CHAPTER FOUR

Data analysis

4. Introduction

Chapter four presents an interpretation of the data collected from the research conducted to explore the experience of transition from student nurse to new graduate nurse in rural practice settings. Firstly, an explanation and justification of the data analysis procedures that were used for this study are presented. Secondly, the presentation and discussion of the demographic data of the participants from this study are provided. This is followed with a discussion of the findings from the analysis of the taped and transcribed interviews.

A hermeneutical-phenomenological approach to the study was used to explore the experience of transition of new graduate nurses in rural practice settings. Thus, the aim of the study was to gain insight and understanding into the transition experience for a small number of new graduate nurses by asking: What is the lived experience of the new graduate nurse making the transition from student to registered nurse in rural practice settings? In exploring the new graduate’s lived experience the researcher sought to address the following research questions.

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

What had the transition experience been like so far?
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?

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

Does the new graduate nurse who has chosen a rural employment position have later regrets about their rural choice, and if so, why?

The first section of this chapter presents demographic data collected from each participant prior to each interview. Demographic data was collected from each participant via the Participant Profile Sheet. For the three phone interviews, the Participant Profile Sheet was posted to each participant prior to the commencement of the interview. A copy of the Participant Profile Sheet is included as Appendix 2.

The information from the Participant Profile Sheet was gathered in an overall attempt to obtain a participant profile. Data gathered from the Participant Profile Sheet included: age and relationship status of participants, as well as details regarding the location of the tertiary institution where undergraduate preparation had been completed and the month that each participant commenced employment at the health care facility. The researcher collected this information because it was felt this was important information that may have influenced the participant's choice for a rural graduate nurse program. Additionally, the researcher was interested to determine how much of the new graduate experience in rural practice settings was influenced by where the graduate had completed their undergraduate preparation. It was also important for the researcher to know how long the new graduate had been employed in the graduate nurse program, as the researcher wanted to know if length of time of employment was a factor in influencing experience of transition.

Consistent with phenomenological inquiry the findings from this study have been presented as themes. The audiotaped interviews were transcribed verbatim at the completion of each interview and then returned to the
participants for validation of the content and for each participant to make any changes to their own transcript that they desired. In analysing the data, the researcher replayed each audiotape to capture the feelings 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. Significant statements and commonalities were identified, and these were then organised or clustered into themes that represented important aspects of the experience of transition into rural practice settings, as experienced by this group of beginning registered nurses.

To provide an interpretation of the participants' narratives, the researcher undertook thematic analysis of the data so that insight into the meanings of the transition experience into rural practice settings could be provided.

Three major themes emerged from the textual data. The aim of the themes is to capture and describe a consistent, re-occurring aspect of the structure of an experience that is experienced by those living the experience, thus allowing the reader to have some understanding of what it is like to experience the phenomenon under study (DeSantis & Ugarriza 2000:356). Each of the three themes interacts with each other to address the aims of this study. As there appeared to be several significant elements simultaneously influencing the new graduates' experience of transition, two of the three major themes have been divided into sub themes to assist with presentation and reading of the data.

As previously stated, the three themes emerged from the narratives of the participants and quotations from the participants are provided throughout the chapter to illustrate each theme. The themes have been presented and sequenced as stages of a journey, and as such the researcher identified three stages to this journey of transition. The three stages and the subsequent themes that emerged from the analysis of the participant stories are as follows:
**Theme 1 Stage 1:** ‘Having rural connections’

**Theme 2 Stage 2:** ‘Socialising to the registered nursing role in rural practice settings’

- **Sub theme 1:** Ward culture within a rural setting
- **Sub theme 2:** Workload within rural practice settings
- **Sub theme 3:** The level of responsibility in rural practice settings

**Theme 3 Stage 3:** ‘Having regrets and unmet promises’

- **Sub theme 1:** Preparedness for rural practice
- **Sub theme 2:** Unmet expectations of the graduate nurse program

### 4.1. Profile of participants

Nine of the ten participants had completed a three-year Bachelor of Nursing Program within NSW and one participant had completed their undergraduate preparation interstate. Seven of the ten participants commenced employment in February 2001. Two participants commenced in January 2001 and one participant commenced employment in July 2001. Thus, at the time of the interviews all of the participants were well established within their new graduate nurse programs, having completed at least six months of continuous fulltime employment within a rural agency.

Previous nursing experience was not included as a category in the participant profile sheet. However, this data emerged during the conversations with each participant because the participant felt that it was important to their story. Of the ten participants only three had had previous nursing experience. Two of these had previously been employed as Enrolled Nurses and one had been employed as an Assistant in Nursing (AIN).
The demographic data is presented in Table 1. The participants have been listed in alphabetical order and to protect the participant’s identity, and to facilitate the reading of the participant’s comments the ten participants were each allocated a pseudonym.

Table 1: Profile of participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age Range</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ANNE</td>
<td>35-39 years old. Anne lives with her husband and children on a property close to several rural communities. She completed her undergraduate nursing preparation at a regional university.</td>
<td></td>
</tr>
<tr>
<td>BECKY</td>
<td>40-44 years old. Becky moved with her partner and children to the rural area. She completed her undergraduate preparation at a metropolitan university.</td>
<td></td>
</tr>
<tr>
<td>EMMA</td>
<td>20-24 years old. Emma lives with her partner. She attended a regional university.</td>
<td></td>
</tr>
<tr>
<td>GAYE</td>
<td>30-34 years old. Gaye is single. She completed her undergraduate nursing program at a metropolitan university.</td>
<td></td>
</tr>
<tr>
<td>HANNAH</td>
<td>25-29 years old. Hannah lives with a partner. She attended a regional university.</td>
<td></td>
</tr>
<tr>
<td>JAMES</td>
<td>20-25 years old. James completed his undergraduate preparation at a regional university. He was single at the time of interview.</td>
<td></td>
</tr>
<tr>
<td>JOEY</td>
<td>25-29 years old. Joey is single. He completed his undergraduate study at a regional university.</td>
<td></td>
</tr>
<tr>
<td>LIAM</td>
<td>30-34 years old. Liam has a partner with children. He completed his undergraduate preparation at a regional university.</td>
<td></td>
</tr>
<tr>
<td>MANDY</td>
<td>20-24 years old. Mandy moved to the rural area to be with her partner. She completed her undergraduate preparation at an interstate metropolitan university.</td>
<td></td>
</tr>
<tr>
<td>SALLY</td>
<td>35-44 years old. Sally attended a regional university and relocated away from her partner and children to complete the graduate year.</td>
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4.2. The journey of transition

In exploring the stories provided by each participant, the researcher believed that the descriptions could be equated to a journey. That is, a journey of role transition. Role transition occurs for new graduates upon entering the nursing workforce as they progress from the ideals of the educational institution to the reality of the workplace and the organisational culture. It is an intense period of
socialisation into the workplace culture of the clinical world where beginning registered nurses learn what others will demand of them in their new role as a registered nurse (Chang & Daly 2001:5).

The new graduates, when providing an account of their transition into rural practice settings, had taken the researcher on a journey that consisted of three stages. When reading and re-reading the interview transcripts, the researcher found that each participant had described their experiences in a way that was saying, ‘this is why I chose to come here’ (Stage 1), ‘this is what my journey has been like and this is how I feel about my journey now’ (Stage 2), and ‘this is what I would have liked, expected or changed during my journey’ (Stage 3).

When describing their journey, the participants talked first about how they came to be in a rural graduate position and what influenced their decision to accept employment in a rural health care agency. This constitutes Stage 1 of their journey of transition into the rural nursing workforce and is represented by Theme 1: ‘Having rural connections’, and arises from responses to the first research question which was, Why did you seek a graduate nurse program in a rural area?

The initial period of entering the work force, the workload expectations placed upon the new graduates, and the level and type of responsibility that new graduates were expected to assume constitutes Stage 2 of their journey which is represented by Theme 2: ‘The socialisation of beginning registered nurses in rural practice settings’. For the new graduates in this study this second stage also consisted of the struggle for acceptance and assimilation into the ward culture. It was some months into their program when the new graduates identified a settling-in period where they began to feel more confident with their practice and expected level of performance and less confused as to the nature of their role and the workforce expectations of them.

The end of the journey, Stage 3, represented by Theme 3: ‘Having unmet expectations and promises’, was marked by the new graduates’ feelings of being empowered in their practice which the researcher felt marked their successful socialisation into the nursing workforce and the ward culture. The
graduates' discussions at this time reflected that they felt comfortable in the agency, and they considered that they were valued and accepted by members of the nursing team. Additionally, they had a clearer idea of which direction they would now like their nursing career to take and were able to reflect back on their experience and discuss regrets and unmet expectations of their first year of registered nursing practice. Thus, the transition experiences of these new graduate nurses have been arranged into three major themes, with several sub themes, which reflect the stages of their transition journey.

4.3. Theme 1

4.3.1. Stage 1: 'Having rural connections'

In anticipation of the graduate year, choosing employment in a health care agency is the initial step that the new graduate makes prior to embarking on their journey of transition from nursing student to registered nurse. There is very little literature that specifically explores this important decision-making process and the factors that influence this process. When conducting this study the researcher felt it was important to ascertain what factors influenced the new graduate's choice of a rural graduate position, as the researcher believed that this may have impacted on their overall experience in a rural practice setting and their subsequent retention in the rural nursing workforce.

The first question the researcher asked each participant was: Why did you choose to accept a rural graduate placement? The researcher asked this question because during the course of her employment at a rural university, the researcher has contact with third year nursing students and has in recent years collected anecdotal evidence from graduating nursing students regarding the reasons for their new graduate nurse program placement choices. This anecdotal evidence is utilised by the researcher, in her capacity as clinical coordinator, to assist with the planning of future undergraduate clinical placement experiences.

The data collected in recent years indicated to the researcher that there was a body of student nurses keen to pursue rural graduate nurse placements. Not all students aspire to becoming part of the metropolitan or regional nursing workforce. Students indicated that their decisions of where to apply for a
graduate nurse position were influenced by factors such as; family, personal and financial commitments, the content of graduate nurse programs, availability of affordable accommodation, and lifestyle choices which were related to geographic location and climate.

The researcher had also gathered anecdotal evidence from rural health care agencies regarding problems that some rural health care agencies experience in retaining new graduates. That is, in rural health care facilities it was becoming common and in some agencies, expected practice for new graduates to exit the rural graduate nurse program before completing the full twelve months. Anecdotal evidence from rural health care facility staff suggested that new graduates were perhaps leaving to pursue metropolitan practice because they were not happy with their rural placement choice. Alternatively, some staff within rural facilities felt that graduates had accepted their rural graduate program offer, while still hoping or waiting to secure a placement in a more favourable metropolitan or regional health care facility. However, no evidence has been gathered to substantiate these claims and there is very little published data that explores the factors that affect retention of new graduate nurses in the rural nursing workforce.

Thus, in this study, the researcher wanted to ascertain if the new graduates had made conscious, well-informed decisions to ‘go rural’. Or, had they accepted a rural graduate nurse placement as a second choice, having missed out on their first preferences, as was alluded to by health care agency staff?

From the conversations with the participants in this study, it became apparent that the biggest consideration for the majority of the participants when making a decision regarding graduate nurse programs was having previous connections with a rural area. Thus, the theme ‘Having Rural Connections’ emerged from responses by the participants regarding why they had chosen to be in a rural graduate nurse position.

The new graduates in this study all indicated a strong desire to complete their graduate nurse year in a rural agency. Of the ten new graduates, seven had chosen the facility in which they were now employed as their first choice for a
graduate position within the NSW New Graduate Nurse Recruitment Consortium. One participant had the facility in which they were now employed as one of their first five choices within the New South Wales New Graduate Recruitment Consortium and two had applied privately to the rural health facility because they graduated mid year and had answered private advertisements for the graduate nurse positions.

It is evident from the data that originally being from a rural area was the main factor that influenced the new graduates' decisions for placement in a graduate nurse program within a rural area. Overall, seven of the ten participants in this study had previously resided in rural areas and they either wished to return 'home' for their graduate year or to remain in a rural area so that they could be within commuting distance from their town of origin.

