BECOMING AND BEING A NURSE: A RESEARCH INFORMED THEORY TO GUIDE CONTEMPORARY UNIVERSITY AND INDUSTRY APPROACHES TO PREPARING AND SUPPORTING GRADUATE NURSES

A Thesis submitted by

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Abstract

Globally, a nursing shortage exists, placing the health and wellbeing of patients at risk. Furthermore, nurses in their first year of their new career have a high attrition rate, exacerbating the shortage. The problem is double-sided in that the health and wellbeing of *new nurses* who are responsible for the health care of *individuals and communities* are in jeopardy. Despite the magnitude of this problem, there has been a paucity of research exploring the contributing stress factors to aligned education and support to ensure nurses retain their health and wellbeing and are enabled to be effective carers for others. Graduate Registered Nurses (GRNs) are uniquely positioned to provide insight about these very aspects through sharing their first year experience to contributing to addressing this gap. This study addressed this gap by exploring the experience of first-year GRNs' work, study and personal life (developed and defined in this study as the *Load Triad*) and identified the factors impacting their Load Triad and their overall life balance. A mixed-methodology was applied and data was collected in 2 phases, with Phase 1 informing Phase 2. In Phase 1, an in-depth inquiry (interpretive) was conducted with 4 first-year GRNs (in their 11th month), employed within health facilities from a single regional city in Queensland Australia. Findings revealed the GRNs first year was 'hard' causing them to question their level of preparedness for the reality of work and life as a nurse. This lack of a broader preparedness experience has led to the identification of a number of negative and positive indicators impacting the GRNs first year experience and its relationship to thoughts of either attrition and or retention. The main negative indicator included GRNs being situated within a workforce in juxtaposition to the 'world of nursing' values. Other negative indicators included GRNs actively prioritising their work role over their personal life and self-care roles, creating a life not in balance and experiencing a decline to their overall personal sense of wellbeing. Other associated negative indicators included a lack of and or absence of targeted and tailored holistic support. GRNs in the throes of this 'hard' year demonstrated resilience and thus positive indicators leading to resilience and thoughts of retention have been equally identified. The main positive indicator included GRNs being situated within a workforce that mirrors the 'world of nursing' values. At the individual level, important

positive indicators were found to be the possession of a temperament towards strong work role salience, intertwined with previous heightened undergraduate study role salience and a strong sense of fellow GRN peer friendship within the work place. Other positive indicators included possession of personal qualities such as agency and internal locus of control. In Phase 2, 71 GRNs, from settings across Queensland were surveyed to confirm, deny or challenge the Phase 1 results (derived from four first-year nurses) with a larger, more diverse sample size. Overall, the Phase 1 themes were confirmed and strengthened in Phase 2. The outcome of this study is the realisation that real opportunities exist to improve the GRN experience. Key takeaways from this research include a set of recommendations to assist in improving nursing preparation and transition support. A key recommendation is to improve the co-ordination, collaboration and communication between key nursing stakeholders by the use of reiterative feedback loops, formal annual reports and timely sharing of these reports. Timely sharing of reports is to facilitate an evidenced based and timely response by education and transition providers to enact reforms that will guide the continual quality improvements to nurses' education and transition support. Additionally, this study recommends inviting GRNs to 'partner' with higher education institutions, health organisations and governance bodies to contribute to decision making and discussions about the delivery and evaluation of nurses' preparation and transition support. Furthermore, the overarching proposition derived through this research is that university-led education and transition support for future and in-practice nurses must exist and be nuanced and informed by the '*Becoming and being a nurse*' transition theory, situated during and post-university (within the workforce) and is my original contribution to knowledge. This new theory is further supported by 2 other new theories entitled, '*Nursing preparedness*' theory and '*21st century life career preparedness*' theory.

Keywords

Careers; Continuing Professional Development; Curriculum; Employability; Experience; Graduate Registered Nurses; Heutagogy; Life Balance; Lifelong learning; Holistic approach; Partnering; Preparedness; Readiness; Retention; Risk Management Role Salience; Self-care; Transition; Wellbeing

Certification of Thesis

This Thesis is entirely the work of Natasha E Reedy except where otherwise acknowledged. The work is original and has not previously been submitted for any other award, except where acknowledged.

Principal Supervisor: Associate Professor Alexander Kist

Co-Supervisor: Professor Shelley Kinash

Co-Supervisor: Professor Jill Lawrence

Student and supervisors signatures of endorsement are held at the University.

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Heidegger

'*Being*' is "specific and general, enduring and even sometimes fragile; barely felt and yet fully conscious" (Barnett, 2007, p. 28).

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List of Abbreviations

AIN – Assistant in Nursing

ANMC – Australian Nursing and Midwifery Council

CN – Clinical Nurse

CPD – Continuing Professional Development

DNE – District Nurse Educator

EEN – Endorsed Enrolled Nurse

GRN – Graduate Registered Nurse

LLL – Life Long Learning

QLD – Queensland, a state in Australia

RN – Registered Nurse

List of Terms and Definitions

Career education falls within life career development. Super (1975) describes career education as "helping students to control the unfolding of their careers, as changing sequences and combinations of roles in education, home, community, occupations, and leisure as they go through life" (p.27).

Continuing Professional Development (CPD) is part of the professional development for nurses to ensure safe, quality practice and has been defined by the Australian Nursing and Midwifery Board of Australia [NMBA] as:

> The means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives. The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities, and reflecting on the value of those activities (Nursing and Midwifery Board of Australia, 2010, p. 1).

To support the purpose, direction, effectiveness and implementation of CPD, guidelines have been developed by the Nursing and Midwifery Board of Australia. Their description of how CPD can be effective is as follows:

> Learning and development occurs throughout a nurse's and/or midwife's career. CPD is an important foundation of lifelong learning and helps nurses and midwives maintain their competence to practice. CPD aims to enable nurses and midwives to maintain, improve, and broaden their professional knowledge, expertise and competence to meet their obligation to provide ethical, effective, safe and competent practice. Research on CPD shows that by engaging others in CPD planning, this results in positive learning outcomes and evidence-based changes to practice…it is more effective when it involves …reflection (Nursing & Midwifery Board of Australia, 2016a, p. 1)

Critical thinking (CT) is an important quality of being a nurse. The basis of critical thinking forms from a modern teaching philosophy of constructionism

(Kosova Education Center, 2011). Constructionism involves knowledge and skill set development of planning and research involving exploring, information gathering, decision-making and reality testing (Niles, 2002; Niles & Goodnough, 1998). In addition to this, a number of critical thinking building blocks were identified specifically relevant for the nursing discourse. These include "10 habits of the mind (affective components) and 7 skills (cognitive components)" (Scheffer & Rubenfeld, 2000, p. 352). These building block are as follows:

> The habits of the mind of CT in nursing…confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Skills…analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge (Scheffer & Rubenfeld, 2000, p. 352).

Existentialism is fundamental to the serious nature of understanding the challenges facing GRNs working and living a life as a nurse. Existentialism is a philosophy concerned with finding self and the meaning of life through free will, choice, and personal responsibility (Barnett, 2007). The belief is that people are searching to find out who and what they are throughout life as they make choices based on their experiences, beliefs and outlook. Personal choices become unique without the necessity of an objective form of truth. An existentialist believes that a person should be forced to choose and be responsible without the help of laws, ethnic rules, or traditions.

Graduate Registered Nurse (GRN) is defined in this research as a nurse with a Bachelor of Nursing or equal qualification, who is licensed to work as a Registered Nurse and is in their first transition year of work as a registered nurse (Australian Health Practitioner Regulation Agency, 2015).

GRN Personhood is the application of personhood to GRNs. Personhood is a construct of person-centred care (Dempsey, 2014). Therefore, it is the GRNs' expression of being human, their humanity. This includes knowing a GRN's interests, what they hold as important, their concerns and what challenges them, such as their health and wellbeing.

Health Workforce Australia [HWA] is a department that has recently been transferred to the Department of Health and Ageing in 2014. Its main function is to:

> Provide the Australian Government, through the Minister, with policy advice and implements programs to address workforce capacity, supply and training needs in the medical, nursing, dental, allied and Indigenous workforce…HWA's explicit charter is to operate across education and health sectors and jurisdictional responsibilities to develop national, integrated solutions to workforce planning and policy in support of health reform (Department of Health, 2013, p. 1).

Heutagogy is concerned with a type of learning approach. Hase and Kenyon (2001, p. 1) have defined heutagogy as a concept of truly self-determined learning which is suitable for the needs of learners in the 21st century as it supports development of individual capability.

KWHLH Critical Thinking Tracking Tool is a tool designed to supports the development and tracking of the thinking process. The acronym KWHLH represents: What I Know? What I Need to Know? How will I find out? What have I Learnt? (Ogle, 1986). The KWHL thinking Model has been adapted in this study to also include a final letter H that represents the final question in this model: How do I know I have learnt? This extra addition is based on the theory surrounding transformational learning (Mezirow, 1997). Thus, this model also tracks the confirmation of whether the learning has changed thinking and practice.

Life Career Theory assists individuals to be active in the selection of their career to promote their career satisfaction and retention and to also benefit the organisation by reducing cost associated with staff turnover and building a work force that increases productivity. In supporting individuals to be active in their career selection, individuals require support in raising awareness about who they are, including their areas of strengths as well as in areas they need developing and or strengthening. This type of self-awareness focus supports individual's life career preparedness and adaptability for the changing nature of life career roles (Holland, 1959, 1973; McMahon & Patton, 1995, 1999, 2006; Parsons, 1909; Pryor & Bright, 2003a, 2013b; Super, 1990).

Lifelong Learning (LLL) conveys more than achieving an education across an individual's life time. Longworth and Davies (2003) provide a comprehensive definition and this is as follows:

> the development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments. (p.22).

Load Triad is a new term developed from this study and is defined as domains related to work, study (undergraduate and or post graduate Continuing Professional Development) and personal life.

Metacognition is 'thinking about the process of knowing,' and refers to "higher order thinking that involves active control over the cognitive processes engaged in learning" (Department of Education and Science, 2000).

Nurse has been defined by the International Council of Nurses (2002) as:

> a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognized program of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorized (1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research. (p. 1)

Nursing has been defined by the International Council of Nurses (2002) as:

> An integral part of the health care system encompasses the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community

> settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual, family, and group "responses to actual or potential health problems" (ANA, 1980, p.9). These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population. The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full of partial independence as rapidly as possible (Henderson, 1977, p. 4). Within the total health care environment, nurses share with other health professionals and those in other sectors of public service the functions of planning, implementation, and evaluation to ensure the adequacy of the health system for promoting health, preventing illness, and caring for ill and disabled people. (p. 1)

Personal Sources of Resilience refers to protective factors an individual has that assists them to be resilient. In the case of GRNs, personal factors include a temperament with a strong sense of agency and internal locus of control, fellow GRN colleagues (the GRN's spider web of support), while generally other protective factors include close bonds with family members (Ramey, Lanzi, & Ramey, 2015).

Prepared: A general definition of preparedness is lacking in the literature, especially relating to education and nursing. However, being able to 'hit the ground running' and or nurses 'linking theory to practice' is accepted. However, there is little mention of the broader holistic goals as aligned to lifelong learning needs in being prepared. Therefore, the following definitions are offered by this study:

> ***GRN preparedness:*** Laying the groundwork to create a GRN who is ready for work, study and personal life as a nurse, incorporating work, study and personal life roles; able to confidently deal and effectively manage these areas in their life, in *all* environments and circumstances, to achieve an overall assent to a life in balance and wellbeing.

In addition to this definition on preparedness, this study also offers the following:

GRN preparedness – an extended definition: is when a particular knowledge and skill is taught in conjunction with critical thinking habits of mind and skills and when teaching and learning is carefully designed, delivered and assessed in a purposeful, upwards - scaffolded manner from theory to practice (simulation) and assessment, to further support the application of the particular knowledge and skill competently and confidently in the authentic clinical professional placement setting where increased complexity and variability exists. Preparedness also includes the opportunity for the particular knowledge and skills (augmented by CT) to be explicitly taught and role modelled, practiced and assessed. Particular emphasis is given to practice with an educator that enables repetitive practice, open discussion and reiterative feedback loops between the educator and the student, with the end goal –the student to gain 100% competency and confidence in the particular knowledge and skill being taught to support transformational learning). Furthermore, emphasis is also placed on aligning the particular knowledge and skills, with CT to assessments and assessment outcomes. These aspects are important building blocks to support the scaffolded student preparedness that is needed for the next preparatory step - to further support the student nurse's effective enablement of the application of the particular knowledge and skills in the authentic clinical professional experience placement setting where increased complexity and variability exists.

Resilience is the ability of individuals to bounce back (or to recover easily and quickly from setbacks) and or to cope successfully despite adverse circumstances or setbacks (Zautra Arewasikporn, & Davis, 2010). Resilience is also referred to as a personality trait (Fredrickson, Tugade, Waugh, & Larkin, 2003, Campbell-Sills, Cohan, & Stein, 2006) with qualities of strength and persistence to overcome challenging obstacles (Hart, Brannan, & De Chesnay, 2014, p. 720).

Role Salience: The person's beliefs, values and attitudes about a particular role or roles in their life that is important to them such as work, study and or Continuing Professional Development (CPD) and personal. It includes the person's self-efficacy, knowledge and associated skills and application of these within set standards (for example: legal, personal, professional and ethical) required to perform this role well. It also acknowledges the level of energy, effort and resources the person is willing to

commit to the performance of this role/s. This definition has been adapted from Matzeder and Krieshok's work and home role salience, (1995), Rajadhyaksha and Bhatnagar (2000) and Thoit's (2012) definitions of life role salience.

Supportive Protective factors (see the term *Personal Sources of Resilience*) are protective factors an individual has or has access to (internal and external) that assists them to be resilient. In the case of GRNs, their internal personal protective factors include a temperament that has a strong sense of agency and internal locus of control. External supportive protective factors are close bonds with their family and fellow GRN colleagues…the GRN's spider web of support.

Under prepared means not prepared sufficiently as aligned to lifelong learning and lifelong education goals. In the discipline of nursing and in the case of GRNs specifically, not being able to 'hit the ground running' and or not 'linking theory to practice' and or not able to confidently and effectively manage their multiple life roles, (work, study and personal). The following two examples illustrate these concepts:

Example one - Particular knowledge and skills are taught, however these are not consistently supported by critical thinking habits of mind and critical thinking (CT) skills within four key moments: 1. Theory, 2. Practice (simulation), 3. Assessment and 4. Authentic clinical professional placement experience.

Example two - Particular knowledge and skills (supported by CT) are either not taught and or are taught at a superficial level and are not applied and or assessed during theory and practice (simulation) sessions and not applied at a conscious level or assessed during the authentic clinical professional experience placement.

21st Century Life Career Preparedness Theory (21st CLCPT) is a direct outcome of this study (Reedy, 2018) and is described and elaborated in Section 6.8. The 21st CLCPT values and respects each individual's personhood and with this knowledge supports the preparation of individuals to respond and adapt to the changing nature of their work environment and careers. Underpinning this support and preparation is enabling individuals to reflect on and raise their self-awareness regarding essential knowledge and associated skills, qualities and attributes that are

transferable and adaptable for any life career. Preparation also includes supporting the individual to implement and evaluate strategies they have chosen to guide their ongoing development and ascent (assent) towards achieving their life career goals. 21st CLCPT goals also promote an individual's sense of life role salience, life balance, health and wellbeing and the wellbeing of organisations and society. 21st CLCPT is guided by a number of philosophies and theories. These include post-positivism, Heidegger's '*Dasein* and *Verstehen'* (1927, 1962), Husserl's (1931, 1962) and van Manen's (2017) '*lived experience'*, Foucault's *care for the self* (1981-1982; 1998), '*discourse'* (Foucault, 1972) and the '*Foucault Heideggarian turn*' (Rayner, 2004). It also includes beliefs, (Argyris & Schön, 1974, 1978; Borg, 2001), Foucault's *Culture* (Rabinow, 1991), 'discourse, power, discipline, governmentality and knowledge, Giddens (1984) duality of 'agency and structure', Freire's (1970, 2005) critical pedagogy, nursing epistemology and education epistemology (with the focus being life-long learning).

Chapter 1: **Introduction**

1.1 CHAPTER INTRODUCTION

Within the nursing profession, a nursing shortage exists globally. Compounding the nursing shortage is high Graduate Registered Nurse (GRN) attrition rates and an expanding demand for health care and service largely due to an aging population who are living longer. High GRN attrition suggests that current understandings about educational and support practices may be inadequate in meeting the needs of GRNs working life, as a Registered Nurse. Currently the focus from governing bodies and health organisations is on nurse retention. As a response, this study was initiated to explore the GRN first year experience and to form an evidence-based platform to detect areas of weakness and to direct reform to turn these areas of weakness into strengths.

Acknowledging and utilising the GRN first year experience is critical to being responsive to their changing education preparatory needs as an RN working and living life in the 21st century. This experience is important to further direct partnering in nurse preparation to improve future GRNs' ability and experience in their new role as an RN and in their other roles such as life career role; and personal life roles. Doing this is important to promote GRN's personal sense of life meaning, wellbeing and overall quality of life. The GRN experience has been identified by this study as a core indicator for directing future strategies that will enable achievement of an optimal GRN *preparatory education and transition year system*. Additionally, gaining a better understanding of the GRN first year experience will also benefit other stakeholders' *wellbeing*, such as patients, higher education nursing programs, health organisations and society. GRNs are the vital core link between all stakeholders and with their insightful comments about their experience, can identify problems and influence change within the undergraduate and transition nursing education and transition care of GRNs and broader components of the education and health organisation processes that benefit the whole *education and health care system*.

Incorporating the GRN first year experience as a partnering strategy into the *preparatory education and transition system* will assist higher education nursing

programs and nursing transition support programs and associated initiatives for GRNs to be responsive to GRNs' work role and other life roles that they value. The routine way of operationalising nurse education needs to integrate the GRN experience into the *preparatory education and transition system*. The GRN experience findings will be used as the evidenced based platform indicators that guide review, refinement and adaption of the nursing preparatory education and transition support needs of GRNs. Thus, the health and education system will then remain responsive and up-to-date with the current epistemologies in play, and will direct targeted improvement to the GRN experience. This study has captured GRNs' first year experience in relation to work, study and personal life (referred to in this study as the *Load Triad*) and identified the factors impacting their Load Triad, the relationships between these *Load Triad* factors, as well as the combined factors', and their overall impact on GRNs' first-year life balance. Thus, the factors have informed either positive and or negative indicators to guide reform that will adequately prepare GRNs, and thus improve the GRN first year experience.

This chapter introduces the rationale and background to this research study into first-year Graduate Registered Nurses' (GRN) experiences and perceptions. Furthermore, the chapter addresses how the researcher (as a GRN, GRN nurse educator in the public health system and now a nursing academic in the university system) became personally compelled to undertake this research. The chapter additionally provides an overview of the overall context of nursing in Australia. There are four key contextual factors that ground this research. These include the social and political landscape of the Australian heath care system, the nursing shortage, graduate nursing attrition and nurses 'work/life balance'. In addition, the term 'work/life, will be explored regarding its adequacy in Section 2.4 and modified to more adequately reflect the reality of the contemporary environment. The chapter concludes by leading the reader to the fundamental research problem, key questions, aim and purpose of the study, as well as implications, and structure of the thesis and a brief chapter summary.

1.2 RATIONALE FOR THIS STUDY

The rationale informing this study emerged from the researcher's professional situated experience of being both a GRN and later a GRN Educator. During this period, the researcher witnessed nursing shortages, attrition of first-year

nurses, and the resultant health and wellbeing risks for both the nurses who remain, and the patients they support. My observations and experiences align with Health Workforce Australia's [HWA] 2013-14 strategic plan (2012), which focuses on a program of workforce and training reforms. These reforms address three primary objectives (Australian Commonwealth Government, 2012), as directly quoted below:

1. Building capacity, boosting productivity, improving distribution (design and support programs for improved distribution of the health workforce across different health care settings, sectors and geographic areas).
2. Supporting more efficient and effective training for nurses.
3. Improving workforce retention …may stem from changes to the practice and workplace environments such as nurses… ability to work at the full scope of practice; flexible work arrangements that support family responsibilities; management of non-nursing/administrative tasks; professional development and career pathways. (p. 12)

New nurses are inexperienced and are likely to be vulnerable when entering the profession, with expectations of being able to manage work, study, and personal life. There is a paucity of research about GRNs' experiences in the context of these inter-related risk factors. This also includes a paucity of evidenced based aligned support for these risk factors to ensure nurses are capable of achieving a life in balance and maintaining a personal sense of wellbeing. The literature as discussed in Chapter 3, links capability with learning preparedness. It shows that little research has been published, exploring whether GRNs possess the awareness, knowledge and skills, to maximise learning to meet their individual personal, and professional requirements now, and into the future. Knowledge gained from investigating the GRN experience will assist in informing efficient and effective workplace education and training. The GRN experience, will also assist with reforms that will build GRNs' capabilities, productivity, and retention through a research-informed broader approach focused on supporting their ascent (assent) to life balance. The ripple effect from these reforms will be in attracting more nurses and retention of nurses, thus improving the supply of nurses to meet growing demands.

1.3 BACKGROUND TO THIS STUDY

Meeting the current and future demands for health care and services in Australia, needs to be supported with adequate nursing numbers. Currently a nursing shortfall has been predicted for Australia within the decade to 2020, raising concern for the ability of the Australian health care system to meet the demand for health care (HWA, 2012). Two primary factors have been identified as contributing to this predicted shortfall. These factors include an aging workforce concomitant with nurses commencing their retirement over the coming decade (Cooper, 2003; HWA, 2012) and an expanding health care system due to increased demand for services, related to ageing of a demographically modal population (Graham & Duffield, 2010; Hatcher, 2010). Compounding this shortfall, is an existing international GRN shortage (International Council of Nurses [ICN], 2004, 2006), high international GRN attrition rates (Booth, 2011) and a largely unknown Australian GRN attrition rate (Cowin & Hengstberger-Sims, 2005; Schluter, Turner, Huntington, Bain, & McClure, 2011). There are heightened calls for shortfall preparations and for finding sustainable solutions, to attract, and retain nurses (HWA, 2012; Watson, 2010). HWA (2012) classification indicates that the highest proportion of Australian nurses are aged 50 to 59 years. This means that by the end of 2020, the majority of these nurses will be retired from the profession. Specifically, Queensland has been predicted to be short of nurses by just under 20,000 by 2025 (HWA, 2012). The predicted point of separation, where the demand for nurses begins to outstrip the supply, was the year 2014. This prediction for a deficit in nursing numbers is expected to grow in momentum as each consecutive year passes (HWA, 2012). Therefore, responding adequately to this predicted nursing shortfall, is essential if the health and wellbeing of the public and the existing nurses within the work force, is to be maintained.

Responding adequately to this predicted Australian nursing shortfall, requires accurate data of the nursing workforce, based on a broader perspective of factors, that reflects the changing nature of a nurse's career span as they move through different career and life role stages. Prediction strategies used by HWA (2012) are based on future strategic workplace reforms, rather than a particular evidenced based measure. Future workplace reforms suggested including modifying the skill mix of nursing care staff, enabling health professionals to work to their full scope of practice and improving care efficiencies, with the uptake of technology such as e-health, and

or telehealth. Additionally, prediction calculations have also included a conservative approach to skilled replacements coming from domestic, international and temporary migration, which reflects the limited number of available nurses outside Australia, due a nursing shortage globally. Australia may not be able to rely on international nurses to close the Australian nursing shortage gap and will need to look to the domestic supply to fill this predicted shortage. However, work place reforms that support career development, in conjunction with life role support of nurses, are lacking. Predictive calculations as adopted by HWA (2012) which are based predominantly on workplace reform strategies and known employment numbers of nurses, and expected graduate numbers of nurses, will fill some of the nursing shortfall. However, predicting the shortfall and responding to the nursing shortfall, requires a broader examination of factors impacting nurse's decisions to leave their profession. For example, the changing nature of a nurse's career span, as they move through their different career and life role stages. Sourcing sustainable solutions that align with a nurses' career stage and life role, may assist the *health and education systems* the nurses operate within, to align reforms to match these stages, and support a better fit, that may aid in retention of nurses within the profession.

Sourcing a sustainable solution to prevent and maintain adequate nursing numbers to meet the demand for health care and health care services may be found in a whole *health and education system* solution. The extant literature reveals that there are many factors influencing the nursing shortfall predictions. These factors include political, socio-economical, organisational, educational and individual (Buchan, 2006; Watson, 2010). Buchan (2006) recommends the best approach to address '*system*' type factors is a whole system approach. Addressing this shortfall adequately and sustainably, means investigating the *health and education system* factors, and the components within these systems, that are issues preventing them from working in harmony with one another. Identification of the issues from a whole perspective, would facilitate planning and implementation of specific strategies that would align, and complement each system, allowing the systems to work as a team, to achieve the expectations, and goals of each system. This aspect however is beyond the scope of this study. This study will focus on a component within the health system, the individual GRN, to explore their experiences and the factors that affect them, with the

aim to target support for GRNs based on those factors, and thus improve their health and wellbeing and retention within the nursing profession.

Currently, knowledge concerning the causes of and solutions for GRN attrition rates, represents a gap in the literature. This gap is worthy of exploration, because work force planners need accurate and reliable data on GRN retention/attrition rates, to enable more accurate predictions of their contribution/supply. In addition, reliable data will support development of evidenced based strategies that will ensure the supply of nurses will meet the current and future demands for health care and services in Australia.

1.4 RESEARCHER'S PERSONAL RESEARCH MOTIVATION

Personal research motivation is important, to promote transparency in the research process. Equally, it is important to acknowledge and harness, to direct future knowledge discovery (Yermentaeyeva, Aubakirova, Uaidullakyzy, Ayapbergenova, & Nurtayev, 2013). In this case, the researcher's personal research motivation encompasses possession of ontological (the nature of truth), epistemological (knowledge about knowledge) understandings, ongoing situated experiences in the nursing profession and axiological (the role of contextual values) orientations. These have richly informed the methodological design and approaches to this research. Thus, these very aspects, will be drawn upon, in sharing openly the researcher's personal motivation to uncover the contemporary broader GRN first year experience.

Ontologically, the researcher's position is that there is not an external truth 'out-there' waiting to be investigated and revealed (Corbin & Strauss, 2008) but rather a 'probable truth', based on a shared truth between one another, and therefore leading to a shared meaning (Raddon, 2011). Contextually, the meaning that nurses experience in their day-to-day interactions are created, shaped and revised through their conversations with one another, and with patients. Hence, reflecting that truth is communicated through multiple layers of influence. These influences are shaped by personal history, culture, gender, philosophical and psychological theories. Thus, these aspects influence how each person, in this case how the nurse sees the world (a framework through an individual observes, interprets and interacts; based on beliefs, values or assumptions), that occurs at both the conscious and subconscious levels (Heidegger, 1962; Robertson-Malt & Chapman, 2017). As such, methodologically,

this research was designed to consist of two phases, one that enables deep discovery with a small group of nurses and the second which takes these described experiences to a broader group for confirmation.

Epistemologically, the researcher's position is that knowledge is gained by the experience of a fact within a situation. Thus, the researcher's epistemological orientation, is that people come to know through situated experiences and that knowledge changes through social interactions in time, and place cultures (Benoliel, 1996; Clark, 1998; Crotty, 1998; Letourneau & Allen, 2006; Vygotsky, 1978). As applied to this research, the focus group method was intentionally chosen because it allowed the GRN participants to put words to their experiences, respond to one another and revise what they come to know as their contextual, and modifiable truths through conversation with knowing-others (Heidegger, 1962; Crotty, 1998). In addition, to give GRNs a voice. An illustrative quote from one of the Phase 1 GRNs about the focus group process reflecting back on their first-year experience was:

> *"It makes you feel good when you know, and you look back and you think this is what I was like. Now you are going, you have learned. Sometimes you think, oh my goodness, but look back and you go, yeah, I'm doing all right."*

Furthermore, knowledge is also gained from a familiarity with and raised awareness of the facts and situations arising from experience. Thus, this forms a notable research design characteristic that follows on from the researcher's social constructionist epistemological perspective, as an informed-knower and participant-observer in the research process (Denzin & Lincoln, 2005). The researcher comes into the research as an experienced GRN, RN and GRN educator, with prior experiences, observations, reflections, thoughts, values and opinions, shaped through many interactions with other GRNs, RNs, GRN educators and patients. The researcher brings this situated knowledge into the research and shares them with the research participants to bring further depth to their own shared experiences and reflections. The researcher fully acknowledges and celebrates that the research processes and outcomes would have been different, if conducted with a different researcher and particularly one who was not richly invested in improving the GRN staff experience (Mills, Bonner, & Francis, 2006). Thus, being an informed-knower is a notable research characteristic that the researcher possesses and consequently, this research possesses and arises from

the researcher's situational experiences in Queensland, Australia from 1987 to the current period 2018.

The researcher's situational experiences are many, however three main experiences form the core of the researcher's reflections here. These include the researcher's initial reflections as a GRN, a District Nurse Educator, with a portfolio that included being a GRN educator and more recently, reflections as a Nursing Lecturer, in a higher education institution in contributing to delivering a three-year Bachelor of Nursing Program. Currently, the researcher is a nursing academic, with the title, Nursing Lecturer, within a School of Nursing and Midwifery in Queensland, Australia. The researcher has 9 years' experience in higher education as an academic and in total, 32 years' experience as a nurse. Initially, the researcher was a hospital trained RN, 1987–1990, gaining the certificate on August 10th, 1990. The researcher has continued professional development by gaining a Bachelor of Health Science (Nursing) in 1998, a Bachelor of Learning Management (Primary) in 2005 and a Master of Education (Learning Innovations and Futures) in 2010.

1.4.1 The researcher's reflections as a GRN

The researcher's reflections are written in first person for this section. Reflecting on my memories as a new GRN, I was excited to have graduated as an RN, wearing my white nurses' uniform and white nursing shoes. I felt exhilarated and couldn't wait to begin the next part of my nursing career journey as an RN. I remember feeling quite proud to have been chosen by the Nurse Unit Manager (NUM) of the Intensive Care Unit (ICU) to be a part of her team. I remember the words she spoke to me at the time. She said:

> "I have to say; I and the other members of the ICU team have been so impressed with your ability to hit the ground running in our unit during your final 6 weeks of your nurse training. The most impressive day out of many, was in fact your very first day in ICU. During handover, when several patients arrested within minutes of one another, we all were so impressed how you were able to participate and respond efficiently and fit in with the team like you had always been here. It is a real credit to you, and we welcome you to our team."

Hearing these words from her about my abilities to critically think and care for patients as part of an ICU team made me feel happy about the training and support, I had received over the previous three years to prepare me for this role as an RN in this acute setting.

Reflections about my first year are largely positive. The ICU team culture was supportive of me as a new GRN. The team, like they were during my training, continued to educate and support me every shift. The staff would role model care and think out loud as they performed the care and encouraged me to participate in new skills as my knowledge grew. The team gave me supportive feedback every day. In fact, the team would advise me on any content I was interested in, not just psychomotor knowledge and skills but other work-related knowledge and skills. For example, how to manage the doctors who were intimidating or nurse managers who spoke aggressively. Other areas they advised me on included relationships, diet, in fact anything I raised. I even remember several of the mature aged women, in their early forties raising my career plan with me. They all advised me to enrol externally at a university to do my nursing degree and said I could easily do the degree while I continued to work fulltime. They were all interested in my long-term success in an education system of nurses that was moving from hospital training at a certificate level, to university at a degree level. They advised that even though I was a Registered Nurses (RN), I would need my degree if I wanted to progress in my future career. The best time they advised to do this was while I was single and childfree. As I had strong trust in my wiser colleagues, I eventually followed their advice and enrolled into a Bachelor of Health Science (Nursing) externally at my local university.

Studying externally as a Bachelor of Health Science (Nursing) student while already an RN was valuable, as it raised my awareness about the type of content taught at university compared to my hospital training content. I remember my thoughts exactly, “Now I know why university GRNs are not prepared to hit the ground running when they begin work as an RN”. I remember feeling at the time, the course content had no real authenticity to the knowledge and work skills required of a nurse. This experience however was valuable to me as an RN working beside GRNs educated by the university setting as it raised my awareness about the difference between these two education settings, hospital education and training and university education. This raised awareness also informed my RN role in mentoring GRNs.

Participating in a nursing degree program raised my awareness about my broader role as an RN in mentoring GRNs in my workplace. My new knowledge gave me a direct path to the type of information and nursing practice I would promote while I worked alongside GRNs. I realised my role needed to build on the GRNs university education during their transition into the work place if they were to improve their nursing care practice. I realised that, for my mentoring role to be effective, I needed to address the gaps in the GRNs undergraduate and transition education and which for me was their critical thinking. Thus, when working with GRNs I began changing my work practice to include being explicit in my thinking process (that is, thinking out loud), to assist the GRN to connect the theory they had learned to informing their nursing care practice. I decided this way of working would assist them to develop as an RN in providing safe, quality care.

During this period of mentoring GRNs, I observed their strengths and weaknesses. Additionally, I also recognised how limited the Continuous Professional Development (CPD) they received was, in relation to supporting their personal and professional development, whether this was at work, study or personally. A concern I had for them regarding their transition education was a shared concern for my own CPD. I noticed the CPD I undertook was limited and repetitive year after year. Despite learning needs analysis surveys being conducted, the CPD remained relatively unchanged for GRNs and for experienced nurses as myself. As such, I always endeavoured to seek out the information I was lacking by reading and discussions with doctors and other allied health professionals. As time passed, I decided that if I was to influence the nursing practice care of more than just a few GRNs I worked alongside, I needed to become an educator. Therefore, with the desire to educate and train the next generation of nurses I enrolled in a Bachelor of Learning Management (Primary) and consequently, due to my qualifications and breadth and depth of nursing care experience, I secured a District Nurse Educator's role in a rural and remote setting in QLD.

1.4.2 The researcher reflections as a District Nurse Educator

The researcher's reflections are written in first person for this section. Reflecting on my role as the District Nurse Educator reveals a number of portfolios, however, one of my important portfolios was educating and supporting GRNs in their

transition. In this role, I was informally referred to as the GRN educator. During this 12-month period supporting 8 GRN transitions into their first-year as an RN, I observed a number of factors that appeared to compromise their well-being, career satisfaction and overall, their decision to stay or leave the nursing profession. The first factor was their lack of preparedness in executing nursing practice knowledge and skills relating to critical thinking in the nursing care approach; assessment, identification of problems, planning and implementing planned care and in evaluating care. I quickly recognised these limitations would negatively affect their ability to be effective as a team member in the high stakes hospital setting caring for patients presenting with common presenting conditions. Lack of critical thinking is a known factor affecting the GRNs' first year in the role as a GRN (Boychuk Duchscher, 2009, 2012; Duchscher, 2008). I knew that such skills were vital in their role as an RN and became concerned for not only the GRNs at the coal face of the care management of patients with the doctor but also the patients care experience; including the patient's safety and quality of care.

The second factor was their inexperience in managing a variety of personal impacts, especially in association with a rural placement. Some of these GRNs were experiencing displacement from their families and home environment and required support adjusting to the rural setting, especially as a rural setting is known for its limited resources, including accommodation and social life. Difficulty in health care workers' ability to adjust to rural contexts reflects an identified risk factor known for its negative affect on career satisfaction and retention (Buchan & Aiken, 2008). Other GRNs were experiencing relationship breakdowns. Thus, I appreciated that the issues affecting these GRNs were multifaceted and a GRN transition program that only focussed on updating and or extending their nursing psychomotor knowledge and skills was deficient. It would also not fully support GRNs in their need for both work and personal life education and support. In addition, another observed factor stemming from the experience of these GRNs and this was their strong motivation to strengthen their curriculum vitaes to improve their job and career prospects post their graduate transition year. However, GRNs' career goals in their transition year were hampered by my inability as a DNE to fully support them, as my role was designed to solely focus on the education, training and support predetermined and costed from an

organisational work need perspective, rather than a personalised GRN needs perspective.

Predetermined support is a missed opportunity to personalise support that will assist GRNs develop according to their individual requirements and needs. The predetermined GRN support I provided between 2006 and 2007 was based on the pre-allocation of hospital funds in the previous year by the District Director of Nurses (DDONs). This type of approach limited addressing GRNs individually and instead was an approach that targeted the organisation's goals. The predetermined support included the following personal and professional aspects. Personal support to GRNs was in the context of receiving twelve months' free hospital accommodation and free meals three times a day, seven days per week. Professional support included set education. This set education involved an initial two-day hospital orientation program that all new staff members receive, plus five days of face-to-face education sessions focused on preparing them for their role as a rural nurse.

Five initial days of education to prepare the GRNs for their RN role within a rural and remote practice was a very short amount of time to educate and prepare the GRNs. However, as these five days were not prescriptive, I was able to personalise these days to meet their needs in relation to their RN role readiness requirements. On reflection, these GRNs requested and received education explaining:

- The rural and remote health system, including the organisational structure, including the availability of doctors during and after business hours and how to respond in an emergency/disaster situation.
- Information about where to access information regarding policies and procedures.
- Information about how to reach a doctor after hours or when to refer to nurses with special qualifications such as the Rural and Isolated Practice Endorsed Registered Nurse (RIPERN).
- Policy informing midwifery care and their duty of care in this type of situation.
- Policies about dispensing medications after hours or in the absence of a pharmacist.

- Explanations of emergency codes, including how to initiate an emergency call, for example a code blue and how to respond to a code blue. Building on from this code blue education, GRNs expressed a deficit in how to manage a cardiac and or respiratory arrest. Therefore, a practice simulation session was set up to allow GRNs to familiarise themselves with the emergency equipment (commonly known in the hospital setting as the cardiac arrest trolley) and to practice a code blue as a leader and as a team member.
- Revisiting common documentation/charting requirements to clarify any areas of uncertainty. For example, how to document observations, read, interpret and use medication charts (including sliding scale insulin orders) and fluid charts, wound charts, etc.
- Use of equipment and the process for reporting faulty equipment. Use of equipment included how to take a manual blood pressure, pulse and respirations. How to use blood pressure machines, thermometers, oxygen saturations, intravenous therapy (IVT) such as to administer large volumes of fluid, syringe infusion pumps, such as to administer very small volumes, such as for sub cutaneous medication, plus equipment such as to take a patient's electrocardiogram (ECG).

During these five days, one final day was devoted to specific education about how to respond to a patient requiring medical/nursing care. This included revisiting the nursing process of care: assessing, identifying problems, initiating a plan of care and implementing and evaluating care. This process was applied to three common presenting conditions chest pain, ketoacidosis and a baby/child presenting with a high temperature. Important information included was how to care for patients as a team with the doctor, other nurses and allied health professionals.

Other education support GRNs received during their twelve months had been predetermined and pre-allocated to twelve days of external training per year. This training included knowledge and skill-sets on practice areas such as basic life support, venepuncture (the transcutaneous puncture of the skin by a needle or by a cannula that allows for the withdrawal of a blood sample and or to facilitate the insertion of a temporary plastic sheath that allows for medication administration, and or for an

attachment of an infusion), suturing, fracture care including cast plastering, primary and secondary assessment, burn care, spinal injury care and prehospital trauma care. This predetermined education did not include education on how to adjust to a rural setting, how to build new relationships in a new setting with differing cultural values, how to care for themselves and each other and how to further their education in the absence of an educator's support.

These experiences contributed to seeking a research approach that facilitates GRNs' voices so that they can be heard and acknowledged. Secondly, these experiences contributed to wanting an approach that would be open and not predetermined. Hence, Phase 1 of this study begins by exploring the GRN first year experience using conversation as the vehicle to seek GRNs' truth, a shared truth between each other and socially co-constructed with one another.

Another reflection during this period as the District Nurse Educator (DNE) included my particular plan of approach in seeking out the learning needs of the staff across this rural and remote district. On my arrival as the new DNE, I commenced a needs analysis survey of the GRNs and all nursing staff working in the district. The rationale for this survey was to determine the nurses' learning needs and priority areas from their perspective. Thus, this approach was an open approach by design and non-verbally signified that I, as the new educator, was open minded to meeting their learning needs, rather than an educator who assumes they know the learning needs of staff. The purpose of gaining these results was to guide future action and priorities. Consequently, galvanised by the results of this survey (and notably through the voices of GRNs), I advocated for broader support and received education from specialists in the areas of their work, study (career goals) and personal goals, such as healthy eating, healthy sleeping patterns and relationship skills at relevant executive meetings.

My ability to advocate and persuade in my role was limited within the particular culture I was positioned within. I was formally informed at the hospital executive meetings that each of the Directors of Nursing (DON's) for each hospital in the district would determine the learning needs of their staff and my role was to implement their decisions. This situation conveyed an autocratic culture rather than a participative culture and appeared unlikely to change. However, I continued to provide the broader study support to the GRNs.

This broader study support encompassed introducing the GRNs to learning opportunities external to the GRN program so that they could strengthen their knowledge and skills and simultaneously strengthen their CV's. The learning opportunities included workshops at private hospitals within regional and metropolitan areas and formal post graduate studies offered at various universities. I also continued to provide personal support to these GRNs but in a less formalised manner, such as in offering my time if they needed someone to speak with and or confide in, healthy eating and exercise habits and the importance of socialising and connecting with others in the community. However, as I was not an expert in these areas, I encouraged their use of the Employment Assistance Scheme (EAS) that could provide them with expert counselling and other professionals such as dieticians and fitness instructors at the local gym. However, this type of approach has limitations, because my response and interventions were based on a trigger, that is I responded only when I became aware of the GRNs concerns, rather than as a predetermined plan of consultation and targeted support. This was one of many experiences that contributed to my motivation to explore and, through research, gain an improved understanding of what was happening and why it happened in that way. The design that is best suited to discover this type of knowledge requires the same approach: that is, to be open minded and not predetermined. The phenomenon also needs to be able to be seen from different viewpoints.

These informative praxis-based experiences led me to apply for nursing lecturer positions in higher education institutions, specialising in nurse education. They drove my axiological (the role of contextual values) motivations to contribute to research and thus, to the generation of new knowledge directed at advancing the career preparation, satisfaction and impact of nurses. These experiences also provided me with an evidence-based voice to add to the curriculum taught to graduates to prepare them for work and life as nurses. Listening to the nurses' own voices through research to enhance nurses' preparation for life as practicing GRNs thus became a primary motivation. I intentionally pursued knowledge, skills and attributes in the disciplines of nursing, learning management and education to enhance my capabilities to positively impact research and practice in the domain of nursing careers. During this time (and through this education), I became aware of, and adopted, the theoretically-driven art and science of learning and teaching as well as contribute to the efficacy of

educators to promote lifelong learning. I also discovered (and embraced) facilitating the role of effective educators to scaffold students' positions from dependence to interdependence and finally to supported independence. This transformative educational approach can assist in preparing students to participate in and contribute to society in meaningful ways.

A transformative educational approach works best when based on rich tasks (real world value and use) that support the development of higher order thinking and the learning process itself. Such transformative learning relies on the learning and teaching (pedagogical) approaches adopted by the academic and the relevance of content embedded in the curriculum. To prepare myself for this higher education academic role, I completed a Bachelor of Learning Management and a Master of Education (Learning Innovation and Futures). I intentionally pursued knowledge, skills and attributes in the disciplines of nursing, learning management and education to enhance my capabilities to positively impact research and practice in the domain of nursing careers. During this time (and through this education), I became aware of, and adopted, the theoretically-driven art and science of learning and teaching as well as the importance of the efficacy of educators to promote lifelong learning. I also discovered (and embraced) the scaffolding of students' positions from dependence to interdependence, and finally to supported independence. In particular, this type of transformative educational approach works best when based on rich tasks (real world value and use) that support the development of higher order thinking and the learning process itself. It also relies on the learning and teaching (pedagogical) approaches adopted by the academic and the relevance of content embedded in the curriculum.

Forging a relevant and effective nursing curriculum that is transformative in nature is important to ensure student nurses are fully prepared for their role as an RN. To do this well I was aware that I needed to prepare myself for this role and the future role of the educator. Therefore, I undertook and completed a Master's in Education (Learning Innovation and Futures). Consequently, after completing this qualification and based on my other nursing and education qualifications and breadth and depth of nursing experience, I gained employment as a Nursing Lecturer in a regional university within QLD and continue in this role today.

1.4.3 The researcher reflections as a Nursing Lecturer

The researcher's reflections are written in first person for this section. Reflecting on my current role as a nursing lecturer reveals a number of portfolios I participate within, however, as part of my role, I work as part of a team involved in the five-yearly cycle to renew the Bachelor of Nursing Program. Part of my contribution is in advocating for the curriculum renewal process to be evidence-based and to address the needs of nursing stakeholders.

Providing an evidenced based Bachelor of Nursing Program that produces quality nursing graduates is important to meet stakeholders' requirements. Stakeholders include the Australian Health Practitioner Regulation Agency [AHPRA], established in 2009 as a result of the establishment of the Health Practitioner Regulation National Law Act 2009 (Australian Commonwealth Government, 2009) and responsible for issuing qualified nursing graduates' licenses to practice. The Australian Nursing and Midwifery Accreditation Council [ANMAC] is responsible for issuing nursing programs accreditation and is an acknowledgement that the nursing standards have been met (ANMAC, 2012). Other important stakeholders to include in measuring the quality and effectiveness of the nursing graduates produced are patients and GRNs themselves. The patients because they are the recipients of nursing care and GRNs because they are the outcomes (or products) of the nursing education programs – nurses delivering patient centred care.

These latter two stakeholders are vital in the evaluative process as their experiences can be used as quality indicators measuring the effectiveness of the nursing programs in fully preparing GRNs for their role and life as a RN. Alongside the patients and GRNs experience as a quality indicator, so too should be the industry's experiences. Both are important to providing evidence that can assist in the continual targeting and refining of the Bachelor of Nursing Programs' curriculum. This type of evaluation upholds the epistemology informing nursing governances and in doing so ensures nurses are meeting society's expectation for safe, quality care and contribute to the broader picture of economic responsibility in the education of nurses. These convictions underlie my informed approach to uncover the contemporary broader GRN first year experience with the intent to direct education and support reform to ensure GRNs' sustainability and retention within the nursing profession. The theories

and theoreticians that shaped my convictions are described and applied in the next chapter.

1.4.4 Researcher's personal praxis-based convictions

The researcher's personal ***praxis-based convictions***, together with the researcher's ***ontological, epistemological, axiological*** stances as applied throughout this research are important to share. These stances highlight the philosophical assumptions which have contributed to shaping of this research design to achieve a rigorous response to the research question. These stances are as follows.

Praxis: The researcher is an experienced nurse and nurse educator. The researcher's motivation to undertake this research was and remains, one that assists GRNs in fully preparing for their lives as nurses. This includes having access to up-to-date information on the knowledge they require to support them in all of their life roles, as well as knowledge about how to create capacity when a knowledge and skill deficit is identified and or needed. The researcher believes, that having this knowledge-base can assist the empowerment of GRNs to make informed decisions that are right for them (and those in their care) and can support nurses to be all they want to be personally and professionally. The research-based approach to preparedness taken in this study has the potential to improve nurses' first year experiences and welfare, as well as retention within the nursing profession.

Ontologically: The researcher's view is that human reality is individual. It is defined, shaped, experienced and articulated in a time and place, context and culture, and is socially constructed between people with whom we associate (Heidegger, 1962; Robertson-Malt & Chapman, 2017), resulting in a reality that is subjective and has multiple realities, based on each individual's perspective (van Manen, 2017). As applied to this research, this means that the researcher and participants - the GRNs, will all have their own personal perspectives based on our individual lived experiences of living and being in our life worlds. Lived experience is described as relating to living through an experience, however this 'knowing' requires a retrospective awareness process (Heidegger, 1962; Zahavi, 2005). Therefore Phase 1 used the processes and reflections, facilitated by the researcher and as an informed knower, guiding the GRNs to a state of awareness about their lived experience and allowing them to make meaning through sharing stories about their first year, how they managed

work, study and personal life and how their overall life balance was impacted. The research for Phase 2 then took these experiences to a larger sample of GRNs. Thus, the results from this research study reflects these GRNs' individual realities. The GRNs reality in this study has been defined, shaped, experienced and articulated in a time period unique to them and occurs in the contemporary 21st century period. Their context is within Queensland and includes an array of educational and clinical settings, geographical locations and culture. In addition, the GRNs' reality has been socially constructed between people with whom they have associated with.

Epistemologically: The researcher believes that our ways of knowing are socially constructed. The mechanisms of coming to know as well as our lived experience of that knowledge vary according to our cultures and contexts (Crotty, 1998; Heidegger, 1962; Vygotsky, 1978). As applied to this research, this means that the GRNs came to know about their first year lived experience and how life balance played out for them. This included the personal meanings that they gained because of the retrospective process of using reflective practice and due to the researcher's own lived experiences in the 'world of nursing'. Firstly, being a hospital educated and trained student nurse during the period July 1987 – July 1990, and secondly, as a GRN during the period August 1990 – August 1991. Other experiences included as an RN working alongside university GRNs, as a GRN educator, a nursing academic educating and training undergraduate university students and now as a nurse researcher. The researcher's conceptions of ontology and epistemology are intertwined and inseparable. This means that there is not an external reality out-there that the author's research can reveal, but that through authentically listening to the voices of nurses and acknowledging and appreciating the researcher's own experiences and cumulative knowledge-base. This faciliatates a shared understanding and advancement towards change and improvement in fundamental domains such as career preparation and success can occur.

Axiological convictions: This stance, in-turn, connects to the researcher's raised awareness through daily reflective practice about the researcher's own life working, study and living as a nurse and a person as one, and reflections of her lived experiences as a nurse in the 'world of nursing' and other life worlds (as aforementioned). This raised awareness is in fact about the researcher's every day experiences across their career to date, and while ordinary, actually does have

meaning. The meaning for the researcher is that the researcher can contribute to research to:

- Generating new knowledge to advance the career preparation, satisfaction and impact of nurses;
- Provide the current generation of GRNs with a voice in the curriculum taught to graduates to prepare them for work and life as nurses;
    - Listen to the nurses' voices through research; and
    - Enhance nurses' preparation for life as practicing GRNs.

1.5 CONTEXT OF THIS RESEARCH

The context where this study was undertaken, included the political and cultural landscape in action at the time. Additionally it included the phenomenon of the nursing shortage as it was encountered within this context, with reference to the worldwide shortages and consequent attrition from the nursing profession. These contexts has occurred in the contemporary 21st century and are described next.

1.5.1 Social and political landscape

Current retention strategies suggested by Health Workforce Australia [HWA] 2013-2014 strategic plan (2012) are targeted at two levels within the health system: organisational and government policy. Organisational level examples include health organisations to support a change in work place environment. These include providing flexible work arrangements that support family responsibilities and continuing professional training and career pathway opportunities to foster professional goals. In addition, Higher Education institutions need to focus on delivering more efficient and effective training and nursing governance bodies need to support nurses to practice within their full scope of practice. However, examining these strategies also reveals that strategies fail to fulfil alignment to the National Safety and Quality Health Service Standards, Standard 2, Partnering with Consumers (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2017) and is a gap in understanding and implementation. Strategies at this level, would include partnering with nurses to ensure representation exists at all levels of the health and education system. Doing so would mean the system would extend its current position, partnering

with patients/consumers to meet the expectations of patients/consumers from their perspective but would also include partnering with nurses to assist in identifying and evaluating problems and solutions from the nurses' perspective as equals and as valuable as the patient/consumer. This study contributes to the HWA retention strategies for nurses and addresses the gap focused at the government level of 'Partnering with Consumers' that needs to also include nurses.

This study complements the HWA retention strategies by focusing retention strategies at the individual level with intent to assist in informing the HWA's strategies targeted at the organisational and governance education and health levels. The study focuses on investigating Queensland, Australia's GRNs first-year experience of 'Work, Study and Personal' life, the Load Triad to address their needs and preferences, to aid in their improved welfare and retention. One of the key educational best practice philosophies underpinning and guiding educational learning goals to improve an individual's welfare in all their life roles is lifelong learning. Lifelong learning, as defined by Longworth and Davies (2003) is:

> Development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments. (p. 22)

Reflecting on this definition of lifelong learning, can be seen as an holistic vision for education, that incorporates not only an individual's current learning goals but is futuristic, guiding educators to prepare individuals for their anticipated life roles and environments. However, while it can be viewed as holistic, Crowther (2004) identifies an important ethical element that is missing: the access and opportunity to learn. Crowther (2004) argues that earlier education visions from the 1970's, such as the learning society and lifelong education were based on social justice concerns advocated by the United Nations Education, Science and Cultural Organisation [UNESCO]. Therefore, educators need to not only be aware of lifelong learning goals but also to put this missing aspect, access and opportunities, into their learning practices for students.

Lifelong learning is an educational philosophy approach to learning. This educational philosophy of approach is evident at the nursing governance level,

specifically in the Registered Nurse Standards for Practice, Standard 3, "Maintains the capability for practice" and sub criteria, 3.3 "Uses lifelong learning approach for continuing professional development of self and others" (Nursing and Midwifery Board of Australia [NMBA], 2016b, p. 4). However, understanding surrounding lifelong learning implementation from a nursing governance to organisational and individual levels, including evidence of its attainment, has been difficult to locate within the literature review to date and is therefore a gap. This study closes this knowledge gap, increasing the improved knowledge surrounding lifelong learning and will assist in designing strategies targeted at the organisational, and individual level, to aid in GRN preparedness, welfare and retention. These specific strategies are transferable from the GRN cohort to the nursing profession as a whole, as well as to other professions experiencing attrition.

1.5.2 Nursing shortage

The nursing shortage is a global phenomenon and involves many countries. Researchers have predicted this shortfall will intensify within the decade due to nurses' retirement (Boumans, de Jong, & Vanderlinden, 2008; Norman et al., 2005). Countries affected were identified in a study by Aiken et al. (2001) and included Canada, United States, England, Scotland and Germany. Chen and McMurray's (2001) study identified Taiwan. George, Quinlan, Reardon, and Aguilera's (2012) study identified South Africa, while Demir, Ulusoy and Ulusoy's (2003) study identified Turkey. While the ageing nurses taking up their retirement have been identified as a contributor to this widening gap in supply of nurses, a secondary factor has also been highlighted, GRN attrition.

1.5.3 GRN attrition

GRN attrition is an added concern to the widening nursing shortfall. Booth (2011) measured GRN attrition rates in the United Kingdom at 60% with one-third of new graduates not even registering as a nurse, while Griffin's (2004) study estimated turnover of new nurses in the United States was as high as 61%. This global impact should heighten concern for Australian health workforce planners (HWA, 2012) as Australian shortages cannot and should not rely on attracting nurses from other

countries to fill local shortages (Watson, 2010). Therefore, a concerted effort to narrow the nursing shortage is needed.

Ensuring the ongoing availability of a sustainable Australian nursing workforce is essential in addressing the predicted national and existing global health care demands. A common bi-fold strategy used by organisations to address staff shortages is through recruitment and retention of staff (Newman, Maylor, & Chansarkar, 2002). The application of this bi-fold strategy in addressing the nursing shortage in Australia is limited in the area of international recruitment but there are opportunities for growth in the area of domestic recruitment and retention. These opportunities include focused, heavier recruitment demands for the domestic supply of nurses. For example, a focus on the re-engagement of trained nurses back into the workforce, increasing the number of GRNs through targeted marketing campaigns to attract local students to enrol in nursing programs (Gaynor et al., 2007) and improved GRN support to aid in GRN retention; a contention of this study. Support that is ongoing for all staff once recruited is as critical as recruitment in sustainably managing and narrowing the nursing supply gap.

1.6 NURSES' WORK-LIFE BALANCE

A life in balance promotes wellbeing, life role satisfaction and retention in the workplace. In this study, nurses' capacities to effectively manage their work, study and personal lives. There is a paucity of research on the 'Load Triad' or life balance experiences of new nurses, including their life role satisfaction and reflections about retention and or attrition. To help address this lack of knowledge, this study will investigate Queensland GRNs' first year experiences and how these experiences are related to nursing attrition. The pertinence of the research study is reinforced because globally, it is recognised that GRN attrition rates in the first year of employment are high. Further, if these high rates attrition are not addressed, accurate predictions about the supply of nursing graduates needed to fill expected vacancies in Australia (HWA, 2012) will remain unclear. Conversely, research on work-life balance has demonstrated that employers who support their employees to have life balance, not only promoted their employees job satisfaction but also their retention (Deery & Jago, 2015; Nayda & Rankin, 2008). Therefore, exploring GRNs life balance is important

to determine if this is an area impacting their ability to effectively enact their life roles and triggering attrition.

Life role salience is closely associated with work-life balance. Life role salience refers to the importance a person places on various life roles they have and the personal satisfaction they derive from these roles in their lives. This includes their role at home and within their family, student, leisure and fitness activities as well as from their community service (Argyle, 1996; Thoits, 2012). Research has revealed that when employers support employees to manage their many life roles outside of work, they were more satisfied in their work roles. Thus, employers who support their employees' life role salience directly influence employee retention (do Rosario Lima, Cruz, & Rafael, 2014). Thus, there are benefits of investigating GRNs' experiences of life balance to understand the ways in which their assent (ascent) to a life in balance and associate life role satisfaction, wellbeing and retention in the workplace can be increased.

GRNs in their first twelve months are new and inexperienced in relation to managing their new work roles with their existing life roles to achieve a personal sense of life balance that is right for them. Therefore, this study is focussed on gaining an understanding of the broader GRN *Load Triad* experiences to help identify and implement appropriate and effective holistic support for nurses in their transitions. This would include identifying the type of support required, who best should deliver this support and the implementation of the support. The intention is to build an evidenced based approach to support that aligns with the contemporary factors affecting GRNs. Thus, this evidenced based platform will be able to improve the GRNs' first year experiences, reduce their attrition from the nursing profession and ultimately narrow the nursing shortage gap. Figure 1.1 illustrates this approach in relation to this study. This broader approach is key to managing the sustainability of the nursing workforce.

Figure 1.1. Procedure of the study.

1.7 RESEARCH OBJECTIVES

The main objectives of this research are to:

a) Establish the relationship of the *Load Triad* impact on GRN life balance and attrition intent.

b) Investigate GRNs' experiences to identify GRNs' lack of preparedness and vulnerability in their experiences as first year nurses making their transition and the relationship of these experiences to attrition.

c) Explore the requirements underpinning the design of a *Load Triad* Assessment tool that uses behavioural indicators that represent GRNs' preparedness and resilience and these factors relationships with retention.

d) Outline and recommend preventative education support that targets the individual domain within the *Load Triad* identified at risk, as well as the *Load Triad* as a whole, to promote balance and retention.

1.8 RESEARCH QUESTION

The primary question guiding this research is:

What are the factors affecting the graduate registered nurses first year experiences in managing work, study and personal life and to what degree do these factors and the possible relationships between them, affect their overall life balance?

1.9 RESEARCH DESIGN: A BRIEF INTRODUCTION

The research design of this study used a Mixed Methodology to address the research question (Section 1.8) and is briefly introduced here and elaborated further in Chapter 4. As the GRN experience in Queensland, Australia, is relatively unexplored in relation to work, study and personal life, a two-phase study was implemented to address this gap. Thus Phase 1 design explored the little understood GRN *Load Triad* experience using a focus group. The strengths of this approach included a) the identification of the actual lived experiences of a group of recently graduated and employed RNs, b) the classification of key contemporary factors affecting GRNs Load Triad, and c) the determination of the interrelationships between these factors and their overall impact on GRNs' overall life balance. The results from the focus group then informed the second method, Phase 2, where data was collected from a wider group of participants (GRNs) using a survey. This survey instrument design used in Phase 2 originated from Phase 1 results - the main factors affecting the GRNs' *Load Triad*. The purpose of the survey was to determine if Phase 1 results could be generalised to a larger sample, that is, the Phase 2 survey sample. This choice of methods for Phase 1 and 2 is the most appropriate, or best fit, to answer the research question. The best-fit approach, as advocated by Creswell (2011), is using the paradigm and methods that are able to provide a comprehensive answer to the research question but one that also considers the practical resources such as skills, time and money. Thus, the best-fit approach used for this study to address this research question (Section 1.8) was a Mixed Methodology.

1.10 THESIS OUTLINE

The following section outlines the chapters for the remainder of this thesis.

Chapter 2 – Philosophies and theories grounding this research study: A number of philosophies and theories underpinning, informing and guiding this research study are presented. Key phenomenologists presented are: Heidegger's '*Dasein*' and '*Vertehen*' (1962), Husserl's '*life world*' (1931, 1962) and van Manen's '*lived experience*' (2017). Additionally, relational power, focusing on Foucault's '*care for self*' (1981-82) and '*discourse*' (1972, 1997, 1988), as well as concepts of belief, culture and cultural safety (Best,2014). Also presented are nursing and nursing philosophies guiding nursing practice; holism, person-centred/family centred care and

the nursing process of care approach and the importance of nursing theory to inform nursing care – praxis; as well as nursing codes and standards governing nursing practice that guide the nursing curriculum and the nature of nurses thinking, behaviour and practice. All of these aspects are evident throughout this research study as they are an integral part of my ontology, epistemology, axiology and praxis. In addition, key educational theories 'signature pedagogies' (Shulman, 2005), learning approaches of lifelong learning, heutagogy, metacognition, learning and development, and '*knowledge building and knowledge creation*' (Bereiter & Scardamalia, 2014) life career education, life balance and life role salience in combination these theories and philosophies explain the lens used throughout this study.

Chapter 3 - **Literature Review**: Provides a review of the key literature pertaining to the focus of this study. This includes the historical background comprising of three sub topics: Global nursing shortage Australian and international GRN attrition and Australia's historical education and training of nurses. Other topics include the GRN lack of preparedness experience and support, as well as topics pertaining to employee life balance and nurses' life balance and specifically GRNs' life balance. A synthesis of the literature review is presented and draws from this, key concepts to form the theoretical and conceptual framework framing this study and this study's research question.

Chapter 4 – **Research Design**: Describes the best-fit approach to answer this study's research question and presents and explains this study's methodology, the post-positivism paradigm and use of a mixed methodology and the method, mixed methods exploratory design that demonstrates two ontological oscillations approach from an three oscillation approach: For Phase 1 the ontological approach is interpretive and uses a focus group as the method. For Phase 2, the ontological approach is positivist (traditional) and uses a survey as the method. Additionally, this chapter also presents the research aims, context, participants, data analysis, and ethics.

Chapter 5 – Results: Presents the findings for Phase 1, the focus group, including how these findings connect to Phase 2. As well as the findings for Phase 2, the survey.

Chapter 6 – Discussion: The discussion provides an interpretation and evaluation of findings, with reference to the hypotheses and the literature. In addition,

this chapter introduces and explains three new theories as an outcome of this study and details the theoretical and practical implications.

Chapter 7 - Conclusion and Recommendations: This chapter completes the research process and reflects on the GRNs' first year experience managing the *Load Triad*. The value and significance of the findings are reaffirmed, with key GRN supportive strategies recommended to support GRN's transition and retention within the workplace and transition into the life as a professional nurse from a holistic '*whole health and education systems'* approach. As part of these strategies, a preliminary model is illustrated and explained to represent this overarching strategy of using the GRN experience as feedback loops to improve the preparation of nurses and first year transition support.

Chapter 8 – Reflections and Final Thoughts: This is closing chapter providing a brief on why this research study was important to me personally and how this process has enlightened and transformed me into a person who has passion and a real purpose and meaning to my role in life, educating and supporting nurses to be all they can be in all their life roles, with confidence, joy and satisfaction.

The following chapter sets out the philosophies and theories grounding this research.

1.11 CHAPTER SUMMARY

Chapter 1 introduced this research project and outlined why GRNs' first year experience is important. Chapter 1 has introduced this research project that investigated GRNs' first year experience in how they manage work, study and personal life (the *Load Triad*). This research took place at a pivotal time in Australia and in the researcher's local region in Queensland facing an impending nursing shortage, a shortage which will also effect Australia as a nation within a decade. In light of the largely unknown status of Australian GRN welfare, combined with a developing and impending nursing shortage worldwide and augmented by high international GRN attrition rates, the project's role in gaining an improved understanding about the QLD GRN *Load Triad* experience is timely and important.

The understanding gained from this study will provide evidenced based recommendations that will act to reduce GRN attrition and the anticipated nursing shortage. The importance of knowing and understanding the GRN *Load Triad*

experience is that their experience informs early feedback loops to educators to design an improved, more effective and more widely applicable undergraduate nursing and GRN transition programs. The benefit of these early feedback loops derived from GRNs' experiences also provides formal evidence that will drive reform that is targeted, timely and specialised. The project will also ensure that reform aligns with the goals of lifelong learning, nursing governance standards and is able to remain responsive to the GRNs' contemporary environment.

The new knowledge gained from this research will assist in improving the GRNs' preparedness for their transition into their first year and contribute to replenishing and maintaining the nursing workforce. Further important outcomes from this study are an improved patient and industry experiences derived from having fully prepared, motivated, happy and healthy nurses delivering safe, quality care.

Chapter 2: Philosophies and Theories in Use

2.1 CHAPTER INTRODUCTION

Presenting and outlining the philosophies and theories used is important as they provide the researcher's personal perspectives which are fundamental to this research study. In this thesis, the researcher draws from European philosophy from the past one hundred years, especially those philosophers who were existentialist in their thoughts. Consequently, this philosophical work is fundamental to the nature of understanding the challenges facing Graduate Registered Nurses (GRNs) working, studying and living a life as a nurse. It is also fundamental to the nature of understanding the challenges facing higher education nursing education programs and transition support initiatives. This is critical as these education programs and transition support initiatives respond to the changing nature of the GRNs role and ongoing change in the health environments GRNs in their first year are situated within. The works of these existentialist philosophers represent current efforts towards creating knowledge to improve our understanding of what is meant when we say, 'to be a human being' and to "being' and therefore, what it means to 'be there in the world' (Barnett, 2007, p. 3). This philosophical perspective is important to unpack because it will assist in improving the understanding about the GRN first year experience 'being a GRN, there in the world as a GRN', and 'being a person there in their myriad life role worlds' and thus their experience is likely to be multilayered and complex by its very nature. Therefore, this chapter extends beyond describing these philosophical thoughts and shows these philosophers' ideas and concepts relate to GRNs first-year experience.

Chapter 1 introduced how the experiences of early-career nurses (after participating in university education) are situated and thereby contextualised in Queensland, Australia. The research presented in this dissertation is contextualised by three main factors. These factors include, first, the social and political landscape of the Australian heath care system; second, the nursing shortage and graduate nursing attrition; and third, nurses 'work/study/life balance'. How this research was

conceptualised and progressed however, was further influenced by the researcher's philosophical assumptions of the world. As demonstrated in Chapter 1, research is always bounded, situated and contextualised by factors in the time, place and environment in which it takes place.

Research is constructed, enacted and shaped through the researcher's conceptualisations of ontology, epistemology, axiology, rhetoric-(ology) and methodology. The researcher's transparency in relation to their philosophical propositions is important as this transparency shows how the researcher comes to know and conceptualise the ontological (nature of reality), epistemological (the researchers relationship to the life-role of knowledge), axiological (the role of contextual values), rhetorical discourse (ethos/ethics, logos/logic and pathos/emotion and relational power inherent in used-language) and methodological (theoretically-derived process) origins. Each of these elements affects the nature of raised questions and interacts with the researcher's own experiences, education, inclinations and situated life experiences. As such, the resulting research design and outcomes have implications for application and thereby practice (Creswell, 2010, pp. 74-75). This chapter introduces the researcher's philosophies and theories used to underpin this thesis.

At the intersection of the researcher's philosophies regarding the nature of existence, knowledge, values, language and research itself and the context of the situated inquiry is theory. Two types of theory form the foundations of this research. Firstly, generalist philosophical theory that informs the overall design of this research and secondly, specific theory, inherent to the situated context of nursing, education and nurses' careers.

The overall philosophies presented in this chapter are post-positivism (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1998, p. xviii) and Heidegger's phenomenology of lived experience' (1962); Husserl's phenomenology (1931, 1962), and relational power as agency focussed on current discourses and GRNs ability to implement self-care; Foucault's care of self and discourse (1981-1982; 1988); the nursing philosophies of holism (Smith, 2014); person-centred/family-centred care (Dempsey, 2014; Shields, Pratt, & Hunter, 2006); and the nursing process of care (Dempsey, Hillege, & Hill, 2014).

In addition, and as relevant, particular nursing, education and career theories also inform the research design. Nursing theory embodies the empirical

evidence that promotes safety, quality of care, improved outcomes and experiences in nursing praxis for all stakeholders: patients, families, health professionals, organisations and society. Therefore, nursing theory is an important in contributing purposeful intent and the '*way of working*' to achieve this study's aims. *Education theory* represents the empirical evidence that promotes the overall quality of the education experience, including the achievement of learning outcomes and graduate attributes to ensure graduates are ready for their work role. Running parallel to education theory is career theory. *Career theory* is important because its intent and purpose is to assist individuals to be active in the selection of their career and to promote career satisfaction and retention. In addition, career theory when implemented well at the undergraduate and into individuals' life careers, can facilitate positive ripple effects. For example, benefits can accrue in an organisation in the form of a competent work force, increased productivity and lower costs associated with reduced staff turnover (Holland, 1973; McMahon & Patton, 2014). Nursing, education and career theories underpin the research design and, combined with the philosophies described in this chapter, form the foundation of the research design discussed in Chapter 4.

This chapter begins with a discussion of phenomenology as a philosophy and the lens it provides to explore the lived experiences of GRNs. The discussion then shifts to relational power which shows how the individual GRNs' sense of agency to change their circumstances is challenged by societal, educational, organisational and workplace cultures and their discourses. The nursing philosophies and associated theories used to highlight the juxtaposition of the GRNs health and wellbeing and current levels of care, including institutional and self-care, are then explored. Finally, the influences of educational theories and life career theories on the lived experiences and life balance of GRNs are presented.

2.2 PHENOMENOLOGY

The nature of phenomenology allows it to be used as a philosophy and as a research methodology. Phenomenology as a research method is commonly adopted by qualitative researchers (Dowling, 2005) and applied accordingly when a shared focus on gaining meaning from human experiences is required (Larsson & Holmström, 2007). This study is focussed on developing shared meaning around the nexus of GRN preparation and transition into the nursing profession from a higher education context

and as such, phenomenology as a philosophy (as discussed in below) represents a powerful means of developing that meaning.

Existentialist philosophers are valued by society as they assist in improving our understanding about ourselves and others and our purpose and meaning for our lives. While it is acknowledged that Heidegger, Husserl and van Manen have all made significant contributions to improve our knowledge about ourselves, the research participants and the stance from which they speak (Ellis & Flaherty, 1992, p. 5), this research study has only used selected concepts from their contributions that improve the understanding about the GRNs' first year experience. The selected concepts include life-world, the lived experience and self. These concepts were selected as they improve the researcher's knowledge but also knowledge about the research participants - the GRNs and the stances they take about their first-year experiences as practicing nurses, managing work, study and personal life. This study sought to illuminate what it is to be a 'Graduate Registered Nurse', in order to offer a deeper meaning of their experiences and their intentions (van Manen, 2002). The following section presents these philosophers' selected concepts relevant to this research study.

2.2.1 Heidegger: Dasein

Martin Heidegger was a hermeneutic phenomenological philosopher with a distinct ontological research approach that reflects a certain perspective about the nature of reality and meaning from life experiences by '*being in the world*'. Heidegger views the nature of reality as constructed from being born human and from '*being in the world' – 'Dasein'* (Heidegger, 1927, 1962). It is important to delve deeper into the '*Dasein*' meaning, 'being-there *in* the world' and therefore forms a quality of place, known as 'placedness' of 'being'. Therefore, '*being*' is much more than just 'there' but is more about 'being *in* there' (Barnett, 2007, p. 28). For example, in '*being in* a hospital setting' can be applied to the GRN context, such as a GRN walking down a corridor in a ward as part of providing care for a patient and the GRN considering what is required for that task. Thus, the GRN is *there,* in a particular place, being part of that place, especially to the extent that they feel themselves to be part of that place, that corridor, that ward and that hospital at that particular time. However, the GRN is (and will be) themselves in any similar place.

Consequently, it is important to recognise that no one can feel the GRNs feelings, however much others, say her fellow GRNs, may empathise. Particularly, as the GRN struggles with the care they are providing or as they grapple with how to effectively manage a patient's family who are upset. Even if complete empathy was possible, this GRNs feelings, their '*being'*, is theirs alone. Thus, their *being* is theirs, in each situation and it is unique to them alone. More than that, their personhood and their feelings are an intrinsic part in their '*being'*. Also, they will experience many of these emotions and feelings across all their work and life roles and so there is a continuity of '*being*' across all their life role settings. Hence, the beginning of an improved understanding about the complexity of the GRNs '*being', being a GRN in their first-year experience*. Importantly, being aware of these existentialist philosophers' thoughts about '*being*' such as Heidegger's, allows these aspects to be illuminated within the GRNs experience, adding a deeper understanding. GRNs '*being'* is "specific and general, enduring and even sometimes fragile; barely felt and yet fully conscious" (Barnett, 2007, p. 28). What is reality then to GRN described in the example above and how is it that they build that reality, considering how enmeshed their '*being*' is to their 'placedness'? Thus, it is important to recognise that part of '*being*' a human being means acknowledging that humans are shaped by internal and external influences.

According to the social constructionist epistemology, the nature of reality is co-constructed in a social-cultural context and is shaped by past experiences, culture, history, gender and future intentions (Koch, 1995). This means that these influences cannot be separated from being human, and that it is important to acknowledge that human existence and what it is to be human, need to be viewed as one together (Koch, 1995; Spiegelberg, 1994; Walters, 1994). Therefore, in Phase 1, the researcher needed to consider seeking out GRNs of different genders, ages, and social cultural, clinical contexts to capture the varying aspects of the individual GRNs reality of being a 'person there in the world'. However, due to the time limits of capturing GRNs close to completing their first year, the first four GRNs in the eleventh month who volunteered were selected and recruited. In this research contexts, 'being in the world' include the following life worlds of the GRNs. These are the '*current and preceding political and social world of society*', the '*world of nursing*', the 'w*orld of nursing education*', the '*world of the health organisation'*, the '*world of being a GRN*' and '*the world as nurse and as an individual person wrapped as one*'.

Additionally, the Heideggarian view of the world where knowledge and meaning are gained by individuals co-constructing their experience together, was applied to Phase 1 by situating the GRNs in a small intimate social group to facilitate the co-construction of their experience together (their reality of their first year as GRN). It was hoped to understand how their reality was being influenced by past experiences, culture, history, gender and future intentions. In addition, this stance parallels that the researcher in that they are human and consequently are also shaped by past experiences, culture, history, gender and future intentions, and this was especially for me as the researcher in this study. Hence the research process at every point was influenced and shaped by me as the researcher, contravening its objectivity in the sense of the bare essence of objectivity. Reflexivity was adopted to represent my subjectivity as an opportunity and as a resource that contextualised and enhanced the quality and value of the research process (Finlay, 2002), rather than be viewed as a threat to the quality of the research and therefore requiring bias management in objective terms (Denzin, 2001). Therefore, the distinct Heideggarian approach, '*being in the world*', is evident in underpinning and guiding Phase 1 of this research study.

