different from what they had experienced during their undergraduate preparation in rural health care agencies. For example, during undergraduate clinical experiences a student nurse is not expected to assume total responsibility for patient care, nor have they experienced ward management, but rather were only able to observe a more experienced clinician. Anecdotal evidence from new graduates and experienced registered nurses also indicates that there is an expectation from health services and staff that the new graduate will have to *hit the decks running*, that is they should be able to assume the workload responsibilities of their more experienced peers. Present staffing ratios and skill mixes within rural health facilities often prevent the new graduate having time to ease into the nursing workforce.

Whilst this researcher agrees that the health services have indeed wasted their investment with new graduates, as suggested by Mosel Williams (2000), and this is detrimental to rural health agencies, the advantage of encouraging the new graduate to seek a wider experience after completion of the graduate nurse program in rural health facilities is that they further develop their professional career. Despite this, there is the benefit for more experienced staff in rural areas that can be gained from working with new graduates. Rural health facility staff

report that new graduates assist them to keep current with best practice and research, thereby assisting with their own professional development.

#### **2.4. Conclusion**

This literature review has provided an overview of the difficulties and complexities of the role transition from student nurse to registered practicing nurse. Section One provided an overview of rural nursing and the issues for newly graduated nurses in rural nursing practice. The experience of transition in rural practice was identified as being complicated by the role and scope of the rural nurse, the availability of staff to provide adequate support in rural agencies, as well as the elements of role stress that are unique to the new graduate in rural practice settings because of the close knit rural community.

In section two, Role Theory as the theoretical framework, and its application to nursing, was discussed. The role transition from student to registered nurse is associated with professional socialisation and reality shock thus the utilisation of Role Theory as a theoretical framework for this study was deemed appropriate. Elements of Role Theory such as role stress, which can have a significant impact on the transition process, were also examined.

In section three, the literature review focused on and presented studies that pertained specifically to the beginning registered nurse. These ranged from the effects of professional socialisation and reality shock, to perceived deficits by the service industry, in the new graduate's practice. In addition it was identified that there is a growing concern for the effect the culture of the environment has upon the new graduate entering the nursing workforce. The unrealistic workload expectations of new graduates upon entry into the workforce, as well as a lack of support and failure of agencies to provide an appropriate environment for the on-going learning and development of beginning registered nurses were also discussed. This section also examined the expectations and role of a graduate nurse program and then presented the literature specific to the graduate nurse making the role transition in rural practice settings.

The following chapter, chapter three, will describe the research design and the methodological approach used to investigate the experience of new graduate nurses making the transition in rural practice settings.

# CHAPTER THREE

## Methodology

### 3. Introduction

This chapter describes the research design and the methodological approach used to investigate the research problem. It commences with a justification for the research design and methodology adopted in this study. The research setting, sample, data collection procedure, data analysis procedure and ethical considerations are described and discussed. Finally, methodological limitations are identified and discussed.

#### 3.1. Justification for the research design and methodology

This qualitative study utilised a hermeneutic-phenomenological framework that is grounded in the neo-positivist paradigm of inquiry (Annells 1999:8). For this study the researcher wanted to provide an understanding of what the first year of practice was like for new graduate nurses in rural practice settings. Thus, the researcher chose a qualitative design for this study because qualitative research methods have been acknowledged in the literature (Hallett 1995; van Manen 1997; Annells 1999; Van der Zalm & Bergum 2000) as most appropriate for nursing research where the focus of the research is on the nature and meaning of human experience.

The researcher rejected the use of a quantitative approach because she was not interested in quantifying factors, nor generating or constructing theories regarding the experience of the transition into rural nursing practice. Rather, the researcher, in exploring the transition process for new graduate nurses in rural practice, aimed to develop an understanding of the feelings/emotions,

interactions, and meanings that the new graduate had of their transition experience into rural practice. Thus, the researcher believed that a hermeneutic-phenomenological approach would be the most appropriate framework to enable the aims and objectives of the study to be met. That is, to expose and understand the meaning of the phenomenon of transition as experienced by a small group of new graduate nurses in rural practice.