The responses by the new graduates in this study are similar to other findings in the literature. For example, Hegney and McCarthy (2002), acknowledge that it is not unusual for health professionals who were raised in rural areas and were familiar with the advantages of the rural lifestyle to be more likely to continue to work there following graduation. This is illustrated by the following participants' comments:

*That's where I was brought up, I have always been rural* (Emma)

*I live in a rural area. It suits me because I have children who are still at school* (Sally)

Two of the seven graduates who returned to their places of origin also had partners that were already residing and working in the rural town. This influenced the new graduate's consortium choices and their acceptance of a consortium graduate nurse placement. For example, the researcher had noted in her reflective journal that Emma had told her about her impending marriage plans. Her partner was a local man who already had an established business in the town and so this as well as her rural origins influenced her decision to choose a rural graduate position. This was also the case for Hannah, who was
originally from the rural town in which she is employed and who also has a partner who was a resident and employee in the town.

One of the seven participants had never lived in a rural area but had accepted the position because her partner was employed within the rural community.

There is a noticeable gap in the literature that pertains to the recruitment and retention of health professionals to rural areas and the recruitment of nurses to rural areas is a longstanding problem. Findings from Blue (1993), Hegney (1996) and Handley (1998), have indicated that very few new graduates enter the rural workforce, and those who do, go to very large regional health services. However, as mentioned in the literature review this could be influenced by the recruitment of graduate nurses through the regional area health services, of which smaller rural health facilities are a part, thus impacting on the perception that very few new graduates enter the rural workforce. As previously mentioned in the literature review, Hegney (1996) comments that one of the influences on the recruitment and retention of rural nurses is the occupation of their partners or spouses who are involved in employment within rural communities such as the police force, teaching and farming.

Of the remaining three participants, two were not from rural areas and had never previously resided in a rural area. Their reasons for going rural were that they wanted to experience a rural lifestyle.

The remaining participant, who had previously resided in a rural community, commented that the geographical environment influenced the decision for them. The participant had a love of surfing and thus wanted to live in a coastal region.

It is important to note that all of the participants had experienced rural nursing practice at some time during their undergraduate clinical preparation. It was evident from the data that, experience in a rural agency during undergraduate nursing preparation was a considerable influence on the new graduates of this study when applying for and accepting rural graduate nurse placements. Participants stated that during their undergraduate clinical placements at these
agencies they became familiar with the agency, the services they offered, the
rotations the placement offered and the prevailing ward and organisational
culture present. This heavily influenced their decision-making when making
placement choices, which is reflected by Joey’s comment:

Being here as a student, I knew the size and the sort of services they
provided. That’s what attracted me. Also what attracted me to come back
after being a student here was not so much the individual staff but the way
the staff on each level work together. The whole work ethic is the same
(Joey)

Overall, these findings regarding factors that influence preferences for the
graduate nurse year from this study are similar to data obtained from Heslop et
al. (2001), which was previously discussed in chapter two. The main factors
Heslop et al. (2001) identified in influencing preferences included; locality,
reputation of the health care facility, rotations to clinical areas and familiarity
with the health care facility.

The new graduates of this current study had the potential and motivational
means to become committed members of the rural nursing workforce. However,
at the time of the interviews, several participants in this study were
actively seeking and applying for nursing positions outside their employing
health care agencies. This was because they did not expect that there would be
positions available for them upon completion of their graduate nurse program.
This predicament is not specific to this cohort of new graduates. A recent study
by Mosel Williams (2000) in Queensland found that the new graduates in rural
agencies within her study had undertaken a ‘de facto training’ (2000:103). There
is no expectation by the agencies for them to stay past the twelve-month period.
In fact, clinicians supported the belief that new graduates should seek more
experiences in larger facilities upon completion of the twelve months.

However, as previously mentioned in chapter two, generally there is a low
turnover of staff in rural hospitals which is due to the stability of rural lifestyles,
plus the fact that many partners of rural nurses are involved in long term
employment within rural communities (Hegney 1996), and as such there were
no permanent positions available for the graduate nurses once they completed the graduate nurse program.

In this study it is interesting to note that three of the ten participants left their placements shortly after the interviews. Of these three, two left to take up permanent employment in regional and metropolitan areas, and one left to travel and work as a Registered Nurse overseas. The remaining seven participants were all aware that there was no guarantee of a permanent position upon completion of their graduate year. However, because seven of the participants had a strong desire to stay on in the rural towns, they intended to take up the offer of becoming part of the casual pool staff in their employing agencies, as well as in other agencies that were within commuting distance from their home, until a permanent position became available to them.

4.3.2. Summary

In summary, this theme highlights the main factors that influenced the new graduates' decision to undertake their graduate year in a rural health care agency. In choosing which journey to embark on for their graduate year the main considerations that influenced their decisions revolved around family and personal relationships, and previous experience in rural areas, as well as the desire for a rural lifestyle.

Thus, the new graduates in choosing a rural graduate nurse placement had all made an informed decision based on past experiences and lifestyle choices. Although some of these participants had no choice but to accept a rural graduate nurse program because of their family commitments and partners' employment commitments within the rural town. However, the graduates in this study did not have any expectations of full-time employment in the health care agency upon completion of their twelve-month programs. They had accepted the choice of having to move out of rural areas to seek permanent employment, or to rely on casual work with the hope of securing a full-time position when, and if one became vacant in the rural town.
4.4. Theme 2

4.4.1. Stage 2: ‘Socialising to the registered nursing role in rural practice settings’

The second theme emerged in response to the second interview question which was, *Can you tell me what the transition period has been like for you so far?* The researcher identified the responses to this question as forming Stage 2 of the journey. During this second stage the reality shock and the realisation of the responsibilities that come with obtaining professional status within rural practice settings were common to all participants. However the interviews also revealed that the emphasis for the new graduates in rural settings was on their assimilation and acceptance into the ward culture, and the workload and level of responsibility that was expected of the new graduate in rural practice.

Stage 2 of this journey for this group of new graduates in rural practice settings was one where their experiences differed depending on the size of the agency, staff ratios and skill mixes within each agency at that time. When reflecting on what their experiences had been like thus far, all indicated that the workload and level of responsibility, and the lack of structured support during the graduate nurse program were major influences on them in the first few months. However, the individual experiences of each new graduate were specifically influenced by the culture of the ward environment where they were employed.

To assist with presenting the findings the researcher has divided the second theme representing Stage 2 of the journey into the following three sub themes; ward culture within a rural setting, the workload in rural practice settings, and the level of responsibility in rural practice settings.

4.4.2. Sub theme 1: Ward culture within rural settings

For the majority of the new graduates in this study their individual experience of the journey of transition into rural health care agencies was influenced and shaped by the effects of the ward culture into which they were trying to assimilate. The social forces at work in a ward environment which often resulted in negative ward dynamics had an enormous impact on the new graduates’ experience of transition, and was discussed by the new graduates in
terms of the type of support they received and from whom they sought support.

During the interviews the participants recounted incidents that had happened to them, or other new graduates, which illustrated the problems they encountered when trying to understand and accept the ward culture. All of the participants commented on the aggressive behaviours from other staff that contributed to hostile undercurrents and negative dynamics within the wards where they were rostered. Additionally, two participants used the term *horizontal violence* when discussing the aggressive behaviours of other staff. The comments from graduates of this study indicated that they were exposed to the aggressive and unprofessional behaviours exhibited by other staff on a daily basis.

From the participants stories it appeared that they were able to overcome the hostile undercurrents that prevailed in some of the wards to which they were rostered because they did not feel it was directed at them personally. However, it resulted in the new graduates having to work in a climate that was fraught with distrust, competitiveness and outright *bitchiness*, as it was termed by the participants.

All of the narratives identified more senior registered nursing staff as the main perpetrators of hostility and aggressive behaviour that affected the climate of the ward. The participants felt that individually staff had been very supportive of them, if the graduates asked for support. However, this depended on who was working at the time and the ward or group dynamics that were operating at any one time, which could affect the climate of the ward and the subsequent treatment of the new graduates.

The following statements illustrate the negative feelings the new graduates had about the hostile undercurrents that they found prevailed in some rural nursing ward cultures:
I found it to be very difficult, not supportive. I was in the firing line being blamed for things that went wrong that really had nothing to do with me. It was a full on target for grads in general from the senior staff (Anne)

I think the hardest is that you used to always hear about horizontal violence that goes on. Being a student you are only in the ward for a period of time and then you go out again... Now it's [bitching] in your face and you’re always there and comments eventually get back to you. It just always goes on, everyone’s bitching about everyone and it’s a real eye opener (Emma)

Some new graduates believed they had to negotiate a minefield when looking for support from nursing colleagues. The hostile and bitchy undercurrents that the new graduates were exposed to meant that they did not trust some colleagues, so they would not seek their support, or would do so grudgingly if there was no-one else available. For example, Anne commented that she felt that most of the staff were able to display supportive actions, that is they would help out when she asked them for help, but their manner or attitude was not always supportive.

Some participants were initially unsure of whom to turn to for support. They found it difficult to ask for support from the more dominant senior staff members because their bitching and hostile attitude toward other staff resulted in the participants not being able to trust them. For example, Hannah stated that the constant bitching and running down of other staff by senior staff meant that she did not trust the staff enough to ask them for support.

The management are really close friends and the morale at work is really poor. It’s really hard to approach them [senior nurses]. They’d have their coffee of a morning and you would hear them run down every single person in the hospital. I have found they are my biggest problem since I have been at work. I think it is a much bigger problem than what most people see on the surface. I think that’s why I don’t go to them [senior staff] for support because I don’t trust them (Hannah)
For Hannah, the hostile environment that she was frequently exposed to was quite distressing to her particularly because it was displayed by people that she had previously worked with and trusted when she had been employed within the rural health care facility as an Enrolled Nurse. As well, many of the senior staff that exhibited these unprofessional behaviours had been family friends who had been part of the rural community during her childhood.

Hannah tried to address her problems with management but felt that she received very little support from them. When Hannah approached more experienced nurses for help or advice regarding clinical decisions that she felt was beyond the scope of her knowledge and experience, she felt the staff to be intimidating. She felt that she was rebuked for not making the same decisions that a more experienced nurse would have in that situation.

However, some participants, for example, Mandy and Anne, felt that their individual personality traits had a great deal to do with their ability to overcome the workplace conflict and idiosyncrasies of the ward culture. Several authors, (Madjar 1997; Kelly 1998) as previously discussed in chapter two, also believe that the successful assimilation into the nursing workforce for the new graduate nurse depends on several factors one of which is the personality traits of the new graduate nurse.

*I haven't had any problems. You are going to have a few teething problems when you start. You have the things like getting used to shift work and building a rapport with people that you work with. But I love nursing, I can't imagine doing anything else and I think that is one of the reasons why I have settled into it so well, compared to other people (Mandy)*

*I am not going to tolerate any nonsense. I am disappointed with people, with adult behaviour (Anne)*

Interestingly, the male participants of this study were able to observe aggressive and hostile behaviours by more senior staff from a distance. They did not feel that their individual experience of transition into the rural nursing
workforce had been shaped or affected by hostile or aggressive behaviours of other nursing staff.

As the researcher used a recursive method of interviewing where previous interviews guided the structure of the next; the researcher prompted the male participants to discuss any experience that they may have had with staff conflict and behaviour. It was evident from their conversation that they did not feel it was an important aspect of their experience. Because the researcher had to prompt them on this topic it would seem that they placed very little emphasis or importance on being accepted into the ward culture. It was evident from their responses that the male participants did not place much emphasis on work relationships nor did they feel a struggle to be accepted into the ward, rather it appeared to the researcher that they assumed and expected that they would be accepted. As illustrated by Joey’s comment, the male respondents generally felt that because they were males, they were not exposed to aggressive behaviours as much as their female peers were. Also, they felt they were able to observe from a distance and not get involved in the *bitching*.