Heidegger's '*Dasein*' has a 'heart' of care. The nature of reality as constructed from being born human and from being in the world – '*Dasein*' also represents the inescapable concern (care) for the world. This concern (care) encompasses the past, the present and having a future (Wilson, 2014). Polt (1999, p. 156) highlights these three care concerns are related to the interconnectedness between 'thrownness', 'absorption' and 'possibility'. '*Thrownness'* pertains to being positioned into the world in a way that matters to us. *Absorption* relates to falling or 'caught up and lost in the moment' (Dostal, 1993, p. 156) and *possibility* concerns being involved in projects that will benefit the future. Applied to this study, the researcher has '*Dasein*' for GRNs past experiences, their current experiences, and their health, quality of life and career aspirations. Hence, my involvement in this research study is to create a future possibility for GRNs that improves their first-year experience in relation to work, study, personal life and the overall life balance, health. Additionally, the researcher has a deep concern for society, to supply at least sufficiently capable nurses to meet the care requirements of people now and into the future. The participants also have '*Dasein*', as demonstrated by volunteering for this research study. The act of volunteering demonstrates concern for their own and each other's welfare and career

aspirations, their welfare and career aspirations of future GRNs, and their care of their patients now and of the future.

Heidegger's future of possibility is based on action. Heidegger describes this action as '*Verstehen*' and comes from a position of seeing 'existence' clearly (Wilson, 2014). Heidegger's action has been described by Wilson (2014) as the "ability to do, the know-how and is based on sense making and capacity" (*p. 2912*). *Verstehen* is therefore important in relation to this research study, where the future possibility is based on seeing this phenomenon, the GRNs first year experience, as something to take future action about. In this case, the researcher's and GRN participants' '*Dasein*' has created a '*Verstehen*' as an outcome of the GRNs first year lived experience to manage work, study, personal life as the driver to improve the GRN first year experience and retention in the nursing profession as well as to close the nursing shortage gap.

2.2.2 Husserl: Life-world

Edmund Husserl introduced the concept of '*life-world*' or lived experience as important to gaining knowledge and meaning. There are a number of definitions of the concept of life-world. Beginning at the dictionary level, life-world is defined as:

> The world as immediately or directly experienced in the subjectivity of everyday life, as sharply distinguished from the objective "worlds" of the sciences, which employ the methods of the mathematical sciences of nature; although these sciences originate in the life-world, they are not those of everyday life. The life-world includes individual, social, perceptual, and practical experiences. The objectivism of science obscures both its origin in the subjective perceptions of the life-world and the life-world itself. In analyzing and describing the life-world, Phenomenology attempts to show how the world of theory and science originates from the life-world, strives to discover the mundane phenomena of the life-world itself, and attempts to show how the experience of the life-world is possible by analyzing time, space, body, and the very

> givenness or presentation of experience (Encyclopedia Britannica, 2018).

A scholarly definition by Edgar (2006, p. xvi) defines life-world as:

> …the social world as it is constructed and maintained through the taken for granted social skills and stocks of knowledge of its members. The life-world is therefore maintained through ordinary people communicating with each other, and thereby establishing a shared understanding of the world as a meaningful place. Other people's actions can be responded to because they make sense – they are part of the process of communication. The life-world carries the traditions of the community and is the source of individual socialization.

However, Froggatt, Hockey, Parker, and Brazil (2011) channel Habermas (1987) life-world concerns as "the worlds of meaning developed for individuals, groups and societies, through interactions with others, and manifested in everyday life; the life-world is characterised by inter-subjectivity and communicative rationality" (p. 263). This thesis adopts the meaning and value of life-world that is derived from these constructs by Froggatt et al., (2011). Therefore, life-world is characterised and recognised, through three structural elements by which individuals inter-relate with others. These three elements are: 1. the abilities individuals have in adding to a common and shared understanding of an event in context; 2. the collective identity of individuals developed and nurtured through belonging to a group; and 3. the culture whose accumulated knowledge, has the capacity and potential to achieve agreement that enables action to instigate and direct change.

Husserl is a philosopher who specialised in the *lived experience* (1998), however his approach differs from Heidegger (a student of Husserl). Heidegger's distinctive feature was of genuine phenomenology inquiry, in that the researcher will *describe* (Kohák, 1978), whereas Husserl, a proclaimed positivist and phenomenologist, held assumptions that the lived experience inquiry can be *objectified* (Husserl 1931, 1962). This very aspect, objectifying the lived experience, indicates a positivist approach (Kohák, 1978) and was applied to this research study in objectifying subjective information - the GRNs first year lived experiences managing work, study and personal life. This approach that gains both subjective and objective information is

consistent with the researcher's epistemology as a '*nurse and researcher as one*' in how nurses' assess patient care subjectively and objectively and hence has adopted the same '*way of working*' as a researcher.

As a researcher, this '*way of working*' is supported beyond the nursing epistemology, by also being supported by Heidegger, in that the researcher cannot be separated from their culture, values and beliefs and Husserl's assumptions about the '*lived experience ways*' can be objectified to gain deep knowledge and meaning about *something* for future possibilities. In this case, the *something* is deep knowledge and meaning about the GRNs first year experience – work, study and personal life and the future possibilities of action that will improve the GRNs first year experience and retention.

2.2.3 van Manen: The lived experience

Max van Manen (1990, 1997, 2017) asserts that phenomenology is a philosophically based enquiry under continual evolution and thus he expects the future to move beyond the leading literature and thinking. van Manen's (2017) focus is the *lived experience* and the importance of knowing what lived experience means. He asserts the lived experience is the "aspects of the experience as we live through them" (van Manen, 2017, p. 812). van Manen captures the lived experience by using the process of retrospective reflection to raise awareness about the experiences and to make meaning. Retrospective reflection places the lived experience in the past, because as soon as the reflection process begins, the living moment experience is gone. This is because the reflective process is the vehicle that moves the lived experience to the consciousness (van Manen, 2017, p. 812). Hence, when using the tool 'reflection' about the lived experience it is important to capture the true 'lived experience' from which to embark on the analysis and consequently to draw conclusions that will direct future strategies for reform.

Applied to this research study, Phase 1 was implemented at the eleventh month of the first year to best capture the GRNs first nursing year 'lived experience'. Therefore, GRNs in Phase 1 of this study were selected purposefully according to their first-year experience as a GRN and hence, selected at their eleventh month of their twelve-month experience. Phase 1 used the retrospective reflection process to capture the GRNs moment, 'living through the first-year experience'. The retrospective

reflection process moved the GRNs from a point of 'living through the experience' to a conscious state of self-awareness about their first-year experience. Consequently, Phase 1 did not collect any more 'lived experience data' beyond this point in time as the GRN 'lived experience – their first year' was completed. The distinct van Manen approach is evident in Phase 1 of this research study.

2.3 RELATIONAL POWER

This study incorporates the notions of truth, power and the lived experience as being central to an improved understanding the *Dasein* of participants. The theories of Michel Foucault in this regard offered a conceptual basis for this project and the understanding of the lived experiences offered by participants. As such, these concepts are embedded throughout this thesis.

2.3.1 Foucault: *Care of self*

Foucault's *Care of self* (1981-82) and Heidegger's *Dasein* are both relevant to this study to assist in analysing the GRN first year experience as they both have the potential to evolve to a natural ontological fit. This means that Heidegger's *being human,* representing the inescapable concern (care) for the world, could evolve naturally to also include the inescapable concern for self, self-care and the practical application of this as advocated by Foucault (McNeill, 1998) in relation to his *Care of the self.* Common ground between Heidegger's '*Verstehen*', position of action, based on future possibilities that encompasses the past, the present and having a future can also be argued as being relevant to Foucault's *Care of the self,* in that it supports the practical application of self-care. McNeill (1998) raises awareness about Heidegger's early thoughts about *being and time* and Foucault's work, *The ethic of the concern of the self as a practice of freedom ethics* as sharing common ground for the theme "*care for the self*" (p. 53). McNeill notes however that it is important to acknowledge they are not saying "the same thing" about '*being*'. Rayner (2004, p. 419) confirms this distinction, but sees that it is a value adding concept, by acknowledging "Foucault's final interview where he claims that he uses Heidegger as an instrument of thought" in relation to viewing '*problematization.*'

Foucault places a positive view on '*being*' by saying '*being*' functions as an object to be "critiqued". The point of difference, value add `identified by Rayner

(2004) continues, with Heidegger on the opposing side to Foucault, equally advocating for the value of 'other thinking' by revealing this type of 'other thinking' liberates us from the mode of subjectivity thinking that dictates the way we view problems (Rayner, 2004, p. 435). This philosophical assumption is known as 'Foucault's Heideggarian turn' and is valuable knowledge about reality, in that it raises our awareness that the ways we construct and deconstruct problems are influenced by *being in the world* and by being influenced by *society and culture*. Rayner (2004, p. 435) highlights that by freeing ourselves from this way of learning and by learning to think like 'the other', as advocated by Foucault and Heidegger, we can be creative to experiment with broader limits of '*being'*. Rayner (2004) articulates the benefits of this type of thinking by saying:

> We are thereby opened to a new beginning in the history and thought - a recommencement without reference to man and origin, but only a practice of freedom that looks to the contingency of what we are so to challenge the necessity of what we have become. (p. 435)

'*Problematizing*' the GRN first year experience (work, study and personal life) by using 'Foucault's Heideggarian turn' is valuable. Underpinning the oscillation of one's perspective to the 'other' perspective will assist in finding solutions to improve the GRNs '*care for self*' and '*concern and care*' for others in relation to their first-year experience, their retention and in closing the loop to the nursing shortage gap.

2.3.2 Foucault: *Discourse*

Foucault's exploration of *discourse* is important to this study as it raises awareness about how discourses are shaped, how meaning is gained and how these aspects influence social systems and processes and why some discourses dominate while other discourses are marginalised. Discourses help to improve understandings about the current nursing discourses and the GRN first year experiences. It can contribute to understanding why disrupting traditional nursing discourses about how we educate and train nurses in the 21st century is important if GRN preparedness is to be improved. Foucault defines a discourse as:

> Ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledge and relations

> between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern. (Weedon, 1987, p. 108)

Foucault's work on discourse is relevant in this study's context in helping to improve the understanding about the GRN first year experience and their preparedness status, as it provides guidance in how we examine and analyse the education and training of nurses from the past, as well as the present and prepare for the future. Foucault reminds us that during our examination of historical points in time, it is important to recognise the various '*epistemes'* present at each of these points in history, (that is knowledge held informed the associated thinking at that time) (Foucault, 1972). Discourses and *'epistemes'* are relevant in exploring the ways nurses were educated and trained in hospital settings, including the historical watershed decision (1984-1994) (Grealish & Smale, 2011) to move the education and training of nurses to the university setting. They are relevant in the contemporary period (2013–2018) in understanding the high global GRN attrition (Booth, 2011), the largely unknown Australian GRN attrition and the nursing shortage (Cowin & Hengstberger-Sims, 2005; Haddad, Moxham, & Broadbent, 2013; HWA, 2012; Schluter et al., 2011). The discourses operating at these historical points in time are important as each period is dominated by decisions about how nurses are educated and trained. Revealing these discourses provides implications for the contemporary GRN first year experience, including levels of preparedness, GRN retention and the nursing shortage.

In any consideration of how individuals act out their lives it is important to have some understanding of the nature of the drivers of their actions and the beliefs which inform those drivers.

2.4 ON BELIEF, VALUES, CULTURE AND CULTURAL SAFETY: GEERTZ, FREIRE AND BEST

The beliefs, values, assumptions and experiences held by each individual influencing the decisions they make, are outcomes of their history and the array of cultural groups they belong to. It is therefore important to be aware of these aspects within one another, as this will assist in examining a 'phenomenon' in a broader, more thoughtful manner. Raised awareness on these aspects, particularly on power constructs within these assumptions, and beliefs and the importance of removing

'*power'* and instead creating a sense of *shared 'power'* will improve relationships between one another (Geertz, 2008). They can be enhanced by interactions based on respect and understanding. For the purpose of this study it is important to establish a shared understanding surrounding these aspects, including cultural safety. This shared understanding will raise the awareness about the factors impacting the GRNs' first year experiences managing work, study, personal life, the inter-relationships of these factors and impact these factors have on the GRNs overall life balance. Additionally, this raised awareness will help guide the way forward to improve the GRNs first year experience and to improve their retention within the nursing profession.

Prior to explaining beliefs, the meaning of values and assumptions is explained to provide a shared acceptance of these term within this study.

2.4.1 Values, assumptions and belief meanings

Values, assumptions and beliefs have specific meanings. A *value* is accepted as something that is important, has worth, and also represents principles and or standards of behaviour and are accepted as motivational orientations about what is considered central to our lives (Boer & Fischer, 2013; Bohner & Dickel, 2011). Values can be described as motivational orientations central to peoples' lives (Boer & Fischer, 2013). However, values on a deeper level represents a concept that consists of two main constructs, normative and existential assumptions, with each of these constructs consisting of a number of elements (Kluckhohn & Strodtbeck, 1961; Hills, 2002). Normative assumption has three elements, cognitive, affective and conative. These are described as: 1. cognitive as the individual's views about the universe and life, 2. affective as what the individual feels are desirable essentials, and 3. conative as the individual's inclination towards selecting a choice and certain course of action. Hence values held by individuals are important in understanding individual behaviours. *Assumption* is something that is taken for granted and is based on a logical construct (Delin, Chittleborough, & Delin, 1994; Thompson, 2011). *Belief* is the acceptance that something exists or is true even without evidence and includes countless constructs of thinking related to knowledge, attitudes, assumptions and perceptions. This study accepts that each individual may consciously or unconsciously hold 'beliefs' (Borg, 2001) that inform their underlying knowledge, decisions (Meirink, Meijer, Verloop, & Bergen, 2009) and actions over time (Lanman, 2008). Beliefs that an individual is

aware of and can easily express to others is known as an *explicit belief*, whereas beliefs that are held unconsciously by an individual and can only deduced by observing their actions, are known as *implicit beliefs* (Basturkmen, 2012). Argyris and Schön (1974, 1978) refer to these understandings about beliefs as theories and theories-in-use and as such provide a reference point and an epistemological outlook for theory of action. This study respects these aspects related to beliefs.

2.4.2 Beliefs within cultures

Belief is also important to consider within cultures to understand how decisions are made by individuals within their culture. Culture is understood to be broader than ethnicity alone and includes the beliefs, ideals and behaviours of a group of people (McDonald, Frehner, & Wharton, 2017). The formation of culture has been noted by Foucault to be the result of a continual process of being shaped by the flux of ideologies such as political, economic, religious and other influences involving a myriad of human actions and interactions, accidents and chances, rather than from a pre-determined process (Rabinow, 1991). Examples of cultures include the culture of social status, organisational culture within workplaces, the culture of power, the culture of gender, the culture of nursing and Foucault's (2005) *culture of the self*. How can a change be brought about, such that an individual might have access to a 'truthful' relation to the world, whatever that might mean? Foucault provides three critical *functions* that constitute a '*care of the self*'. These are a '*critical'* function, a function of *'struggle'*, and a '*curative and therapeutic'* function. All of these functions contribute in some way to the process of transformation and *becoming* the 'other. The '*critical* function' consists in ridding "oneself of all one's bad habits and all the false opinions .... To unlearn (*de-discere*) is an important task of the **culture of the self**" (Foucault, 2005, p. 495). The function of '*struggle'* is understood in the sense that the "practice of the self is conceived as an ongoing battle" (2005, p. 495). Insofar as the subject is not a "pre-existing determination that can be found ready-made" (Deleuze, 2006, p. 341), the process of creation is not a linear one but is continually constituted in relation to the unfolding world. The '*curative and therapeutic'* function suggests that people need to live the best form of life that they possibly can (being able to respond to the world in a way that lives up to the challenges that it presents). This is an ongoing process because *there is no absolute or final truth to be reached at the end*.

As it does not reach towards an end point of a fully formed person, *the care of the self* is not "therefore just a brief preparation for life; it is a form of life" (Foucault, 2005, p. 494). Foucault's main aspects of the self's relationship to itself or '*ethical self-constitution*' point to various ways that education can help individuals to ethically constitute themselves: by ethical work that a person performs on their self with the aim of becoming an ethical subject; the way in which individuals relate to moral obligations and rules; and the type of person one aims to become in behaving ethically (Foucault, 1997, 1998). Hence, having a raised awareness about 'cultures' improves our understanding about how decisions are made by individuals within the culture and where deconstruction needs to occur to trigger changed thinking, behaviour and action within a culture.

Foucault (1998) highlights several important aspects in relation to culture of self and power that can be applied across any culture and associated discourse. Firstly, he identifies how the culture of the self is embedded within a power structure. Secondly how this positioning influences the individual's attitudes towards others and themselves. Thirdly and foremost, how this power positioning causes the culture of self to lose its independence. To address these aspects within the culture that are not positive, Foucault highlights situations can change. He recommends that rather than designing a system to do this, it is best to create within individuals the instrument of thought, "step by step, on the basis of reflection (necessarily historical in certain of its dimensions) on given situations" (Olanike, 2010). Thus, raising an individual member's awareness within a culture about their beliefs and the influence this has on the decisions they make, can instigate a change to the individual's future decision making. This encompasses the move towards making decisions from a shared power platform that recognises the value of each member of the group. This repositioning of power marks the beginnings of an improved relationship based on respect and improved understanding about each other, guiding a more thoughtful and considered decision making process, before moving to an 'action state'.

2.4.3 Geertz and cultural portraits

Understanding how cultures operate is important when designing reform. Geertz (2008) contributes knowledge about how to study culture and raises awareness about three aspects. These three aspects are concerned with the particular, webs of

significance and cultural portraits. The *particular* relates to specific cultural influences highly relevant to an individual, while *webs of significance* represent how these cultural influences connect to the web in which individuals find themselves in. *Cultural portraits* are concerned with coming to know how communities operate and how the members within those communities make sense of their worlds. The purpose behind gaining this type of knowledge is to understand how cultures change over periods of time. At its core, is knowledge creation about cultures and cultural change which can only be achieved through reflective practice to raise awareness (reflexive consciousness) (Yengoyan, 2009). Thus, a key process in change is gaining an improved understanding about the culture, how it thinks, behave and acts and the influences guiding how the culture operates through the use of reflection. This knowledge is important in relation to this study in recognising the influence of 'culture' within the GRNs' first year experience.

2.4.4 Freire and critical consciousness

The power of reflective practice improves an individual's understanding and is a necessary precursor to instigate change. This assertion has been a key discipline area for the philosopher Freire (1970, 2005). Freire's work shows particular 'concern and care' and 'being in the world' for oppressed groups. The concern is to empower oppressed groups to be progressive towards reform by raising their '*conscienticizao'* (translated as 'critical consciousness') that will instigate change towards an improved experience, 'liberation'. A key aspect in Freire's work is the importance of the educators' role in facilitating the process of reflective practice with the members of the culture to empower them as a key active and progressive member within the system (Lankshear & McLaren, 1993; McLaren & Leonard, 1993), rather than accept a fatalistic belief that power and oppression that will continue to exist unabated (Burbules & Berk, 1999). Hence, Freire's significant pedagogical contribution, 'critical pedagogy' and the value of the educator to facilitate this process.

Freire's work has particular relevance to the context of this study, facilitating GRNs to raise their 'critical consciousness' and improved understanding about their first-year experience managing work, study and personal life, the inter-relationships between them and the impact this had on their overall life balance through reflection. Thus, the GRNs reflections as an outcome from this study provide

an improved understanding about the influences shaping the education and nursing culture and the impact that these influences had on their first-year experience. This improved understanding will serve to instigate a targeted reform strategy for change and action.

2.4.5 Cultural safety

Building on awareness and reflective practice to improve relationships within one another and within cultural groups and society is *cultural safety*. A central tenet of cultural safety is, that those people who receive care decide what is culturally safe or unsafe, and this view, shifts power from the providers to the consumers of health care (Papps & Ramsden, 1996). Culturally safe practices are "those actions that recognise, respect and nurture the unique cultural identity … and safely meet their particular needs, expectations and rights" (Whanau Kawa Whakaruruhau, 1991, p. 7). Cultural safety is aimed at encouraging individuals to reflect on their assumptions about how they view the world and their own culture. The goal is then to also acknowledge and recognise each person has their own unique assumptions and culture, with no-one's culture being better than another. The five principles of cultural safety include: reflecting on your practice, consciously deconstructing colonisation type thinking, minimising power differentials, engaging genuinely with others to seek out their unique needs, values, preferences and concerns, and consciously avoiding diminishing and disempowering others through words and actions (Best, 2014). Therefore, with this raised knowledge, the goal of cultural safety is to improve respectful relationships between individuals and groups. Together, these cultural aspects combined with reflective practice are important in relation to improving the knowledge (awareness) surrounding this study's focus, the factors impacting the GRNs first year experience managing work, study and personal life, the inter-relationships between these factors and the overall impact on GRN overall life balance.

The philosophies presented by Heidegger (1927, 1962), Husserl (1962, 1973, 1998), van Manen (2017), Foucault (1972, 1981-1982) and Freire (1970, 2005) underpin and guide this research. Their philosophical lenses help to theorise the praxis between the GRN nursing experiences and GRNs intention to remain or leave the nursing profession. The philosophies also frame the theories relevant to and applicable for an exploration of the lived experiences of 'being and becoming' a nurse.

The following section presents the definition of nursing, including the nursing philosophies, theories and standards guiding contemporary professional nursing practice.

2.5 NURSING, NURSING PHILOSOPHIES, NURSING THEORIES AND STANDARDS

Nursing practice and the role of a nurse is underpinned by three pillars, nursing philosophies and evidenced-based nursing theory, and framed by the nursing profession's codes and standards to ensure care is delivered respectfully, upholding the rights of individuals, their safety and at a clinically competent level. Nursing philosophies, nursing theory and nursing standards are important to the advancement of nursing practice and the nursing profession. This section highlights that the researcher as a nurse and person is self-aware that their approach to all their life roles is based on the three pillars – nursing philosophies, nursing theory and nursing standards. The researcher's current role as nurse researcher, continues to approach research studies in the same way – based on the three pillars and connects evidenced-based theory to practice by adopting the nursing way of thinking, behaving and acting '*in the world of nursing*' of research. It is central to my whole research approach; to advance the care of GRNs respectfully by adhering to ethical standards and thus enabling GRNs to reap benefits to their life balance and their associated health and wellbeing, as well as for the patients in their care, including the GRN's family, the organisation, community and society.

This section will reveal the researcher's '*world of nursing*', including the three pillars. Importantly though, acknowledging the '*world of nursing*' has morphed to form the researcher's personal culture, the culture of '*being'* a nurse. These beliefs and values of a nurse are now the researcher's, embedded and intertwined and therefore have become the researcher's lens in how the world is viewed and how sense is made of the world the researcher lives in. This heightened self-awareness facilitates the researcher's capability to manage this research study ethically, systematically and strategically.

2.5.1 Nursing defined

Nursing includes the many varied roles of the nurse. The International Council of Nurses [ICN] (2012a) defines nursing as:

> Nursing is an integral part of the health care system, encompasses the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual, family, and group "responses to actual or potential health problems" (ANA, 1980, p. 9). These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population. The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full of partial independence as rapidly as possible (Henderson, 1978, p. 4). Within the total health care environment, nurses share with other health professionals and those in other sectors of public service the functions of planning, implementation, and evaluation to ensure the adequacy of the health system for promoting health, preventing illness, and caring for ill and disabled people. (p. 1)

Nursing practice within these varied roles include nursing practice, research, education and development and is underpinned by nursing philosophies and theories. These philosophies and theories are used by the nurse as practical reference points to frame how they think and behave '*in the world*' regardless of the role they are acting out; that is, whether their professional and personal roles. As a result, the nurse becomes a very important communicator, forming the bridge of care with the patient and their family from the broader health team and health organisation. This very practice within a nurses' role ensures in essence that the care is personalised, participative and consensual and meets the professional codes of ethics, conduct and standards of the nursing profession to facilitate safety, quality of care and improved patient and family health outcomes.

2.5.2 Nursing philosophies

The four nursing philosophies include: holism, person centred care, family centred care and the nursing process of care. These philosophies contribute to and are

essential in the way the researcher approached this research in that the researcher is a nurse across all roles.

2.5.2.1 Holism – health and wellbeing

The philosophy of holism is fundamental and underpins care of the patient to promote their sense of health and wellbeing. Holism recognises that a person consists of body, mind and spirit, and includes several dimensions, notably intellectual, environment, spiritual, sociocultural, emotional and physical (Smith, 2014). Within this philosophy it is generally accepted that these dimensions do not operate alone but operate in harmony with one another to form the whole person, as well as how a person interrelates with their environment (Dempsey, 2014). Consequently, for a person to feel healthy and have wellbeing (in the holistic sense) all these separate dimensions need to be in accord.

This broader understanding of health is reflected in the World Health Organization's [WHO] (1946a) definition of health, the Australian Aboriginal definition of health and the Maori philosophy of health. The WHO (1994) defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease" (p. 1). This definition reflects the multidimensional nature of health, and therefore directs the goals of improving health and wellbeing for individuals to a broader, multidimensional focus, and not simply a sole focus on treating illness. The WHO (1986) has since revised this definition of health adding that health is a commonplace resource needed for everyday life.

The National Aboriginal Health Strategy (1986) definition of health is:

> Health to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. [It calls for a] … a holistic approach to health issues…requires support for healthy and interdependent relationships between families, communities, land, sea and spirit. The focus must be on spiritual, cultural, emotional and social well-being. (pp. 3-4)

This Aboriginal definition of health, like the WHO definition, is also multidimensional but extends to include cultural, spiritual and community. Importantly, it highlights the inter-connectedness of these elements in promoting the

full potential of an individual and its relationship to promoting the health and wellbeing of the community and a whole life view that includes the cycle of life and the interconnectedness of health with the land and generations past and emergent. These particular aspects, promoting the full potential of individuals to benefit the communities' health and wellbeing and the interconnected with the cycle of life is insightful, and are important concepts to apply to the current contemporary health environment in relation to promoting nurses, health organisations and society's health and wellbeing (Aboriginal Health and Medical Research Council NSW, 2017).

The Maori philosophy of health is also important to highlight as it also promotes the multidimensional aspects of health. Specifically, spirituality, mental wellbeing, family and physical (Barnes & Rowe, 2008). Importantly, this concept of health promotes the importance of balance and stability between these four dimensions. This particular aspect, balance and stability between the dimensions to benefit the individual's health and wellbeing is also an important concept to apply to nurses in the contemporary health environment in relation to promoting nurse's health and wellbeing, the wellbeing of organisations and society's health and wellbeing.

Health and wellbeing for individual people is unique and is typically based on how the person feels, their values, beliefs and cultural influences from their family, community and society in general (Baum, 2008). Importantly then, a person's perception of health and wellbeing needs to be acknowledged and respected. Thus, it is essential to seek out from nurses as individuals their individual perception of health and wellbeing and support them in the dimensions that are significant to them. Doing this will then have positive ripple effects for nurses' patients, health organisations and society. Thus, the need for an approach to life balance care that considers the whole person, their community and environment such as the one adopted for this study.

2.5.2.2 Person centred care

Person-centred care is an approach that considers the whole person and hence is made up of several constructs. Importantly though, person-centred care (PCC) is also associated with improving health outcomes of individuals and their families (Arbuthnott & Sharpe, 2009; Arnetz et al., 2010; Beach et al., 2005; Boulding, Glickman, Manary, Schulman, & Staelin, 2011). Finding a globally accepted definition of PCC in the literature proved difficult. However, the main construct of

PCC found to be widely accepted is '*personhood'*, person and inter-related with this construct in improving health outcomes, is effective communication.

Personhood is the expression of being human or one's humanity and includes knowing a person's interests, knowing what they hold as important, knowing their concerns, and knowing what challenges their wellbeing (Dempsey, 2014). The term *'Person'* reflects that a person is a human being, made of several human dimensions, namely intellectual, environment, spiritual, socio-cultural, emotional, and physical, operating together to form the whole person (Smith, 2014, p. 23). These human dimensions are illustrated by the researcher in Figure 2.1. The term *'person'* also acknowledges a human being has rights, especially in relation to decisions and choice (including being sensitive to nonmedical/spiritual aspects of care; patient needs and preferences) being respected (ACSQHC, 2012). Importantly though, the element of person-centred care is vital to improving health outcomes is effective communication, together with information sharing (Dempsey, 2014; Kitson, Marshall, Bassett, & Zeitz, 2012). For communication to be effective, it has to be based on mutual trust and respect. Trust and respect are known to be key enablers in the establishment of a therapeutic relationship with the patient (Dempsey, 2014; Kitson et al., 2012). Other core dimensions of PCC include: education, emotional and physical support, continuity, transition and coordination of care, involvement of family and friends and access to care (ACSQHC, 2011, p. 7). These core dimensions of PCC are illustrated by the researcher in Figure 2.2.

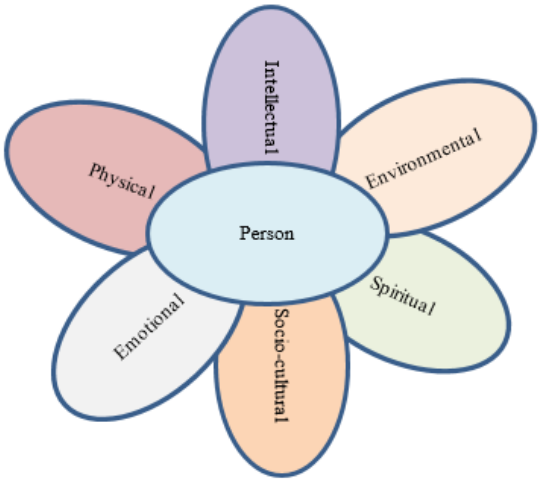


Figure 2.1. Person's human dimensions, interdependent and compose the whole person.

It is important to consider all these constructs and dimensions when adopting a person-centred approach to care, as they all work together to improve the health and wellbeing outcomes of patients. Therefore, they work well in their application to life balance as a whole approach.

As a whole approach, the person's dimension, '*environment'* raises awareness that it is important to consider not only the person's personal environment/s but also their work environments and the context of this work environment in relation to its position within a larger organisational system environment and the larger society's system environment. Therefore, the whole approach informs the care approach needs to additionally consider the work, organisations and society's wellbeing status too. Thus, a whole approach to care targets three levels, the individual, the organisation, and society at the governance level.

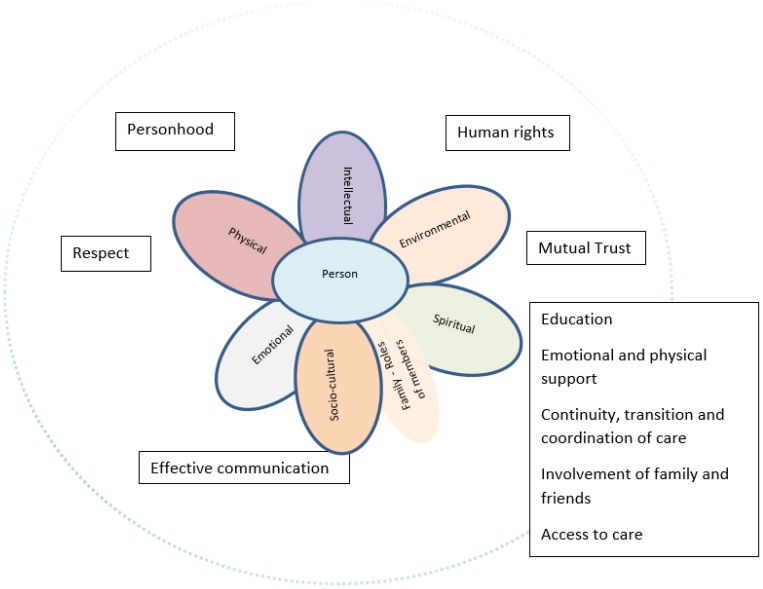


Figure 2.2. Person-centred care elements.

2.5.2.3 Family-centred care

Family-centred care approach is an important human dimension to draw focus on within PCC, the patient's social/family dimension. The family dimension of the person is illustrated in Figure 2.2 to convey it is part of a person's human dimensions. Patients are often part of a larger family group and this family group needs to be included when promoting an individual's health and wellbeing. Including the family as a joint focus in approaching patient care is known as Family-Centred Care (FCC). Therefore, it can be seen that complimentary parallels can be found between

the field of psychology whole approach, looking at supporting an individual's balance in all their life roles (Super, 1975; 1980; 1990) within the domains of work, life, including family and nursing's whole approach to patient care, based on the philosophies' holism, PCC and FCC. FCC is a whole approach to caring for the individual, in recognition they are a part of a family.

FCC is planned around the whole family and their roles in relation to their needs, interests, concerns and challenges in conjunction with the individual patient. This care approach recognises all family members have roles they play and need to enact. Along with support to maintain and enhance their roles, FCC will benefit the family member and family as a whole unit and ultimately the individual patient (Shields, Pratt, & Hunter, 2006, p. 1318) see Figure 2.2. FCC philosophy can be applied to patients of all ages and is suitable in many care settings (Institute for Patient and Family Centered Care, 2017) especially in the paediatric setting (Smyth, Abernathy, Jessup, Douglas, & Shields, 2017). Family-Centred Care (FCC), like PCC is associated with improving health outcomes of individuals and their families (Charmel & Frampton, 2008; Franck & Callery, 2004). Consequently ACSQHC (2011, p. 8) has recognised the valuable input from parents and family members in improving the quality and care outcomes of patients and recommends FCC as a key strategy complimenting PCC, to be implemented by health organisations. The importance of identifying the individual's family role and supporting them to act out this role supports the individual's broader life goals outside of work and facilitates their sense of overall life satisfaction, quality of life and wellbeing.

2.5.2.4 Nursing process of care approach

The nursing process of care approach consists of five aligned and interrelated elements, assessing, identifying problems (actual and potential), planning care, implementing care and evaluating care (Dempsey, Hillage, & Hill, 2014) and is illustrated by the researcher in Figure 2.3. Thoughtful practice is an important thread running through each of the interrelated five elements and includes self-awareness, reflection and critical thinking, leading to the nurse's reflective practice (Dempsey et al., 2014) and ongoing development. Thoughtful practice also involves the cognitive process of thinking, essentially, "how we learn, think and solve problems" (Sweller, Ayres, & Kalyuga, & 2011, p. v). A type of thinking that is essential to thoughtful

practice is clinical reasoning. Levett-Jones et al. (2009) described clinical reasoning as:

> The process by which nurses (and other clinicians) collect cues, process the information, and come to an understanding… [about] the patient problem [and supports the enablement of the five elements of the nursing process with an extra component], reflecting on and learning from the process. (p. 516)

The nursing process of care philosophy is important in patient care as it tracks the entire process of care and importantly, evaluates the effectiveness of the process to ensure the patient's end goal, improved health outcomes, is achieved. If the individual's health outcome goals are not achieved, this process is reiterative, with revisions made at every point.

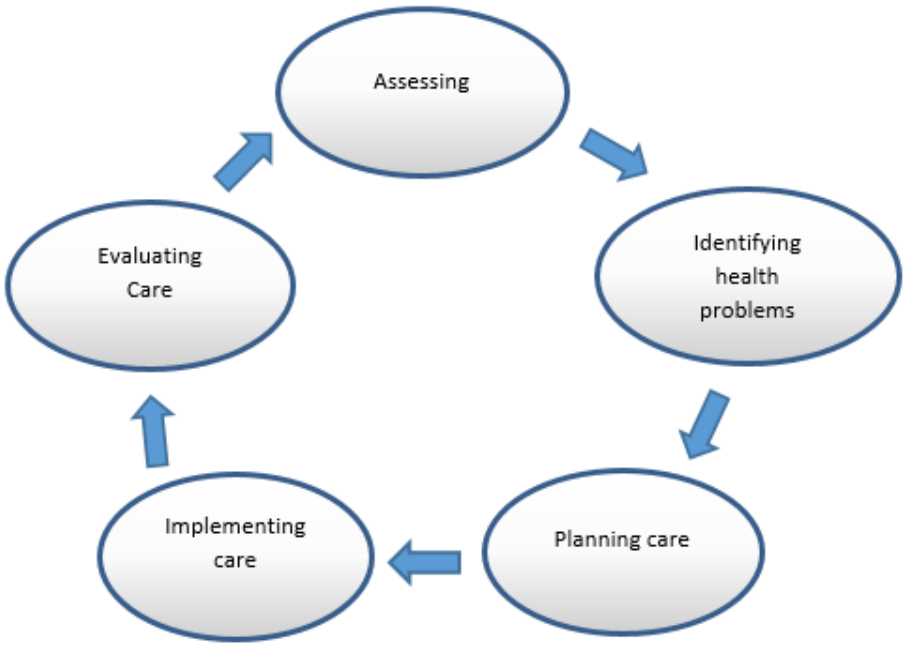


Figure 2.3. The nursing process of care approach.

The nursing epistemological position of this study draws on the four nursing philosophies explained above to frame and align the individual's life balance/and health and wellbeing assessment (subjective and objective data), the identification of problems and the planned care and evaluation of life balance/and health and wellbeing care (the subjective and objective measures of the effectiveness of the planned and implemented care). Together these enable a comprehensive and

evidenced based approach to improve the individual's life balance/ and health and wellbeing, and thus their quality of whole life experience. It is acknowledged this targeted approach at the individual level forms only part of the '*whole health and education system'* approach in closing the loop from the employees and or families' perspective. A cyclical evidenced based approach to work/life balance targeted at the individual, organisational and governance levels 'whole systems' approach, to improve the work/life balance of individuals, [in this case GRNs], and forms one of this study's conclusions (see Chapter 7).

2.5.3 Nursing theory

Historical and future evidenced based nursing theories are important in guiding and developing nursing practice to ensure the continual goal of improving care of all individuals, and in all settings and situations. Theory has been defined as a "system of applying a series of ideas or possibilities in a systematic way to explain a phenomenon or solve a problem" (Griffin, 2009, pp. 4-5). In the domain of science, theory is understood to be evidenced-based. Therefore, nursing theory is important for nurses' practice as it informs nurses of the important components within the '*system*' that they need to take heed of and target their care in response to help improve and or '*solve the [patient/family care] problem*' in focus.

An important part of nursing theory is the '*real world*' application to '*real time nursing*'. This personal view has always been the researcher's '*way of working/caring*' since a student nurse, beginning nursing at the age of seventeen. On reflecting back to this period, 1987–1990, this '*way of working*' was the nursing culture the researcher was situated in. It was shared by the leaders of the health organisation, including the Director of Nursing, nursing educators, liaison nurses and fellow student nurses and experienced nursing colleagues. However, over time, working in various clinical settings and exposure to nurses educated and trained at different facilities, the researcher became aware that a divide existed for some nurses between the perceptions of theory as not being useful and or practical to the application to '*real nursing*'. This observation has also been noted by Greenwood (2000) where new nurses learn from other experienced nurses that real nursing is about physical care and not about espoused theories, when in fact real nursing is about drawing on theories to inform practice, such as person-centred/family centred care.

2.5.4 Nursing values - Codes of ethics, conduct and standards

The nursing profession has a number of governances consistent with the Health Practitioner Regulation National Law (Queensland) (Queensland Government, 2017) that help shape a nurse's professional identity within the culture of nursing. These nursing governances highlight how a nurse should think, behave and act and serve to provide the profession with integrity and the public with an expected standard of care that is safe and of high quality (NMBA, 2018). Three specific codes detailed in this section include the ICN Code of Ethics (2012b), the Code of Professional Conduct for Nurses (NMBA, 2018) and the Registered Nurse Standards for Practice (NMBA, 2016b).

ICN Code of Ethics (2012b) has four main elements that detail the standards of ethical conduct for nurses. Each of these four elements includes a detailed descriptor of the qualities, attributes and behaviour of the nurse. The four elements are 1. Nurses and people, 2. Nurses and practice, 3. Nurses and the profession, 4. Nurses and co-workers. As part of the code of ethics, a suggestion is provided in how the code of ethics should be used. The ICN advises the code of ethics is to be used as a living document, thus ensuring the code of ethics remains meaningful to the realities of nurses and a health care in a changing society. Additionally, the code of ethics provides details on how nurses need to apply the elements and is important for educators to support the application of theory to practice.

The Code of Professional Conduct for Nurses (NMBA, 2018) aligns with the Health Practitioner Regulation National Law (2017) and details the expectations of a nurse's behaviour and conduct in all settings in Australia. The code acknowledges all nurses have their own beliefs and values, however the nursing profession uses the code to raise nurses' awareness of the standards that need to be adopted in their practice. The reasoning behind this is to ensure "people's interests and concerns are put first and to ensure nurses practice is safely and effectively" (NMBA, 2018, p. 3). The code includes seven principles grouped into four domains. Each principle is deconstructed further into several points to ensure the principle is clearly understood and therefore enabling application to practice. The seven principles grouped within the four domains (NMBA, 2018) are as follows: 1. Practice legally; 2. Practice safely,

effectively and collaboratively; 3. Act with professional integrity; 4. Domain: Act with professional integrity; and 5. Domain: Promote Health and wellbeing.

The Registered Nurse Standards for Practice is a set of criteria stipulating the requirements by the nurse in delivering safe, competent care (NMBA, 2016b). The criteria consist of four domains: 1. Thinks critically, 2. Engages in therapeutic and professional relationships, 3. Maintains the capability for practice 4. Comprehensively conducts assessments. 5. Develops a plan for nursing practice. Each standard has a criterion that details how the standard is to be demonstrated by the nurse and is contextual to practice. At the core of each standard is that is to enable a nurse rather than limit the nurse (NMBA, 2016b, p. 1).

Applied to this study, determining the factors impacting GRNs first year experience, these three nursing codes that help shape a nurses professional identity within the culture of nursing - how a nurse should think, behave and act' (the '*world of being a person and a nurse as one'*) will be drawn upon to improve the knowledge surrounding the GRNs first year experience managing the *Load Triad*.

2.6 THE PHILOSOPHICAL APPROACH: OSCILLATING ONTOLOGIES

The enquiry approach that guides this research uses the paradigm post-positivism. Post-positivism has been used because evidence is not restricted to what can be physically observed (objectivist epistemology) but accepts that the nature of reality is interpretive (Annells, 1997; Crossan, 2003). The post positivism paradigm approach facilitates a number of philosophical ontologies and epistemologies of 'best fit' to guide the research process. As aforementioned, these included: Husserl's life-world concept (1931, 1962) provided a justification of how we exist in the world, while Heidegger's 'Being in the world' and his '*Dasein*' concept (1927, 1962) provided insight into raising our self-awareness about ourselves, in that we cannot escape from our perception as being anywhere else other than in our life worlds and caring because of our existence in our life worlds. Foucault's formation of the self, power, truth and subjectivity (1972, 1982) provided insight into ourselves and how we develop into who we are, including how we perceive and manage power and inequalities (such as in this research case, between the experienced nurses and the inexperienced GRN, and the inexperienced GRN and the health organisation) and what we accept to be true.

van Manen's four existentials (2017) also provides guidance for the phenomenological 'GRN lived experience' discussion writing.

Thus, these philosophers' views underpin the first ontological enquiry of this study, constructivism/social-constructionism interpretivism that then links and moves to the ontological enquiry - positivism. This philosophical overall approach, oscillating ontologies, is depicted in a conceptual model, illustrated by the researcher in Figure 2.4. This model oscillates to illustrate part truths that assist in developing a more complete truth and thus strengthens the rigor of this research study. This oscillation is used in the construction of the methodology guiding the research: The oscillating ontologies is developed further and presented in Chapter 4.

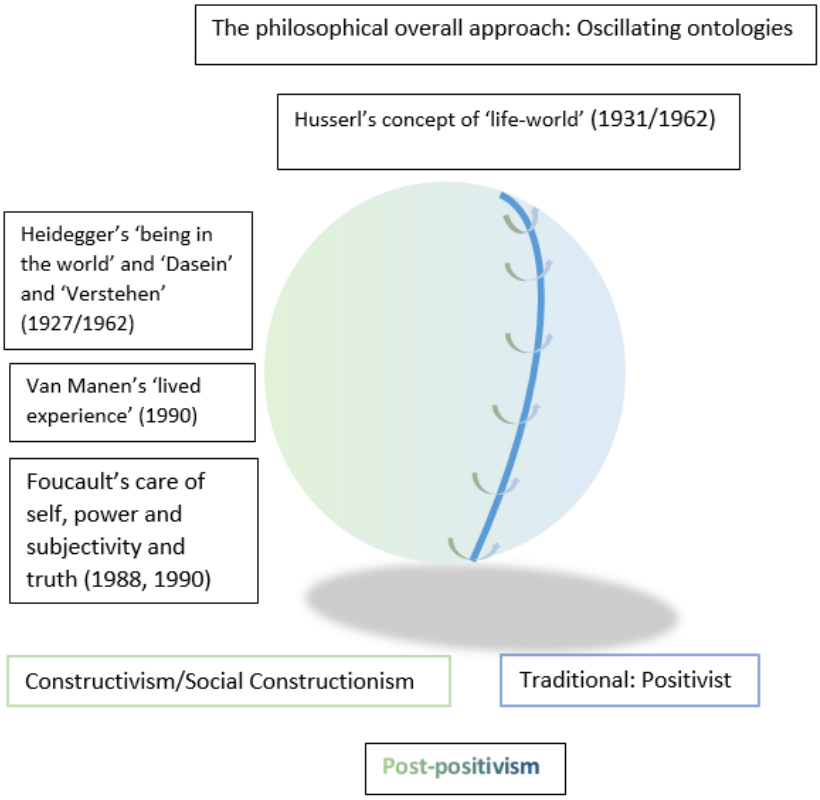


Figure 2.4. The philosophical overall approach: Oscillating ontologies.

This conceptual model illustrates the broader factors impacting the GRNs' first year experience managing the '*Load Triad*' that may have otherwise been hidden, and to depict meanings that are contextual and relevant for GRNs in the 21st century.

The purpose of the life-world approach is to determine part meanings. On one level, separating individual meaning can be determined, for example separating

the purpose of educating and training student nurses to be prepared for their life career and life roles. Preparation is invaluable groundwork that enables student nurses to make judgements about their readiness for their life roles within a life career. One of the purposes of preparation is to confirm that student nurses are confident and competent to perform an array of professional and personal settings. We can understand the meaning of preparation, to the extent of our current beliefs, attitudes, knowledge and experience. However, a new level emerges as reflections about the pedagogical approach and life-world significance of nurse preparation is considered for all nursing stakeholders. Formulating meaning thus becomes more complex. Knowledge building and knowledge creation (Bereiter & Scardamalia, 2014) advocates that meaning can be gained by raising awareness through public display, meaning that is not static and can evolve in response to the context of the environment and the needs of its members. Applied to this study, determining the factors impacting GRNs first year experience, 'the life-world approach and various lenses' will be drawn upon to enhance the knowledge surrounding the GRNs' first year experiences managing the *Load Triad*.

There are a number of education theories which collectively add to the theoretical framework which informs this research are discussed next.

2.7 EDUCATION THEORIES IN USE

The education theories determined as relevant to this study include Shulman's (2005) Signature Pedagogies, 21st century learning approaches, Vygotsky's (1978) Zone of Proximal Development and Bereiter and Scardamalia's (2014) Knowledge Building and Knowledge Creation. These theories are presented next.

2.7.1 Shaping the nurse: Signature pedagogies

The GRN develops into the professional they will become as a result of the preparation they receive during their undergraduate nursing program and the education. Shulman (2005) identified a key to understanding why professions develop as they do, which is to study the 'nursery' of that culture. The nursery in the education context is where the undergraduate student receives their education and training and includes the pedagogy adopted by their lecturers to prepare them for their future professional role and practice. In study these 'nurseries', typical characteristics about

the form of teaching and learning adopted by the lecturers emerge, identified by Shulman (2005) as '*signature pedagogies*' for that profession. Shulman defines signature pedagogies as "the types of teaching that organize the fundamental ways in which future practitioners are educated for their new professions (2005, p. 52). Applied to this study, '*signature pedagogies*' within nursing's '*nurseries*' is a factor that may impact GRNs' professional development and preparedness in their first-year experience.

Higher education prepares professionals for their role by aligning their programs to meet academic and the particular profession standards to ensure a quality, educational program, student experience and importantly to prepare students for their professional role upon graduating. Shulman (2005) identifies preparing students for their professional role is an area of challenge for schools. Typical preparation, he asserts, involves theory and practice, including "how to think, to perform and to act with integrity" (p. 52). However, he argues these aspects vary between professional nurseries, and thus result in varying levels of professional preparedness. Applied to this study, determining the factors impacting GRNs first year experience, theory exploring 'signature pedagogies' will be drawn upon to improve the knowledge surrounding the GRNs first year experience managing the *Load Triad* and the impact this has on their overall life balance.

2.7.2 Learning approaches for the 21st century

Governments throughout the world value equipping their people with a quality education because education has been attributed to be a precursor for a prosperous country (European Union Centre RMIT University, 2014). Consequently, the governments' solutions to their country's problems, is the desire to instil within its people a commitment to learning throughout their life time in order for innovation, improved productivity and improved health outcomes (European Commission, 2012). As part of the commitment to advancing individuals' learning to prepare them for the changing nature of the world and the world or work, lifelong learning, heutagogy, metacognition and critical thinking will be presented next. These education theories illustrate how a quality education can support individuals' desire and capability to learn across their lifetime and support them in their array of life roles, thus contributing to a country's success in solving their problems.

2.7.2.1 Lifelong learning

Lifelong learning may be misinterpreted due to lack of a shared meaning which is important to clarify as this study positions lifelong learning as a driver underpinning the achievement of a quality education that is meaningful to the individual, the culture and the society the individual is a part of. Lifelong learning has been defined by Longworth and Davies (2003) as the:

> Development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments. (p. 22)

This definition of lifelong learning articulates the vision for education, guiding educators to prepare individuals for their anticipated roles and environments. A strong aspect of this definition is that it conveys the broader program curricular objectives, content topics, the pedagogy and the assessment indicators (see Table 2.1). While the weak aspect of this definition is that it leaves these various aspects open for the educator to interpret and thus presents an opportunity for life career preparedness to be overlooked. Determining the factors impacting GRNs first year experience, 'lifelong learning as a broader educational objective' can inform understandings surrounding the GRNs first year experience managing the *Load Triad* and its impact on their overall life balance. Table 2.1 presents the lifelong broader curricula objectives, including content topics, pedagogy, processes and assessment indicators that will serve as a reference point for the discussion on the factors impacting the GRNs first-year experience.

Table 2.1

Lifelong Learning: Broader Curricula Objective, Content Topics, Pedagogy, Processes and Assessment Indicators

Broader Program Curricula Objective
Development of human potential through a continuously supportive process which stimulates and empowers individuals to acquire all the knowledge, values, skills, and understanding they will require throughout their lifetimes and to apply them with confidence, creativity and enjoyment in all roles, circumstances and environments

Content topics conveyed	all life roles knowledge, values, skills, and understanding they will require throughout their lifetimes [for all life-roles]
Pedagogy elements conveyed:	*develop* an individual's potential *stimulate* the individual *empower* the individual [for their life-roles] – including lifelong learner role
Processes identified:	continuously supportive process *apply* them [knowledge, values, skills, and understanding] with confidence, creativity and enjoyment [in all their roles, circumstances and environments]
Assessment indicators includes:	
Behavioural indicators	confidence creativity enjoyment
Role indicators	in all the individual's life-roles
Circumstance indicators	all circumstances
Environment indicators	all environments
Evaluation process conveyed	continuously supportive process

Lifelong learning (LLL) may be mistaken for lifelong education, therefore lifelong education is also defined here to create a shared meaning. Lifelong education

(LLE) has been defined by a number of scholars. Wilson (1998, p. 4) defines LLE as "enabling people to develop awareness of themselves and their environment and encourage them to play their social role at work and in the community". Knapper and Cropley (1991, p. 20) define LLE as "a set of organisational and procedural guidelines for education practice aimed at fostering learning throughout life". Therefore, LLE has a key role to play in supporting the delivery of LLL within the education system at the government and organisational level to support the individual in life role preparedness, satisfaction, retention and thus contribute to society's broader goals, solving the countries problems and improved prosperity and health and wellbeing of its people. Determining the factors impacting GRNs first year experience, '*lifelong learning*' and '*lifelong education*' can improve the knowledge surrounding the GRNs first year experience managing '*the Load Triad*' and its impact on their overall life balance.

2.7.2.2 Heutagogy

Heutagogy is essentially the art and science in developing adult learners' capability to be independent, reflective and self-directed with their learning with the goal to enable them to be all they can and need to be, in response to the changing nature of the world generally and the world of work in particular. Hase and Kenyon (2000, p. 2) define heutagogy as:

> the study of self-determined learning may be viewed as a natural progression from earlier educational methodologies…in particular from capability development…and may well provide the optimal approach to learning in the 21st century.

The origin of heutagogy can be traced back to the Greek verb *Heureskein*, meaning to discover (Parslow, 2010). *Heureskein* is also the etymology for the word heuristic, which means enabling a person to discover or learn something for themselves and their own experiences (Cambridge Dictionary, 2012). Heutagogy builds on the art and science of adult learning andragogy (Parslow, 2010). Andragogy is understanding adult learners and the ways adults prefer to learn (Knowles, 1968). Learning in the modern age is increasingly aligned with what individuals do to support their life roles. Information is so readily available now and where change is so rapid in society and the world of work, discipline-based knowledge and associated traditional methods of education and training are proving to be somewhat inadequate. Heutagogy can be the support and enabler to prepare individuals for living and

working in a society in constant flux and complexities. Therefore heutagogy, has the potential to be the pedagogy of choice and driver to complement and support individuals to make decisions about what they need to know and how to do learn, based on their reflective evaluation (Hase & Kenyon, 2000; 2001) 'Heutagogy' can improve the knowledge surrounding the GRN first year experience managing the *Load Triad* and its impact on their overall life balance.

2.7.2.3 Metacognition

Metacognition is essentially thinking about thinking and is an important life skill that learners need to be prepared in for their life roles and transitions from role to role. It involves educators supporting learners to build capability as independent and self-determined learners. Metacognition was defined by Flavell (1979, p. 906) as "cognition about cognitive phenomena…thinking about thinking…knowledge about one's own strengths and weaknesses". Other scholars in the field build on this definition by fore fronting aspects related to awareness about one's own thinking (Hennessey, 1999; Kuhn & Dean, 2004), including the knowledge and management individuals have about their own thinking and learning (Cross & Paris, 1988; Martinez, 2006). The constituent elements of metacognition are metacognitive knowledge and metacognitive regulation (Cross & Paris, 1988). In supporting teachers and learners in developing metacognition processes within individuals, a number of scholars have categorised the types of knowledge of cognition.

A foundational point to developing individuals' thinking about thinking and the management of their thinking lies in raising their awareness about the knowledge surrounding the types of cognition knowledge and reflective practice. Flavell (1979) describes three types of cognition: knowledge, person, task and strategy. Person knowledge is the person's beliefs about their cognitive processes. Task knowledge is knowledge about the smaller pieces or units of work and the associated demands that fall within the larger job/work/project. Strategy knowledge is knowledge about devising a plan that will produce the best outcome for a given situation. Other scholars in the field describe other types of cognitive knowledge, declarative and procedural (Cross & Paris, 1988; Kuhn, 2000). Declarative and procedural cognitive knowledge are also important for educators to be aware of as they direct the achievement of different types of learning. *Declarative* is knowledge is an awareness through reflective evaluation about one's self, one's experience and the factors that

may influence one's performance (Kuhn & Dean, 2004; 1990). *Procedural* knowledge is an awareness through reflective evaluation about managing one's thinking, the strategies available, including the conditions when to apply certain strategies and one's experience (Cross & Paris, 1988, Kuhn & Dean, 2004). The main conclusions that can be drawn from this knowledge on metacognition knowledge is that in order to develop an individual's metacognition capability, interconnecting knowledge, experience and reflective practice is required.

Understanding 'GRNs metacognition capability' can illuminate GRNs first year experiences.

2.7.2.4 The importance of critical thinking

Metacognition is also an important skill in supporting an individual's development of critical thinking, a needed life career skill to help prepare an individual for the changing nature of their work and the array of life roles they will have in the 21st century world. Critical thinking (CT) as a definition has evolved over time from a few elements to a more detailed construct. It is recognised that CT can evolve to reflect the requirements of specific disciplines, such as nursing. In the mid 1980's CT was defined as "reflective reasonable thinking" (Ennis, 1985, p. 45). In the early 1990s CT was defined as "the art of thinking about your thinking while you are thinking in order to make your thinking better" (Paul, 1992, p. 643) and consisted of three elements, thought, intellectual standards and affective traits (Paul, 1993). In the late 90's as an outcome from a Delphi study (Facione, 1990) consensus was reached to what CT entails and the following statement was formed:

> We understand critical thinking to be purposeful, self-regulatory judgement which results in interpretation, analysis, evaluation, and inference as well as explanation of the evidential, conceptual, methodological, criteriological, or contextual considerations upon which judgement is based. (p. 2)

The nursing profession, however, believed that a discourse specific definition was needed to reflect nursing needs to produce nurses ready for their role in the nursing profession. Therefore, as an outcome from applying a Delphi study to the nursing discourse, nursing scholars achieved consensus for the meaning of CT (Scheffer & Rubenfeld, 2000). A number of CT building blocks were identified relevant for the nursing discourse, including "10 habits of the mind (affective

components) and 7 skills (cognitive components)" (Scheffer & Rubenfeld, 2000, p. 352). These building blocks are as follows:

> The habits of the mind of CT in nursing…confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Skills…analysing, applying standards, discriminating, information seeking, logical reasoning, predicting and transforming knowledge.

Identifying these building blocks of CT assist educators in designing active learning experiences that will support the development of these CT elements in students, as well assists educators in determining achievement of these CT elements when assessing student's competency of these elements. Literature surrounding the importance of designing authentic learning experiences to develop students CT and assessments to determine CT has been noted (Carvalho et al., 2017). Applied to this study, determining the factors impacting GRNs first year experience, 'recognising the building blocks of GRNs critical thinking can reveal more about GRNs' first year experiences.

2.7.3 Vygotsky (1978): Learning and development

An individual's current and future performance is the reflection of their learning as an outcome of their social and cultural influences. Vygotsky (1962; 1978; 1997) asserts that cultural development of a child occurs on two platforms, firstly, social (between people) and then secondly, psychological (within the mind). In determining development, Vygotsky focused on an individual's behaviour and cognition within four areas of development, 1. Human evolution (phylogenesis), 2. Human cultures (sociocultural history), 3. Individual (ontogenesis), and 4. During a learning activity (microgenesis). The main emphasis Vygotsky highlights is that the development of an individual's learning is through a mediation (fostering) process. Vygotsky also argued that this mediation process is a part of the social and cultural context and therefore these aspects can't be separated from this process (Vygotsky, 1962). Therefore, observing an individual's behaviour, one can recognise the individual's cognitive process and understand these two aspects are due to the individual's mediated learning through social and cultural influences. Graduates self-reports on their performance behaviours and confidence levels and their social and

cultural influences' will be reviewed to improve the knowledge surrounding their first-year experiences in managing the *Load Triad.*

The Zone of Proximal Development (ZPD) is a concept that describes the development of higher order thinking important for individual's development to be a competent and active participant in society and in their life roles. The ZPD is defined by Vygotsky (1978) as:

> The distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peer. (p. 86)

An important aspect of the ZPD is determining the individual's ZPD in order to develop future, desired behaviour. The ZPD is the learner's current level and the next (slightly more complex) level that needs to be achieved and guides both the learner and the teacher/more competent peer during the mediated learning process. This ZPD concept of Vygotsky (1978) is described by Roosevelt (2008) as the 'learning' is firstly jointly performed by the learner and the teacher/more competent peer. This is then followed by the learner performing the same learning independently, with the teacher intervening/assisting as required. This process repeats until the learner can perform the learning independently and competently; the desired outcome and thus the learners' ZPD is raised.

Vygotsky (1997) asserted this type of learning is not mindless copying but is the result of the learner demonstrating their understanding within a social cultural influence as a result of the mediating process maturing their functions to operate a higher level than previous. Vygotsky (1998) further asserted that the ZPD should form the basis of assessments. Sternberg and Grigorenko (2003) confirmed this type of assessment is where the examiner-examinee relationship is transformed, and assessment is for learning. In addition, the teacher's role is active, continually keeping the learner's ZPD in constant motion, and as an outcome, the teacher too requires their ZPD in relation to 'pedagogy' is in constant motion (Helsby & McCulloch, 1996). This movement by the learner and the teacher ensures the learner is prepared for the changing nature of the world and world or work. Determining 'learners and teachers ZPD in constant motion' will help inform GRNs' first year experiences.

2.7.4 Bereiter and Scardamalia (2014): Knowledge building and knowledge creation

Preparing students for their life career and associated roles requires educators to be aware of student's immediate learning needs but also cognisant of their future learning needs to support their future roles within the society of the future. Bereiter and Scardamalia's (2014) concept of knowledge building and knowledge creation, is designed to raise educators' awareness that knowledge building and knowledge creation is one concept not two separate entities and that, together, they form the basis for the two broader goals of education. These two goals are to support students to attain knowledge and competency but also to prepare them for their future, supporting and enabling their ability for ongoing knowledge building. Thus, the broader goal of education is to create a culture of awareness 'preparing students for their immediate future upon graduation but also beyond this, long term life career future'.

The origins of knowledge building and knowledge creation (KBKC) occurred separately in the 1990s and in different fields. Both organisational sciences (Nonaka, 2008) and learning sciences (Bereiter & Scardamalia, 2014) are similar in their idea base (Bereiter & Scardamalia, 2014). The literature identifies knowledge creation as the organisations ability to not only store knowledge but to create knowledge and harness this knowledge creation to propel them to advance (Nonaka, 2008). Similarly, knowledge building in the literature describes knowledge as the outcome from intentional and purposeful actions (Nonaka, 1991). The emphasis of knowledge building and knowledge creation is the "deliberate, conscious action, which produces knowledge that has a public life… [while not] discount[ing] chance discoveries, insight…internal cognitive activity" (Bereiter & Scardamalia, 2014, p. 35). Important aspects within KBKC are encapsulated in the words 'has a public life' as these liken knowledge to a living organism undergoing development and change in response to its environment (Lindkvist & Bengtsson, 2009). 'Has a public life' concept allows the knowledge created to be explored in the public arena and studied collaboratively. There by it does not remain static but continually grows (Lindkvist & Bengtsson, 2009). The created knowledge keeps growing and evolving in response to its environment and the needs of its members, remaining relevant and the more effective in its creativity in problem-solving.

Knowledge building knowledge creation (KBKC) has the potential for disrupting the education and organisational discourses to cause a positive change in the business of educating and preparing students for their immediate and long-term futures and life roles within organisations and society. The main barrier to disrupting the current discourse is attitudinal rather than scientific with origins that can be tracked to an individual's epistemological orientation in how individuals come to know (Bereiter & Scardamalia, 2014). In the education sector this is realised by the heavy emphasis placed on the teacher to impart knowledge (as *transmission*) to the student. In contrast, KBKC emphasises gradually shifting the epistemic agency, traditionally reserved for the teacher, to the student, to formulate knowledge (Bereiter & Scardamalia, 2014) as *transformation*. However, for this to occur, a cultural shift by the education sector, organisations and society about how individuals come to know would need to occur first. KBKC can then be effectively introduced within the education sector into the curriculum and as a course within a program and integrated throughout the program as a 'way of working' that includes reflection followed by action (Bereiter & Scardamalia, 2014). Thus, an indicator of an education sector, classroom, organisation and society functioning well would be evidence of KBKC.

KBKC has the potential to prepare students for their future life career but also in providing a rewarding life as an outcome from collaboratively contributing to improving life situations. KBKC also embraces all individuals and recognises the value of each including their strengths, weakness and dispositions. Other benefits of KBKC comprise each member's skills development in the variety ways that contribution is recognised, as well as the development of students' individual contribution styles and skills. Thus, it is through this process of recognition in being a part of KBKC – shaping the future world and the world of work and education and valuing each member in this process – that individuals experience reward and fulfilment (Bereiter & Scardamalia, 2014). KBKC will help inform GRNs' first year experience managing the '*Load Triad'* and its impact on their overall life balance. Applied to this study determining the factors impacting GRNs first-year experience managing the 'load Triad', KBKC will be able to be determined if it is a factor impacting GRNS' overall life balance.

2.8 LIFE CAREERS THEORY

Life careers theory is burgeoning in the twenty first century and relevant to this study due to the changing nature of the work environment and careers and concerns for preparing and supporting individuals with knowledge and skills that are transferable and adaptable for any life career. Life careers theory is also important in relation to retention and attrition within a profession and the associated organisation. Applied to this study, preparing GRNs for a nursing career where their role will be required to evolve and adapt in response to meeting growing health service demands and associated technological advances. Therefore, identifying factors that supports GRNs' ability to transfer their knowledge and skills and adapt is vital, especially in light of GRN attrition within a nursing profession experiencing a nursing shortage. Examining the literature, a number of career theories are evident from the past one hundred years. The structure of these theories falls into five main areas with various categories and associated areas of focus. Patton and McMahon (2014, pp. 13-15) list the five main areas of career theories as 1. Theories of content, 2. Theories of process, 3. Theories of content and process, 4. Wider explanations and 5. Constructivist/social constructivist approaches. Each of these career theory types have a number of categories and are listed in Table 2.2 (Patton & McMahon, 2014, pp. 13-15).

Table 2.2

Structure of Career Theory

Theories of Content	
Tait and factor theory	Parsons (1909)
Theory of personality	Holland (1973, 1985, 1992, 1997); Nauta (2010, 2013)
Psychodynamic theory	Bordin (1990)
Values based theory	Brown (1996, 2002a, 2002b)
Work adjustment person-environment correspondence theory	Dawis and Lofquuist (1984); Dawis (1996, 2002, 2005)
Five factor theory	McCrae and John (1992); McCrae and Costa (1996a, 1996b, 2008)
Theories of Process	

Developmental theory	Ginzberg, Ginzberg, Axelrad, and Herma (1951); Ginzberg (1972, 1984)
Lifespan life-space theory	Super (1953, 1957, 1980, 1990, 1992, 1994); Super, Savickas, and Super (1996); Hartung (2013)
Theory of circumscription and compromise	Gottfredson (1981, 1996, 2002, 2005)
Individualistic approach	Miller-Tiedeman and Tiedeman (1990); Miller-Tiedeman (1999).
Theories of Content and Process	
Social learning career theory (SLTC)	Mitchell and Krumboltz (1990, 1996)
Happenstance Learning Theory (HLT)	Krumboltz (1976, 2009, 2011); Krumboltz, Foley, and Cotter, (2013)
Social Cognitive Career Theory (SCCT)	Lent (2005, 2013); Lent and Brown (1996, 2002);
Cognitive Information Processing Approach (CIP)	Peterson, Sampson, Reardon, and Lenz (1996, 2002); Reardon, Lenz, Sampson and Peterson (2011); Sampson, Reardon, Peterson, and Lenz (2004)
Developmental-contextual approach	Vondracek, Lerner, and Schulenberg (1986); Vondracek and Porfeli (2008)
Contextual approach to career	Young, Valach, and Collin (1996, 2002); Valach and Young (2009); Young, Domene, and Valach (2014)
Personality development and career choice	Roe (1956); Roe and Lunneborg (1990)
Wider Explanations	
Women's career development	Astin (1984); Hackett and Betz (1981); Betz (2005); Farmer (1985, 1997); Betz and Fitzgerald (1987); Cook, Heppner and O'Brien (2002a, 2002b); Richardson and Schaeffer (2013); Schultheiss (2009, 2013)
Racial and ethnic groups	Arbona (1996); Brown (2002b); Hackett, Lent, and Greenhaus (1991); Smith (1983)

Sexual orientation	Fitzgerald and Betz (1994); Morgan and Brown (1991)
Sociological or situational approaches	Roberts (1977, 2005, 2012); Blau and Duncan (1967); Miller (1983); Hotchkiss and Borrow (1996); Johnson and Mortimer (2002)
Constructivist/Social Constructivist Approaches	
Systems Theory Framework	McMahon and Patton (1995); Patton and McMahon (1997, 1999, 2006)
Career construction theory	Savickas (2001, 2002, 2005, 2011a, 2011b, 2013)
Chaos theory	Pryor and Bright (2003a, 2003b, 2011)
Ecological approach	Conyne and Conk (2004)
Narrative	Bujold (2004); L. Cochran (1997); McIlveen and Patton (2007a, 2007b)
Relational/Cultural	Blustein (2001, 2006,2011); Schultheiss (2009, 2013)
Contextual Action theory	(see Theories of content and process)
(Patton & McMahon, 2014, pp. 13- 15)	

In addition to these career theories listed are intellectual-identity theories (Holmes, 2001, 2013). The main theories include: Parson's (1909) conceptual framework for career decision making, Holland's (1973) theory of vocational personalities and work environments, Super's (1975) career education, career guidance for the life span and for life roles, and Super's (1980) life span, life space approach to career development theory. Constructivist/social constructivist approaches are also relevant, in particular Systems Theory Framework (Holmes, 2001; 2013) and the graduate identity and Chaos Theory of Careers (Pryor & Bright, 2003a, 2003b, 2011). These chosen career theories will be referred to during the discussions in Chapter 6. Prior to presenting the career theories relevant to this study, Parsons (1909), Holland (1959), Super (1990), McMahon and Patton (1995) Systems Theory Framework, Holmes (2001; 2013) the Graduate Identity theory and Chaos Theory of Careers (Pryor & Bright, 2003a), relevant terms associated with career development

discourse are defined. Relevant terms associated with career development discourse include '*work*', '*job*', '*career*' and the '*individual's role*' in career development.

Defining the main terms associated with career development discourse is important. Patton and McMahon (2006) offer useful definitions: '*Work*' refers to the "domain of life in which people, paid or unpaid, provide labour for an outcome of a service or a good" (p. 5). '*Job*' is understood as "a specific work position which may be permanent full-time or part-time and in a particular role or organisation" (p. 5). '*Career*' has traditionally been understood as "the [linear] sequence of or collection of jobs held over an individual's life which have a [characteristic] vertical advancement trajectory" (p. 5). Other career definitions have been offered by scholars in this field. Arthur, Hall and Lawrence (1989) define career as "the evolving sequence of a person's work experiences over time (p. 8). However, a point of difference is raised by Nicholson and West (1989) who recommend that the term 'work histories' should be used to represent the sequence of jobs an individual may have over time. Nicholson and West (1989) advise the term career should be reserved for "the sense people make of them" (p. 181).

This latter view of career reflects the period in time where awareness about the traditional objective views, facts and absolute truth are being challenged as not the only view worth valuing. A subjective view, feelings, the constructivist view, to gain an individuals' truth by seeking their '*reality*' about a phenomenon is also valued. The individual's reality, or their truth, is constructed from their thinking and environmental influences (Steenbarger, 1991). Extant literature surrounding the career construction supports the notion that career is a subjective phenomenon, individually and uniquely created by the individual and therefore influenced by their perceptions, attitudes and actions (Collin & Watts, 1996; Herr, 1992; Miller-Tiedeman, 1989, 1999; Miller-Tiedeman & Tiedeman, 1990). The emergence of constructivism during this period was an important development, as this view revealed the [individual] "person as an open system, constantly interacting with the environment, seeking stability through ongoing change" (Patton & McMahon, 2006, p. 187). This system view also revealed where focus is placed and equally where the focus is not placed. A systems view is that the focus is placed on the process, rather than the outcome. Lastly, the term, the '*individual's role*' as an active contributor in their career development emerges in the scholarly of work of Tyler (1959) where this active quality and attribute of the

individual is evident when Tyler states "each person is a self-made man" (p. 81). The factors impacting GRNs' first year experience is better understood if the GRN is viewed 'as an open system interacting with their environment in order to gain stability'.

The following sections briefly present each of these career theories to identify the beneficial aspects that will help inform the direction of a career preparedness theory relevant for nurses with applicability to other professions.

2.8.1 Parsons (1909): Choosing a vocation

Seminal work by Parsons (1909) on career development theory provides a foundation for understanding how individuals can develop their career and for later research entering the field as detailed in Table 2.2. Parsons (1909) theoretical framework consists of three aspects to guide career counsellors in assisting individuals to choose a career that was suitable for them. The first aspect of this framework assists the individual to become aware of their own "aptitudes, abilities, interests, ambitions, resources, limitations, and their causes" (p. 5). The second aspect is where the individual researches the role of interest. Parsons (1909, p. 5) focused the research the individual needed to explore about the role by listing the following areas. These included the knowledge requirements of the role, factors that would support the success in this role, the positive and negative aspects relating to the role, compensation, opportunities and future job possibilities as an outcome from this role. The third aspect was to engage in true reasoning about the former two aspects (Parson, 1909, p. 5) that is to critically think about the information and thus form a conclusion from which to make an informed decision. *Is this career role for me, do I have what this role requires or am I able to put into place what I need, to be successful in this role*?

An important conclusion to draw from this theory is the recognition that each individual needs to be supported in raising self-awareness about themselves to identify their strengths, as well as the areas they need to develop to support their life career. GRN's self-awareness about their life roles and associated strengths and weakness including their aptitudes, abilities, interests, ambitions, resources (including support) can be used to enrich knowledge surrounding the GRNs' first year experiences.

2.8.2 Holland (1959, 1997): *Personality-environment*

Holland's (1959/1997) career development theory builds on previous career theories by focusing on personality-environment, to support individuals with a good work fit, work satisfaction and commitment to stay in the work place. Holland's theory of vocational personalities and work environments asserts that the degree of work environment fit is relational to a personality fit. This theory is important because it provides explanations on three fundamental questions relating to supporting individuals in their career choice. These are:

1. What personal and environmental characteristics lead to satisfying career decisions, involvement, and achievement, and what characteristics lead to indecision, dissatisfying decisions, or lack of accomplishment?
2. What personal and environmental characteristics lead to stability or change in the kind of level and work a person performs over a life time?
3. What are the most effective methods for providing assistance to people with career problems? (Holland, 1973, p. 1)

Holland's (1973) theory categorises individuals according to their resemblance to six personality types and to six environment models, "realistic, investigative, artistic, social, enterprising and conventional… [to predict their] vocational choice, vocational stability and achievement, educational choice and achievement, personal competence, social behaviour, and susceptibility to influence" (Holland, 1973, p. 2). An important aspect of his theory is the recognition of influences on forming an individual's personality type, such as cultural and personal factors, including interests that form a specialised set of competencies. Holland (1973, p. 2) asserts these interests and competency sets create a particular personal disposition, including the way each individual thinks, perceives and acts. Knowledge this theory provides to the career counsellor is important to guide the individual towards a career with a good fit and likeliness for the individual to feel satisfied and committed to their work and organisation. Holland's theory is well accepted (Furnam, 2001; Srscic & Walsh, 2001), however there is criticism in that it is not "reflective of the distinct experiences and expectations of the modern professional" (Price, 2009, p. 269).