Phenomenology as a qualitative research design is the study of phenomena that are related to human experiences (Annells 1999:5). A descriptive form of research, phenomenology aims to understand the nature of the meaning of our everyday life experiences (van Manen 1997:9). It is a method of inquiry that attempts to gain insightful descriptions of a person's reality and experience by asking the question: *What is that experience like?* Thus, the phenomenological method of inquiry provides descriptions of a lived experience, that is, a reflection of an experience that has already passed or been lived (van Manen, 1997:10). This method of inquiry does not aim to provide causal explanations for an experience (Van der Zalm & Bergum, 2000:11) nor does it aim to build or construct theory. Rather it aims to provide careful descriptions of the person's reality and experience of phenomena (van Manen 1997:181; Van der Zalm & Bergum 2000:11).

Hermeneutical-phenomenology is a post-modern philosophy (Annells 1999:705) that arose from the work of the philosophers Heidegger and Gadamer (Koch 1995:828). These philosophers were responsible for a major shift and refinement of the phenomenological method. That is, a shift from traditional Husserlian phenomenology that involved the pure description of the life world or the 'lived experience' (Koch 1995:827; Annells 1999:706) where the research question is answered by phenomenological reduction. In the Husserlian tradition, the researcher must refrain from making judgements or assumptions about causes, consequences or significance of phenomena under study, by eliminating preconceived notions, so that the phenomena can be seen and understood in their primordial state without interpretation (Koch 1995:828; Corben 1999:53).

In Heideggerian hermeneutic phenomenology, phenomenological descriptions are taken further to include the practice of interpretation of descriptive texts to provide understanding of 'being in the world' (Annells 1999:706). Bracketing to eliminate one's beliefs is thought to be not truly possible in hermeneutical-phenomenology, as people come to a situation with a background *pre-understanding* that results from sharing a common culture and language (Koch 1995:829) and this common background of understanding cannot be eliminated or bracketed as it is already with us in the world. Thus, within the hermeneutical-phenomenological approach, the researcher brings their own understanding to the text because pre-understanding cannot be eliminated, only corrected and modified (Koch 1995:830). For example, in this study the pre-understanding of the researcher assisted in understanding the experiences of the graduate nurses.

Hermeneutical-phenomenology is a research design that is both descriptive and interpretive and it uses the process of phenomenological reflection and writing to not only *describe* but also to provide *understanding* of phenomena experienced in life. Through analysis of the meaning of an experience, the experience having been expressed via text, (van Manen 1997:9) hermeneutical-phenomenology aims to identify and provide an understanding of the 'variety of constructions that exist about phenomena' (Annells 1999:708). Specifically, it involves individuals who experience phenomena describing their experience in their own words. The researcher interprets the subjective data to identify themes, commonalities and also aspects of the experience that maybe unique (Annells 1999:5).

As previously stated, phenomenological methods of inquiry requires the bracketing or suspension of one's beliefs, assumptions or suppositions about a phenomenon that is being investigated so that the essential structures of the phenomenon can be exposed (van Manen 1990:47). To enable the focus of this research to be on the individual's experience or reality of their conceptual world, the researcher implemented a form of bracketing to suspend the beliefs of the researcher and to eliminate preconceived notions that the researcher may have (Crotty 1996; Koch 1995). However, because the researcher is a nurse, who for many years has practised in rural health care settings, it was not possible for

personal knowledge to be truly separated from life experiences so that an objective description of the phenomenon could be obtained (Byrne 2001:831). Therefore, in this study, whilst the researcher used bracketing, she was aware of her own assumptions and suppositions regarding the experience of transition for new graduate nurses in rural nursing practice.