_I have the advantage of normally being the only male on the shift and so I thankfully get bypassed with the bitching. I don’t know whether it is competitiveness that drives one person to talk poorly of another but I think it has not affected me because I am male_ (Joey)

Some new graduates in their descriptions were able to separate out excuses to account for the behaviour of their colleagues and as to why they thought there were such hostile and aggressive undercurrents present within the culture of nursing. Although they did not specifically identify these as being unique to rural practice, the culture of nursing in general proved difficult to accept. Liam and James illustrate this with the following comments:

_There has been a problem with one or two of the nurses in particular and it’s their problem not ours. It’s not our problem that they feel insecure. It was more the attitude of what was said like, ‘how dare you do something that way, you have no right’. They have been working as RNs for twenty, thirty, forty years and have never done any extra education so they are_
feeling insecure because we are coming out of uni with what they think is this great wealth of knowledge that they don’t possess (Liam)

Everyone is bitching about each other because of the hospital move and management cutting staff and jobs and the patient allocations and patient loads. If someone doesn’t do it the way they think it should be done they say ‘oh no you don’t do it like that!’ then they [senior staff] argue and bitch about which way it should be done (James)

However, James and Liam felt removed from the effects of aggressive staff behaviour. Yet, in the following examples they express concern for the welfare of other staff members, who they feel have been victims of aggressive behaviours from more senior staff.

The people I work with are good, the ENs they are invaluable. They work so hard. I don’t believe how they get treated. They get treated fairly badly by other staff. Everyone is sort of bitching about each other (James)

We had two [new graduates] drop out because they did get a hard time from some of the RNs (Liam)

Conversely, the female participants in this study placed a lot more emphasis and importance on the development of work relationships and being accepted into the ward. The rural nursing workforce is predominantly a female profession (Hegney et al. 2002), and the relationships that women have at work have been found to be extremely important to them (Raphael 1992 cited in Jackson et al. 2002). However, the female participants in this study identified an extra element for new graduate nurses in rural practice, which influences their assimilation into the rural nursing workforce. The extra element is, having to deal with the social issues of living and working in a very small community. For example, staff in rural communities have often been working together for a number of years, have trained together, may have had partners that worked together and perhaps had children who played together, thus having formed social cliques in their work relationships. In the researcher’s experience the formation of close knit social cliques is a unique element of rural nursing that is
not common in larger health care facilities and it can be difficult to accept the social clique that results. The new graduates in this study found it hard to be socially accepted and to form friendships within some of the rural health care facilities because of the social clique that had developed within the rural facilities. Additionally, there is also a lack of anonymity that occurs on several levels for rural nurses, and this can cause discomfort for new graduates who are not used to the lack of privacy in their day-to-day practice as a nurse. For example, Hannah illustrates the lack of anonymity when she commented that she frequently heard senior staff constantly bitching and gossiping and generally speaking unprofessionally about other staff. Emma’s comment of ‘You’re always there, it just always goes on’ also refers to the lack of anonymity, the close working environment, and the small staff numbers within rural health care facilities. This made it difficult to escape and ignore aggressive behaviours and staff conflict that the new graduates found hard to accept and which also made it difficult for there to be any professional privacy.

Additionally, and as previously discussed in the literature review, working in close knit rural communities can result in a role diffuseness for nurses and is a common occurrence in rural communities. Role diffuseness occurs as there is often a mixing of professional, personal and social roles that can affect an individual’s ability to integrate into the rural community (Taheri-Kennedy 1997). Often in rural communities the professional roles involve a social role, as people you work with closely may also be familiar acquaintances. Thus, role diffuseness also results in a lack of anonymity for the rural nurses with regard to being known as a nurse within in the community.

The new graduate nurse will have to adhere to the values and norms within the rural community that may be in conflict with their professional role and can influence their acceptance into the rural community. This is illustrated in the following quote from Sally. Throughout Sally’s interview it was obvious to the researcher that she had not enjoyed her rural graduate nurse placement. It appeared to the researcher that Sally’s year had been a struggle for her. Sally acknowledged that her acceptance into the small rural community was influenced by how she fitted in to the pecking order at work and whether she
conformed to what the social clique within the rural facility expected of new graduates whilst at work.

If you don’t conform to their expectations then you get off on a bad foot, it’s not just necessarily a registered nursing specific thing, it’s nursing. Having to realise that people who have grown up in the same community, they have gone to school together, they have gone through nursing together and they are working together. So there is that element of the pecking order, and as a grad you fit into the pecking order right at the bottom end of the scale. And you have to comply with everybody else’s expectations and you might jeopardise your position in that pecking order if you overstep those boundaries that are set by those people (Sally)

From the transcriptions it was obvious that there were a number of elements of horizontal violence operating at anyone time in each ward. As well as bitchiness, the respondents gave examples of competitiveness and unhelpful, uncooperative and unprofessional behaviours that were displayed by more senior nursing staff towards each other and in some cases directed at the new graduates. The new graduate had to deal with a variety of these behaviours on a daily basis as well as cope with the workload allocation and the level of responsibility. Additionally, for the new graduate there was no escape from the hostile undercurrents prevailing in the wards because of the small size of some rural agencies which meant that the graduates would be working with these people and as well as sharing coffee and meal breaks on a daily basis.

There is only a small body of literature that specifically explores the social forces in the nursing workplace that shape the experience of new graduate nurses.

As previously mentioned in chapter two, workplace conflict in nursing is not a new phenomenon but only recently has this problem been acknowledged as perhaps an important influence on the recruitment, retention and career satisfaction of nurses and in particular new graduate nurses (Jackson et al. 2002).
Recent literature from Farrell (1997, 2001), Freshwater (2000), Jackson et al. (2002), explore the problems of horizontal violence within nursing and the factors which influence this behaviour. Pressures of workload that impact on staff morale, lack of support from management, the formation of clique environments and the hierarchical nature of nursing has been discussed as major factors in the prevalence of this problem in nursing.

For the new graduates in this study, horizontal violence was manifested in the form of gossiping, backstabbing, unhelpful/uncooperative behaviour, as well as professional jealousy or competitiveness exhibited by other nursing staff towards them, and it was a significant influence on their experience of transition.

Interestingly, only two of the new graduates in this study had the confidence to report or discuss their concern for aggressive and uncooperative behaviours with nursing management. However both participants felt that management was very unsupportive in assisting them to deal with this problem. This is not surprising because as previously discussed in chapter two, a lack of support from management has been shown in literature from Jackson et al. (2002) to influence a person’s decision to report such behaviours. As well, senior nurses are often the main perpetrators of horizontal violence which means that these problems are often overlooked or dismissed by management (Jackson et al. 2002:3).

Hinds and Harley (2001) and Farrell (2001), as mentioned earlier in chapter two, discuss how the clinical culture of the ward can work to shape the mindset and practice of new graduate nurses. That is, power relations between staff influence the new graduate experience and their subsequent acceptance into the ward culture. Also these authors identify that a clique formation in nursing can be a very persuasive instrument in marginalising those who are perceived as being different or seen as a threat. In this present study of new graduates in rural practice the aggression and staff conflict that the new graduates were exposed to can be attributed to the power relations that occur between staff. As well as power relations, two of the participants in this study commented on the
clique formation within their rural agencies which influenced their transition experience.

4.4.3 Summary

In summary, this sub theme identified the influence of ward culture on the socialisation of the new graduate nurse as significant in shaping and influencing the experience of transition into rural practice. It appeared that behaviours of other staff and undercurrents within the ward were most certainly operating within rural agencies to shape the behaviours of the new graduates so that they would conform to the agencies' expectations of a registered nurse. The literature has identified that this is not unique to rural practice settings. However, what is unique and different for the graduate in rural practice settings is how ward culture is affected by the close working environment of rural practice settings. The new graduates have to adjust to working with people they know socially and professionally, and have to work with the same people everyday because of the small staff ratios within rural agencies, that means there is no escape from the aggressive and hostile undercurrents that may prevail in the rural wards. As well, the graduates were reluctant to seek out support because the unprofessional behaviours came from the staff, who were supposed to be supportive role models for the new graduate. This resulted in the graduates not trusting some staff and not having anyone to turn to for support in dealing with these issues. However, also important for this cohort of new graduates was the culture of the rural ward environment where the graduates had to adjust to and deal with the role diffuseness and lack of anonymity that comes with working in rural communities. This was a significant aspect of the graduates' socialisation to registered nursing practice in rural health care facilities because they were continually struggling with trying to be accepted as part of the team, yet they felt self conscious and intimidated by the way staff were speaking unprofessionally about other staff.

4.4.4. Sub theme 2: The workload in rural practice settings

The narratives revealed that workload expectations were another significant influence on their experience of transition and their socialisation to the professional nursing role in rural health care facilities. The size and services
offered by rural agencies and the staffing ratios in rural agencies resulted in differences between participants in the type and level of responsibility that they were expected to undertake and the amount of settling in time they were allowed. As well, there were differences between participants in the workload that they were expected to carry in the first few months.

Initially, the participants of this study all thought that their time management skills were problematic, especially given the patient load that they were expected to manage almost immediately upon entering the nursing workforce. What they could expect as a student patient load and what they were given as a beginning registered nurse patient load was very different. They had never as a student had to assume a full patient load responsibility. The participants acknowledged that they were inexperienced with carrying a full workload and the responsibilities associated with it and felt that there was no recognition of this by the health care agencies. This is illustrated by the following comments.

_In 3rd year you are supposed to have your own patients, and you are under supervision. Whereas, now you have your own patients but you are not really supervised. I usually had the ones who are self-caring as a student, and then I would do some pills, which was all supervised. But now its, ‘these [patients] are the bed bound ones that no-one wants, so you have them!’_ (James)

_It was a shock to be working as an RN, instead of always just tagging along with the RN_ (Liam)

The participants were concerned with managing the workload allocation and workload responsibilities that had been placed on them as soon as they commenced employment. Also, Sally and James felt that there was no difference between their workload and the workload of more experienced staff upon commencement of their program.

_I thought what have I done? After 3 days of orientation you sort of get left to your own devices. I was thrown in at the deep end_ (Sally)
They don’t see you as a new grad here. They see you as having RN next to your name, you can have the full patient load, don’t talk to me unless you have a problem (James)

James felt strongly that the workload allocations were unfair and reflected hostile attitudes by more senior staff to university graduates. This participant felt that being able to cope with the workload was a test that would confirm his acceptance into nursing and that having an easier workload was a reward for hard work, and not a support measure for new graduates as illustrated by the following comment

A lot of the senior ones that are hospital trained—they don’t like new grads or the newer trained, because they reckon you have to learn, like into the deep end first. As they had learned. That’s probably why they give you the worst patients because they did it twenty years ago. They got the hard ones then they worked their way up to having the good ones [patients] (James)

This comment reflects findings from Mosel Williams (2000) who asserted that competence is often perceived by an ability to cope with the workload rather than the application of knowledge and skills in practice and that there were barriers to effective transition such as tests to prove the graduates capable of the workload. For example, tests such as being able to cope when understaffed and conforming to workplace practices.

It would appear from the responses that the participants expected to be given more support allowing them time to settle in, adjust to the role change and become familiar with the workplace environment, before being given a full workload responsibility.

A full patient load in rural agencies can mean that one Registered Nurse and one Enrolled Nurse work together and between them they are expected to care for some twenty patients. The participants who had experienced this level of staffing explained that the workload was divided so that the Registered Nurse was responsible for the management of the ward, the dispensing of medications
and management of intravenous therapies, and was responsible for monitoring the care the Enrolled Nurse delivered. The participants of this study found this to be extremely stressful and overwhelming during the first stage of their journey, because they were not exposed to this type of workload and ward management during their undergraduate education. Anne illustrates this dilemma with her account of her experience in a medical ward.

I had two days orientation and then they said 'right this is you' and I had 14 patients to look after and I nearly died. I was shocked. I had to walk up and down for ten minutes trying to get my head around it. I think fourteen patients for a new grad without any other RNs around is too much (Anne)

Anne stated that she had tried on numerous occasions to address this situation but was not given the extra support that she had asked for. She felt strongly that it was unsafe practice for her and new graduates to be expected to manage this volume of workload without support. She also commented that she felt it was setting up new graduates to fail.

I asked for help and they gave me another EN. I said this is not what I need. I need another RN to break up the medication load and the RN specific skills such as managing the IV therapies and blood transfusions (Anne)

For the participants in this study the experience of entering the workforce was generally similar to the findings of previous studies. For example, Green (1988), Dufault (1990), and Madjar (1997) have identified the transition process, from that of a student nurse to a practising registered nurse to be an extremely stressful experience, especially within the first three months of entering the nursing workforce. However as chapter two discussed, staff mix and staff reductions have meant that new graduates are expected to be accountable, responsible and competent as quickly as possible upon entering the workforce. Studies by Reddick (1998), Mosel Williams (2000), De Bellis et al. (2001), have found that the competence of new graduates is generally measured by an ability to cope with the workload, rather than an application of knowledge. Also new graduates are expected to function as registered nurses with a full
patient load within a very short space of time. These studies also suggest that it is not the educational preparation of new graduates that is inadequate but rather the service industry and more experienced colleagues who place unrealistic expectations on the beginning registered nurse as they enter the workforce. Furthermore, new graduates experience difficulty with the workload and time management because they are beginning registered nurses who are inexperienced with the workload and the level of responsibility.