However, an important conclusion to draw from Holland's (1973) theory, as previously drawn from Parson's (1909) theory, is the recognition that an individual would benefit from a raised awareness about who they are, including their areas of strengths and areas they need to develop and or strengthen. This type of self-awareness focus would support individuals' life career preparedness and adaptability for the changing nature of life career roles. The theories focus attention on the importance of identifying:

1. GRN personal and environmental characteristics that lead to satisfying career decisions, involvement, and achievement
2. GRN characteristics that lead to indecision, dissatisfying decisions, or lack of accomplishment
3. GRN self-awareness preparedness for their career role and the changing nature of their work role.

In addition, in relation to the criticism raised by Price (2009) of career theories not being "reflective of the distinct experiences and expectations of the modern professional" (p. 269), this study will embrace the opportunity to explore this aspect. However, the mindset will be not to dismiss career theories as not relevant but rather build on these existing career theories to provide a career theory that supports holistic life balance life career preparedness.

2.8.3 Super (1990): Life span, life space theory

Super's life span, life space theory (1990) is a careers theory building on previous career theories which focus on a developmental approach according to the individual's life stage and life space. The origins of the life stages and development task theory dates back to 1957, where the stages within this theory were established and include "Growth, Exploratory, Establishment, Maintenance, and Decline" (Super, 1957, p. 28). Super's theory asserts each stage moves sequentially or at times the different stages may occur simultaneously. Each stage occupies a position, role and tasks. Life roles include ten roles, "child, student, worker, spouse, parent, homemaker, citizen, leisure, annuitant … and patient" (Super, 1957, p. 31). Super (1990) has since categorised these roles to include eight roles: child, student, leisure, citizen, worker,

parent, spouse and homemaker. It is important to be aware of the life stage the GRNs are positioned within and the varying roles GRNs are occupying at the one time.

According to Super, occupying a position means that the individual adopts the position's role and the associated expected functions of this role, including behaviours. Therefore, as an outcome of such a phenomenon, the role can be seen to shape a person and equally, the person shaping the role. These roles will be played out in different types of theatres (settings). These theatres include the home, community, school, workplace, retirement community or home, with these theatres including sub theatres, for example the home sub theatres would include the "kitchen, playroom and study, [while the community theatre sub theatres would include] its service, recreational, welfare, health, and other facilities" (Super, 1975, pp. 31-32). Thus, knowing the various like roles and the expected thinking, behaviour and action, assists educators to direct the learning that is required to be effective in these various life roles and settings.

Applied to this study it is important to be aware of the different settings GRNs are positioned within to gain knowledge about the broader influences impacting GRNs from these settings and their effects as these may also be factors impacting their first-year experience. For example, the GRNs first year work setting may be within a particular clinical setting, such as surgical, medical, theatre, aged care, etc., while additionally, they be within a sub setting, such as GRN Transition Program or be in the clinical setting without a support program. Awareness of the different settings GRNs are positioned within and the broader influences associated with these settings and their effects will augment knowledge surrounding the GRNs' first year experiences.

Super's life space theory (1957, 1974) relates specifically to how many different roles the individual occupies, the associated theatres the individual is in and the manner in which the individual acts these out (Super, 1975, p. 32). Applied to this research, life space raises awareness about the need to identify the broader perspective of a GRNs life to inform the type of preparedness and support they would require currently and into the future. This raised awareness about the broader experience is important as it may also be a further factor in the GRNs first year experience impacting

their work, study, personal life satisfaction and may be a factor impacting their experience, satisfaction and attrition intent.

Super established within his life span, life space theory a concept titled '*Career Patterns*' to raise awareness to career educators and guidance counsellors the varying types of support an individual may require across their career to promote their satisfaction and retention. Career was defined by Super from a psychological and sociological perspective and is "the sequence of positions occupied by a person during the course of a working and work-related life" (1975, p. 32). Career patterns for men and women differ slightly due to gender influences. For men these are "conventional, stable, unstable and multiple trial, [while for women these are] conventional, stable, interrupted and double-track (simultaneous paid work and homemaking)" (Super, 1975, p. 32). Applied to this study, determining the factors impacting GRNs first year experience, 'career pattern awareness and preparedness and support' will help explain GRNs' experiences.

Super's intent from the life span, life space theory was to promote a guiding framework for career education. The first step in the education process is to establish objectives. Essential elements within the objective include what the program needs to accomplish at a general level and then sub objectives that detail the attitudinal and behavioural components. Importantly objectives need to be written in a way that the components can be measured. Therefore, objectives are important in expectation management, for the educator and the learner. It is important to get the objectives *right* and this should be a major concern for a school and the director of education. These career education objectives need to be written with expert support and in collaboration with a "team of curriculum specialists, counsellors, career psychologists, classroom teachers and evaluation experts" (Super, 1975, p. 33). Evaluation at the completion of the program is important to measure whether the expectations set, were met and to inform the further reiteration of the program to promote its effectiveness. Super (1975) offered general career education objectives to guide career educators. These include:

1. To provide students with an understanding of the nature and sequence of life stages and of career stages, of the developmental tasks which characterize these stages, and of the changing major roles which

people play (in sequence and simultaneously) in various theatres or spheres of activity in the several stages;

2. To help students develop realistic self-concepts, with esteem for themselves and others, as a basis for career decision;
3. To develop in students a realistic and appreciative understanding of the world of work, with a broad perspective on opportunities and a specific focus on one or more clusters of occupations, together with knowledge of the educational and occupational pathways that lead to them and of the work and ways of life that they involve;
4. To help students know and appreciate the many avocational, domestic, and civic outlets which in an automated society often supplement, complement, or even supplant, paid work in making a satisfying life;
5. To provide a basis for the making sequential and increasingly specific career decisions in which self and occupational knowledge are synthesised for self-realization in work, in homemaking, in civic life, and in leisure, in ways which meet social as well as individual needs;
6. To make these experiences available in ways appropriate to all students at each stage of their formal education.

Understanding broader nursing program objectives (including career education objectives and achievement of these objectives) will augment understandings about the GRNs' experiences.

2.8.4 McMahon and Patton: *Systems theory framework*

Systems Theory Framework (McMahon & Patton, 1995; Patton & McMahon, 1997; 2006; 2014) is a career theory based on a constructivism/social constructionism perspective that facilitates a broader approach than its career theory predecessors to support individuals and counsellors design career development that is relevant and reflective of the contemporary environment in constant change. Extant literature exists that supports this assertion and advocates the importance of career theories not be static but rather be flexible and adaptive to the changing nature of the world and world of work and life in order to remain relevant and responsive (Amundson, 2005; Watson & Stead, 2006). In relation to the underlying world view

of the Systems Theory Framework (STF), constructivism and social constructionism, this is important to include as it guides behaviour, thinking and action - our praxis. Constructivism and social constructionism origins lay within the same paradigm, where the ontology (nature of reality) is a reality that is individually and socially constructed (Atweh, 2009; Creswell, 2011, Crotty, 1998; Young & Collin, 2004). The aspect of difference between construct*ivism* and construct*ionism* lies in the epistemology (theory of knowledge and truth). Construct*ivism* contends that knowledge is constructed in the individual's mind as a result of their own thinking processes. Construct*ionism* on the other hand, contends that knowledge is constructed from social processes (Young & Collin, 2004). It is important to note that there is no single correct way of viewing the world as indicated by the history of career theories (Savickas, 1995) over the last one hundred years and the variances to date reflect the notion that knowledge is constructed by valuing the '*other*' as an instrument of thought (Olanike, 2010; Rayner, 2004). Thus, the ontology and epistemology informing career theories, such as for the STF are vital to improving a shared goal towards a career theory that aims to be responsive and reflective of the needs of individuals and counsellors by preparing and supporting individuals and counsellors in career development.

The STF consists of a number of key aspects to promote a whole system approach to career development by ensuring the system's process is recursive in nature, responding and adapting to changes as they occur over time. Two main premises of this system include context and decision making, while the main inter-related parts consist of the "intrapersonal system of the individual, the social system and the environmental-societal system" (Patton & McMahon, 2014, p. 24). Another key element of the STF is viewing the nature of the individual as '*active*' rather than passive. This '*active*' nature means that the individual is viewed as a "self-organising system" (Ford, 1987), that is, a system that has an innate goal to self-build and renew (Patton & Mc Mahon, 2006). This particular aspect reflects the STF contextualist world view is embedded within a construct*ivist* epistemology.

This construct*ivist* epistemology is important to note as it guides the STF career development theory to practice, including the pedagogy. Pedagogy with an 'active' component places emphasis on the learning process that builds the individual's capacity to effectively manage their responses to life events, maturation, development

and environmental influences. Whereas, viewing the individual's nature as 'passive' implies that the individual will experience and be impacted by life events, maturation, development and environmental influences (Patton & McMahon, 2006) while the pedagogy may lean towards teacher/counsellor directed and reliance. Thus, it can be seen the STF is aiming to not only be adaptable and flexible for the needs of individuals in the 21st century but self-generating to transform in response to the changing nature of individuals, culture and society. Applied to this study, determining the factors impacting GRNs first year experience, systems theory will enhance knowledge surrounding the GRNs' experiences.

2.8.5 Holmes (2001; 2013): The graduate identity

The graduate identity (GI) approach aims to provide a convincing case for an alternative approach to improving graduate employability. Holmes (2001) asserts that the graduate identity approach is based on two premises, "a conceptual and theoretical analysis of the nature of human behaviour and that situated behaviour can only be properly understood by interpreting activity as performance of a kind" (p. 111). Holmes' (2001; 2013) GI approach raises awareness about the differing discourse surrounding skills between higher education and the employment context. This aspect is important as it identifies the need for a collaborative relationship between higher education and industry to ensure undergraduate knowledge, skills, qualities and attributes are aligned with industry. A good place to begin this analysis is with performance or behaviour of graduates in their work place to inform reform to curriculum development and identify various ways to support graduates in raising their employability. This approach has merits as essentially observing human behaviour is evidence of transformative learning (Mezirow, 1997). This type of approach is importantly reflective, that leads to improved understanding to direct educational strategies that will improve the graduate's performance identity and capability in this role.

'Graduates self-reports on their performance behaviours and confidence levels' will be drawn upon to improve the knowledge surrounding the GRNs' first year experiences managing the *Load Triad* and the impact this had on their overall life balance.

2.8.6 Chaos theory of careers

Chaos Theory of Careers (CTC) is important in careers development as it aims to bring the reality of careers and decisions surrounding careers closer to reality in order to be useful to individuals and career counsellors in the 21st century. Four vital elements are included in this career development theory that other career theories have omitted to date. These four elements include: complexity, change, constructiveness and chance (Pryor & Bright, 2003a). These elements are described as follows:

> Complexity - of human experience and the range potential influences on people's careers, in particular the influences of objective and subjective context; Change - the dynamic, interactive and adaptive nature of human functioning in the world and in making careers and taking career action; Constructiveness - the tendency of humans to construe and construct experiences and perceptions into meaningful and often unique interpretative structures for understanding themselves, their experiences and their world, Chance – the human experience, and career development in particular, tends to be laced with unplanned and unpredictable events and experiences that are often crucial and sometimes determinative in the narrative of people's careers. (p. 13)

In addition, this theory articulates the intellectual influences to demonstrate its breadth by encapsulating a whole approach that recognises the realistic experience that has to consider the myriad of complexities in decision making. These intellectual influences include "contextualism/ecology; systems theory; realism/constructivism; and chaos theory" (Pryor & Bright, 2003, p. 12). Chaos theory is an important component of CTC as it aims to raise awareness about the nature of careers development consists of elements such as complexity, order, randomness and sensitivity to non-linear change (p. 12). The main aim of CTC is to support individual's early in their career to enhance the individual's potential in all their dimensions, a whole life benefit. 'Chaos theory of careers' can deepen the knowledge surrounding the GRNs' first year experiences. Applied to this study, determining the factors impacting GRNs first-year experience, 'Chaos theory of careers' will be drawn upon to improve the knowledge surrounding the GRNs first-year experience managing the '*Load Triad and the impact this had on their overall life balance'*.

Summarising the literature on respective life careers theories, a gap is evident in relation to a life career theory that is holistic in nature and that supports a broader life balance preparedness to approaching life careers, as underpinned by the essence of lifelong learning goals and a recursive evaluation process. The development of such a life career preparedness theory is important as it forefronts the individual's preparedness.

2.9 LIFE BALANCE THEORIES AND TOOLS

Life theories also underpin how this study progressed and unfolded. These Life theories also underpin how this study progressed and unfolded. These theories help extend our understanding of how individuals strive to attain and maintain a personal sense of balance in their lives and as such are important to this study. The following sections offer a brief unfolding of life balance theories which are relevant to this study.

2.9.1 Life balance

This section focuses on why life balance is a contemporary concern, examines the current metaphor of work/life balance and investigates life balance as a whole approach linked to nursing's holistic approach and associated nursing philosophies. The terms this thesis uses to represent a whole approach to life balance are presented and justified. Additionally, work/life balance models and theories are presented, followed by review on the work/life balance experience of employees generally, with a focus on health professionals, nurses generally and GRNs. This knowledge contributes to a broader understanding surrounding the GRNs' first year experiences.

A life in balance is important for all individuals as it associated with positive benefits such as improved personal health and wellbeing, happiness and overall life satisfaction, with positive ripple effects to the individual's family, community and society. This notion of life balance can be applied to improving the understanding of the GRNs first year experience and their overall life balance. A person's life is said to be in balance when they are able to spread their energy and effort between the range of areas in their life that are important to them (Aggarwal, 2012; Nayda & Rankin, 2008) and experience an improved quality of life because of

this balance spread (Lambert, Kass, Piotrowski, & Vodanovich, 2006). A number of other definitions and descriptions have emerged. These include the individual's balancing act of life, which includes balancing three areas, organisational, societal and personal (Poulose & Sudarsan, 2017). Other definitions highlight the relationships between various life components. For example, "the relationship between the institutional and cultural times and spaces of work and non-work in societies where income is predominantly generated and distributed through labour markets" (Felstead, Jewson, Phizacklea, & Walters, 2002, p. 56). Agreeing on a definition for this thesis is important to ensure a shared understanding between the researcher and reader. Therefore, the definition of life balance this thesis adopted is the definition offered by Aggarwal (2012), Nayda and Rankin (2008), as their definition matches the nursing epistemology, that health and wellbeing is improved when a whole approach is used, whereas other definitions offered don't use this type of discourse.

Life balance as a concern is not new. Concern about life balance can be dated back to the industrial revolution when child labour existed (Guest, 2002). Recent improved societal awareness about the importance of a life in balance in promoting individual's life satisfaction, happiness and their health and wellbeing to benefit them and society has seen life balance as a key concern being raised by governments, organisations and employees in response to preventing employee life imbalance, life dis-satisfaction, unhappiness and health and wellbeing decline (Chang, McDonald, & Burton, 2010; Guest, 2002; Karassvidou & Glaveli, 2015; Lambert et al., 2006). In the contemporary work climate many employees are experiencing excessive demands from their work and personal life (DiRenzo, Greenhaus, & Weer, 2011; Frone, 2003; Mauno, Kinnunen, & Pyykkö, 2005), creating conflict, as they feel the push and pull between the two domains and resulting in a life not in balance (Glavin & Schieman, 2012). Yet, despite advances since the industrial revolution and contributions by the extant literature on life balance, life *not* in balance is still being experienced by many employees and it is important to assess and identify employees at risk and to address employee's risk in a meaningful and measured way to promote their health and wellbeing and society.

Work/life balance is a metaphor implying at first glance that an employee needs to have an equal weighting between their work and personal life (excluding time for sleep). This impression matches the intent of the definitions offered earlier by

Aggarwal (2012) and Nayda and Rankin (2008). However, there are concerns regarding assumptions about what the work/life metaphor means because it is likely to have different meanings for different people and contexts (Guest, 2002). Therefore, assumptions about its meaning are cautioned. Examining the separate components of *work, life* and *balance* reveals the following understandings. *Work* has been defined by Guest (2012, p. 261) as "paid employment", while *life* as "non-work…rest of life…activities outside of work" (p. 262). The definition of *balance* in relation to work and life has been difficult to locate in the literature on work/life balance. Guest (2002) supports this observation. Without a clear definition of *balance*, misunderstandings between individuals and researchers can be created and therefore it is important to define. Guest (2002) interestingly cautions against defining balance, and asserts balance is often a subjective experience. However, having a shared meaning of work/life balance is necessary for this study to create shared meaning and to assist in analysing and drawing conclusions about GRNs' overall work/life balance status.

It is important to have shared meaning of what 'balance' means in this context as it forms part of the concept names; work, life balance. In objective terms, the term 'balance' has a number of meanings. As there is a paucity of definitions of balance relating to work- life in the literature it was necessary to explore the various meanings offered in dictionaries. For example, The Concise Oxford dictionary (2013) describes 'balance' as a noun, with the following meanings, "to bring into equilibrium", "an equal distribution of weight", "enabling someone or something to remain upright and steady". The Merriam-Webster dictionary (2013) also adds, "physical equilibrium", "mental and emotional steadiness", and "an instrument for weighing", and "means of judging or deciding". Verb use includes, "put (something) in a steady position so that it does not fall" and "offset or compare the value of (one thing) with another".

Considering these meanings of balance and for the purpose of this thesis, *balance* is understood to mean:

> A state of equilibrium (a state of balance between opposing forces); enabling someone [GRN] to remain upright and steady; physical, mental and emotional steadiness; shared understanding of judging or

> deciding (The Concise Oxford Dictionary, 2013; The Merriam-Webster dictionary, 2013).

The literature reveals several common terms in relation to life balance. The common term used to describe *balance*, is work/life balance (WLB) (Chang, McDonald, & Burton, 2010; Clark, 2000; Guest, 2002; Jamieson & Andrew, 2013; Kalliath & Brough, 2008; Poulose & Sudarsan, 2017; Zheng, Molineux, Mirshekary, & Scarparo, 2015) and or work/family balance (WFB) (Kariassvidou & Glaveli, 2013; Lambert et al., 2006; Glavin & Schieman, 2012). However, it is important to form a meaning of these terms because of this literature review. Therefore, for the purpose of this thesis, the meaning of the term work/life balance is understood to mean:

> work + life + balance = a state of sustainable equilibrium between opposing forces contained with a person's various life worlds enabling them to achieve physical, mental and emotional steadiness.

In selecting terms to represent the contemporary life experience it is important to reflect on what constitutes the contemporary experience. Currently, 'work/life/balance' and 'work/family balance' terms, reflect the domains and associated life roles important to the common population; notably work and life/family (Brooks & Anderson, 2005; Clark, 2000; Wilson & Baumann, 2015). Life roles have been further categorised by Super (1990) to include eight roles: child, student, leisure, citizen, worker, parent, spouse and homemaker. Reflecting on these domains from a contemporary position regarding life roles that are important to society, it is evident that these roles can be broadly categorised within either work, study and or personal. Hence, the domain, *study* is identified as standing out from all other life role categories and so becomes deserving of a domain place in the work/life balance term. Additionally, '*study*' is underpinned by lifelong education and is valued by our society due to the associated benefits.

The value placed on lifelong education is reflected in international and national policy and associated discussion papers (Aspin & Chapman, 2001; Australian Government, Department of Employment, Education and Training, 1988; Dawkins, 1987; Edwards, Ranson, & Strain, 2002; Elliott, 2006; European Commission, 2012; European Union Centre RMIT University, 2014; Fryer, National Advisory Group for Continuing Education and Lifelong Learning [NAGCELL], 1997, 1999). Hence, this

thesis argues that '*study*' as a domain needs to be included in its own right within work/life balance. Consequently, there is a need for a more accurate assessment of the life balance domains important to the common population. Thus, a contemporary assessment of what is considered the life balance domains important to the common population is a gap in the literature and forms one of the contentions of this study.

Lifelong learning education is about accessing and participating in learning education throughout life. Lifelong education begins in the early years, carries through into primary and high school, then commonly onto TAFE and university (Kearns, 2004; Queensland Government, 2002) and further, into professional development and associated professional annual license renewals. Many professional annual license renewals include education in the form of continuing professional development (CPD) hours and consist of informal and formal modes of CPD. For example, for the nursing profession in Australia, the Australia Health Practitioner Regulation Agency [AHPRA] (2010) mandates 20 hours of CPD annually (NMBA, 2010) with informal examples offered as reading journal articles, while formal examples offered are post-graduate university courses. Therefore, due to the contemporary social and professional climate surrounding the importance of study, this thesis included study as a domain to be recognised and included with work and life/family balance.

Examining further the other terms within work/life/family balance, the terms 'life/family', reveals that 'life' is a broad term. Guest (2002) highlighted this broad context to represent life is meant to convey an encompassing view of non-work. Thus, non-work relates to home, family and leisure (Schieman, Glavin, & Milkie, 2009). While the term 'family' is not as broad it enables a clear focus of attention to the 'family' within the broad context 'life'. Family is a socially constructed concept that has in recent times moved from meaning two parents and their children, to a broader view. This broader view is captured in Langtree's (2015) definition of *family*:

> A basic unit of society consisting of individuals, …[genders], youth and adult, legally or not legally related, genetically or not genetically related, …considered by the others to represent their significant persons. (p. 478)

Wright and Bell's (2009) definition of family extends further than the physical and legal attributes, to also include acknowledgement of the emotional attributes of a family and how members hold value and deep interest for one another. This aspect is clearly identified in their definition of family, where they state family is "a group of individuals who are bound by strong emotional ties, a sense of belonging, and a passion for being involved in one another's lives" (p. 46). This shared value evident in the meaning of family reveals family as a culture all of its own. Additionally, each family has its own culture and therefore shared values and beliefs (Langtree, 2015, p. 478). Langtree (2015) links this aspect back to the cultural origin of the family. In the context of work/life balance assessment and interventions/support, it is important to understand the family is unique for each family group because a families' culture influences and shapes the family's structure, ways of interacting, including health care practices and coping mechanisms (Langtree, 2015). Therefore, it can be seen that these factors all contribute to influencing the work/life balance and health of family members as a whole unit.

This 'whole approach' is not a foreign concept to the nursing profession and is known in nursing as the philosophy of 'holism' that works in unison with three other nursing philosophies, person-centred care (PCC), family centred care (FCC) and the nursing process of care (NPC) and is additionally underpinned by thoughtful practice (see Section 2.5). Thus, the 'whole' approach is the platform for health care assessment, delivery and evaluation of care. In comparing nursing's 'whole' approach in unison with the cyclical nursing process of care approach to the field of psychology - work/life balance approach, the literature reveals a paucity of research and is a gap in knowledge. This cyclical life work/life balance process is a 'way of working' to improve work/life balance of individuals (and their family) and forms one of the contentions of this study. Thus, drawing on the nursing epistemology position, as underpinned by holism, PCC, FCC and the NPC approach, is applicable to measure the effectiveness of work, study, personal life balance at the individual level to assist in closing the loop from the employees and or families' perspective. This approach aligns with the KCKB concept advocated by Bereiter and Scardamalia (2014). In addition, this approach provides the empirical evidence that individual's life is in balance, with associated improvements to their health and wellbeing and quality of life

experience. Applied to this study, the cyclical life work/life balance process is a 'way of working' to improve work/life balance of GRNs (and their family).

2.9.1.1 Person/Family-Centred Work, Study and Personal, Life Balance

Due to the contemporary health climate surrounding the importance of the many constructs that contribute to a whole approach to PCC and FCC care, this thesis exchanges the terms *life/family* for the term *personal.* The aim of this exchange of terms is to reflect all the dimensions of a person and the elements associated with person-centred care, while *life* encompasses all domains. Therefore, the unified terms this thesis uses are *work, study and personal, life balance* (PFCWSP- LB) rather than the common terms *work/life balance* (WLB) and or *work, life/family balance* (WLFB). A concern this study addresses is that failure to perceive a person as a whole (made of several constructs working in harmony), may lead to aspects of the individual's person hood to be missed in the assessment and management of life balance. This aspect of inattention to the parts that makeup the whole has been identified by Aggarwal et al. (2000) and Nayda et al. (2008) as a core contributor to imbalance, and therefore is important to identify and support the individual to restore balance in their life. Applied to this study, determining the factors impacting GRNs first year experience, the philosophy of holism, person-centre/family centred care and the nursing process of care approach will be drawn upon to improve the knowledge surrounding the GRNs first year experience managing the '*Load Triad*' and the impact on their overall life balance.

2.9.2 Life balance theories

There are a number of life balance theories that attempt to describe the concept of work/life balance and explain how a person's life roles relate with each other and or intersect, creating work/life harmony and or disharmony and its relationship to a person's sense of overall wellbeing. It is acknowledged there are many life balance theories, however, the following examples aim to capture a representation of these. These life balance theories are: Spillover, Compensation (Edwards & Rothbard, 2000; Zedeck & Mosier, 1990), Instrumental (O'Driscoll, 1996), Segmentation (Staines, 1980; Zedeck, 1992), Work-Family Enrichment (Greenhaus & Powell, 2006), Work/family Border theory (Clarke, 2000) and Boundary theory (Ashforth, Kreiner, & Fugate, 2000; Nippert-Eng, 2008). Each of these theories have

slightly differing aspects. The particular unique aspects of each of these theories is presented next.

The spillover, compensatory and instrumental theories are relevant evidenced based theories that can help raise awareness to the effects of when an individual's life domains intersect. The *spillover theory* asserts that the domains of work and non-work influence each other either positively or a negatively (Guest, 2002; Bulger, Matthews, & Hoffman, 2007; Williams & Alliger, 1997). The *compensation theory* differs by asserting that if one domain is deficient or lacking in fulfilment, the individual can seek and find fulfilment in another domain (Guest, 2012). Thus, this theory demonstrates that satisfaction can still be achieved through a life domain counterbalance. The *instrumental theory* asserts an individual's activities in one domain can benefit the other domain and hence each domain is nourished, further improving an individuals' personal sense of life role and life balance satisfaction. For example, working longer hours means an increase in income that can benefit a person's personal life such as buying a car, home and or a holiday. *Segmentation theory* asserts the two domains, work and non-work are separate and do not influence each other. However, an important critique offered by Guest (2002) of this particular theory is that it is not evidenced-based. This raises awareness that life balance theories can act to assist individuals to understand their individual life balance situation and how to direct change. Another useful life balance theory to improve an individual's understanding of their situation is the Work-Family Enrichment and Conflict theory.

The Work-Family Enrichment theory recognises the benefits of multiple life roles. This model is evidence based and predicts work and family enrichment occurs because of the ability to transfer resources from one domain another and vice versa (Greenhaus & Powell, 2006; Guest, 2002). The aspect of combining multiple life roles from both work and personal domains is the vital aspect that enriches the individual's quality of life (Siu et al., 2010). Positive outcomes from an individual being able to fulfil multiple life roles includes improved job satisfaction (Carlson & Grzywacz, 2008; McNall, Nicklin, & Masuda, & 2010; Shockley & Singla, 2011) and improved health outcomes (Grzywacz & Bass, 2003). However, when an individual's life roles conflict with their other life roles, such as their family role, dissatisfaction and disharmony is felt by the individual and their family members. Hence the development Work/family Border theory.

Work/family Border theory is beneficial to explain the reality of individuals juggling multiple life roles. Within this theory, conflict is described as when an individual experiences excessive demands in both their work and personal domains, resulting in the individual feeling overloaded and needing to make decisions for one domain that results in conflict in another domain. Work/family Border theory describes, "People are daily border-crossers between the domains of work and family" (Clark, 2000, p. 747). This theory is different from other theories in that it includes the '*bigger picture'* shaping and influencing a person's life and thus influencing and shaping a person's work and family domains. Clark's (2000) theory includes a person's interpretation of events and their interaction. This *'bigger picture'* consideration by Clark (2000) is known as a person's philosophical assumptions (Creswell, 2010). Philosophical assumption is how a person sees the world; that is, the framework through which a person observes, interprets, interacts; and includes their beliefs, values or assumptions (Creswell, 2010, pp. 74, 78, 86). This philosophical assumption is evident when Clark (2000) states:

> People shape these worlds [work and family domains], mould the borders between them, and determine the border-crosser's relationship to that world and its members. Though people shape their environments, they are in turn, shaped by them. (p. 748)

This aspect is important to seek out those who offer support, for example, as it helps to improve the understanding surrounding the drivers that trigger when border crossing occurs, their interpretation and interaction and hence how to communicate and support a person to achieve life balance. Clark (2000) also identified the importance of communication as an enabler to support the individual to achieve work/life balance. A critique of Work/life Border theory is that initially, there was little empirical evidence to support it (Voyandoff, 2007). However, evidence to support this theory has emerged since this critique (Glavin & Schieman, 2012; Karassvidou et al., 2015; Lambert et al., 2006). A theory with growing empirical evidence is boundary theory.

Boundary theory describes how employees manage and transition between their life domains work and family. The key aspect of this theory involves the individual creating and maintaining boundaries between the domains and their

respective roles. Management involves an employee's preference for permeability and flexibility (the physical dimension - spatial and temporal of a domain boundary) (Daniel & Sonnetag, 2016, p. 410) that is, choosing to keep work at work or allowing the domains of work and family to integrate. Permeability is "the degree to which a role allows one to be physically located in the role's domain but psychologically and/or behaviourally involved in another role" (Ashforth et al., 2000, p. 474). While this theory is supported by empirical evidence (Daniel et al., 2016; Guest, 2002), a limitation of this theory is the aligned interventions and evaluation of the effectiveness of the interventions as mapped back to the assessment indicators and problems identified, is limited. A study by Michel, Bosch, and Rexroth (2014) partly addressed this limitation by measuring the effectiveness of a mindfulness strategy that promoted work-life balance.

While work/life balance theories are important to describe and explain, the theories are also significant in predicting work/life imbalance. Therefore, it is important to apply these theories to practice and measure the effectiveness of this practice. To support the link from theory to practice as highlighted earlier in the nursing philosophy of care approach, these theories would benefit from embedding them within a framework that supports a quality, reiterative cyclical process. This study has adopted the nursing process of care approach (as indicated in Figure 2.5), including the cyclical process which consists of assessing the individuals work/study/personal, life-balance, identifying problems from this assessment, offering a shared plan with the individual and associated significant others, and then tracking the implementation of the plan and evaluating the effectiveness of the plan. This cyclical process is a reiterative process based on the evaluation to assist the individual to restore balance back to their life and to maintain and enhance this balance over their career. Figure 2.5 encapsulates the theoretical model adopted for this study. The preceding discussion has shown that life balance is an important contributor to a person's wellbeing, especially in their world of work.

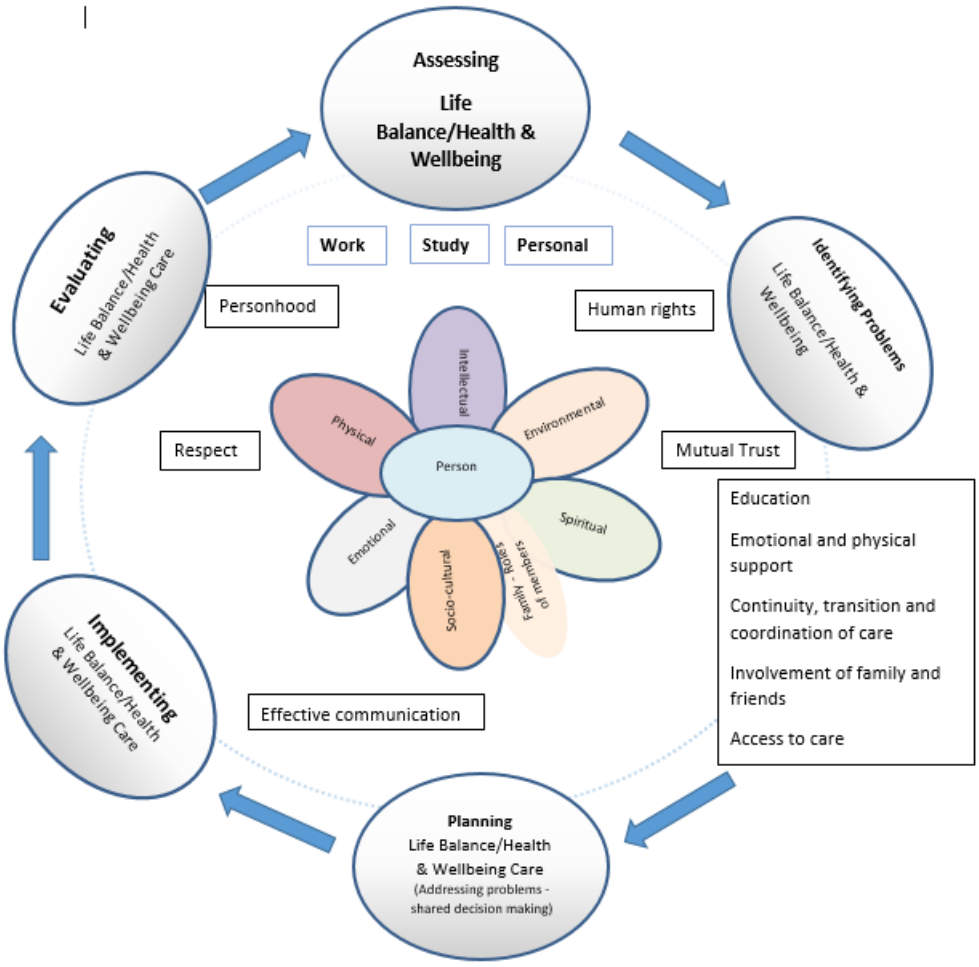


Figure 2.5. The nursing process of care approach underpinned by person-centred care and applied to work, study and personal, life balance care.

Determining the risk factors for work/life imbalance and the individual's health and wellbeing decline, provides valuable data to inform the life balance/health and wellbeing assessment. Main risk factors include work/life conflict (Amstad, Meier, Fasel, Elfering, & Semmer, 2011; Carlson et al., 2011; Schluter et al., 2011) and role blurring. Conflict arises when the employee feels they are unable to adequately meet the demands arising from their work and personal life domains (Hosie & Sevastos, 2010; Guest, 2002; Schieman, Glavin, & Milkie, 2009; Warr, 2007). Consequently, the employee experiences tension, pressure and stress, leaving them feeling unhappy and dis-satisfied in their work (DiRenzo et al., 2011; Skinner & Pocock, 2011) leading potentially to a life out of balance as determined by the definition of work-life balance outlined above. While *role blurring* has been described by Desrochers and Sargent (2004) as:

> The experience or difficulty in distinguishing one's work from one's family roles in a given setting which these roles are seen as highly integrated, such as doing paid work at home. (p. 41)

Role blurring has been attributed to several broader demographic characteristics. These include: age (Voydanoff, 2007; Winslow, 2005), occupation (Bellavia & Frone, 2005) and education (Schieman, Kurashina, & Van Gundy, 2006). Other factors include marital and parental status (Grzywacz & Marks, 2000; Jacobs & Gerson, 2004; Mennino, Rubin, & Brayfield, 2005), gender (Moen & Roehling, 2005), race and ethnicity (Bellavia & Frone, 2005), and advances of technology and increased availability of staff to work outside of business hours due to the internet (Anandarajan, & Simmers, 2005; Schieman et al., 2009). While these broader demographic characteristics are important to help identify employees at risk of role blurring, associated work, life conflict descriptive indicator examples to reflect this characteristic, are also important as descriptor indicators assist in the reliability of the assessment and in identifying employees at life imbalance risk and health and wellbeing decline.

Role blurring, work, life conflict descriptive indicator examples are important in forming the individual employee's life balance and health and wellbeing assessment and in identifying associated problems. Voydanoff (2007) offers other useful descriptors which include descriptors that are both '*behavioural'* and '*psychological'* indicators. Behavioural examples of work, life conflict would include employees performing paid work during personal time outside of paid employment times. Such as when an individual is at home and they accept phone calls to manage work situations, responding to work emails and or creating reports for work. Psychological examples would include thinking and talking about work when at home (Guest, 2002). Voyanoff (2007) offers one particular indicator as alarming and this indicator describes a person who completely blends work and home roles and is unable to make a distinction between the two roles. Voyanoff (2007) classified this particular indicator as high role blurring. Missing from the indicator types offered by Voyanoff (2007) are the subjective indicators and the inter-related indicators to assess health and wellbeing. For example, an individual would voice their life balance and health and wellbeing experience, "*Life is my work, I don't seem to see my family very much and I have put so much weight on*". Subjective indicators such as these identify the

individual is experiencing a situation where work hours are exceeding beyond normal business hours and are impacting on the individual's time with their family, highlighting work/family imbalance. Additionally, these comments reveal the individual's time for self-care, exercise and healthy eating habits has also been negatively impacted. Thus, subjective indicators are important to include with objective indicators to ensure an improved understanding of the life balance and health wellbeing assessment.

Another indicator to be considered in this assessment mix is '*functioning effectively'*. Greenhaus and Powell (2006) identified that a general measure of work, life balance is the individual's demonstration of functioning effectively in their work and personal non-work roles. It is acknowledged this indicator could be grouped under the broader indicator *'behavioural'*; however, its point of difference is that the behaviour is described in the positive. However, a precise, detailed description of what the work role and non-work roles indicators would be to reflect effective functioning in the WLB mix were not offered. However, a behavioural indicator to represent '*functioning ineffectively'* as a possible outcome of an employee's work invading their personal life is reduced time, energy, and ability to participate and devote to non-work life (Guest, 2002; Frone, 2003; Konig & Caner de la Guardia, 2014). Additionally, Greenhaus and Powell (2006) did not extend their life balance focus to include the inter-relationship with health and wellbeing and the indicators that reflect effective functioning of health and wellbeing. Therefore, having a broad and focused palette of indicators included in work, life balance tools that include both life balance and health and wellbeing would improve the individual's life balance and health and wellbeing assessment, and in identifying associated problems.

Work/Life/balance (WLB) are useful in determining an individual's work/life balance status as long as the tools accurately reflect an individual's life. One particular study by Hayman (2005) evaluated a WLB tool adapted from the Fisher-McAuley, Stanton, Jolton, and Gavin (2003) for validity and reliability. Hayman (2005) found the tool was valid and reliable in assessing an employee's work and non-work life and attributed this to the tool using a more inclusive term '*personal life*'. The term '*personal life*' resonated with all users of the tool and hence was seen to be inclusive. Whereas the term 'family' segregated employees because many employees did not identify with having a family. Inclusivity of terms used in work, life balance

tools are therefore important considerations to ensure the audience they are meant for, can identify with the tool in the first instance and therefore benefit from using the tool.

A number of other well-known life balance tools exist. Examples include the 'Wheel of Life' (Byrne, 2005) and the 'Life Career Rainbow' (Super, 1980). The 'Wheel of life' tool (Byrne, 2005) assists individuals to move through three key points. These are: 1. Identify eight priority areas in your life, 2. Write the goals or outcomes for each of the eight areas. 3. List two to three actions to achieve these goals and or outcomes. This tool, while it provided an example of the eight areas that need prioritising in a person's life, no descriptors were provided to assist the individual to determine the various areas in the life they should prioritise, nor the levels that people felt they were affected. This point raises concerns, as the individual may not be fully informed of the areas in their life they should examine and thus this assessment has the potential for omissions and thus an inaccurate life balance and health and wellbeing assessment is made. Again, the goals and actions become the onus of the individual to formulate. Goals are at risk of misalignment to the initial concerns and without evidenced based actions, the individual is at risk of not achieving their goals and addressing their initial concerns. Evidence of the effectiveness of this tool to improve life balance and the inter-relationship with improving health and wellbeing, has been difficult to locate in the literature and forms a gap.

The 'Life Career Rainbow' assists individuals to identify the various life roles they have. The 'Life Career Rainbow' tool (Super, 1980) offers eight life roles with an associated description for each role. These life roles include child, student, leisure, citizen, worker, parent, spouse and homemaker. The tool also provides the stages of life the individual may fall into and assists the individual to understand the pattern of the time and effort they invest in particular roles at certain times of their life. Again, with this tool the onus falls on the individual to determine and manage the balancing of their life roles. How to determine the individual's life role imbalance and the inter-relationship of this with their health and wellbeing was not identified by this tool. In examining this tool, the measure '*self-care role' or 'health and wellbeing care role*' was not included as part of the eight life roles and therefore the inter-relationship of life role imbalance with health and wellbeing was not addressed. Evidence on the effectiveness of this life balance-role tool to improve life balance together with the inter-relationship with improving health and wellbeing has been difficult to locate and

forms another gap. Supporting individuals to work, life balance is important to prevent a decline in employees' health and wellbeing and the ripple effects to the organisation and society.

Applied to this study, determining the factors impacting GRNs first year experience, 'life balance theories and associated tools' may be drawn upon as relevant, to improve the knowledge surrounding the GRNs first year experience managing the '*Load Triad*' and the impact this had on their overall life balance.

2.9.3 Life balance theories: Limitations in the context of this study - point of difference for this study

The existing theories surrounding life balance and associated life roles are important in helping to understand some of the factors effecting an individual's ability to achieve life balance together with the expected outcomes. While these theories and tools offer many insights into the causes for life imbalance and associated weighting and some indicators, these theories do not extend application to practice interventions that align to achieving health and wellbeing as well and the measuring and evaluation of these aspects in a combined way. For example, these theories do not extend to include aligned targeted interventional strategies based on the work/life balance assessment and then the associated evaluation of these strategies to guide the ongoing monitoring of a person's work/life balance risk status, support and progress. Inclusion of these aspects can help guide an evidenced based approach to help counteract the known negative effects emanating from life imbalance, health and wellbeing decline and promote a proactive management that acts to create a life in balance. This study sought to develop a preliminary predictive model with built-in supportive strategies to address this gap. The model helps identify when and what type of support needs to be implemented that acts to help prevent or limit an imbalanced life, health and wellbeing decline and attrition intent to promote happy GRNs satisfied with their overall life balance and the various life roles important to them, including their health and wellbeing.

2.10 THE PHILOSOPHICAL AND THEORETICAL APPROACH DEVELOPED FOR THIS STUDY

The approach developed for and implemented in this study focused on developing understanding of the meaning of '*Being'* and '*Becoming'* by understanding

the nature of existence in the Heideggerian sense (what was it like to *be* a GRN) together with revealing the essence of their lived experience as Husserl and those described above propose. The 'essences' themselves were not sufficient to bring deep meaning to all the possible nuances involved in the lived experiences of the participants' *life-worlds*. The researcher was very interested in how and why participants became and remained GRNs '*being-in-the-world*' of nursing and everything that entailed (especially their practice), however difficult or easy that was for them. The researcher did so through a detailed consideration of how various nursing and education theories are linked to this project and to the philosophies detailed above and how these are all brought into play in the lived experiences of participants. Figure 2.6 illustrates these various links and details the progression of this study from its underpinning driving paradigm (post-positivism) which naturally flows into the various philosophies which help explain the place of lived experience and life-world in the roles people play out across their lives. The paradigm and philosophies then link to various theories of nursing, education and life-careers which help in their own specific ways in understanding the position GRNs find themselves in post-graduation.

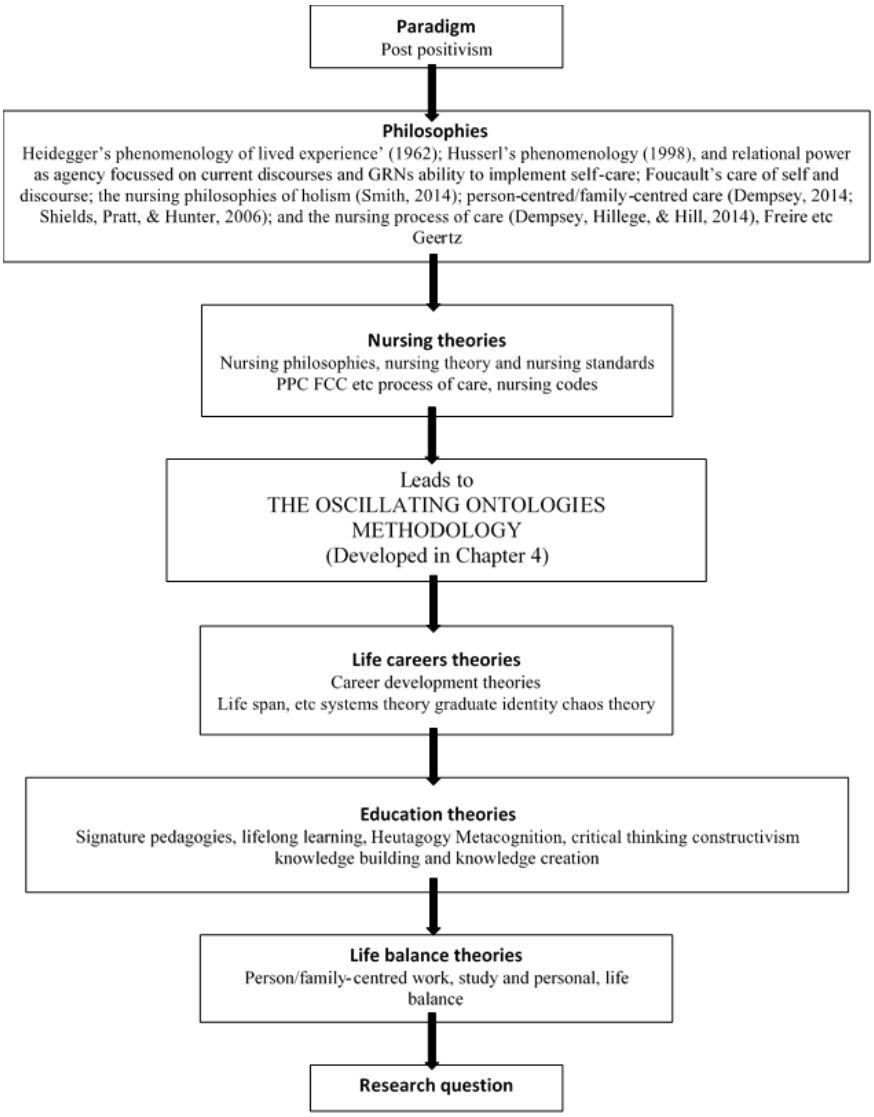


Figure 2.6. The overall philosophical and theoretical approach linked to study paradigm.

2.11 CHAPTER SUMMARY

The philosophical stances and theories adopted to underpin and support the methodological approach for this study was presented in this chapter. The philosophical stances support the use of phenomenology as both a philosophy and a research methodology and lived experience and life-world as a means of accessing GRNs work, study and personal life role experiences. The main theories presented related to nursing epistemologies and education processes and are drawn upon in the discussion Chapter 6 to improve the knowledge surrounding the GRNs first year experience.

The literature surrounding the concepts of nursing preparedness, lived experiences and life roles are explored in the following chapter.

Chapter 3: **Literature Review**

3.1 CHAPTER INTRODUCTION

Conducting a literature review is important to gain insight into the discourse surrounding the GRNs' first year experience. It allows the researcher to examine in a balanced way what is already known in the literature about the area of research interest, such as its strengths, the issues and the shortfalls. Thus, it provides an opportunity to guide the formation of this study's research questions, theoretical and conceptual framework, and eventually, seek answers to these research questions. The review also provides an opportunity to extend understandings about the GRN first year experience.

Chapter 2 provided the philosophical perspectives and key theories that will be drawn upon and applied in the discussion Chapter 6 to improve understandings about the experiences of GRNs in '*becoming and being a nurse*'. The context for this application of these philosophies and theories is in relation to GRNs embarking on their transitions from their education and transition '*nurseries*' into their RN roles whilst facing the challenges of working, studying and living a life as a nurse. The philosophical perspectives and theories reviewed in Chapter 2 introduced interpretations of the GRN first year experience at a deeper existentialist level of '*becoming and being'* a nurse as their experiences are likely to be multilayered and complex.

This chapter provides a review of the literature that informs this study. The literature includes several topics, followed by the theoretical model and conceptual framework, a summary, and finally the research question. The chapter first reviews the historical background which provides the context for the study. It includes the global nursing shortage, Australian and international GRN attrition and Australia's historical education and training of nurses (Section 3.2). The GRN's lack of preparedness experience and GRN transition programs is discussed in Section 3.3. Next, the chapter revises employees' life balance and examines nurses' life balance and GRNs' life balance in Section 3.4. Section 3.5 reveals the theoretical model framing this study and provides a conceptual framework to reflect this. An outcome of this critical review of

the extant literature is the identification of gaps in the knowledge surrounding links between the GRN lived experience, attrition rates and management of this issue. Section 3.6 summarises the literature review and presents the research question for this study as an outcome from the literature review.

3.2 HISTORICAL BACKGROUND

This section outlines the historical positioning that informed the development and genesis of this thesis. A discussion of the global shortage of GRNs is followed by the national and international GRN attrition trends. A brief outline of the historical education of nurses completes this section.

3.2.1 Global nursing shortage concerns

Nurses are critical in the delivery of health care and services. The concern that a nursing shortage raises is that it places the quality of care for individuals, families and communities at risk of being significantly undermined (World Health Organization [WHO], 2006, 2014). As indicated by the 2006 WHO Health Reports, 57 countries were identified as having critical nursing shortages. These shortages are apparent in both developed and undeveloped countries. Bangladesh and Liberia had the lowest nurse to population ratio. Hossain and Begum's (1998) study identified that Bangladesh's critical shortages occurred mostly in rural and remote areas. Similarly, Hegney, McCarthy, Rogers-Clarke, and Gorman's (2002) study identified critical shortage similarities evident in Australia's rural and remote areas. Close to one decade later and despite the 2006 WHO Report detailing strategies to address the nursing shortage, a transnational health work force shortage remains. Strategies recommended by this report included adjusting the skill mix, promoting full scope of practice of RNs and retention strategies (WHO, 2014). The WHO (2014) Report advocates moving away from old practices to adopting new and innovative ways to meet the demand in the 21st century and address the nursing shortage. Addressing the nursing shortage is critical in meeting the demands for health care and services and to mitigate risks of being unable to adequately deliver quality and safe care to individuals, families and communities.

Researchers have inquired into the causes of the global nursing shortage. An early seminal study by Buchan (2006) identified that causes of the global nursing

shortage stem from a health system problem, thus contributing to its ineffectiveness in meeting the demands for health care services and professionals. Buchan recommended that health systems need to move to adopting practices that is informed by evidenced based approaches. A later study by Buchan and Aiken (2008) confirmed the global nursing shortage study stemmed from a health system problem and identified key problem areas within the system. These included "inadequate workforce planning and allocation mechanisms, …undersupply of new staff, poor recruitment, retention and 'return' policies, …ineffective use of available nursing resources…poor incentive structures and inadequate career support" (p. 1). Thus, the evidenced based system practice approach offered by Buchan (2006) is highly relevant and supports this study's contention: that leading causes for the nursing shortage are that health systems are not operating from an evidenced-based platform.

Several problems exist within the health system that impact on the supply of nurses. The main problems emerge from limitations in replenishing older nurses as they reach retirement and exit from the profession, struggles in recruiting nurses and difficulties in retaining nurses to meet the growing demands for health care (Douglas, 2011). These types of problems are not new and were identifed within the American health system over two decades ago in relation to the nurses who identify as being from the baby boomer era. Norman et al. (2005) conducted a national survey of 1,783 American nurses across a number of health settings. The objective of the study was to seek solutions from nurses themselves to help resolve the nursing shortage. The main solutions offered by the sample of nurses from all age groups, was to increase salaries and benefits and to improve the work environment. Norman et al.'s (2005) study also found that older nurses intended to take up their retirement within the following three years. Norman et al. (2005) predicted the worldwide shortage of nurses would worsen within the decade. This they saw as stemming from the intent by older nurses to retire combined with an increasingly ageing population and growing demands for health services. Coupled with these factors was the absence of evidenced based plans to inform the attraction and retention of nurses.

In Australia, similar 'health system' reasons have been identified as contributing to a predicted national nursing shortage. Christopher, Fethney, Chiarella, and Waters (2018) conducted a national survey of 208 Registered Nurses across a range of health settings. Their study found three important features associated with

turnover intentions that were symbolic of a health system not functioning well. Inadequacies were found with the organisational structure in providing opportunities for effective professional interactions. There was also a lack of strategies designed to develop effective and collegial interpersonal relationships as well as ineffective support from managers. This study is important as it moves away from the focus from baby boomers, such as in the Norman et al. (2005) study, to include generation X's transition to retirement from 2025. Christopher et al. (2017) predict that Australia will be approximately 110,000 nurses short in its ability to meet the expected 2025 health demands. Their study, despite its low number of participants and use of convenience sampling, is still useful, as it raises awareness about the importance of planning for the future in replenishing the work force to meet the growing health needs of an ageing population as generation X nurses exit.

Worldwide, older people are living longer than ever before experienced in history. The Australian Institute of Health and Welfare 2010 report detailed demographic studies that included Australia and countries around the world and found Australia identified as one of the countries with the longest life expectancies. Australia's growing fastest population is the older person aged 85 and over (Hatcher, 2010). This age group doubled in numbers during the period of 1994 to 2014. This is an increase of 153%, compared with the total population growth of 32% for this same period (Australian Bureau of Statistics [ABS], 2014). The impact of a growing older population is the increase in demand for health care services and for nurses to provide complex care. As nurses are the front line of delivering health care and services, this means more nurses will be needed to meet this growth in demand. While these global and Australian primary factors affecting the nursing shortage are reported in the literature, secondary factors such as Australian GRN attrition rates are not. The following discussion focuses on Australian and international GRN attrition.

3.2.2 Australian and international GRN attrition

GRN retention is important in replenishing, growing and sustaining the nursing workforce to help close the loop on GRN attrition and the nursing shortage. Internationally, GRN attrition is a secondary factor intensifying the global nursing shortage (Booth, 2011), with attrition rates well documented. In Australia, GRN attrition rates are largely unknown (Christopher et al., 2018; Cowin & Jacobsson,

2003; Schluter et al., 2011). Consequently, there is a lack of evidence informing the HWA's Health Workforce 2025 Doctors, Nurses and Midwives Report (2012). The Report estimates that the precise GRN numbers needed to fill vacancies after a 12-month transition is not understood and therefore effectively planning for the future health needs of Australian society is inadequate. An informed position about GRN attrition is needed by Australian health workforce planners to accurately replenish, grow and maintain the supply of nurses in a sustainable and measured approach. Implementing an evidence-based approach will assist in understanding and managing GRN attrition and the nursing shortage.

Internationally, GRN attrition rates are well documented. Consequently, the international community is more equipped to seek out the causes and solutions to rectify the phenomenon. Seminal research by Aiken et al. (2001) initially raised the concern regarding GRN attrition. Aiken conducted an international study that included five developed countries, United States (US), Canada, England, Scotland and Germany, and surveyed a total of 43000 nurses across 700 hospitals. The study found that 33% of nurses were aged 30 years and under expressed thoughts of leaving nursing within the year. In addition, Aiken found that the current health system continued to model industrial models of productivity improvement rather than listen and respond to the concerns of nurses in finding sustainable solutions that not only attracted and retained nurses but also contributed to improving care for patients. A limitation of Aiken's study was not extricating GRNs in their first 12 months of experience in particular, as GRNs can be mature aged, not school leavers, and therefore were unable to isolate GRNs data about why they were thinking of leaving. Aiken's research is still important as it is raises awareness about the need to be responsive in seeking out causes and solutions to rectify GRN attrition. Other countries during this same period of 2001-2003 experiencing GRN attrition included Taiwan (Chen & McMurray, 2001), Turkey (Demir et al., 2003) and South Africa (Cilliers, 2003).

Investigating GRNs thoughts about why they intend to leave, and do leave, is important if interventions that address GRNs concerns are to be developed. While several studies have captured why GRNs leave, there is a paucity of studies measuring the effectiveness of targeted interventional strategies to address these reasons. Several studies have found that up to 60% of new nurses leave within 6 months due to lateral violence acted out against them (Beecroft, Kunzman, & Krozek, 2001; McKenna,

Smith, Poole, & Coverdale, 2003). However, one particular study by Griffin (2004) argued that new nurses needed education and strategies in this area to better equip them to manage lateral violence when it occurred. Griffin's study entailed 26 newly licensed nurses from a large acute care tertiary hospital in Boston, Massachusetts who participated in a specially designed education session on lateral violence and cognitive techniques to shield them from the negative effects on their learning and socialisation. These same nurses, one year later, engaged in three different focus groups answering pre-set questions which were videotaped, to determine the effectiveness of this new lateral violence knowledge and skill set. Results from their targeted intervention was determined as positive, as measured by the new nurses' retention rates one year later (91%). A limitation of Griffin's study is that their method engaged pre-set questions, rather than open ended questions, which by default could influence responses. Additionally, protective factors associated with resilience (McAllister & Lowe, 2011) were not explored in association with this intervention and thus not taken into account in this sample of nurses' retention.

A qualitative study by Rheaume, Clement, & LeBel (2011) documented 23 GRNs' first year experience working in New Brunswick, Canada. The study explored the factors leading GRNs to leave their employer. The findings revealed that the GRNs' first year experience difficulties were encapsulated in five main themes. These included "surviving the first months, induction into the hospital, culture, struggling to maintain a balance and being a nurse, and assuming a professional role" (p. 80). Planning for a life career was also included. There were several reasons for attrition with the acknowledgement that deciding to leave was complex and, in the end, a personal decision. Recommendations from the study included improved support from the health organisations through programs such as mentorships, comprehensive orientation programs, adopting best practices identified in other professions, and initiating a broader strategic approach to GRN transition and retention. Their study also identified the need for improved expectation management in undergraduate education programs to acquaint senior student nurses with the realities of working as a nurse. GRNs, like industry, perceived that they had been inadequately prepared. This perceived lack of preparedness suggests that undergraduate and transition are only sporadically implementing targeted, measured interventions.

A quantitative study conducted by Rheaume, Clement, LeBel, & Robichaud (2011) surveyed 348 GRNs in Eastern Canada over a 5-year period from 2004 to 2008 and found there was a divide in GRN's intentions to either stay or leave. In relation to why nurses stay or leave, their study found that GRNs who felt supported to practice their care in alignment with how they were taught by their educational program were more likely to stay within the organisation and profession.

Gaining an understanding of why nurses are leaving nursing and finding out from them their thoughts on what leads them to consider leaving is important, because this knowledge empowers programs to build capacity and resilience early in nurse's careers. It is also important to know if GRNs thoughts about leaving nursing are an indicator that can predict attrition or a warning indicator that signals targeted intervention at the GRN personhood level is required. This is a gap in knowledge, which this study seeks to address by investigating links between GRNs experiences relating to work, study and personal life and their thoughts about leaving nursing in relation to these aspects. Understanding the GRNs first year experience and how it came to be the way it is from this broader perspective, supports the development of targeted, evidence-based approaches to manage the preparation and retention of GRNs within the nursing profession in Australia. The next section reviews the ways nurses have been trained, educated and prepared.

3.2.3 Australia's historical education and training of nurses

The historical education and training of nurses in Australia and its transition from hospital to university contexts is important to note. Firstly, to determine the premises behind this move and secondly, to equally determine if the reasons were justified in balance with the outcomes from such a move. This review evaluates whether this move and the discourse surrounding it remains 'fit for purpose' or whether a further move or disruption to the education and training discourse is required. Understanding the historical cannon of education and how it operated in the past assists the understanding of the current nursing education context and also looks forward to future reform, because only through knowing the past can we truly plan for the future.

The historical education and training of nurses was situated in hospital settings. The hospital based, competency education and training system produced certificate level Registered Nurses (RNs) who were prepared for their role and who could (and were expected to) 'hit the ground running' in their role as a RN. This was considered appropriate for the time period from the Nightingale era to approximately 1990 (Russell, 1990). The hospital education apprentice training system was guided by the National Competencies Standards of the Registered Nurse as the 'curriculum' (Kako & Rudge, 2008) to ensure graduating nurses were competent in delivering safe, quality care (Nursing and Midwifery Board of Australia [NMBA], 2006). These standards have recently been updated (NMBA, 2016b). It is acknowledged this training was predominantly focused on caring for the ill and dying and needed to evolve to meet the broader health needs of society, largely through an evidenced based approach. In response to the changing education discourse and nursing role during the 1970s and 1980s, it was recognised that education and training needed to move to the higher education sector to ensure a broader focus of the nurses' role (Australian Government Department of Health, 2013). This broader role included research, a broader public health population focus (Patten, 1979; Watson, 1982) and a greater professionalism (Bottorff & D'Cruz, 1985; Hart, 1985; Pratt, 1980). Building on the need for a broader role, included the emergence of the 'professional nurse'. Thus, the discourse surrounding this transition confirms that the 'nursing education and training culture portrait' needed to be responsive to the changing requirements and expectations of the nurses' role in the 21st century.

Movement of the education and training of nurses from the hospital setting to the higher education setting constituted a response to this new nursing education discourse. The first state in Australia to initiate the transition was Western Australia in 1975 where the first graduands graduating in March 1979 with a Bachelor of Applied Science from Western Australian Institute of Technology (Division of Health Science, Western Australia Institute of Technology, 1984), now known as Curtin University. Other states followed during 1984-1994 (Grealish & Smale, 2011). However, some states delayed this move until a consensus was achieved in the early 1990s among nursing leaders on using the National Competency Standards for the Registered Nurse (NMBA, 2006, 2016b) as the single outcome measure (Percival, 1995). The collaborative decision making process among the leaders in the nursing profession

demonstrated a '*holistic cultural, state by state portrait*' that reflected the value of having a national set of quality competency standards to ensure a consistent, quality level of competency between graduates. Thus, this move from the hospital-based education to the university setting as guided by the National RN Competency Standards was on target to meet the expectations of nurses for their role in the 21st century and the public in receipt of their care.

The National Competency Standards for the Registered Nurse is a set of criteria that guides the required knowledge and skills and attainment level to deliver safe, quality care. The Nursing and Midwifery Board of Australia [NMBA] (2006, p. 10) defined being competent, as "the combination of skills, knowledge, attitudes, values and abilities that underpin effective and/or superior performance in professional/occupational area". The standards at this time period included criteria consisting of four domains with associated sub criteria of knowledge and skills, including the relevant associated learning process the nurse needed to demonstrate competency in. These four domains included: 1. Professional practice, 2. Critical thinking and analysis, 3. Provision and coordination of care and 4. Collaborative and therapeutic practice. These standards assured safe, quality practice of RNs that would protect the public from harm and maintain the high profile and reputation of nurses and the nursing profession.

The standards have since been revised in 2016. These seven standards include: 1. Thinks critically and analyses nursing practice. 2. Engages in therapeutic and professional relationships. 3. Maintains the capability for practice. 4. Comprehensively conducts assessments. 5. Develops a plan for nursing practice.6. Provides safe, appropriate and responsive quality nursing practice. 7. Evaluates outcomes to inform nursing practice (NMBA, 2016b, pp. 1-5). Each of the seven standards contains sub criteria of key knowledge and skills in which the nurse needs to demonstrate competency to deliver safe, quality care in the contemporary environment. This move also facilitated a comparative check against the contemporary nursing environment perspective as well as the determination ensure nursing education was 'fit for purpose'. The discourse surrounding these recent changes to the National Competency Standards for the Registered Nurse reflects the ongoing responsiveness of the 'nursing education and training culture portrait' to the changing needs and expectations of nurses for their continued role into the next decades of the 21st century.

In addition to 2016 update of the National Competency Standards for the Registered Nurse, the Code of Conduct for Nurses (NMBA, 2018) was also updated in 2018. This update included additional principles in relation to promoting teaching, supervising and assessing, as well as advocating for personal wellbeing of self and others. The NMBA (2008) Code of Ethics for Nurses was retired, with the NMBA now adopting the ICN Code of Ethics for Nurses (2012b). Hence, the National Competencies Standards of the Registered Nurse, together with the Code of Conduct and Code of Ethics for Nurses, form the overarching curricula criteria that guides the contemporary knowledge and skills education focus. This entails ensuring nurses achieve the competencies in the knowledge and skills that will enable them to deliver safe, quality care for their patients, themselves and each other, including delivering quality education, supervision and assessment.

Internationally, the nursing discourse also continues to evolve. The ICN (2012b) Code of Ethics for Nurses has updated their definition of nursing. The ICN's (2012a) defines nursing as:

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness and the care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation shaping health policy and in-patient and health systems management, and education are also key nursing roles. (p. 1)

The ICN definition fits with the role of the nurse in the contemporary environment and has a broader role than the narrow historical intent of a nurse focusing on the care of the ill and dying within a hospital setting. ICN's action in updating the nursing definition ensures the role of the nurse is clear to all stakeholders but also importantly shows how the role is progressive and responsive to the changing health, health system and education discourses to remain effective. Therefore, moving hospital education and training of nurses to higher education based on the broader role requirements of the nurse was an appropriate decision. In addition, based on the role requirements and the type of preparation required to effectively meet these broader role requirements of a nurse, keeping the education and training '*nursery*' within the higher education setting remains an appropriate decision.

The ICN definition of nursing together with the nursing governance standards enables nursing educators to identify the expected outcomes that student nurses need to achieve from the governance level that will enable them to transition confidently into their new roles as RNs in delivering safe, quality care. Appreciating these broader objectives enables educators to guide the curricula of nurse education, including expectations of content and assessment outcomes to reliably guide the preparation of undergraduate nurses and empower them to successfully transition into the role of an RN. However, it is also important to identify the strengths and weakness within nursing education discourses to foster reform so that these strengths are harnessed, and weaknesses mitigated.

One of the main areas of weakness within the current education and training discourse is in relation to assessment practices, both at the theoretical and clinical practicum level. Kako and Rudge (2008) pinpointed validity concerns between higher education nursing schools' education curricula and graduate outcomes stemming from the open interpretation of the standards and thus variability in both curricula and graduate preparedness outcomes. Kako and Rudge (2008) undertook a discourse analysis of nursing curriculum from 1950 to recent times and found that the curricula reflected the beliefs and hopes of the nurse educators in the contexts of each higher education location. A strength identified was that curriculum development and design for each school of nursing was "collaborative between profession, industry and discipline" (p. 1). Kako and Rudge (2008) recommended that, to establish validity between higher education nursing programs, a national curriculum should be established. Hence raising validity between nursing programs needs to be strengthened, in particular, in the area of assessment.

Validity in the discipline of education is one of several important features of effective assessment practice. The Australian Skills Quality Authority (ASQA) (Australian Government Australian Skills Quality Authority, 2015, p. 1) defined assessment validity as "assessed against the unit(s) of competency and covers the broad range of skills and knowledge essential to competent performance". To address validity concerns between higher education institutions in producing graduate nurses with consistent capabilities and levels of preparedness, a national curriculum is recommended (Darbyshire & Fleming, 2008; Kako & Rudge, 2008). In addition, both studies suggested that a suitable time to initiate a national curriculum would be when

the state based registration moved to the nationally based registration, in 2009. Eleven years on and with little explanation, in 2019 a national curriculum remains absent and therefore validity concerns remain intact.

Reliability is another feature of effective assessment practice. Within the nursing curriculum, reliability concerns were also being raised, especially in relation to clinical competence assessment (Watson, Stimpson, Topping, & Porock, 2002). Reliability is defined as "evidence presented for assessment is consistently interpreted and assessment results are comparable irrespective of the assessor conducting the assessment" (Australian Commonwealth Government, 2017, p. 1). Poor reliability can lead to variability in assessors accurately interpreting and determining the evidence, as well as students' understandings of assessment requirements. A systematic review of literature by Watson et al. (2002) between 1980 and 2000 on clinical competence assessment identified 2 main issues. Firstly, that competence was a poorly defined term and secondly that the instruments and methods used to assess competence lacked rigour. Watson et al. (2002) concluded that the competence-based training system nurse educators had adopted in preparing nurses for the real world of work had largely failed and questioned why it was still in use. Identifying weaknesses within the current education nursing discourse is important in raising awareness but also in seeking solutions from an evidenced based platform to mitigate these weaknesses and transform them into strengths, with the goals of promoting rigor and reliability.

The current nursing discourse is actively responsive to the challenges of reliability, in particular in relation to clinical assessment. Ossenberg, Dalton, and Henderson (2016) found that the current Nursing Competency Assessment Schedule (NCAS) tool in use in the assessment of students in the authentic practice setting had validity and reliability issues. In response to addressing these inconsistencies between assessors in the interpretation and application of clinical practice assessment tool to a student nurse's competency performance, a new tool, the Australian Nursing Standards Assessment Tool (ANSAT) was piloted. This involved 2 universities, with 23 clinical assessors completing 220 clinical placements assessments in parallel with completing the existing tool in use. Interviews and a post-test survey provided further data on the validity and reliability of the new tool. Conclusions drawn from this study identified assessment tools with high validity and reliability were needed in the nursing education discourse. Tools such as the ANSAT provided this through supporting behavioural

cues. In addition, this pilot demonstrated the benefits of being responsive in addressing weaknesses within the education assessment practices that were negatively contributing to determining nursing students' achievement of the clinical placement knowledge and skills sets required. In addition, Ossenberg et al. (2016) study also concluded that the adequacy of the competency approach used by higher education in preparing nurses was not definitive. This aspect is important and raises the need for further research into undergraduate clinical assessment practices. Such research would ensure assessment practices are evidence based and responsive to the requirements of ensuring practice readiness. The educational approach that links to practice readiness supports one of the contentions of this study. The weaknesses highlighted by these researchers reveals concerns in the open interpretation of the nursing standards and in the validity and reliability of assessment practices that are impacting the variability of graduates' practice readiness observed by industry.

While the open interpretation of the standards contributes to the variability in both curricula and the observed variability of graduates' practice readiness, other researchers see this open interpretation as a strength. A key strength of the standards being open to interpretation is its flexibility, for example to be contextualised, reflective and responsive to the changing education discourse. Darbyshire and Fleming (2008) identified open interpretation of the nursing standards by higher education institutions facilitated flexibility with curricula design, preparation and clinical experiences they offer nursing students. Curricula design focused on flexibility to assess the needs of students in preparing them for their role as an RN and respond to their changing needs by evolving the education discourse through an evidenced based reform, would improve the practice readiness consistency of graduates in the 21st century.

Examining decisions to move the education of nurses to the university sector to prepare nurses for their broader role has high value and merit. Basing the curriculum on the nursing governance standards and codes also has high value and merit, with the content knowledge and skills fitting well with the role of the contemporary nurse. What has emerged as an area of concern is the education discourse in not actively evaluating their assessment practices against the practice readiness outcomes of an RN from an evidence-based platform. After four decades, it is timely for nursing education reform and supports one of the contentions of this study

that education approaches need to be evidence based to measure their effectiveness. That is, for evidence-based approaches that show the link between the educational approach and the outcome from that approach. The preparedness of the graduand nurse to be practice ready and their retention within the workplace due to that preparedness is presented in the next section.

3.3 GRN LACK OF PREPAREDNESS EXPERIENCE

GRN lack of preparedness has been a recognised phenomenon in Australia for past four decades and raises concern for both their whole wellbeing and for the patients in receipt of their care. Lack of preparedness has been noted since the 'historical watershed' decision in 1984-1994 to transfer the hospital education and training of nurses (on the job training) to higher education institutions (Grealish & Smale, 2011). Four decades on from that decision, GRNs' lack of preparedness remains an ongoing concern for health industry (Levett-Jones & Fitzgerald, 2005; Romyn et al., 2009). This becomes a renewed and heightened concern as the health industry tries to meet the nursing shortfall predicted for this decade (Haddad et al., 2013; Health Workforce Australia [HWA], 2012). It is important to identify, from an evidence-based platform, precisely why GRNs' lack of preparedness remains a phenomenon. This evidence would assist in aligning education and support to address these causes and to improve the GRNs' holistic wellbeing. This, in turn, would enhance patients' wellbeing and outcomes.

GRNs preparedness is important to ensure they are work and life ready as an RN. Lack of GRN preparedness, however, is a term that industry has used to convey GRNs are not always work ready when they begin their practice in the work place (Romyn et al., 2009). Being ready for life as an RN, is an ongoing concern raised by industry. Examining the term 'lack of preparedness', and the meaning ascribed to it by industry, suggests that industry has formed their judgment about the GRNs' 'practical, real work' competency levels based on face validity (what GRNs work readiness actually looks like to employers). When industry deems the GRN as not being work ready, they are forming a judgement that the GRNs are falling below the clinical competency level required and expected for work readiness in the health setting. Face validity is a test that appears at face value, to measure what it claims to (Messick, 1994). This conflict between higher education and industry judgements (reliability) of

what competence means in the RN role, is a mismatch and an issue that needs urgent attention. Such attention would ensure there is a match between higher educations' preparation of RNs and industry's' requirements and expectations for the RN role in the context of the 21st century.

Whilst it is important to acknowledge industry's argument that many GRNs lack work readiness, it is also important to investigate GRNs' perceptions of their work experience to view this phenomenon more closely. Rheaume, Clement, & LeBel (2011) qualitative study showed nurses struggled in maintaining life balance and enacting their RN role. While Rheaume, Clement, LeBel, & Robichaud (2011) quantitative study showed that GRNs struggled to enact their role but determined this was due to experiencing opposition by the nursing workplace culture to implement nursing care as they were taught by their educational program. Hence these two studies raise the awareness about what work readiness relates to and it is more than being able to enact their psychomotor knowledge and skills associated with their RN role, but to enact their RN role within the additional challenge of an unsupportive workplace culture. This lack of work readiness suggests that undergraduate and transition '*nurseries*' need to be responsive to the broader GRNs' work, study and personal life needs and expectations aside from the predominant psychomotor knowledge and skills discourse.

Preparing for a life career as an RN also requires undergraduate and transition '*nursery*' education programs to provide nurses with opportunities to develop future roles and to meet the legislative expectations of an RN to enact their role (Australian Commonwealth Government, 2009; NMBA, 2016b). An ethnographic study by Bjerknes and Bjork (2012) investigated 13 GRNs' (working in a Norwegian hospital setting) experiences of the opportunities and limitations they encountered when taking on their new roles as RNs. A combination of methods was used, including observation, interviews and document analysis. Initially the experiences were recorded as positive. This was due to their enthusiasm to learn and to care for their patients with empathy. However, the organisations or staff did not harness these qualities. Instead, the GRNs' experienced colleagues were unsupportive and disrespectful, creating stressful interactions, and were allocated heavier workloads than the GRNs expected, along with the responsibilities associated with these workloads. Bjerknes and Bjork's (2012) study revealed these GRNs learned to cope the hard way and recommended

that for GRNs transition to be effective, it needed to be positioned within a well-structured ward and supportive environment. In addition, their study recognised that support initiatives needed to extend beyond clinical orientation and ward mentoring. A limitation of their study was in failing to investigate the opportunities that GRNs could seek to develop their roles as RNs in the short, medium and long term, including associated recommendations to support their implementation of professional life career role plans. Preparing and supporting GRNs during their transition year requires the transition '*nursery*' to provide opportunities for GRNs to identify their personal life career role goals and to harness these goals. This could be achieved providing GRNs with opportunities to develop both their immediate and future life career roles and thus increase the possibilities of their retention within the organisation and profession beyond the first year.