The purpose of this study was to obtain rich descriptions of the new graduates' experience of transition so that an understanding of that experience could be gained. Thus, individual face to face interviews was the method used for data collection. Face to face interviews are considered to be an appropriate data collection tool for qualitative research where the purpose of the research is to provide understanding of a phenomenon by uncovering participants' thoughts, perceptions, and feelings regarding an experience (Minichiello, Aroni, Timewell & Alexander 1999; Schneider, Elliot, LoBiondo-Wood & Haber 2003).

### **3.2. Reflective journal**

The researcher kept a reflective journal throughout the data collection stage. The aim of keeping a reflective journal was to assist the researcher to focus on the new graduates' account of the experience rather than the researcher's perspective. As well, the journal was kept so that notes could be made by the researcher regarding important information such as facial expressions, details of the setting and perceptual impressions and also speculation regarding themes and connections between data that were 'invisible' to the tape recorder during the interviews (Minichiello et al. 1999:216).

In addition, the journal allowed the researcher to make decisions about any subsequent interviews. For example, the researcher made notes regarding changes to interview techniques, and the interview schedule for subsequent interviews to ensure that the information obtained was relevant to the topic under investigation and focused on the participants' lived experience. This form of bracketing by the researcher assisted in ensuring validity of the data and also assisted to protect from researcher bias. Furthermore, the journal served to guide and refine the inquiry process to ensure that the data obtained was rich and that data saturation was reached.

### **3.3. Setting**

This study was conducted in rural towns of northern New South Wales (NSW) whose health care facilities at the time of the study had employed a new graduate nurse in a graduate nurse transition program in 2001, and which were geographically accessible to the researcher.

Towns whose population base is classified to be rural, according to the Rural, Remote and Metropolitan Areas Classification Method, (Department of Primary Industries and Energy 1994 cited in Handley 1998:2) or whose geographical location, or distance from metropolitan centres were such that they were considered to be rural by the Rural, Remote and Metropolitan Areas Classification Method (Department of Primary Industries and Energy 1994 cited in Handley 1998:2) were included in this study.

Four towns chosen for inclusion in this study were considered by the Rural, Remote and Metropolitan Areas Classification Method (Department of Primary Industries and Energy 1994 cited in Handley 1998:2) to be large rural towns and the health care facilities within these large rural towns provide similar medical and nursing services. For example, the bed capacity ranged between 100 and 150, and staff ratios, skill mixes, and graduate nurse programs within these facilities were very similar. The remaining four agencies included in this study were located in what is considered by the Rural, Remote and Metropolitan Areas Classification Method (Department of Primary Industries and Energy 1994 cited in Handley 1998:2), to be small rural towns whose bed capacity ranged between 30 and 60. As well, medical and nursing services within these health care facilities were similar, as was the content and structure of graduate nurse programs within these agencies.

The health care facilities within these rural towns form part of three area health services of northern NSW. Utilising these health care facilities provided a comparison of geographical and social environments in which new graduates are employed, as well as providing insights into the diversity of rural nursing practice that new graduates experience. A further advantage of selecting participants from these agencies was that they provided a cohort of graduates from different higher education institutions which have diverse curricula and

clinical undergraduate preparation. For example, there are differences in the number of hours and timing of undergraduate clinical practice between institutions. Additionally, the content, structure and delivery of undergraduate nursing curricula differ among higher education institutions.

#### **3.4. Sampling procedure**

The population for the study were new graduate nurses in three area health services within northern NSW, and purposive sampling was used to select a small cohort of new graduate nurses. This method of selecting participants involved the researcher deciding who was able to provide the desired information regarding the research questions (Schofield & Jamieson 1999:158). That is, purposive sampling includes only those who have experienced phenomena and who are able to understand and articulate their thoughts about experiencing the phenomena (Corben 1999:55).

To enable the objectives of the study to be met, the inclusion criteria included participants having to be employed as a new graduate nurse in the first year of a graduate nurse transition program, in rural agencies located within northern NSW.