4.4.5. Summary

This expectation of having to hit the decks running by the health service industry proved to be very much the case for the cohort of new graduate nurses in this study, who entered rural practice with expectations of being eased into the rural workforce.

However the restructuring and relocation of health services out of rural towns to regional centres has resulted in reduced staff ratios and skill mixes that do not provide a supportive or nurturing environment for new graduates, thus the new graduates of this study found that there is a culture of having to get the work done. Additionally, the staffing ratios and skill mixes within rural health care facilities resulted in the new graduate often having to work beyond their level of experience and education immediately upon entering rural nursing practice. They were expected and needed to become very quickly, productive members of the rural nursing team. The new graduates of this study were concerned to find that they were expected to perform as experienced registered nurses and carry the workload and responsibilities of more experienced rural registered nurses upon their initial entry to the rural nursing workforce.

4.4.6. Sub theme 3: Level of responsibility in rural practice settings

From the conversations regarding what it had been like for the new graduates so far, the researcher identified that the level of responsibility and the role that the new graduates were expected to fulfil was also a significant issue influencing the second stage of their journey.

In chapter two literature from Amos (2001) identified the level of responsibility as being one of the main issues that still causes new graduates extreme stress.
and nervousness in their graduate year. However, there are differences in the level and type of responsibilities that new graduates in rural practice settings will be expected to assume upon entering the rural nursing workforce, especially when compared to their peers in metropolitan and large regional practice settings.

As mentioned in the previous theme the size of the health care agency, the services it provides and the staffing ratios present in that agency influenced not only the workload expectations but also the level of responsibility and an extended role that the new graduates were expected to undertake. The interviews identified inconsistencies throughout rural health care agencies concerning the level of responsibility that the new graduate was expected to assume, and the level of performance and the role they were expected to function within.

For example, the downsizing and rationalisation of rural health services specifically within NSW to larger regional centres means that the individual wards within rural health care facilities may accommodate a mix of patients. That is, there may be paediatric, maternity and medical patients accommodated in one area. Alternatively, one ward may be allocated for long stay medical, psychiatric and geriatric patients, and one ward for acute patients that may also involve accommodating different mixes of patients. Also it is not uncommon in rural health care agencies for Accident and Emergency areas to be left unattended until a patient arrives. This means that the registered nurse working at that time not only manages a patient load and coordinates the activities of the enrolled nurses, but also attends to patients when they arrive in this area.

The new graduate nurses in this study who were in the smaller rural agencies, were expected to assume extra responsibilities often with very limited supervision or guidance. The new graduates were almost immediately placed in charge of whole wards and were also expected to attend the Accident and Emergency area should the need arise during the course of their shift and, as beginning registered nurses, they had not been prepared to fulfil these roles that are generally required of more experienced registered nurses.
Having to take on these extra nursing roles and the extra responsibilities associated with rural nursing, with very little support or guidance, was a frequent occurrence for several of the new graduates. This was a cause for concern to the graduates who found it stressful and also experienced self doubt and loss of confidence regarding their practice ability, especially since it was expected that they would be able to assume these extended roles and extra responsibilities immediately upon entering the rural nursing workforce. The following comments illustrate the graduates concern and experience with respect to this issue.

"Being able to sign everything and being able to take full responsibility. You just got pretty much booted into the job. It was like go for it because we were so busy. I was like, 'oh ok' (Emma)"

"I was usually one of two RNs with two to three ENs. I was in charge of twelve patients! I’m like ‘What the hell am I doing. Are these people going to survive? Am I doing the right thing?’ Some days I didn’t want to go back (Hannah)"

"When I first started, there was the aged care unit and the registered nurse was in charge of the aged care unit, so you are in charge straight away. It has its certain level of responsibility which you are not trained to fulfil. Yet that’s what your responsibility is! (Sally)"

"I was the only RN for the Emergency and Surgical Ward and I usually had one enrolled nurse. I was a postgrad, I had every key to the hospital in my pockets and at lunch, my lunch break would be, I’d go outside under the tank stand and smoke. I’d have every key to the hospital. The ambulance would come and I would have to leave because there would be no one else to collect the ambulance (Hannah)"

The new graduates felt that the level of responsibility that they were expected to fulfil was beyond their level of competence, knowledge and experience of this beginning stage of their nursing careers. The participants who had this experience felt strongly that they were not at all prepared for either working
independently or being in charge of these areas. Most of them had very limited exposure to emergency nursing in their undergraduate preparation and lacked experience with ward management and responsibilities of being in charge. The new graduates were very much aware, from their undergraduate preparation, of the Australian Nursing Council Incorporated Competency Standards (ANCI 2000) required for beginning registered nurses', and that they must practice within the boundaries of their knowledge and skill acquisition. Yet in the smaller rural agencies staffing practices and staff expectations necessitated the beginning registered nurse to frequently overstep those boundaries. They expressed concern that the management and staff of these agencies simply expected that because they were now a Registered Nurse they should be able to assume all levels of responsibility very early in their graduate nurse year. The following comment from Sally highlights how she believed she was expected to perform at levels similar to more experienced staff.

*Because of the environment [rural environments] you are put into a setting where you don't have any experience such as the Emergency Department. You might have only minimal exposure to that through your course. It [working in emergency] requires certain levels of further training to qualify for that area. You know the intolerance of other staff members. You know you're a registered nurse therefore you perform at registered nurse level (Sally)*

It has been acknowledged in chapter two that the services offered by rural health care agencies and the staffing ratios and skill mixes available in rural health care agencies often result in rural nurses having a multi-dimensional role that requires a broad range of skill (Hegney 1996). Rural nurses, as Hegney (1996) points out, are often the primary care giver and *jack of all trades* in rural practice settings. This necessitates rural nurses having to work beyond legal boundaries. For the new graduates who had experienced this level of responsibility, it was obvious that the experience had been confusing and overwhelming for them. This was made even more stressful because they were also trying to come to terms with the ward culture and its associated dynamics, their change in role, and their time management skills.
However, for the new graduates who were employed in larger rural health care agencies their experiences of being a beginning registered nurse were somewhat different and easier. This was because the expectations of workload capacity differed from agency to agency due to the services offered by that agency. Subsequently nursing ratios and staff skill mix present in these larger rural health care agencies were much better and allowed for the provision of a supportive nurturing environment to ease the new graduate into the nursing workforce. These new graduates were not expected to assume the level of responsibility as did their peers in smaller health care agencies. They were, to some extent, eased into assuming more responsibility as they progressed in their graduate nurse year, with the results that these new graduates felt more comfortable and confident in their working environment and their role as a beginning registered nurse. This is illustrated by the following quotations.

*It has been really good. I started out the first week as supernumerary, and after that I was working as the RN on the ward. So I basically just learnt from experience* (Liam)

*It's been good. They have slotted us in really well; we are incredibly short staffed here as everywhere is. But I think I stopped being a new grad after about four months. It took about four months before I was in a position where there really was no choice so I was it. Time management is something that you sort of have to learn and even as a student you can't really be in-charge of a full load. But then from day one you are more or less expected to be* (Joey)

Other new graduates described their journey as a steep learning curve and their experience so far was discussed in terms of their learning during this time.

*I had a stage where I thought I am not learning anything new, but then I realised I am learning all the time. Just because I am not learning new tasks or skills doesn’t mean that you are not learning* (Becky)
It was good for your learning because you know that you can do it yourself and it boosts your self-confidence. Being able to say 'Oh yeah I know what I am doing'. It's that breaking away part from always having people by my side. It's a bit of a shock but good in a lot of ways (Emma)

I have learnt a lot. It has been a confusing time. A challenge, a good challenge (Gaye)

As mentioned at the beginning of this theme, there were inconsistencies throughout rural health care agencies with respect to the level of responsibility that the new graduate was expected to assume, the level of performance expected of new graduates and the role that they were expected to function within. For example, some wards immediately rostered the new graduates at an Enrolled Nurse level. The aim of this, according to the graduates, was to ease them into the workload and to assist the graduate to develop their time management and prioritising skills. However, although this aimed to ease workload responsibilities for the new graduate, it also added confusion and an element of conflict for some of the new graduates, as they were unsure of what their role really was and what was expected of them. This element of confusion was further compounded since this was not a consistent occurrence and only occurred in some wards of some health care agencies where staff ratios and skill mix necessitated this type of rostering and staffing. For example, Sally illustrates this with the following quote.

The other area that you are exposed to is an acute ward. Because there is another RN, that RN is in charge of the hospital. So you basically do no less than any other enrolled nurse. In fact, most shifts you do less than the enrolled nurse. You have patient allocation [in this acute area] but you are not responsible for anything but toileting and showering and that’s it! (Sally)

For Sally, this was an especially confusing time. In one ward of the hospital she was expected to be in charge and fulfil RN duties, yet on another ward she was expected to function at the EN level and she had to ‘take on an extra load if you
want to do RN specific duties'. Sally describes what happened when she tried to initiate taking on more specific RN duties and consequently more responsibility.

I was called into the office. I was informed that I was not pulling my load. So I felt rather agitated and I wanted to know specific areas, issues that they felt I was not fulfilling. They couldn't comply with that. I addressed the RNs. If they were concerned that I wasn't pulling my load I wanted them to let me know. One of them said, 'perhaps it's your time management' and I thought, 'ok time management in what capacity? In what role? What specific role are you referring to? Is it my registered nursing role or is it my general duties role?' (Sally)

Sally has experienced what is known as role ambiguity. As mentioned in chapter two role ambiguity presents for the new graduate when the role is unclear, vague and ill-defined and there is a lack of clarity as to the role expectations that other staff have of the role. Adding to this is role incongruity, as in one area of the hospital she was expected to function at the level of more experienced colleagues, and be in charge, yet in the other ward she was not expected to do any more than that of an Enrolled Nurse.

Anne illustrates how the individual idiosyncrasies of the ward where she spent a lot of time during her first few months made her feel confused and concerned regarding her expected role as a new graduate. Anne believed that she experienced role ambiguity and role conflict because she was being treated differently from another beginning registered nurse who was not part of a graduate nurse program.

There was this big thing on the medical ward that ENs don't sign medications with the new grad RNs. And I just cleared that up. I said to the RN in charge, who I thought was really uncooperative 'oh well if that is your rule then it is not very good for this person [casual RN] and I to sign and check each others medications because we went to uni together. They are a new grad too!' And she said [In charge RN] 'they are employed as an RN, you are a grad (Anne)
The role ambiguity and role conflict that these two new graduates experienced are elements of role stress or role strain, which were discussed in chapter two. They occur when an organisation puts very difficult, conflicting or impossible demands on individuals. To some extent role stress and role strain are to be expected with the transition to professional practice as they are elements of role transition that manifest in a role transition within any social organisation (Hardy & Conway 1978). Role stress is prevalent in nursing because of the multiple sub-roles within the professional nursing role, the organisation and delivery of health care and prevailing economic conditions which impact on the nurse's role.

However, these incidents experienced by Sally and Anne are also associated with the enculturation process that new graduates are exposed to by more experienced clinicians that was also discussed in chapter two. Mosel Williams (2000), in her study of new graduates in rural practice, described barriers that existed for new graduates. Barriers were put in place by clinicians that related to concepts of controlling and restraining new graduates. The study found that control was exerted by more experienced clinicians through behaviours such as 'not referring to graduates as registered nurses', and 'a reluctance to acknowledge an increasing competence of graduates'. Also 'a reluctance to share responsibility', and 'discouraging critical thinking' were behaviours used in restraining new graduates. Mosel Williams (2000:103) provides an analogy of this behaviour as having a genie in a bottle where one never knows if the genie is good or bad. The genie must be let out cautiously and with great care. So too the new graduate must be accepted and acknowledged with great care.