GRNs are inexperienced and vulnerable to stress as they transition into their new role as an RN. They thus require support in the areas causing stress. Several authors have identified that, within a nurse's life career, the first year entering the workplace is the most stressful (Martin & Wilson, 2011; Rudman, Gustavsson, & Hultell, 2014). Duchscher's (2008) study used qualitative interpretative inquiry to seek out the GRNs' transition experiences to guide the potential provision of support. Fourteen GRNs were selected from 2 major cities in Canada. The methods involved an initial demographic survey, one on one interviews at 1, 3, 6, 12 and 18 months, focus groups attended at 1 and 2 months with participants from the second major city, as well as pre-interview survey questionnaire activities such as letter writing, picture drawing, monthly journaling and ongoing emails for the 18-month period. The main cause for GRNs' stress was their under preparedness for their new role as RNs. An outcome from Duchscher's (2008) study, together with four preceding qualitative studies and other extensive research in this area by Duchscher, was the formation of a transition theory (Cowin & Hengstberger-Sims, 2005; Duchscher, 2001, 2003b, 2007). The transition theory was important as it identified the GRNs moving through three phases in their 12 months. These phases are 'doing' (0-4 months), 'being' (4–5 months) and 'knowing' (8-12 months). Each of these phases distinguishes progressive indicators for each period: 1. Inexperienced and lacking confidence in their knowledge and skills. 2 Building knowledge and skill competency. 3. Demonstrating competence, confidence and self-belief in their abilities. Recommendations from Duchscher's

(2008) study included: improving the undergraduate preparation on transition response; bridging the gap between senior student nurses' expectations and the reality of work; and improving the transition support, such as through a structured orientation process. Duchscher's (2008) transition theory fits with the contention of this study: that identifying and characterising expected indicators as the GRN moves along the first-year time line is important in providing GRNs with knowledge and support aligned to these indicators with the goal of improving their holistic wellbeing. While knowing the expected GRN transition indicators is important to guide support, these indicators need to also be equally informing reform in undergraduate nursing programs to ensure GRN preparation for the workplace improves. In this way GRN stress can be mitigated. However, this type of collaborative feedback loop is currently absent in the education and health systems employing GRNs.

Expectations by industry and graduate nurses are that the outcomes for GRNs from a university education and training is that they are work ready. Several authors have shown that in spite of research, for example Duchscher (2008; Boychuk Duchscher, 2009, 2012) advocating for GRN transition support, the industry continues to hold the expectation that GRNs need to be work ready upon graduating (Wolff, Pesut, & Regan, 2010; Woods, West, Mills, Park, & Southern, 2015). GRNs also have the expectation of being fully prepared and confident when they enter the work force so they can meet their own expectations and those of their employers (industry) (Dyess & Sherman, 2009). However, the voices of industry and GRNs regarding their expectations around work readiness and the responsiveness to this concern by higher education to a large degree, remain unheard and unaddressed (Casey, Krugman, Fink, & Propst, 2004; Halfer & Graf, 2006). Revealing industry and GRN expectations in line with research on GRN transition response is needed if these situations are to be rectified. Equally, responsive reform is also needed in how this research (feedback) from stakeholders can be communicated and coordinated to higher education nursing programs to foster a coordinated and measured reform to increase GRN preparedness.

At present, at the national level, there is active interest in measuring student nurses' experiences and GRNs' outcomes via the Quality Indicators for Learning and Teaching (QILT) survey program. This QILT (2018a) program is funded by the Australian Government Department of Education and Training. QILT actively assesses the student experience (2018a) and graduate employment (2018b) outcomes

from three key surveys. The Student Experience Survey (SES) (2018e) collects information in relation to six indicators: overall quality of educational experience, teaching quality, learner engagement, learning resources, student support and skills development. The Graduate Outcomes Survey (GOS) collects information four months after graduates have completed their program. The GOS collects information in relation to four indicators, graduates in full-time employment, graduates in overall employment, graduates in full time study and median salary of graduates in full time employment. As part of the GOS there are 2 additional surveys. The Course Experience Questionnaire (CEQ) with three indicators measuring graduate's overall satisfaction (2018d), good teaching and generic skills and the Employer Satisfaction Survey (ESS) (2018c). The Employer Satisfaction Survey (ESS) is in response to graduates who participated in the Student Experience Survey (SES). In this survey the graduate's supervisor rates their graduate on three indicators, generic skills, technical skills and work readiness. Thus, the QILT survey measuring student nurses' experience and GRNs outcomes is an important gauge of the institution's learning and teaching quality.

Surveys are a trusted method for data collection, however, as with any method, there are always limitations to be considered. Examining the QILT (2018b, 2018c, 2018d, 2018e) survey data, three major limitations are noted. Firstly, the QILT surveys do not acknowledge any limitations. Secondly, a limitation has been found in relation to the survey questions not seeking information about student values regarding the importance of education theory to inform their practice. Thirdly, QILT (2018a) does not seek to liaise and or collaborate with the discipline accrediting bodies. For example, in this case, nursing educating accrediting bodies are not asked to collaborate to close the loop on any deficiencies identified to improve the quality of nursing education programs. Thus, a gap in closing the loop remains in assuring quality education that meets both the expectations of student nurses and the industry to be work ready.

Closing the loop in effectively responding to industry and GRNs concerns about lack of work and life preparation from an evidenced based platform is emerging in the literature. Dyess and Sherman's (2009) qualitative study of GRNs in an American community-based transition program was in response to GRNs, preceptors and leaders of health organisations expressing dissatisfaction with the preparation of

GRNs. Dyess and Sherman's (2009) study focused on the learning/practice needs of GRNs and aligned these needs to the educational requirements of the GRN transition program. For example, a known preparedness gap, clinical decision making (Del Bueno, 2005; Li & Kenward, 2006), was targeted to address this gap by enabling the GRNs' clinical decision-making knowledge and skills. The program topics for both short and long-term learning goals, also revealed this program was aligned with RN standards of practice objectives. Its educational approach was holistic in that it included a focus on work knowledge and skills and included self-care and career success and advancement strategies (Dyess & Sherman, 2009, p. 404). Improving the responsiveness to industry and GRNs concerns about the need to be work ready from an evidence-based platform is an important step in evolving the preparation education discourse of GRNs and mitigate the researched causes of GRN transition stress.

Mitigating risk is a critical part of everyday nursing practice and it is important to extend this practice to GRN welfare. Risk management is governed in Australia by the National Safety and Quality Health Service [NSQHS] Standards (ACSQHC, 2011; 2017). Determining GRN welfare in relation to work, reveals GRNs commonly experience stress in their first year of practice (Martin & Wilson, 2011; Rudman & Gustavsson, 2011; Rudman, Gustavsson, & Hultell, 2014). Common causes for GRN stress include ineffectively managing their professional roles, making decisions, including clinical judgements, managing time, lateral violence (bullying) and moral distress (Casey, et al., 2004; Kelly & Ahern, 2008; Mason, et al., 2014; Myers et al., 2010; Rhéaume, Clément, LeBel, & Robichaud, 2011; Spence Laschinger, & Grau, 2012). In particular, Casey et al. (2004, p. 307) contended that GRNs also experienced stress with prioritising, managing relationships with colleagues and communicating well with physicians. Issues of risk management has been apparent for some time in relation to effective nursing practices, especially pertaining to vulnerable groups (Mackenzie & Reedy, 2017). A proactive response to reducing risk, mitigating GRN stress and promoting their wellbeing is needed.

GRN welfare has been an ongoing concern for the past four decades. Examining historical literature, Kramer's Theory of Reality Shock (1974), found that new nurses struggle with transitioning into their new RN roles in the care setting. Four and a half decades on from Kramer's (1974) classic study, *reality shock* remains an ongoing issue affecting GRNs. For example, Duchscher's (2008) study, *GRN*

Transition Shock, found that GRNs experienced stress adjusting to their new roles as RNs in four main areas. These included responsibilities, roles, knowledge and relationships. Importantly, it was ascertained that GRNs struggled with factors that were a blend of work and broader factors. These broader factors included personal factors – GRNs' life roles and life balance and study factors such as their continuing professional development (CPD). However, regardless of the historical and contemporary literature identifying reality shock and key attributers, reality shock remains an ongoing issue for GRNs. If reality shock is to be addressed, a targeted and measured intervention such as a proactive risk management strategy is required. However, such a risk management approach needs to be broader and include all GRNs' life roles and environments.

Work environments that are perceived to be culturally and emotionally harsh are also known to contribute to GRN stress and a consequent decline in wellbeing. Harsh work environments exhibit unrelentingly high workloads combined with complex patient care and high emotional burdens due to the nature of caring for sick and dying patients (Altun, 2003; MacKusick & Minick, 2010). Indeed, Ross and Rogers (2017) describe the nurse working within this type of environment as a *Rubber Nurse,* rather than a Registered Nurse, because of industry's expectations that nurses will spread themselves to complete many non-patient tasks alongside patient care. The Australian Nursing Federation [ANF] (2009) and Watson (2010) have expressed concern that nurses' welfare and patients' care outcomes are likely to decline if the current stressful work conditions of nurses remains unaddressed. Extant literature has shown that unresolved work stress leads to burnout and absenteeism (Aiken, Clarke, Sloane, Sochalski, & Siber, 2002; Davey, Cummings, Newburn-Cook, & Lo, 2009; Donovan, Moore, & VanDenKerkhof, 2008; Garrouste-Orgeas et al., 2012; Leigh-Edward & Glyo-Hercelinsky, 2007; MacPhee, Ellis, & Sanchez- McCutccheon, 2006; Schaufeli & Maslach, 2017; Spooner-Lane & Patton, 2005). This presupposes a need for support that entails a broader proactive risk management strategy. To assist in reducing GRN stress and to promote their wellbeing, addressing issues at a health system level by a proactive quality risk assessment approach is needed.

GRNs report a number of broader factors in relation to work and personal life that contribute to their stress. Casey et al.'s (2004, p. 307) study of GRNs' work experience, found GRNs were impacted by high workloads and experienced

difficulties adjusting to shift work. GRNs felt overwhelmed with their high workload and attributed that directly to the nursing shortage, which was forcing them to work in contexts which were chronically understaffed. Other stressors included a work culture that did not support them to take holidays at the same time as their children's school holidays. Work/family life factors such as this impacted the GRN further by reducing their quality of life and the quality of life of their families. Factors such as these are highly relevant and support a contention of this study, which is to understand the factors affecting the GRNs *Load Triad* and the degree to which these factors impact the GRNs' overall life balance.

The review of literature concerning GRNs' lack of preparedness reveals it is a phenomenon that continues to exist in the contemporary context and can be traced to an education and health system not adequately responding to the recommendations offered in the extant literature to address the known issues and shortfalls. Many factors in the literature have been identified as contributing to GRN lack of preparedness and the risks to their wellbeing and consequently to attrition rates. Factors are multilayered and evident at the individual, organisational and governance levels. At the individual level for example lie the largely unaddressed causes of transition reality shock. At an organisational level sits often harsh work environments and unfriendly family/work practices. At the government level is the absence of proactive strategies to adequately address nursing shortages, harsh work environments, and the inadequacy of preparing GRNs to be work and life ready. Addressing GRNs' lack of preparedness requires a whole system level approach where all stakeholders are prepared to work collaboratively from an evidenced based platform.

3.3.1 GRN transition programs

In Australia, many hospitals employing GRNs offer them support in their first year in the form of a structured transition program to aid in their transition and retention. GRN transition programs are a purposely designed strategy to attract and retain new nurses (Aggar, Bloomfield, Thomas, & Gordon, 2017). These programs provide both formal and informal support to aid GRN's smooth transition into their role as an RN facilitating their workplace readiness. Cubit and Ryan (2011) and Levett-Jones and Fitzgerald (2005) both confirm that the goals of transition programs are to provide support for a period of 12 months, typically in the form of an orientation phase,

education and training, and formal and informal mentorships and or preceptorships. Preceptorship includes RNs trained specifically for assisting GRNs to demonstrate workplace requirements and responsibilities and to support them in socialising with team members to promote their sense of belonging and community.

At the time of this study, it was unclear how effective such transition programs and their associated support structures were in preparing and supporting new GRNs, in reducing the factors causing GRN stress and in addressing GRN attrition. Additionally, examining the literature reveals the GRN experience in rural/regional settings is limited, together with the effectiveness of the supports available (Ostini & Bonner, 2012). Thus, understanding the GRN experiences working, studying and living in a rural and regional city is just as important as understanding the GRNs experience in metropolitan areas to tailor education and support to the specific context. Tailoring education and support are known to aid in improving the GRN experience and retention within the nursing profession (Bell, Daly, & Chang, 2007; Goode, Lynn, McElroy, Bednash, & Murray, 2013; Lea & Cruickshank, 2005, 2014; Lynn, 2014; Mills, Birks, & Hegney, 2010; Ulrich et al., 2010). Thus, exploring the GRN's contemporary experience in Australian regional cities would benefit from exploration. This lack of empirical evidence about the effectiveness of transition programs has previously been identified by Levett-Jones and Fitzgerald (2005) and more recently by Goode et al. (2013). The type of empirical evidence available in the literature on the effectiveness of GRN transition programs consists of aspects within the transition programs that are either effective and or ineffective, rather than evidence evaluating the program as a whole. Hence this observation is important to note as it further supports the need for whole-approach-support program evaluation.

Effective support within GRN transition programs promotes GRN satisfaction and confidence, while ineffective support leads to GRN dissatisfaction and low confidence levels. Evans, Boxer, and Sanber (2008) found that transition programs were effective when support was available to the GRN in the form of an educator and a preceptor. Their evidence confirmed that GRNs sense of belonging and satisfaction with their work and workplace environment were enhanced and that consequently GRNs were less likely to leave. However, their study also found that other elements within GRN transition programs were less effective. For example, when support available during the day did not extend to evening, night and weekend shifts

contributing to these GRNs feeling unsupported, isolated and not part of the team. Additionally, Evans et al. (2008) found that despite GRNs participating within a transition programs, they did not develop confidence and competence during their transition year. This is of concern as confidence are two of the lifelong learning outcomes. Thus, measuring the effectiveness of GRN programs against educational goal posts such as lifelong principles helps to guide improvement and progress towards achieving these goals and assuring that quality processes are in place to meet stakeholder expectations, such as GRNs' expectations of a smooth transition and the development of their competence and confidence.

Meeting GRN expectations for support in 'after business hours' is important in consistently supporting GRNs developing competence and confidence. Guhde (2005) found that the adoption of a 'buddy system' within transition programs was an effective strategy in providing GRNs with after-hours support when assigned educator and preceptors were unavailable. The effectiveness of the 'buddy system' strategy was measured in three areas: feedback, after hours support and team work. It was noted that the amount of positive feedback, after hours learning opportunities and support provided for GRNs improved, together with improved teamwork. However, Guhde's (2005) study did not assess the relationships between effective GRN transition program strategies and retention.

There are expectations from government bodies, such as Health Workforce Australia that effective GRN transition programs will result in GRN retention. Rush, Adamack, Gordon, Janke, and Ghement (2015) found that ineffective transition programs resulted in GRN attrition from the workplace and the nursing profession. However, their study did not investigate the negative indicators in transition programs of ineffective support and link this to attrition. This included investigating the consequences of negative indicators such as transition programs overlooking interventions and support aligned to factors causing GRN stress and thoughts of attrition. These are significant omissions, revealing one of the gaps in the literature.

Despite many hospitals globally introducing transition programs, GRN attrition continues. In part this may be attributed to undergraduate and transition curricula not responding to known causes of GRN stress and thoughts of attrition through targeted, measured and quality educational and supportive approaches. The

areas GRNs demonstrate difficulties with include adjusting to their work roles, work environments and related knowledge and skills (Casey et al., 2004; Duchscher, 2008; Petersen, McGillis Hall, O'Brien-Pallas, & Cockerill, 2011; Ross & Rogers, 2017) as well as the broader aspects, for example how to maintain a good quality of life (Duchscher, 2008). Understanding the factors that contribute to GRNs lack of preparedness and the context in which this phenomenon is situated, is critical in guiding not only reform in transition programs but also in undergraduate nursing programs. Further, these programs need to design quality curricular that clearly maps with these factors and contexts and is delivered in a quality and measured way. Several researchers have, argued that, regardless of evidence about nurses' work stress, education that *transforms* practices to reduce and or eliminate these stressors effectively, remains limited (Cleary, Horsfall, O'Hara-Aarons, Jackson, & Hunt, 2011; Edwards & Burnard, 2003; Ross et al., 2013). Therefore, to improve the GRN transition year, undergraduate and transition curricula need to improve their responsiveness to address the causes of GRN stress and attrition using targeted, measured and quality educational and supportive approaches. These approaches that also need to involve communication between the undergraduate nursing programs and organisations conducting GRN transition programs and GRNs.

As aforementioned, the goals of GRN transition programs are to aid GRN transition and retention through support typically consisting of an orientation phase, education and training, and formal and informal mentorships and or preceptorships for 12 months (Cubit & Ryan, 2011; Levett-Jones & Fitzgerald, 2005). Therefore, GRN transition programs warrant an evidence-based, quality design carefully constructed on best practice. Currently, educational programs that are proved to be effective, are programs designed considering best practice. Best practice considerations include focusing on learners' career goals that include short, intermediate and long-term goals (Holland, 1959, 1973; Holmes, 2013; McMahon & Patton, 2006; Parsons, 1909; Pryor & Bright, 2003a; Super, 1990), and underpinned by educational philosophy and theory; lifelong learning (Longworth & Davies, 2003); heutagogy (Hase & Kenyon, 2000); metacognition (Hennessey, 1999; Kuhn & Dean, 2004) ; critical thinking (Scheffer & Rubenfeld, 2000); ZPD (Vygotsky, 1978); signature nurseries (Shulman, 2005;); knowledge building and knowledge creation (Bereiter & Scardamalia (2014) and assessed against quality educational criteria (Wiggins & McTighe, 2001). For any

training program (or educational program) to be effective, three core elements need to exist and align cognitively and constructively (Boud, 2012). Wiggins and McTighe (2001) contend that these core elements include curricula, pedagogy and assessment. *Curricula* is essentially what the learner needs to know and do. *Pedagogy* is the art and science of how the program is delivered. *Assessment* provides the evidence required to judge what the learner has learned. Often assessment is observational, assessing whether learners have indeed changed their behaviour and practice (Mezirow, 1997). Importantly, as a part of this trilogy, Mezirow (1997, pp. 8-9) suggested that a fundamental goal of adult education is to promote learners' development of autonomous thinking through reflective practice. Mezirow contends that this is underpinned by lifelong learning principles. Evaluating these core educational principles forms a critical element in accurately measuring the overall effectiveness of any educational program.

Building learners' capacity is a key goal of educators as part of an effective education program. Building learners' capacity stems from learners knowing how to learn and is embedded within the particular pedagogical approach known in the educational field as heutagogy (Hase & Kenyon, 2001). The focus of learning on heutagogy extends from the prescribed curriculum and task-based learning (andragogy) to using the learner's own experiences and experiences of others, together with internal processes such as reflection, to manage their own learning (Parslow, 2010). Reflective learning, whilst a key part in heutagogy, is also an essential element of lifelong learning teaching and learning approach and importantly drawn upon within the RN Standards for Practice. Standard 1.2 "develops practice through reflection on experiences, knowledge, actions, feelings, beliefs to identify how these shape practice" (NMBA, 2016b, p. 3). Building capacity can be achieved by focusing on 2 main areas. The first relates to learners' short-term objectives, such as learning new subject content knowledge and skills. Applied to the nursing context this relates to the RN Standards for Practice, Standards 1 to 6 (NMBA, 2016b). The second targets learners' long-term goals linked to the concepts of lifelong learning, transition and career theory, all equally applicable to nursing contexts. GRNs are adults and any GRN transition program needs to include these aspects, for example, designing educational programs that draw on lifelong learning's pedagogical approach or a recognition that self-determined learning builds capacity.

Evidence of the effectiveness of GRN transition programs based on the aforementioned core educational principles is limited. While some evidence exists, it is restricted to particular programs and often contains missing information. For example, Anderson, Linden, Allen, & Gibbs (2009) study measured GRNs' job satisfaction and engagement after completing specific interactive educational modules. Curricula objectives, pedagogy and assessment were not clearly articulated and only commencing topics, for example, short-term work knowledge and skills, were evaluated. However, the modules were authentically based and included a range of approaches (didactic, experiential and situational, that is positioned within case studies). While experiential learning was utilised as a form of assessment, no set of criteria to measure the GRNs' performance against was covered.

An example of a GRN transition program that was carefully designed, monitored and evaluated for improvements to GRNs competence, confidence and retention, is a study by Goode et al., (2013). The study highlighted that the University Health System Consortium [UHC]/American Association of Colleges of Nursing [AACN] has been supplying quality, evidenced based programs to American health organisations since 2002. The program included core educational principles related to curriculum, pedagogy, content and assessment alignment. The curriculum was facilitated by AACN nursing education providers and followed the AACN Essentials of Baccalaureate Education for Nursing Practice. Benner's (1984) novice to expert framework (Camp & Chappy, 2017) was also utilised. The pedagogy included monthly educational and simulation sessions with support from preceptors for clinical care guidance and mentors for their professional role (Camp & Chappy, 2017, p. 130). Assessment was competency based. Evaluations reported a direct increase in GRN retention rates, along with improvements in GRN confidence and competency. While initial competency rates were reported at 88% during the period 2002 to 2006, they steadily improved to 95% in 2013 (Lynn, 2014). Lynn's report did not include any references to lifelong learning and associated lifelong goals.

The Versant New Graduate RN Residency is another evidence-based transition program in America that has been shown to be effective, improving GRNs' preparedness and retention rates (Camp & Chappy, 2017; Lynn, 2017; Versant New Graduate RN Residency, 2016). The program included a set curriculum and structure following Benner's (1984) novice to expert framework. Where this program differs

from the previous UHC/AACN program is that there was little collaboration with nursing education providers (Camp & Chappy, 2017, p. 130). Consequently, there was a lack of rigor in relation to mapping the curricula, pedagogy and content against the factors affecting GRN preparedness and lifelong learning goals. Despite this, retention rates have been significant. GRN retention rates prior to the programs' implementation rose from 73% to 92.9% (Ulrich et al., 2010). These programs demonstrate that an active quality assurance process in delivering and monitoring transition programs and evaluating their outcomes, improves GRNs' preparedness and retention. The success of evidence-based transition programs in America such as these raise awareness that Australian health organisations need to offer GRN transition programs, especially in the light of national and international GRN attrition rates and the global nursing shortage.

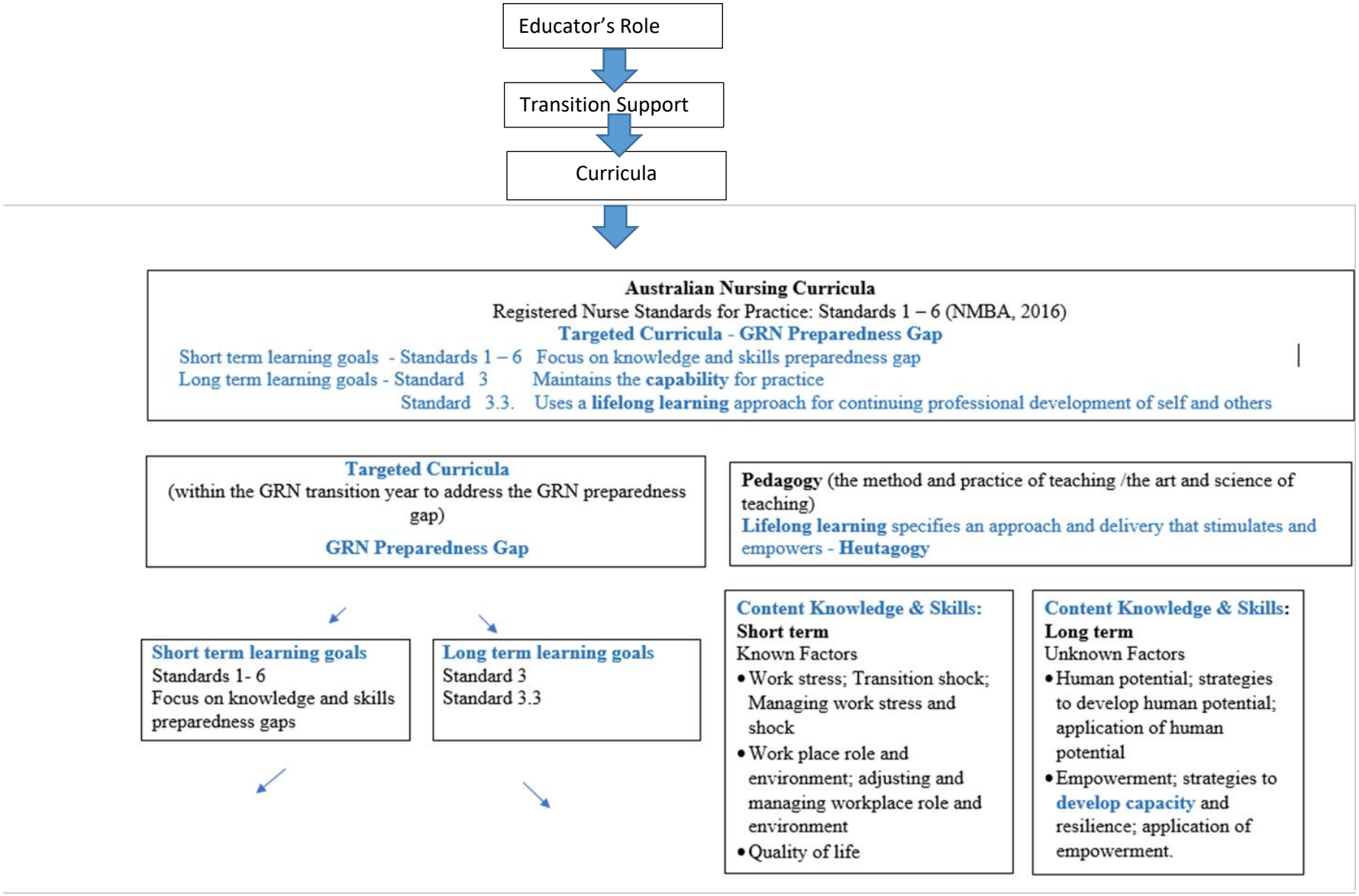
This review of GRN transition programs also supports the contention that transition programs are not consistently being designed, delivered and evaluated in relation to core education and agreed quality indicators in Australia. These core educational quality indicators include:

- Cognitive and constructive alignment of curricula, pedagogy, content knowledge and assessment;
- Curricula guided by the learners' short term and long-term career goals and underpinned by lifelong learning goals;
- Evaluations measuring the effectiveness of education programs, including learners' engagement and retention rates.

Evaluation measuring the effectiveness of GRN transition programs represents a gap in the literature. These gaps are significant in themselves but the cumulative effects of these gaps, as well as how they interrelate and affect the GRN first year experience are also important. This study will focus on the first year GRN to determine their experiences in terms of a quality indicator measurement of their GRN educational preparedness at both the undergraduate and transition levels.

Therefore, core themes arising from this literature review are encapsulated in Figure 3.1 *A framework for effective GRN transition CPD.* The relationships indicated in Figure 3.1 take account of the educator's role in promoting GRN preparedness by assisting the educator to identify the: broader nursing curricula; 2.

target areas within this curriculum showing gaps in GRN preparation and transition support; including short-term and long-term learning goals; and associated learning topics 3. Lifelong learning's pedagogical approach - heutagogy; 4. Broader culminative assessment indicators, and 5. GRN transition program evaluation indicators.


Educator's Role
Transition Support
Curricula
Australian Nursing Curricula
Registered Nurse Standards for Practice: Standards 1 – 6 (NMBA, 2016)
Targeted Curricula - GRN Preparedness Gap
Short term learning goals - Standards 1 – 6 Focus on knowledge and skills preparedness gap
Long term learning goals - Standard 3 Maintains the capability for practice
Standard 3.3. Uses a lifelong learning approach for continuing professional development of self and others
Targeted Curricula
(within the GRN transition year to address the GRN preparedness gap)
GRN Preparedness Gap
Pedagogy (the method and practice of teaching /the art and science of teaching)
Lifelong learning specifies an approach and delivery that stimulates and empowers - Heutagogy
Short term learning goals
Standards 1- 6
Focus on knowledge and skills preparedness gaps
Long term learning goals
Standard 3
Standard 3.3
Content Knowledge & Skills:
Short term
Known Factors
• Work stress; Transition shock; Managing work stress and shock
• Work place role and environment; adjusting and managing workplace role and environment
• Quality of life
Content Knowledge & Skills:
Long term
Unknown Factors
• Human potential; strategies to develop human potential; application of human potential
• Empowerment; strategies to develop capacity and resilience; application of empowerment.

Known factors

Lack of preparedness

- shock and stress when entering the workplace (Kramer, 1974; Duchscher, 2008)
- difficulty adjusting to work role (Romyn et al. 2009), work (Casey et al., 2004; Duchscher, 2008; Petersen, 2011; Ross, et al, 2017)

Known factors

Lack of preparedness (Continued…)

…environment and related knowledge

broader factors, such as maintaining quality of life (Duchscher, 2008).

Unknown factors

Lifelong learning goals

- to develop [GRN] human potential
- to stimulate and empower the [GRN] to acquire the knowledge, values, skills, and understanding they will require throughout their lifetimes.

Unknown factors

Lifelong learning goals (Continued…)

- to apply [the above knowledge] with confidence, creativity and enjoyment in all roles, circumstances and environments.

(Longworth & Davies, 2003, p.22)

Assessment

Evidence of transformative learning across the transition year and career life span:

- Effectively manages work stress, transition shock, wellbeing, work role, work environment and application of related work knowledge and skills with confidence.

Assessment

Evidence of transformative learning across the career life span:

- Effectively manages all life roles with knowledge; confidence, creativity and enjoyment and circumstances and environments.

Assessment

Aligned to Australian Nursing Curricula

GRN demonstrates RN Standards for Practice: Standards 1 – 6 competency.

Targeted Curricula - GRN Preparedness Gap

- GRN demonstrates RN Standards for Practice: Standards 1 – 6

Educator collects subjective evidence.

For example: GRN states "I am happy."; "I am unhappy"; "I'm not sure".

For example: GRN states "I am effectively maintaining my quality of life" or "I am not maintaining my quality of life."

Educator collects objective evidence.

For example: GRN rate their happiness and quality of life: 1- 5 scale.

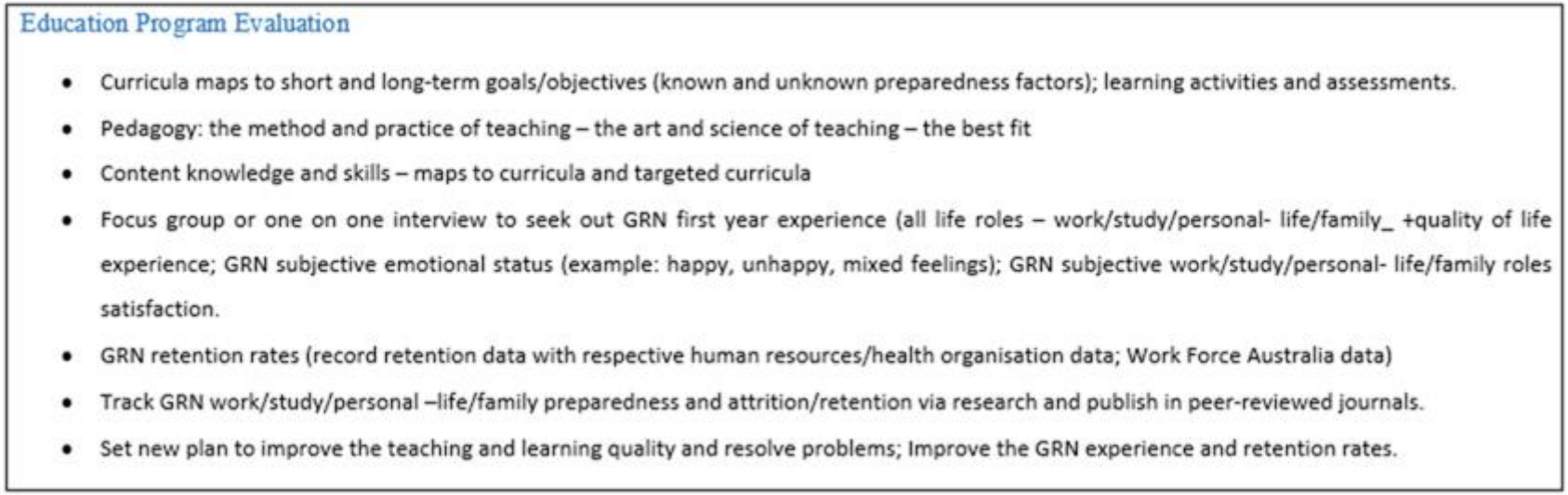


Figure 3.1. A framework for effective GRN transition continuing professional development.

The following section focuses on the impact of life balance and associated role salience. The section investigates whether part of an educator's role is to support GRNs' lifelong learning goals: that is "to acquire all the knowledge, values, skills, and understanding individuals [in this study's context, the GRN] will require throughout their lifetimes… in all roles, circumstances and environments" (Longworth & Davies, 2003, p. 22). Reviewing the literature on life balance adds another layer to the exploration of GRN preparedness from a broader life-roles perspective.

3.4 EMPLOYEE LIFE BALANCE

Restoring and supporting an employee's ascent (including assent) to a balanced life is important for promoting their health and wellbeing as well as the health and wellbeing of their families, the organisations they work for and society as a whole. Health and wellbeing is a unique experience and is broader than simply the absence of disease (WHO, 1948). Health and wellbeing are multifaceted, embodying a holistic experience reflecting the many dimensions that make up a person – the intellectual, physical, mental, emotional, social, cultural, spiritual dimensions and the environment (Smith, 2014) important to them. In bolstering an employee's holistic health and wellbeing, support for each of these dimensions is required to ensure employees function well both individually, as a whole person, and collectively.

A balanced life provides individuals and their families with a sense of personal happiness and overall satisfaction with the quality of their life. Research shows that when a person perceives that their health and wellbeing is functioning well and in harmony, a common positive affect is a feeling of happiness (Hosie & Sevastos, 2010; Warr, 2007). Closely connected to happiness are self-reports and family reports reflecting the improvement in quality of life (Magee, Stefanic, Caputi, & Iverson, 2012; Meyer & Maltin, 2010; Siu et al; 2010; van Steenbergen, Ellemers, & Mooijaart, 2007; Wayne, Randel, & Stevens, 2006). Supporting individuals to achieve a life in balance is important in promoting their overall holistic health and wellbeing, as well as that of their family. The benefits of achieving life balance extends from the individual to organisations.

Promoting employees' life balance needs to be an important goal in organisations to promote the organisations wellbeing. Positive organisational outcomes include improved work morale, productivity (Goetzel & Ozminkowski,

2008), decreased absenteeism, improved retention, and lower turnover intention rates (Beauregard & Henry, 2009; Frone, 2003; Greenhaus & Powell, 2006; Haar & Bardoel, 2008). Additionally, promoting life balance goals also benefits the increasing numbers of employees with mental illness (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Assisting employees with life balance extends organisational wellbeing to improve employee's personal sense of 'work wellbeing'. The importance of organisations supporting employees to achieve life balance assumes greater significance

Supporting employees' life balance promotes 'work wellbeing' and the goals of holistic health. 'Work wellbeing' is a term used to describe the positive functioning of an employee both professionally and personally. It includes positive affective measures such as employees feeling happier and well physically and psychologically (Meyer & Maltin, 2010; Warr, 2007). Research shows that when employees experience a life in harmony, they also experience improved satisfaction in their work and personal life (Magee et al., 2012; Meyer & Maltin, 2010; Siu et al., 2010; van Steenbergen et al., 2007; Wayne et al., 2006). It is important to correlate 'work wellbeing' against holistic health goals (see Section 2.5.1) and, more specifically, against an individual's intellectual, environmental, physical, mental and emotional dimensions. Organisations thus have a direct interest in supporting employees' 'work wellbeing' to promote their holistic health goals.

Organisational neglect in supporting employees' life balance can lead to a decline in both worker and organisational wellbeing. A decline in organisational wellbeing is demonstrated by absenteeism, high turnover, increased attrition, low work morale and reduced productivity (Kumar & Paramashivaiah Shivakumaris, 2011; Spence Laschinger & Grau, 2012). These symptoms form risk factors that can alert organisations that employees' wellbeing is in jeopardy. Being aware of these risk factors assists employees and organisations in mitigating these risks (Spence Laschinger, Grau, & Wilk, 2012). If employees and employers are able to share responsibilities in promoting wellbeing, then healthy reciprocal relationships can be formed.

One main risk factor threatening an employees' 'work wellbeing' is work/life conflict. This is when the employee feels they are unable to adequately meet

the demands arising from their work and or personal life (Amstad et al., 2011; Carlson et al., 2011; Guest, 2002; Hosie & Sevastos, 2010; Schluter et al., 2011; Warr, 2007). Symptoms include tensions between their work and personal/family roles increasing their pressure and stress and contributing their feelings of being unhappy and dissatisfied in their work. Reduced personal time means less time for the employees' parental and family roles and can lead to a decrease in the employee's family's overall functioning and quality of life (Chang et al., 2010; Guest, 2002; Karassvidou & Glaveli, 2013; Lambert et al., 2006; Magee et al., 2012). Supporting employees to manage a life in balance not only increases workers', families' and organisational wellbeing, but also community wellbeing.

Community wellbeing emerges from family, employee (worker) and organisational wellbeing. Communities are concerned about parents' abilities to manage childcare arrangements and to meet their parental roles and responsibilities (Australian Commonwealth Government, 2017; Hilton, Sheridan, Cleary, & Whiteford, 2009; Williams, Pocock, & Bridge, 2009). Parental responsibilities include physical, psychological, emotional, social (Ramey, Lanzi, & Ramey, 2015) and spiritual (Pandya, 2017) care. Specific examples include providing environments where children can feel safe and secure, creating a sense of belonging and significance for each child. Other important aspects include providing children with nutrition, hygiene, grooming, exercise and mentoring (education/support/guidance). Additionally, parental responsibilities include facilitating their children's schooling/education, sporting and personal interests and hobbies and friendships. Fulfilling their parental role improves employees' satisfaction as well as that of their children's/family lives (Chang et al., 2010; Guest, 2002; Karassvidou & Glaveli, 2013; Lambert et al., 2006; Magee et al., 2012).

Providing facilities and infrastructure that supports employees' goals of fulfilling their parental role also reflects society's values. Society values the role of parents in ensuring that the family unit functions well. A functioning family is associated with producing children who are resilient, happy, confident and well adjusted (Orbuch, Parry, Chesler, Fritz, & Repetto, 2005) as well as children who are more likely to develop into healthy adults contributing to society in positive ways (Doty, Davis, & Arditti, 2017). Therefore, supporting parents to fulfil their parental role not only reflects the values of the individual and their family but also the values

of society. Consequently, promoting the employee's life balance is important as it is directly connected with promoting family, organisation and society wellbeing and, in turn, holistic health outcomes and life balance outcomes.

In summary, restoring and supporting an employee to achieve a balanced life is important in promoting their' health and wellbeing, organisational health and wellbeing and that of society as a whole. If effective support is provided the employee, the family, the organisation and society each need to be scanned for positive indicators of a life in balance: happiness and satisfaction with life, organisational reports of productivity and retention and society's values and standards. These positive indicators require a shared responsibility for assisting employees to achieve a life in balance. Nurses fall within all four of these categories – as employees of health organisations and as members of a 'family', community and society. They also need to focus on shared approach to attaining and achieving a personal sense of life balance wellbeing.

3.4.1 Nurses' life balance

It is clear that there is growing societal awareness about the importance of life balance to the health and wellbeing of nurses, and its ripple effects on patient care, family life, organisational outcomes and community wellbeing. This has resulted in life balance becoming a key contemporary concern for all stakeholders, including governance bodies. It is critical, for example, in the sustainable retention of skilled nurses in the light of an escalating nursing shortage. While the literature acknowledges the ways that life balance can be promoted, for example by flexibility in full and part-time working hours, it more commonly revealed the negative impacts experienced by nurses as well as on the effects on health organisations and society. A consequence, according to the literature, of nurses' work context and the nature of their work.

Work stress is the main factor effecting nurses' health and wellbeing. Stress is a healthy reaction and consists of the body's flight or fight response in responding to demands, pressures, conflict and threats. Some physical reactions include an increased heart rate, respiratory rate and blood pressure (Hogh, Hansen, Mikkelsen, & Persson, 2012; Tosevski & Milovancevic, 2006). The body's response is to assist individuals to cope with life's demands, pressures, challenges and

experiences. These events can be positive, such as getting married, having a baby and securing a new job. Negative experiences might include interpersonal communication breakdown, job loss and or someone dying. Stress only becomes a concern when there is too much stress or when stress is prolonged and or ongoing, such as can occur in a nurse's work environment. This ongoing stress is attributed to a decline in nurse's health and wellbeing (Hosie & Sevastos, 2010; Matheson, O'Brien, & Reid, 2014; Warr, 2007). Therefore, it is important to understand the practices in place to reduce nurse's stress and thus promote their health and wellbeing.

The literature reveals that nurses' work environments are harsh, taxing them physically, psychologically and emotionally. Physically, nurses work involves high patient acuity, shorter patient hospital stays, fewer resources, including fewer nurses, all of which contribute to a high work burden (Aitken, Clarke, Sloane, Sochalski, & Siber, 2002; Altun, 2003; De Cola & Riggins, 2010; Japanese Nursing Association [JNA], 2007; Laschinger, Borgogni, & Consiglio, 2015; MacKusick & Minick, 2010; Ross & Rogers, 2017). Additionally, nurses also care for patients, families and communities in devastating contexts, generating a high emotional burden (Nolte, Downing, Temane, & Hastings-Tolsma, 2017). The nature of nurses work also means they are exposed to biological hazards and carcinogens (Triolo, 1989) and consequently, these types of daily exposures also impact nurses' health and wellbeing (McNeely, 2005). The harsh health work environments place nurses' health and wellbeing at risk and exacerbate feelings of being physically, psychologically and emotionally exhausted.

In addition to harsh health work environments and their negative impacts, nurses also need to manage the challenging nature of shift work. Shift work can negatively affect nurses' health and wellbeing with negative effects flowing onto patient health outcomes (Nelson & Tarpey, 2010), health organisations and the broader community (Boamah & Laschinger, 2016; Gormley, 2010; Poulose & Sudarsan, 2017; Yu et al., 2016). Shift work involves providing 24-hour service seven days a week (24/7). Many organisations provide such a service, including health organisations such as hospitals, respite centres and aged care facilities (Matheson et al., 2014). To manage 24/7 care provision, the period is divided into three shifts, with employees allocated to each shift. Shifts can be fixed or rotated. The ill effects of shift work are due to the body's circadian rhythm being interrupted or not being in harmony with environmental

factors, notably the change between light and dark, the cycle of sleeping and waking, work and social life (Boivin & Boudreau, 2014). Trying to sleep during daylight hours is not in harmony with their circadian rhythm and thus nurses are likely to experience difficulty achieving quality sleep.

Poor quality sleep impacts the health and wellbeing of the individual nurse and raises concerns about the nurse's capacity for safe practice. Research has shown poor quality sleep leads to nurses feeling tired and moody (Matheson et al., 2014), making errors at work and in their personal life, especially if they commute to and from work (Caruso, 2014; Schluter et al., 2011). In particular, poor quality sleep affects nurses' ability to stay healthy, with a raised risk in developing obesity (Caruso, 2014) and chronic disease. Chronic diseases include cardiovascular, gastrointestinal, cancer (Matheson et al., 2014), low back pain and chronic fatigue (Schluter et al., 2011). Mental health problems include depression (Schluter et al., 2011). Broader concerns include work/family/life balance (Zheng, Kashi, Fan, Molineux, & Ee, 2016) and nurses' ability to meet their non-work care giving roles due to the nature and context of their work (Schluter et al., 2011). Thus, a nurse's work context and work nature impact directly on their health and wellbeing. However, its impacts on their ability to achieve work/life balance is equally important.

Work/life balance has positive effects on an individual's personal sense of wellbeing and satisfaction with their overall life. Equally, work-life conflict is a recognised risk factor that impacts on an individual's work, life satisfaction and job retention (Beauregards & Henry, 2009). Considering the nurse's work context and the nature of their work by seeking out their work/life balance status is therefore important in understanding whether this is an area of nurse stress as well as the design practices that can reduce nurses' stress and promote their health and wellbeing. The literature reveals that disruption between work and personal life raises concerns. These concerns relating to health and marital relationships, dissatisfaction with work and life and associated stress, strain and burnout (Boamah & Laschinger, 2016). Research by Jamieson and Andrew (2013), localised to Generation Y nurses in New Zealand, identified that high workloads combined with set shift work, led to nurses' devoting personal time to recovery, rather than more personal pleasurable or family pursuits. Their research confirms that life balance is not only important for nurses but for their families, the patients in their care, organisations and society (Magee et al., 2012;

Munir, Nielson, Garde, Albertson, & Carneiro, 2012). Ensuring life balance of nurses is also important for nursing governance bodies.

Nursing governance in Australia is known for promoting the safety and wellbeing of the public but they also promote the safety and wellbeing of nurses. The new Australian Code of Conduct for Nurses, released by NMBA in March 2018, has a specific domain, Number 7, devoted to promoting nurse's health and wellbeing. This domain, 'Promote Health and Wellbeing', states that "Nurses promote health and wellbeing for people and their families…and *themselves* and in a way that addresses health inequality" (NMBA, 2018, p. 4). In addition, the International Council of Nurses [ICN] Code for Ethics for Nurses, element 2, states, "The nurse maintains a standard for *personal health* such that the ability to provide care is not compromised" (ICN, 2012, p. 3). The literature reveals however, that how these governances are implemented by nurses as individuals and by health organisations is not currently clearly articulated or understood and as such constitutes a gap in knowledge.

Furthermore, these nursing governances identify and highlight health inequality. This is important in drawing attention to the potential and actual power imbalances negatively impacting on the health outcomes of individuals. Health inequalities emerging from power imbalances are exacerbated by the limited interventions (including support) implemented to address these impacts at both the individual employee level (Ng, Chen, Ng, Lin, & Kaur, 2017) and at the organisational level (Gormley, 2011; Jamieson & Andrew, 2013). These imbalances also affect nurse turnover (Gormley, 2011) and the health and well-being of health professionals (Ng et al., 2017). While the imbalances are described in the literature, research outlining strategies to overcome them are not present. The review of the literature confirms then that nursing governance codes are not being consistently applied and evaluated by organisations to promote the health and well-being of nurses.

Australian Commonwealth laws support employee's rights to have a work/life balance. Positive work/life reforms have been initiated at the Australian Commonwealth government level in the form of legislation (see Section 2.5.1) to support employees to negotiate with their employers about flexible work hours which would assist them to meet their personal and family responsibilities (Ng et al., 2017). Yet, despite this legislation, health professionals continue to experience work/life

imbalances and the decline in their wellbeing. Organisations continue to experience turnover (Ng et al., 2017; Schluter et al., 2011). Examining the literature for effective strategies and practices that support nurses to manage their work/life balance and to promote their health and wellbeing, reveals that the onus often falls on the individual nurse to navigate work/life strategies within their own organisation's policies and practices (Gormley, 2012; Jamieson & Andrew, 2013; Poulose & Sudarsan, 2017). Research has also shown that for effective work/life practices, a shared responsibility is needed between the individual and the organisation. In particular it is incumbent on the organisation's human resource department and nurse managers to design, implement and support quality strategies that will be effective and sustainable (Ng et al., 2017). However, the quality and effectiveness of these measures have not been evaluated, and as such it remains unclear whether simply offering opportunities for self-management in general is an effective strategy to manage work/life balance and health and wellbeing risks.

Health organisations need to position themselves on the forefront by playing an active role in managing employee's work/life balance and the health and wellbeing and to address issues associated with health inequality and associated power constructs. Research in this area recommends decentralising decision-making and creating shared governance models to enable nurses to control their work schedule and environment (Tanaka, Maruyama, Ooshima, & Ito, 2010). Other recommendations involve nurse managers allocating nurses' shift work and workloads mindfully and fairly accommodating their personal/family needs, including their health and well-being assessed against organisational needs (Jamieson & Andrew, 2013; Nelson & Tarpey, 2010; Ng et al., 2017). Research on distributive justice regarding working schedules and procedural justice regarding fairness of working schedules shows work scheduling satisfaction increases with mindful and fair allocations (Brockner & Wiesenfeld, 1996; Scminke, Ambrose, & Noel, 1997). Other research indicates nurses are less likely to leave the organisation when allocation methods are perceived to be fair (Nelson & Tarpey, 2010). Overall, research reveals work/life balance self-management (especially for nurses) remains under debate (Burgess Henderson, & Strachan, 2007; Cowan and Hoffman, 2007). However, there is generally limited research on shared work/life balance accountability between the nurse and the health organisation to address nurses' health inequalities and the power constructs.

Supporting nurse ascent (assent) towards a life in balance is crucial in retaining a skilled nursing workforce to meet the demands for nurses, as well as to support nurses in their goals of being healthy and satisfied in their life roles. Thus, positive effects of supporting nurses in their ascent (assent) towards a life in balance include improved health outcomes for patients, health organisations and the broader community. Efforts to understand nurses' work, encompassing their life balance experiences at individual, organisational and governance levels is important in designing authentic practices that will act to reduce nurses' work, life stress and thus promote their health and wellbeing – especially when GRNs are concerned.

3.4.2 GRNs' life balance

GRNs are new and inexperienced and therefore are vulnerable and at risk of life imbalances. This can contribute to a decline in their wellbeing and their attrition from the profession. In light of the global nursing shortage and high GRN attrition rates (Booth, 2011), the importance of a risk management strategy to mitigate these risks would be beneficial for all stakeholders. Augmenting this vulnerability and risk, is the awareness that the first year in a nurse's career is the most stressful time (Cheng, Liou, Tsai, & Chang, 2015; Martin et al., 2011; Parker, Giles, Lantry, & McMillan, 2014; Rudman et al., 2014). Evaluations of specific GRN risk management plans, aside from individual health organisations GRN transition programs (see Section 3.3.1) is not present in the literature. There is also a paucity of literature on the education and practices that support nurses in the context and nature of their work and life. One study however, by Ng et al. (2017), confirms nurses do lack support at an organisational level managing their work commitments with their personal commitments. What is not clear in the literature is whether the absence of life balance and life-role salience preparedness (knowledge, skills, awareness and capability, to manage life balance and life-role salience effectively) are contributing factors to GRN stress, health and wellbeing decline and attrition. This study explores and examines this gap.

Life balance preparation strategies are important to support GRNs in their first year to manage work and life commitments and to promote GRN wellbeing and retention. Research on the specific life-balance preparation strategies and support GRNs receive, for example Continuing Professional Development (CPD) on career counselling (including coaching) to manage their work, study and personal life

balance, particularly shift work, has revealed little. Furthermore, there is little literature documenting the outcomes of work/life balance preparation strategies. There is also little critical discussion surrounding life balance and life-role salience and its inter-relationships with broader GRN preparedness. Nor is there evidence of case studies evaluating GRN life balance, health and wellbeing preparedness and status in their first year. In addition, there little evidence of research on GRNs' work/life balance/life role salience preparedness and or their happiness and confidence. There a few reports, including self-reports of work, study and personal life satisfaction, and of overall life balance satisfaction and its interrelationships with retention. To rectify this gap, one of the main purposes of this study is to improve understanding about these relationships and thus boost GRN retention and wellbeing.

How GRNs might gain the capacity to manage their health and wellbeing, apart from their life experiences, is a concern, not only for nurses themselves but also for the organisations for which they work. Many organisations have CPD programs focused on self-management but their effectiveness in terms of meeting the NMBA's recently updated Code of Professional Conduct for Nurses (NMBA, 2018), Domain Promote Health and Wellbeing, has not been evaluated. The question then becomes, *'How do we know these CPD programs are effective?'* The lack of research on measurable (and measured) outcomes supporting CPD programs is a common theme in the literature (McWilliam, 2007). Other conclusions drawn from the literature include the assertion that many programs are 'a one size fits all' and fail to consider the *individual* needs of nurses within their contexts and the nature of their practice, as well as their learning needs, learning styles and preferences (Gallagher, 2006). A further conclusion relates to the passive positioning of nurses by educators, rather than as active and reflective learners (Liang, Wu, & Tsai, 2011). Re-positioning nurses as active learners is reflective of transformational practice and has the potential to improve patient outcomes (NMBA, 2016b). These identified limitations place nurses at further risk of not being (and feeling) adequately educated and supported at the levels they require and may be factors contributing to negative impacts on GRNs' work, study, personal life experiences.

The paucity of literature on work/life preparedness does not mean that the work, study/personal life CPD is not available for new and ongoing nurses generally or that it is not being evaluated at departmental/organisational levels. For example, the

QNU conducts online CPD for Queensland Health (QH) Rostering – Equity and Work Life Balance, during 2018 (Queensland Nurse Calendar Online, 2018). Precise details of QNU education and training's content however was not provided on their QNU site. The Queensland Government also provides education and has published an information sheet entitled 'Work/life balance and stress management' (Queensland Government, 2013). This information sheet is general and an example of a 'one size fits all' approach, with the onus on the individual to understand and follow through with actions. Embedded is a web link for the individual to access further resources. However, the web link led to information on 'Supporting mental illness and work' and did not direct the reader to extended resources based on its original topic, 'Work/life balance and stress management'. Resources benefitting the reader could have directed the reader to specialist career counselling support regarding work, study and personal life balance. Educational opportunities such as these online examples *may* help nurses manage their work/life balance within their health organisations context, however the evidence-base is not yet there to support these assertions. Further information that would assist in evaluating these resources would include evidence about who is accessing these resources (and how often) with embedded follow up support and evaluations to assess any improvements in nurses' wellbeing, happiness, and retention.

Improving knowledge about the GRNs' broader preparedness experiences in managing negative contexts and the nature of nurses' work is important in forming an evidenced based approach enhance their health and wellbeing and retention with the goal of reducing both GRN attrition and the nursing shortage.

3.4.3 Effects of GRN's life imbalance

Failure to determine and track GRNs' risks in terms of life balance, health and wellbeing and retention throughout their transition year and to develop proactive interventions may lead to negative outcomes for nurses and their organisations. Negative outcomes for GRNs include declines in health and wellbeing and work/life dissatisfaction. For organisations, negative outcomes include low morale, absenteeism and attrition (Kumar & Paramashivaiah Shivakumaris, 2011; Spence Laschinger & Grau, 2012). Supporting GRNs more broadly than simply with a work focus to include work/life balance knowledge, skills and awareness is therefore crucial. Examining the literature for work/life balance education and support, including career counselling

support as part of GRN broader undergraduate preparation and or transition program, is not present in the literature and points to a gap in the literature.

Thus, preparing nurses at a broader level than the work alone is important in mitigating the negative nature of nurses' work and life and promoting their overall personal sense of health and wellbeing and work/life satisfaction and retention within the profession.

3.5 THEORETICAL AND CONCEPTUAL FRAMEWORKS

Several philosophies, theories and educational concepts inform this research study as discussed in Chapter 2. The main theory informing this study is life balance as explained in Section 2.9 and associated life role salience (Section 1.6), together with the educational concepts of lifelong learning, heutagogy, metacognition and critical thinking (Section 2.7). The section investigates whether the concept of preparedness is present in the literature and whether such literature embodies strategies that can be integrated to resolve GRNs' transition difficulties. The literature will also be explored to determine whether there are links with life career theory and readiness for work as outlined in Section 2.8. The theoretical perspectives employed to investigate these relationships is presented in the next section. This is followed by the development of a conceptual framework combining the philosophies, theories and concepts utilised to demonstrate the holistic relationships influencing GRNs' first year experiences.

3.5.1 Theoretical framework

The theoretical framework used to investigate GRNs' first year work, study and personal life and overall life balance experience is presented in Figure 3.2.

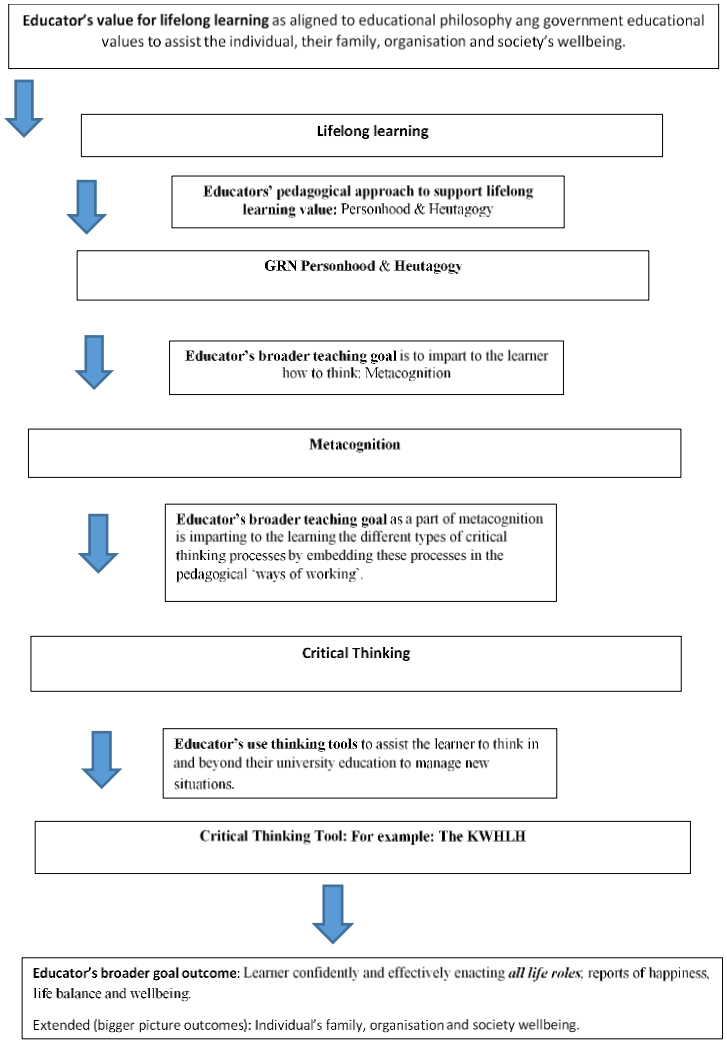


Figure 3.2. Theoretical framework informing the GRN first year experience.

Figure 3.2 illustrates the theoretical perspectives, and the relationships between them, used to support GRNs empowerment to achieve *all* their life role goals in relation to their work satisfaction, wellbeing and retention. These goals are applied to the profession, GRNs' families and organisations and in society. The overarching educational value of lifelong learning is presented first as its value is understood by both governments and educators. Underpinning lifelong learning are the pedagogical approaches educators engage to assist students to respond to the constant change forces impacting their work roles and lifelong learning goals. These goals include developing GRNs' skills and knowledge as professional RNs and aligning these with their personhood and self-management capabilities. Appropriate learning approaches to fulfil these purposes are personhood and heutagogy contextualised to the environment and situation GRNs inhabit. An additional step is the educator's espousal of

metacognition to provide students with 'ways of working' with content and assessment. Then, to support students' development of critical thinking in the '*nursery*' and beyond the '*nursery*' thinking tools are introduced to support students' development of critical thinking. An example such as the K – What I know; W- What I need to know? H – How will I find this out? L – What I have learnt? H – How do I know I have learnt? (KWHLH) for example. The learner then finally arrives at a position where they are enabled to enact their learning within the university setting (theory, practice and assessment) and beyond the university environment – in their place of work and across *all* their life roles to are able to achieve both work readiness and a fully developed sense of life balance and wellbeing. This theoretical framework provides reference points to guide this study. A conceptual framework has also been designed to provide an overview and improved understanding about the broader GRN first year experience and is presented next.

3.5.2 Conceptual framework

To enhance understanding of the broader GRN first year experience, a conceptual framework has been developed. The conceptual framework has an important role in presenting the relationships between the philosophies, theories and concepts that underpin the research design, including the analysis and discussion. The conceptual framework integrates the theoretical framework with relevant literature and underpins these concepts with the philosophies and theories guiding the research in relation to 'preparedness'. This conceptual framework, *Load Triad preparedness model: Personalising learning for the Graduate Registered Nurse*, is illustrated in Figure 3.3.

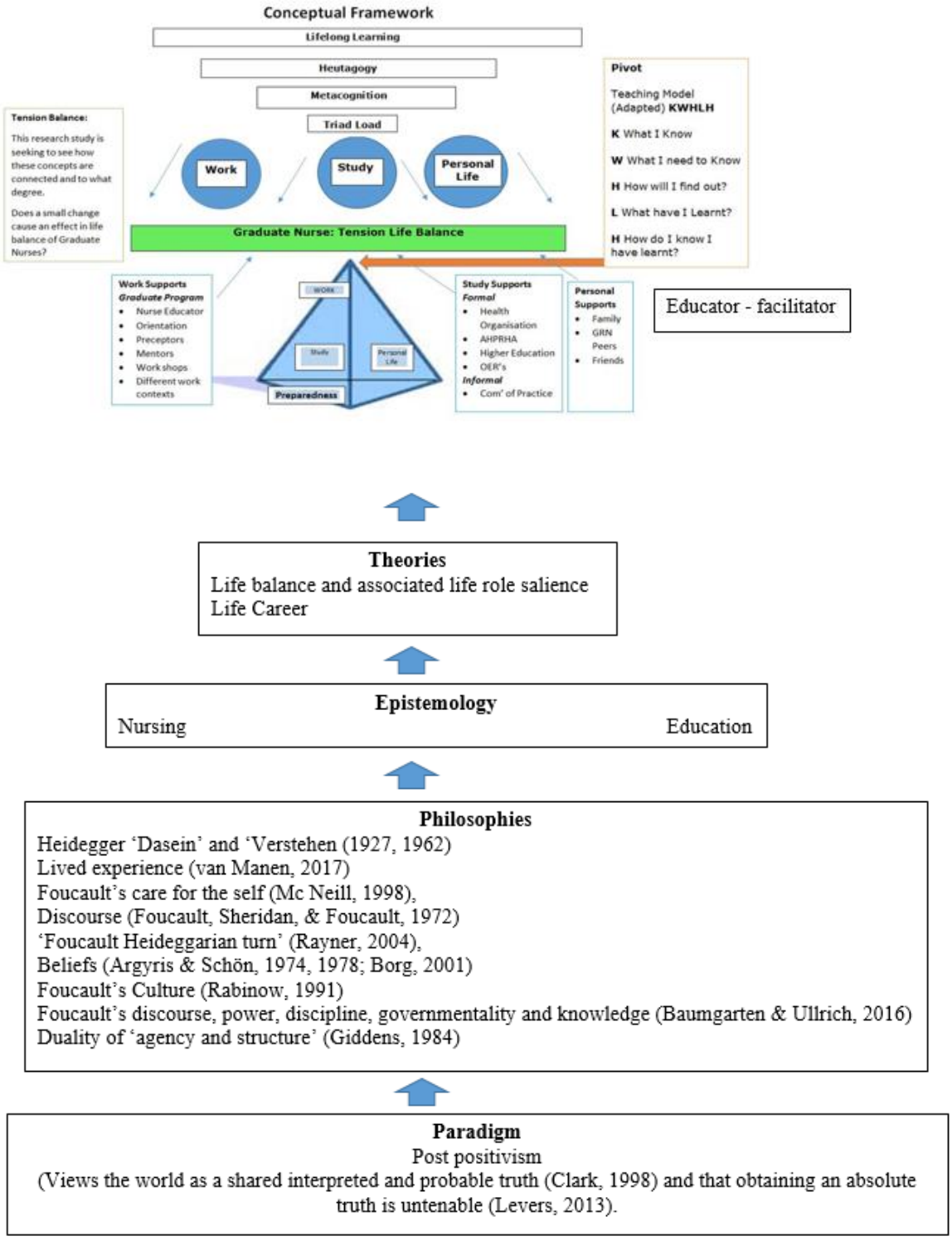


Figure 3.3. Load triad preparedness model: Personalising learning for the graduate registered nurse.

The conceptual framework represents the individual GRN's tensions impacting their ability to keep their life roles of work, study and personal life in balance. The beam represents the tensions experienced as they try to balance the

counteracting forces. Each GRN's balancing act encompasses both known and unknown factors and this reflects their levels of preparedness However, it is the responsibility of the educational and transition '*nurseries*' to increase each GRN's level of preparedness by reducing the unknown factors. Thus, to improve GRN's preparedness to effectively manage *all* their life roles (their personal sense of balance), the '*nurseries*' need to broaden their approach. This approach would need to include the adoption of various key philosophies and understandings of GRN's lived experiences and the theories emerging from the two chapters of literature. This would enable the '*nurseries*' to improve GRNs' preparedness in becoming and being an active participant in society and accomplish *all* that they can as nurses.

3.6 CHAPTER SUMMARY

This literature review aimed to set the scene for this research by providing a series of connected building blocks that describe the broader environment that GRNs are positioned within and thus extend the discourses representing the GRN first year experience. Chapter 3 included the historical background in Section 3.2; the global nursing shortage, Australian and international GRN attrition rates and Australia's historical education and training of nurses. Also reviewed was GRNs' lack of preparedness (Section 3.3) and employee life balance (Section 3.4). The review identified the strengths, issues and shortfalls impacting GRNs first year experience. The strengths included the WHO advocating a move away from traditional practices to the adoption of new strategies to address the nursing shortage. In Australia, nursing governance bodies are responsive to meeting the challenges of addressing GRNs' needs and expectations, encompassing a broader public health population focus, research and a professional profile in the process. Other strengths include health organisations implementation of GRN programs to support GRNs' transitions. A number of issues were identified however with these programs. At the *undergraduate* level, concerns emerged from undergraduate clinical skills assessment and quality clinical placement experience opportunities. At the *transition* level there are the ongoing issues of GRN lack of preparedness and GRN transition programs adopting a 'one size fits all' approach. At the *organisational and systems levels*, there was a failure to consistently practice from an evidenced based platform. Shortfalls have included health organisations failing to recognise the need to support GRNs from a broader life balance platform to mitigate risk factors, such as when entering a harsh

work environment and the negative effects associated with the nature of nurses' shift work. The review of the literature has identified gaps that inform further research directions. In particular, research directions on the life balance and wellbeing 'concern and care' of GRNs.

Nurses leave the profession for a number of reasons. The main reason to date is attributed to 'across the life span' events associated with retirement, however, new nurses are also leaving. Work stress contributed to this along with emerging links to work/life conflicts. Considering the broader examination of the literature presented, together with the gaps previously identified, the following research question was proposed.

3.7 RESEARCH QUESTION

> What are the factors impacting the Graduate Registered Nurses first year experiences in managing their work, study and personal lives and to what degree do these factors, and the possible relationships between them, impact on their overall life balance?

The methodology used to gain an understanding and derive some meaning around GRNs' *life-worlds* and lived experiences in their professional practices, study and personal life roles is described in Chapter 4.

Chapter 4: **Research Design**

4.1 CHAPTER INTRODUCTION

Research design as a whole consists of several inter-related components working in harmony. Understanding the role of each component not only assists in ensuring they work well individually but also in unison with each other in a considered, predetermined and organised sequential way. This design approach is augmented by the development of understandings about the research process and qualitative and quantitative approaches, their strengths and weaknesses, as well as strategies to harness their strengths and to mitigate their weaknesses.

Chapters 2 and 3 provided the philosophical and theoretical perspectives underpinning the broader environment in which Graduate Registered Nurses' (GRNs) are positioned, as well as the discourses buttressing the GRN first year experience. An overall resonating theme that emerged, was the importance of the health system and its components effectively functioning in both an inter-related and holistic manner by the application of an evidence-based platform. GRNs are a component of the health system and need to function well at individual and inter-related levels with other components of the health system. The literature review examination provided insight into the discourse surrounding the GRN first-year experience and identified strengths, issues and shortfalls impacting GRNs first-year experience. This critique of the existing knowledge pool, has enabled an informed approach that has carefully guided the formation of this study's theoretical and conceptual framework and in seeking answers to this study's research question: What are the factors impacting the Graduate Registered Nurse first year experience to manage work, study and personal life and the possible relationships between them, impact on their overall life balance?

This chapter describes the research design aligned to this study's research objectives listed in Section 1.7. Section 4.2 details the research aims. Section 4.3 presents the research design framework. Section 4.4 details the research process to ensure quality research outcomes. Section 4.5 describes the research context. Section 4.6 details the mixed methodology includes a description and explanation of the paradigm used by this study, post-positivism, and the two enquiries of approach,

social-constructionism interpretivism and positivism. Section 4.7 presents the research method, mixed method exploratory design, and describes participants of Phase 1 and 2. This is followed by details about Phase 1- a qualitative method: focus group implementation and Phase 2 – a quantitative method: survey. Further details about Phase 2 survey instrument development and validation is provided and the survey's pilot testing and implementation. Section 4.8 details the data analysis for Phase 1 and Phase 2. Section 4.9 presents the ethical considerations. Section 4.10 discusses the research limitations. Section 4.11 presents the chapter summary.

4.2 RESEARCH AIMS

This study's aim was to determine the specific factors within the GRN's work, study and personal life, the *Load Triad*, to identify the preliminary indicators that signal that GRNs are at risk of life imbalance. The purpose was to align these risk factors to GRN education and support strategies that will provide meaningful and on time support to GRNs. Overall, the aim was to improve GRN preparedness from a broader life balance platform and aid in their retention in the profession and, ultimately, contribute to closing the nursing shortage gap. To achieve this overall aim, this study followed a purposeful research design framework that produced a design of best fit to meet this study's aim and to achieve its purpose and is detailed next.

4.3 RESEARCH DESIGN FRAMEWORK

This study's research design followed a purposeful research framework that investigated the GRN's first year experience of work, study, personal life, their *Load Triad* and was important as it corroborated the rigor of this research study's design (Atweh, 2009; Creswell, 2011; Crotty, 1998; Denzin & Lincoln, 2013). The research framework consisted of eleven essential connected elements These connected elements are listed next.:

1. The trigger or concern (the phenomenon to be investigated)
2. The paradigm lenses
3. The research question
4. The ontology (perspective about the nature of reality)
5. The epistemology (theory of knowledge and truth)

6. The methodology (ways of finding out)
7. The method (process of finding out)
8. The data collection instrument
9. The analytical framework
10. The interpretations
11. The implications of the study

The interconnectedness of these eleven elements are presented as a nested, cascading pattern and is illustrated in Figure 4.1.

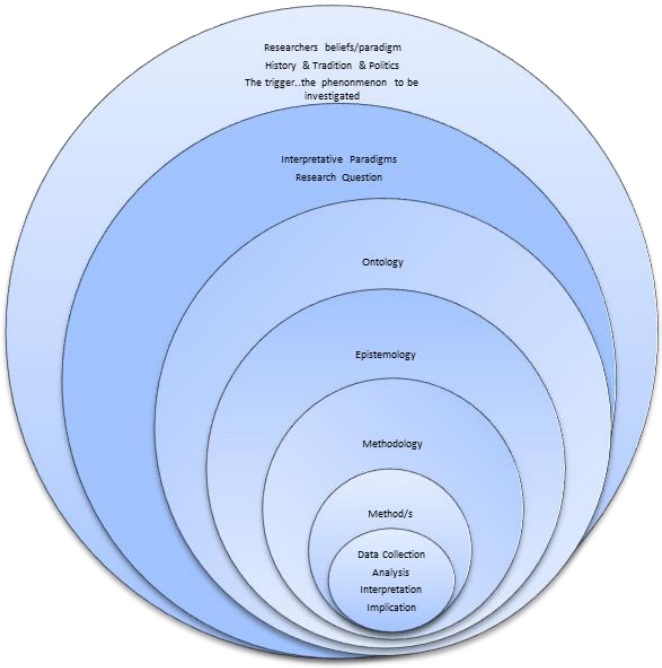


Figure 4.1. Eleven essential connected elements of research design framework model.

Thus, this framework has been applied to this research study as a 'way of working' to guide this study and to ensure quality research outcomes. The first nine elements of this framework are detailed next, while element number ten, interpretation and element number eleven, implications, are respectively presented in Chapters 6 and 7.

4.4 ENSURING QUALITY RESEARCH OUTCOMES

Ensuring quality research outcomes for this research study began by implementing the enquiry framework process as detailed in Section 4.3 and began by articulating the research concern, followed by the researcher taking a step back to gain

an overall perspective in relation to the research enquiry. These aspects are presented next.

4.4.1 The research concerns

This research study's trigger or research concern to be investigated was the life balance, wellbeing and 'concern and care' of GRNs in their first year and their attrition. Therefore, in investigating this phenomenon and to ensure quality outcomes, identifying and implementing a design of best fit to meet this study's aim and to achieve its purpose was determined. This was achieved by taking a step back to gain an overall perspective.

4.4.2 Gaining an overall perspective

Gaining an overall perspective enabled potential methodologies to be examined that could guide this study's investigation to achieve its aim and purpose. Gaining an overall perspective involved three aspects of self-examination: 1. The researcher's own view; 2. The researcher's outside influences and 3. examination of available paradigms to illuminate the phenomenon under investigation. These three aspects were adopted and implemented in the design for this research and are explained as follows.

4.4.2.1 The first aspect: Researcher self-examination

The design process firstly involved a self-examination of the researcher's view of the world or paradigm and situated place in this research study, to ensure strengths were harnessed, while any weaknesses mitigated. The importance of this researcher's self-reflection shows the researcher's personal motivations, including situated knowledge, as an informed knower that benefited the research process and that enabled a rigorous research design process around this (Denzin & Lincoln, 2005, 2013; Mills, Bonner, & Francis, 2006). Doing this facilitated the trustworthiness of this research enquiry. Thus, the researcher's own epistemology originated from their caring role as a Registered Nurse and how nurses assess patients. In this nursing role, as a person and a nurse, the researcher values the objective and subjective assessments of the patient in forming the health story required to identify the patient's problem/s (actual problems and potential problems) (Dempsey et al., 2014). This nursing assessment approach can be seen to be reflected in the post-positivist paradigm

adopted for this research where objective and subjective views are valued in conjunction with the GRNs' stories. Self-disclosure of the researcher's epistemology early in this research design process is an important part of the process to ensure transparency and to raise trustworthiness, however the purpose of the researcher's self-disclosure extends beyond this. The purpose also demonstrates that as a researcher in this study, the researcher is an informed knower. As an informed knower the researcher can enrich the research process (Mills et al., 2006), compared to another researcher, who is not the researcher of this study and who has not had the researcher's education and training, experiences (past and current) and who are not part of the researcher's life worlds and associated cultures. Examples of the researcher's life worlds relevant to this study include the 'world of being a person and a nurse as one', the 'world of nursing', the 'world of being a student nurse in a hospital setting', the 'world of being an undergraduate student nurse in a university setting [already as an RN]', the 'world of working alongside new GRNs, the 'world of being a GRN educator in a rural and remote Queensland setting', the 'world of education' and the 'world of nursing education as an academic'. The researcher being transparent about their nursing epistemology and situated place in this research study design process as an informed knower, helped to harness the researcher's strengths and mitigate the researcher's weaknesses to enrich this research process.