All new graduates who met the above criteria were initially approached by the researcher and asked if they would be interested in participating in this study. At the time of the study, the researcher was the Clinical Coordinator of an undergraduate nursing program in NSW and a regular visitor to rural agencies, and it was not unusual for her to enter into conversations with new graduates and staff at each agency. During these visits the researcher discussed the research project with new graduates and enquired as to whether they would be interested in participating in the study. Those who indicated an interest were telephoned at a later date to arrange dates, times and venues for the interviews. Three participants were asked to consider participation in this study via a telephone interview, as the timing of the visits did not always mean that the new graduates were present in any one agency at one time.

Thus the sample consisted of ten participants who were all established in graduate nurse transition programs. That is, they had all completed at least six

months of full-time employment in a graduate nurse transition program within a northern NSW rural health care facilities. Seven of the participants were female and three were male. Demographic details of the participants are presented in chapter four.

Consistent with qualitative research, this study had a small sample size, as it did not aim to provide representativeness of the new graduate nurse population (Beanland, Schneider, LoBiondo-Wood & Haber 1999:280). As previously mentioned, the study aims were to obtain rich descriptions from the new graduates who were experiencing the phenomenon of transition into rural practice settings. The researcher was cognisant of when data saturation was achieved, that is, when the information obtained from the participants became repetitive and no more new data emerged (Beanland et al. 1999:281). The researcher identified that data saturation began occurring during the ninth interview and continued throughout the tenth interview, at which stage no further data was collected.

### **3.5. Data collection procedure**

As previously stated, the researcher employed the use of individual face to face interviews as the data collection method for this study. In addition, the researcher kept a reflective journal throughout the data collection stage.

A pilot interview was conducted in August 2001. The pilot interview served to identify strengths and weaknesses in the research plan (Roberts & Taylor 1998:259) and allowed the researcher to further refine her interview skills so that experience with the data collection method could be gained (Nieswiadomy 1987:33). In addition, the pilot study allowed the researcher to identify problems with the data collection method. For example, it allowed her to test for clarity of the questions, to note how long the interview took, and to ensure that 'the areas covered or the questions asked by the interview... measured what they are supposed to measure' (Crookes & Davies 1998:143).

The pilot interview participant was chosen because the participant had experience of the phenomenon under investigation. That is, the pilot participant

was a new graduate nurse who was making the transition into a rural practice setting and had knowledge of the phenomenon under investigation.

Feedback was gathered from the pilot participant, regarding the appropriateness and clarity of the questions, the appropriateness of the setting, and interview technique. Notes regarding the pilot interview from the researcher's journal indicate that the interview was extremely long and that the researcher tended to let the participant wander 'off track' with descriptions and stories. This information was then used to refine the questions asked during the subsequent interviews.

Roberts and Taylor (1998:260) suggest that data obtained from the pilot interview may be included in the results if no new changes are made and if the study is short of participants. For this study the researcher decided to include the pilot interview data into the main results because the only change the researcher deemed necessary was to shorten the length of the interview. Additionally, only a small number of new graduate nurses enter rural practice settings in northern NSW and several potential participants had already exited their graduate nurse programs before this research study could begin, so the researcher decided to include the pilot data.

Between the months of August and November 2001, the researcher conducted the ten interviews. The interviews were conducted in the participants' own time, and away from their employing facility to ensure privacy and confidentiality for the participants. The researcher believed that conducting the interviews away from their workplace would reassure the participants that the study was in no way related to the conditions of their employment within that health care facility, and it would also assist the participant in speaking freely about their experience in rural health care facilities.

Seven of the interviews were conducted as face to face individual interviews. The interviews were conducted in quiet, private locations that had been suggested by each participant. For example, interviews were commonly conducted at the participant's residence. However, two participants resided on properties located some distance from the township and so the first interview

was conducted in a quiet café within the town, at the suggestion of the participant. This proved to be a very difficult interview because of numerous interruptions. The researcher then used her office as an interview venue for the next participant who resided on a property one hour from the town and who had declined to have the interview conducted at her home. The office venue proved to be satisfactory as illustrated by notations made in the researcher's journal, which states 'a good interview, kept on track... very enjoyable'.