4.4.7. Summary

In summary, this second sub theme highlights the concerns the new graduates had for the volume of workload, the level of responsibility and the roles they were expected to assume, almost immediately upon entry to the rural nursing workforce. It is clear from these findings that during this second stage of their journey, the new graduates felt overwhelmed and out of their depth with the workload allocation and the consequent level of responsibility they were expected to cope with upon initial entry to rural practice.
The researcher found that there were inconsistencies across rural health care agencies as to the expected and actual level of responsibilities that the new graduates were given. It appears that the larger rural agencies had the staff and resources to provide a nurturing environment that resulted in a mediated entry into the workforce, which eased the role transition to some extent for the new graduates.

It appeared from the data that socialisation into the rural nursing workforce had occurred quickly for most of the participants. The workload and workforce issues that strongly impact on rural health services had forced the new graduates to either cope with the expected workload and level of responsibility or leave rural practice. Leaving rural practice was not an option available to most of the participants in this study because of their ties to the rural area because of partners, families or financial commitments.

However after the initial reality shock that formed the beginning of their journey into the rural nursing workforce, the participants described what could be called a settling in period. The timing of this period appeared to the researcher to have occurred around and after the fourth month but was dependent on the nature of the ward culture and the amount of support the new graduate received. It was a period marked by the new graduate feeling that they were coming to grips with the workload expectations, the level of responsibility that was placed upon them, and also when they felt their time management skills were improving. As a result the new graduates began to feel more comfortable and confident in their practice, with their professional status and also with the culture of the ward environment. They felt that they were becoming accepted and recognised as useful members of the nursing team.

4.5. Theme 3

4.5.1. Stage 3: 'Expectations of rural graduate nurse programs'

The final stage of this journey of transition is presented in this third theme as a time where the new graduate was able to reflect on where they had been on their journey and what aspects of their journey they would have liked to change. This stage also reflects a period in the conversations when the
The researcher was using prompts to guide the conversations so that the participants could address the research questions that had not been covered during the initial conversations regarding what the transition experience had been like thus far. For example, the researcher specifically wanted to address the following research questions:

What were the new graduate’s perceptions of their educational preparedness for rural practice?

What was the level and type of support and how effective did the new graduates perceive that support to be?

Did the new graduate have any regrets about their decision to enter rural practice and if so why?

4.5.2. Sub theme 1: Preparedness for rural practice

The findings in this first sub theme result from the researcher asking each participant if they felt they had been well prepared during their undergraduate education for beginning registered nursing practice, and specifically if they felt they had been well prepared for rural nursing practice.

Reflection on the conversations regarding this question the researcher noticed that participants in their responses, placed emphasis on three main aspects of undergraduate education. First, all initially addressed this question with respect to their technical skill preparation. Second, the respondents talked about the length and quality of their undergraduate clinical placements in preparing them for registered nursing practice and then specifically for rural nursing practice. Third, the respondents discussed their perceived lack of clinical knowledge resulting from their educational preparation.

Generally, most participants stated that they felt they were well prepared for practice as a beginning registered nurse. Specifically all of the new graduates initially stated that they felt they had very good technical and procedural skills for a beginning registered nurse.
All of the participants acknowledged that they lacked skills in time and ward management and clinical decision-making, considering the workload and level of responsibility that they were given upon their initial entry into the rural nursing workforce. The participants attributed their lack of skills in time and ward management to their lack of experience. As well they felt that the amount, quality and nature of their individual clinical placements and their individual ability to benefit from their undergraduate clinical placements had influenced their preparation for registered nursing practice.

Several participants from regional universities stated that they felt that the amount and nature of their clinical placement had prepared them well for rural practice. These participants felt that they had experienced quite a lot of rural nursing placements and this had prepared them for the type of nursing work involved in rural practice.

The participants acknowledged that during clinical placements they had not experienced the level of responsibility and the volume of workload that they had experienced as a beginning registered nurse in rural practice. They felt strongly that as a beginning practitioner they should not be expected to assume the responsibilities and carry the workload of their more experienced peers. Hannah’s comments generally reflect those of other participants who completed their undergraduate preparation at regional universities.

I did quite a few rural pracs, I knew it wasn’t going to be easy, but I don’t think anyone can prepare you for what you are going to get when you walk out that door [university]. But I think it did prepare us as well as it could (Hannah)

Other participants, for example Gaye, Becky, Mandy and Liam, all felt that their knowledge base was lacking in the areas of clinical decision-making and that they lacked knowledge of disease processes that affected their clinical decision making skills. These participants acknowledged that they had deficits in some areas. They felt that because of the diversity of rural nursing, as well as the staffing and skill mixes present in rural agencies they would have liked to have had an opportunity to develop some skills in these areas prior to commencing
rural employment. They attributed these perceived deficits to different models of learning and clinical placement that were operational in their educational institutions during their undergraduate preparation. For example, two of the participants complained that they were required to be self-directed in the majority of their theoretical preparation. Becky illustrates by her comments how the model of theoretical preparation within the tertiary institution did not adequately prepare her for caring for paediatric patients that were part of the patient mix of the medical ward within the health facility where she was employed.

*We didn't really cover paediatrics, we were told the difference in drip rates and things like that, but I don't remember a lot because we worked on problem based learning and you don't cover them thoroughly enough because you don't know how far you should be going with it* (Becky)

Mandy also felt that self-directed learning was not beneficial for her learning or for preparing her for rural nursing practice. She, like Becky, did not really know what it was she needed to know for beginning rural nursing practice or indeed registered nursing practice. Becky initially felt that her undergraduate clinical preparation was very good because she was given a lot of exposure to paediatrics, operating room, and community-based placements. However, Becky realised upon commencement in her first medical ward rotation that she had only experienced adult ward nursing once as a first year student nurse and feels that more ward nursing experience would have prepared her better for the workload that she was now experiencing.

Gaye, having had previous experience as an enrolled nurse, felt very strongly that she had not been clinically well prepared for registered nursing practice. She felt that her undergraduate preparation was unbalanced because she felt it focused too much on academic preparation and not enough on clinical preparation. She stated that her clinical placements did not prepare her for registered nursing practice, let alone rural practice. All of her clinical placements were in metropolitan agencies and she felt that the quality of her clinical placements was poor.
Not all but most of them were spent just doing showers and things, nothing like being and RN or working as a RN. In many things we were well prepared but I think they (university) lost sight of other things that are more important (Gaye)

Liam felt that he was academically well prepared, however he regretted his choice of electives. He stated that he wished he had chosen Aboriginal Health as an elective, given the indigenous population present in the rural town where he was employed. Also, given the medication load at the rural agency, he regretted not having taken the pharmacology elective in his undergraduate preparation. Also Liam felt that the clinical practice component did not adequately prepare him for registered nursing practice.

It wasn’t that great because we didn’t do a lot, not enough clinical pracs (Liam)

These four participants felt that their undergraduate programs had not adequately prepared them for registered nursing practice or rural nursing practice. They had had very little exposure to rural nursing and so did not know what was required and what was involved in the registered nurses role in beginning rural practice.

There is much debate surrounding the educational preparation of nursing graduates and there is still much criticism directed toward tertiary institutions for failure to adequately prepare nursing students with the clinical skills required to cope with the day to day of practice nursing. There is also debate as to whether undergraduate programs can adequately prepare students for the broad scope of rural nursing practice. Failure of some tertiary universities to provide adequate clinical experiences has been noted in the literature by authors such as Pigott (2001) and Kluge (2001) and there are strong recommendations regarding the quality, extent and duration of undergraduate clinical experience that need to be addressed by tertiary institutions.
However several studies have suggested that the difficulties encountered in the transition arise from the unrealistic work expectations, and the unsupportive environment and culture in which the new graduate is employed (Reddick 1998; Mosel Williams 2000; De Bellis et al. 2001; Thomka 2001) rather than inadequate undergraduate preparation. They argue that tertiary institutions cannot teach years of experience, and that undergraduate preparation aims to develop practitioners who are able to practice across a wide variety of clinical settings at a beginning level. The researcher also supports this view that tertiary institutions cannot teach years of experience.

4.5.3. Summary

In summary, participants in this study felt well prepared with technical skills required for registered nursing practice, however were able to identify areas of undergraduate education that could have better prepared them for rural practice. The researcher believes that the downsizing and restructuring of rural health services has resulted in staff reductions and skill mixes within rural agencies that does not recognise the new graduate as a beginning registered nurse and thus new graduates of this study were unprepared for the workload responsibilities that were expected of them in rural practice.

4.5.4. Sub Theme 2: Expectations and unmet promises of rural graduate nurse programs

This sub theme results from participants' conversations that centred on the new graduates' perception of the level, type and effectiveness of the support that they received during their journey of transition. Also, during these conversations the participants were asked to address any regrets that they may have had with their choice to undertake a rural graduate placement.

Previous themes in this study have already addressed and identified the influences on the nature and type of support that the new graduates sought or received in rural practice settings. The influence of more senior registered nurses on the ward culture, and the workload and staffing problems present in some agencies were talked about by the participants as influencing their request for and the offer of support they received. However, the participants also made comments that expressed disappointment regarding the content, structure,
rotations and support offered by more the formal structured support mechanisms, such as the Graduate Nurse Programs (GNP).

All the new graduate participants in this study felt that their experience in rural health care facilities, as beginning registered nurses, had provided them with a broad range of experiences as well as a broad skill base. They stated that they enjoyed the diversity of rural nursing practice, and generally, in hindsight, the participants did not have any regrets with their choice of entering rural nursing practice. As previously mentioned, quite a few of these participants were keen to stay on in rural nursing practice upon completion of their graduate nurse programs.

When reviewing the transcripts the researcher noted that the participants initially had stated that they had no expectations of the graduate nurse programs and the type of support that they would need or would receive during their initial entry into the nursing workforce. However, on reflection the new graduates in this study expressed their dissatisfaction and disappointment with several aspects of the new graduate programs. For example, they felt that the health care facilities had not delivered what was stated would be delivered in advertisements and at formal orientation sessions in larger regional agencies, regarding the graduate nurse programs on offer within these rural facilities. There were a number of inconsistencies that the participants identified.

The ward rotations that were offered initially did not eventuate for most of the participants. There was also a lack of formal support during their programs in that there was no mentoring or preceptorship support system in place to support the new graduate nurse, as was alluded to by the employing facility. Nor was there a specific support person to whom they could refer and who could spend time with them. The graduates had also never been given any formal or informal feedback regarding their clinical performance, so were unsure if they were meeting performance expectations.

Most of the new graduates in this study had to travel to larger regional agencies at the commencement of their graduate nurse program for orientation. The orientation usually involved an introduction to the Area Health Service, its
specific policies and procedures as well as an overview of what the new graduate nurse program for that particular Area Health Service entailed. It was at this point that the new graduates began to identify discrepancies in the information they had been given. The new graduates who returned to the smaller rural agencies found that upon commencing employment at their rural agencies their program did not progress as it was stated it would at the area level, and in fact that was the only orientation they received. For example, Anne, Sally and Hannah felt that they had been misinformed by the health services regarding the content of the graduate nurse programs that were offered.

Orientation at the Base was totally removed from what you’re expected to adhere to once you arrive in your rural setting. I found that what applied in the larger hospital did not really apply here. In actual fact there is not a specific program here with specific guidelines for a grad nurse. I had been told I would be doing a theatre rotation. It seems to be really dated information, perhaps there were theatre days but obviously they have been culled down (Sally)

They said, ‘you will go back and have another orientation day and you will be given a mentor or a preceptor’. It didn’t happen. I just turned up on shift and was one of two RNs and I thought, ‘ok this is good!’(Hannah)

What it is and what we were told almost amounts to two different things. It was glorified with any inquiries (Anne)

Sally felt that she was mislead with respect to the types of clinical services available at the health agency. Not being from the rural area in which she was employed and not having previous undergraduate clinical experience within the rural agency, she relied on information from the Area Health Service regarding the size and services offered by the particular rural health care facility when choosing to accept the graduate nurse position. She was disappointed to find that there were in fact only two rotations offered; the acute area or the long-term area, and was also disappointed to discover that the
hospital actually did not do surgery at all except the occasional minor day surgery cases.

Becky and James also felt misinformed about the size and services offered by their rural agencies. They had also not had previous undergraduate clinical experience at these agencies. However they acknowledged that they had made assumptions about the services and the size of the agencies.