4.4.2.2 The second aspect: Researcher's self-examination of outside influences

Secondly the design process involved the researcher's self-examination of outside influences that would potentially influence informing the research design process. Outside influences included history, tradition, politics and ethics to ensure that these did not influence my methodological choices (Denzin & Lincoln, 2013). Outside influences identified included those from the researcher's fellow nursing academics who suggested the research should only use a qualitative enquiry. For example, phenomenological research was suggested. Academics the researcher knows from the science, engineering and maths faculties predominately preferred and recommended a positivist approach. To overcome these influences, it was important for the researcher to first note these influences in the research design process in a transparent way. This transparency raised awareness about these potential outside influences and facilitated an ethical management of these in order to stay true to the

design process enquiry that values examination of available paradigms to discover the paradigm best suited to this investigation.

4.4.2.3 The third aspect: Available paradigms

The third aspect of the design process involved examination of available paradigms to illuminate the phenomenon under investigation. The following four paradigms were examined: positivism-post-positivism, constructivism-interpretivism, critical interpretivism and feminist paradigms. Positivism is the notion that reality is absolute, singular and independent of the observer (Lakoff & Johnson, 1980, p. 159). Post-positivism is that there is likely to be many shared interpreted and possible truths. Social constructivism is the concept that there are many realities that are individually and socially constructed (Schwandt, 1994, p. 125) whilst critical interpretivism sees truth as a social construct, noting that not all are equally valid (Denzin & Lincoln, 2013, p. 26). Feminist means understanding women from their lived experience or standpoint (DeMarco, Campbell, & Wuest, 1993). By examining each of these paradigms the researcher was able to discover the kind of evidence that could be expected from each of these paradigms and the type of research questions that could be asked of each.

Awareness about the philosophical assumptions and underpinnings was therefore important to being open to other ways of approaching the inquiry and to benefits or concerns each of them raises. This type of approach that included awareness about the philosophical assumptions and underpinnings of the methodologies, supports researchers' creativity in their approach, rather than limits their approach. As such, it can address growing challenges arising within nursing (Racher & Robinson, 2002) and can assist in addressing this study's concern about GRNs. Thus, this awareness about the various philosophical assumptions was important to underpin this study's research design and question and consequently optimised opportunities for a better understanding of the phenomenon being investigated. Therefore, based on these premises, this study's research question (as below) was confirmed to be appropriate.

> What are the factors impacting GRNs first year experiences of managing work, study and personal life and to what degree do these factors and the possible relationships between them, impact on the individual's overall life balance?

Following confirmation of the research question as appropriate, it was then examined against the four main paradigms construct*ivism* – interpretivism, positivism, critical interpretivism and feminism. This included the researcher as either a: positivist-post-positivist (coloured sky-blue), constructivist-interpretative (coloured tree-green), critical interpretivist (coloured orange) and feminist (coloured purple) and are illustrated in Figure 4.2.

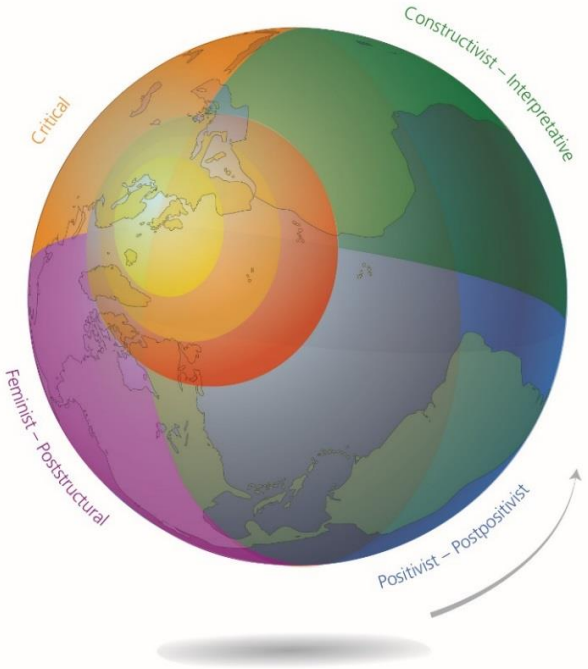


Figure 4.2. Four main research paradigms (or enquiry) as a researcher.

As an outcome of this examination of the research question against these four main paradigms, it was determined that post-positivism paradigm was the best fit. This was due to the remaining three paradigms, construct*ivism*-interpretivism, critical interpretivism and feminism being limited, in that they all fell short in one main area. This area was that they only facilitated one type of enquiry and were therefore considered too narrow for this research study's aim and purpose, and not fully aligning to answering this study's research question. Whereas the paradigm post-positivism was broader in its approach of enquiry, as it enabled the form of the enquiry to change as the research context determined the need for change. In this research study's case,

the first part of the research question directed the need for an exploratory social enquiry, such as social construct*ionism*-interpretivism could provide (which falls within the constructivist-interpretivism paradigm), while the second part of the research question directed the need for an enquiry that could measure, such as the enquiry, positivism could deliver. This need for an enquiry that could change the enquiry lens as needed was determined to be the characteristic of the post-positivism paradigm. This change of enquiry lens is illustrated in Figure 4.3. This change of enquiry is further demonstrated in its application to this study's research question below and is represented using two colours and two text fonts: tree green and bold text to represent social construct*ionism*–interpretivism enquiry and the positivism enquiry as sky blue italicised text.

> **What are the factors impacting GRNs first year experiences of managing work, study and personal life** and *to what degree do these factors and the possible relationships between them, impact on the individual's overall life balance*?

Therefore, applied to this study, the form of enquiry began with a qualitative, social construct*ionism*–interpretivism enquiry – Phase 1, which informed the next enquiry change, the quantitative, positivist enquiry – Phase 2. Therefore, the enquiry order of this research study was as follows:

Phase 1 – social construct*ionism*-interpretivism

Phase 2 - positivism

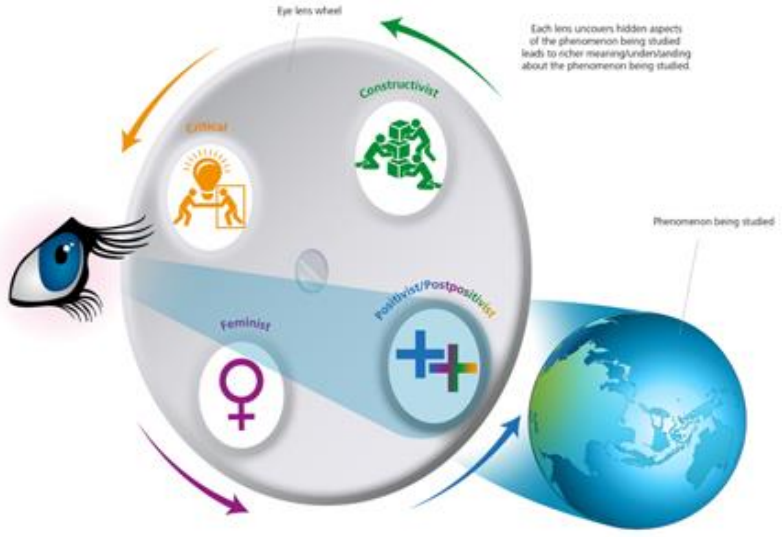


Figure 4.3. Examination of paradigm of best fit for this research study: Post-positivism.

Therefore, this process to gain an overall perspective enabled potential methodologies to be examined that could potentially guide this study's investigation to achieve its aim and purpose. However, importantly, this process enabled the design of the *best fit* to be determined which is post-positivism.

4.5 RESEARCH CONTEXT

The context for this research study is GRNs first year *Load Triad* experience, working and living life as a nurse and person in Queensland and consists of two linked research phases during the period 2013-2015. Phase 1 context is further detailed in Section 4.7.5 and Phase 2 context is further detailed in Section 4.7.10.

4.6 METHODOLOGY: MIXED METHODOLGY

Research methodology is a 'way of working' by researchers when investigating a research concern. Methodology has been formally defined as "the theoretical, political and philosophical backgrounds to social research and their implications for research practice and for the use of particular research methods" (Robson, 2011, p. 528). Applied to this study, the 'way of working' was a mixed methodology that used two enquiries. Phase 1 used social construct*ionism* – interpretivism – a qualitative enquiry, which informed Phase 2. Phase 2 used positivism – a quantitative enquiry. Consequently, the researcher followed the ways of working (set procedures) for each of these two enquiries, whilst upholding the overarching paradigm, post-positivism. Each of these two enquiries are presented in this section, however the overarching paradigm guiding this research, post-positivism, is detailed first.

4.6.1 Paradigm: Post-positivism

Overall, this study was guided by the post-positivism paradigm. Post-positivism views evidence as not being restricted to what can be physically observed (objectivist epistemology) and accepts the nature of reality is interpretive (Annells, 1997; Crossan, 2003). The epistemology (theory of knowledge and truth) is objectivist, truth is objective and value free, and the ontology (the nature of reality) is critical realist (Annells, 1996).

The post-positivism paradigm views the world as a shared, interpreted and probable truth (Clark, 1998) and that obtaining an absolute truth is untenable (Levers, 2013). Due to the critical realist ontology, the post-positivist approach accepts the nature of reality is interpretive. Emphasis is placed on meaning, the person and their expression of humanism, experience and knowledge as "multiple, relational and not bounded by reason" (Henriques et al., 1998, p. xviii), and shaped by contextual influences (McEvoy & Richards, 2003). Consequently, in post-positivism research, truth is constructed through a dialogue (discourse). This dialogue provides the members of the group and or community, the vehicle for valid knowledge claims to emerge. The knowledge coming to the fore is a result of the negotiation process between the conflicting interpretations and discussions around action possibilities. The nature of reality is interpretive due to the expression of humanism, how sense making is achieved with members of the group and/or the community, and that truth is not restricted to physical evidence and not bounded by reason. These understandings will be particularly evident in the results section for Phase 1, the *qualitative* data, where the Discussion chapter and the conclusions drawn *make meaning* of the Phase 1 themes. While Phase 2 *quantitative* descriptive statistical results are objective, making meaning of these results in the Discussion chapter, the *post-positivist* researcher asked questions such as: "*What do these numbers mean? What understanding can be gained from these numbers?"*

The value of post-positivism enquiry is accepted as being robust (Patton, 2002). However, it is important that the researcher generates a story that is reasonable, credible and legitimate and can be readily achieved by the researcher drawing on these very qualities (Patton, 2002). Furthermore, post-positivism provides the opportunity to ensure the rigor of the overall study if more than one type of enquiry is applied. This is because each type of enquiry comes with unique strengths and limitations and so, the 'first' enquiry can counteract some of the limitations identified in the 'second' ontology applied (Racher & Robinson, 2002).

The very nature of post-positivism has enabled this study's mixed methodology and its associated philosophies of enquiry to guide the sequence of enquiry in conducting the research. In this study, as the respective perspective shifts (the ontological view) to the research needed at the time and within the context being explored, a corresponding shift will also occur to the associated epistemology,

axiology, rhetoric-(ology) and methodology. This notion of philosophical shifting at the ontological level, forms the central concept of the 'Oscillating ontologies' developed for this study (Section 4.6.4). Two ontologies of enquiry are applied to this study, Phase 1 - social construct*ionism* – interpretivism and Phase 2 – positivism, which are now presented.

4.6.2 Construct*ivism* and social construct*ionism* - interpretivism

Social construct*ionism*-interpretivism falls within the overarching paradigm construct*ivism*-interpretivism. Construct*ivism* and social construct*ionism* interpretivism have long been viewed and accepted within the field of psychology through the generic lens of constructivism (Raskin, 2002; Savickas, 1994). However, a difference between the two enquiries is evident and is important to note and define, as this study uses social construct*ionism*-interpretivism for Phase 1. Construct*ivism*-interpretivism asserts that "making meaning and the constructing of the social and psychological worlds [are attended] through individual, cognitive processes" (Young & Collin, 2004, p. 375), while social construct*ionism* "emphasises that the social and psychological worlds are made real (constructed) through social processes and interaction" (p. 375). Therefore, using the generic lens of constructivism, the epistemology (theory of knowledge and truth) for Phase 1 views truth as a function of finding out and forms as an outcome of sophisticated construction on which there is agreement among the members and is subjective and value laden (Atweh, 2009; Creswell, 2011, Crotty, 1998). Unlike positivism, evidence "is not confined to what can be physically observed" (Crossan, 2003, p. 53). Thus, the outcome for an interpretivist researcher is not in asking "Is this the absolute truth?", instead, the interpretivist researcher identifies and shares valid knowledge claims raised by the members, such as the members concerns, and issues raised during their conversations. The researcher also describes the members' reactions and the shared interpretations of these interconnecting ideas (Henriques et al., 1998). In this context, the aim for the researcher is to share these interpretive discussions, the thinking and how the ideas might be used by our respondents. This means in adopting a social construct*ionism* – interpretivism approach to Phase 1, it is important for the researcher to realise the ways of working will follow inductive and or deductive reasoning strategies that will produce knowledge that is subjective and value laden. It will also build themes and

categories (Petty, Thompson, & Stew, 2012). For example, in this study, the qualitative component, Phase 1 used thick description to represent the different individual GRN perspectives. The following section details the second research enquiry, positivism.

4.6.3 Positivism enquiry

Positivism is a scientific enquiry that underpins quantitative research. Ontologically reality is viewed as singular and importantly, independent of the observer. Additionally, positivism considers reality is controlled by fixed rational laws based on cause and effect. Epistemologically, the assumption about truth includes, a set of statements reflect reality, the knower and the known are independent of one another and truth is objective and value free (Atweh, 2009; Creswell, 2011, Crotty, 1998). This means in adopting a positivist approach to Phase 2, it is important to demonstrate the ways of working follow strict laws that produce objective knowledge. In this study, the quantitative component, Phase 2 used descriptive statistical analysis and presents data using tables and graphs (Petty, Thompson, & Stew, 2012). As part of the researchers' way of working, is also in establishing rigor and is detailed next.

4.6.4 The oscillating ontologies

The oscillating ontologies enquiry approach enables the same phenomenon under investigation to be considered from different viewpoints. Thus, each oscillation – the ontological (nature of reality) contributes to gaining part truths that assist in developing a more complete truth and thus strengthens the rigor of the research study. In this study, two oscillating ontologies enquiries were raised in the following order: social construct*ionism*–interpretivism and positivism. The use of two ontological perspectives (different perspectives about the nature of reality) has provided a more comprehensive picture and associated meaning to this picture ('truth') about the GRN first year *Load Triad* experience (the phenomenon of study). Table A.1 in Appendix A provides further details about each of these two ontologies and their relationship to the research question.

The oscillating ontologies within the overarching post-positivism paradigm enables the post-positivist researcher to shift the ontological perspective (lens) for research study enquiry as required. For example, in this research study, Phase 1 enquiry used the ontological lens – social construct*ionism*-interpretivism. As the

focus of the research needed to change, Phase 2 enquiry used the ontological lens - positivism. Moving the ontological perspective as required for research is supported by Creswell (2011) and Clark (1998). This approach used in this study revealed nuances that may have remained hidden from view if only a single ontology was used.

At a philosophical level, many researchers contend that it is not possible to mix objectivist and constructivist paradigms (Creswell, 2011). The argument behind these claims is to consider the epistemological (theory of knowledge and truth) and ontological (nature of reality) viewpoints (Atweh, 2009; Creswell, 2011; Crotty, 1998; Denzin & Lincoln, 2013; Teddlie & Tashakkori, 2003). Raddon (2011) however identifies a world view that is located between the objectivist and constructivist paradigms, known as post-positivist, meaning 'probable truth'. This world view allows the objectivist and constructivist paradigms to be complementary to one another in the research design.

Furthermore, a single research paradigm did not fit well with the nuances of understanding required for this study. For example, positivism requires absolute truths, while a constructivism-interpretivism requires shared and or individual truths. These respective epistemological truths are further detailed in Table A.1 in Appendix A). Whereas this study is concerned about seeking a shared probable truth to gain a more comprehensive understanding about the phenomenon being investigated, hence post-positivism. The post-positivism paradigm implemented by the 'oscillating ontologies' enquiry approach, enabled shared, interpreted and probable truths to emerge (Howe, 1998; Weick, 1995). This approach of enquiry guides this research.

4.7 METHOD

Methods are tools used by the respective enquiry. Method has been formally described as the procedures used to obtain and analyse data to construct knowledge (Creswell, 2011; Denzin & Lincoln, 2013; Petty, 2012). Thus, the overarching method used by this study to obtain data was a mixed method exploratory design involving two phases. Phase 1 is a qualitative method, focus group using thematic analysis. Phase 2 is a quantitative method, survey using descriptive statistics. The Mixed Method Exploratory design is detailed next.

4.7.1 Mixed method exploratory design

Mixed methods exploratory design as a method cascades from the mixed methodology and fits well in answering this study's research question. Mixed methods exploratory design is a method promoted by Creswell (2011). This distinct design is not simply the collection of two methods of research but rather comprises two methods that build to obtain benefits that would not otherwise be obtained (Creswell, 2010; 2011) if a single method of research was used. The distinct exploratory mixed method design used in this study is presented in Figure 4.4.

This research sequencing is represented as:

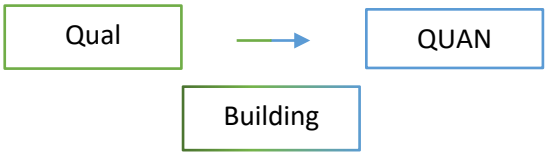


Figure 4.4. Exploratory mixed method design.

Figure 4.4 illustrates Phase1 and Phase 2 relationship and sequencing in this study and is detailed next.

Phase 1 is qualitative and is first in the sequencing. Phase 1 is less dominant and has the Qual abbreviation, with the letter Q as an upper case, followed by the remaining letters in lower case. This designates a lighter weighting will be given to this stage of the research (Teddlie & Tashakkori, 2003). As this is written first in the sequence, means this phase of the research method will be conducted first and will be known as Phase 1. **Phase 1** used the qualitative method: **focus group.**

Phase 1 builds to Phase 2 and is illustrated in Figure 4.5 as an arrow coloured in a gradient of tree green to sky blue ⟶ and follows the Qual abbreviation and shows the direction of the research method sequencing.

Phase 2 is quantitative and is presented second in this study's sequencing. Phase 2 is more dominant in the design and has the QUAN abbreviation, with all letters as upper case, designates this phase carries a heavier weighting. **Phase 2** used the quantitative method: **survey.**

This section detailed this study's research design, mixed methodology within a post-positivist paradigm and using a mixed methods exploratory design

consisting of two phases. Phase 1 - qualitative method, focus group and Phase 2 - quantitative method, survey.

The next section details the research participants for Phase 1 and 2.

4.7.2 Participant inclusion criteria for Phase 1 and Phase 2

Participants for Phases 1 and 2 of this study were Graduate Registered Nurses (GRNs) in their first twelve months of employed nursing experience. A GRN is defined in this research as a nurse with a Bachelor of Nursing or equal qualification, who is licensed to work as a Registered Nurse and is in their first transition year of work as a registered nurse (Australian Health Practitioner Regulation Agency [AHPRA], 2015).

During recruitment, this definition of a GRN was espoused to add to the credibility of this study's findings for both Phase 1 and 2, underpinning the rigor of the study. Rigor has also been enhanced by adhering to a specific criteria list of inclusions and exclusions created and applied during recruitment:

4.7.2.1 Phase 1 and 2: Inclusion criteria

- Registered as a Registered Nurse (RN) with the Australian Health Practitioner Regulation Agency
- Nurses employed in a Queensland health facility.
- Nurses working as RNs for preferably 1 to 12 months since graduating from a Bachelor of Nursing Program.
- Either gender
- Aged 18 or over

4.7.2.2 Phase 1 and 2 Exclusion criteria

- Graduates from a Bachelor of Nursing Program not registered with APHRA
- Not currently working in a health facility
- Time periods of working as RNs 13months and over
- Aged under 18

The following section describes and justifies Phase 1 focus group method selection and details the context, recruitment and selection of the four GRN participants. Additonally, details are also provided about the focus group instrument and implementation, as well as the focus group timeline, reflexivity and implementation. Furthermore, details are also provided about how the standards are applied, to ensure trustworthiness of the focus group method and procedures.

4.7.3 Phase 1: Focus group

Focus groups by design have a specific purpose in facilitating meaningful, rich data to emerge. A focus group is a "carefully planned series of discussions to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (Krueger & Casey, 2009, p. 2). This method was selected as it aligned to the ontology selected to guide Phase 1 of this research, social construct*ionism*-interpretivism (Section 4.6.2) as it accepts the nature of truth as shared knowledge, encompassing many individual realities with these realities being socially constructed (Schwandt, 1994, p. 125).

It was important to place a small number of GRNs together to facilitate an intimate and safe group that would encourage them to share with each other their individual realities, their first-year experiences working, studying and living life as GRNs. The process of sharing experiences, insights, behaviours and actions with one another was important as this process is known to create a synergy between members that could ignite further thoughts and encourage members to probe one another and explain themselves to one another (Morgan, 1996). Thus, the data collection is not just made up of members own experiences, but the sum of their experiences teased out (Bloor, Frankland, Thomas, & Robson, 2001; George, 2012; Morgan & Krueger, 1993). The goal of using a focus group was to allow rich and meaningful data to emerge as this was paramount to the aim of Phase 1 in exploring the factors impacting on GRNs' first year managing work, study and their personal life. Through this process, the researcher gains an improved understanding about GRN lived experience and gives each GRN a voice to express this and be heard. The focus group method by design enabled the collection of rich, meaningful data to provide an improved understanding about the GRN's lived experiences. However, ensuring the focus group was properly conducted was equally as important in collecting data.

4.7.3.1 Advantages and disadvantages of using focus groups for this study

Focus groups have practical advantages and disadvantages. These practical advantages and disadvantages are presented in Table 4.1. As a researcher, it is important to be cognisant of both to harness the focus group strengths and to manage and or mitigate any disadvantages. Examining the practical advantages and disadvantages, allows a balanced approach to the decisions involved in implementing a focus group. It included careful management of the disadvantages to achieve the Phase 1 aim of collecting meaningful data using credible procedures.

Table 4.1: *Advantages and Disadvantages of Focus Groups to Gather Data*

Advantages	Disadvantages
Time collecting data is reduced	May incur a small cost for catering
Small room allocation as less space is required for four participants	Difficulty may arise in organising a date, time and place that suited all participants
Reduced travel requirements for local participants and local researcher	Participants who are not local would require travelling time
	Difficulty may arise in finding a private space
Less intrusive than an interview	Rapport between participants may not be established.
Communication is enhanced	
Researchers can take notes easily without interrupting the flow of conversation	Conversation may digress to other topics other than the research topic

(Creswell, 2010; 2011; Creswell, Hanson, Plano Clark, & Morales, 2007)

Understanding the GRN's characteristics and work contexts was important in acknowledging and facilitating focus group implementation. GRNs typically work rostered shifts and enjoy conversing in small private groups. Choosing the small focus group method would allow each of the GRNs to share their experiences in an intimate manner and be heard easily and clearly by one another, including being taped by digital recorders. Other benefits of this method included providing space for each participant to reflect on one another's experiences and respond to non-verbal cues in the conversation too. This method allows the data to build naturally. Focus group design also enables the knowledge to be owned by the participants and to be captured by the

researcher, rather than the researcher presuming the point of knowledge and designing questions from that position (Creswell, 2010; 2011; George, 2012). Therefore, conducting a small focus group has clear advantages over alternative qualitative research methods such as an organised and structured one-on-one interview, where building data is limited to the sole participant being interviewed.

While it is also acknowledged that is it small, that organising the group still required effort and awareness of issues pertaining to both participants and the researcher to ensure it could be planned well in a timely manner. These issues included being aware of the GRN's rostered shifts, especially the two GRNs working a rotating roster with their health facility, as well as all four participants' free personal time and commitments. Participant number four was also involved in her children's schooling, sports and personal gym visits. Additionally, the need to be cognisant of the researchers' critical thirteenth month period as a critical exclusion factor, approached rapidly with participants currently in the eleventh month of their graduate year.

Addressing the practical disadvantages of focus groups is important to ensure the collection of data is successful. The list of disadvantages identified in Table 4.1 determined that issues were caused by geographical location, the logistics of organising a small group, communication rapport and remaining research focus were vital to the success of this method. Explicit measures were planned prior to recruitment. Recruitment was targeted at the local regional city area to address geographical distance as a potential barrier to focus group success. While the logistics of organising a small group to meet at the same time was managed by obtaining the participants' emails, phone numbers and employment rosters to facilitate timely and effective communication in selecting a day and time suitable to all GRNs.

Implementing a small focus group was selected as the preferred Phase 1 research method as it facilitated the exploration of the GRNs' first year experience managing work, study and their personal lives to gather meaningful, thick and rich data to answer this study's research question (as well as to easily fit in with the GRN's work and private lives).

Part of ensuring quality research outcomes, meant being aware of and upholding trustworthiness standards. This is presented next.

4.7.4 Trustworthiness and reflexivity

Implementing quality and trustworthiness standards to guide qualitative research ensures the research is dependable (Anderson, 2010). Therefore, for the qualitative phase of this research, Phase 1, four criteria as promoted by Guba (1981) were adopted. These are credibility, transferability, dependability and confirmability. Additionally, member checking and reflexivity also need to be made explicit in the research design. These standards are detailed below in their application to Phase 1.

4.7.4.1 Credibility

Credibility is about how consistent the study's findings are with what occurred. To promote this consistency, several features were implemented, including being transparent with the details of the research process and implementation. These features include:

- Research question presented clearly in Section 3.7 and authenticated in Section 4.4.2.3.
- Research design appropriate for the research question (see Chapter 4)
- Sampling strategies appropriate for Phase 1 focus group and applied (see Section 4.7.4)
- Data collected and managed systematically (see Section 4.7.8)
- Data analysed fittingly (see Section 4.8.1) (Russell, Gregory, Ploeg, DiCenso, & Guyatt, 2005).

In addition, to build a therapeutic relationship and to establish rapport between the researcher and the focus group participants, the researcher adopted a 'concern and care' approach towards them to ensure a relationship developed built on respect and trust. This approach facilitated an open conversation where the participants felt safe to share and not be judged. Thus, this approach was a strategy that promoted data credibility or 'truth value' (Baxter & Jack, 2008). For example, the researcher visited the participants in their work place to explain the study and emailed them at regular intervals leading up to the focus group to obtain and share information. This regular communication promoted a collegial and supportive relationship (Dempsey, 2014) and by design fostered an open, safe platform for participants (Krefting, 1991).

Additionally, Phase 1 participants were also informed of their right to withdraw from the study as well as withdraw their evidence, at any time without disclosing a reason.

4.7.4.2 Transferability

Transferability is the second criteria in promoting trustworthiness and is where the reader is invited to make connections with the results identified and their own experience. For readers to effectively make connections, knowledge of context is required, therefore the context has been provided by this study and is described in Section 1.5. Providing the research context enables readers to accurately determine whether the research assertions are similar or dis-similar from their own experiences (Graue & Sherfinski, 2011). It is important to note that the results for this study relate to this study sample alone and are not generalisable to the GRN general population at large.

4.7.4.3 Dependability

Dependability is the third criteria in promoting trustworthiness. Dependability is understood to mean that similar results would be attained if the study was repeated in the same context with the same methods and the same participants (Shenton, 2004). To assist in promoting the criteria dependability, a detailed explanation of the research design has been provided in Section 4.3 and 4.4, as well as the implementation in Section 4.5. Data collection details are provided in Section 4.7, reflexivity is described in Section 4.7.4.6, and the data analysis is described in Section 4.8.1.

4.7.4.4 Confirmability

Confirmability is the fourth criteria in promoting trustworthiness. Confirmability is where the details of the steps the research study has undertaken is publicised to ensure the findings are indeed the result of the experiences of the participants and not the researcher's preferences and or characteristics (Shenton, 2004). The main components of confirmability the researcher adopted for this study included positionality, that is, the researcher being an instrument and reflexivity as previously discussed in Section 1.4. Reflexivity is expanded further in Section 4.7.4.6.

4.7.4.5 Member-checking

Member-checking is when members check and confirm the transcribed data is correct (authentic). Such practice in qualitative research fosters the credibility

and rigour of the raw data (Foley & Valenzuela, 2005). Member checking of Phase 1 data was attended to immediately post interview, while the analysis was attended to immediately following the analysis and in the design of Phase 2 scenarios and statements (Creswell, 2011). Adopting this practice would ensure participants had an opportunity to correct any information and or withdraw any information they were uncomfortable with or had made them feel vulnerable. Including the participants as active members in the Phase 2 survey scenario designs ensured the scenarios were authentic and able to be understood by the intended GRN audience. Additionally, participants were informed that, aside from this member checking process, the researcher reserved the position to write understandings about their experience. However, the researcher wanted them to know that they would not write anything they wouldn't be prepared to say to them in person (de Laine, 2000; Seidman, 2013).

4.7.4.6 Reflexivity

Implementing the practice of reflexivity promotes the integrity of this research study. Reflexivity as a theory informs research practice. Within reflexivity theory is a number of typologies. Seminal literature by Wilkinson (1988), describes three types of reflexivity that interconnect with one another and these are personal, professional and disciplinary. *Personal* consists of acknowledging the individual researcher's motivation, knowledge, preferences and choice of phenomenon to be investigated. *Professional* consists of acknowledging the preferred research practice approaches for the profession, including the discourse and how the participants are viewed. Discipline consists of acknowledging the researchers preferred position towards philosophy and theory. Another reflexivity typology involves five types. These types are personal, intersubjective reflection, mutual collaboration, social critique and ironic deconstruction (Finlay, 2002). However, the reflexivity typology practice adopted for this research study are the three interconnecting typologies offered by Wilkinson (1988) as this typology resonated with this research design due to being a natural fit.

Applied to this research study, reflexivity practice advocated by Wilkinson (1988) is evident at all three levels. At the *personal level* (see Section 1.4), the researcher's personal motivation for this research was revealed. At the *professional level* (see Section 2), the researcher's personal paradigm of how they viewed and made meaning from the world was revealed. The *discipline level*, the nursing discipline

preferring sole enquiries, either qualitative or quantitative over mixed methods research (Doyle, Brady, & Byrne, 2009). Additionally, enhancing the reflexivity practice applied to this research, a journal was initiated by the researcher at critical stages of the research process when important decisions were made (Finlay & Gough, 2003; Gough & Madill, 2012). An example of this was the time when the overarching paradigm for this research study, post-positivism and two oscillating ontologies (social construct*ionism* – interpretivism and positivism were determined as being needed to answer this study's research question. Other critical stages journaling was used was during the analysis process to address and manage the researcher's personal bias (Creswell, 2010). The journaling associated with this involved the researcher acknowledging their reactions/emotions and triggers in response to reading the raw data and how it related to their experiences (Auerbach & Silverstein, 2003, p. 29). Thus, implementing the three types of reflexivity typologies personal, professional and disciplinary to this research study procedure, promoted the integrity of this research study.

4.7.5 Phase 1 context

The context for Phase 1 – focus group was a regional city in Queensland, Australia. The rationale for selecting a regional setting for recruitment for Phase 1 of this study was based on current research identifying that the GRN experience in rural/regional settings was limited, together with the knowledge that Registered Nurses (RNs) in Australia are sourced primarily from newly graduated nurses (Ostini & Bonner, 2012). Understanding GRN experiences working, studying and living in a regional city was important when tailoring education and support to aid in improving their experience and retention within the nursing profession (Bell et al., 2007; Lea & Cruickshank, 2005; Mills et al., 2010). Additionally, selecting a regional setting was also based on convenience, as the researcher worked and lived in this region. Convenience is viewed as an acceptable decision, as concurred by Creswell (2011). Importantly though, it was recognised from literature searches, that GRN's contemporary experience in Australian regional cities was relatively unknown and would benefit from exploration.

4.7.6 Recruitment of focus group participants

Recruiting GRNs for Phase 1 focus group included identifying several local health facilities most likely to employ GRNs. The health facilities approached included the public hospital, three private hospitals and six aged care facilities. Recruitment began by contacting the approved facility's Director of Nursing (DON) and/or nurse educator and obtaining permission to visit the GRNs to promote the study's research aims. From these health facilities, only two of the three private hospitals employed six GRNs each as part of their organisations GRN transition program. From the six aged care facilities approached, only one employed two GRNs. Permissions were only obtained from the public hospital, one private hospital and one private aged care facility. The latter two health organisations were finally selected because they had employed GRNs in 2013 due to vacancies whereas the public hospital had not employed any GRNs due to the absence of vacancies. GRN employment is well known to be related to job vacancies (Beyea, Von Reyn, & Slattery; Halfer, 2007) and/or government policy. At the time this study was conducted, November 2013, the Queensland and national government had implemented a fiscally constrained economic policy, with vacant GRN nursing positions being cancelled (Nurseuncut Conversations Start, 2013). Six GRNs from the one private hospital and two GRNs from the aged care facility were then targeted for recruitment.

Recruitment of GRNs began November 2013 with a face-to-face promotion of the study. During this promotion, ethics considerations as detailed in Appendix B were upheld. This included ensuring each GRN was supplied with participant information and consent forms. Information highlighted during this time included that participating in the study was voluntary and de-identification guaranteed. Adverse risks to participants were highlighted as low and information about withdrawing was provided. To complement this promotional visit, each GRN was given a flyer and postcard brochure about the research to act as a reminder of the visit and to encourage the GRNs to read about the research aims after the presentation had finished as well as who to contact if they decided they would like to participate.

Additionally, to promote recruitment numbers for this study, benefits for participating in the research study were highlighted. This included identifying the benefits focused on long term benefits for GRNs, rather than short term benefits. For

example, a goal of the study is to determine support for future GRNs in learning how to manage work, study and personal life in their first year to assist them in achieving life balance and wellbeing. Other benefits highlighted including assisting nursing work force planners with up to date information on the GRN experience and support requirements to contribute to improved GRN retention rates. From these promotional activities, a total of four GRNs were recruited.

4.7.7 Selection of focus group participants

The four GRNs recruited were selected by use of convenience sampling. During these recruitment promotions attempts to attract diversity of participants, such as age, gender, ethnicity, and employment within or not within a GRN transition program were made to assist in obtaining a more representative GRN sample. Due to time imperatives as dictated by this study's research timeline as detailed in Appendix C, as well as the GRNs available for recruitment and selection being in their eleventh month – November 2013, selection was made on convenience. Therefore, the first four GRN participants who volunteered were selected. The selection process was inclusive and did not act to exclude any cross section of the GRN population.

4.7.8 Focus group participants

Four Caucasian female participants in their eleventh month of nursing practice experience post graduating and on the cusp of entering 12 months of nursing experience were recruited for Phase 1 in November 2013. As formerly mentioned, this time in experience was critical to capture GRNs reflections about their experiences and provide data rich in detail about their first year after graduating. Having four GRNs with these qualities for the focus group upholds the rigor of this research study method (Liamputtong & Serry, 2013) and is an adequate number to conduct a focus group discussion (Creswell, 2011). Further demographic characteristics of Phase 1 participants is presented in Section 5.2.1 and detailed further in Appendix E, Table E.1) as these characteristics have shown to be significant in relating to their experience managing work, study and personal life.

The response rate from the private hospital employing 6 GRNs within a GRN transition program was two, with a response rate of 33%. Whereas the aged care facility employing only two GRNs as Registered Nurses (RNs) and not within a GRN

transition program, had a response rate of 100%. Together this totalled 4 GRNs who volunteered and consented to participate in the 2-hour focussed group discussion.

4.7.8.1 Conducting the focus group

Conducting the focus group discussion adhered to the instrument Interview/resource management plan, ethical requirements and the research study's topic, 'Keeping the balls in the air: How graduate nurses manage work, study and personal life'. The discussion duration was a total of 120 minutes.

Prior to beginning the discussion and to facilitate social constructionism-interpretivism between members in the group, rapport was established in the following four ways.

1. Implementing an icebreaker that consisted of a welcoming smile, introductions and handshake, speaking about the weather and finding the venue and car park.
2. Personal introductions were continued as each participant arrived with a warm welcoming smile and a thank you for coming.
3. Small talk extended to include the catering offered and to recent events prior to the session, such as the trade man drilling minutes prior to the live, recorded session.
4. Sharing with all participants why the method for data collection, the focus group chosen, was to facilitate an understanding of expected behaviours in the group. This process was also used to gauge participant's body language and to implement further strategies of building rapport if negative signs were detected.

Formalities were also addressed, this included reading the plain language statement and consent forms and answering any queries. Participants were also advised that the discussion would be recorded and how the management of the audio file would be enacted to meet ethical requirements. Queries were answered and participants were asked to voluntarily sign the consent form if they wanted to stay and participate in the study. The plain language statement detailed the aims of the study and information regarding that participation was voluntary and they could withdraw from the study at any time up until the data was de-identified, as after this time it would be impossible to determine their inputs. The consent form detailed that the participants agreed that

the plain language statement had been read and explained to them, the purpose of the research, that they were aged 18 and over and their identity would not be revealed in any publications.

As part of the qualitative focus group method, participants were invited to raise a topic they felt was relevant to additionally frame the discussion 'Keeping the balls in the air: How graduate nurses manage work, study and personal life.' Inviting the GRN participants to raise a topic of their choice demonstrated to them that the researcher was open to the issues they felt were important to their first-year experience, providing them with a voice, which underpins the qualitative research (Anderson, 2010). The topic they chose and agreed upon was, "Did university prepare us?"

Participants were also informed about the focus group process and implementation to ensure assent to the overall focus group goal. This included information that the session would be digitally recorded using an iPhone 4 and that manual notes would be taken simultaneously by the principal researcher and the research assistant. Participants were also informed that the research would be following a pre-planned Interview/Resource Management Plan to guide the discussion (see Appendix D) and ensure the discussion stayed focused on the research concern and stayed within the 2-hour duration. It was also explained that if the researcher felt the time frame was at risk, the researcher would interrupt the conversation to facilitate the movement to the next research concern. Explaining the data collection process as a transparent process facilitated benefits, such as obtaining group consensus early to the group's overall goal and avoiding any confusion about the direction in which the group was headed within the set time frame to achieve the Phase 1 research study aim.

The focus group discussion began once these considerations were completed. The following statement was used by the researcher to open the discussion:

> "Let's talk about your experiences in your first year as a Graduate Registered Nurse. So just feel free just to chat amongst yourselves, tell each other how your year has been. What has your first year working as a Registered Nurse been like?"

The following questions were raised during the discussion to facilitate movement to the other Phase 1 research concerns:

Work Stress

"Can I just ask you then? So, you're saying that you do get stressed, so what do you do then to balance that out or to take care of yourself?"

Study

"In relation to study, what was that experience like?"

"Does the study actually help in your practice, do you think?"

Life balance

"Okay, so just lastly I just want to just ask you about life balance. Life balance and health and wellbeing in relation to yourself."

Focus group participant's topic

"Brooke's very short question that she thought we could talk about, "*Did university prepare us for working as a nurse?*"

At the end of the discussion, participants were invited to check the notes taken by both researchers for accuracy and given an opportunity to correct any misinformation. Member checking promotes the trustworthiness of qualitative data (Teddlie & Tashakkori, 2003). This process also allowed the GRNs another opportunity to add further information related to the topic under discussion, remove information and or correct information.

Prior to closing the discussion, all members of the research group were then asked whether they felt all had been said that they wanted to say and their experiences they wanted to share had reached saturation point. A decision by all members was made that this had been achieved.

4.7.8.2 Phase 1 focus group timeline

The time line for this research study is important as it provides the contextual understanding relating to the period of time this study was conducted 2013 – 2015 and is detailed in Appendix C. The following details the timeline imperative due to the period context.

Phase 1 was conducted in November 2013 to capture the GRN's 'lived experience'. This time period was important for two main reasons. *Firstly,* in selecting GRNs close to completing their 12 months of their graduate year experience. As this

qualitative phase was exploratory in nature, GRNs with this level of experience in months and currency of experiences would encourage GRNs easy recall for their reflections and the rich, deep, thick descriptive data to emerge. Obtaining GRNs' subjective experiences and their shared interpretations reflect the essence of qualitative research aims and the ontology social constructionism - interpretivism (Liamputtong, 2010). Thus, capturing the GRN's 'lived experience' was critical.

Secondly the time line provides the contextual background information in relation to the time period the research was conducted. The year 2013 is important to note as the current state government had implemented a fiscally economic policy which limited the availability of GRN positions within public hospitals. This impact was experienced by the local regional city public hospital, where the research was conducted, with fewer GRN positions being made in 2013.

4.7.8.3 Focus group instrument

Focus group instruments act to ensure the method is conducted appropriately and in an orderly, professional manner. Thus, applied to this study, the focus group discussion followed a pre-planned Interview/Resource Management Plan (see Appendix D), to collect the data. Providing this resource management plan to guide the focus group discussion was important in this study to promote transparency that the focus group was conducted properly and thus promote the overall trustworthiness (Guba, 1981) of Phase 1 data collection process. Thus, the focus group instrument supports the focus group data emerged as an outcome of a properly conducted and managed focus group.

4.7.9 Phase 2: Survey

Surveys by design have a specific purpose in collecting numerical data to explain a quantitative research enquiry. Phase 2 of this study chose surveys as it was aligned to the ontology – positivism. This paradigm accepts that reality is controlled by fixed rational laws and that the nature of truth is singular, independent of the observer and is objective and value free (Atweh, 2009; Creswell, 2011, Crotty, 1998). This ontology was selected to guide the second sequence in the exploratory mixed method design.

4.7.9.1 Instrument development

This section describes the survey instrument development for this research study. Prior to developing a survey instrument pertinent to this study, a search for existing instruments related to life balance domains of work, study and personal life, including self-care was conducted. This search included looking for instruments specifically designed for nurses. Several instruments were found relating to work/life balance, but none focused specifically on nurses and or the graduate nurse entering their nuanced workplace context and nature of work, and their requirements to manage continuing professional development, personal life. Equally, instruments were vague about their objectives. The instrument in this research study needed to measure the Load Triad impacts on GRN life balance and attrition intent and identify areas of lack of preparedness, behavioural indicators of preparedness, and preventative education and supports promoting GRN life balance and retention. Many instruments focused on various life roles and the energy and time devoted to these roles (Super, 1980). Specifically, the life role, self-care, was not clearly evident in Super's (1980) Life Career Rainbow instrument. Bryne's (2005) Wheel of Life instrument evaluated several areas of life, with options to include more areas, but like Super's instrument, it did not offer behavioural indicators to demonstrate effective functioning in each of these roles/areas. These instruments also did not offer behavioural indicators that demonstrated effective life role function indicators and life balance and wellbeing indicators and / or nuanced indicators based on authentic work and life contexts such as nursing.

Consequently, due to the insufficiency of existing instruments appropriate for the target topic and audience (GRNs) and difficulties adapting these instruments, a new survey instrument needed to be developed. The new survey instrument would be designed to specifically align with the study's objectives and be informed by the theories and philosophies presented in Chapter 2. The instrument was also designed to facilitate the mixed method exploratory design (Phase 1 findings –themes and subthemes informing Phase 2 survey). Thus, the following content variables were determined to be essential in the new survey instrument:

1. Life balance preparedness

   (work, study and personal friendship role salience; management of competing life roles; levels of worry to manage competing life roles).

2. Work preparedness

   (principles of care; level of worry about harming a patient; seeking advice; seeking further advice if needed; referring to work resources).

3. Study preparedness

   (topics match learning needs; learning needs tailored to work learning needs; learning tailored to personal life/life balance; how to learn; resources)

4. Personal self-care preparedness

   (level of happiness; nutrition self-care; seeking support from a friend; seeking support from a Doctor; implementing self-determined self-care strategies)

5. Personal wellbeing preparedness – work stress combined with feeling low

   (intention to call in sick; intention to find another nursing job; intention to find a different job; intention not to share feelings; intention to seek support from Doctor; intention to seek support from online support group; self-determined self-care support implemented).

6. Work support culture – alignment to the Code of Ethics for Nurses in Australia, value statement 2: Nurses value respect and kindness for self and others

   (peers being unkind; peers being kind; support to learn positively; timely support; preparedness support; work support extended to include broader life support).

7. Thoughts on university and nursing graduate year education

   (undergraduate work knowledge and skills preparedness; self-determined preparedness related to personal self-care, learning preparedness, preparedness to manage multiple life roles, lifelong learning preparedness to manage new situations arising related to work, study and personal life).

To establish these variables within GRNs' work and life contexts, they were presented in the survey instrument as 5 authentic scenarios portraying *preparedness* topics on life balance, work, personal life, study and support (see Appendix G for the survey instrument). A number of related 5-point Likert scale statements were presented with each scenario. The GRN participant would use the Likert scale to assess the strength of their belief in these areas. Additionally, variables were also presented to measure GRNs' beliefs about their university nursing education and graduate year education, with a focus on their broader work, study and personal life preparedness.

4.7.9.2 Instrument validation

Survey instrument validation is important to establish that the instrument has been well constructed. Three forms of validity in survey instruments are content, construct and criterion-related (Christensen, 2015). In this study's survey instrument, the *content validity* concerns were the variables as detailed in Section 4.7.9.1, the *construct* concerns were the scenarios and associated statements and the *criterion-related* validity concerns were the 5-point Likert scales.

4.7.9.3 Part 1: Pilot testing

Pilot testing the Survey titled: *Keeping the balls in the air: How graduate nurses manage work, study and personal life'* was important to determine the survey instrument's validity. That is the survey instrument's ability to measure what it has been designed to measure (Evergreen, Gullickson, Mann, & Welch, 2011). In this case, to confirm and validate the variables (factors) and the degree (measured in a 5-point Likert scale) these variables (factors) impacted the GRN overall life balance. To facilitate this validation of the survey instrument, key nursing stakeholders such as nursing academics and GRNs familiar with this study's research aims, objectives and context would need to be solicited to evaluate the survey instrument. These nursing stakeholders role in evaluating the survey instrument would include several areas: 1. assessing the scenarios and associated statements for the predetermined variables (factors); 2. the ability of the instrument to measure the degree (measured in a 5-point Likert scale) these variables (factors) impacted the GRN's overall life balance; 3. suitability for the target respondents – GRNs; 4. technical problems; 5. areas that require refinement and 6. providing feedback on the survey instruments validity. The qualified nursing stakeholders included the 4 GRNs from the Phase 1 focus group and

3 critical nursing academic colleagues who were asked to test the survey instrument as their qualifications and experience combined, would ensure rigor of this process.

The pilot survey instrument evaluator's (testers) provided feedback on the survey instrument's validity in the areas of content, construct and criterion-related the variables and their measurement. Their feedback identified two problems relating to the three areas of validity in one of the survey scenarios and associated statements. This particular scenario and associated statements identified were rectified with the assistance of the GRNs and the three critical nursing academic colleagues. Additionally, one technical problem was also identified with the survey instrument in its inability of the survey to move backward once a forward click had occurred and this was rectified. Thus, this pilot test and refinement of the survey established this research study's instrument's validity to measure the *Load Triad* variables (factors) and the degree these variables impacted GRN's life balance.

4.7.9.4 Part 2: Survey implementation

Part 2 implemented the survey instrument with the primary purpose to determine the generalisability of Phase 1 qualitative findings with a larger sample. The survey instrument was implemented as an online survey, with an expected duration time to complete being a total of 10 minutes. The online survey opened with general information to participants about the research study aims. Further information followed, providing participants about participant risk, that risk being low and details about ethics approval and points of contact regarding concerns about the conduct of the study. Information about the consent process was also provided and explained, being that consent would be taken as tacit when the survey button was clicked to begin.

The survey instrument comprised of three main sections and is available for viewing in Appendix G.

The first section involved six authentic scenarios based on topics life balance, work, study, personal, personal wellbeing and support.

The second section involved GRNs' reflecting on their university education and nursing graduate year education.

The third section involved GRNs' demographics.

Survey items for each section includes numerical and string values, with survey items in sections two and three being based on a 5-point Likert Scale with data

reflecting these numerical ratings. Depending on the context in these sections, the language of the 5-point Likert scale changed to reflect this, with the two contexts and their values being either:

5 = Strongly Disagree, 4 = Disagree, 3 = Somewhat Disagree/Agree, 2 = Agree, 1 = Strongly Agree

5 = No Chance, 4 = Very Little Chance, 2 = Some Chance, 1 = Very Good Chance, 3 = Unsure

4.7.10 Phase 2 context

The context for Phase 2 – survey was Queensland, Australia, between the period November 2014 and June 2015, one year after Phase 1 data was completed. The rationale for being inclusive to Queensland wide was to capture as many GRNs working across a variety of geographical and clinical settings. The survey was initially planned to be open for six months, however this timeframe was extended due to not only capturing GRNs close to completing their 12 months in the year 2014, but also to secure GRNs in their first 6 months in the year 2015. Contextually, the background information had not changed from Phase 1, 2013, with the government continuing to implement a fiscal economic policy limiting available GRN places in public hospitals.

4.7.11 Recruitment of survey participants

Recruitment of GRNs for Phase 2 began by identifying organisations most likely to support this study and give their approval. It was identified that the Queensland Nurses Union [QNU] with a large membership and interest in nurses' wellbeing would be an appropriate choice in seeking support and approval. A formal email was sent to QNU and written approval was obtained. Ethic approval was then obtained for Phase 2 survey (H13REA200). Once ethics was approved, QNU released a news announcement with the live survey link in their November 2014 online newsletter. This news announcement was repeated in February 2015. Further sharing of this article with the embedded survey to GRNs was disseminated by social media and a regional university's nursing alumni email. During this promotion and recruitment, ethics was upheld (See Appendix B).

Participant information was supplied via the live survey link with consent being explained as being tacit once participants had clicked the start button. Information was included stating that participation was voluntary and de-identification guaranteed, as the survey was anonymous. Adverse risks to participants was determined as low. Information about withdrawal was provided with an explanation that if participants withdrew after they had provided information their information could not be deleted as it was de-identified. Additionally, to promote recruitment numbers for this study, the benefits of participating were highlighted and included long term benefits for GRNs, rather than short term benefits in the form of targeted education and support.

4.7.12 Selection of survey participants

GRNs recruited to complete the survey were selected by use of convenience sampling. This involved selecting the first 71 GRNs living across rural, regional and metropolitan areas within Queensland, Australia having consented and completed the survey during the period November 2014 to the end of June 2015. This number of GRNs recruited is low but expected due to the influences of the economic approach promulgated by the Queensland state. This number of 71, reflects the recruitment period of 6 months. Capping the recruitment period to 6 months, ensured the research progressed in a timely manner, as proposed in the timeline (see Appendix C).

4.7.13 Survey participants

The 71 participants recruited for Phase 2 were from Queensland and included Queensland cities, inner and outer regional areas and several remote locations. These 71 GRNs had 12 months, or less, of experience. Additionally, they were situated in various clinical settings and these settings. All GRNs were employed within a health facility, with 44 specifically employed within a GRN transition program, 26 not employed within a graduate program and one GRN who had experienced both. In total respondents consisted of 65 females and 6 males.

It is acknowledged that having a small representation of males in this Phase 2 of the study is important in identifying if their experience was similar or different to the females in the sample. There is very little literature on GRN males' experiences.

Empirical research on the male GRN experience managing work, study/CPD with personal life and its impact on their personal wellbeing and life balance is very limited and could be a focus area for further research to aid in both male GRN recruitment, support and retention. It is also important to note that the age of respondents was not measured in Phase 2 and is an identified limitation of this study, as age could be an important factor in this study's focus and is an area that would benefit from research. Overall, the 71 survey participants reflect a diverse group, geographically, clinical settings, experience levels within the 12 months and within GRN transition programs.

4.7.14 Structure for presenting Phase 1 and Phase 2 method results

Presenting the results from this mixed method design approach has required a flexible approach as it is not always a straightforward process due to several factors. Wesley (2013, p. 1) identified three main factors. Factor 1 is the amount of data generated requires careful reduction to ensure a viable and comprehensive report can occur. Factor 2 is that different reporting styles are required for qualitative and quantitative methods and thus a balance between the two needs to occur in the report. Factor 3 is that findings from the two methods may not come together in a clear way.

Overcoming the challenge of presenting mixed methods is to present the results to reflect the main types of mixed method research design approach used. As such, Wesley (2013) promoted three main ways of presenting mixed methods results to reflect the main types of mixed method research design approaches and to overcome the barriers to presenting mixed method results. These are non-integrated data description and illustration, phase wise data description and illustration and data description and illustration based on cases, themes, or research. Applied to this study, the best approach was determined to be phase wise data description and illustration. This structure by Wesley (2013, p. 4) is presented as three overarching layers and has been adapted to this study's research design.

These three layers are:

Layer 1: Phase 1 presentation of findings

Layer 2: Phase 1 connection to Phase 2

Layer 3: Phase 2 presentation of findings in relation to generalising Phase 1 findings.

This three-layered approach to presenting the results aligns to this study's mixed methods exploratory design and how the results from Phase 1 and 2 will be presented. An important aspect underpinning this results presentation is Layer 2. Layer 2 demonstrates how Phase 2 results were built from its connection to Phase 1 results. Each layer will be presented separately in Chapter 5.

4.8 DATA ANALYSIS

This section presents the details on how this research study's data was analysed to answer this studies research question and help to achieve the research aims. The process used to analyse Phase 1 focus group data is presented first followed by the procedure to analyse Phase 2 survey data.

4.8.1 Phase 1 data analysis methods

Data from Phase 1 focus group consisted of textual transcriptions of the discussions. This qualitative study used thematic analysis to analyse the focus group transcript to identify the factors impacting the GRN in their first year. Thematic analysis is a method that has been described by Braun and Clarke (2006, p. 79) as a process that involves "identifying, analysing and reporting patterns (themes) within the data." Boyatzis (1998) extends this definition to add it is a process that also interprets these themes. This involves reading between the lines, regarding the various aspects of the research. This aspect is particularly important to show as it allows alignment (the golden thread) between the epistemological and ontological positions taken in the research design to the analysis of the data. As thematic analysis is a flexible process this clear relationship to a firm theoretical or epistemological position is not always required or taken by researchers, but an option and can be independent of this relationship (Braun & Clarke, 2006). This research design however took the former approach that has a firm theoretical and epistemological and ontological position (see Chapters 2 and Section 4.6.4) that framed the thematic analysis of this data.

Thematic analysis is commonly known for its inductive reasoning process (Teddlie & Tashakkori, 2003). This process typically involves moving from the specific, such as the raw text to identifying relevant text, repeating ideas and patterns. It may also move to a broader theory (Auerbach & Silverstein, 2003). Applied to this study, the thematic analysis process of Phase 1 focus group transcript began by

transcribing the digital audio files. This process was attended by an external transcription company. To ensure the accuracy of the transcript prior to analysis, the transcript was checked against the audio file and manual notes taken by the principal researcher and research assistant, for accuracy and any errors were amended.

The inductive thematic analysis used NVivo initially to analyse the raw data. These initial broad themes from this process included:

- Experience and confidence
- Life balance, health and wellbeing
- Self-care
- Stressors
- Study
- Work relationships
- Working patterns

This inductive thematic analysis using NVivo to analyse the raw data from the initial broad themes, then moved to a manual process and compartmentalised the data set under each of the research topics; Work, Study, Personal Life and Life Balance. The next steps involved six key phases as promoted by Braun and Clarke (2006). 1. Reading and rereading the data to become acquainted with the data. This also involved constantly comparing participants' transcripts (Braun & Clarke, 2006; Glaser, 1965); 2. Creating further codes; 3. Searching for themes; 4. Reviewing and refining themes; 5. Defining and naming themes and 6. Presenting these themes as a descriptive analysis. Specifically, features of interest were coded that related to lifelong learning; heutagogy, preparedness, under preparedness and preparedness, as well as to the broader demographic characteristics of each participant. Parallel to this process was the process of reflexivity to raise trustworthiness of the analysis process by using a reflexivity journal to address and manage the researcher's personal bias (Creswell, 2009). This journaling involved acknowledging the researcher's own reactions/emotions and triggers in response to reading the raw data and how it related to the researcher's experiences (Auerbach & Silverstein, 2003). From the inductive analysis of the focus group data several themes and subthemes were created over a period of time. These themes are listed in Table 4.2.

Table 4.2

Themes and Sub-Themes Developed from Focus Group Data

Theme	Sub-theme
Theme 1: Under preparedness for the reality of work	Life balance and personal wellbeing
	Take me back to the start: Fundamental & specialty nursing knowledge and related skills
	Managing competing roles
	Self-care
Theme 2: Work satisfaction	Raising GRN resilience at work
Theme 3: Work role salience under preparedness	Personal wellbeing decline
Theme 4: Support	Little spider web of support
	A broader approach
Theme 5: Broader Demographics	Life experience levels

The strength of these themes and subthemes was determined by identifying these themes in each of the participant's transcripts (Glaser, 1965). Additional to this process a collective interpretation of the data (Liamputtong, 2009) was conducted to assist the development of an overarching theme to encapsulate all these themes and subthemes. For example, an initial code: 'Work role importance' was more broadly developed into 'Work role salience' and then was further developed into an overarching theme to encapsulate all themes, 'Life role salience under preparedness.'

4.8.2 Phase 2 data analysis methods

In the Phase 2 survey sample, nominal data was analysed using the IBM Statistical Package for Social Sciences (SPSS) 22. Due to the small sample size the analysis was limited to descriptive statistics to identify trends. This included initially filtering the data to ensure the sample consisted only of GRNs in their first year and living in Queensland. The first step was to produce frequency tables of each variable

to assess the level of variability of responses to the original survey items. Items that showed limited variability in responses were collapsed to form binary variables and required recoding of the original data to reflect this change. As part of the descriptive statistical analysis, bivariate analysis was conducted in the form of cross tabulations between all pairs of variables. As part of this cross tabulation analysis, GRN data both within and outside GRN transition programs were measured against all variables, with subtle trends being observed. Descriptive statistical results comparing GRNs within and outside transition programs were presented.

String variables for each of the survey items were analysed separately using thematic analysis. To do this, the process involved removing the string variable data from the quantitative data set in order to manually conduct a thematic analysis of the string data, using the process by Braun and Clarke (2006), (see Phase 1 analysis). Initial broad themes that emerged from this process were:

- Awareness of own preparedness levels
- Confidence and agency – self determined learning ability
- Competing life roles
- Culture
- Judgement about the effectiveness of university modes of learning
- Individual value system
- Organisation structure and value system
- Support
- Work role salience

Each of these themes were colour coded. Continued refinement of themes continued in parallel to the implementation of a reflexive journaling that tracked the researcher's thought process during theme refinement, including the documentation of a reactions/emotions and triggers in response to reading the raw data (Auerbach & Silverstein, 2003). Over a period of time, the inductive analysis of the Phase 2 string data was refined to generate two themes and associated subtheme/s. These themes are listed in Table 4.3.

Table 4.3

Themes and Sub-Themes Developed from Phase 2 String Data Thematic Analysis

Theme	Sub-theme
Theme 1: Individual GRN's value system of life roles work/study/personal and life balance.	1. Impact of GRN life role values.
Theme 2: GRN's perception of higher education and health facilities values about their life roles work/study/personal and life balance and the impact of these values on their life roles and life balance.	1. Values and impact of higher education values (as perceived by GRNs) on preparing them (GRNs') for their work, study and personal life roles. 2. Values and impact of health facilities values (as perceived by GRNs) on supporting them (GRNs') for their work, study and personal life roles.

4.9 ETHICS

Ethics has been considered throughout the design and development of this study. Phase 1, the focus group and Phase 2, the survey of this research had ethics approval from university's Ethics Committee: Reference number H13REA200 (see Appendix B).

Phase 2 – survey: The distribution of the online survey was approved by the Queensland Nurses Union by use of their online newsletter (see Appendix H).

4.10 LIMITATIONS OF METHODOLOGY

The limitation for this study is that the research outcomes are relevant for only this research study's context and GRN sample. The research outcomes are not generalisable outside of this study; however, individuals are invited to make their own meaning to their own contexts.

4.11 CHAPTER SUMMARY

The research design of this study aim was to determine specific factors within the GRN *Load Triad* to form preliminary indicators that will identify GRNs at risk of life imbalance. The purpose of this research was to align targeted GRN education and support strategies to indicators identifying GRNs at risk of life imbalance that will provide meaningful and on time support to GRNs and assist GRNs

in their *Load Triad* balance and their retention within the profession. Additionally, the two interconnecting phases of this whole study, Phase 1 and 2 was presented. The research study context was explained, along with the details of the mixed method exploratory design, Phase 1 informing Phase 2. Phase 1 deployed a qualitative approach, focus group, enacted through a social construct*ionism*-interpretivism lens using an approach informed by the life-world-lived experiences and a philosophical stance. Phase 2 deployed a quantitative approach, survey, enacted through a positivism lens.

Data analysis for Phase 1 used thematic analysis and Phase 2 used descriptive statistics. Results for Phase 1 and 2 are presented in the next chapter.

Chapter 5: **Results**

5.1 CHAPTER INTRODUCTION

This chapter presents the findings from a mixed methodology design using mixed methods exploratory design involving two phases. Phase 1, qualitative (less dominant) - focus group. Phase 2, quantitative (dominant) - survey. Phase 1 explored the experiences of 4 Graduate Registered Nurses (GRNs) in their first year, in relation to their work, study and personal life, the *Load Triad* and identified the factors that impacted their *Load Triad* and the relationships between these factors and the impact this had on their overall life balance. The context for Phase 1 involved GRNs employed in health facilities in a regional city, Queensland, Australia. Phase 2 involved GRNs employed in Queensland health facilities from metropolitan, regional and rural areas, Australia. Participants for Phase 1 included 4 GRNs in their 11th month, while for Phase 2 included 71 GRNs in their first 12 months of employment.

Phase 1: a qualitative study involved a small focus group containing 4 GRNs to explore the GRN *Load Triad* experience, framed by the concept, preparedness. Each GRN has a pseudonym in use as part of maintaining their anonymity.

Phase 2: a quantitative, anonymous survey that also contained a section to allow respondents to add comments. The purpose of Phase 2 survey was to generalise the findings from Phase 1 to a larger population. The survey design was informed by Phase 1 results. This research study design was guided by the overarching paradigm post-positivism using a mixed methods exploratory design in order to answer this study's research question:

> What are the factors impacting the graduate registered nurses first year experience to manage work, study and personal life and to what degree do these factors and the possible relationships between them, impact on their overall life balance?

These findings are also presented in response to the initial research concern, the rising global GRN attrition rate discussed in Section 3.2.2 and the life balance, wellbeing and 'concern and care' of GRNs in their first year presented in Section 4.2.

Chapter 4 provided the research design guiding this study to improve the understanding surrounding the GRN first year *Load Triad* experience. The overarching paradigm chosen was post-positivism where evidence is viewed as not being restricted to what can be physically observed (objectivist epistemology) and accepts the nature of reality is interpretive (Annells, 1996; Crossan, 2003). To accommodate this view, this study linked this view about the post-positivism enquiry downwards, towards the ontological levels of enquiry. At this level, two *oscillating ontologies* enquiries were raised by this study in the following order: social construct*ionism*–interpretivism and positivism. This enquiry approach supports the movement of the ontological lens as required during the research process, to ensure the best fit of research enquiry and that associated 'proper procedures' are applied, as the context of the research changed. Importantly, though, the overarching paradigm remains guiding the enquiry approach and was respected throughout the research procedures. Consequently, Chapter 5 results, will include the application of this approach for Phases 1 and 2.

The *oscillating ontologies* guided by post-positivism paradigm applied to Phase 1 – qualitative results, the nature of reality views the nature if reality as encompassing multiple realities that are individually and socially constructed. Consequently Phase 1 results will constitute a construction of reality and demonstrate social construct*ionism*-interpretivism's ways of working, following procedures that produce social constructionist-interpretivist knowledge. Additionally, as the post-positivist ontology (the nature of reality) is critical realist (Annells, 1996), statements will also be made that reflect the post-positivist researcher: "*What does this knowledge mean*?" Phase 2 – survey quantitative data results will be viewed as controlled by fixed rational laws based on cause and effect. The results demonstrate positivism's ways of working, following strict laws and procedures that produce objective knowledge. Thus Phase 2 results will include descriptive results presented in tables, with objective statements that are reflective of a positivist researcher. However, as the overarching paradigm is post-positivism with the nature of reality being viewed as interpretative (Annells, 1996; Crossan, 2003; Henriques et al., 1998) and the epistemology (theory

of knowledge and truth) as objectivist. Statements will also be made that reflect the post-positivist researcher: "*What do these numbers mean?*" Thus, this broader understanding about the philosophical views and their implications for how results are presented will enable the research outcomes to be received with confidence and satisfaction.

The results for this study are now presented as Phase wise data description and illustration and are presented as three layers. Layer 1 presents Phase 1 focus group qualitative results. Layer 2 presents the 'building process' phase that connects Phase 1 qualitative results to the design of Phase 2 quantitative, survey (as previously detailed in Section 4.7.1). Layer 3 presents Phase 2 survey quantitative and qualitative results. It is important to note that the results for this study relate to this study sample alone and are not generalisable to the GRN general population at large. However, readers are invited to apply connections between the results identified in this study to their own experience.

5.2 LAYER 1: PHASE 1 FOCUS GROUP PRESENTATION OF RESULTS

Layer 1 presents Phase 1 focus group qualitative results for the following specific research concern areas: Demographics; *Load Triad* factors (work, study and personal); Life Balance Impact; and GRN Preparedness.

5.2.1 Demographics

Phase 1 presents the GRN focus group demographic data as these characteristics are important when implementing a student-centred learning design. Student-centred learning based on students' demographic characteristics is critical in the transition experiences of GRNs (Mulholland, Anionwu, Atkins, Tappern, & Franks, 2008). Thus, demographics has been included in this study with the same premise in mind. Little is known about the general demographics of GRNs and the broader general nursing population aside from age, gender, clinical work context and employment mode status. The specific demographic characteristics chosen for the study include both these, as well as the broader characteristics deemed relevant when thinking about the work, study and personal life mix of a new nurses. Broader characteristics included nursing practice experience (time in months), gender, age, marital status, dependants, geographical location, employment, transition program

enrolment status, mode of employment, work context and previous nursing practice experience. These characteristics are detailed in Table E.1 in Appendix E and are described in the following section. It is important to note however; the demographic inter-relationships will be presented in Sections 5.2.2 to 5.2.3.

5.2.1.1 Nursing practice experience (time in months)

The focus group consisted of 4 GRNs in their eleventh month of their experience. The relevance of this experience in time of months is important as it confirms authenticity and reliability (Liamputtong & Serry 2013), regarding the breadth and depth of the GRNs' reflective experiences, including their considerations about whether university had prepared them for their graduate year.

5.2.1.2 Gender

The 4 GRNs were all female. Males were approached during the recruitment period, but none expressed an interest in participating. Nursing is known worldwide for its female gender predominance (Stanley et al., 2016) and this dominance is reflected in Australia and in the state of Queensland where this study was conducted (NMBA, 2014a). Subsequently, this gender dominance is also reflected in this study sample.

Nurses experiences based on gender may differ. Current literature reveals that female nurses generally experience similar issues to males, with the main similarity being job dissatisfaction attributed from work stress (Brown, 2009). Differences between the genders has noted that females are less likely to experience lack of full time opportunities and negative gender based stereotypes both inside the world of nursing and their private lives compared to male nurses (Brown, 2009; Loughrey, 2008; Meadus, 2000; Twomey & Meadus, 2008;2016; Rajacich et al., 2013; Strong, 2004; Weaver, Ferguson, Wilbourn, & Salamonson, 2013). Therefore, exploring the GRN's first year experience based on gender is warranted.

It is acknowledged having no males represented in Phase 1 focus group is a limitation of this study, as little is known about the male GRN experience and may be different to females. Improving understanding surrounding this gender perspective would be beneficial in recruitment and retention strategies and an area of future qualitative studies to assist GRN transition programs in tailoring curricula and support appropriately.

5.2.1.3 Age, marital status, dependants and community activities

The GRNs' age, marital status, dependents and personal commitments is important in relation to their personal roles and associated responsibilities outside of work. Current literature reveals that the contemporary GRN is often mature in age, life and professional experience and subsequently have multiple role responsibilities, as well as stress from striving to meet these role expectations (Yarbrough, Haas, Northam, Duke, & Wieck, 2016). Role responsibilities, aside from work, include caring for children and parents, being a spouse, being a student and being committed to professional and community activities (Thoits, 1986; Yarbrough et al., 2016, p. 106). Improving this understanding will identify whether these aspects impact the GRN experience by generating a push-pull effects in managing their multiple roles with work, study and personal life. Understanding about these aspects is important to design targeted and tailored support that will help retain GRNs within the nursing profession. The following presents the 4 female GRNs' details:

Dianna is aged 21 years, single, with a boyfriend and no dependents. She lives with a relative who is also a nurse. She has no reported personal commitments.

Brooke is aged 21years, single and has no dependents. Brooke is not currently dating. She lives with her parents. Her Dad works away for lengths of time. She has a cat pet and is part of a community organisation that requires regular training sessions.

Anne is aged 22 years, currently in a defacto relationship and has no dependents. She has no reported personal commitments such as being part of a community group and or formal study.

Tina is aged 41, married with two children aged 13 and 15 years. She is the primary carer of these children due to her husband working away for long periods. She has no personal commitments aside from her children's activities and schooling.[1]

[1] Each GRN has been given a pseudonym to maintain their anonymity.

5.2.1.4 Geographical and employment contexts

The geographical location where the 4 female GRNs, Diana, Brooke, Anne and Tina all live and work is in a regional city within the state of Queensland. Results reveal that living and working in this regional location has impacted their experience in relation to work, study and personal life. This will be discussed in Section 5.2.2.2.

The 4 GRNs are employed as Registered Nurses (RNs). Diana and Brooke are employed by a private hospital as GRNs as part of a temporary 12-month transition program. Anne and Tina are employed by a private aged care facility as permanent RNs. Employment for all GRNs consisted of part-time hours which fell short of full-time hours (0.8hrs).

Employment conditions differed between the two facilities. This was due to how the health facility approached GRN employment. As Diana and Brooke were employed by the private hospital as part of a 12-month contract employed within a GRN transition program, they were required to work a set shift work schedule (morning, afternoon and night shifts), along with a fixed 3 monthly rotation through different work areas, for example through surgical, medical, orthopaedic and palliative care. As Anne and Tina were not employed as a part of a GRN transition program but as permanent part-time RNs, they were supported by the private aged care facility to select a work schedule and clinical context that suited their personal preference. Both Anne and Tina's preference were to work Monday to Thursday day shifts with weekends off. The clinical areas differed for each of them, with Anne choosing to work in high care, while Tina chose to work in low care (the hostel).

This section presented GRN demographics in relation to the focus group, Phase 1. This knowledge has contributed to the limited knowledge on GRN demographics working in regional settings in Queensland, Australia (Lea & Cruichshank, 2014; Ostini & Bonner, 2012).

The next section presents the findings for the second research concern: the factors impacting the GRN's Load Triad and the impact these factors had on their overall life balance.

5.2.2 Impacts on the load triad then onto life roles

This section presents the findings for the second research concern: the factors impacting the GRN's *Load Triad* and their impact GRNs' overall life balance. There are three areas of interest: *Load Triad Impacts*, *Other Impacts* and *University preparation for the work of professional practice*. The *Load Triad* each element of the *Load Triad*: *Work, Study and Personal* as themes which emerged from the data analysis. The themes emerging from the *Work* domain of the *Load Triad* is presented first.

5.2.2.1 Work

Work is the first load of the *Load Triad*. This section presents Phase 1's focus group results of the factors impacting the GRNs as they managed their work. *Work* refers to the GRNs' paid employment. The themes that emerged included: 1. Preparedness for the reality of work 2. Work satisfaction, and 3. Work role salience under preparedness and 4. Support.

To provide a deeper understanding of these four *Work* themes, associated sub themes were also identified and are listed in Table 5.1. Each theme is described and presented next in association with its respective subthemes.

Table 5.1

Phase 1 Focus Group Work Themes and Subthemes

Phase 1 Focus Group Work Themes and subthemes
Load Triad Impacts
Work
Theme W1 Under preparedness for the reality of work
Subtheme W1.1: Life balance and personal wellbeing
Subtheme W1.2: Take me back to the start: Fundamental & specialty nursing knowledge and related skills
Subtheme W1.3: Managing competing roles
Theme W2 Work satisfaction
Subtheme W2.1: Raising GRN resilience at work
Theme W3 Work role salience under preparedness
Subtheme W3.1: Personal wellbeing decline
Theme W4 Support
Subtheme W4.1: Little spider web of support
Subtheme W4.2: A broader approach

Work:

Theme W1: Under preparedness for the reality of work

GRNs' testimonies revealed that they felt that university did not prepare them fully for the reality of work. This lack of preparation covered concerns relating to the employment context and life balance interruptions; feeling under prepared in fundamental and specialty nursing knowledge and skills; heavy workloads whilst managing deteriorating patients; feeling the strain from their nursing care role; and that they felt ill prepared for caring for themselves.

Subtheme W1.1: Life balance and personal-social wellbeing

The *Life balance and personal-social wellbeing* subtheme reveals how the GRNs felt under prepared to manage the reality of work in their first year and the impacts on their life balance and personal-social wellbeing.

The GRNs Brooke and Diana who were employed by a private hospital as part of a 12-month GRN transition program, had to manage a dominantly inflexible approach to work. This consisted of managing three monthly clinical rotations, together with shift work. They testified that a key impact was an immediate interruption to their sense of life balance, in particular their social life. This interruption caused an immediate negative impact to their personal-social wellbeing.

The GRNs, Anne and Tina were employed by a private aged care facility as RNs and were not part of a GRN transition program. Their employer gave them the option of choosing a work context of their choice, high care or low care, along with a choice of days and hours. Both Anne and Tina chose to work day time hours with weekends off. This choice enhanced their personal-social wellbeing and confirms the assertion that supporting employees in the life balance ascent improves an individual's wellbeing and quality life (Hosie & Savastos, 2010, Magee et al., 2012). However, in what works well to support GRN retention is a new observation.

Life balance interruption and subsequent personal-social wellbeing decline for Brooke and Diana was found to stem from their feelings of job insecurity as their transition program employment was for only 12 months. This relationship between job insecurity and personal-social wellbeing decline impacting GRNs is a new observation. While the health facility did make it known that they would be offering RN positions at the completion of the transition program, the GRNs selected would only be announced at the program's completion. With little job certainty, Brooke and Diana were worried about this and decided to prioritise their work over their social life to increase their chances of securing a fulltime position. The interplay between these elements thus contributed to Brooke and Diana choices to sacrifice their personal-social lives, by committing to their work schedule without question and not asking for special requests, like weekends off. Brooke articulates this aspect well.

> *"Ours jobs at the moment aren't very secure. We finish in a month and we have no job. So, its yes, sir, no, sir, three bags full. I'll*

work every weekend unless requested off. It's a sacrifice that I've decided to make."

Diana also noticed her compliance to the employment schedule and its negative effect to her social life. She reflects that.

"I was actually thinking about this the other week. Before starting the graduate nursing program, I used to go out clubbing all the time, used to have fun with friends, used to go see movies. Shift work massively prevents that."

Diana expresses the strength of this social wellbeing impact when she says:

"None of my friends work weekends. I see them like once every two months. It really, really suffers. So, it sacrificed a lot and it takes its toll definitely."

Diana, however, also identifies the impact of her work employment schedule on her life balance.

"My work, life balance is terrible. I sacrifice so much for the job. God, I just do work and then you're so exhausted from work that you don't want to socialise."