Three of the ten interviews were conducted via the telephone because the researcher was unable to organise face to face interviews due to the participants' rostering arrangements. The telephone interviews were organised at least three weeks in advance and were conducted with the participant using their residential telephone.

At the commencement of each interview the researcher introduced herself and once again outlined the purpose and aims of the research and the interview process. Participants were given a Plain Language Statement (Appendix 1) that provided an outline of the aims and purpose of the research plus the names and contact details of the people who were associated with the research such as the researcher's supervisors. Also included with the Plain Language Statement was a consent form. The participants were encouraged to ask questions after reading the Plain Language Statement and prior to signing the consent form. The participants were informed that the interview would be taped with their permission and that a copy of the transcription would be sent to them so that they could verify the transcript and make any changes or modifications that they desired. The participants required no changes or modifications to the transcripts. When the researcher was assured that the participants were fully informed they were asked to sign two consent forms. One form was given to participants for their personal records and the researcher retained the other.

Participants were asked at the commencement of the interview to complete a Participant Profile Sheet (Appendix 2). The purpose of the Participant Profile Sheet was to collect demographic data related to age, relationship status, date of commencement of the graduate nurse program, and location of the tertiary

institution where the graduate had studied. Collecting this information allowed the researcher to obtain a demographic profile of the ten participants.

For the telephone interviews, a covering letter (Appendix 3), the Plain Language Statement, the Participant Profile Sheet, and two consent forms plus a reply paid envelope were mailed to each of the three participants, with instructions to keep one consent form for their personal records. Upon receipt of the signed consent form and the Participant Profile Sheet, the researcher once again made contact with the participants to confirm the date and time of their interview. The day before the scheduled interviews the researcher telephoned the participants to remind them of the arrangements, and to see if the participants had any queries.

Each interview was transcribed verbatim immediately following each interview. This was important because it allowed the researcher to constantly compare and contrast each participant's information to identify emerging themes and it allowed the researcher to determine when saturation had occurred.

### **3.6. Interview schedule**

The major data collection instrument was a semi-structured interview schedule. A conversational style of interviewing was adopted to enable the researcher to obtain 'detailed and richly textured person-centred information' (Minichiello, Madison, Hays, Courtney & St John 1999:396), concerning the phenomenon of transition as experienced by the new graduates.

The structure of the interviews was consistent with a phenomenological research approach, utilising a recursive method of in-depth interviewing as described by Minichiello et al. (1999). This method of in-depth interviewing involves questioning that has a conversational style. Specifically, the conversational style enabled the development of a rapport between the researcher and the new graduate nurse, which assisted in achieving a greater level of understanding of the new graduate's experience. A further advantage of using the recursive method of questioning was that it enabled the researcher to treat each participant and their situation as unique, allowing the researcher

to change or modify the interview technique because of information gathered from previous interviews. The interviews continued in this way, until the researcher recognised that no new data was emerging, rather the information from participants was becoming repetitive, thus it was deemed that data saturation had been reached.

The interview questions arose from three sources. First, and as previously mentioned, the researcher had obtained information from new graduate nurses in rural practice, when visiting rural health care facilities as Clinical Coordinator of the undergraduate nursing program. Second, some of the questions emerged from the research literature surrounding the transition experiences of new graduate nurses. Third, emergent interview questions were guided by the concepts of role transition and professional socialisation, elements of Role Theory which provided the theoretical framework for this study.

The researcher constructed an interview schedule to assist with guiding the interviews (Appendix 4). The schedule did not necessarily determine the order of the conversation but rather it served to assist the researcher to focus on the participant, and assisted with ensuring that all topics had been addressed (Minichiello et al. 1999:400). For example, the second interview question was, *Can you tell me what it has been like for you here so far?* When answering this question some participants covered areas such as support and their preparation for practice. These were topics the researcher had included in the interview guide, to be addressed at a later stage of the interview or if they had not previously been addressed.