_This hospital is smaller than I thought. I thought it would have been a bigger hospital for the area_ (James)

*I am disappointed with the surgery. They only do minor cases. I don’t know why but I thought they would cover all kinds of theatre even though _it is a small hospital_ (Becky)*

Although these three graduates had chosen to participate in the graduate nurse programs within these agencies they all acknowledge that if they had undertaken clinical experience in these agencies as an undergraduate they probably would not have accepted these rural positions. They all felt that having surgical experience was important for them during their graduate year and had they known, they perhaps would have pursued an agency that provided more surgical experience.

However several of the other participants in this study were also disappointed with the rotations that they were allowed to complete within rural agencies. Five of the participants from the larger rural agencies believed that upon completion of the medical and surgical rotations they would be given an _elective_ where they could choose a term in an area of high dependency. Most participants were excited at the prospect of a term in Intensive Care, Accident and Emergency or Operating Room. They stated they had accepted their graduate nurse positions based upon their undergraduate clinical experience in these agencies and a belief from the agency information that they would be given exposure in these areas towards the end of their graduate nurse program. However, staffing issues and financial constraints within these rural agencies resulted in the high dependency rotations being cancelled, which was a great
disappointment to the participants. For some this was their only regret about their choice for rural graduate nurse positions.

Only three participants from this study actually received a rotation in an elective area. The remaining seven stayed in either medical or surgical areas for the duration of the graduate year. James was so disappointed with the lack of choice of clinical rotations within his graduate nurse program and with the agency's inflexibility with specialty rotations that he had decided to exit his graduate program. James had initially been informed of elective rotations available but upon commencement was not given any choice regarding which rotation he undertook. Consequently, at the time of interview, James had already submitted his resignation from his position and had accepted a position at a larger regional health care facility that had been able to guarantee his desired specialty rotation.

The disappointment by participants in this study with their clinical rotations during their graduate program is not surprising and their choice for clinical rotations support the findings of Heslop et al. (2001) who identified the most common choices for clinical rotations for the graduate year are Surgical, Paediatrics, Emergency, Medical, Critical and Coronary Care. There was little interest by participants of the Heslop et al. (2001) study for aged care, community, oncology and palliative care and this is consistent with findings from this cohort of graduate nurses in rural practice who were also disappointed that there was very little surgery done in rural health care facilities resulting in mostly medical aged care clinical experience.

Another aspect of the graduate nurse programs that did not eventuate for this group of beginning registered nurses were the formal support structure that they were told would be in place for them upon commencement of their employment. When specifically questioned about what they expected the level of support would be all participants stated that at first they had no expectations of support. They stated that they generally had been given 'good' support from colleagues and peers when they requested it, however as the conversations progressed the participants all identified a lack of formal structured support within these rural agencies. Emma's comment illustrates this point.
The graduates were also disappointed and confused with the role and support offered by nurse educators within these rural agencies. The participants believed and expected that nurse educators would be available specifically for them. They expected that educators would provide a formal support role, as well as a monitoring role of the graduates performance and progress. However, because of the diversity of the nurse educator's role in rural facilities, the nurse educators were not always available to the new graduates. They were often busy with other professional roles that they assume. The graduates were able to acknowledge this and felt that the little support they received from educators was good support, given the workload they had to carry. However, for most graduates the only exposure they had to nurse educators or a formal support person was at the orientation day. Thereafter the new graduate nurse was expected to seek out support if they needed it. The following comments illustrate the difficulties with the provision of formal support.

We had an education coordinator who was just a phone call away, but other than that our support was the Nursing Unit Managers. But I thought there would have been a higher level of support here. Someone to get us together to debrief. We only got 3 student days a year because of budget cuts. I really thought there would be someone to come around at least check on me and make sure everything is ok (Becky)

They said I could go and see the educator if there was a problem. Which I did, but I think that she could have come and seen us, especially in the first few weeks at least once a week (Mandy)

'The educators were only a phone call away' was a common response from these participants when commenting on formal support structures. However the new graduates expressed a desire to have a specific support person for them who was available to occasionally work with them, chat with them, check up on them, and provide frequent education and feedback on their progress. That is, they expected to have someone continuously and consistently coordinating and
maintaining the graduate nurse program, someone who was frequently accessible to them without the graduate having to seek them out when they had a problem. The participants also had expectations of formal education events that would be provided for them and that they would be expected to attend.

All of the participants stated that they were aware of education days, but very few, towards the end of their programs, had continued attending them. Education sessions appear to have met the expectations of the participants, however most cited difficulties getting off work, not being given enough notice, as well as not being motivated to travel to other agencies, as barriers to attending education days. The participants' comments indicated that they found the education days interesting and informative and a chance to catch up with other graduates. The participants indicated that the most valuable education sessions were those specifically targeted at enhancing and consolidating clinical skills and applying knowledge to practice. For example, education sessions on interpretation of Electrocardiograph and pathology results were considered by the participants to be the most useful.

Several participants from the smaller rural health care facilities where Accident and Emergency departments were attached to general wards suggested that a First Line Emergency Care (FLEC) course needs to be incorporated specifically into rural Graduate Nurse Programs. This suggestion came from participants who were often required to work in Accident and Emergency areas and who had very few skills in this area. Other common suggestions for education sessions that the participants thought would be useful for incorporating into rural Graduate Nurse Programs were conflict resolution and ward management strategies.

Of particular concern for these participants, was information given during their orientation and, when applying for the graduate nurse position, which led participants to expect that the graduate program, would involve a preceptor or a mentoring arrangement. Only one participant could actually comment on what it was like having a preceptor. All other participants said that they did not have specific support person-preceptor for them during the year as they were
told they would during their orientation. The following comments illustrate this.

The policies and procedures they outlined at the regional agency were the same when I got here. But also they said you will have a mentor or a preceptor. It just didn’t happen. The educator said ‘oh! Didn’t they put you with anyone? Well, I told them too! You were meant to have a preceptor’. Well I didn’t get one. So she tried to line something up and there was one nurse who said, ‘well I can answer any questions but we don’t have enough staff for me to work with her all the time’. So it just turned out that the person I was working with was told that I was going to ask a lot of questions! (Hannah)

They said I was going to have a mentor all the time. For the first 6 months I was alone. I think because I was an EN they thought I knew what I was doing (Gaye)

When I arrived here that person was not even aware that they were to be my preceptor. Really, it was not possible here because of the environment. I was basing the information on what I had received at the regional hospital (Sally)

Well I didn’t find anyone volunteering information. They promoted the hospital very well and made it sound like it was really good place to go that there was heaps of support which is not necessarily the case. It is there if you look for it but it is not volunteered (Anne)

From these responses it is clear that the expectations the new graduates had of the formal support that would be offered to them was very different to what actually happened in the workplace. Staffing and rostering issues meant that there was no preceptor and the new graduate just had to manage as best they could. The new graduate had to seek support and guidance from more experienced colleagues when and if problems arose.
The final issue regarding the un-met expectations of the Graduate Nurse Programs for this cohort of new graduate nurses was that most were told that after each rotation or at six monthly intervals their progress would be formally evaluated. Only two of the ten participants could remember ever being given any formal feedback and very few of the remaining participants were given any informal feedback, regarding their progress in the graduate nurse graduate program. Generally, the new graduates did not know how other staff perceived their progress or what criteria were used to judge their performance. However, for the participants of this study, interactions by the more experienced clinicians served to confirm to the new graduate whether they were performing at the level expected by the more experienced clinicians. For example, being observed to be coping with the workload, being asked to relieve in another area and the number of in charge shifts they were given were factors which confirmed acceptance of the new graduate into the team and thus validated for the new graduate that they were performing satisfactorily. The following quotes illustrate how new graduates knew they were performing satisfactorily.

Yes we had a sort of peer review but I have had no feedback. I have not seen them since I put it in. But I just sort of know I am doing well because I am getting all these in charge shifts (Liam)

I was requested to go down to casualty for a few weeks and staff commented on me being moved down there when there was other staff that they felt were also capable of being moved. The NUM of CAS said she specifically wanted me because I was capable of doing the job (Joey)

Every 6 months they said they were going to evaluate me but we have just been to busy and I just think I am going ok because I have had no problems. If I ask the RNs they are happy to tell me (Gaye)

We had to be assessed on IV protocol and I have had the same review that everyone gets annually but I believe that towards the end we may get an evaluation. But I have just presumed I was going ok because no one has said anything. You know you hear the gossip about people being sent to the office for a little talk and that has never happened to me (Becky)
The new graduates in this study were surprised and somewhat disappointed that evaluations of their performance were not initiated by the health agencies and that more experienced clinicians did not think to provide constructive informal feedback to them.

The use of structured support systems to provide professional role modelling, assist with professional socialisation and to provide a mediated entry into the nursing workforce has been advocated by many studies (Clayton, Broome & Ellis 1989; Nayak 1990; Moorehouse 1992; Jasper 1996; De Bellis et al. 2001; Heslop et al. 2001). However there has been very little research into the effectiveness of the graduate nurse program from the new graduates’ perspective. As discussed in chapter two, De Bellis et al. (2001) found similar criticisms of graduate nurse programs to what the participants of this study have described. They refer to a ‘Clayton’s Preceptorship’, where issues such as, rostering, attitudes and skill mixes, as well as a lack of understanding by the health services of the needs of new graduate nurses’ meant that the objectives and expectations of the Graduate Nurse Program were not being realised. New graduates in their study identified a lack of confidence and powerlessness, which was largely influenced by the lack of support they received. De Bellis et al. (2001) found that graduates at the end of a formal Graduate Nurse Program believed they would be at the same level of development with or without it. The findings of this study are similar as the majority of participants believed that they had successfully managed their journey of transition without structured formal support.

4.5.5. Summary

In conclusion, this final sub theme identifies the inadequacy and failure of some rural graduate nurse programs to meet the expectations of support that the new graduates of this study expected and were told they would receive. For this group of beginning registered nurses their biggest disappointment was the failure of the health service to deliver what was initially offered through the GNP with respect to support and clinical rotations. There was a lack of appropriate, effective and individualised support. The graduates felt that there was no one specific support person to look out for or speak up for them, or to maintain and monitor their Graduate Nurse Program.
4.6. Conclusion

In this chapter the data has been analysed and the findings grouped under three themes representing stages of the journey of transition, that emerged from reading and rereading the narratives. In describing these themes the researcher has attempted to capture the experience of role transition into rural nursing practice from the perspective of new graduate nurses making the role transition. The first theme ‘Having rural connections’ represents the first stage of the journey of transition and identifies the reasons behind the new graduates preference for a rural graduate nurse program. Participants identified a previous connection with rural area and the commitment of partners, spouses and family to the rural area as significant influences for their choice of a rural graduate nurse program. Additionally, previous clinical experience in the rural health facility was a contributing factor that also influenced their decision to go rural. It was also found that participants were keen to stay on in the rural area once the graduate nurse program was completed, despite no guarantee of a permanent position being available for them.

The second theme that emerged represents stage two of the journey of transition, where the new graduates were describing what the role transition had been like for them. During this time the participants described several factors that they perceived were impacting simultaneously on their socialisation into the rural nursing workforce. The ward culture and the aggressive and unprofessional behaviours of senior staff emerged from the data as significant in shaping the new graduates’ experience of transition into rural practice settings, which the new graduates confirmed affected the level of support they received and from whom the new graduate sought support. However, from the data emerged a unique aspect or an extra element that the new graduates found difficult to accept and adjust to during their initial socialisation in rural practice settings. The problems associated with working in a close knit social cliques, as well as the role diffuseness and lack of anonymity within rural nursing were problematic for this group of new graduate nurses and added additional stress to the role transition.

The size of the rural agencies, the staffing ratios and skill mixes present, which are the result of downsizing and rationalisation of health services out of rural
agencies to larger regional centres, impacted on the expectations of the workload the new graduates were expected to carry within rural health care facilities. The participants perceived that there was no recognition from the health care facilities and some staff as to their beginning registered nursing status. The culture of having to get the work done resulted in the new graduate nurse having to fulfil the workload of more experienced staff immediately upon their initial entry into the rural nursing work force. Also in this second theme, there emerged inconsistencies between rural health care facilities with regard to the level of responsibility that the new graduates were expected to assume. In some facilities the graduate nurses were expected to work beyond their level of experience and skill. For example, having to attend to the emergency department, being in charge of wards and, being the sole RN—having to monitor and delegate the activities of the Enrolled Nurses. These were responsibilities that the graduates felt strongly that they had not been adequately prepared for in their undergraduate education and which made their transition very difficult.