The strength of this decline to both Brooke's and Diana's personal-social wellbeing and life balance is also evident in Brooke's comparative experience before commencing the transition program when she says:

"I went from spending a lot of time with friends - and I had a really good social life at uni, really good - and then it went to my life revolved around these guys [fellow graduates nurses at the private hospital] and Diana a lot and what we were going through and then going home from work; being completely utterly mentally and physically exhausted, sleeping, getting up and doing it all again kind of thing."

These results identify that an inflexible shift work schedule as part of GRN transition program, underpinned by job insecurity, has relationships with GRN life imbalances, and in this case, their personal-social wellbeing decline.

While this study found job insecurity was a contributing factor to personal-social wellbeing decline, it also found a link between job security and enhancing GRN coping strategies in their first year. This was evident when Anne, employed as an RN in an aged care facility noted: "*Having a stable job has helped me get through this year as well"*.

The evidence demonstrates that Anne and Tina, who were able to select a work context and schedule to match their preferences, enhanced their life balance, in particular their personal-social wellbeing, and made more informed decisions about whether they would apply for a GRN transition program.

Anne and Tina chose not to apply for a transition program and instead applied for an RN position in aged care as they believed this would allow them a better life balance.

Tina reflected:

> *"It definitely is easier to have a balance of personal life and work life when you have a regular roster, because we can plan. "I want to enjoy the kids, so now that's why I like doing the shifts I do. I have weekends off. If I want to join the gym now, I can go where before I couldn't."*

Anne had similar positive feelings about gaining a work schedule that matched her personal preference. In relation to her previous nursing employment experience she revealed:

> *"So I used to work as an AIN. I worked shift work. I worked all sorts. So I feel really lucky this year to have got what I've got, because it's not common, a 22 year old to have a job that's day shifts Monday to Thursday with weekends off, so I know I'm very lucky with it."*

Choosing a work context and schedule of their preference can enhance GRNs' work, life balance and retention and is a new observation.

Anne and Tina had prior experiences as an Assistant in Nursing (AIN) and an Endorsed Enrolled Nurse (EEN) assisted them to have realistic perceptions about their GRN roles, including knowledge about the nature of nurses' work involving shift

work, including working weekends. These prior experiences also informed their decisions to seek employment free of shift work post-graduation compared to Brooke and Diana who did not. These experiences influenced the employment context the GRNs' pursued post-graduation.

Tina was also influenced in her choice of employment context by her age (being 41 and mature) and her multiple life roles as wife and mother of two children.

> *"So, when I first started working as an AIN and then as an Enrolled Nurse, I did shift work. I did every shift. I bent over backwards, did double shifts and everything. Now that I'm finished uni, I want to enjoy the kids, so now that's why I like doing the shifts I do. I have weekends off."*

Previous nursing experience as an important broader demographic characteristic impacting GRNs' management of work and life, is also evident in Anne's testimony. Anne is 22, but she has had three years previous nursing experience as an AIN working shift work and understands the impact shift work can have on life balance.

> *"So, I used to work shift - as an AIN, I worked shift work. I worked all sorts. So, I feel really lucky this year to have got what I've got, Monday to Thursday, with weekends off. I can have a life. I can say, yeah, we'll go out for dinner Wednesday night, because I don't work Wednesday night. Or I can go and visit my family on the weekends. My sister, who I'm really close with, doesn't live [here], so if I didn't have weekends when I could go and see her, I think that would have a big impact on me.*

Previous nursing experience therefore assisted Anne and Tina to manage their work and life balance in their transition year. Brook and Diana did not have previous nursing experience and for example were less prepared for the disruption of shift work. Brooke commented:

> *"Diana and I especially, we went to high school, then we went to uni, then we started nursing, but nowhere in that time had we worked in a hospital, in a nursing home. We were in completely different fields of work and never done any kind of nursing."*

Results from this study have shown that broader demographic characteristics, in particular an absence of previous nursing experience places GRNs more at risk of life balance interruption and personal-social wellbeing decline. Whereas previous nursing experience and multiple life roles assists GRNs' work and life balance preparedness.

For Theme 1: Preparedness for the reality of work and subtheme: *Life balance and personal-social wellbeing*, the findings can be summarised as follows:

1. GRNs lack of preparedness about the impact of shift work is a factor negatively impacting GRNs' life balance and personal wellbeing.
2. Having little previous nursing experiences places GRNs at risk of life balance interruption and a decline in their personal wellbeing.
3. Previous nursing experiences and /or experiencing multiple life roles enhances GRN's life balance and personal well-being preparedness.
4. Inflexible shift work schedules as part of GRN transition programs and underpinned by job insecurity can be linked to GRN life imbalance.
5. Job security has a relationship with enhancing GRNs' capacity to cope in their first year.

The following section presents results for the second subtheme, Fundamental and specialty nursing knowledge and related skills.

Work:

Theme 1: Under preparedness for the reality of work

Subtheme 2: Take me back to the start: Fundamental and specialty nursing knowledge and related skills.

Basic knowledge and skills in relation to managing the care of a dying person were not covered or developed in Diana's undergraduate nursing degree.

> *"The palliative, they're going to die, but you don't expect them to be comatose. You don't expect the secretions to gurgle and be obstructive and the patient to require suctioning. You don't*

prepare that their peripheral circulation will go cool and that you touch the skin and you can get some indentation."

Diana recalls further gaps in her basic knowledge about death and dying.

"They [university] don't prepare you for the physiological signs of death. They just give you one lesson on how to grieve."

Brooke adds to this discussion, recalling her experiences about not knowing how to remove clothing from a deceased patient who was stiff and immobile.

"Even just the basics - I remember my first patient that passed away on me, I was with an EN and he was really, really experienced. We had a patient who had died and a pyjama top that we had to get off this gentleman that could no longer do anything and was getting rather stiff. But sorry, that really seems bad to say. The EN looked at me and he said, oh, he said, do they not teach you this at uni? No."

Work:

Theme 1: Under preparedness for the reality of work

Subtheme 3: Managing competing roles

Managing competing roles is the second subtheme for Work Theme 1, Under preparedness for the reality of work.

Diana reflects about her experiences managing competing roles whilst working in the palliative care unit as part of her transition program rotation.

"Palliative care is a huge stressor, because you're not only caring for a patient that requires so, so, much attention, but you also have to provide that emotional support... for the family. I think that's more draining than actually caring for the patient. It's the emotional drainage and the mental drainage. I had such a patient today together with so many full nursing care patients - and it's just hard when the family's crying"

Diana's reality was one of stress as she struggled to manage delivering palliative care to her patient and their family, all within the context of a heavy work

load. Additionally, she was also struggling to manage her own "*emotional drainage and the mental drainage*". Diana's experiences confirm Henderson, Rowe, Watson, and Hitchen-Holmes (2016) research which found that new graduates were not work ready in relation to caring for palliative patients. Strategies such as specific education about palliative care, as well as supporting students' growth of self-efficacy was recommended to overcome this deficiency. The data here suggests that GRNs are not just work ready in relation to palliative care, but also under prepared about the contexts they found themselves in, managing competing roles of equal priorities, including self-care to prevent declines to their personal wellbeing.

Managing stressful care situations involving the patient and the family was not unique to Diana, but also was experienced by Brooke, her fellow GRN colleague.

> *"Even with just medical or surgical questions from the family. I think half the time our job is looking after them as well. They get frustrated and have to vent and get worried about what's happening to Mum or Dad or anything like that. They take it out on you and so that just stomps you back into the ground a bit better".*

Brooke's experiences replicate the issues that Diana faced and further demonstrate that GRNs are ill prepared for both their undergraduate study and transitional program curricula for managing competing work roles. For example, they revealed that they were also under prepared for managing the verbal abuse of distressed relatives.

Brooke's recount highlights her under preparedness in not fully being trained for her nursing role. Brooke believed her nursing role was to care solely for the patient, rather than to care for both the patient and the family. Legal and ethical elements of nursing care include fully informing the patient and their family and this also includes facilitating and accessing information and care from the multidisciplinary team members (ICN, 2012b). Recent research links new graduates' work stress to being under prepared for their nursing role. Recommendations to reduce work stress by role clarification (Boychuk Duchscher, 2009, 2012; Duchscher, 2008) is not new, however, these results suggest that *further emphasis* in the undergraduate education programs is *still required*.

Brooke's recount also highlights the silent and often unreported work place violence from families of sick patients that is experienced by nurses.

> *"They [family] get frustrated and have to vent and get worried about what's happening to Mum or Dad or anything like that. They take it out on you and so that just stomps you back into the ground a bit better."*

Brooke found she was ill prepared to manage work place violence, including her self-care in relation to this. Work place violence has not been previously identified in the literature pertaining to GRN factors contributing to work stress and or attrition. Campbell, Burg, & Gammonley (2015, p. 321), report that work place violence is often unreported and advocate for increased reporting and monitoring of staff as it "may have serious consequences on health care workers' quality of life, work satisfaction and work force commitment". Results from this study confirm that under preparedness in relation to the RN role clarification stems from undergraduate nursing programs. Findings relating to under preparedness pertaining to fundamental nursing knowledge include:

1. Work place violence prevention, management, reporting and reporting process.
2. Care of the patients' families.
3. Personal self-care in managing the negative effects of experiencing verbal abuse.

The strength of Brooke's reaction to patients' families' violence can be seen when she shared what she does when she comes home from a challenging day at work:

> *"I find I hit a brick wall. I spent lots of times where I'd go home and just stare at a blank wall, because a blank wall doesn't buzz at you. A blank wall doesn't need pain relief. They don't need medications and there's no family berating you about something that you really can't control."*

Nurses' self-care is emerging in the literature as being important for maintaining both their health and their ongoing care of their patients (McElligott et al.,

2009). Brooke's experience affirms self-care is warranted to maintain her wellbeing, however, her experience also shows that her self-care in this instance was limited in that it was reactive in nature.

The following section present results for Theme 2, work satisfaction.

Work:

Theme W2: Work satisfaction

GRNs' testimonies revealed that despite the negative effects of diminished sleep quality and ongoing work stress, GRNs had work satisfaction due to the personal rewards of caring for their patients. This very quality of work satisfaction gave the GRN's work resilience.

Subtheme W2.1: Raising GRN resilience at work

The *Raising GRN resilience at work* subtheme reveals how the GRNs' negative work impacts, diminished quality of sleep and worrying about completing their work satisfactorily and work stress was leveraged by the satisfaction they experienced when caring for their patients. Brooke shares how work stress contributed to her lack of sleep:

> *"I don't know how many times I've rung the ward at 2:30 in the morning because I've woken up, freaking out, that I haven't given something or I left a Flagyl running when I left because that's when it was due, but they only needed half the Flagyl and I think I put in the whole bag. I'm on the phone to them going, please go and check what I've done."*

This worry about 'overlooked/forgotten' care also impacted Diana's quality of sleep:

> *"I've woken up after having terrible dreams like you forget something. [Then] I count hours, like if I don't go to sleep now, I'm not going to have as many hours sleep. Then you're stressing because I know I won't be able to get to sleep in that amount of time. Those six hours have gone [and now I only have] three hours and 45 minutes and 10 seconds [remaining]."*

Brooke's and Diana's reports of job satisfaction occurred straight after they had just finished speaking about their sleepless nights. Brooke "*It does sound like we don't like our work*"; Diana "*I love my work*" and Brooke "*It's very rewarding*."

The literature confirms the negative effects of diminished sleep quality derived from negative work performance and job dissatisfaction (Caruso, 2014; Keller, 2009; Matheson et al., 2014; Morshead, 2002; Muecke, 2005; Schluter et al., 2011; Westfall-Lake, 1997). While this study did not find a link between shift work, diminished sleep and job dissatisfaction, it did reveal a link between work role salience (the value GRNs place on their work role) and diminished sleep and work satisfaction.

Brooke was very excited to share her recent work joy. The following comment highlights her personal reward from caring.

> *"One of my patients took photos of me today, because she'd been with us for a couple of weeks and I was one of the ones who looked after her the most. So she took a photo. She wanted a photo of me, because I'm the one who looked after her and I'm the one who was there when she was first initially stressing and everything and because she lives in Brisbane. But she wanted a photo of me so she could remember me by it."*

Like Brooke, Diana also had a happy work moment to share, but her comment revealed how her work satisfaction builds her resilience for times when work is more challenging.

> *"It was so good actually the other day seeing a patient walk out the door after being really sick...to actually walking out, no assistance, so it was like, ah [laughs]. Yeah, you know what? I helped do that. Those moments, I think they'd outweigh all the terrible ones."*

Just as the GRNs in the transition program experienced work satisfaction and built resilience for when times were tough, Anne, who works in high care at the age care facility, also experienced work satisfaction.

> *"I find sometimes at work when you're having a stressful day and you're just thinking about work, work, work, work, work, stress, stress, stress, stress, stress, you'll go over to someone and they'll*

hold your hand. I'm really, really grateful for everything you do for me. I remember this one man, he said, here's my darling girl. He held my hand and just looked at me and said I'm so appreciative of everything that you do. Or you get the beautiful old lady that pulls you down to the bed and gives you a kiss or something like that. This is why I do it."

Anne's comments highlight her work role salience and the effects of stress from this. However, work satisfaction is apparent for her even in the face of high work stress.

"Yeah, all the relatives say we really, really appreciate all of what you've done, like I had a man that I had looked after for end stage palliative care this year and he passed away. It was a couple of weeks after he passed away and I came back out and there was something on my desk. It was a big jar and a big thank you note on it. It was full of chocolate. Attached to it a note saying how grateful they were for everything. It's moments like that, you're like, oh… I'm in the right job. I think all those cards are just reminders of why you're doing what you're doing."

Anne's resilience to work stress stems from her work satisfaction. This resilience is revealed when she reflected:

"I think we are all in the right job. I think we've got the stressing moments, but I think we love it."

This was confirmed by Brooke: "*We do*."

This confirmation by Brooke has particular relevance for this study. This is because it was Brooke who experienced an emotional break down in week three where she reported she would have left nursing if it wasn't for her fellow GRNs providing emotional support and care for her. Her reflection back at week three also revealed her other personal building blocks of resilience. These included her strong sense of work role salience that had developed from her prior study role salience at university. Resilience can now be extended to also include the building block of work satisfaction.

Work:

Theme W3: Work role salience under preparedness

GRNs' testimonies revealed that they placed high importance to their work role, that is they placed most of their energy and effort into their work role at some cost to their other life roles. However, university did not prepare them fully in how to care for themselves whilst in the throes of managing their work and life roles effectively. This lack of preparation covered concerns relating to managing their self-care whilst managing their heavy workloads and work stress with adequate rest periods and healthy meal breaks at work to refuel and recuperate; and feeling the drain on their personal life roles. Consequently, the GRNs were not fully aware of the self-care management needed in relation to positioning work at this high level to avoid erosion to their personal wellbeing.

Subtheme W3.1: Personal wellbeing decline

The *Personal wellbeing decline* subtheme reveals how the GRNs prioritised their work role at a sustained level over their self-care role and the impacts this had on their personal wellbeing decline. Tina reflects about the reality of her unrelenting fast work pace augmented by her strong work commitment in managing this pace, by working through her meal breaks.

> *"You just go, go; like in the hostel, it's so spaced out. You could be in an area here and now you are here, and you go, go all day. Or you're on your lunch break, the doctor comes, or you sit there for morning tea and the pharmacist's here. When you're on your break, there is an emergency".*

Tina's daily unrelenting work reality coupled with her sense of responsibility, as the only RN working in the hostel, meant that she was prepared to sacrifice her meal breaks:

> *"I mean, you can't leave it. Most other jobs, if you were in an office job or something, you can leave, have your lunch. When you're a nurse, you go on your staff break for your lunch, something happens. You've got to get up and go. You don't get that 40 minutes of just no-one disturbing you today."*

As part of self-care, Tina also identifies her under preparedness in the professional attribute of advocating for herself. Advocating is a well-known

professional attribute nurse's implement on a daily basis with their patients (NMBA, 2010a, 2010b). While Tina advocates for her patients, she doesn't demonstrate this in relation to her own care requirements. In doing so she illustrates how perceptions of powerlessness can arise in situations like these. This evidence shows how power balances and care of the self (Batters, 2011; Baumgarten, & Ullrich, 2016; Foucault, 1972) emerges in contexts like health care. The impact of this unrelenting work pace negatively impacts Tina's physical energy for self-care at work and in her personal life.

> *"Actually, I find it hard some days when you're working, I just couldn't be bothered getting lunch ready for myself."*

Tina describes her energy focus in her personal life for the past year has been directed to her children.

> *I've just gone - like the 12 months without doing anything, - with the hubby working away and having the kids and getting them to the school and all that and then working the days and things. [Unclear] I'm thinking, what do I do for myself?*

This is concerning as Tina is caring for her children, preparing their school lunches, but forfeits her own lunch preparation. This inattention to her nutritional needs indicates her under preparedness in taking care of her personal self-worth and self-care:

> *"I find I'm really bad, because if there's chocolate round, I'll eat it. At morning tea, afternoon tea, they'll put leftovers on our staff room table. We went in there today, sat down and had a piece of whatever slice was there.*

Tina's reflections suggest that she is aware her work environment – a busy schedule and a work culture of sharing leftover food with staff impacts her ability to eat well when at work. She also openly admits she is aware of this: "*I'm eating unhealthily...I've put on weight*."

Specific risk factors for overweight/obesity in nurses includes environment, social, cultural, age, emotion, genetics and health conditions (Center for Disease Control and Prevention, 2016). The data here substantiates that work role

salience prioritisation over personal self-care (nutrition) role salience is a potential risk factor for overweight/obesity in nurses.

Furthermore, the impact of Tina's life role as the primary carer of her children Monday to Friday to her mental wellbeing decline becomes evident when she says:

> *My hubby said he can notice - because he leaves on the Monday, come Sunday afternoon he can see my stress level has increased when he knows I'm going back to work on Monday.*

Tina's competing life roles, as the primary carer of her children and an employee, shows these particular broader demographic characteristics increases her risk factors for further reductions in her personal wellbeing as a GRN in her first year of employment.

The findings for the third Work theme, *Work role salience under preparedness* and subtheme *Personal wellbeing decline* reveal that:

1. Work role salience is a factor in self-care (nutrition) erosion.
2. Competing life roles: work and primary carer of children form potential joint risk factors for a decline in GRN physical and mental wellbeing in their first year.

Work:

Theme W4: Support

GRNs' testimonies revealed that support in their transition year largely overlooked the need for a broader, holistic, personalised support, particularly the need for social-emotional support to prevent erosion to their holistic wellbeing.

Subtheme W4.1: Little spider web of support

The *Little spider web of support* is the first of two subthemes under the Work theme, *Support*. It involves how GRNs needed to seek support outside of the formal work support offered by their employers in order to manage their social-emotional needs in relation to work stress.

Brooke firstly shares about the support she received from the nurse educator as part of the GRN transition program. This type of support was beneficial for Brooke in helping her manage her work role stress.

> *"We have an educator at work. The way it runs with our program that we're doing is so fantastic. It's great. She is a phone call away. She's there Monday to Friday with us. If you had any problems whatsoever, like two minutes and she'd be on the ward to help you."*

The support the nurse educator offered also extended from one-on-one assistance on the wards and included regular debriefing sessions. Brooke describes this type of support on behalf of her and Diana.

> *"The graduate program we had our graduate meetings with the other grads and our graduate nurse educator. We'd get together and we'd have a formal debriefing of what's happened, let your stresses out, that kind of thing. But that's still a very formal thing. We often get together outside of that, the grad group. We'll go to a pub somewhere or we'll go to someone's house and we'll put a movie on. We just vent with each other, vent with food and drinks [laughs]."*

This formal graduate debriefing offered opportunities for professional support from their nurse educator. However, Brooke's comments reveal this mode did not entirely meet her and the other GRNs' needs in managing their stress. Therefore, as a group they chose to meet outside these formal sessions to connect and share with the other graduates in ways that were more meaningful to them.

> *"The grad group is a little spider web of support. It's incredible. We're all really, really close with each other. We also have an issue of separating - we always get in so much trouble, especially when we go out with another group of people. We talk and talk and talk and talk. Shut up. Come on. Stop talking about it."*

Brooke's comments reveal that this type of support differed from their formal work support because it included social and emotional aspects that the GRNs felt they needed to manage their work stress. This is a new observation. Diana

identifies that not everyone can provide support she needs. She shares her experience about her boyfriend.

Diana identifies that not anyone can provide support. She shares her experience about her boyfriend in relation to this.

> *"I find this with my boyfriend and other friends as well. They try to act supportive, but they're like, oh, okay. They don't know what to say. They don't know how to reassure you. They just listen. My boyfriend, well he doesn't even listen. You need someone to understand, not just listen - to understand."*

Brooke adds to this discussion about the importance of support being meaningful and that this meaningful support can only be provided by others who can empathise.

> *"I don't actually think our friends understand the extent. It is a hard job. It is incredibly hard. I think that's part of the reason that they don't quite get it- and they're like, oh, I don't know what you're stressing about. Yeah, we've got 14 patients' lives to deal with in that day to get them through that day."*

Brooke believes she would have left nursing if it wasn't for the support from her fellow GRNs.

> *"Yeah, with these guys, with the other grads that were there -if I didn't get to go through this with them, I honestly don't know if I'd still be there because of - I had a really, really rough start to it. I was so stressed."*

The benefits of connecting with fellow GRNs was also identified by all the GRNs participating in this focus group discussion. Diana reflects:

> *"With Brooke especially and the others being in the exact same situation, I feel relieved that it's not me. I'm not falling down. I'm not suffering because someone's out feeling the exact same thing. It makes you feel normal."*

Diana felt better about her work stress after participating and sharing with the GRNs in the focus group discussion. She came to realise that she was doing well

in her graduate year after all, realising this once she heard the other GRNs' experiences and feelings. She felt particularly satisfied that she is managing as expected. "I'm not falling down." "*I'm not suffering because someone's out there feeling exactly the same.*" This choice of words reveal that Diana had been suffering quietly until now, because she believed that she was not coping well and not managing at the higher level that other GRNs were. This honesty was an essential ingredient that allowed the focus group to connect with one another socially and emotionally. This kind of honesty and connection has the potential to be a key strategy GRNs can utilise to manage their stress more effectively.

Brooke adds to the positives of the GRN focus group in her reflections about her graduate year:

> *"It makes you feel good when you know, and you look back and you think this is what I was like. Now you are going, you have learned. Sometimes you think, oh my goodness, but look back and you go, yeah, I'm doing all right."*

These GRNs' comments illustrate that having no meaningful indicators to gauge if they are operating at expected work, study, personal performance levels magnify their stress. Having clear indicators of performance over the duration of their graduate year from a broader work, study, life perspective would assist in GRN self-assessment and reduce and manage work stress.

The aged care facility supported Anne and Tina working as RNs in their first year. Anne and Tina's work support were different to that provided to Brooke and Diana. Anne and Tina's support were facilitated by the nurse manager leaving her office door open indicating she was available for advice. Anne commented:

> *"I noticed the first couple of months was good. The nurse manager was helpful, but I had to go and find her and tell her that I'm struggling with this or I don't know this."*

Tina was also aware of how often she needed to seek support from her nurse manager in the beginning:

> *"I used to be in her office several times throughout the day saying so and so has this and this happened, and the doctor said this and*

this is what I've done. She'd be there going, yeah, okay. Over time my visits became less and less.

After several months, Tina and Anne started to find the nurse manager's office door was shut. Tina shares her thoughts about this:

"Is she shutting the door because she doesn't want me to knock, or want me here, because usually the door is open? You feel there's a boundary where she is saying stand on your own two feet. You know you can go, but sometimes there's a little bit of a - vibe I find and sometimes you just can't find her."

As the support from the nurse manager tapered off, they found support in one another, checking and confirming they were providing the right care. Tina describes these times:

"Sometimes you just need another RN to check what you've just done or check what you have to do, so that you just make sure that its right."

Anne add:

"I can reflect on that, because Tina and I work at the same place. I think it's good we can bounce things off each other. I'll say to Tina, such and such has happened what do you think? It's been good having other backup. We're both brand new to this and finding our feet."

Aside from this work support from the nurse manager and each other, Tina and Anne also sought support outside of work from other nurses and family. Anne describes her need to connect with other nurses:

"I find when I get together with a group of nurse friends from work, we vent about work, but when I'm at home, I don't, because my partner can't understand. My partner's an accountant."

However, Anne added that while family wasn't the most appropriate support about her work stress, they were beneficial in helping her manage her diagnosis of cancer and treatment while working as an RN. Anne describes this support:

"If I didn't have, yeah, my partner and my sister…; my sister doesn't live here, she lives in down Brisbane. But I wasn't coping. Every day I needed just someone to be there. So, my biggest thing this year for getting me through this year was my family for support."

Tina revealed it was her husband who noticed the patterns of her work stress:

"My hubby said he can notice, come Sunday afternoon he can see my stress level has increased, he knows I'm going back to work on Monday and has to put up with me. He leaves for work on Monday. But then he says he notices come the Thursday when he's home, he goes, soon as you finish work, [clicks fingers], you change, you're good again Friday, Saturday, Sunday."

While Tina's waxing and waning stress levels was identified by her husband as being in line with her work patterns, it can also be seen that her work stress levels also correlated with her husband's absence. Rising of stress levels can then be attributed to having to solely manage the two important roles of parenting and work by herself when her husband was away at work. She was concerned that the others understood that this was not related to the fact that she didn't like work:

"I don't want to sound like I don't like my work, because I do."

Tina was mindful of being present in the conversation as well as the potential for her audience to gain an inaccurate impression about her level of job satisfaction. Research identifies a "significant negative relationship between nursing stress and job satisfaction" (Healy & McKay, 2000, p. 681), however Diana's evidence does not confirm this negative relationship.

Tina's demonstration of mindfulness during this conversation was replicated by being aware that her moods impacted on her husband: "he [hubby] has to put up with me". This sense of mindfulness extends to Tina's action to address her stress levels.

"I've just gone - like the 12-months without doing anything. So, I've actually joined the gym and I'm finding it helps with my stress levels to stay down."

Tina's mindfulness has come at the close of her graduate year, but at a critical time for her personally to maintain her strong position, managing work and family in the year to come. Tina's experience is important as it has revealed that she has several key qualities that are critical in building resilience, especially in the absence of support from work. Her mindfulness together with her life role salience of work, family and personal self-care constitute personal building blocks to resilience.

Extensive literature reviews stress and coping. Two common coping strategies are "problem focused coping or seeking information, and emotion focused coping or seeking others company" (Lazarus & Folkman, 1984, p.179). The GRNs' experience of work support includes problem-focused coping, while experiences of support from fellow GRNs and family is emotion-focused coping. For example, in preparing GRNs for the reality of work, Diana volunteered a strategy that she had found helpful. Her approach involved discussing the realities of the first year which new GRNs face. Diana suggests:

> *"Honestly if there was one day that someone with chocolate could just sit down and chat with you and say I'm not going to lie to you…you're going to find that your grad year is going to be hard."*

Diana's views are particularly important because her demographic characteristics point to her lack of familiarity with the realities of nursing practice (being 21, leaving school and going straight to university as the first of her family to go to university and having no previous nursing experience). Her life roles up until working as a GRN was that she was a student, working part time in hospitality. However, during her undergraduate studies, she demonstrated high study role salience which then underpinned her high work role salience. Being successful at university and having a professional career are both very important to her and simultaneously helped her overcome the risks accompanying the work reality shock in her transition year.

The theme *Support* and the first subtheme, *Little spider web* of support findings can be summarised as follows:

1. Work support is missing elements that could foster the development of honest discussions with other nurses that would assist GRNs to more effectively manage and prevent their work stress.
2. GRNs' needed support aside from their work support in order to meet and manage their social-emotional needs in relation to work stress.
3. Support gained outside work was meaningful and effective in managing GRN work stress if it included social and emotional connections that were underpinned by honesty.
4. Fellow GRNs and close members family members can be meaningful pillars of support that aid GRN retention.
5. Identifying specific GRN demographics, including life role salience, together with under preparedness, can comprise risk factors for declines in GRN personal wellbeing decline in their first year.
6. Small focus groups, as a supportive strategy, can assist GRNs in meaningful ways. Their benefits identified here include:
    a. The capacity to track GRN learning in managing stressful work realities of nursing over the 12-month as well as to affirm GRN's levels of personal and professional growth.
    b. Identifying effective strategies in managing the stressful work realities of nursing.
    c. Establishing the levels at which GRNs are operating over the 12-month period can contribute preliminary assessment standards in relation to how GRNs are managing over the 12-month period.
    d. Establishing the kinds of effective support required and when it is needed.
    e. Providing value to GRNs by helping them to gauge a balanced perspective in relation to other GRNs about how they are, or should be, managing their stressful work realities

Work:

Theme 4 Support

Subtheme 2: A broader approach

A broader approach is the second subtheme under the Work Theme *Support.* It emerged from the data revealing how GRN support needs to be broader in its approach because the many intersecting elements involved in the nurse's role and life. This broader approach needs to align with the concept of life-long learning (LLL) to better prepare and support GRNs in their journeys over time. Applying Longworth and Davies' (2003, p. 22) definition of LLL to the GRN broader support approach would support the development of GRNs' full potential. It would guide the implementation a of continuously supportive processes to stimulate and empower GRNs to acquire the knowledge, values, skills, and understanding they need for their life roles, circumstances and environments and to be able to achieve this with confidence, creativity and enjoyment. Without broader LLL support GRNs may be more vulnerable and without meaningful support, whether in a transition program or not. Current Australian nursing CPD guidelines (NMBA, 2016a) identify the importance of nurses developing lifelong learning as a foundation stone to CPD, however its application to date has been limited to the nurses' work role.

A particular skill that GRNs revealed that were under prepared for was the management of other nurses' harmful comments and attitudes regarding their knowledge and skills at entrance level. Diana expressed how the other nurses on the ward made her feel when she made a mistake.

> *"If you made a mistake, you felt like they were staring you down and they were like, oh, you made a mistake. You're a terrible nurse. What are you doing in this graduate program? You felt almost inferior and disempowered by that."*

Brooke was also worried about judgment from other staff members. She describes her strategy to overcome this:

> *"One particular grad, I called her my safety bubble, because if I had to go to the RNs I knew I was going to be judged or laughed at by one of them, so I would go to her instead, my safety bubble."*

Tina, who worked in aged care, also related to other nurses' judgement.

"Yeah, I found the same thing and the same as Anne when I first started as well. Dominantly it was older aged care nurses that had been doing the role. Then the graduate nurse came in and the staff were like, - like if you told them you were a grad nurse, they'd just pounce on it. You'd ask them something and it's like they roll their eyes. What would she know?"

Brooke identified here:

"It was kind of tiptoe-y for us around the beginning while we were trying to find our feet. I found they took real offence like, oh, you've never done that before."

Brooke perceived that the staff were unfair and felt they should be more gracious in their support at the beginning stages: "Come on. Give us a break."

Tina realised quickly that her work situation and stress related these kinds of judgements were only going to escalate, so she adopted this approach:

"So, I found it was easier not to say. Because of my age, they don't really go, oh, are you just finished uni? So, if I told them, they'd just - they use that power to put - find something. It's like a weakness, so I don't say I've just finished uni last year. Instead I say, Oh I've been nursing quite a long time. That was better for me."

Even though Tina was an experienced nurse in aged care as both an AIN and EN, she still experienced negative comments from other nurses. However, she thought that she would manage these aspects better in the aged care setting better than if she was doing her post grad year in the hospital. She describes this:

"That's why one of the reasons I didn't get a postgrad. I didn't want one actually. Instead I chose aged care, because I'd been doing aged care as an AIN and enrolled nurse for 15-odd years. I knew the ins and outs of it. I'm familiar with this."

Tina felt her strengths in managing the unsupportive attitudes from other nurses came from several places: her previous nursing experience as an AIN and EN, as well as her confident and clear communicative approach:

"You know your boundaries and things like that. When staff do something, you've got that, I know that. You don't say, oh, well, I know that because I did that, but you know when they're trying to put something over you. You try and get them to do something and they say, oh, no, we don't do it this way. It's like, well, you might not, but I'd like you to do it this way."

Tina has her life experiences helping her manage transition into her new role as an RN as well as the negative attitudes of other nurses in relation to her GRN status, However, she also demonstrated emotional intelligence (Jackson, Firtko, & Edenborough, 2007) and confidence. Tina would none the less have benefited from undergraduate education and transition support to guide and reassure her and to enable her development as a leader in her nursing career. Life experience and emotional intelligence are not available to all GRNs. This study has observed that GRN under preparation in managing nurses' negative attitudes remains a factor impacting GRNs in their first year. Education and support including the development of nurses' emotional intelligence and leadership would therefore be beneficial.

The Load Triad, Work, findings corroborate GRNs' under preparedness for aspects of their work, study and personal life. Work theme 1 revealed the factors impacting on GRNs' in their first year: under preparedness for the reality of work including both fundamental and specialty work knowledge and skills; managing work whilst maintaining life balance and personal wellbeing; self-care in response to caring in stressful and challenging environments; and inability to foster multiple life role saliences, such as study, work, personal life roles, including personal self-care role salience. Providing support to build new GRNs' resilience in these areas is key to increasing GRN retention.

This support needs to encompass listening to and analysing GRN experiences, partnering with the GRNs and heeding their recommendations. Literature is emerging about the importance of the patient experience and partnering in care to inform meaningful changes to patient care. However, literature promoting the importance of early feedback loops reporting GRN practice back to undergraduate and transition curricula is not appearing. Diana reflects about this broader level of support:

"I think when it comes to keeping all the balls in the air - just going back to your thing - I think from what we've all spoken

about and how I feel, support is what keeps them all up in the air - not just us doing it ourselves, but support at work, support from your friends, support from your family, support from other grads, where we get to do something like this. You get to talk to you guys and see that you guys are feeling exactly the same. You're not alone. It's all - support I think is what really keeps them up."

Brook verifies this:

"Yeah, like a conversation like what we have just had here is - yeah, it's good."

Literature on the value of reflecting about self-learning and its application to one's nursing practice is beginning to materialise (Bradbury-Jones, Hughes, Murphy, Parry, & Sutton, 2009; Byrne, Happell, Welch, & Moxham, 2013; Hughes, 2005; Russell, 2004). However, literature has yet to emerge in relation to nursing and lifelong learning.

This study has observed that reflecting and applying this to one's practice and then providing feedback loops from the graduates to transition and undergraduate curricula and transition support are important in developing and/or strengthening education programs to better prepare GRNs for and in their graduate year.

The section on Support, a broader approach, disclosed that GRN support needs to encompass lifelong learning education, including support to develop GRNs' broader knowledge and skills. These skills include capabilities in relation to values throughout their lifetime and in measuring GRNs' understanding and ability with new indicators of learning adequacy. Indicators of learning adequacy (Longworth & Davies, 2003 p. 22) include "confidence, creativity and enjoyment in all roles, circumstances and environments".

The following section presents the findings for the second load of the *Load Triad*: *Study*.

5.2.2.2 Study

Study is the second load of the *Load Triad.* This section presents Phase 1's focus group results of the factors impacting the GRNs as they managed *Study*. Study relates to the GRN's learning, both at the undergraduate level and their transition year, in relation to their Continuing Professional Development (CPD). The themes that

emerged included: 1. Under preparedness to foster self-directed learning and 2. Study barriers impacting work, career and personal role salience trajectory.

To provide a deeper understanding of these two themes, sub themes were also identified and are listed in Table 5.2. Each theme is described and presented next in association with its respective subtheme.

Table 5.2

Phase 1 Focus Group Study Themes and Subthemes

Phase 1 Focus Group Study Themes and Subthemes
Theme S1 Under preparedness to foster GRNs self-directed learning
Subtheme S1.1: Forewarned, forearmed
Theme S2 Study barriers impacting, work, career and personal role salience trajectory
Subtheme S2.1: Positioned behind the eight ball

Study:

Theme S1: Under preparedness to foster GRN's self-directed learning

GRNs' testimonies revealed that university did not prepare them fully in fostering their self-directed learning in their graduate year to assist them to effectively manage their transition into new environments, contexts and situations proactively. This lack of preparation covers concerns relating to GRNs being positioned to be reactive to triggers in their work and life environment, rather than proactively positioned to source learning and or strategies that would help them effectively and confidently manage these triggers. This theme has two subthemes: 1. Forewarned, forearmed, and 2. Positioned behind the eight ball. These subthemes are presented next.

Subtheme S1.1: Forewarned, forearmed

The *Forewarned, forearmed* subtheme reveals how the GRNs found themselves reacting to triggers in their work and life environments that motivated them to source strategies and or learning to help them cope.

Brooke shares about her reaction to the reality of working as an RN in her first three weeks. Her reaction reveals an automatic stress response known in the nursing discipline as reality shock (Boychuk Duchscher, 2009, 2012; Duchscher, 2008).

"I had a really, really rough start. I was so stressed. My emotional breakdown hit - I think it was week three I think I had my big emotional breakdown."

Brooke's reactive self-management strategy was to seek emotional support from her immediate transition graduate group:

"With these guys, with the other grads, if I didn't get to go through this with them, I honestly don't know if I'd still be there."

This response was based on a trigger-reactive response position, rather than a forewarned-forearmed awareness position about the realities of work shock and how to manage these effectively. This under preparedness stemmed from a deficiency in reality shock management in undergraduate and transition curricula. This is significant as Brooke would have left the nursing profession at this time.

Anne, also found herself experiencing a stressful work reality in the aged care facility:

"I have had a particularly stressful work unit this year as well. One of the reasons was I think that - if I didn't have my partner at home, I don't know how I would have coped as well this year because he's been a real support for me.

Anne, just like Brooke, found herself under prepared about how to manage reality shock and, without her husband's support would have left nursing. Anne's response was similar to Brooke's in terms of seeking emotional support. Like Brooke's situation, Anne's response was based on a trigger-response position, rather than a forewarned-forearmed awareness position.

In addition to experiencing work reality shock, Anne also found herself being stressed by an alarming health diagnosis:

"I got diagnosed with…cancer in July, so I had that as well. I had surgery for that and then stress and concern and worry about that."

This health diagnosis was significant, increasing her stress and placing Anne in a highly vulnerable position.

"I found the lump in May or June, so from that until beginning of November, I've been stressed, also a bit stressed from other things. I was stressed and I was tired."

Diana, like Anne and Brooke, also found herself ill prepared about how to manage work reality shock and, without support from her sister and fellow GRN Brooke, would have left the nursing.

> *"I feel the same. I think, too, my sister's also studying nursing as well, so she can relate - she's on prac as well. If I have a bad day, she's like, it's okay, I understand. She's studying psychology as well, so I think that massively makes me feel better. But I couldn't have done it without Brooke."*

Diana's response was to seek emotional support. In Diana's case this included support from her sister and her fellow GRN, Brooke, as both could relate to her and understand the impacts of what she was experiencing. Again, like Anne and Brooke, Diana's response was based on a trigger-response position, rather than a forewarned-forearmed awareness position about work reality shock and how to manage it effectively. However, on the positive side, Brooke, Anne and Diana, exhibited positive self-care behaviour (Forbes & While, 2009) in managing their work and life stress by seeking support from those they felt could relate to and understand their experience:

> *"You need someone to understand, not just listen - to understand."*

Brooke adds to this discussion.

> *"We're ready to curl up into a ball and die and where at least if you can vent to someone who's got a bit of an idea about what's going on, they don't just look at you like you're an idiot and why are you stressing that much about it?"*

A lack of empirical evidence about the effectiveness of transition program support from a whole program approach has previously been identified by Levett-Jones and Fitzgerald (2005) and more recently by Goode et al. (2013). This study's findings contribute to this knowledge, by observing that a shared understanding about the type of support required, is needed between the GRN and the organisation's transition program to ensure GRNs are adequately supported. In this study's case, the type of additional support these GRNs needed, aside from the traditional support of orientation, preceptorship, mentorship and skill development, was formal emotional

support. However, it should be noted that these 4 GRNS without limited formal emotional support, were still able to demonstrate resilience in managing their stress.

Tina's experiences differed to Brooke's, Anne's and Diana's as she did not experience work reality shock. However, she did experience stress in managing her work as well as being a parent and wife and ensuring her personal self-care. This stemmed from Tina's demographics (Tina was 41) and had 15 years of previous nursing experiences and was the parent of two children. That her life experiences mitigated against her reality shock contributes to knowledge exploring resilience. Tina also recognised this:

> *"When I was younger, I used to work, work, work, work, work, work. Then I had the kids and then that changed. You go through stages in your life, you've got to go, re-evaluate and go, okay, I've got children now. Okay, what do I do? So I've got to work shifts that work around the children, so you do that. Then they get older and then it's, well, what am I going to do now? So I'll do night shifts."*

The impact of this work pattern whilst managing her parenting role however contributed to a decline to Tina's wellbeing:

> *"You're up all day, your kids running around. You're tired. You're tired. You're tired. But you go, look, I'm just going to persevere, do a couple more years."*

Tina's previous nursing work juggling her work schedule around the children and feeling tired, informed her decision about choosing a work context and work pattern as an RN that would help her juggle her life role salience:

> *"Now that I'm finished, I want to enjoy the kids, so now that's why I like doing the shifts I do. "I work four days a week. I work 6:00 till 2:30 Monday through to Thursday" I have weekends off. I've never had weekends off.*

Tina adds:

> *"Previously my husband and children would go to my friend's barbeque without me because I'd be working. So now I like it,*

because I've got the opportunity to go to the barbeque as I have the weekend off or if I want to join the gym now, I can go where before I couldn't."

Additionally, Tina had further experience managing work and family when she was studying to be an RN:

Oh, I'm going to do my RN. You're studying. You've got kids. Now that it's all come together and they get older, I'm going, well, you know what? I'm over the night shift. Yeah, I'm over it. I'm over not spending time with my family. I'm over not doing things as a family because I've got to work.

Together these life experiences helped prepare Tina for the realities of work and life as a nurse. Despite this, Tina still experienced difficulties managing multiple life roles during her graduate year. In particular, she neglected her personal self-care:

"I've just gone - like the 12 months without doing anything, you just - with the hubby working away and having the kids and getting them to the school and all that and then working the days and things. I'm thinking, what do I do for myself?"

In this instance her reaction was to sacrifice her personal self-care role salience in order to support her other life roles of work and parenting that she deemed to be more important. Tina's difficulty in managing these life roles was noticed by her husband*:*

"…Hubby said he can notice…my stress level has increased…"

The length of time that passed before Tina thought about herself and her own care is also a concern for her:

"I've just gone - like the 12 months without doing anything. I'm thinking, what do I do for myself?"

This proactive action is an important quality, as it reveals she her high personal role salience:

"I've always done something, I've put myself on the backburner."

She added:

"So, I've actually joined the gym and I'm finding it helps with my stress levels to stay down."

Tina's action demonstrated her resilience in managing her multiple life roles, in particular the protective factors of her personal resilience which included multiple life roles salience (McAllister & Lowe, 2011). However, Tina's experiences also highlight deficiencies in undergraduate and transition education in terms of the inter-relationships between work, study and personal life roles.

The deficiencies stemming from nurses under preparedness, and its consequences, are significant. These finding verify previous findings in Load Triad, Work, Theme 1 and subtheme 1. This evidence confirms the findings that the GRNs, Brooke and Diana, were sacrificing their personal role salience in preference to their work role salience in order to cope. Highlighting the inter-relationship between the factors associated with the Loads Work and Study is important to demonstrate that the factors are not singular in nature, but inter-related.

The findings from the theme *Study* and first subtheme, *Forewarned, forearmed* include:

1. GRNs are under prepared a consequence of deficiencies in undergraduate and transition curricula in relation to reality shock management. The level of this impact is significant as indicated by GRN attrition intentions.
2. Support for GRNs does not incorporate managing work reality shock so that they are able to promote their personal wellbeing and retention.
3. GRNs' self-sacrifice their personal role salience in preference to their work role salience in order to cope in their first year.
4. Previous life, nursing and parenting experiences can interrelate to decrease work reality shock.
5. Multiple life roles combined with shift work are risk factors to personal wellbeing.
6. New inexperienced nurses with little history previous nursing experiences are at risk of declining personal wellbeing.

7. Broader demographics, for example, previous nursing experiences and managing shift work and parenting roles assist life balance preparedness that would support multiple life role salience.
8. Possession of multiple life role salience forms a key component of personal resilience.
9. Undergraduate and transition curricula do not prepare GRNs for lifelong learning and for the applying lifelong learning to manage their study, work and personal lives (both current and future).
10. The Load factors, Work, Study and Personal are not singular in nature, but are inter-related.

The following section presents results for the Study Theme 2, Study barriers impact career and personal trajectory and subtheme, Behind the eight ball.

Study:

Theme S2: Study barriers impact career and personal trajectory

The GRNs testimonies revealed they were unprepared in being unable to manage barriers to their learning including learning that would support their career and personal trajectories.

Subtheme S2.1: Positioned behind the eight ball

The *Positioned behind the eight ball* is the subtheme reveals these GRNs possessed a high study role salience that stemmed from their undergraduate studies and was a role they were keen to foster. However, they found themselves experiencing barriers in fostering their study role salience in their transition year. They specifically wanted fundamental and specialty education that would support them in their current practices as well as in achieving their career aspirations.

Tina and Anne, who worked in aged care as RNs, had both initially experienced concerns prior to commencing their RN positions. The concerns related to their capacity to perform at a competent level as leaders and in particular, delegating to others. Tina shares this concern:

"I found that before I started as an RN, I started to worry about having to delegate to more experienced Enrolled Nurses. This delegating was concerning me."

Anne also found the adjustment to the RN role concerning

"I was always so paranoid about what the other staff who I used to work beside as an AIN would think and how they would take me and treat me. On the most part, it was good, but you had particularly the older ones that had been there for a long time and stuck in their ways and you're young, just finished uni."

Brooke confirms that she and Diana had the same problem:

"It makes us feel so good that even you guys have that same problem [laughs]. It's a universal problem."

Diana added: "It's hard."

Brooke also acknowledged she could also see older staff having difficulty adjusting to them in their RN role and in their delegation because of their young age.

"Diana and I especially, we went to high school, then we went to uni, then we started nursing, but nowhere in that time had we worked in a hospital in a nursing home. We were in completely different fields of work and never done any kind of nursing. So then to be 21 and to jump up and then delegate to someone who is 30 years older than you with 20 years more experience than you have, they found it really hard to - and they're like, oh, so you weren't an AIN before you did this? No."

These findings recognize that GRNs were under prepared by their undergraduate and transition education in relation to their leadership role and the management of this role in their transition year. GRNs having trouble adjusting to their new roles is not new (Bjerknes & Bjørk, 2012. However, this study confirms that this remains an ongoing concern for GRNs with regard to education and support. Therefore, considering her limited preparation, Tina responded to the trigger of work role stress about delegating to other nurses by initially seeking support from her daughter. She describes this:

"I spoke to my daughter about this. So, she was really good and supportive. She said, you'll probably find that other people aren't going to react as badly as you think; they will to need to adjust, as well as you. You've work alongside these people, you're friendly with these people and stuff. But if they're doing something wrong, you do need to pull them up on it and not be afraid to do that, because it's your responsibility. So, it was me - I had to make a big adjustment."

Tina realised this emotional support from her daughter was good, helping her to understand that she needed specialty knowledge about how to adjust from her previous roles as an RN student and EEN. Tina decided to seek help through formal study on leadership from her employer.

"I actually went and talked to the manager…about that leadership course… so hopefully."

Tina's action in approaching her employer shows her sense of agency in supporting her work and study roles, together with supporting her career role. However, these CPD plans soon turned to disappointment. Tina shares:

"We were going to do a leadership course, but they didn't have enough people, so it got canned. I was disappointed, because it took a little while for me to get the courage to go up and say to them, we want something, we need something."

Tina shares how this news impacted her:

"I thought I can't just stay here doing the same thing day after day. I need some stimulation. That's when I was getting itchy feet thinking."

Tina's disappointment in not studying the courses she needed to assist her in her role as an RN, also negatively impacted her planned career trajectory. Tina had private career goals and the achievement of this leadership qualification, knowledge and skills was important to her. Consequently, lack of support from her employer in supporting her to access CPD directed towards her work and career goals, triggered thoughts of attrition. Thus, GRNs' study role salience, if not supported, is a trigger to thoughts of attrition.

Tina and Anne's study role salience are further evidenced by the type of courses they would like to complete to further support their work role. Tina shares:

"I'd like to do the wound management course [and]… dialysis."

Anne agrees and shares about the courses she would like to complete:

"I'd love to do wound management and …palliative care."

Tina and Anne's comments demonstrate their study role salience and its inter-relationship to improving their nursing practice and career pathways. Hence, this study has observed that supporting GRNs study and work role salience are key to developing strategies that will retain them as GRNs in aged care. In addition, this study has observed that self-advocating for professional development demonstrates GRN agency and combined with their study role salience and work role salience are building blocks of resilience.

In the aged care environment where study role salience support was absent, Anne and Tina began to seek out courses for themselves, independently from their employer. They soon realised the cost of these courses was too expensive for them to manage. Anne reflects:

"Financially…some of those courses that look really good can be really expensive."

Tina agrees and says:

"Yeah, and like that ones at QUT and UQ, they were two, three-day courses. They're like $700, $800. But financially I couldn't manage to do that for myself."

All 4 GRNS (in aged care and the private hospital) reveal that their employers would subsidise part of the cost. Brooke shares financial assistance information from her private hospital employer:

"If we put in to do a course elsewhere, they will cover two out of three costs, so they will either the course or the accommodation or the course and the transport or flights and stuff."

Tina describes her employer's views based on a conversation with a fellow nurse in the aged care facility:

"They do, because I talked to one of the guys there. There was a wound management course we were going to do. It was a two- or three-day course in Brisbane and they were quite happy for both of us. I think if we push the fact that we need to do courses, they will pay."

Anne reveals traveling to courses is another factor they must manage:

"The other thing I've noticed, though, with looking into courses and stuff is that you need to travel for them. Most of them are in Brisbane."

Anne acknowledges that, while travelling is not a problem for her, she can see it is a problem for Tina who has children and her husband working away:

"Travelling is not an issue. I can travel for it. I can take a day off work or two or however long it is and travel down. See, I've got a dog, a cat and a partner at home. That's it, so I can leave. So, a bit different to Tina when you've got... kids and sorting."

Barriers include a lack of support from employers, both financially and geographically. These barriers are well known in the literature (Hughes, 2005; Ross, Barr, & Stevens, 2013) and are not new findings. However, an additional barrier was identified in this study and this relates to course prerequisites. Tina shares how course prerequisites listed in formal post graduate studies form barriers to career pathway development beyond aged care.

"It's a little bit frustrating. I wish I was learning more. Because I find with aged care even though I'd like to do some more study, it really restricts you in what you can study because if you want to go and do a postgrad in something, you have to be working in an area at least 0.6 of the time, so it makes it really hard."

Prerequisites listed in formal study has been identified by this study as a barrier to developing GRNs career development. Conversely if Tina wants to pursue a career in Aged Care this is not a problem for her because she meets the prerequisite criteria. However, she does not want a career in aged care and hence again her career development is negatively impacted:

"If I want to go and do their Master of Aged Care or something, that's fine but is that where I want to be. I don't want to do years of things and then come out and go, no, it's not what I want".

In light of these challenges, Tina, who works in Aged Care and Brooke who works in the private hospital, share how they have overcome these study barriers.

Tina shares about available online learning sites through information promoted by the Queensland Nurses Union:

"I've got a lot of those online through the Queensland Nurses Union one. I just forget the web address. They've got one there…aged care, palliative. It costs money and our boss was saying that they will actually pay for us to do that course, because they have to pay a certain amount of money to get our CPD points."

Brooke evaluates the usefulness of the information:

"I think now its general knowledge 11 months down the track, because I've already learnt that previously, because I only discovered this website three months ago."

Brooke's evaluation and the GRNs' previous comments verifies that GRNs need affirmation of their knowledge to boost their self-confidence that they had learnt what they needed to during their undergraduate studies. While the online learning sites fulfilled the GRNs' immediate need for the affirmation of their learning, the sites failed to advance the learning that would transform their nursing practice and assist them to develop in their career and personal trajectories. Additionally, the online learning sites fail to provide support in the process of learning, by requiring GRNs to reflect on what has been learnt and its application to current and future nursing practice. These aspects have been previously identified in the literature (Hughes, 2005; Kataoka-Yahiro & Richardson, 2011; Nalle, Wyatt, & Myers, 2010).

The findings reveal that organisations CPD and online nursing educational sites focus predominantly on work knowledge and skills that directly support nursing practice related to patient care. While CPD to foster broader aspects, such as career and other life roles, in line with the goals of lifelong learning (see list of terms and definitions) and nursing CPD goals – for CPD to be based on the "foundation of

lifelong learning" (NMBA, 2016a, p. 1) is overlooked. However, this broader requirement of nurses' learning (all life roles as aligned to lifelong learning) is also not clearly evident in the NMBA's (2010) definition of CPD:

> The means by which members of the professions maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities needed throughout their professional lives. (p. 4)

Subsequently, the CPD definition provides education providers with a mixed message on what education needs to focus on. A clearer message from the NBMA' (2010, p. 4) that aligns to lifelong learning goals would simply be the addition of the words 'in all life roles'. For example, "the development of nurses personally and professionally [in all their life roles] throughout their professional life" (p. 4).

This section presented the results, identifying the themes and subthemes on the GRN experience relating to study, both at the undergraduate level and relating to their learning needs during their transition year. These themes have revealed GRNs' educational concerns that they are aware of, as well as education concerns that remain hidden from their view.

The concerns that GRNs were aware of included their feelings of not being adequately prepared at the undergraduate level to confidently care for patients, including delegating and co-ordinating care when they began their roles as RNs. Consequently, the 4 GRNS sought external affirmation from online learning resources to confirm and consolidate their knowledge base as this need was unmet by their organisation in their transition period. In addition, GRNs identified they did not have the specialty knowledge and skills to care for patients such as those in palliative end of life care approach and dialysis, as well as the ability to care for the patients' families, and or when families become increasingly distressed. The education concerns that were hidden from the GRNs included their broader personal and professional learning requirements, emanating from lifelong learning, that remained unmet by their education providers.

5.2.2.3 Personal life

Personal life is the third load of the *Load Triad*. This section presents Phase 1's focus group results of the factors impacting the GRNs as they managed their

personal life. Personal life refers to aspects in their life aside from work and study. The themes that emerged included: 1. Under preparedness regarding life balance importance and lack of life balance support 2. Personal life role salience imbalances and 3. Lack of awareness about how to manage competing life roles (work, study and personal life)

To provide a deeper context of these three themes, sub themes were also identified and are listed in Table 5.3. Each theme is described and presented next in association with its respective subtheme.

Table 5.3

Phase 1 Focus Group Personal Life Themes and Subthemes

Phase 1 Focus Group Personal Themes and subthemes
Theme P1 Under preparedness regarding life balance importance and lack of life balance support
Subtheme P1.1: Varying awareness levels about life balance ability to maintain life balance
Subtheme P1.2: Varying awareness levels about self-care and ability to maintain self-care
Theme P2 Personal life role salience
Subtheme P2.1 Uniqueness of personal role salience
Theme P3 Varying awareness levels in how to manage competing life roles (work, study and personal life, including self-care)
Subtheme P3.1: Varying awareness levels in recognising life role imbalance and ability to manage and restore life role balance

The following section presents the results for these three Personal life themes and their associated subthemes by providing a selection of GRN's comments in the form of excerpts.

Personal:

Theme P1: Under preparedness regarding life balance importance and lack of life balance support

GRNs' testimonies revealed that university did not prepare them fully in the importance of maintaining a life in balance to promote their overall personal sense of wellbeing and quality of life. This lack of preparation covered concerns relating to early detection and prevention such as recognising the signs and symptoms of when their life is not in balance, along with the knowledge and skills to achieve a life in balance, especially in the context of study needs and living and working as an RN.

Subtheme P1.1: Varying awareness levels about life balance ability to maintain life balance

The subtheme *Varying awareness levels about life balance ability to maintain life balance* reveals how the GRNs varied in their awareness levels about the importance of life balance and maintaining a personal sense of life balance in the context and nature of working as a new nurse and transitioning into a new stage of life. The following excerpt by Diana revealed she had been working the whole year without the conscious awareness that her life was not balanced until this research study came along. She shares her life balance description first, followed by a description revealing the moment of her awakening about her life balance and why her life has been unbalanced.

Diana

"My work balance is terrible. I sacrifice so much for the job."

"I was actually thinking about this the other week when this research came up. But before starting the graduate nursing program, I used to go out clubbing all the time, used to have fun with friends, used to go see movies. Shift work massively prevents that."

In Diana's excerpt about her late awareness of her life not being in balance is the beginning evidence of the 'system' colonising her personal life evidenced when she says, "*Shift work massively prevents that*" and is a new observation impacting the GRN's first year life balance experience.

Diana also shares some more of the 'health system - GRN transition program' context behind their experience:

Diana

"Sorry, sorry, can't do it, sorry. Because I'm on the graduate program and I want to make a good impression, I work weekends. None of my friends work weekends. I see them like once every two months now to every second weekend. It really, really suffers. So, it sacrificed a lot and it takes its toll definitely."

Brooke, Diana's fellow GRN also adds to why their life is so unbalanced by sharing further about the 'system' context behind their experience.

Personal:

Theme P2: Personal life role salience

Personal life role salience has been defined in this study as a disposition that gives time and energy to something that a person either believes in or must do and this pertains to the person and their life rather than anyone else (Cambridge Dictionary, 2016). This theme highlights the GRNs were not educated in the knowledge about the importance of their personal life role salience and their self-care role salience in promoting all their other life roles and their overall personal sense of wellbeing and quality of life. Additionally, their education did not include early detection and prevention, such as recognising the signs and symptoms of when their personal life role salience, including their self-care, was being threatened, along with the skills to meet their personal life role salience, including their self-care, especially in the context of their study needs and living and working as an RN.

Subtheme P2.1: Uniqueness of personal role salience

With the definition of person life role salience in mind all GRNs in this focus group study did have personal role salience of varying focus, even though the younger nurses Diana, Brooke and Anne were most likely not aware they did, whereas Tina, the mature aged married women with two children was clearly aware of her personal role salience to her self-care and parenting role. Based on literature, this could be attributed to Tina's strong sense of self-efficacy (Bandura, 1977; 1986; 2001) and life role salience or the importance she places on her family role (Super, 1990; Super, Savickas, & Super, 1996).

Diana was particularly interesting, as initially she did not identify as having any personal commitments, yet in fact she did. She was actually personally committed to being successful post grad and in her post graduate transition program and to securing a nursing position once this was completed. This aspect was only revealed later in the group discussion when Diana exposed, she was the first in a low socio-economic family to have a degree and to gain a post graduate transition program position.

Diana

> *"I don't know if this is relevant or not, but I think coming from a low socio-economical background, I was the first one to finish university. No-one's really had a career in my family. It's all been hospitality and concrete. To get a career and to get a grad program, it's the best opportunity I've had in my life."*

This achievement was significant to Diana and she wanted to ensure her success was ongoing as a nurse and consciously prioritised her work as her personal commitment to succeed. Based on the literature this could be related to attribution theory (Forsterling, 2014; Weiner, 1992), where Diana attributes these events as closely tied to her self-perception and self-efficacy. Therefore, through this reflection Diana has conveyed a strong personal role salience in relation to her identity but has also revealed that this personal role salience would not be possible unless she had study role salience.

Together, these three life role saliences, work, personal and study, show to be intricately connected for Diana. Like Tina and Brooke afore mentioned, these interconnected role saliences are showing to be a key factor impacting Diana's first year nursing experience and in building her resilience This is a new observation contributing to the pool of knowledge on nurse resilience (McAllister & Lowe, 2011). Thus, a crucial factor also impacting her sense of overall life satisfaction and willingness to sacrifice her life balance to succeed personally as an RN. This is evident when she says:

"To get a career and to get a grad program, it's the best opportunity I've had in my life. So, I'm willing to push all the other balls aside to keep that".

Diana's personal disposition, a proactive personality (Bateman & Crant, 1993), places her personal values and beliefs regarding what is important to her as well as to her family has been highlighted in this excerpt "*I was the first one to finish university. No-one's really had a career in my family"* and is her personal factor contributing to her drive and devotion to having a successful nursing career.

Based on the literature, role salience is known to significantly affect the career plans of young adults (Neville & Calvert; 1996; Niles & Goodnough, 1996; Super et al., 1996) and is evident in Diana's career plan.

Brooke also initially identified has having no personal commitments, just as Diana had done. Yet she revealed during the discussion she had a keen interest in learning how to be an assessor for a particular training organisation and this required her to meet once per week in the evening.

Brooke

"I'm a trainer assessor through [a particular organisation] now. I got that appointment last year and so I help the new members come through and train them up. We meet every Tuesday night".

Anne, similar to Diana and Brooke, could not initially identify any strong personal commitments, and is identified by the below statement.

Anne

"I don't have any strong personal commitments that I can think of at the moment".

However, later in the discussion, Anne revealed that she did indeed have a very strong personal commitment and it was to stay connected to her family. This can be seen in the following statements.

"I've got - my dad's family in Toowoomba. My sister - who I'm really close with and doesn't live in Toowoomba. So, if I didn't have weekends when I could go and see her, I think that would have a big impact on me".

Anne, Brooke and Diana are all young nurses and role salience was a hidden factor impacting their first-year experience, within this theme Personal and sub theme Personal Commitment.

Tina on the other hand readily identified her personal commitments as her children and their immediate needs and activities. Interestingly, Tina recently became aware of her need to give herself personal time and attention, by deciding to go to the gym regularly.

Tina

> *"I've just gone - like the 12 months without doing anything, with the hubby working away and having the kids and getting them to the school and all that and then working the days and things. I'm thinking, what do I do for myself? So, I've actually joined the gym and I'm finding it helps with my stress levels to stay down".*

Theme P3 Varying awareness levels in how to manage competing life roles (work, study and personal life, including self-care)

Awareness about managing life roles (work, study and personal life, including self-care) effectively is an important aspect of achieving a personal sense of life balance. Furthermore, being aware doesn't often come intrinsically and needs to be fostered. GRNs' testimonies revealed that university did not fully prepare them in the knowledge of how to effectively manage their competing life roles. This theme has one subtheme: 1. Varying awareness levels in recognising life role imbalance and ability to manage and restore life role balance. This subtheme is presented next.

Subtheme P3.1: Varying awareness levels in recognising life role imbalance and ability to manage and restore life role balance

Role salience between work, family and personal for Tina is clearly expressed here as she highlights to the group of her awareness that her time and effort needs to be balanced between all the areas that are important to her and this not only includes work and family, but to her self-care. Anne shares about her awareness to balance her life to promote her overall personal sense of wellbeing:

Anne

"I have had a particularly stressful unit this year as well. One of the reasons was I think that - if I didn't have my partner at home, I don't know how I would have coped as well this year because he's been a real support for me. I got diagnosed with … cancer in July, so I had that as well.

I had surgery for that and then stress and concern and worry about that. But end of story, it was all good.

"I found the lump in May or June, so from that until beginning of November, I've been... ...also a bit stressed from other things. So, if I didn't have my partner at home, I really don't think I would have coped so well. I did find thought, that I [unclear] [lazy habits] because I just couldn't be bothered. I was stressed, and I was tired."

"Also, then because I had [surgery and had the cancer] removed I was tired. I was so tired. I'd go to bed and I'd go to bed early. I'd sleep solidly through the next day and I'd wake up tired."

"So now that's all sorted as well. I'm feeling much more positive and happier with everything. But if I didn't have, yeah, my partner and my sister; my sister didn't live here, she lives in [unclear] down Brisbane … way. But I was ringing her every day just someone to … so my biggest thing this year for getting me through this year was my family for support."

Diana

"I feel the same. I think, too, my sister's also studying nursing as well, so she can relate - she's on prac as well, so I'm like, oh, yeah, I've been there, I've done that, it's good. But then if I have a bad day, she's like, it's okay, I understand. She's studying psychology as well, so I think that massively makes me feel better. But I couldn't have done it without Brooke."

"I find this with my boyfriend and other friends as well. They try to act supportive, but they're like, oh, okay. They don't know what to say. They don't know how to reassure you. They just listen. He

[boyfriend] didn't even listen. You need someone to understand, not just listen - to understand."

Brooke

"I don't actually think they understand the extent. It is a hard job. It is incredibly hard. I think that's part of the reason that they don't quite get it- and they're like, oh, I don't know what you're stressing about. Yeah, we've got 14 patients' lives to deal with in that day to get them through that day."

These findings have improved the understanding of how different GRNs' first-year experience can be managing work, study and personal life in relation to their broader circumstances.

5.2.3 Supplementary impacts on life roles

Results presented in this section relate to impacts apart from those acting on and emanating from the *Load Triad*. These impacts were deemed significant to life role salience due to the nature of and passion evident in the discussions with the GRNs in the focus group. These results are also presented as themes which emerged from the analysis of the data: 1. *Awareness of the Importance of life balance Awareness;* 2. *Awareness of their personal role salience; 3. Wellbeing as a result of any perceived imbalances,* and 4. *Thoughts of attrition when life roles are threatened;* and encapsulate supplementary impacts on the GRNs work, study and personal roles. The first theme to be presented is *Awareness of the Importance of life balance*.

5.2.3.1 Awareness of the importance of life balance

Phase 1 revealed the varying levels of life balance awareness by the 4 GRNs. In particular, the GRNs Diana and Brooke fresh from high school and university, were not aware of the importance of life balance and ways to achieve life balance considering the context of the 'health system' they were positioned within. In particular in relation to the 12-month GRN transition program involving shift work and working weekends.

This lack of awareness about the importance of life balance was evident from Diana's comments about the fact that life balance was 'hidden' from her, until her participation in this study.

"I was actually thinking about this the other week when this research study came up. But before starting the graduate nursing program, I used to go out clubbing all the time, used to have fun with friends, used to go see movies."

Diana's growing awareness about the 'system' influencing her life balance is revealed when she says, *"My work balance is terrible… Shift work massively prevents that [time to spend with friends and going out socialising]."*

While the 2 GRNs, Anne and Tina who were employed as RNs in the aged care setting, had a high level of life balance awareness as a result of their previous experiences. Anne working as an AIN and Tina working as an AIN and EEN. This life balance awareness was demonstrated by Tina when she actively sought work hours to facilitate achieving a balanced life between work and family. Tina shares:

"I got sick of that [shift work and working weekends] and I thought, oh, I need something else. So now I'm at the age now that I've got a 6:00 till 2:30 job Monday to Thursday. ...I've got weekends off now. I want to enjoy the kids, so now that's why I like doing the shifts I do. I don't have the morning, the afternoon, then coming back the morning with that shift work."

Closely tied to Tina and Anne's awareness to seek work hours that facilitated a balanced life, was their awareness to ensure they could also meet their other life role salience aside from their work role. For example, Tina wants to enjoy time with her kids. This aspect of personal life role salience is highlighted in the following section.

5.2.3.2 Awareness of their personal role salience status

Phase 1 identified each of the 4 GRNS' personal life role salience. For Diana and Brooke, their personal role salience may have been hidden from their conscious awareness but was strongly evident in their comments. Anne and Tina's personal role salience emanated from their conscious awareness. It is important to note that this study initially defined personal life as life outside of work, however the following excerpts reveal that personal life is intricately interweaved with an individual's personal life role salience and may involve their work role salience and or other life roles aside from work.

For Diana, her personal role salience was not in her conscious awareness and not articulated as such but rather more like an unconscious positioning based on her comments. Her comments revealed her personal role salience was closely connected to be the first in her family to secure a professional position as a result of successfully completing her three-year undergraduate Bachelor of Nursing degree.

> *"My cousin and I graduated at the same time… We're the first ones to have an actual career."*

Secondly, it was to be capable in her new work role as an RN.

> *"With Brooke especially and other people being in the exact same situation, I feel relieved that it's not me. I'm not falling down. I'm not failing because someone's out there feeling the exact same thing. It makes you feel normal."*

Thirdly, it was to secure a full-time position at the same health organisation at the completion of her GRN year.

> *"Ours jobs at the moment aren't very secure. We finish in a month and we have no idea if we will have a job. So it's yes sir, no sir, three bags full. I'll work every weekend unless requested off."*

Brooke's personal role salience included being successful in her work role, the same as for Diana. Brookes' personal role salience also entailed being successful in her community role, as an emergency trainer, however, Brooke felt it was important to prioritise her work role in light of her job insecurity concerns:

> *"I'm a trainer assessor through [an emergency organisation] now. I got that appointment last year and so I help the new …members come through and train them up. We meet every Tuesday night. We go from there and go through training. …This Tuesday night I won't be able to be there, …that's when my shift has fallen… but that's my assessment night for my group and so I've had to find someone else to take over the assessment. …Our jobs aren't secure, and we don't know if we have a job, I'm not going to start saying, can I have every Tuesday night off so I can do this, please? If they want me to work, I'm going to damn well work."*

Anne's personal role salience was also to be successful as an RN in her first year, but she also held personal goals of developing her work leadership skills, as well as specialty palliative care approach and wound care knowledge and skills.

> *"I'd love to do leadership; management and I'd love to do palliative care. Palliative care's something that I'm really interested in."*

Alongside this were her personal goals to achieve a balanced life so she could spend time enjoying life with her partner, her parents, sister and her dog, as well as in allocating time for herself. In light of her cancer diagnosis, this particular personal life role salience helped her cope. Anne shares:

> *"I found this year the importance of having nothing days… That's how I cope. I can go and do what I want to do. I like reading. I can go for a walk to the park. I can read. I'm obsessed with my dog. I can go sit outside with my dog, talk to my dog which talks to me and walk the dog or that sort of thing. I can do what I want when I want to do it. I think that makes me feel better having a day like that."*

Tina had similar goals to Anne being successful in her work role as an RN and working towards developing herself professionally as part of working towards her life career goals. Additionally, like Anne, she wanted to devote spending quality time with her husband, children, herself and her friends. Tina shares her study role salience, in particular her planned CPD to develop her leadership qualities and attributes and how she felt excited when it was scheduled, then equally disappointed when it was cancelled:

> *"We were going to do a leadership course, but they didn't have enough people, so it got canned. I was disappointed, because it took a little while for me to get the courage to go up and say to them, we want something, we need something. Then we finally got something. I was excited, and it was at it was at the same time I was getting itchy feet, thinking I can't just stay here doing the same thing day after day. I need some stimulation. Then I thought finally getting the stimulation, I was excited!"*

This study confirms that GRN's individual personal life role salience is important to identify the main 'push and pull' factors and specific facilitators and barriers that may affect their life role salience. Identifying these aspects is important in improving the understanding surrounding GRNs' life balance. Furthermore, this knowledge will help to identify strategies to improve GRNs' personal life role salience preparedness and support initiatives.

5.2.3.3 Wellbeing as a result of any perceived imbalances

All 4 GRNs faced declines in their wellbeing when they experienced imbalances. The following excerpts represent the array of influences of a life not in balance.

Diana shares how she feels when her life is consumed with work:

> *"My life balance; God, I just do work and then you're so exhausted from work that you don't want to socialise. Then you get so consumed in work that you don't realise that there is actually a world out there."*

Brooke shares her behaviour when she comes home from work mentally and physically exhausted from her work experiences. She shares how she thinks about how her life used to be when it was more balanced:

Brooke

> *"I spent lots of times where I'd go home and just stare at a blank wall, because a blank wall doesn't buzz at you. A blank wall doesn't need pain relief. They don't need medications and there's no family berating you about something that you really can't control. I don't know. I went from spending a lot of time with friends - and I had a really good social life at uni, really good - and then it went to my life revolved around these guys and Diana a lot and what we were going through and then going home from work, being completely utterly mentally and physically exhausted, sleeping, getting up and doing it all again kind of thing."*

Anne discusses the decline in her wellbeing as a result of work and other personal stresses.

"I have had a particularly stressful unit this year as well…. I got diagnosed with … cancer in July, so I had that as well. I had surgery for that and then stress and concern and worry about that… I've been also a bit stressed from other things too."

While for Tina, despite her best intentions to seek a balanced life, she feels her work life has encroached on her ability to care for herself and this is impacting on her personal sense of wellbeing:

"Actually, I find it hard some days when you're working, I just couldn't be bothered getting lunch ready for myself. I find when I am on my lunch break, the doctor comes, or the pharmacist comes, or you get called 'Can you come here?' So, I find I've stopped taking lunch because I don't get it…I'm eating unhealthy...I've put on weight."

Anne and Tina share their 'signs and symptoms' of the decline in their wellbeing:

Anne

"I get frustrated at work at times and I vent a lot.

Tina

"I've probably been a little bit frustrated, it's been a year. I sometimes think, what else can I learn here? Then I actually went and talked to the manager and just said, look, I'm getting itchy feet and I just feel you haven't provided any courses."

5.2.3.4 Thoughts of attrition when life roles are threatened

Thoughts of attrition were evident in the 4 GRNs experiences. Each GRN experienced these thoughts at particular times and for different reasons. These reasons included reality shock, having a bad day, illness and study needs not being met. These experiences are presented sequentially for each GRN, Brook, Diana, Anne and Tina.

Brooke:

"I had a really, really rough start to it. I was so stressed. My emotional breakdown hit - I think it was week three I think I had my big emotional breakdown…The other grads that were there, if

I didn't get to go through this with them, I honestly don't know if I'd still be there."

Diana:

"My sister's also studying nursing as well, so she can relate… if I have a bad day, she's like, it's okay, I understand. She's studying psychology as well, so I think that massively makes me feel better. But I couldn't have done it without Brooke."

Anne:

"I have had a particularly stressful unit this year as well. One of the reasons was I think that - if I didn't have my partner at home, I don't know how I would have coped as well this year because he's been a real support for me. I got diagnosed with … cancer in July, so I had that as well…I've been also a bit stressed from other things too. So, if I didn't have my partner at home, I really don't think I would have coped so well."

Tina:

"I thought I can't just stay here doing the same thing day after day. I need some stimulation. That's when I was getting itchy feet thinking."

While these results pertaining to reality shock are not new (Boychuk Duchscher, 2009, 2012; Duchscher, 2008), the other reasons listed, having a bad day, when illness occurs and when study needs are not being met are important to identify as they are linked to the GRNs' life role salience and attrition. Research by Rheaume, Clement, LeBel, & Robichaud (2011) highlights the decisions behind why nurses leave is complex and assert that leaving is ultimately a personal decision.

5.2.4 University preparation impacts on GRN's work, study and personal life

The 4 GRNs from Phase 1, Diana, Brooke, Anne and Tina, share their thoughts and concerns with one another about their university preparedness. They shared their concerns: not feeling prepared in fundamental knowledge and skills, specialty knowledge and skills; working with confidence at an autonomous level; not

being prepared at an appropriate mental and emotional level for their role as an RN; and how to manage competing life roles and life balance (see Section 5.2.2.1). The evidence presented by the four GRNs (see Section 5.2.2.1), also reveal that their thoughts about university preparedness was in relation to under preparedness which extended beyond fundamental employability knowledge and skills for their specific RN roles. It also included under preparedness in their personal life roles development and management knowledge and skills. The findings highlight that the knowledge and skills the GRNs possess do not always equate to being readily able to transfer these to new contexts, new practices and at levels that demonstrate confidence. The lack of confidence in their roles as RNs influencing GRNs' perceptions of preparedness is not a new finding (Boychuk Duchscher, 2009; 2012; Duchscher, 2008). However, the level of practice to achieve confidence that transfers to clinical practice settings and to other life roles is a new observation.