During the interviews participants were asked to describe their experience of the transition into the rural nursing workforce. Specifically, the participants were asked the following questions:

*Can you tell me why you have chosen to be in a rural graduate position?*

*Can you tell me what it has been like here for you so far?*

*Can you tell me about the level of support you have received or are receiving?*

When necessary the researcher used a series of prompts to help guide and focus the interviews. That is, the prompts and headings in the interview guide were used to jog the researcher's memory regarding concerns or issues that the researcher wished the participants to address. Prompting questions were also used if the participant lost their train of thought or became sidetracked. The interview guide was revised following each interview, to include important issues or topics raised by the participants that had not been previously covered by the researcher, and this helped to refine and guide the research process (Minichiello et al.1999:400). For example, the following questions resulted from this process.

*How did the staff inform you about your progress and performance in the program?*

*What educational support have you been receiving here?*

*Can you tell me about the support from your registered nurse colleagues/peers?*

### **3.7. Data analysis procedure**

The audiotaped interviews were transcribed verbatim by the researcher immediately following each interview. Each audiotape was allocated an identifying code number with the date, time and location of interview. When transcribing the interviews the researcher cleaned the data for punctuation and grammar to assist with reading and presentation of the data. Also, to ensure confidentiality and privacy the researcher removed any names of persons or agencies that participants may have referred to during the interview.

The transcripts were sent by mail to each of the participants for validation of the content and also for the participant to make any changes, modifications or clarification to their transcripts that they wished. None of the ten participants wished to make any changes to the transcriptions.

In analysing the data the researcher replayed the audiotapes to capture the feeling of the experience of the journey of transition and the transcriptions were read and re-read. The researcher implemented a selective or highlighting approach as described by van Manen (1997:93) when reading and re-reading the transcribed conversations. That is, significant statements and commonalities were identified and these were then organised into three major themes that represented important aspects of the new graduate nurses' experience of their transition into rural practice settings.

### **3.8. Ethical considerations**

Ethical approval for this study was sought and granted from the University of New England's Human Research Ethics Committee prior to the commencement of the study (Approval Number HEO1/103). Included in the ethics application was the Plain Language Statement, Participant Profile Sheet and consent form. Data collection did not commence until ethical approval was obtained.

This research study was guided by the National Health and Medical Research Council Guidelines (NH&MRC 1999) and the University of New England's Human Research Ethics Committee Guidelines (1999). These guidelines are aimed to prevent or reduce the potential risk of physical harm, as well as the risk of social harm that includes the privacy and reputation of participants involved in research (Parsons, 1999:77).

As previously described, potential participants were initially approached by the researcher whilst she was visiting health care agencies in northern NSW. Once an interest was shown, the researcher then contacted the potential participants by telephone to further explain the study and to discuss a mutually convenient date and time and location. Thus, the participants in the study were all volunteers who at no time during the study were under any pressure to participate. The participants were not considered to be part of a special population or cultural group that may have been at risk because of their vulnerability or inability to provide an informed consent (Parsons 1999:86), but were capable of providing a voluntary informed consent. Participants were not offered any financial reward or compensation for their participation in this study.

To obtain an informed consent from each participant the researcher provided a Plain Language Statement explaining the study, which enabled the participant to consider the project and their required involvement. The Plain Language Statement outlined the aims and purpose of the study; duration of the participant's involvement; a description of the procedure; confidentiality of records as well as names and numbers for contacts should the participant have any queries or require clarification. In addition, a statement clarifying the participant's right to withdraw from the study at any time, without penalty or prejudice and the right to confidentiality and privacy was included. Permission to have the interview audiotaped was obtained from each participant, and then each participant was asked to sign the consent form.