The third theme identified aspects of the graduate nurse program that may have resulted in the participants regretting their choice for rural employment and also identified the participants perception of their educational preparation for registered practice in rural settings. Participants felt well prepared with their technical skills, however, they perceived that their educational preparation had not adequately prepared them for the level of responsibility and the workload that they were expected to carry.

Emerging from the data were several unmet expectations that the participants had of the graduate year. The first was the inability of rural health care facilities to allow the new graduates to complete the clinical rotations that were initially offered to them. Once again staffing ratios and skill mixes influenced the ability of the health facility to fulfil promises of clinical rotations. Second, the majority of the participants identified that the graduate programs within the rural agencies failed to the deliver a structured support program which the graduates expected and which was promised to them.
Overall, the new graduates of this study in reflection of their time within a rural health care facility commented that they had enjoyed their graduate year and felt that they had now gained a broad skill base that would stand them in good stead for the rest of their nursing career. However, they expressed regret that they did not receive structured support in the form of a preceptor or specific support person, and that their educational preparation had not adequately prepared them for the level of responsibility and the workload that they would be expected to assume. Also they expressed concern that they were not adequately prepared to deal with the ward culture within rural settings. Additionally, the new graduates believed that the rural health care facilities had an unrealistic expectation of the beginning registered nurses' abilities as they enter the rural workforce.

The following chapter will discuss the research findings and review the major findings of the study. Conclusions about the research questions and the implications for nursing and undergraduate nursing education, including recommendations for further studies will conclude this thesis.
CHAPTER FIVE

Discussion and Conclusions

5. Introduction

The purpose of this study was to explore the experience of the transition of new graduate nurses in rural practice settings. A hermeneutical-phenomenological approach to the study was utilised as it was deemed by the researcher to be the most appropriate methodology to enable the purpose of the study to be met, that is, to gain insight and understanding into the transition experience for graduate nurses within rural practice settings. Individual in-depth interviews with ten newly graduated nurses employed within rural health care facilities were analysed using thematic analysis. Three major themes emerged from the narratives of their journey of transition. The three themes are Having Rural Connections, Socialising to the Registered Nursing Role in Rural Practice Settings, and Having Regrets and Unmet Promises.

Whilst the previous chapter presented the major themes this chapter will provide a review of the major findings and the conclusions reached about the research problem. Implications and recommendations for undergraduate nursing education, the recruitment and retention of graduates within rural practice, and the implications for nursing practice are discussed. The chapter concludes with recommendations for further research into this field of study.

5.1. Major findings and conclusions

1. This study found that the graduates' decision to accept a rural graduate position was made because of previous connections with the rural area, and/or because of family and relationship commitments which
prevented them leaving the rural area. Previous experience in the rural health care facility was a significant factor that also influenced the graduates' rural preference for graduate nurse programs. Additionally, the fact that there was no guarantee of permanent employment upon completion of the graduate program, plus the graduates' disappointment with the lack of clinical rotations offered and the subsequent failure of rural health facilities to follow through with clinical placement rotations were important factors that influenced their retention within the rural health care facilities. At least half of the participants regretted their choice for a rural graduate position because of these issues. Several participants also indicated that if they had undertaken undergraduate clinical preparation within a rural agency, they would not have accepted the position because they would have known what clinical rotations were offered and more importantly, what clinical rotations the health care facility was capable of providing.

2. The participants in this study felt that they were prepared as well as they could have been for registered nursing practice, however, this study found that the rural health care facilities did not recognise the graduates beginning level of practice as evidenced by the workload capacity expected of them. Graduates lacked experience in coping with the workload and they felt that there was often no difference between their workload and that of more experienced staff. Workload expectations were influenced by insufficient staff numbers plus an inappropriate skill mix within rural health care facilities which resulted in the graduates having to carry a full patient load right from the start of their graduate year with very little support provided to them.

3. Very few of the graduates were eased into their new registered nurse role and the associated responsibilities. Further, the graduates were frequently required to overstep the boundaries of their level of competence and experience. For example, being in charge of wards, attending to Accident and Emergency areas and working as the sole RN with one EN, was a common occurrence for the graduates. Having to take on this level of responsibility with very little experience and support.
were the reasons the graduates experienced role ambiguity and role conflict. There appeared to be no recognition by the health care facility of their beginning registered nurse status and their lack of experience in managing wards and speciality areas such as Accident and Emergency.

4. This study found that the graduates had expectations of graduate nurse programs that were not met because of inadequate staffing ratios and skill mixes present within the rural health care facilities. Thus, the graduate nurse programs could not provide a supportive, nurturing environment, and as previously stated, clinical rotations through specialty areas did not eventuate. These issues were of a significant concern and disappointment for the graduates.

5. The study also found that the level of individual support the graduates received from more experienced colleagues was influenced by the prevailing culture and the horizontal violence present in some wards. A unique and significant factor that affected the graduates' experience was the close working environment of rural health care facilities where the graduate experienced a role diffuseness and a lack of anonymity. Additionally, horizontal violence demonstrated by staff behaviour impacted on the graduates' ability to trust staff which also resulted in graduates feeling intimidated by more experienced staff to the point where they were reluctant to seek support.

6. In the absence of formal and informal feedback regarding their progress, the graduates identified several measures to confirm their positive progress in the role transition from student to registered nurse and thus confirm their acceptance into the ward culture. These included: not being talked about by more experienced colleagues; the number of in-charge shifts they were given; their ability to cope with the workload; the fact that nobody said anything to them regarding their practice or their progress; and being relocated to other wards to relieve staff members.
Despite these findings, the participants believed that overall their journey of transition had been beneficial as they had acquired valuable knowledge, skills, and experience from working as a rural nurse.

5.2. Implications and recommendations for undergraduate nursing education

Several of the graduates in this study were from regional universities where their undergraduate clinical preparation included mainly rural nursing placements. Consequently, these were the graduates who felt well prepared to enter rural practice, and so their undergraduate clinical preparation could be viewed as adequate. However, they acknowledged that they were not prepared for the lack of support, nor the workload and level of responsibility placed upon them. Nor were they prepared for the negative ward dynamics and staff conflict that they were exposed to on a daily basis in the close rural working environment. Thus, this researcher recommends that undergraduate nursing students need to be further prepared to deal with the culture of ward environments and social interactions within rural practice settings which can have a significant influence on their transition experience. Nursing in the higher education sector may also need to address organisational and management topics when preparing graduates for the reality of the rural nursing workforce. These suggestions are supported by The Commonwealth Department of Education, Science and Training (2003) who identified interpersonal skills and management as two areas in undergraduate nursing education that need to be taught within a rural context.

Whilst this researcher acknowledges that organisational and management topics are covered in some undergraduate nursing programs, the participants in this study had not received any instruction on the management functions in nursing. Despite this, the researcher is cautious about placing too much emphasis on this finding as she is aware that whilst organisational and management concepts taught in a nursing program can alert the student to the organisational environment, it is usually experience gained in the workforce that equips the RN with effective coping skills.
The findings from this study indicate that if possible, it is important to offer nursing students experience in the rural facility of their choice so that they are made aware of the graduate nurse program within that rural health facility and they can also become familiar with the facility's prevailing organisational culture. The National Rural Health Alliance (2002) put forward a recommendation to increase the number of rural clinical placements to assist with undergraduate students' preparation as potential rural nurses. This strategy could also effectively promote rural nursing as a career option for graduates. The Australian Universities Teaching Committee Final Report (2002) suggests that consideration needs to be given to including extended periods of clinical practice within one health care agency. The rationale for this recommendation is that an extended period of clinical practice in one agency would assist to further develop knowledge and skills, integration within the health care agency would be facilitated, and the cultural environment of that agency would be identified.

However, implementation of these recommendations is far from straightforward. Today, it is recognised within the nursing profession that the cost of the clinical component of undergraduate nursing preparation is becoming increasingly high across Australia. As such, the clinical placement of undergraduate nursing students is an ongoing challenge for universities and health care facilities due to a number of issues that impacts both directly and indirectly upon clinical placements.

First, staffing pressures within rural health facilities are impacting on the ability of these facilities to support undergraduate students for clinical experience. Today, skill mixes and staffing ratios within NSW rural health facilities are such that there is no longer a viable number of RNs available to offer preceptorship or mentorship to undergraduate students. Some universities still rely on the preceptor model of clinical education within small rural agencies, and this extra role and responsibility for RNs has not been recognised in monetary terms by all universities, plus the extra burden of preceptoring student nurses is not always recognised by health care facilities. Thus, it can be appreciated that RNs can be reluctant to take on this extra role.
In 2001, the Senate Community Affairs Reference Committee conducted an inquiry into nursing, and submissions were received from many organisations within the nursing profession (Senate Community Affairs Reference Committee 2002:58). Whilst it was emphasised during the inquiry that quality clinical placements in a variety of health services are vital to the achievement of fitness to practise as a professional nurse, concerns were raised in relation to the availability and cost of undergraduate clinical placements. The Australian Deans of Nursing indicated in their submission that each Head of School has to find health care agencies, which are able and willing to accept students and offer them supervised practice. However, they also noted that ‘it is becoming increasingly difficult to make arrangements because hospitals and other organisations are themselves short of resources, they are able less and less to spare the time of hard-pressed nurses to assist in the training of students, and some clinical nurses resent this extra load’ (Senate Community Affairs Reference Committee 2002:58).

As a result of these submissions, the Committee made many recommendations in the area of nursing eduction, including the need for additional funded undergraduate places in nursing programs, and enhancing clinical training and assistance with clinical placements (Senate Community Affairs Reference Committee 2002:xiv).

Following the Senate Inquiry, the Commonwealth established a National Review of Nursing Education in 2001, which was completed in 2002 (National Review of Nursing Education 2002:148). In a call for submissions to the National Review, the costs associated with clinical placements and the pressure of finding adequate clinical placements for students was highlighted several times. It was recognised that this is a priority area and funding for nursing education needs to be increased to reflect the real costs of clinical practice. The National Review of Nursing Education (2002:129) reported that ‘although nursing was placed in a median category for the process of developing the relative funding model, it could well be argued that this level of support only accommodated the additional costs to deliver an applied science education on site in a university’, and ‘there is no direct funding to support clinical education despite the heavy cost of supervision of students on the 1:8 ratio expected in
many States’. According to the Review, ‘whatever model of education is promoted, the availability of useful field experience reflective of the contemporary scope of nursing practice will remain a challenge’ (National Review of Nursing Education 2002:148). These challenges significantly impact on rural nursing practice and adequate financial resources are needed to provide reimbursement and incentives to rural RNs for the clinical education of undergraduate nursing students.

Second, the personal cost for undergraduate nursing students attending clinical placements at rural health care facilities can be the deciding factor as to whether they choose to undertake a rural clinical placement. This financial burden has been partly addressed by offering scholarships, which assist with students’ travel and accommodation. For example, the Federal Government’s 2003 Health Budget has targeted rural communities with scholarship initiatives to assist people from these areas to undertake nursing degrees (Department of Health & Ageing 2002). This strategy is appropriate given that the graduates in this study who were from rural backgrounds had made the decision to return to the rural area following registration. While this has the potential to enhance the recruitment of graduates to rural areas, there is a need to increase the number and monetary value of undergraduate scholarships, and also to establish a consultative selection process between nursing academics and the funding bodies to determine appropriate applicants.

In summary, and at the time of writing this thesis, the researcher, in her capacity as Clinical Coordinator, at a regional university was alerted to a National Rural Health Alliance Project. A recommendation which stemmed from a national workshop conducted by the National Rural Health Alliance (2002) called for all Schools of Nursing ‘to provide nursing courses that prepare graduates for the realities of rural and remote areas, including through curriculum content, placements and the needs of marginalised groups’ (National Rural Health Alliance 2002). These issues have been discussed in the above section and as the reader will appreciate they are ongoing challenges for nursing in the higher education sector.
5.3. **Implications and recommendations for the recruitment and retention of graduates in rural nursing practice**

Despite being disappointed with the lack of clinical rotations and structured support, five participants in this study intended to remain in the rural facility as part of the casual staff until a permanent position became available. This demonstrates that some graduating nurses are interested in pursuing rural nursing practice. Despite this, it would appear from the findings of this study and from previous studies that some rural health agencies do not place much emphasis on recruiting new graduates and do not see them as an important and long-term investment. The investment by a rural health facility into the development of graduates can be lost at the completion of their 12-month graduate nurse program.