The four GRNs also expressed concerns regarding the quality of their undergraduate clinical practicum experiences and believed that a lack of quality control surrounding clinical practicums impacted GRNs' preparedness status. Anne shares:

> *"The one thing that scares you is – because you talk to people and I was lucky. I did get to do things on my clinicals, but some people are saying I didn't get to do anything on my clinicals. Then they graduate."*

Brooke reflects:

> *"Some never got to go to a hospital and spent their entire clinicals in aged care".*

Anne deliberates:

> *"So, I was lucky. I got to do all those major basic skills that you need to do – inserting catheters and that sort of thing, I got to do them on my clinical. So, if I had to do it when I was finished, it wasn't so bad. But I think if you're one of those people that missed out on doing certain skills, you'd feel really nervous, because you would be like, I've only practiced that on a dummy and now I'm allowed to go and do that on a person."*

Brooke concurs:

> *"That's the difference. It's a dummy. It doesn't talk. It doesn't move. It's not going to die. They will. They will die if you screw up."*

5.2.4.1 Workplace shock

Work place shock is well known in the literature, dating back to Kramer's theory of reality shock (1974) and Duchscher (2008) GRN transition shock. Two of the four GRNs employed in a 12-month transition program revealed in their reflections, that workplace reality shock remains an issue for GRNs transitioning into the workplace (see Sections 5.2.2.1 and 5.2.2.2). *"I had a really, really rough start to it. I was so stressed. My emotional breakdown hit - I think it was week three I think I had my big emotional breakdown."* While the two GRNs who worked as RNs in an aged care facility did not experience reality shock as they chose to work in an area previously known to them in their earlier life career roles as either an AIN and or EEN. Tina reflects - *"Yes, because I think if I had gone into hospital - do you know what I mean? It's foreign. ... It's made it a bit easier having that aged care unit there"* However, the four GRNs believed that this was because their undergraduate clinical preparation was not as adequate as it could have been. They specifically related this to the quality of clinical placement experiences (see Section 5.2.4) but also the quality of their teaching, lab simulation and assessment. They share these aspects.

Diana shares about not being prepared for when a patient dies:

> *"…communication skills with the patient's family would definitely help and educating the family. They're palliative, they're going to die, but you don't expect them to be comatose. You don't expect the secretions to be loud and that the patient will require suctioning. You don't get prepared about that their peripheries will go cool and that you touch the skin and you can get some indentation. They don't prepare you for the physiological signs of death. They just give you one lesson on how to grieve."*

Brooke recounts her clinical lab assessment experiences and how the assessment did not prepare her for her role as an RN:

"Okay, this is kind of how the [clinical simulation] runs…you freak out so much about them. You've got 20 minutes, right. You've got an injection to do. You've got this to do and that to do. You're running around like mad. Real life isn't like that. It's not even close to being like that. I think what we should have been learning in labs is the basics, going through how do you give someone a sponge? Nursing someone who has passed away, how do you manoeuvre the body to do different things with? Rolling people properly, doing that kind of stuff rather than going, okay, you've got five things that you've got to get done now and do it. Just going back to the very basics of just even just people and stuff like that."

The GRN findings reflect current literature on views by industry identifying that GRNs are not work ready, as well as views by GRNs not feeling adequately prepared (Romyn et al., 2009). What is significant here is the advice the GRNs are offering higher education about ways to improve the education and clinical preparedness of student nurses that would assist in reducing reality shock and improving their preparedness for their roles as RNs.

5.2.5 Layer 1: Phase 1 focus group results summary

Layer 1 presented the findings from Phase 1. Factors that impacted the Graduate Registered Nurse (GRN) first year experience as they managed their work, study and personal life, the inter-relationships between these and the impact this had on their overall life balance have been analysed and discussed. Work factors were found to be the strongest domain impacting on GRN transition due to the GRN's high work role salience. However, this study also found that there was a strong inter-relationship between the GRN's high personal role salience towards their work role salience because of their previous high undergraduate study role salience. These three interlinked factors then caused a tipping of the GRN's life balance, specifically in the area of personal self-care and wellbeing.

The evidence verified that these same three interlinked factors, together with a close spider web of support of fellow GRNs or very close family members, contributed to GRNs' retention in their graduate year, helping them manage their

stressful and hard graduate year. These findings add to the pool of knowledge about the experience of GRNs in their first year and the factors impacting GRNs as they manage work, study and personal life and its impact on their life balance and personal wellbeing.

This study found the inter-relationship between these factors influence the GRN experience and at times contributed to the GRN having thoughts of leaving the profession. Absence of support in this area was also identified as significant factor impacting the GRN experience, and without support targeting the broader aspects of GRN's life, GRNs will continue to have thoughts of attrition when these aspects converge. This knowledge will help address rising global GRN attrition rates (Aiken, 2001; Booth, 2011).

The four GRNs, Diana, Brooke, Anne and Tina testimonies about their first-year work experiences highlight the overall reflective theme for this study focus: "Did university prepare us?" Their accounts demonstrate that the factors impacting GRNs' first year experience managing work, study and personal, are integrated rather than singular in nature. Knowing their experiences are integrated helps to ascertain that GRN support requires a matching integrated approach that has a broader platform than that previously considered if their personal wellbeing and sense of life balance are to be enhanced.

The main results from Phase 1 focus group, the GRNs' lived experience are epitomised and objectified (Husserl, 1931, 1962) as:

1. Demographics
2. *Load Triad* impacts (and associated impacts: life role salience, personal wellbeing and support)
3. The strength of the *Load Triad* impacts (and associated impacts: life role salience, personal wellbeing and support)
4. The overall impact on life balance (from the *Load Triad* factors and associated factors: life role salience, personal wellbeing and support)
5. GRN transition education
6. GRN university education ("Did university prepare us?")

The next stage interrogates Layer 2, connecting Phase 1 results to Phase 2 survey results.

5.3 LAYER 2: CONNECTING PHASE 1 TO PHASE 2

Layer 2 connects Phase 1 to Phase 2 – thus the building process from Phase 1 to Phase 2 as explained in Section 4.7.1) is made explicit here. Layer 1, Phase 1 presented the focus group results. Examining Phase 1 results several research areas were determined and objectified (Husserl, 1931, 1962). These are:

1. Demographics
2. *Load Triad* impacts (and associated impacts: life role salience, personal wellbeing and support)
3. The strength of the *Load Triad* impacts (and associated impacts: life role salience, personal wellbeing and support)
4. The overall impact on life balance (from the *Load Triad* factors and associated factors: life role salience, personal wellbeing and support)
5. GRN transition education
6. GRN university education ("Did university prepare us?")

The sixth research concern in the list above was important to highlight as it was the topic the GRN focus group raised as the main topic to frame their focus group discussion. The concern they raised was this question: "*Did university prepare us?"* and has been referred to in the list of the research concerns as 'GRN university preparedness'. The six research concerns identified from Phase 1 results have been objectified to inform Phase 2 survey design (see Section 2.2.2 for the concept explanation of objectification) and to facilitate the movement from Phase 1 social constructionist lens, to Phase 2 where a positivist lens is needed. Importantly, Phase 1 and 2 ontological lenses, are also informed by this study's overarching paradigm, post-positivism as discussed in Section 4.6.1. The quantitative results from Phase 2 - survey are presented next in Layer 3.

5.4 LAYER 3: PHASE 2 SURVEY PRESENTATION OF RESULTS

Layer 3 presents Phase 2 survey results for the nominal data for the following six research concern areas: Demographics, *Load Triad* impacts, Wellbeing,

GRN Thoughts on their university education, Support and GRN thoughts on their transition education. Results for these research concerns is presented in sequential order. Following the descriptive analysis of the survey, the results of the thematic analysis of the survey string data (qualitative comments) are presented.

5.4.1 Demographics

71 GRNs in the period of 0 to 12-months post-graduation volunteered to undertake the anonymous online survey 'Keeping the balls in the air: How graduate nurses manage study, work and personal life'.

Demographic results presented in this section includes the following characteristics; nursing practice experience (time in months), gender, marital status, dependants, geographical location, employment, including transition program enrolment status, mode of employment and work context. Age as a characteristic has not been included in these results and is a limitation of results (see Section 7.5.2).

The inclusion of broader demographic characteristics in the Phase 2 survey emanate from the Phase 1 study as being relevant to further investigate the subtle nuances experienced in relation to the factors impacting the GRN's *Load Triad* and overall life balance. However, descriptive analysis using cross tabulation, revealed that in the broader demographic characteristic, the GRN transition program enrolment status was the only characteristic showing subtle or marked differences. Therefore, results in Sections 5.4.2 to 5.4.7 have been differentiated and interpreted according to this characteristic only.

5.4.1.1 GRN nursing practice experience in time (measure in months)

Figure 5.1 illustrates participants' months of experience since graduation.

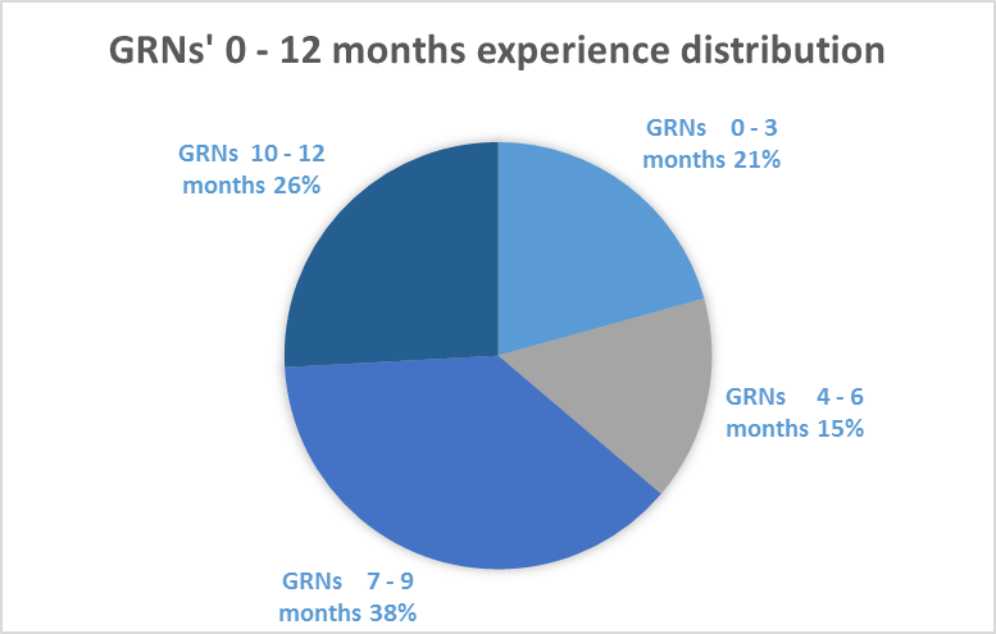


Figure 5.1. GRNs' nursing practice experience distribution post graduate year.

Figure 5.3.1, 21% (n=12) illustrates GRN participants' nursing experience were 0 to 3 months, 15% (n=9) 4 to 6 months, 38% (22) 7 to 9 months period, while 26% (15) were in their concluding 10 to 12 months period. A reasonable spread between the GRNs within this twelve-month period is evident and hence provides a good representation of GRNs within the 3 monthly time periods.

The 3 monthly interval ranges were selected as measures for time because the Phase 1 focus group thematic analysis revealed these as the highest for the doubt and stress in relation to nurses' preparedness status. However, this was not confirmed for GRNs between 0 – 3 months in Phase 2. The 9 to 12 months period was identified in Phase 1 as an important time period for GRNs to receive specific work and life career role development and recognition. However, this too was not confirmed in Phase 2. Therefore, these two particular cross tab variables have not been included in Phase 2 results.

5.4.1.2 Gender

Participants' gender was dominantly female, at 91% (65), while 9% (6) were male. This result closely reflects Australia and Queensland's general nursing gender population. At the time this quantitative study was undertaken, there were

314,626 (89.51%) female nurses compared with 36881 (10.49%) males. In Queensland, there were 60,594 (89.92%) female nurses and 6,796 males (10.08%) (Nursing and Midwifery Board of Australia, 2014a). This study has predominantly grouped female and male GRNs together as in most instances little difference was detected and therefore there was no value in separating the data. In instances where difference was noted (see Section 5.3.1, Full Time Employment), these results have been included.

5.4.1.3 Marital Status

Marital status of GRNs is diverse with 45% (32) identifying as married, 17% (11) as defacto, 32% (23) as single and 7% (5) as single but in a relationship. In terms of male gender marital status specifically, 80% (6) males were married, while the remaining two were single, however one of these was in a relationship. This gender marital data reflects the diversity of the general nursing population.

5.4.1.4 Dependants

32% (23) GRNs have dependents. The number of dependents varied within this group. Those with one dependent included 10% (7) married, 1.4% (1) single and 1.4% (1) single but in a relationship. Those with two dependents, included 13% (9) married, 3% (2) defacto, 1.4% (1) single and 1.4% (1) single but in a relationship. While only 1.3% (1) married had 3 dependents.

5.4.1.5 Employment

Females and male participants responding to this survey were not employed at similar rates to one other. Initial analysis of results showed that male nurses obtained higher rates of fulltime employment when compared to female nurses. Considering the male sample population percentage was 9% compared to 91% for females, it was important to determine the reliability for this result. The statistical analysis to determine the reliability of this result was unable to be conducted due to the small male sample size.

Table 5.4

GRN Employment Mode by Gender

Variable	GRN Full Time	GRN Part-Time	GRN Casual	Total
Female	21 32%	33 51%	11 17%	65 100%
Male	2 33%	2 33%	2 33%	6 100%
Total Count				71

Table 5.4 shows the comparison of male and female GRN employment modes.

GRNs Employed within a GRN transition program

GRN transition programs constitute a formal type of support for GRNs that has shown to be an initiative that aids retention of GRNs within the nursing profession. Figure 5.2 identifies GRNs' employment within a GRN transition program.

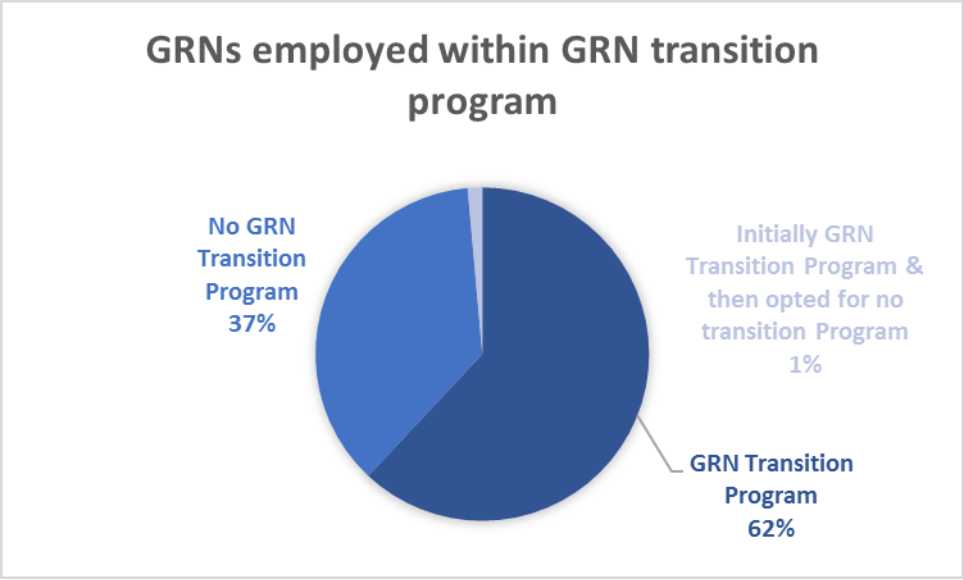


Figure 5.2. GRNs employed within a GRN transition program or not.

Figure 5.2 identifies GRNs employment within a GRN transition program. Examining figure 5.4 it is evident that GRNs' participation rates are higher within formal transition programs at 62% (44) compared to those not employed within these programs, at 36.6% (26). While 1.4% (1) of GRNs opted out of their GRN program to pursue employment as a nurse in a work context (a GP clinic) which was not within a supported GRN transition program. Therefore, this particular demographic characteristic has been deemed as relevant and subsequently results in Sections 5.3.2 to 5.3.7 are presented following the cross tabulation analysis of this variable.

Gender employment rates within GRN transition programs

Table 5.5 shows gender employment rates for this study within GRN Transition Programs.

Table 5.5

Gender Employment Rates within Transition Programs

Variable	GRN Transition Program	No GRN Transition Program	GRN Program Initially & then changed to No GRN program	
Female	43	21	1	65
	66.1%	32.3%	1.6%	100%
Male	1	5	0	6
	16.7%	83.3%		100%
Total Count				71

Table 5.5 shows gender employment rate percentages within transition programs and not within transition programs.

Clinical Settings

Phase 2 GRNs were positioned in a range of clinical settings that included, aged care, emergency departments, general medical and surgical, general practice, operating theatres and rural.

5.4.1.6 Summary of demographics

This section has presented Phase 2 demographic results. These results build on the knowledge about GRN demographic characteristics previously identified from the Phase 1 focus group results and contribute to the limited pool of knowledge describing GRN demographic characteristics. The importance of knowing and understanding these broader demographic characteristics and how they influence GRNs' experiences managing their work, study and personal lives are demonstrated in the following section: the factors impacting the *Load Triad*.

5.4.2 Load triad impacts

This section presents Phase 2 survey results. Results presented for topics 1 to 6 are outcomes based on 6 authentic scenarios and associated statements designed from Phase 1 focus group data. Scenarios and statements presented have been confirmed by Phase 1 focus group members and three critical nursing colleagues for authenticity. Results are outcomes from adjusting the survey's initial 5-point Likert scale during analysis, collapsing the scale to 2 or at times 3 points to gain a crisper picture to enabling interpreting of results (see Chapter 4.8.2). Table 5.6 presents a summary of how these results are presented.

Table 5.6

Impact Factors

Element	Topic	Sub-topic	Scenario	Statement
Load Triad - Work	Life role salience	-	1	1, 2, 3, 4, 5
	Ill-preparedness	Knowledge skills	2	1, 2, 3, 4, 5
Load Triad - Study	Study role salience	Competing life roles	3	1, 2, 3, 4, 5
Load Triad - Personal	Personal role salience	Self-care role salience	4	1, 2, 3, 4, 5
Wellbeing Impacts	Wellbeing role salience	Wellbeing preparedness and attrition intent	5	1, 2, 3, 4, 5, 6, 7
		Thoughts on university study	-	1, 2, 3, 4, 5, 6
Support Impacts	Wellbeing culture	Kindness and caring approach to peers	6	1, 2, 3, 4, 5, 6
		Thoughts on transition education	-	1, 2, 3, 4, 5, 6

Results are presented below for each Load Triad, work, study and personal in sequential order.

5.4.2.1 Work

Topic 1: Life role salience

The results presented are an outcome based on the survey Scenario 1 and its five statements.

Scenario 1

> You have been working hard all week and feeling tired at the end of each shift. You know your best friend has a BBQ Birthday lunch on tomorrow and you haven't seen her for the last 2 months or so. You have an early shift tomorrow and an in-service training session has also been scheduled first thing in the morning to fit in with your work time.

Statement 1: Work is a priority, so I would go to work as scheduled.

The role of Statement 1 was to determine GRN's life role domain, work and its importance compared to their life role domain, personal friendship.

Table 5.7

GRN Load Triad Importance: Statement 1 - Work is a priority, so I would go to work as scheduled

Variable				
Scenario 1				
Statement 1.		GRN Program	No Program	Total
Work is a priority, so I would go to work as scheduled.	Somewhat agree/disagree	8.7%	4%	
		4	1	
	Strongly agree/agree	91%	96%	
		42	23	
Total Count		44	24	70

Table 5.7 reveals that the majority of GRNs at 93% whether employed within a formal transition program or not, would prioritise work over seeing their friend whom they have not seen for a while. Literature identifying what life roles are important to GRNs and whether this is a factor impacting GRNs as they manage work,

study and personal life has not been found to date. In this study it has been found that work role salience is a factor impacting GRNs.

Statement 2: My best friend is important, so I would let her know I will be there.

The role of Statement 2 was to determine if GRN's life role domain, personal friendship is more important when competing with their work role.

Table 5.8

GRN Load Triad Importance: Statement 2 – My best friend is important, so I would let her know I will be there

Variable				
Scenario 1				
Statement 2.		GRN Program	No Program	Total
My best friend is important, so I would let her know I will be there.	Strongly disagree	16	12	
		36.4%	44%	
	Somewhat agree/disagree	11	4	
		25%	15%	
	Strongly agree	17	11	
		38.6%	41%	
Total Count		44	27	71

Table 5.8 reveals that GRNs' who held their friendship role as important were similar for GRNs employed within a formal transition program at 38.6% and not within a program at 41%. GRNs who believed that their work commitment was important was similar for GRNs employed within a formal transition program (36.4%) and not within a program (44%). This augments the literature by identifying whether competing life roles is a factor impacting GRNs as they manage work and personal life. These results recognise that GRNs do have work and friendship life role salience. These role saliences and the competing aspect between them is a factor impacting GRNs in their first year and is a new observation.

Statement 3: In-service training is important, so I would go to work so I could attend.

The role of Statement 3 was to determine if in-service training is an extrinsic motivation for GRNs to prioritise their work role commitment above their life role personal friendship.

Table 5.9

GRN Load Triad Importance: Statement 3 – In-service training is important, so I would go to work so I could attend

Variable				
Scenario 1				
Statement 3.		GRN Program	No Program	Total
In-service training is important, so I would go to work so I could attend.	Strongly disagree	2	1	
		4.5%	3.7%	
	Somewhat agree/disagree	9	4	
		20.5%	14.8%	
		33	22	
	Strongly agree	75%	81.5%	
Total Count		44	27	71

Table 5.9 reveals the majority of GRNs in their first-year value work in-service training and that this is an influencing factor that places their work role above their personal friendship role. GRNs not in a transition program value work in-service training at a slightly higher rate at 81.5%, compared to GRNs employed within a transition program at 75%.

Statement 4: I would feel I could easily reschedule, to fit them all in.

The role of Statement 4 was to determine GRNs' preparedness for the reality of managing important life roles, work, study and personal friendship.

Table 5.10

GRN Load Triad Preparedness: Statement 4 – I would feel I could easily reschedule, to fit them all in

Variable				
Scenario 1				
Statement 4.		GRN Program	No Program	Total
I would feel I could easily reschedule, to fit them all in.	Strongly disagree	25	13	
		56.8%	52%	
	Somewhat agree/disagree	9	6	
		20.5%	24%	
	Strongly agree	10	6	
		22.7%	24%	
Total Count		44	25	69

Table 5.10 reveals that over half of the GRNs do not feel prepared about how to manage competing life role roles of work, study and personal friendship, to fit them all in. No difference in competing life role preparedness is evident in responses between the GRNs in a transition program and those not in a program.

Statement 5: I would feel worried if I had to best manage this situation.

The role of Statement 5 was to determine if GRNs feel worried about how to manage this competing life role situation; where they felt their personal friendship role, conflicted with work and study (in-service training) role.

Table 5.11

GRN Load Triad Preparedness: Statement 5 – I would feel worried if I had to best manage this situation

Variable				
Scenario 1				
Statement 5.		GRN Program	No Program	Total
I would feel worried if I had to best manage this situation.	Strongly disagree	18	14	
		40.9%	51.9	
	Somewhat agree/disagree	7	5	
		15.9%	18.5%	
		19	8	
	Strongly agree	43.2%	29.6%	
Total Count		44	27	71

Table 5.11 reveals that just over half the GRNs not in a transition program did not feel worried about how to manage this scenario, compared to with just over one third of GRNs within a transition program. This still leaves a significant portion of GRNs who do feel worried about to manage this.

Topic 2: Under preparedness for the reality of work

Subtopic: Take me back to the start**:** Fundamental and specialty nursing knowledge and related skills.

The results are an outcome based on the survey Scenario 2 and its five statements.

Scenario 2

> You are working in an area/ward well known to you; however today you have been assigned a patient whose presenting condition is new to you.

Statement 1 - I can care for this patient quite well based on principles of care.

The role of Statement 1 was to determine GRNs' preparedness status for the reality of caring for a patient whose condition is new to them, based on fundamental principles of care.

Table 5.12

GRN Load Triad Work: Statement 1 - I can care for this patient quite well based on principles of care

Variable				
Scenario 2				
Statement 1.		GRN Program	No Program	Total
I can care for this patient quite well based on principles of care.	Strongly disagree	4	0	
		9.1%	0.0%	
	Somewhat agree/disagree	13	7	
		29.5%	26.9%	
	Strongly agree/agree	27	20	
		61.4%	74.1%	
Total Count		44	27	71
		100%	100%	100%

Table 5.12 reveals that just over half of GRNs in a transition program feel confident in caring for a patient whose condition is new to them based on principles of

care compared to a slightly higher rate of GRNs not in a transition program at 74.1%. This still leaves just over one quarter of GRNs' feeling limited confidence. Lack of confidence at work is well known in the literature, however what is a new observation is the difference in confidence levels between GRNs within a transition program to those not employed within a transition program.

Statement 2 - I'm worried that I might do something wrong to the patient.

The role of Statement 2 was to determine GRNs' preparedness for the reality of caring for a patient whose condition is new to them and their level of worry related to harming the patient.

Table 5.13

GRN Load Triad Work: Statement 2 - I'm worried that I might do something wrong to the patient

Variable				
Scenario 2				
Statement 2.		GRN Program	No Program	Total
I'm worried that I might do something wrong to the patient.	Strongly disagree	6	8	
		13.6%	30.8%	
	Somewhat agree/disagree	9	8	
		20.5%	30.8%	
	Strongly agree/agree	29	11	
		65.9	40.7%	
Total Count		44	27	71
		100%	100%	100%

Table 5.13 shows differences across each range between the GRNs employed within a transition program. The range that identifies those who are not worried about harming the patient is just over 10% of GRNs employed within a transition program, compared to just under one third of GRNs not within a transition program. Worrying about harming a patient is well known in the literature whereas the difference in worry levels between GRNs employed within a transition program to those not within a transition program is a new observation.

Statement 3 - I can check and verify with my senior nurse my plan of care and seek further advice as required.

The role of Statement 3 was to determine GRNs' ability to problem solve their own support when faced with this scenario by seeking support from senior nurses.

Table 5.14

GRN Load Triad Work: Statement 3 - I can check and verify with my senior nurse my plan of care and seek further advice as required

Variable				
Scenario 2				
Statement 3.		GRN Program	No Program	Total
I can check and verify with my senior nurse my plan of care and seek further advice as required.	Strongly disagree	1	1	
		2.3%	3.8%	
	Somewhat agree/disagree	0	1	
		0%	3.8%	
	Strongly agree/agree	43	25	
		97.7%	92.6%	
Total Count		44	27	71
		100%	100%	100%

Table 5.14 reveals that the majority of GRNs can problem solve this scenario and seek support from senior staff. Very little difference is evident in the responses between the GRNs employed within a transition program and those that are not regarding their ease of ability to seek support from senior nurses.

Statement 4 - As the situation evolves itself, I would refer to an experienced colleague in my work area and ask them to talk me through the care needed.

The role of Statement 4 was to determine GRNs' preparedness for graded assertiveness in seeking further support in caring for a patient whose condition is new to them to assist in reducing their worry and worry of harming the patient.

Table 5.15

GRN Load Triad Work: Statement 4 - As the situation evolves itself, I would refer to an experienced colleague in my work area and ask them to talk me through the care needed

Variable				
Scenario 2				
Statement 4.		GRN Program	No Program	Total
As the situation evolves itself, I would refer to an experienced colleague in my work area and ask them to talk me through the care needed.	Strongly disagree	2	3	
		4.5%	11.1%	
	Strongly agree/agree	42	24	
		95.5%	88.9	
Total Count		44	27	71
		100%	100%	100%

Table 5.15 reveal that many GRNs are prepared for graded assertiveness in seeking further support in caring for a patient whose condition is new to them. However, there remains GRNs who are not able to do this. The rate differs for GRNs in a transition program at 4.5%, compared to just over 10% at 11.1% for GRNs not in a transition program.

Statement 5 - If time permits, I would refer to resources in my work to help me care for my patient.

The role of Statement 5 was to determine GRNs' preparedness to access work resources to support the care of their patient.

Table 5.16

GRN Load Triad Work: Statement 5 - If time permits, I would refer to resources in my work to help me care for my patient

Variable				
Scenario 2				
Statement 5.		GRN Program	No Program	Total
If time permits, I would refer to resources in my work to help me care for my patient.	Strongly disagree	1	2	
		2.3%	7.4%	
	Somewhat agree/disagree	7	2	
		15.9%	7.4%	
	Strongly agree/agree	36	23	
		81.8%	85.2%	
Total Count		44	27	71
		100%	100%	100%

Table 5.16 show that many GRNs at over 80% are prepared in seeking out work resources to support their care of a patient whose condition is new to them.

The following section reports results for the factors impacting the Load Triad. The area of focus is: Study.

5.4.2.2 Study

Topic 3: Study role salience

Subtopic: Competing life role salience

The results are an outcome based on the survey Scenario 3 and its five statements.

Scenario 3

> You are at work and training has been scheduled for you at a time that allows you to participate. However, in the back of your mind you are thinking about a situation that needs attention and resolving.

Statement 1 - Even though I have a personal issue, I will attend this training session as it is just right for my work learning needs.

The role of Statement 1 was to determine GRNs' life role salience between training (study) and personal.

Table 5.17

GRN Load Triad Study: Statement 1 - Even though I have a personal issue, I will attend this training (study) session as it is just right for my work learning needs

Variable				
Scenario 3				
Statement 1.		GRN Program	No Program	Total
Even though I have a personal issue, I will attend this training session as it is just right for my work learning needs.	Strongly disagree	1	1	
		2.3	3.7%	
	Somewhat agree/disagree	3	5	
		6.8%	18.5%	
	Strongly agree/agree	40	21	
		90.9%	77.7%	
Total Count		44	27	71
		100%	100%	100%

Table 5.17 reveals that the majority of GRNs as a homogenous group would prioritise their work training over their personal issue that requires attention. GRNs as a heterogeneous group reveals GRNs in a transition program prioritise their work over personal circumstances at a higher rate (90.9%), compared to GRNs not in a transition program (77.7%). Additionally, just under one quarter of GRNs not in a transition program are positioned in a grey area, signifying they have mixed concerns regarding this situation.

Statement 2 - This training session has resulted from an experienced colleague at my facility speaking with me to find out what my work learning needs are.

The role of Statement 2 was to determine if GRNs' training (study) requirements have been tailored to their work learning needs.

Table 5.18

GRN Load Triad Study: Statement 2 - This training session has resulted from an experienced colleague at my facility speaking with me to find out what my work learning needs are

Variable				
Scenario 3				
Statement 2.		GRN Program	No Program	Total
This training session has resulted from an experienced colleague at my facility speaking with me to find out what my work learning needs are.	Strongly disagree	5	4	
		11.4%	14.8%	
	Somewhat agree/disagree	16	8	
		36.4%	29.6%	
	Strongly agree/agree	23	15	
		52.3%	55.6%	
Total Count		44	27	71
		100%	100%	100%

Table 5.18 reveals that just over half of GRNs have their training personalised to meet their work learning needs. This rate is similar for GRNs in a transition program to those who are not. There remains approximately one third of GRNs who have had a mixed response, while approximately just over 10% have clearly noticed their training has not sought out their personal work learning needs.

Statement 3 - I wish these training sessions covered topics to help me with my personal life too. Like to help with my work, life balance, for example, like my situation that needs attention and resolving.

The role of Statement 3 was to determine if GRNs' training (study) requirements would benefit from a broader approach to work to also include assistance with managing life balance and or personal issues causing concern.

Table 5.19

GRN Load Triad Study: Statement 3 - I wish these training sessions covered topics to help me with my personal life too. Like to help with my work, life balance, for example, like my situation that needs attention and resolving

Variable				
Scenario 3				
Statement 3.		GRN Program	No Program	Total
I wish these training sessions covered topics to help me with my personal life too. Like to help with my work, life balance, for example, like my situation that needs attention and resolving.	Strongly disagree	17	7	
		38.6%	25.9%	
	Somewhat agree/disagree	11	7	
		25%	25.9%	
	Strongly agree/agree	16	13	
		36.4%	48.1%	
Total Count		44	27	71
		100%	100%	100%

Table 5.19 shows GRNs as a homogenous group are divided in their views about training being broader than a work focus, including personal and life balance focuses. GRNs within the group, employed within a transition program, are divided on this topic too, with over one third agreeing this would be helpful, while one third disagreeing. However, a noticeable difference occurs in the GRNs not employed

within a transition program, with just under half of the GRNs agreeing training that is broader in its approach to just work topics would be helpful.

Statement 4 - I wish these training sessions would give me information to help me with how to improve my learning generally.

The role of Statement 4 was to determine if GRNs' training (study) requirements would benefit from a broader approach to work to also include assistance with strategies on how to improve their learning generally.

Table 5.20

GRN Load Triad Study: Statement 4 - I wish these training sessions would give me information to help me with how to improve my learning generally

Variable				
Scenario 3				
Statement 4.		GRN Program	No Program	Total
I wish these training sessions would give me information to help me with how to improve my learning generally.	Strongly disagree	9	5	
		20.5%	18.5%	
	Somewhat agree/disagree	15	7	
		34.1%	25.9%	
	Strongly agree/agree	20	15	
		45.5%	55.6%	
Total Count		44	27	71
		100%	100%	100%

Table 5.20 shows approximately half of GRNs would whether employed within a transition program or not employed within a transition program would like their training sessions to be broader in focus to also include help with learning generally. While less than one quarter either are mixed in their views or disagree.

Statement 5 - I wish these training sessions could provide me with resources about available training on different topics that would help me as a graduate nurse generally.

The role of Statement 5 was to determine if GRNs' training (study) requirements would benefit from a broader approach to include information and resources about available training that would help them develop as GRNs generally.

Table 5.21

GRN Load Triad Study: Statement 5 - I wish these training sessions could provide me with resources about available training on different topics that would help me as a graduate nurse generally

Variable				
Scenario 3				
Statement 5.		GRN Program	No Program	Total
I wish these training sessions could provide me with resources about available training on different topics that would help me as a graduate nurse generally.	Strongly disagree	3	2	
		7%	7.4%	
	Somewhat agree/disagree	7	3	
		16.3%	11.1%	
	Strongly agree/agree	33	22	
		76.7%	81.5%	
Total Count		43	27	70
		100%	100%	100%

Table 5.21 reveals the majority of GRNs whether employed within a transition program at 76.7% or not employed within a transition program 81.5% agree they would like training sessions that provided them with resources about available training opportunities.

The following section continues results for the factors impacting the Load Triad. The area of focus is: Personal Impacts.

5.4.2.3 Personal

Topic 4: Personal role salience

Subtopic: *Self-care role salience*

The results are an outcome based on the survey Scenario 4 and its five statements.

Scenario 4

You have been feeling overwhelmed at home for the past few weeks, the dirty clothes always seem to need washing, the house work never seems to get completely done, you haven't done a full week's grocery shop again and you have had an argument with someone close to you. It's lunch time.

Statement 1 - Generally I feel unhappy with my personal life.

The role of Statement 1 was to determine GRNs' satisfaction with their personal life generally.

Table 5.22

GRN Load Triad Personal: Statement 1 - Generally I feel unhappy with my personal life

Variable				
Scenario 4				
Statement 1.		GRN Program	No Program	Total
Generally, I feel unhappy with my personal life.	No chance/very little chance	14	9	
		31.8%	34.6%	
	Some chance/very good chance	12	10	
		27.3%	38.5%	
	unsure	18	7	
		40.9%	29.9%	
Total Count		44	26	70
		100%	100%	100%

Table 5.22 reveals under half of GRNs employed within a transition program (40.9%) are unsure if they are happy or not, compared to just under one third of GRNs not employed within a transition program (29.9%). As a homogenous group approximately one third have positioned themselves as happy with their personal life generally.

Statement 2 - I make myself a healthy lunch from what is available and/or go grocery shopping and buy something like that on the way there.

The role of Statement 2 was to determine GRNs' preparedness for nutritional self-care when experiencing personal challenges.

Table 5.23

GRN Load Triad Personal: Statement 2 - I make myself a healthy lunch from what is available and/or go grocery shopping and buy something like that on the way there

Variable				
Scenario 4				
Statement 2.		GRN Program	No Program	Total
I make myself a healthy lunch from what is available and/or go grocery shopping and buy something like that on the way there.	No chance/very little chance	16	5	
		36.4%	18.6%	
	Some chance/very good chance	4	9	
		9.1%	33.3%	
	Unsure	24	13	
		54.5%	48.1%	
Total Count		44	27	71
		100%	100%	100%

Table 5.23 reveals GRNs, as a homogenous group, practice self-care in relation to maintaining nutrition is low when feeling overwhelmed with personal challenges. Half positioned themselves as unsure whether they would or wouldn't seek out a healthy lunch. As a heterogeneous group, results show less than 10% of GRNs employed within a transition program would make themselves a healthy lunch, compared to a slightly higher rate of one third, for GRNs not in a transition program at 33.3%.

Statement 3 - I phone my friend or someone close to me and chat about my situation.

The role of Statement 3 was to determine GRNs' preparedness for emotional self-care when experiencing personal challenges.

Table 5.24

GRN Load Triad Personal: Statement 3 - I phone my friend or someone close to me and chat about my situation

Variable				
Scenario 4				
Statement 3.		GRN Program	No Program	Total
I phone my friend or someone close to me and chat about my situation.	No chance/very little chance	20	11	
		45.5%	44%	
	Some chance/very good chance	8	7	
		18.2%	28%	
	unsure	16	7	
		36.4%	28%	
Total Count		44	25	69
		100%	100%	100%

Table 5.24 reveals approximately one quarter of GRNs as a homogenous group would phone a friend to chat about their situation. Under half of the GRNs would not phone a friend for support, while approximately one third of GRNs have positioned themselves as unsure.

Statement 4 - I make an appointment to see my local Doctor to chat about my situation and how I am feeling.

The role of Statement 4 was to determine GRNs' preparedness for psychological self-care when experiencing personal challenges.

Table 5.25

GRN Load Triad Personal: Statement 4 - I make an appointment to see my local Doctor to chat about my situation and how I am feeling

Variable				
Scenario 4				
Statement 4.		GRN Program	No Program	Total
I make an appointment to see my local Doctor to chat about my situation and how I am feeling.	No chance/very little chance	42	19	
		95.5%	73.1%	
	Some chance/very good chance	2	5	
		4.5%	19.2%	
	Unsure	0	2	
		0%	7.7%	
Total Count		44	26	70
		100%	100%	100%

Table 5.25 reveals that the majority of GRNs, as a homogenous group would not seek psychological support from a Doctor when experiencing personal challenges. As a heterogeneous group, the rate is higher for GRNs employed in a transition program at 95.5%, compared to 73.1% for GRNs not employed in a transition program.

Statement 5 - I would think about strategies that can help me with this situation, that perhaps I could action.

The role of Statement 5 was to determine GRNs' preparedness for self-determined self-care learning when experiencing personal challenges.

Table 5.26

GRN Load Triad Personal: Statement 5 - I would think about strategies that can help me with this situation, that perhaps I could action

Variable				
Scenario 4				
Statement 5.		GRN Program	No Program	Total
I would think about strategies that can help me with this situation, that perhaps I could action.	No chance/very little chance	5	2	
		11.4%	7.7%	
	Some chance/very good chance	20	9	
		45.5%	34.6%	
	Unsure	19	15	
		43.2%	57.7%	
Total Count		44	26	70
		100%	100%	100%

Table 5.26 reveals a mixed response from GRNs. Under half employed within a transition program were confident in their self-determined learning capability (implementing self-care strategies) compared to one third not in a transition program. While one quarter were either unsure or had little self-determined learner capability to implement self-care strategies.

5.4.3 Wellbeing impacts

Topic 5: Wellbeing role salience

Subtopic: Wellbeing preparedness and attrition intent

The results are an outcome based on the survey Scenario 5 and its seven statements.

Scenario 5

> You have been feeling low at home and you are also feeling stressed about work and right now you are thinking about calling in sick for your next scheduled shift.

Statement 1 - You ring in sick.

The role of Statement 1 was to determine GRNs' wellbeing level based on their intention to call in sick.

Table 5.27

Personal Wellbeing: Statement 1 - You ring in sick

Variable				
Scenario 5				
Statement 1.		GRN Program	No Program	Total
You ring in sick.	No chance/very little chance	29	15	
		65.9%	55.6%	
	Some chance/very good chance	9	4	
		20.5%	14.8%	
	unsure	6	8	
		13.6%	29.6%	
Total Count		44	27	71
		100%	100%	100%

Table 5.27 reveals that the intention rate for GRNs employed within a transition program to call in sick is low, at 20.5%, compared to even a lower position for GRNs not in a transition program at 14.8%.

Statement 2 - You think about finding another nursing job at another place.

The role of Statement 2 was to determine GRNs' wellbeing level based on their work satisfaction level; intention to find another nursing job at another place.

Table 5.28

Personal Wellbeing: Statement 2 - You think about finding another nursing job at another place

Variable				
Scenario 5				
Statement 2.		GRN Program	No Program	Total
You think about finding another nursing job at another place.	No chance/very little chance	27	17	
		61.4%	63%	
	Some chance/very good chance	10	4	
		22.7%	14.8%	
	unsure	7	6	
		15.9%	22.2%	
Total Count		44	27	71
		100%	100%	100%

Table 5.28 reveals the intention rate for GRNs to think about finding another nursing job is low. GRNs employed within a transition program is at 22.5% while GRNs not in a transition program is lower again at 14.8%. This is a new observation.

Statement 3 - You think about finding a different job other than nursing.

The role of Statement 3 was to determine GRNs' wellbeing level based on their work satisfaction level; intention to nursing by seeking a job other than nursing.

Table 5.29

Personal Wellbeing: Statement 3 - You think about finding a different job other than nursing

Variable				
Scenario 5				
Statement 3.		GRN Program	No Program	Total
You think about finding a different job other than nursing.	No chance/very little chance	27	20	
		61.4%	74%	
	Some chance/very good chance	8	5	
		18.2%	18.5%	
	unsure	9	2	
		20.5%	7.4%	
Total Count		44	27	71
		100%	100%	100%

Table 5.29 reveals GRNs as a homogenous group intention rate to think about finding a different job other than nursing is low. The majority of GRNs have no intention to leave nursing to find another job.

Statement 4 - You don't tell anyone how you feel.

The role of Statement 4 was to determine GRNs' wellbeing level based on their personal connectedness with others; their willingness to share how they are feeling.

Table 5.30

Personal Wellbeing: Statement 4 - You don't tell anyone how you feel

Variable				
Scenario 5				
Statement 5.		GRN Program	No Program	Total
You don't tell anyone how you feel.	No chance/very little chance	14	15	
		31.8%	55.6%	
	Some chance/very good chance	14	7	
		31.8%	25.9%	
	unsure	16	5	
		36.4%	18.5%	
Total Count		44	27	71
		100%	100%	100%

Table 5.30 reveals approximately one third of GRNs employed within a transition program at 31.8% would not share their feelings with anyone, compared to over half of GRNs not in a transition program at 55.6%.

Statement 5 - You seek support from your local doctor.

The role of Statement 5 was to determine GRNs' wellbeing preparedness for psychological self-care when experiencing personal and work challenges.

Table 5.31

Personal Wellbeing: Statement 5 - You seek support from your local doctor

Variable				
Scenario 5				
Statement 5.		GRN Program	No Program	Total
You seek support from your local doctor.	No chance/very little chance	40 90.9%	20 74.1%	
	Some chance/very good chance	2 4.5%	4 14.8%	
	unsure	2 4.5%	3 11.1%	
Total Count		44 100%	27 100%	71 100%

Table 5.31 reveals GRNs as a homogenous group are less likely to seek psychological support from a Doctor. GRNs employed within a transition program is at 4.5%, compared to GRNs not in a transition program at 14.8%. This is a new observation.

Statement 6 - You seek support from an online support group for strategies on how to manage these feelings.

The role of Statement 6 was to determine GRNs' wellbeing preparedness for self-determined self-care learning when experiencing personal and work challenges.

Table 5.32

Personal Wellbeing: Statement 6 - You seek support from an online support group for strategies on how to manage these feelings

Variable				
Scenario 5				
Statement 6.		GRN Program	No Program	Total
You seek support from an online support group for strategies on how to manage these feelings.	No chance/very little chance	37	23	
		84.1%	88.5%	
	Some chance/very good chance	4	3	
		9.1%	11.5%	
	unsure	3	0	
		6.8%	0%	
Total Count		44	26	71
		100%	100%	100%

Table 5.32 reveals evidence of self-determined capability to implement self-care strategies using the online resources is low, with little difference between GRNs employed within a transition program at 9.1% compared to GRNs not in a transition program at 11.5%.

Statement 7 - You go for a walk or similar and or/plan to do something nice for yourself.

The role of Statement 7 was to determine GRNs' wellbeing preparedness for self-determined self-care learning when experiencing personal and work challenges.

Table 5.33

Personal Wellbeing: Statement 7 - You go for a walk or similar and or/plan to do something nice for yourself

Variable				
Scenario 5				
Statement 7		GRN Program	No Program	Total
You go for a walk or similar and or/plan to do something nice for yourself.	No chance/very little chance	7 15.9%	5 18.5%	
	Some chance/very good chance	15 34.1%	8 29.6%	
	unsure	22 50%	14 51.9%	
Total Count		44 100%	27 100%	71 100%

Table 5.33 reveals GRNs as a homogenous group, who possess a self-determined capability to implement self-care strategies such as going for a walk or doing something nice for themselves is low. GRNs employed within a transition program at 34.1%, compared to GRNs not in a transition program at a slightly lower rate, 29.6%.

5.4.4 Support impacts

Topic 6: Wellbeing culture

Subtopic: Kindness and caring approach of peers

The results are an outcome based on the survey Scenario 6 and its six statements.

Scenario 6

> You come to work feeling down and sometime during the shift you make an error. Your nursing peers made some comments that made you feel worse. You start to think about how you care for your patients and wonder why your peers responded to you this way.

Statement 1 – I have had similar situations at work.

The role of Statement 1 was to determine GRNs' wellbeing level based on work place culture (unkindness to one another).

Table 5.34

Support: Statement 1 - I have had similar situations at work

Variable				
Scenario 6				
Statement 1.		GRN Program	No Program	Total
I have had similar situations at work.	Strongly disagree/disagree	12	9	
		29.3%	36%	
	Somewhat agree/disagree	6	5	
		14.6%	20%	
	Strongly agree/agree	23	11	
		56.1%	44%	
Total Count		41	25	66
		100%	100%	100%

Table 5.34 reveals over half the GRNs in a transition program have experienced a situation where nurses have been unkind, at 56.1%, compared to under half of GRNs not within a transition program at 44%. This is a new observation.

Statement 2 – I have had similar situations at work but I felt my peers responded with empathy.

The role of Statement 2 was to determine GRNs' wellbeing level based on work place culture (empathy).

Table 5.35

Support: Statement 2 - I have had similar situations at work but I felt my peers responded with empathy

Variable				
Scenario 6				
Statement 2.		GRN Program	No Program	Total
I have had similar situations at work.	Strongly disagree/disagree	6	5	
		14%	20%	
	Somewhat agree/disagree	12	8	
		27.9%	32%	
	Strongly agree/agree	25	12	
		58.1%	48%	
Total Count		43	25	68
		100%	100%	100%

Table 5.35 reveals over half the GRNs in a transition program have experienced a situation where nurses have been kind, at 58.1%, compared to just under half of GRNs not within a transition program at 48%. This is a new observation.

Statement 3 – I have had similar situations at work and I felt I received support that helped me learn in a positive way.

The role of Statement 3 was to determine GRNs' wellbeing level based on positive work place support.

Table 5.36

Support: Statement 3 - I have had similar situations at work and I felt I received support that helped me learn in a positive way

Variable				
Scenario 6				
Statement 3.		GRN Program	No Program	Total
I have had similar situations at work and I felt I received support that helped me learn in a positive way	Strongly disagree/disagree	6	4	
		13.6%	16%	
	Somewhat agree/disagree	8	7	
		18.2%	28%	
	Strongly agree/agree	30	14	
		68.2%	56%	
Total Count		44	25	70
		100%	100%	100%

Table 5.36 reveals half the GRNs as a homogenous group have received support that helped them to learn in a positive way; GRNs in a transition program at 68.2%, compared to GRNs not within a transition program at 56%.

Statement 4 – I have had similar situations at work and I felt I received support right on time.

The role of Statement 4 was to determine GRNs' wellbeing level based on satisfaction with timely work place support.

Table 5.37

Support: Statement 4 - I have had similar situations at work and I felt I received support right on time

Variable				
Scenario 6				
Statement 4.		GRN Program	No Program	Total
I have had similar situations at work and I felt I received support right on time.	Strongly disagree/disagree	12	5	
		28.6%	20%	
	Somewhat agree/disagree	12	11	
		28.6%	44%	
	Strongly agree/agree	18	9	
		42.9%	36%	
Total Count		42	25	67
		100%	100%	100%

Table 5.37 reveals GRNs as a homogenous group do not consistently receive support right on time; GRNs in a transition program at 42.9%, compared to GRNs not within a transition program at 36%. This is a new observation.

Statement 5 – I have had similar situations at work and I felt I received support prior to such situations that helped me manage both the work and personal impact from making such an error.

The role of Statement 5 was to determine GRNs' wellbeing level based on preparedness to manage future work and personal impacts when an error is made.

Table 5.38

Support: Statement 5 - I have had similar situations at work and I felt I received support prior to such situations that helped me manage both the work and personal impact from making such an error

Variable				
Scenario 6				
Statement 5.		GRN Program	No Program	Total
I have had similar situations at work …received support prior…helped me manage the work and personal impact from making an error.	Strongly disagree/disagree	15	8	
		36.6%	34.8%	
	Somewhat agree/disagree	13	6	
		31.7%	26.1%	
	Strongly agree/agree	13	9	
		31.7%	39.1%	
Total Count		41	23	64
		100%	100%	100%

Table 5.38 reveals GRNs' preparedness to manage the work and personal impact from making an error is low; GRNs in a transition program at 31.7%, compared to GRNs not within a transition program at 39.1%. This is a new observation.

Statement 6 – I have had previous similar situations at work and I felt I received support that offered help with other issues related to work, study and personal life.

The role of Statement 6 was to determine GRNs' wellbeing level based on satisfaction with work place life balance support.

Table 5.39

Support: Statement 6 - I have had previous similar situations at work and I felt I received support that offered help with other issues related to work, study and personal life

Variable				
Scenario 6				
Statement 6.		GRN Program	No Program	Total
I have had previous similar situations at work …received support with other issues related to work, study and personal life.	Strongly disagree/disagree	22	13	
		52.4%	54.2%	
	Somewhat agree/disagree	11	9	
		26.2%	37.5%	
	Strongly agree/agree	9	2	
		21.4%	8.3%	
Total Count		42	24	66
		100%	100%	100%

Table 5.39 reveals GRNs' support with other issues related to work, study and personal is low. GRNs in a transition program at 21.4%, compared to a lower rate at 8.3% for GRNs not within a transition program. This is a new observation.

5.4.5 Reflections about preparedness and ongoing development

Topic 7 a): Thoughts on university education

Results presented for Topic 7 are an outcome based on the authentic thoughts originating from Phase 1 focus group data. Each of the six statements presented have been confirmed by Phase 1 focus group members and three critical nursing colleagues for their authenticity.

Statement 1 – I am confident in my nursing work abilities generally (knowledge and practical skills).

The role of Statement 1 was to determine GRNs' satisfaction with their university education preparation; work place competence and capability based on their confidence level.

Table 5.40

GRN University Preparedness: Nursing Work Confidence Levels (Knowledge and Practical Skills)

Variable				
Topic 7:				
Statement 1.		GRN Program	No Program	Total
I am confident in my nursing work abilities generally (knowledge and practical skills).	Strongly disagree/disagree	9	5	
		20.5%	18.5%	
	Somewhat agree/disagree	14	7	
		31.8%	25.9%	
	Strongly agree/agree	21	15	
		47.7%	55.6%	
Total Count		44	27	71
		100%	100%	100%

Table 5.40 shows that only half of GRNs feel confident with their university education preparation regarding nursing knowledge and skills. This is not a new observation, however, the fact that GRNs continue to feel unprepared for work is of concern to many stakeholders.

Statement 2 – I am confident in my ability to further my own learning, to support my nursing work.

The role of Statement 2 was to determine GRNs' competence and capability to further their own learning, to support their nursing work; based on their confidence level.

Table 5.41

GRN University Preparedness: To Further Own Learning, To Support Nursing Work

Variable				
Topic 7:				
Statement 2.		GRN Program	No Program	Total
I am confident in my ability to further my own learning, to support my nursing work.	Strongly disagree/disagree	0	3	
		0%	11.1%	
	Somewhat agree/disagree	6	1	
		14%	3.7%	
	Strongly agree/agree	37	23	
		86%	85.2%	
Total Count		43	27	70
		100%	100%	100%

Table 5.41 reveals the majority of GRNs as a homogenous group feel confident in their ability to further their learning to support their nursing practice.

No difference is evident between GRNs in a transition program at 86% or not in a program at 85.2% in regard to their confidence levels to further their learning to support their nursing practice.

Statement 3 – I am confident in my ability to support my personal life in caring for myself.

The role of Statement 3 was to determine GRNs' competence and capability to further their own learning, to support their personal life in self-care; based on their confidence level.

Table 5.42

GRN University Preparedness: To Support Personal Life in Self-Care

Variable				
Topic 7:				
Statement 3.		GRN Program	No Program	Total
I am confident in my ability to support my personal life in caring for myself.	Strongly disagree/disagree	5	2	
		11.4%	7.4%	
	Somewhat agree/disagree	11	5	
		25%	18.5%	
	Strongly agree/agree	28	20	
		63.6%%	74.1%	
Total Count		44	27	71
		100%	100%	100%

Table 5.42 reveals GRNs' confidence levels to further their learning to support their personal self-care is 63.6% for GRNs employed in a transition program, compared to not in a program at a slightly higher rate at 74.1%.

Statement 4 – I believe I have been prepared in regard to how to learn so I can feel confident in how to manage new work situations in and beyond my nursing graduate year.

The role of Statement 4 was to determine GRNs' preparedness in how to learn in order to support management of new work situations in and beyond their graduate year.

Table 5.43

GRN University Preparedness: To Manage New Work Situations In and Beyond the Nursing Graduate Year

Variable				
Topic 7:				
Statement 4.		GRN Program	No Program	Total
I believe I have been prepared in regard to how to learn so I can feel confident in how to manage new work situations in and beyond my nursing graduate year.	Strongly disagree/disagree	8	8	
		18.2%	32%	
	Somewhat agree/disagree	9	4	
		20.5%	16%	
	Strongly agree/agree	27	13	
		61.4%	52%	
Total Count		44	25	69
		100%	100%	100%

Table 5.43 reveals approximately half the GRNs feel confident to manage new work situations in and beyond their graduate year, highlighting that a lack of preparedness for this category is of concern.

Statement 5 – I believe I have been prepared in regard to how to manage work with study and personal life in and beyond my nursing graduate year.

The role of Statement 5 was to determine the GRNs' competence and capability to further their own learning, to support their lifelong learning to do with work, study and personal life; based on their confidence level.

Table 5.44

GRN University Preparedness: To Manage Work with Study and Personal Life In and Beyond Nursing Graduate Year

Variable				
Topic 7:				
Statement 5.		GRN Program	No Program	Total
I believe I have been prepared in regard to how to manage work with study and personal life in and beyond my nursing graduate year.	Strongly disagree/disagree	11	10	
		25%	38.5%	
	Somewhat agree/disagree	13	6	
		29.5%	23.1%	
	Strongly agree/agree	20	10	
		45.5%	38.5%	
Total Count		44	26	70
		100%	100%	100%

Table 5.44 reveals less than half of GRNs believe they have been prepared to manage work with study and personal life in and beyond their graduate year.

Statement 6 – I am confident in my abilities to support myself to manage any new situations that may arise, whether it is work, study or personal life related.

The role of Statement 6 was to determine GRNs' preparedness to further their own learning, to manage new situations to do with work, study and personal life; based on their confidence level.

Table 5.45

University Preparedness: To Manage Any New Situations That May Arise, Whether it is Work, Study or Personal Life Related

Variable				
Topic 7:				
Statement 6.		GRN Program	No Program	Total
I am confident in my abilities to support myself to manage any new situations that may arise, whether it is work, study or personal life related.	Strongly disagree/disagree	5	3	
		11.4%	11.5%	
	Somewhat agree/disagree	12	7	
		27.3%	26.9%	
	Strongly agree/agree	27	16	
		61.4%	61.5%	
Total Count		44	26	70
		100%	100%	100%

Table 5.45 reveals over half of GRNs as a homogenous group feel prepared to manage new situations to do with work, study and personal life. This result suggests a new finding.

Topic 7b): Thoughts on transition education

The results are an outcome based on the survey Topic 7: Thoughts on transition year education and its six statements.

Statement 1 – I am confident in my nursing work abilities generally (knowledge and practical skills).

The role of Statement 1 was to determine GRNs' satisfaction with their transition year education preparation; work place competence and capability based on their confidence level.

Table 5.46

GRN Transition Preparedness: Nursing Work Confidence Levels (Knowledge and Practical Skills)

Variable				
Topic 7:				
Statement 1.		GRN Program	No Program	Total
I am confident in my nursing work abilities generally (knowledge and practical skills).	Strongly disagree/disagree	4	7	
		9.5%	30.4%	
	Somewhat agree/disagree	12	5	
		28.6%	21.7%	
	Strongly agree/agree	26	11	
		61.9%	47.8%	
Total Count		42	23	65
		100%	100%	100%

Table 5.46 show transition education satisfaction regarding nursing work abilities varies between GRNs in a transition program at 61.9% to those not in a transition program at a lower rate, 47.8%. Further research is needed in this area to identify gaps in GRNs transition year education to enable transition curricula to target these areas and improve GRN work competence and capability.

Statement 2 – I am confident in my ability to further my own learning, to support my nursing work.

The role of Statement 2 was to determine GRNs' transition competence and capability to further their own learning, to support their nursing work; based on their confidence level.

Table 5.47

GRN Transition Preparedness: To Further Own learning, to Support Nursing Work

Variable				
Topic 7:				
Statement 2.		GRN Program	No Program	Total
I am confident in my ability to further my own learning, to support my nursing work.	Strongly disagree/disagree	0	3	
		0%	13.6%	
	Somewhat agree/disagree	5	0	
		11.6%	0%	
	Strongly agree/agree	38	19	
		88.4%	86.4%	
Total Count		43	22	65
		100%	100%	100%

Table 5.47 reveals transition education preparedness in supporting GRNs nursing practice is high, with the majority of GRNs reporting feeling confident.

Statement 3 – I am confident in my ability to support my personal life in caring for myself.

The role of Statement 3 was to determine GRNs' transition competence and capability to further their own learning, to support their personal life in self-care; based on their confidence level.

Table 5.48

GRN University Preparedness: To Support Personal Life in Self-Care

Variable				
Topic 7:				
Statement 3.		GRN Program	No Program	Total
I am confident in my ability to support my personal life in caring for myself.	Strongly disagree/disagree	5	2	
		11.4%	9%	
	Somewhat agree/disagree	14	3	
		32.6%	13.6%	
	Strongly agree/agree	24	17	
		55.8%	77.3%	
Total Count		43	22	65
		100%	100%	100%

Table 5.48 shows transition education preparedness to further GRNs' learning to support their personal life in self-care is fair for GRNs in a transition program at 55.8% compared to just over three quarters of GRNs not in a transition program at 77.3%. GRNs' confidence levels in furthering their learning to support their personal life in self-care in their transition year is a new observation, along with the lower level of confidence for GRNs in a transition program compared to GRNs not within a program.

Statement 4 – I believe I have been prepared in regard to how to learn so I can feel confident in how to manage new work situations in and beyond my nursing graduate year.

The role of Statement 4 was to determine GRNs' transition preparedness education in how to learn in order to support management of new work situations in and beyond their graduate year.

Table 5.49

GRN Transition Preparedness: To Manage New Work Situations In and Beyond the Nursing Graduate Year

Variable				
Topic 7:				
Statement 4.		GRN Program	No Program	Total
I believe I have been prepared …to learn so I can feel confident … to manage new work situations in and beyond my nursing graduate year.	Strongly disagree/disagree	1	6	
		2.3%	28.6%	
	Somewhat agree/disagree	13	3	
		30.2%	14.3%	
	Strongly agree/agree	29	11	
		67.4%	52.4%	
Total Count		43	21	69
		100%	100%	100%

Table 5.49 reveals transition education preparedness to manage new work situations is slightly higher for GRNs in a transition program at 67.4% compared to half of GRNs not in a transition program at 52.4%. Results showing GRNs' transition preparedness confidence levels to manage new work situations in and beyond their graduate year as sound is a new observation.

Statement 5 – I believe I have been prepared in regard to how to manage work with study and personal life in and beyond my nursing graduate year.

The role of Statement 5 was to determine GRNs' transition education preparedness to further their own learning, to support their lifelong learning to do with work, study and personal life.

Table 5.50

GRN Transition Preparedness: To Manage Work with Study and Personal Life In and Beyond Nursing Graduate Year

Variable				
Topic 7:				
Statement 5.		GRN Program	No Program	Total
I believe I have been prepared … to manage work with study and personal life in and beyond my nursing graduate year.	Strongly disagree/disagree	10	7	
		23.8%	31.8%	
	Somewhat agree/disagree	12	7	
		28.6%	31.8%	
	Strongly agree/agree	20	8	
		47.6%	36.4%	
Total Count		42	22	64
		100%	100%	100%

Table 5.50 reveals transition education preparedness and confidence levels to manage work with study and personal life in and beyond their graduate year is low. For GRNs in a transition program the rate is at 47.6% compared to GRNs not in a transition program where the rate drops further to 36.4%. Results showing transition education preparedness managing work, study, personal life results as low is of concern.

Statement 6 – I am confident in my abilities to support myself to manage any new situations that may arise, whether it is work, study or personal life related.

The role of Statement 6 was to determine GRNs' abilities to further their own learning, to manage new situations to do with work, study and personal life.

Table 5.51

GRN Transition Preparedness: Confidence in Own Ability to Manage Any New Situations That May Arise, Whether it is Work, Study or Personal Life Related

Variable				
Topic 7:				
Statement 6.		GRN Program	No Program	Total
I am confident in my abilities to support myself to manage any new situations that may arise, whether it is work, study or personal life related.	Strongly disagree/disagree	3	2	
		7%	9.1%	
	Somewhat agree/disagree	11	4	
		25.6%	18.2%	
	Strongly agree/agree	29	16	
		67.4%	72.7%	
Total Count		43	22	65
		100%	100%	100%

Table 5.51 reveals under three quarters of GRNs feel confident in their own ability to manage new situations to do with work, study and personal life.

5.4.6 Thematic Analysis

This section presents Phase 2 survey findings for the string data (qualitative comments) section of the survey. The comments section in the survey allowed the respondents to add reflective comments about the topics Life balance, Work, Study, Personal, Personal Wellbeing, Support and Thoughts about their university and transition year education raised in the survey. The themes that emerged from the thematic analysis included: 1. Individual GRN's values on their life roles - work/study/personal and life balance, and 2. GRN's perception of higher education

and health facilities values about their life roles work/study/personal and life balance and the impact of these values on their life roles and life balance To provide a deeper understanding of these two themes, sub themes were also identified and are listed in Table 5.52. Each theme is described and presented next in association with its respective subtheme.

Table 5.52

Themes and Sub-Themes Developed from Phase 2 String Data

Theme	Sub-theme
Theme 1: Individual GRN's values on their life roles - work/study/personal and life balance.	Impact of GRN life role values.
Theme 2: GRN's perception of higher education and health facilities values about their life roles work/study/personal and life balance and the impact of these values on their life roles and life balance.	1. Values and impact of higher education values (as perceived by GRNs) on preparing them (GRNs') for their work, study and personal life roles. 2. Values and impact of health facilities values (as perceived by GRNs) on supporting them (GRNs') for their work, study and personal life roles.

The first theme, *Individual GRN's values on their life roles - work/study/personal and life balance*

5.4.6.1 Theme 1: Individual GRN's values on their life roles - work/study/personal and life balance

GRN's holding unique values concerning their work, study and personal life roles emerged and revealed how these values impacted their life role experiences and overall life balance.

Subtheme 1.1 Values and impact of GRN life role values

The *Impact of GRN life role values* subtheme emerged and revealed how the GRNs values reflected their choices in relation to either managing their work and study roles with their personal life role to achieve a personal sense of life balance or prioritised their work role over other life roles and experiencing a life not in balance. The first life role described is *Study role to support work role.*

Study role to support work role

The GRNs value for safe and quality nursing practice emerged, together with a value towards upholding their study role to support their work role to ensure their nursing practice was safe and of high quality. To support these values, it emerged that GRNs initiate proactive strategies such as informal self-directed learning and or formal study with higher education institutions.

> *"I often read over my notes, look up medications, use the primary clinical care manual (PCCM) and I am looking to further my studies with [a regional university and complete] a post graduate certificate with a rural and remote speciality."*

> *"I have already undertaken further study to further my learning in the field I am working in at the moment."*

Additionally, other strategies emerged and included seeking mentorship from experienced nurses, especially in the context of when they were unsure about nursing care needed.

> *"I wouldn't feel comfortable nursing a patient with a medical condition I'm not familiar with and prefer to learn from a senior, more experienced nurse."*

> *"This is my job. I need to develop myself to be able to safely care for any patient I am expected to care for. Safe practice doesn't mean avoidance but trial with supervision to develop confidence and competence."*

> *"It's important to challenge yourself when nursing but working within your scope of practice is vital. After assessing the acuity of the patient, I would make a judgement about whether or not I was equipped to care for them."*

To further support their study and work role and to maintain safe and quality nursing practice, it also emerged GRNs valued attending in-service education sessions.

> *"I enjoy in-service training and find it relevant to my practice."*

Study role to support all life roles

The GRNs value for their *study role* to extend to include supporting *all* their life roles, emerged as low for one participant.

> *"I don't think that in-service should be wasted on work-life balance topics. This should be encouraged by management but at the initiative of individual nurses."*

Personal: Self-care role

GRN's value in supporting their personal/self-care role emerged and included mainly proactive strategies, rather than reactive strategies. Proactive strategies are described first, followed by reactive strategies.

Proactive strategies GRNs enacted included staying home from work when unwell, ensuring adequate rest, positive self-talk, identifying problems early, exercising, eating healthy and making time to enjoy friends and interests.

> *"Unless I am sick, I go to work…"*
>
> *"Sometimes a 'mental health day' is in order to help you recuperate but I love my job so would never consider leaving."*
>
> *"You try to remain positive but when you are given a hard to constantly from staff and not supported it gets to you very quickly and makes it very hard to remain positive."*
>
> *"It's important to identify problems early before they become too big to handle."*
>
> *"…I make sure I also find time to exercise, eat healthy, travel and socialise."*

While reactive self-care strategy emerged in one GRN participant's excerpt and included seeking out close friends for support and venting concerns.

> *"I have close friends who I am able to 'vent' to regarding any issues that I might be having."*

Personal - All life roles

GRNs personal value in supporting *all* their life roles emerged as GRNs devoting time and effort to supporting *all* their life roles.

> *"I have a very healthy balance when it comes to work and personal life. It is so important to have a balance. I love going to work. But I make sure I also find time to exercise, eat healthy, travel and socialise."*
>
> *"Time management is vital in all areas of my life."*
>
> *"I am very organised. Due to shift work and often being on call I do meal preparation in advance, so I stay healthy and fuel my body with good foods. I regularly exercise, at least an hour every day if not 2-3 hours. [The community where I live] offers a lot of sport and I have found it a good way to switch off from work. It's also really important to get involved in the community to keep a healthy mindset."*

However, to maintain their value of these life roles in times of conflict, several types of additional proactive strategies also emerged. These included harnessing the health facility's organisational processes that enabled swapping of shifts and or in seeking alternative arrangements to catch up on missed CPD and or friends.

> *"I would tell my friend I may make it after work and would try to get there and unwind."*
>
> *"Within my workplace I am able to request unavailable days within each fortnightly roster. I would have requested this day as unavailable so that I was able to balance my work and personal life."*
>
> *"I would see if I could swap my shift to a late shift and change in service to another day when some of the other staff are going so, I could attend my friend's birthday lunch but still work that day."*

"I would go to work and arrange to meet up with my friend at another time."

These findings show that for these GRNs who are managing their life roles effectively are knowledgeable and confident in negotiating the organisations' structure and processes regarding changing shifts and requesting days off. They also possess qualities of being flexible and adaptable, as well as firm to implement life role boundaries in their approach to managing their competing life roles effectively.

While for some GRNs, their life role values differed. For example, it emerged that some GRNs chose to value their work role over their personal/friendship role. This value prioritisation emerged as GRNs' devoting more time and effort into their work role. In addition, it emerged that this value prioritisation was based on important concerns the GRNs' held. One GRN participant revealed their work role prioritisation was due to ensuring safe practice.

"If I have an early shift the next day, I wouldn't attend the BBQ as I would forever be thinking what time it is and how much sleep I would require functioning safely in my job."

Another GRN participant shared that they prioritised their work role due work imperatives.

"I have not taken sick leave or carer\'s leave because of work priorities, as I feel I cannot afford to miss a day at work."

These findings show that these GRNs work role prioritisation is based on their personal and professional concerns in maintaining a level of safe nursing practice in their role as an RN, as well as for their health facility.

Life Balance

Life balance value held by GRNs emerged and included devoting time, effort and energy into creating a personal sense of a life in balance.

"Time management is vital in all areas of my life."

"I have a very healthy balance when it comes to work and personal life. It is so important to have a balance. I love going to work. But I make sure I also find time to exercise, eat healthy, travel and socialise."

Additionally, it emerged that GRNs who had a balanced life also expressed thoughts of job satisfaction.

"I love going to work."

The findings from Theme 1: *Individual GRN's values on their life roles - work/study/personal and life balance* and subtheme *Impact of GRN life role values* include:

1. GRNs' first-year transition experience can be varied due to their differing values about their work, study and personal life roles.
2. GRNs work and study roles were valued to enhance their work role performance and to ensure safe practice and quality patient care.
3. Patient safety is a meta value underpinning GRN work role and study roles.
4. Life balance value differed between GRNs.

Results presented in the next section relate to GRNs' perceptions about higher education and health facilities values and the impacts of these organisations values on the GRNs level of life role preparedness and transition support.

5.4.6.2 Theme 2: GRN's perception of higher education and health facilities values about their life roles work/study/personal and life balance and the impact of these values on their life roles and life balance.

GRN's perception of higher education and health facilities values about their (GRNs') life roles work/study/personal and life balance emerged as influencing their level of support in developing and or to confidently enact these life roles. This theme has two subthemes: 1. *Values and impact of higher education values (as perceived by GRNs) on preparing them (GRNs') for their work, study and personal life roles,* and 2. *Impact of health facilities values (as perceived by GRNs) on supporting them (GRNs') for their work, study and personal life roles*. The first subtheme is presented next.

Subtheme 2.1 Values and impact of higher education values (as perceived by GRNs) on preparing them (GRNs') for their work, study and personal life roles

GRNs' perception of higher education institutions' work, study and personal life roles values emerged as impacting the GRNs level of preparation, life

role experience and satisfaction, personal sense of health and wellbeing in their transition year.

Work role

The GRNs' perception of higher education institutions value in preparing them for their *work role* as an RN emerged as impacting their confidence. Furthermore, it emerged that high confidence suggests an outcome from adequate *work role* preparation, while low confidence suggests an outcome from inadequate *work role* preparation. High confidence outcomes are described first, followed by low confidence outcomes.

High confidence as an outcome from adequate *work role* preparation.

> *"I feel I have been taught well. I have just completed my graduate year with Queensland health in [a rural area] in Queensland. I have felt confident and competent in most aspects of work. I have had a great year. I was often on call, in charge of shifts. … I have had cardiac arrests, snake bites, heart attacks, car and motorcycle accidents, substance abuse, mental health, snake bites, paediatrics. Everything!"*

> *"[The university where I studied at] was a fantastic institution. I felt a great amount of support and guidance…which set me up well."*

Low confidence as an outcome from inadequate *work role* preparation.

> *"I wouldn't feel comfortable nursing a patient with a medical condition I'm not familiar with..."*

> *"I wish we had an intern year like Dr's. The grad year doesn't give enough support in learning. I am a grad nurse who doesn't have a background of previous nursing experience."*

Inadequate preparation to cope and manage an unkind workplace culture also emerged.

> *"…once graduated you are not prepared for what your about to face and how full on and nasty staff can get."*

Study role

The GRNs' perception of higher education institutions value in preparing them to support their *study role*, as well as to support their other life roles emerged as being inconsistent between higher education institutions.

An absence of study role support.

"University didn't prepare me for this at all."

The presence of study role support.

"I learnt this skill through studying ...

"...at university you are able to access support or assistance whenever you require..."

Consequently, this variability of *study role* preparation between graduates impacted their ability and confidence to support *all* their life roles. Furthermore, it emerged that high confidence suggests an outcome from adequate *study role* preparation, while low confidence suggest an outcome from inadequate *study role* preparation. High confidence outcomes are described first, followed by low confidence outcomes.

High confidence as an outcome from adequate *study role* preparation.

"I have been taught how to improve my learning through studying at uni."

"I often read over my notes."

Low confidence as an outcome from inadequate *study role* preparation did not emerge.

Personal - self-care role

The GRNs' perception of higher education institutions value in developing and enabling them to enact their *personal - self-care role* as an RN emerged as impacting their confidence. Furthermore, it emerged that high confidence suggests an outcome from adequate *personal - self-care role* preparation, while low confidence suggests an outcome from inadequate *personal - self-care role* preparation. High confidence outcomes are described first, followed by low confidence outcomes

High confidence as an outcome from adequate *personal - self-care role* preparation.

> *"I am very organised. Due to shift work and often being on call I do meal preparation in advance, so I stay healthy and fuel my body with good foods. I regularly exercise, at least an hour every day if not 2-3 hours. [The community where I live] offers a lot of sport and I have found it a good way to switch off from work. It's also really important to get involved in the community to keep a healthy mindset."*

Low confidence as an outcome from inadequate *personal - self-care role* preparation.

> *"Personal life once graduated is non-existent due to working constantly and unable to plan anything due to it being too difficult to get everyone together when you have a day or days off."*

Life balance

GRN's perception of higher education values about GRNs' life roles work/study/personal and life balance emerged as the level of support in developing them to enact these life roles in their transition year. It also emerged that the level of preparation varied between graduates and consequently impacted their transition year life balance experience.