The researcher acknowledged that the nature of the information concerning the new graduate's experience of their transition into rural practice could prove uncomfortable and emotionally distressing to the participant. Thus, the interviews were held in quiet, private areas away from the employing agency at a location nominated by the participant. This helped to ensure confidentiality for the participant. The researcher further explained that any identification of the participant's name or the health facility would not be included in the transcriptions. The researcher coded the tapes and allocated a pseudonym to the transcriptions, to further ensure confidentiality for the participant.

The researcher informed the participants that dissemination of the study results in subsequent journal articles or conference papers would contain no identifying information. Participants were also informed that all audiotapes, transcriptions, computer discs, consent forms and Participant Profile Sheets, would be stored in a locked filing cabinet in the researcher's office for a period of five years. Participants were informed that all data would be accessed only by the researcher and her supervisor in accordance with the NH&MRC Guidelines (1999), and that after a five-year period they would be destroyed.

### **3.9. Rigour and trustworthiness of the study**

Hallett (1995:57) outlines several measures other than conventional scientific criteria that must be adopted by phenomenological researchers to ensure rigour and trustworthiness of qualitative research. These measures include ensuring

that the work has '*credibility or truth value*' (Hallett 1995:57). That is, the data is a true reflection of the participants' understanding of the phenomenon under study. As well, the research process must have *auditability*, and/or *consistency*. That is, to what extent did the researcher make clear their actions to the reader in reporting on the research and also the extent to which those actions can be recognised as logical and consistent? Additionally, the research must have *confirmability* (Hallett 1995:57), that is, the data presented is recognisable by the research participants as their own views, serving to confirm the researchers neutrality.

To ensure rigour and trustworthiness in this study the researcher first used a research design that was consistent with qualitative methods, and the research process has been outlined in detail in this chapter. Second, to ensure credibility of the data, the researcher purposively chose the study participants ensuring that only new graduates experiencing the phenomenon of transition in rural practice settings were included in the study. To ensure neutrality the researcher adopted several strategies that are consistent with qualitative research methods. First, the researcher kept a reflective journal to bracket or suspend her own beliefs regarding the transition experience within rural practice. Second, the researcher transcribed the interviews verbatim and then returned the transcripts to the participants for verification. Third, the emergent themes from the data were verified by the researcher's principal supervisor as being applicable and relevant to the context of the research.

### **3.10. Methodological issues and limitations**

This study was only conducted in eight rural towns of northern NSW and therefore is not representative of the new graduate nurse populations in rural areas. However, it was not the intention of the researcher to make statistical conclusions, nor to generate or construct theories that could be generalised to the new graduate nurse population in rural practice. Rather, the researcher wanted to obtain rich data via interviews regarding the experience of graduates. Thus, the data has been used to gain a better understanding of the experience of new graduate nurses making the transition into rural practice.

It could be viewed by the reader that a limitation of this study was that all the data collected and interpreted for this study was conducted by a single researcher, who had prior involvement with five of the ten participants because of her role as a Clinical Coordinator within a regional university. However, as stated above, the researcher adopted several measures to ensure neutrality, credibility and trustworthiness of the data because of her prior involvement. The researcher also assured participants at the commencement of each interview that she was only interested in exploring their experiences of rural practice purely from a research perspective and she encouraged the participants to speak freely about any issues which they felt impacted on their experience thus far. Additionally, the researcher had for many years previously been a rural nurse, and so had experienced social and cultural environments similar to those the graduates were experiencing. Thus, the researcher's experience influenced her awareness of and understanding of the experiences of the graduate nurses within this study.

### **3.11. Conclusion**

This chapter commenced with a justification of the research design and methodology utilised used in this study. A qualitative design using a hermeneutic-phenomenological approach was deemed most appropriate. Within the justification it was demonstrated how the aims of the study would fit within this qualitative research design.

The chapter then identified the research methodology, specifically the setting, sample, and data collection procedure used. The interview schedule was presented and discussed and the ethical issues relating to the participants were presented. Finally, methodological issues and limitations were identified.

The following chapter will present the data analysis and identify the relevant emergent themes which arose from the data.