In 1992, Thornton said that many rural nurses advocated that 'a period of rural nursing for interested staff on a two year contract would be a more constructive method of recruitment and retention than trying to employ staff for an indefinite period' (1992:125). However, ten years later, the issue of recruitment and retention of rural nurses still remains a major problem. It would appear that the issue is not whether graduate nurses choose to enter rural nursing practice, but rather the constraining factors faced by rural area health services such as the increasing commodification and rationalisation of health services within rural areas. In addition, rural nurses who advocated such a proactive move to Thornton may need to make a stronger case to management in area health services who may not see recruiting graduate nurses as a potential long-term investment. Addressing this long-standing problem of recruitment and retention is of vital importance to the salvation of rural nursing practice in Australia and it needs further discussion by rural nurses’, health care policy makers, and the nursing profession. In addition, further research needs to be conducted, and this will be discussed later in this chapter.

Numerous discussion papers and reports have also identified initiatives and made recommendations regarding the recruitment and retention of rural nurses to ensure that rural and remote residents 'have access to adequate and safe health care provided by skilled and competent staff' (National Association of Rural Health Education and Research Organisations 2001:6). As a Clinical
Coordinator in a regional university, the researcher knows that the rationalisation of health services and the commodification of health in NSW rural areas have been contributing factors towards the shortage of rural nurses. The researcher has observed that as RNs leave NSW rural facilities they are often not replaced, thus there is a significant decrease in the number of RNs and an increase in ENs within these rural health care facilities. The researcher believes that because of the rationalisation of health services there is a reluctance by area health services to employ newly graduated nurses as they believe it is more economical to employ an experienced RN plus ENs in order to provide adequate and safe skill mixes in rural areas.

However, if rural nursing practice in Australia is to be salvaged then new graduates should be encouraged to enter rural nursing, and rural health staff need to become more proactive in addressing recruitment and retention problems at both the rural and area health service levels. It is likely that the employment of new graduates in rural nursing will not be seen as a viable long-term investment until these problems are resolved.

5.4. Implications and recommendations for rural nursing practice

The study findings also have implications for rural health facilities and experienced rural registered nurses in the provision of adequate and timely support for new graduate nurses as they enter the rural nursing workforce.

In 2001, the Association for Australian Rural Nurses Workforce Inquiry Submission stated that 'most good graduate programs are conducted within large metropolitan hospitals and this is where graduates tend to stay' (National Review of Nursing Education 2002:168). If graduate nurses are to be retained within rural graduate nurse programs, the problems identified by graduates in this study in relation to the content and delivery of graduate nurse programs need to be addressed both locally and at the area health service level. For example, area health services need to direct more financial resources to rural health facilities to support and further develop new graduates. As previously stated, rural nursing staff also need to become proactive in ensuring that their rural agency has an appropriate number of staff to support a graduate nurse program and that the program is effective and achieves the desired outcomes.
However, until the problems in section 5.3 are addressed, the issues associated with rural graduate nurse programs will remain unresolved.

Additionally, rural health facilities need to address the expectations that staff have of new graduates as they enter the nursing workforce. Education programs offered by the higher education sector could assist rural health staff to understand the beginning level skills and knowledge of new graduate nurses. An understanding of could assist staff with planning and implementing appropriate support strategies to ensure that graduates are effectively integrated into the rural workforce.

In addition, the workplace cultural issues that were highlighted by graduates in this study and which have been recognised as having a significant impact on the retention of graduates will need to be also addressed locally and at the area health service level. For example, the NSW Nursing Workforce Action Plan (2001) recommends that awareness needs to be raised regarding workplace bullying through the formation of ‘no tolerance policies’, which should form the basis of all job descriptions and performance appraisals, and that processes be implemented for the reporting of staff harassment and bullying. Whilst these recommendations are commendable, the researcher feels that some staff do not recognise that their behaviours are forms of horizontal violence. Alternatively, some staff members may acknowledge that it is occurring but they feel powerless to address it with management. Thus, this issue could also be addressed through ongoing education of staff that focuses on identifying what constitutes horizontal violence and bullying within the workplace, and on strategies for managing workplace conflict.

5.5. Recommendations for further studies

It was not the intention of the researcher to generalise the findings from this study to the graduate nurse population but rather to identify and explore the experience of role transition within rural practice settings so that the findings could generate an awareness of issues specific to graduates in rural areas. It is hoped that these research findings will assist rural nurses to provide more adequate support during the transition for graduates, which in the long term, could assist with the recruitment and retention of graduates to rural areas.
It is important to note that not all the findings from this study are entirely specific to rural nursing practice. For example, the researcher believes that the graduates, as newcomers to the nursing workforce may have had unrealistic expectations and assumptions regarding their graduate year because of several factors. First, several of the participants, because of their young age, had not been previously employed within an organisation and so it is likely that they entered the workforce with a knowledge deficit in workplace cultural issues and role transition processes. Furthermore, they entered the workplace with a minimum level of work experience. As a result, graduates experienced a fear of the unknown in their graduate year because of the unpredictability of the nursing environment and the change in role from student to that of registered nurse. This was evidenced by graduates who stated they felt as well prepared as possible, given the unpredictability of nursing practice and their lack of experience in the workforce.

Despite this, the researcher believes that clinicians and nurse academics can address these issues to improve the role transition process for graduate nurses in rural practice. Furthermore, they need to investigate ways in which graduate nurses can be recruited and retained in the rural workforce. Thus, this study has exposed several areas that warrant further investigation.

As previously stated, several potential participants for this study had already exited the rural graduate nurse programs before this research study commenced. A small qualitative study to identify the reasons why new graduates do not complete their graduate nurse programs could provide valuable information concerning the retention of graduates. It would also shed further light on the major findings identified in this study.

The perceptions of experienced rural nurses regarding the performance of graduate nurses in rural health facilities and the issues surrounding the recruitment and retention of them would also yield important information which could be obtained through a qualitative approach. Furthermore, there is a need to explore the concept of organisational culture in rural health facilities. Cultural factors that benefit or impede the role transition process for graduates could help rural nurses better understand this process. Thus, research that
examines in more detail the prevailing workplace cultures in rural health settings would help uncover cultural barriers and identify strategies needed to enhance the overall recruitment and retention of nurses.

Finally, the researcher recommends that a study be conducted to evaluate the effectiveness of the structure and content of graduate programs. The findings from such a study could identify the functional elements of these programs which would assist in future planning and development. Furthermore, the researcher agrees with Roberts and Farrell's (2003) recommendation that Clinical Nurse Consultants and preceptors assess graduate performance at three, six, and nine months.

5.6 Conclusion

In conclusion, the researcher believes that this study which has explored the issues that pertain to graduate nurses making the role transition to registered nurse within rural settings will make a valuable contribution to the nursing literature as it has identified specific graduate issues within the rural nursing workforce. It has examined issues that affect the retention of graduates within rural graduate programs and it has also provided an insight into the effectiveness of current rural programs in easing the role transition. This study has also exposed aspects of the transition experience that are unique to graduates within rural practice settings. Finally, the findings of this study have highlighted the serious recruitment and retention problems faced by the rural health sector.

It is hoped that the findings from this study will be utilised by nursing academics when reviewing the preparation required for new graduates entering rural practice. Additionally, area health services and rural health facilities could utilise the findings to assist with the planning, implementation and maintenance of graduate nurse programs within rural practice settings. It is also hoped that this study will alert area health services to the recruitment and retention problems currently being experienced in the rural health sector and to show them that new nursing graduates can be valuable long-term assets in the rural nursing workforce. This is a fundamental issue which needs to be addressed if nurses are to be retained in this unique nursing specialty.
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APPENDICES

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INFORMATION SHEET FOR PARTICIPANTS AND CONSENT FORM.

PROJECT NAME:
The New Graduate nurse’s lived experience of Transition into Rural Practice Settings.

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PURPOSE OF THE RESEARCH:
The purpose of this research is to explore the new Graduate Nurse’s experience of their transition from student to registered nurse in rural practice settings. The researcher is interested in hearing the opinions of beginning registered nurses, on issues related to their educational preparedness for rural practice, as well as, the level of support they feel has been provided for them during their postgraduate year. Also the research aims to discover some of the reasons why the New Graduate has chosen a rural employment position.

It is important that participants are aware that there are no right or wrong answers, and that the researcher will remain neutral on the subject and that this research is unrelated to any employing body.
METHOD:

The method of data collection will be by taped individual, unstructured interviews. This means that the researcher will ask all willing participants to discuss their experience of transition into rural practice settings. Each individual interview is expected to be of 40-60 minutes duration. The location at which the interview will take place will be mutually negotiated between the participant and the researcher.

RESPONSIBILITY:

All individual interviews will be audio taped with permission from the participant. The audio tapes of all interviews will be transcribed by Jackie Lea. All data will be stored in a locked cupboard in the office of the researcher. Data on audio tapes, computer discs and hard copy will remain in the possession of the researcher and be accessed only by the researcher and her supervisor. Data will be kept for a period of five years in accordance with the National Health and medical Research Council, Australian Health Ethics Committee Guidelines (1995), after which they will be destroyed.

IMPORTANT NOTES:

• INDIVIDUALS ARE AT NO STAGE UNDER ANY PRESSURE TO PARTICIPATE.

• ALL PARTICIPANTS ARE FREE TO WITHDRAW CONSENT OR DISCONTINUE WITH THE INTERVIEW AT ANY TIME WITHOUT EXPLANATION.

• WITHDRAWAL FROM OR NON-PARTICIPATION IN THIS RESEARCH WILL HAVE NO IMPACT ON PROFESSIONAL EMPLOYMENT OR FUTURE CAREER PROSPECTS.

• THIS STUDY IS UNRELATED TO ANY EMPLOYING BODY.
Any questions concerning the project titled “The New Graduate nurse’s lived experience of Transition into Rural Practice Settings” can be directed to Jackie Lea (Principal Investigator) of the School of Health, University of New England. Telephone: 02 67732974.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HEO1/103, Valid to 8/7/02)

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351
Telephone: (02) 67733449 Facsimile (02) 67733543
Email: Ethics@metr.une.edu.au

CONSENT FORM:

I (the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that research data gathered for the study may be published, provided my name is not used.

................................................................. Date
Participant or Authorised Representative

................................................................. Date
Investigator
Please tick appropriate box

Gender:
Male ☐ Female ☐

What is your age group?
20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ Over 45 ☐

Relationship Status
single ☐ single parent ☐ partner ☐ partner + children ☐

Nationality ________________

Month that you entered post-graduate program? ________________

Name of tertiary institution where you completed your BN ________________
28th November 2001

Dear

Thank you for agreeing to participate in my research, regarding the transition process for new graduate nurses in rural areas.

I have enclosed a copy of the consent form, as well as a demographic questionnaire. Could you sign the consent form on the last page please and complete the questionnaire and then return it to me at your earliest convenience in the reply paid envelope provided.

Should you wish to discuss any aspects related to this research or the interview please do not hesitate to contact me on the above address.

Thank you once again for your assistance and participation in research.

Kind regards

Jackie Lea
Clinical Coordinator
INTERVIEW SCHEDULE

Why have you chosen to be in a rural graduate position?

Can you tell me what your transition into the nursing workforce has been like for you?

How do you feel about the adequacy of your educational preparation for what you have experienced so far?

PROMPTS

• Can you talk about your preparedness for practice?
• How well prepared do you feel for your role as an RN?
• How well prepared were you for rural practice?
• Is there material that you would have liked covered in your educational preparation for your graduate nurse year?

Can you tell me about the level of support you have/are receiving?

Do you feel you have been well supported in your transition program?

PROMPTS

• Support from peers, educators, management, family?
• Is the level of support what you expected?
• Where/who did the support come from?
• What was ‘good’ support for you?
• Other types of support you would have liked to receive?
• How do you think the support could be improved?
Can you talk more specifically about the educational support provided to you?

**PROMPTS**
- At the Hospital in which you are employed, at ward level, area level
- Was the graduate program what you were told it was going to be?

Do you regret your choice in a rural graduate nurse position?

- What will you do for employment next year?
- What areas do you think you would like to work in, in the future?