The impact of adequate *life role/life balance* preparation emerged as GRNs achieving a personal sense of life balance.

> *"I have a very healthy balance when it comes to work and personal life. It is so important to have a balance.* ***I love going to work****. But I make sure I also find time to exercise, eat healthy, travel and socialise."*

While the impact of inadequate *life role/life balance* preparation emerged as GRNs not achieving a personal sense of life balance. It also emerged that when feeling overwhelmed, GRNs have increased thoughts of attrition and need ongoing support from their family and close friends.

> *"I think **this year is completely overwhelming and there is no way to balance the work commitment and pressures with the home life routines.** I wish my family and partner would be more understanding, instead they think they have put up with my study commitments for the past couple of years and don't think it's fair for them to wait another year for me to try and find my feet."*

Results for this section now move to the health facility values (as perceived by the GRNs) supporting them (GRNs') ongoing development of their life roles and their life balance and impact from this support on their life role and life balance in their transition year.

Subtheme 2.2 Values and impact of health facilities values (as perceived by GRNs) on supporting them (GRNs') for their work, study and personal life roles

Work role

The GRNs' perception of health facilities value of their ongoing development to further enable their *work role* as an RN during their transition year emerged as GRNs' experiencing facilitators and barriers. Facilitators impacted the GRNs positively and enabled their further development of their work role, while barriers impacted the GRNs' negatively and stalled their further development of their work role. Facilitators are described first, followed by barriers.

A few facilitators emerged concerning effective support. These included a positive work place culture that fostered a safe and non-judgemental environment to learn and the right type of support.

> *"I have the support of the people I work with if something arises that I am unfamiliar with."*

> *"I work in an environment where I am fully supported by my peers."*

> *"…nurses have been supportive…"*

> *"…the right support and great staff willing to help you learn you might just survive."*

Barriers also emerged concerning ineffective support that stalled their further development of the GRN's work role. These included not qualifying for education sessions and an unkind and unsupportive workplace culture.

> *"I was recognised as a graduate but not on the graduate program, so I did not receive the grad program education."*
>
> *"If you want to learn more you have to be willing to put yourself out there and sometimes be made to look like an idiot by some staff.*
>
> *"…the ward's educator is not as supportive [than the nurses]. It depends on each individual and their workload on how much support is given."*

Study role

The GRNs' perception of health facilities supporting GRNs' continuing professional development (CPD) *study role* to support *all* life roles values emerged as GRNs *study role* support varying due to a number of facilitators and barriers. Facilitators impacted the GRNs positively and fostered their *study role*, while barriers impacted the GRNs' negatively and stalled the fostering of their *study role* and development of their *work role*. Facilitators are described first, followed by barriers.

A few facilitators emerged concerning effective *study role* support. These included a positive work place culture that fostered learning to fit in with the GRN's work/life pattern.

> *"I would see if I could…change in service [CPD] to another day…."*
>
> *"I am lucky enough to be in a workplace where staff are encouraged to seek assistance and all staff on the ward are always happy to help."*
>
> *"I enjoy in-service training and find it relevant to my practice."*

Barriers also emerged concerning ineffective support that stalled their *study* and *work roles*. These barriers included the health facility not offering CPD during scheduled work hours, as well as the work rostering schedule depleting GRN's energy levels, leaving little or no energy to devote to their CPD - *study role*.

"Nothing was ever offered within work time for me to attend. It was all additional to my workload."

"Unfortunately, I am not rostered on very often for my graduate education."

"I'm too tired on my days off to have time to recover from my shifts, to contribute to my ongoing-learning and to prepare myself for another 10shifts."

Study role – all life roles

The GRNs' perception of health facilities value to support their s*tudy role* to support *all* life roles, did not emerge.

Personal life role

The GRNs' perception of health facilities value to support GRNs' *personal life role* emerged as GRNs experiencing a number of facilitators and barriers within the work rostering support offered. Consequently, these facilitators and barriers impacted the GRNs ability to develop and enact their *personal life role*. Facilitators are described first, followed by barriers.

Ability to request unavailable days within the roster system emerged as a positive impact that enabled GRNs to enact their *personal life role*.

"Within my workplace I am able to request unavailable days within each fortnightly roster. I would have requested this day as unavailable so that I was able to balance my work and personal life."

While difficulty rescheduling within the work place rostering system emerged as negative impact to enabling the GRN's *personal life role*.

"It is far from easy to reschedule and socialising is not considered in the work/life balance of the facility I was working in."

Another barrier that emerged within the rostering scheduling system was the interpretation of a 'family friendly roster', that acted to exclude GRNs that weren't identified as having a 'family', rather than facilitate a work/life balance experience.

"...family friendly rostering is only for those with children! ...I worked 8 weeks straight without being given a weekend off and most of those shifts were nights or afternoons!"

Life balance

The GRNs' perception of health facilities value to support their life balance emerged as the level of support in developing them to enact a life in balance in their transition year. It also emerged that the level of life balance support impacted personal sense of health and wellbeing, life balance, life role satisfaction and thoughts of retention and or attrition.

Adequate life balance support emerged as GRNs experiencing a personal sense of life role/life balance, as well as health and wellbeing, happiness and job satisfaction.

*"I have a very healthy balance when it comes to work and personal life. It is so important to have a balance**. I love going to work.** But I make sure I also find time to exercise, eat healthy, travel and socialise."*

"Time management is vital in all areas of my life."

"I am very organised. Due to shift work and often being on call I do meal preparation in advance, so I stay healthy and fuel my body with good foods. I regularly exercise, at least an hour every day if not 2-3 hours. [The community where I live] offers a lot of sport and I have found it a good way to switch off from work. It's also really important to get involved in the community to keep a healthy mindset."

In adequate life balance support emerged as GRNs experiencing a life not in balance, health and wellbeing decline, as well all as being unhappy, low job satisfaction and thoughts of attrition

"Once you graduate you are so busy keeping up with work and as a result, your personal life becomes non-existent. I have been sicker this year from things then when at university, personal health is not great at times due to stress and anxiety."

"My personal life has suffered during my grad year because I have been isolated from my family (because I work in the rural setting). I've been too tired to make an effort for friends, text them or talk on the phone. I've gained weight too because of working shift work therefore I have low self-confidence/esteem. ***If I had my time again, I wouldn't be a nurse****. It's such an unsustainable lifestyle. I've gone from being an outgoing, extroverted person to a depressed loner."*

The findings from Theme 2: Subtheme 2 *Impact of health facilities values (as perceived by GRNs) on supporting them (GRNs') for their work, study and personal life roles* include:

1. GRNs' first-year transition support experience can be varied due to the varying levels and types of work, study and personal life role and life balance support.
2. GRNs' first-year transition *all* life role support was enhanced when the health facilities structures and supports were easy to access and implement, as well as when kind and supporting workplace culture existed.
3. GRNs' first-year transition *all* life role support enhanced their personal sense of life role satisfaction, and life balance, as well as their personal sense of wellbeing.
4. GRNs' first-year transition *all* life role experience was negatively impacted when the health facilities structures and supports were difficult to access and implement, as well as when little of no '*all* life role support was offered.
5. GRNs' first-year transition *all* life role and life balance experience was negatively impacted from little or no '*all* life role' support. Outcomes from this included a personal sense of health and wellbeing decline, life role dissatisfaction, and a life not in balance, as well as thoughts of attrition.

Phase 2 survey results summary is presented in the next section.

5.4.7 Layer 3: Phase 2 survey results summary

Phase 2 survey results for the main research concerns within Section 1 and Section 2 of the survey has been presented. Section 2 was presented first and included GRNs' Demographics followed by Section 1, and presented results for the *Load Triad*, Wellbeing and Support Impacts, and GRNs' perceptions about their university and transition education preparedness. A summary of Section 1 and 2 results is presented below, beginning with Section 2, demographics.

5.4.7.1 Section 2

Section 2 focussed on demographics and revealed GRNs are diverse with most characteristics mirroring the GRNs in Phase 1 of this study. The benefits of understanding these broader characteristics is twofold. Firstly, they contribute to the limited pool of knowledge regarding the broader demographic characteristics of GRNs across the rural, regional and metropolitan areas in Queensland, Australia. Secondly, this knowledge assists key nursing and educational stakeholders enhance work force retention and education design.

5.4.7.2 Section 1

Section 1 focused on the *Load Triad*, Wellbeing and Support Impacts, including GRNs' perceptions about their university and transition education preparedness.

The study found that GRNs placed high importance on their work and study roles, while their personal self-care importance was low in comparison. This positioning of work, study and personal role importance mirrored their positioning of study topic focus: that the majority of GRNs preferred work topics over topics including the broader aspects of life generally.

GRNs were also found to be predominantly unsure about their happiness status. However, it was also observed that regardless of their happiness status and even the context of experiencing work stress and personal challenges, they were firm on their commitment to their RN work role and not likely to call in sick or leave nursing.

GRNs received support regarding work errors and most of the time found the support helpful, however the timeliness of this support was low. Support regarding their personal impact of making an error or support beyond the work focus was also low.

GRNs thoughts about their university and transition education preparedness for the graduate year working as an RN revealed they were divided about this.

Section 1

The load triad: Work

Topic 1: Life role salience

Scenario: 1

GRNs as a homogenous group have strong work role salience. Just over half identified that they would have difficulty managing competing life roles; that is, in this example, personal friendships against work and in-service training. As a heterogeneous group based on the broader demographic characteristic, employed either within or not within a transition program, GRNs employed in a transition program worried more about how to manage competing life roles.

The load triad: Work

Topic 2: Under preparedness for the reality of work

Subtopic: Fundamental & specialty nursing knowledge and related skills

Scenario: 2

GRNs as a homogenous group are prepared in how to seek out resources to support the care of a patient whose condition is new to them. As a heterogeneous group, RNs employed in a transition program are less prepared in how to care for a patient based on principles of care and worry more about how harming the patient.

The load triad: Study

Topic 3: Study role salience

Subtopic: Competing life role salience

Scenario: 3

GRNs as a homogenous group have strong study role salience regarding work, with GRNs in a transition program being higher in terms of this result. Consultation regarding work learning needs was identified as occurring for half of GRNs as a homogenous group, while most agreed they would like training on available

topics that would assist them generally as GRNs. Training topics assisting GRNs about how to learn, as well as topics about how to manage personal issues, were found to be trending differently for GRNs as a heterogeneous group, with GRNs employed in a transition program positioned lower compared with half of GRNs not employed in a transition program.

The load triad: Personal

Topic 4: Personal role salience

Subtopic: Self-care role salience

Scenario: 4

GRNs as a heterogeneous group trended differently regarding their happiness status, with under half of GRNs employed within a transition program unsure whether they were happy or not compared to just under one third of GRNs not employed within a transition program.

As a homogenous group, self-care in relation to maintaining nutrition when feeling overwhelmed with personal challenges, was low. However, a subtle trend was noted as a heterogeneous group with one third of GRNs not in a transition program prepared to make themselves a healthy lunch even when experiencing a personal issue.

Self-care in relation to seeking personal support from either a friend or doctor was low. However, results regarding self-determined self-care strategies to action, suggested a trend in GRNs as a heterogeneous group, with GRNs employed within a transition program more confident in this skill compared with GRNs not in a transition program.

Wellbeing impact

Topic 5: Wellbeing role salience

Subtopic: Wellbeing preparedness and attrition intent

Scenario: 5

GRNs, as a homogenous group, have conflicting work, personal role salience when feeling low and experiencing work stress. Thus, their intentions to call in sick varied. A trend was noted however, with GRNs employed within a transition program less likely to call in sick compared with GRNs not in a transition program.

Perceptions about finding another nursing job at another place or finding a different job other than nursing were found to be unlikely. However, a subtle trend was noted, as a heterogeneous group, with GRNs not in a transition program positioned as having more steadfast attitudes about this.

GRNs' wellbeing, based on personal connectedness about sharing how they were feeling with others, as a heterogeneous group trended differently. GRNs not in a transition program were more willing to share how they were feeling compared with GRNs employed within a transition program.

As a homogeneous group, participants showed they were steadfast in not seeking support from a doctor. However, a subtle trend was noted as a heterogeneous group with GRNs in transition programs being more steadfast about this.

GRNs, as a homogeneous group, were less likely to implement self-determined self-care strategies by referring to online support groups. GRNs as a homogenous group were not committed, either, to self-care strategies that included going for a walk or similar and or planning something nice for themselves.

Support impact

Topic 6: Wellbeing culture

Subtopic: Kindness and caring approach to peers

Scenario: 6

GRNs, as a homogenous group, experienced situations at work where nurses were both unkind and kind to them after errors were made.

Support received in the work place after an error was identified as mostly helpful, helping them to learn in a positive way. However, findings about work place support being timely was low, with GRNs, not within a transition program, experiencing less support than those in transition programs.

Preparedness education on how manage the work and personal impacts of making errors was limited, as perceived by GRNs as a homogenous group. Support received in the work place after an error and extending beyond the work error focus, including offers of support for other issues related to work, study and personal life, was perceived by the GRNs, as a homogenous group, to be low.

Topic 7

Thoughts on university education

GRNs as a homogenous group revealed they are split regarding their level of satisfaction with their university education preparation regarding their confidence on nursing knowledge and skills and in managing new work situations in and beyond their graduate year. While less than half were prepared on how to manage *all* their life roles. Areas GRNs were confident in were in their ability to further their learning to support their nursing practice and their personal self-care role

Thoughts on transition education

GRNs as a homogenous group revealed differences regarding their levels of satisfaction about their transition education support in their ongoing development of their nursing knowledge and skills. In relation to work support initiatives in the context of making an error was high, while support in relation to managing new work situations was sound. Support in developing their self-care was fair for those in a transition program but higher for GRNs not in a transition program, while support to manage *all* life roles was low. However, GRNs self-reported abilities to manage all life roles was high, however this result conflicted with earlier results where self-determined strategies to manage self-care role was low. However, phase 2 thematic analysis revealed that GRNs displayed several proactive strategies to manage self-care. Consequently, these differing results provides an opportunity for further research.

Phase 2 thematic analysis provided supporting evidence for GRNs experiencing adequate and inadequate support of *all* life roles. Importantly, these results identified the positive impact from adequate support. These included outcomes of confidence and satisfaction in *all* their life roles and a personal sense of health and wellbeing. While negative impacts were identified from inadequate support. These included low confidence and dissatisfaction in *all* their life roles and a personal sense of health and wellbeing decline and thoughts of attrition. Together, these findings show that transition education programs need to operate from an evidence-based platform to ensure their programs, including the CPD and support initiatives offered are more responsive to GRNs' needs to be more supported in *all* aspects of their work, study and personal life roles.

5.5 CHAPTER SUMMARY

The research concern results presented revealed trends across all topics. The main finding is that GRNs' have high work role salience followed closely by high study role salience. This high role salience however is not always transferred to their personal role salience, including personal self-care. This emphasises that GRNs' first year experiences are not in balance. Reinforcing this imbalance, are findings relating to GRNs' lack of self-determined wellbeing in implementing self-care strategies for themselves. The lack of support is exacerbated by work place cultures not able to offer support that is broad enough. This means that GRNs' life imbalances often remain unnoticed and unsupported.

Augmenting this life in imbalance, are GRNs' thoughts about their undergraduate and transition curricula which revealed that they were under prepared for managing their work, study and personal lives to promote their sense of overall life balance and wellbeing in their first year.

Subtle variances were also noted between the GRNs as a heterogeneous group which indicated that this broader demographic characteristic was an inter-relating factor.

Chapter 6: **Discussion**

6.1 CHAPTER INTRODUCTION

The Graduate Registered Nurses (GRNs) first year experiences in relation to work, study and personal life are important measures in their own right in relation to the quality and effectiveness of GRNs' undergraduate education and training: '*becoming*' a nurse and transition support to enact their role, '*being*' a nurse. This study's discussion of Phase 1 and Phase 2 results are presented as two separate, but linked chapters. Furthermore, to provide an enhanced meaning of the results, Phase1 and Phase 2 discussions are anchored in relation to this study's research question, philosophies and theories in use, the literature examined, and the theoretical and conceptual framework and hypotheses. The meaning of Phase 1 and Phase 2 results are demonstrated in the following ways. Firstly, they demonstrate how the knowledge gained extends the current pool of knowledge. Secondly, they show how it contributes new knowledge in nursing education and the inter-related disciplines of psychology – life roles, including life career role preparation and organisational management of GRNs' safe transition into the work place using risk management. Thirdly, the results direct future reform in improving student nurse preparation, '*becoming*' a nurse, and GRN transition support in '*being*' a nurse. Fourthly, the results are important in seeking to identify the additional impacts within GRN transition that other professions do not experience. For example, entering unsafe work environments and traditionally hospital-based environment. Lastly, the results direct a targeted improvement in GRN preparation and support to manage the additional nursing transition impacts and prevent their health and wellbeing decline and attrition and close the loop on the nursing shortage.

The chapter commences by revisiting the research rationale, aim and research question to anchor the discussion. The chapter then summarises the study's original and significant contributions to knowledge. The hypotheses are revisited, but with the intention of proving or disproving them, supported by an in-depth interpretation of the results in light of the current discourses exemplifying the GRN first year experience. In addition, as an outcome the discussion and in relation to the philosophies and theories discussed in the literature review and the theoretical and

conceptual frameworks advanced, three new inter-related nursing theories are presented. Theoretical and practical implications are provided to guide recommendations, followed by a chapter summary.

Prior to delving into this chapter, Chapter 5 results are briefly revisited. Chapter 5 found that GRNs' have high work role salience followed closely by high study role salience. This high work and study role salience, however, is not transferred to personal role salience, including personal self-care. Thus, this type of life role prioritisation designates that their first year is not balanced. Reinforcing this imbalance is the GRN's low self-determined wellbeing abilities to implement self-care strategies. Augmenting this, is the transition support work place culture, which does not consistently offer a broader support that includes life balance and life role salience and self-care. Thus, there is a decline in GRNs' life imbalances and personal self-care and further, this remains unnoticed and unsupported. This lack of awareness by the transition support 'nurseries' places GRNs' wellbeing and retention at risk. Furthermore, this study also argues that the undergraduate nursing education 'nurseries' also do not consistently provide broader transition preparation to promote students' personal sense of wellbeing (and their potential retention) in their first year, and beyond, to enact all their life roles. The following section revisits this research study's current research understanding which includes, the rationale, aim and research question to anchor the discussion chapter, before progressing the research understanding.

6.1.1 Revisiting this study's research understanding so far

This brief recount, underpinning the research rationale, aims and research question, provides an opportunity to re-establish the connection between these, the results and the discussion which follows.

6.1.1.1 Rationale

Revisiting the research rationale reinforces initial understandings about the research concern and the impetus for undertaking the study. The rationale for this research study emerged from my professional situated experience of being both a GRN and later a GRN Educator. During this period, the researcher was a witness to nursing shortages, the attrition of first-year nurses and the declines in the resultant health and wellbeing and the wellbeing risks for nurses who remain and the patients they care for.

Current literature confirms the concern of health services in relation to their ability to supply adequate numbers of nurses to meet the expected demands for health care due to the current global nursing shortage. Thus, to help close the loop on the nursing shortage, this study chose to focus on improving understandings about GRNs' first year of work, study and personal life, the *Load Triad* experience. The desired outcome of this improved understanding is to provide organisations that focus on workforce and training reforms, such as the HWA and health organisations employing GRNs, with knowledge about how to improve the education and transition support for nurses Such improved support will aid in GRNs' retention and increase the supply of nurses to meet the imminent demand for nurses.

6.1.1.2 Aim

Revisiting the aim of this study is important in reiterating the research intentions and the desired outcomes of the research. The aim of this study was to determine specific factors in GRNs' work, study and personal lives, the Load Triad, to form preliminary indicators that identify GRNs at risk of life imbalance. The purpose of identifying these indicators is to align these indicators to targeted education and support strategies that will provide meaningful and on time support to GRNs. Overall, the aim of this study was to improve the GRN first year experience by gaining an improved understanding of the factors impacting their first-year experience from a broader life balance platform, to aid in their retention and assist in closing the loop on the nursing shortage. To achieve this overall aim, this study implemented a mixed methodology with two interconnecting phases (see 4.7.1). Phase 1 and Phase 2 are described below.

Phases 1 and 2

Phase 1: Qualitative Method: Focus Group. To explore the data regarding factors impacting the GRNs first year experiences managing the Load Triad and its overall impact to their life balance and intent to leave the nursing profession.

Phase 2: Quantitative Method. A survey designed to determine the generalisability of Phase 1 qualitative findings. The survey also included a qualitative component that enable respondents to add comments for each of the survey's six topics.

6.1.1.3 Research question

Revisiting the research question is important in highlighting the key research topics of concern and the targeted direction of the answers being sought. The answers are important to enhance awareness about the GRN first year Load Triad experience and advance act as quality drivers for reforms. Evidence-based reforms are vital to improving the GRN first year experience and their retention within the profession. This study's research question was:

> What are the factors impacting the Graduate Registered Nurses first year experience in managing their work, study and personal life and to what degree do these factors and the possible relationships between them, impact on their overall life balance?

In response to this research question, several factors emerged within the life balance domains of work, study, and personal life, with two main themes resonating –GRN preparedness and GRN under preparedness – so that nurses are empowered to effectively enact their roles of 'being' a nurse. This discussion primarily focuses on areas of weakness, GRNs' under preparedness that negatively impacted their transition experience and personal wellbeing and life balance, in order to guide reforms that will aid GRNs' retention in the profession. These areas of weakness fall within being under prepared and under supported in the following areas:

1. the reality of work:
    a) entering unsafe workplace environments,
    b) entering a traditionally hospital-based environment and associated workplace culture,
    c) to confidently enact their new role, as an RN;
2. managing RN role transition with competing life roles, in particular their personal role - self-care role to maintain and or enhance their personal wellbeing.

This chapter discusses these areas of weakness as unfolding transition journeys, firstly sustained by evidence from Phase 1 and secondly drawing on Phase 2 findings to either confirm or deny these.

The discussion about the unfolding GRN transition journey highlights several inter-related factors in play which are ranked by research participants in terms of the impact on their personal life roles and life balance values. The chapter reveals how these factors do not operate in isolation and are inter-related for research participants. The following sections will map the unfolding transition journeys of 'becoming and being a nurse' and the relationships between factors. The main factors include:

1. Personal cultural life role and life balance values and life role and life balance values of nursing workplace cultures
2. Typical life career role transition challenges
3. Additional transition impacts unique to nursing •
    a) Transition shock
    b) Entering unsafe work environments
    c) entering traditionally hospital-based environments and associated values, attitudes and views of new graduates,
    d) Fundamental nursing practice knowledge, skills and clinical experience
4. The nexus of workplace culture life role and life balance values and individual GRN life role and life balance values and GRN self-care, life role satisfaction and their personal health and wellbeing.

Prior to progressing to proving and or disproving this study's hypotheses, an early summary of the original and significant contributions to knowledge is presented next.

6.2 ORIGINAL AND SIGNIFICANT CONTRIBUTIONS TO KNOWLEDGE

A summary of the study's original and significant contributions to knowledge are provided here to forecast conclusions emerging from the discussion. The study found the central factors, from the perspectives of the participants, were inadequate preparation in terms of the importance of life balance and self-care to maintain personal health and wellbeing and inadequate broader 'concern and care' transition support. Such inadequacies place GRNs at increased risks of life imbalance and declines in life role and wellbeing and associated thoughts of attrition. These increased risks stem from GRNs' lack of awareness, knowledge and action strategies about life balance and life roles, including life career role preparation, effectively due to the education 'nurseries' not responding to the changing nature of the health work environment. One very important aspect to emerge from the findings was that 'becoming and being a nurse' needed to occur in relation to a broader life role education platform and framework of risk assessment and care management of GRNs, primarily to support GRNs' safe and healthy transitions. Within the broader framework of GRN risk assessment, the study also found two key areas which need to occur to fully enable the transition from '*becoming a nurse*' to '*being a nurse*'. These areas are disruptions to the current nursing education and training, to nurses' discourses and to nursing workforce environment and culture that both receives the GRNs and supports their transition to '*being a nurse*'. These concepts permeate the discussion. This conflation of factors is a new contribution to knowledge.

The following section revisits this study's hypotheses, with an explanation divulging how the findings prove the study's hypotheses.

6.3 HYPOTHESES

It is hypothesised that GRNs who are adequately prepared and supported to become nurses with transitional supports into and throughout their first year of nursing, will express higher degrees of happiness and perceptions of life balance, including life role salience. This transition support enables GRNs to effectively function in all their life-roles, increasing their overall satisfaction, health and wellbeing, compared with those nurses who have not experienced this degree of preparation and support.

6.3.1 Sub-hypothesis 1

It is further hypothesised that GRNs who are adequately prepared and supported by experts is an outcome of careful educational planning. This includes educational design which aligns the immediate and long-term goals and expectations of the student nurse and or GRN with the broader goals and expectations of society. Such educational design needs to also be aligned with the requirements and expectations of health work force planners, health organisations and higher education and with nursing professional philosophies and their associated governances.

6.3.2 Sub-hypothesis 2

It is also hypothesised that a change in preparedness impacts on GRNs' life balance.

6.3.3 Hypotheses - proved

The findings from this study support the main hypothesis and sub-hypotheses 1 and 2: that without these factors in place, GRNs are unable to express enhanced degrees of happiness. This includes their perceptions of life balance and a life role salience which enables them to effectively function in all their life-roles as well as with overall satisfaction, health and wellbeing. Thus, making changes to GRN preparedness will improve life balance and in the absence of making these changes, GRN life balance will not improve.

To further support the study's hypotheses, the following section presents an in-depth substantive discussion of the results in light of the current discourses surrounding the GRN first year experience. The first transition merged from the shift involved from '*becoming*' to '*being*' a nurse. It draws on evidence from Phase 1, focus group GRNs, and will use their words as 'instruments of thought' to improve the GRN first year experience. Phase 2 results will also be included to confirm the applicability of Phase 1 results to the wider Phase 2 sample and its interpretation of meaning. Understanding the GRNs' transition from '*becoming*' (undergraduate stage) to '*being*' a nurse (practicing as an RN), is critical in their personal and professional development because of the need to support their life roles, assent and ascent, and to their life balance and wellbeing and their retention in the profession.

6.4 GRN LIFE CAREER ROLE TRANSITION CHALLENGES

Transitioning into new professional roles may present challenges for many graduates regardless of the professional discipline they may be entering for the first time. However, the contemporary health workplace environments nurses enter along with how nurses work has changed and presents additional and unstandardised transition challenges.

Standardised transition challenges graduates may encounter are often due to entering a new life stage and or needing varying levels of coping and adaptability skills and support to manage their new work role with their other life roles and wellbeing (Arnett, 2000; Savickas, 1997; Schulenberg, Bryant, & O'Malley, 2004; Super, 1980). Additional challenges include a lack of realistic well-informed expectations (Murphy, Blustein, & Bohlig, & Platt, 2010). To assist with these typical transition challenges, higher education institutions offer life career role education and support, to assist graduates confidently enact their new professional roles with their other life roles to ensure their personal sense of job satisfaction, wellbeing and retention (Holland, 1973; Holmes, 2013; Longworth & Davies, 2003; Patton & McMahon, 2014; Richardson & Schaeffer, 2013; Savickas, 2013; Super 1975; 1980).

Additional and unstandardised transition challenges GRNs encounter are due to the safety and wellbeing risks health environments pose. For example, nurses are at risk of physical and psychological harm from physical and verbal abuse from patients, their families and visitors, as well as lateral violence from colleagues (Howerton Child & Mentes, 2010). Additionally, they are at risk of fatigue, insomnia, anxiety and depression from fulltime time shift-work (Eldevik, Flo, Moen, Pallesen, & Bjorvatn, 2013). In addition, they are responsible for the delivery and coordination of safe, quality patient care (NMBA, 2016b) in the context of "funding constraints, staff shortages, increased work hours, casualised workforce, new skill mix and an ageing workforce (Manser, 2009; NSW Nurses & Midwives Association, 2013, p. 9). Other risks (ICN, 2006) include:

> biological (viruses, bacteria), chemical (Glutaraldehyde, cytotoxic drugs), ergonomic (overexertion, falls, lifting [manual handling]), physical (radiation [medical technology and insufficient training], sharps), …lack of maintenance, inadequate access to protective clothing and safe equipment, inadequate allocation of resources, and

> community settings in which hazards are not appropriately controlled, …geographically and professionally isolated settings. (p. 1)

Furthermore, GRNs are entering traditionally hospital-based environments, steeped in hospital-based training constructs creating a mixture of personal values by the nursing staff who may either be hospital or university educated and trained (Freeling & Parker, 2015). Combined, these additional impacts create higher transitioning challenges that threaten GRN wellbeing and attrition. In consideration of these additional transition impacts, it is important to ensure GRNs are adequately prepared and supported to manage these risks to prevent erosion to their work role and other life roles to assist them to feel safe in the work place and in their ability to maintain their personal sense of health and wellbeing.

The following GRN transition story of '*becoming* and *being a nurse'*, reflects the GRN's life career education preparation and transition support by their education and transition support '*nurseries*' to confidently enact their new role as an RN with their other life roles.

6.4.1 Becoming and being a nurse

Successful transition is directly related to effective educational and training preparation and transition support by the 'signature nurseries'. Consequently, adequacy of a graduate's education preparation and transition support is evidenced by the individual being able to confidently and effectively extend their effort and energy across *all* their life roles in a purposeful way to achieve a personal sense of life role satisfaction, life balance and wellbeing (Magee et al., 2012; Meyer & Maltin, 2010; Longworth & Davies, 2003; Pryor & Bright, 2003a). This context is highly relevant to GRN work and life readiness, considering the changing nature of health environments and how nurses work. This study has found under preparedness in '*becoming*' an RN has emerged as a major risk indicator to GRNs' ability to effectively and confidently transition into '*being*' an RN and to fully enacting their other life roles. Additionally, this study has found that as outcome of this under preparedness, the GRNs personal sense of life role satisfaction and wellbeing declined, together with thoughts of attrition. Specific areas relating to under preparedness and inadequate transition support included: 1. GRN's awareness of feeling low confidence to enact their RN role in an unfamiliar clinical setting; implementing fundamental knowledge and skills;

delegation; and clinical experience, 2. Health work place culture, 3. Health work environment, 4. Transition shock, 5. Self-care, 6. Wellbeing and the nexus of culture, and 7. Life balance and life role salience. These combined areas generate risk indicators threatening GRNs' successful transition into '*being*' an RN and to effectively provide safe, quality patient care. These risk indicators provide improved understandings about the factors impacting the GRN first year *Load Triad* experiences and can direct reform to improve GRNs' transition experiences in '*being*' an RN and their retention within the profession. The key then is to reduce these 'under preparedness' and 'inadequate transition support' risk indicators. These aspects are discussed next.

6.4.2 Phase 1: Transition journey

The health work environments that GRNs enter and how nurses work has changed, therefore, it is timely to reflect and review the GRN transition journey experience to explore the adequacy of their education and training preparation and support in effectively '*becoming and being a nurse*'. As well as to reflect and review the support GRNs received to manage these additional transition challenges. Gaining an improved understanding about their experiences will establish quality indicators of the effectiveness of their '*nurseries*' education and training preparation and transition support in suitably preparing nurses for the 21st century nursing context. Furthermore, the GRN's experiences will inform reform strategies to improve their '*becoming and being a nurse*' experiences to further mitigate their risk of health and wellbeing decline, life role dissatisfaction and attrition from the profession and close the gap on the imminent national nursing shortage.

The following GRN transition story of '*becoming and being a nurse*', reflects the GRN's life career education preparation and transition support by their education and transition support '*nurseries*' to confidently enact their new role as an RN.

6.4.2.1 Student nurse to Registered Nurse: GRNs initial concerns

The GRNs transition story begins at the very point of their role transition from student nurse to Registered Nurses (RN) and reveals their initial transition position was vulnerable due to inadequate work ready status. This weak positioning revealed their transition challenges would be augmented. Diana begins:

"It's been hard, definitely."

"Previously I went from working in hospitality, sandwich artistry, to nursing. It's a lot harder to begin with. I don't have the experience...that people have as an AIN showering people, manual handling."

Brooke adds:

"Yeah, we'd never showered or dispensed pharmacology, except for pracs, we'd never done that before where... I suppose if you've [Anne and Tina] worked at that same place and had the experience, you know the routine of the place. You know the patients. Yeah, that would make it so much easier… You know how to get them up and you know the best way to work. It was kind of tiptoe-y for us around the beginning while we were trying to find our feet. I found they took real offence like, oh, you've never done that before. Come on. Give us a break. We've left school and we've just left university."

The story moves to Anne and Brooke who share about their thoughts in transitioning from their nursing student role to RN role. Anne reflects:

"Yeah, you feel like it's - yeah, you study, study, study, study. Okay, now it's yourself now...no-one's going to watch me do it. Yeah, because at uni you learn all your skills but you're all learning them being supervised…When I first started, I used to do something and then I would go to my manager and say this is what I've done".

Brooke shares her insights:

"That's what it feels like. You think, do I know enough? Will I be able to do this? Yes, thinking you can't do this. You're like, oh, should I back out now?"

Diana, Anne and Brooke's experiences reveal a lack of confidence in enacting their work roles autonomously as RNs due to inexperience. Based on lifelong learning and associated life role outcomes, confidence comprises a life role outcome

and is further evidence of an effective education (Longworth & Davies, 2003). For these three GRNs, their prior education and training in '*becoming*' a nurse did not produce an outcome of confidence in '*being*' a nurse. These three GRNs' lack of confidence indicates an under preparedness to effectively enact their role '*being*' an RN, suggesting ineffective education and training by their '*nurseries*' in effectively preparing them for their RN roles.

Tina's experience is slightly different from the previous three GRNs. She shares her thoughts at the time:

> *"That's why one of the reasons I didn't get a postgrad. I didn't want one actually. But I found aged care, because I'd been doing aged care for so long as an AIN and EEN. For 15-odd years, I knew the ins and outs of it. I thought, no, I'm not going to get a postgrad. I'll do something I'm familiar with."*

Whilst Tina's experience revealed a confidence to enact her RN role within an aged care setting due to her previous nursing work role experiences an Assistant in Nursing (AIN) and as an Endorsed Enrolled Nurse (EEN), a lack of confidence to enact her RN role in a health setting other than aged care emerged. Based on lifelong learning and associated life role outcomes, confidence to enact one's role in 'all environments and circumstances' is also important and also forms part of outcome measures designating an effective education (Longworth & Davies, 2003). For Tina, her prior education and training in '*becoming*' a nurse did not produce an outcome of confidence in '*being*' a nurse to enact her RN role in 'all environments and circumstances'. Consequently, Tina's reflection also highlighted that her purposeful choice in choosing a familiar work environment was essentially to compensate for her inadequate education and training and to boost her self-confidence to effectively enact her RN role. This was confirmed when Brooke asked her this question:

> *"Did you find that that boosted your confidence after starting out in the beginning?"*

Tina responded:

> *"Yes, because I think if I had gone into hospital - do you know what I mean? It's foreign. I mean, I've already got that rapport with the residents. You know what I mean? You know your*

boundaries and things like that. When staff ask you something, you've got that - well, I know that. You know what I mean? You don't say, oh, well, I know that because I did that, but you know when they're trying to put something over you. You try and get them to do cares a certain way and they say oh, no, we don't do it this way. It's like, well, you might not, but I'd like you to do it this way. It's made it a bit easier having that aged care unit there."

Anne agrees with Tina about her thoughts and decisions to support enacting her RN role and adds her own thoughts about her transition choice to also work in a familiar environment: Aged Care. Anne shares her thoughts:

"Generally, yeah, I was worried because you're nervous, coming out from uni because - you had someone with you for all these things all the time at uni. On clinical pracs you've got that RN with you for everything you're doing. So, for me, being an RN totally on my own, doing it in aged care where I've been working for three years prior, it makes it easier because you're familiar with it because I'd seen what the RNs would do there when I was an AIN. So, I knew what to expect."

Anne and Tina's life career role transition decisions reveal their lack of confidence to enact their RN role in 'all environments and circumstances', but it also discloses a transition choice that is compensatory in nature in response to ineffective education and training preparation, and to address their education inadequacies, they embodied their agency to support their success in enacting '*being*' a nurse due to ineffective education and training by their '*nurseries*'.

The four GRNs lacked confidence to enact their RN role as they embarked on their new career as nurses reflects more than an under preparedness in life career role education by their '*nurseries*', it reflects inadequate education and training and assessment of preparedness at the fundamental level by the higher education '*nurseries*'. Consequently, this inadequate level of preparedness impacted their ability to effectively and confidently transition from their previous student life roles to enacting their new RN role.

Fundamental knowledge and skills combined with authentic clinical experiences are the basic building blocks for professional nursing practice delivered by the undergraduate '*nurseries*' to ensure students are prepared for their role in '*being*' a nurse (an RN) in the contemporary health setting. Without the possession of adequate fundamental knowledge and skills and an opportunity to apply these within in a variety of meaningful authentic clinical settings (together with a shared understanding about what these are between stakeholders) GRNs' transition to successfully enact '*being*' an RN is at risk.

The four GRNs revealed further they were not prepared in a range of knowledge and skills. The two GRNs Diana and Brooke identified their areas of weakness were showering, recognising when a person was deceased and removing clothes from a deceased person and providing families, especially distraught families, information about patient care. However, all four GRNs confirmed they also had trouble with making clinical decisions, giving injections, providing palliative care and peritoneal dialysis. One main concern that all four GRNs shared was role delegation.

Role delegation knowledge and skill is an example of a fundamental knowledge and skill set. Role delegation is a critical part of an RNs' central role to ensure that safety and quality care are delivered to patients, as well as to support the overall efficiency of the nursing team (NMBA, 2016b). Delegating is an authorised part of the RN role for which the RN is responsible and accountable. Delegating effectively is based on ensuring safety and quality of care is delivered to the patient and their family, as well as the safety and wellbeing of the individual nurse and the individual nurse's scope of practice in accepting the delegation (NMBA, 2018). With these aspects in mind, it is critical that the RN delegates from a position of being well informed prior to delegating the care to be implemented (Mueller & Vogelsmeier, 2013). The GRN transition story continues, with Anne and Tina shifting the conversation to delegating.

Anne and Tina revealed they also had personal concerns about delegating to others as an RN, with their concerns emerging prior to commencing their new role as an RN. Tina shares her concern:

> *"I found that before I started as an RN, I started to worry about having to delegate to more experienced Enrolled Nurses. This delegating was concerning me."*

Anne shares how she was also worried about the adjustment she needed to undergo to '*be*' the RN. She describes this worry:

> *"I was always so paranoid about what the other staff who I used to work beside as an AIN would think and how they would take me and treat me. On the most part, it was good, but you had particularly the older ones that had been there for a long time and stuck in their ways and you're young, just finished university."*

Brooke also shares her concern about her ability to be able to effectively and confidently delegate to nurses older than she was:

> *"Diana and I we went to high school, then we went to uni, then we started nursing, but nowhere in that time had we worked in a hospital, in a nursing home. We were in completely different fields of work and never done any kind of nursing. So then to be 21 and to jump up and delegate to someone who is 30 years older than you and with 20 years more experience than you have – they found it hard to."*

In addition, Brooke and Diana express their relief that Tina and Anne had similar concerns about delegating.

Brooke:

> *"It makes us feel so good that even you guys have that same problem [laughs]. It's a universal problem."*

Diana reinforces:

> *"It's hard."*

While Anne shared her concern in relation to the responsibilities of her RN role:

> *"It's having the responsibility that scares you. I used to as a student nurse, document, you're documenting things. The uni would say make sure you tell your RN everything. When you document, inform the RN. I was like, oh, my God I'm the RN now."*

Brooke agrees about the concern surrounding the level of responsibility she has as an RN and adds her similar experience working within the hospital ward setting.

> *"They come and ask you a question like, and you're like, I don't know if I'm the right person to be asking right now [laughs]. You're like, oh God, no, it lands on my shoulders. That's my responsibility."*

> *"Come back to me. Yeah, that was daunting, but I'm not scared by it now, whereas 11 months ago [laughs]. I think that's made me confident. That's the biggest thing, I think, is the confidence."*

Anne and the other GRNs agreed with Brooke, that delegation is all about confidence.

These results signify that being under prepared for their role is an area of concern that requires immediate action. GRN under preparedness in fundamental knowledge and skills and associated lack of confidence is an area already known in the literature (Dyess & Sherman, 2009; Olson, 2009; Romyn et al., 2009). Furthermore, the literature has revealed the longstanding mismatch in GRN preparedness expectations between industry, GRNs and the university setting (Duchscher, 2008; Rheaume, Clement, & LeBel, 2011; Woods et al., 2015). There are also concerns associated with the validity and reliability issues of practical clinical assessments in adequately assessing GRNs' competency (Ossenberg et al., 2016). Thus, this study validates that GRN under preparedness in fundamental nursing knowledge and skills remains a concern for GRNs.

The second main concern shared by the four GRNs was their undergraduate clinical simulation and professional clinical placement learning experiences. Clinical experience is an important developmental component of a student nurses' undergraduate preparation for their role as an RN to assist them to apply what they have learned into real world practice. The four GRNs shared their thoughts and concerns about university simulation and clinical placement experience in preparing them from their role as an RN. Anne shared her thoughts.

> *"The one thing that scares you is – because you talk to people and I was lucky. I did get to do things on my clinicals, but some*

people are saying I didn't get to do anything on my clinicals. Then they graduate."

This lack of quality clinical experience during undergraduate nursing programs was confirmed by all of the GRNs, "*yeah" ... "yeah*". Brooke complemented Anne's story:

"Some never got to go to a hospital and spent their entire clinicals in aged care".

Anne added:

"So, I was lucky. I got to do all those major basic skills that you need to do – inserting catheters and that sort of thing, I got to do them on my clinical. So, if I had to do it when I was finished, it wasn't so bad. But I think if you're one of those people that missed out on doing certain skills, you'd feel really nervous, because you would be like, I've only practiced that on a dummy and now I'm allowed to go and do that on a person."

Brooke reflected:

"That's the difference. It's a dummy. It doesn't talk. It doesn't move. It's not going to die. They will. They will die if you screw up."

The GRNs as a group were equally concerned about the adequacy of undergraduate clinical experience. Anne stated that "*I was lucky*" twice, which indicates she strongly believed her work role preparedness status came relied on the chances of obtaining quality experiences in clinical practicums. In addition, the GRN's anecdotal stories about other GRNs' undergraduate clinical experiences illustrate the inadequate aligning of fundamental knowledge and skills across into clinical experiences by the education '*nurseries*'. Best practice teaching and learning approaches stipulate the importance of cognitive and constructive alignment of curricula to achieving the specified learning outcomes (Boud, 2012; Mezirow, 1997; Tertiary Education Quality and Standards Agency, 2017; Wiggins & McTighe, 2001). In addition, clinical experiences need to also occur across a range of clinical areas to assist the student to fully enact the scope of their role as guided by the Australian

nursing standards (AHPRHA, 2009, Halcomb, Antoniou, Middleton, & Mackay, 2018; NMBA, 2016b). GRNs' beliefs that chance is the predictor of adequate and or inadequate clinical experience are a reflection that the education '*nurseries*' are not providing access to quality clinical experiences to adequately prepare their students for their role as RNs. This is an area for further research. The inadequate undergraduate positioning of students in meaningful authentic clinical settings to enable their full application of their fundamental knowledge and skills constitutes a major risk indicator to GRN work readiness.

Chance is not only acknowledged in the field of career development as playing a realistic part in the development of an individual's career, it is also an identified element in the formation of culture. Within career development theory, the chaos theory of careers (Pryor & Bright, 2003a), chance is described as the "human experience, and career development…laced with unplanned and unpredictable events and experiences that are often crucial and sometimes determinative in the narratives of peoples careers" (p. 13). This description of 'chance' in career development theory does not imply that 'chance' is the default position in relation to an individual gaining the expected and measurable outcomes to prepare them for their role, but rather complements individual career development. Phase 1 GRNs' perceptions verify that GRNs are not provided with appropriate quality clinical experiences to enact their role as RNs and to be work ready. The GRNs' awareness about their own and other GRNs' undergraduate clinical experiences have 'created knowledge' (Bereiter & Scardamalia, 2014) as a collective group, and 'objectified the knowledge' (Husserl, 1931, 1962) that 'chance' does play a critical part in GRN preparedness status due to a lack of predetermined processes by the education nurseries. This is a new observation.

GRNs' perspectives are important for undergraduate nursing programs to be more informed by and more responsive in a number of areas. Firstly, they need to ensure a shared understanding about essential knowledge and skills and clinical experiences and apply them to quality clinical health experiences. Secondly, formal evaluative processes need to reflect the indicators of RN role preparedness. Thirdly, clearly communicating RN role preparedness indicators to nursing students is mandatory to reassure them they have attained the expected benchmarks and to build their confidence. Together these form new observations in relation to impacting

GRNs' preparedness in fundamental knowledge and skills and in receiving adequate clinical placement experiences.

The four GRNs reflections regarding the quality of undergraduate clinical experiences demonstrate their '*concern and care*' for future GRNs transition challenges. Their concerns were clear about raising awareness about the inadequacy of undergraduate clinical experiences in preparing nursing students for their future roles as RNs. Thus, these GRNs' reflections are important in directing improvements to provide nursing students with opportunities to participate in a range of quality clinical experiences that will fully prepare them to enact their role of '*being*' an RN. Additionally, these GRNs' concerns duplicate Heidegger's '*Dasein*' (1927, 1962) and Freire's 'critical pedagogy' (1970, 2005) about how inadequate quality clinical experiences by the education '*nurseries*' shortchange students. Their reflections act as 'instruments of thought' to guide clinical placement reform '*Verstehen*' to enhance GRNs' preparedness for their role. Thus, the GRNs' reflections about 'being in the world of nursing as a GRN' has improved our understandings about essential fundamental knowledge and skills and appropriate clinical experiences to ensure GRNs are enabled to '*be*' work ready.

The variation in the quality of undergraduate nursing student's clinical experiences is a concern recognised by industry, GRNs and key researchers and understood to negatively impact on GRN transition and work readiness. The literature has reported inconsistencies in the quality of nursing students' clinical experiences offered by education institutions (Dyess & Sherman, 2009) along with GRNs' resultant lack of preparedness (Boychuk Duchscher, 2009, 2012; Duchscher, 2008; Levett-Jones & Fitzgerald., 2005; Rhéaume, Clément, & LeBel, 2011; Romyn et al., 2009). Additionally, concern around variances between higher education nursing programs (Darbyshire & Fleming, 2008) and the variances in GRN preparedness levels (Kako & Rudge, 2008; Ossenberg et al., 2016) are also themes in the nursing literature. However, it is evident that the focus is predominantly on the RN work role preparedness and not on the GRN's broader life career preparedness experiences. This difference represents an important gap in the GRN educational experiences which contribute to an underdeveloped view of what being prepared as a nurse actually means and the direction required to preparing GRNs. Thus, the need for reiterative formal evaluation processes of fundamental (essential) knowledge and skills and fundamental

understandings about clinical experience between stakeholders (GRNs and industry) are needed to direct education '*nurseries*' to be more responsive to the changing contemporary health environment and the needs of GRNs.

In responding to meeting the expectations and needs of GRNs, education institutions need to deliver their education based on best practice. Best practice is present in the literature about life career education, developing critical thinking, authentic learning and pedagogy based on cognitive and constructive alignment to assist in students' transformational learning (Boud, 2012; Longworth & Davies, 2003; Patton & McMahon, 2006; Mezirow, 1997; Super, 1975; Vygotsky, 1978; Wiggins & McTighe, 2001). However, a paucity of research exists on the nursing education '*nurseries*' effectively responding with targeted intervention strategies and evaluating the effectiveness of these interventions as aligned to best education practice. Actively and effectively addressing GRN under preparedness in fundamental knowledge and skills and clinical experiences, are critical in aligning targeted interventions that are assessed to inform reform to education practice and improve GRNs' successful transition from '*becoming to being an RN*'.

GRN under preparedness for the reality of work in terms of fundamental knowledge and skills has revealed transition challenges. The primary challenge emanates from the need to develop shared understanding between educators, student nurses, GRNs and industry and governance bodies. Specific challenges stem from what preparedness means; what the associated behaviours of preparedness are; and the fundamental knowledge and skills required for the role of an RN in the 21st century. This study has also revealed the GRNs' perspectives about delegation and clinical experience which they perceive to be critical and core fundamental knowledge and skills of preparedness. Furthermore, from the GRN perspective, positive behavioural cues indicating the adequacies of delegation and clinical experience preparedness, in feeling confident and being not worried about enacting their roles as RNs are required. Thus, the GRN's positive behavioural cue of confidence needs to be a part of assessment outcomes. Thus, confidence constitutes a study outcome, aligning with one of the broader outcome goals of lifelong learning (Longworth & Davies, 2003). This study argues that a lack of confidence is an indicator of under preparedness in fundamental knowledge and skills and clinical experience.

Producing well informed, prepared and confident GRNs ready for their broader role and the range of contexts they will practice in as RNs, needs to begin with the educator seeking a shared understanding with GRNs. Then from this shared understanding design curricula to adequately develop students' fundamental knowledge and skills and clinical experiences so that they begin their professional practice from a position of strength. Seeking a shared understanding between all stakeholders is also key to directing a responsive change from nursing education and training practices and discourses in preparing nurses. Challenges emanate from understanding transition, associated fundamental knowledge and skills and appropriate clinical experiences and in designing effective learning practices and associated preparedness measures. These challenges are documented in the evidence presented here and is a new observation

Lastly, GRNs under preparedness to be work ready to enact their RN roles can be attributed to higher education '*nurseries*' remaining static in 'historical epistemologies' and inadequately responding and implementing work role education against the broader lifelong learning measures. Consequently, this lack of fundamental knowledge and skills preparedness by the education '*nurseries*' places GRNs at risk of lateral violence from nursing colleagues known to 'eat their young' (Bartholomew, 2006; France et al., 2011), as well as placing patient care at risk. Understanding this situation is important as it highlights the renewed importance of directing the implementation and evaluation of nursing education and transition support for GRNs that also considers the broader outcomes. These broader outcomes include, confidence to enact their RN role in 'all environments and circumstances', self-reports of wellbeing, and retention within the program and nursing profession.

While preparing student nurses in fundamental knowledge and skills and through adequate clinical experiences are vital to their successful transitioning in performing the practical aspects of their work role, so too is the importance of preparing GRNs for the health workplace cultures they will be positioned within.

6.4.2.2 Health workplace culture

Health workplace cultures in juxtaposition to the nursing governance standards are an additional transition challenge for GRNs that poses a risk to their wellbeing and retention within the profession. Health work place cultures are traditionally hospital-based environments, steeped in hospital-based training

constructs creating a mixture of personal values by the nursing staff who may be either hospital or university educated and trained (Freeling & Parker, 2015). Preparing student nurses for the health workplace cultures they will encounter will aid their transition, resilience and ability to effectively enact their RN role with their other life roles, together with supporting their retention within the profession.

A nursing workplace culture that mirrors the nursing governance standards aids in the successful transition of GRNs into their new role of '*being*' a nurse. However, being immersed in a nursing workplace cultures that is in juxtaposition to the nursing governance standards can hinder GRNs' transition. The expected 'portrait' of the nursing 'workplace culture support' is one that should portray safety and care for the public, the patients and their families in receipt of their care, their colleagues, especially their 'young' GRNs, and themselves, and should reflect Australian Commonwealth Governances. Governances in the form of laws, standards, charters and systems, include the governances specific to each discipline, for example in this study's context, the nursing discipline. The nursing '*portrait*' at a governance level informs the desired '*nursing workplace culture support portrait*' and thus the '*nursing workplace culture support portrait*' should fully form the mirror reflection of the nursing governance '*portrait*' that includes expectations, such as the 'concern and care' nature of a nurse and how a nurse should think, behave and act and the expected outcomes, providing a safe, nurturing health care environment for patients and their families, the public, their colleagues and themselves. This study's findings on the '*nursing workplace culture support portrait*' as perceived by GRNs, is discussed next in alignment with the main nursing governances and nursing philosophies of care, as well as philosophies such as Geertz's (2008) cultural '*portraits*', '*discourse, power, discipline, governmentality and knowledge, including care of self*' (Foucault, 1972, 1976, 1988, 1997, 1998), duality of '*agency and structure*' (Giddens, 1984), critical pedagogy (Freire, 1970, 2005) and risk assessment theory. Whilst this represents a general nexus between culture and GRNs, more specific discussions on the effects of culture and '*being*' a nurse are presented throughout the remainder of this chapter. For example, the nexus of the range of cultures GRNs are part of, signifies their wellbeing.

Nurturing an effective workplace culture has benefits and can be enabled by key values. In health organisations, an effective workplace culture is known to enable effective patient outcomes (Manley, Sanders, Cardiff, & Webster, 2011;

NMBA, 2018; 2016) as well as aid in the successful transition of GRNs into their life career role as an RN (McMahon & Patton, 1995; Patton & McMahon, 1997, 1999, 2006). Nursing workplace culture differs for each work unit and organisation and this is due to the behaviours of the workplace culture, reflecting the values, beliefs and attitudes held by the larger group. Thus, work place culture can result in either an effective, supportive workplace culture or an ineffective and unsupportive workplace culture (Manley et al., 2011). An effective workplace culture has been found to be enabled by ten core values. The first five core value enablers are person-centredness, lifelong learning, high support and high challenge, leadership development, involvement, and participation and collaboration with all stakeholders (Manley et al., 2011). The remaining five core value enablers are evidence-use and development, positive attitude to change and commitment to learning, open communication, team work and safety (Manley et al., 2011). Thus, the importance of developing a positive workplace culture based on clear values improves the experience of patients and new staff transitioning, in this case, the GRNs.

Strong inter-personal relationships within the team are important building blocks of a positive workplace culture of support portrait. The GRNs' story continues and reflects the GRNs transition '*being*' new in their RN role and into the workplace culture they have entered.

Diana shares about '*being*' a new nurse and the types of support that enabled her to '*be*' an RN. She shares about her medical ward workplace culture.

> *"My medical palliative ward, the stronger team work that's been created is just so uplifting and empowering. They're like, oh, you made a mistake. No worries. It happens… I think that 150 per cent has changed my outlook. It's brought me back to life again, I'd say."*

Brooke continues this conversation by also acknowledging other key members within the organisation, the nurse mangers and the educator, who were also supportive.

> *"To begin with, we were rostered mornings, so we did morning shifts during the week so that that's when the majority of the staff were there. That's when our nurse unit manager was there, and*

our nurse educator was there, so if we needed help, they were there to do it… So, I think they were really, really fantastic."

This study has found that effective support mirrors governance standards and is person (GRN)-centred. A key enabler has been the '*concern and care*' from members within the workplace culture. These members have been effective due to their positioning within the culture and being able to truly relate with the newcomer. These two aspects formed indicators to effective support to keep Diana and Brooke 'upright' and progressing forward in their life career roles of '*being'* a nurse'. This behaviour by the members within the workplace culture, reflects '*concern and care*' for one another ('*Dasein* and *Verstehen*'). It also highlights that receiving the right emotional support, at the right moment, from the right source and in the right manner, can act to help GRNs feel supported, remain upright and be retained within the profession. Building strong relationships is a known building block of care and resilience (Kester & Wei, 2018) and can occur in a positive, supportive workplace culture. This study extends knowledge about resilience by developing the efficacy of the support nexus in building resilience and promoting retention. It includes four intertwining essential elements: 1. Recognised value of one another's role and life career stage; 2. Recognised value of emotional comfort 3. Emotional support provided at the right time and 4. Work role salience. Differences in the type of support offered most likely stem from historical epistemologies at play and would require targeted education awareness programs to disrupt current discourses, extending the type of support to include emotional support.

GRNs' transitions included rotation through several clinical settings. Movement between clinical settings also exposed the GRNs to different workplace cultures within a large health organisation. Consequently, Diana, found herself also positioned within a 'nursing workplace culture support portrait' that was in juxtaposition to nursing governance standards. Diana shares about '*being*' a new nurse her surgical ward workplace culture and recalls a moment when she made a mistake. She reveals in this moment how she felt when her colleagues treated her in an unkind and unsupportive manner.

"I noticed from my first ward, surgical, if you made a mistake, you felt like they were staring you down and they were like, oh, you made a mistake. You felt almost inferior and disempowered

by that. You're a terrible nurse. What are you doing in this graduate program?"

The behaviour exhibited by the surgical ward 'culture', was in juxtaposition to the nursing governance standards and the ten core values of an effective workplace, particularly the value of being 'person-centred'. The literature has identified that GRNs do struggle with making clinical judgements and experience lateral violence (bullying) when managing relationships with colleagues (Casey et al., 2004; Kelly & Ahern, 2008; Laschinger & Grau, 2012). However, there is a lack of research on targeted, tailored, 'on time' interventions that assist GRNs to manage these known transition risks to help assuage declines in GRN's work/study and personal role salience and wellbeing. Furthermore, there is also a lack of research on targeted, tailored and measured interventions to improve the inter-relationships between nursing work place cultures and GRNs. The important aspect this study found is the harm GRNs like Diana experience are due to being positioned within an unsupportive workplace culture. This may have been avoided if education nursing programs and transition support '*nurseries*' had responded effectively to these known risk factors.

Thus, for the GRN's transition to '*being*' an RN is to improve, the education institutions and transition '*nurseries*', together with the health organisations' institutional managers, need to respond collectively to the evidence presented here. Thus, education providers can raise students' awareness by firstly providing education about workplace cultures and, secondly by providing student nurses with evidence-based strategies to assist them to effectively manage in unfamiliar workplace cultures. Transition support needs to continue the education and support for GRNs and proactively seek out GRNs at risk from workplace cultures in juxtaposition to the nursing governances and ten core values of an effective workplace, intervening with 'on time', tailored support.

Managers of health organisations need to be proactive in minimising the risks to GRNs from work place cultures acting in opposition to Governances promoting safety and care for its employees. An example of being proactive would be implementing a risk assessment system (ACSQHC, 2014) focused on promoting GRNs' safety, 'concern and care'. Risk indicators would include workplace culture behaviour '*being*' in juxtaposition to the nursing governance standards and the ten core values of an effective workplace. For example, workplaces neglecting person-centred

practice. Thus, if these indicators, informed by associated behaviours, are identified in risk assessment, it enables executive managers together with human resource and department managers to intervene. Interventions can then be targeted, tailored and applied to all the levels of the system, to affect a 'whole' of institution approach, using risk assessment as the framework. Such interventions will prevent and or mitigate the broader risks to GRNs' holistic welfare in a sustainable and responsive way.

This study found the '*nursing workplace culture support portrait*' contains a duality. On one side positive elements existed within the culture that reflected the '*concern and care*' nature of nursing, while at other times, negative elements occurred within the culture that did not reflect the nature of nursing. This dual nature of the nursing cultural portrait resonates with the gothic novella, Strange Case of Dr Jekyll and Mr Hyde (Stevenson, 1886) where Dr Jekyll's behaviour was good, while Mr Hyde's was shockingly evil. However, in this thesis Dr Jekyll represents supportive behaviour, while Mr. Hyde represents unsupportive behaviour. The supportive behaviour displayed (to just over half of the GRNs) was in relation to GRNs' receiving support that helped them to deliver direct patient care. Another supportive behaviour was that learning sessions occurred as a direct result of GRNs' being personally consulted regarding their nursing practice needs. Another positive element was that this learning was perceived by GRNs to be delivered in a positive way.

An important aspect of this study is that GRNs' negative transition experiences can be prevented and or mitigated. Prevention and or mitigation can be facilitated by education nursing program and transition support '*nurseries*' responding effectively to known risk factors from a broader holistic, person-centred platform that reflects acknowledgement of the inter-relatedness with the GRNs' work role of '*being*' an RN. For example, a broader education could include life role salience and self-care role salience to enable GRNs' to support themselves to build capacity within their life roles, including their life career roles in preventing declines in their life role salience. Supporting the GRNs' holistically will also mirror the broader 'concern and care' values promoted by governance bodies and society to foster the health and wellbeing of all individuals, including employees. However, moving to a broader holistic platform of GRN preparation and transition support would require a significant disruption to nursing education discourses about what undergraduate and organisational transition education and support can and should achieve. Achieving a

nursing workplace culture that mirrors the nursing governance standards will advance the successful transition of GRNs into their new roles of '*being'* a nurse. A broader life career education and support platform is important in enabling and equipping GRNs to be proactive in developing all their life roles. These roles include the need to develop GRNs' self-care roles to effectively support *all* their life roles, maintain and enhance their wellbeing, and to assist in mitigating risks of attrition.

As part of supporting GRNs' transition, the work environments GRNs enter also need to be considered in preventing and managing their transition.

6.4.2.3 Health work environments

Health work environments that are harsh and unsafe are additional transition challenges for GRNs to effectively enact their role as an RN and poses a risk to their life role salience, wellbeing and retention, however, the rewards of '*being*' a nurse work as a counter weight. Therefore, situating GRNs into a safe work environment ensures their safe transition from '*becoming*' to '*being*' an RN and requires a purposeful and well deliberated, evidenced based plan, as part of a continuum of 'concern and care' for their new role as an RN. As part of this purposeful plan, it is also important to prepare the new environment to be conducive to the GRN's transition, to aid in their successful development in '*being*' a nurse, their role satisfaction, wellbeing and retention. The following GRN transition story of '*becoming*' and '*being*' an RN continues and reflects the plan by their transition 'nursery'.

Anne focuses the conversation back to why it's been particularly hard for her and Tina transitioning as an RN within the aged care setting.

Anne

> *"Tina has a larger patient load than I do. The hostel area is larger [than high care]. I look after 21 high care residents, but I also have one wing, there is 4 wings, in the work group, three AINS and I'm the RN. So, I look after 32."*

Tina agrees with Anne about the high work load and the associated level of responsibility they have both endured. She adds further details about the daily challenges she faces working in the hostel, in providing and co-ordinating patient care

and the impact this has had on her ability to care for herself at work, for example in taking her allocated rest and meal breaks.

> *"We have 40 residents. You just go, go; like in the hostel - because mine's so spaced out but from here you could be in an area here and now you are here now and you're go, go all day. The AIN's are continually calling can you come here? Can you come here? Or you're on your lunch break, the doctor comes or you sit there for morning tea and the pharmacist's here. When you're on your break, everything's an emergency or a silly thing that could just be dealt with later on."*
>
> *So, I find I've stopped taking lunch because I don't get it. I mean, you can't leave it. Most other jobs, if you were in an office job or something, you can leave, have your lunch. When you're a nurse, you go on your staff break for your lunch, something happens. You've got to get up and go. You don't get that 40 minutes of just no-one disturbing you today."*

Anne and Tina both describe a high workload burden and associated responsibility and values to ensure safe and quality care is delivered at all times, prevents them from being able to take adequate meal breaks and is negatively impacting their ability to meet their self-care and their nutritional needs. High workloads and the need for speed are reported in the literature as causing GRNs' stress, as well as the impact of speed contributing to a lower quality of care being delivered to patients (Pellico, Brewer, & Kovner, 2009). This study extends this knowledge by bringing to the fore GRNs' inability to effectively meet their nutrition and rest needs while positioned in this type of environment. This study also identifies these work conditions and work imperatives, combined with GRNs values for safe and quality nursing care, form a risk indicator in the nurses' ability to simultaneously effectively meet their patients' care and their own nutritional and rest needs.

Such harsh work conditions and work schedules, combined with unresolved work stress, is known in the literature to lead to burnout and absenteeism (Davey et al., 2009; Garrouste-Orgeas et al., 2012; MacKusick & Minick, 2010; Ross & Rogers, 2017; Schaufeli & Maslach, 2017). To help protect employees' welfare, Work Health

and Safety laws exist (Australian Government, 2011), and specifically promote nurse's welfare, nursing codes of practice exist (NMBA, 2018). Specifically, the Code of Conduct for Nurses, Principle 7 - Health and Wellbeing, value states, "Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequity" (NMBA, 2018, p. 14). However, despite these governances promoting nurse's health and wellbeing practices, Anne and Tina's experiences emphasises that these governances are being inadequately applied by their transition '*nurseries*', to effectively support GRNs health and wellbeing and consequently raising their risk for health and wellbeing decline burnout, absenteeism and attrition.

Despite Anne and Tina being situated within harsh work conditions and under prepared to meet the associated challenges, they found the rewards of their RN role served as a counter weight to their challenging experiences and provided them with an overall sense of RN role satisfaction. Anne shares:

> *"I find sometimes at work when you're having a stressful day and you're just thinking about work, work, work, work, work, stress, stress, stress, stress, stress, you'll go over to someone and they'll hold your hand. I'm really, really grateful for everything you do for me."*
>
> *"I remember this one man, he said, here's my darling girl. He held my hand and just looked at me and said I'm so appreciative of everything that you do. Or you get the beautiful old lady that pulls you down to the bed and gives you a kiss."*
>
> *"This is why I do it. That's why I do it."*

Brooke sympathises:

> *"One of my patients took photos of me today, because she'd been with us for a couple of weeks and I was one of the ones who looked after her the most. So, she took a photo. She wanted a photo of me, because I'm the one who looked after her and I'm the one who was there when she was first initially stressing and everything and because she lives in Brisbane. But she wanted a photo of me so she could remember me by it."*

Diana concurs:

> *"It was so good actually the other day seeing a patient walk out the door after being really sick...to actually walking out, no assistance, so it was like, ah [laughs]. Yeah, you know what? I helped do that. Those moments, I think they'd outweigh all the terrible ones."*

While Anne agrees:

> *"I think we are all in the right job. I think we've got the stressing moments, but I think we love it."*

These comments made by Anne resonated with Brooke and Diana. They agreed whole heartedly about the joy they experience in caring for others and added to this conversation about their RN role satisfaction: Brooke "*We do*.", Diana "*I love my work*" and Brooke "*It's very rewarding*."

The low nurse-patient ratio that Anne and Tina experienced in their aged care setting becomes dangerous when comparisons are made with other health contexts. This inequity between aged care and private hospital nurse-patient ratios becomes evident when Brooke makes a comparison to the private hospital where she works.

> *That makes our 14 patients insignificant, mostly we have at least 10 and I have an EEN as part of my team.*

Furthermore, when different disciplines are compared with aged care, such as education child care ratios, this inequity becomes wider. For example, educator to child ratios for the categories birth to 24 months is 1:4, 25 months to 36 months 1:5 and 37 months to preschool 1:11 (Australian Children's Education and Care Quality Authority, 2016). These marked differences reflect society's values towards children versus older people. In particular, the care of older people reflects that 'historical perspectives (the flux of ideologies - political, economic, religious and other influences as epistemes)' are still in play, including the associated 'power' imbalance for nurses and older people. Aged care facilities operating from traditional epistemologies such as low RN to resident ratios contribute to the negative factors impacting the GRN in their first-year transitioning into '*being*' an effective RN.

GRNs positioned as a 'Rubber Nurse' within the workplace are at risk of self-care declines. Tina's experience is an example of being a Rubber Nurse (being thinly stretched to meet competing demands deemed by the organisation as part of her RN role), rather than as a RN, with time focused on patient care (Ross & Rogers, 2017). Tina, at this point, is trying to manage her taxing work environment by compensating, skipping on her lunch breaks. In addition to Tina's perceptions of being a 'Rubber Nurse', her consequent actions and behaviour are identified by this study as reflecting her lack of education and preparation by the higher education '*nursery*', regarding the importance of self-care and managing her self-care within harsh work environments. This self-care education needs to include action strategies that she can use to address her harsh environment and to generate improved changes for her, her team and her patients. This situation is an example of where the link between preparedness, worry and confidence found by this study is critical in identifying GRNs' at risk of work, study, personal life wellbeing declines. Tina *knew* she was struggling but was not prepared enough or even confident in acting to remove or reduce the tensions that were conspiring to affect her well-being. Tina's undergraduate nursing educational experiences (her '*nursery*' nursing experience) and CPD in her transition year had overlooked these aspects as vital elements in supporting transition for GRNs like her. This area of self-care is discussed in Section 6.4.1.6.

This situation also reveals that undergraduate and transition support '*nurseries*', have not responded adequately to the needs of nurses like Tina and or the values GRNs hold about supporting and maintaining *all* their life roles. This inadequacy includes preparing them for the harsh employment context in which they find themselves and preparing the environment to be conducive to effectively transitioning GRNs. This study has found that lack of self-care preparation by the nursing education '*nurseries*' reflects 'historical epistemologies' and an inadequate adaption in response to research findings. For example, developing responses to the fact that the health environments that GRNs enter are often harsh and challenging. Yet despite this knowledge, nursing education '*nurseries*' continue their GRN preparation predominantly focused on psychomotor knowledge and skills and clinical experience to enact these, rather than a broader preparation to assist in the authentic enactment of the RN role. A broader preparation and support would include:

- Managing professional roles in harsh and challenging health environments;
- Self-care strategies to help GRNs cope more effectively; and
- Strategies to assist in negotiating with management about their work loads.

Such a preparation may assist in alleviating GRNs' risk to their wellbeing and attrition from the profession. Without the education and transition '*nurseries*' broadening their life career preparation and support platforms for nurses, the type of risks of 'being stretched' as a 'Rubber Nurse' will not be mollified and thus GRNs will continue to struggle with these type of work stresses.

This study asserts that to support GRNs effectively in their life career role transition and beyond, broader and more holistic platforms are needed, with the vital core comprising self-care. The current education '*nurseries*' overlook the importance of self-care and the need to develop agency, reflecting 'historical epistemologies', such as in Super's (1975) career development theory, where the self-care role is not identified. Super's (1975) career development theory focuses on eight life roles, however, a vital life role found to be essential, in this study, to an individual's revitalisation and sustenance – the self-care role, is missing from Super's eight life roles. This aspect has been hidden to date and is a life role that needs to be the core on which to build all other life roles. This study raises this awareness about self-care being a core life role structure to all other life roles and is a new observation. The study has found that self-care has to be included within life career role development theory and education and organisational strategies, to draw awareness to the importance of nurturing this core role for students, as it is inter-connected with supporting *all* other life roles.

In addition, the evidence presented here validates nursing governances stemming from current laws designed to promote health and wellbeing. However, the evidence also reveals that they difficult to implement for GRNs like Tina due to minimal or even lack of support from the organisational culture she works in. On one side, at the nursing governance level, Tina is situated within the '*world of nursing values*', as per the Australian Code of Professional Conduct for Nurses, "nurses promote health and wellbeing of patients…and themselves and in a way that addresses

health inequality" (NMBA, 2018, p. 4). The International Council of Nurses [ICN] Code for Ethics for Nurses adds that "the nurse maintains a standard for personal health such that the ability to provide care is not compromised" (ICN, 2012b, p. 3). However, Tina's evidence demonstrates a juxtaposition '*in the world of aged care organisations and associated aged care residential culture*'. This study found that nursing governances promoting nurses' health and wellbeing are not adequately implemented by GRNs' at an individual level. This is due to a lack of support at the organisational level in providing health and wellbeing information and associated strategies. This lack of information and support stems from a number of inter-related areas, such as human resource managers, workplace health and safety managers, nurse managers and educators CPD programs, being limited by organisational learning goals. As such, they contribute to barriers and GRNs' feelings of not being supported in self-care which impacts on GRNs' ability to adequately care for themselves at work.

GRNs need to be empowered and develop agency so they are better equipped to implement strategies at the coal face of work. The risks of workplaces not implementing health and wellbeing standards at the individual GRN level, places GRNs at risk of harm. Therefore, workplace cultures require reform so that they are able to value safe work places and self-care at work. Addressing harsh work environments and promoting self-care at work, can be achieved by the organisation and managers implementing risk management processes focussed on improving work place environments, with outcomes aligned to GRN self-care at work, their health and wellbeing outcomes and retention rates. Along with the preparation and support for the 'concern and care' of GRNs in their transition into harsh health environments, is the need to prepare them in fundamental knowledge and skills and adequate clinical experiences.

As part of supporting GRNs' transition and the additional challenges they will encounter, is also the need to be supported in recognising and managing transition shock.

6.4.2.4 Transition shock

Transition shock occurs from being under prepared in life career role education and subject to inadequate life career role transition support. It places the graduate at risk of a difficult transition into their new career role and further risks their wellbeing and attrition from the profession (Duchscher, 2008). In the context of the

nursing professions' global nursing shortage and imminent national nursing shortage, it is imperative to provide student nurses with adequate life career role education during the phase of '*becoming*' a nurse. Additionally, it also critical to provide adequate life career role support during their first year as an RN, '*being*' a nurse, to prevent their attrition and to maintain the supply of GRNs to help meet the health demand. The most appropriate way to do this is to ensure life career role education and transition support is embedded within education programs (Patton & McMahon, 2006; Super, 1990) and, in this case, embedded within the undergraduate and transition nursing '*nurseries*'. This proactive position will assist to mitigate against GRNs' experiencing transition shock and the negative effects of low work confidence and a decline to their personal sense of wellbeing. As well as to mitigate their under preparedness about how to effectively manage transition shock if it was to occur. The GRN's transition story continues, '*being*' new in their role as an RN and reflects their life career role education and transition support by their '*nurseries*'.

Brooke and Diana are positioned within a formal transition program and share their experiences '*being*' new RNs. Their reflections reveal 'transition shock'. Brooke says:

> Brooke
>
> *"I had a really, really rough start to it. I was so stressed. My emotional breakdown hit - I think it was week three I think I had my big emotional breakdown."*
>
> *"The other grads that were there, if I didn't get to go through this with them, I honestly don't know if I'd still be there."*

Brooke's reaction exhibits the signs and symptoms of 'transition shock'. Transition shock signs and symptoms include a wide range of negative reactions, thoughts and feelings. These include doubt, confusion, loss and disorientation (Duchscher, 2008). Brook's experience identifies her under preparedness in life career role education for her new RN role, a consequence of her higher education '*nursery'* and her inadequate transition shock support by her transition '*nursery'*. Brooke later adds her stress emanating from her concern regarding her responsibility in caring for patients adequately. This is revealed when she declared *"people say what are you stressing about… people's lives maybe*". Brooke's transition shock reflection,

however, is also important in demonstrating the proactive 'concern and care' response by her peers to support her. The peer support she received was effective for her personally in helping her manage her 'transition shock', as evidenced by her continuation in the graduate transition program.

Diana shares her feelings as a new RN as a result of her work environment and the nature of her work.

Diana

> *"It's the emotional drainage and the mental drainage. When you're new and you have patients deteriorating and a large patient load. You look at your list of things to do and the time that you have to do it in. You know that it's not achievable and then you get stressed out because of time management. Then your patients are buzzing. It's just overwhelming that you don't have the confidence, the time management, the hands-on deck to do everything that you need to do. As a result, you don't feel like you're providing your patients with effective patient care. It's more just like here's your medication. See you later. Please don't die. Here's your medication. See you after lunch. Hope your pain goes away."*

Diana's reflection underscores her moral distress in not being able to provide her patients with the care she has been educated and trained to provide, due to her work environment and the nature of her work. Thus, her emotional and psychological reactions can be categorised as 'transition shock'. GRNs who experience moral distress during their transition year has emerged in the literature (Duchscher, 2008). Along with managing moral distress, their professional role includes managing time effectively, prioritising and making clinical judgements and associated decisions (Casey et al., 2004; Mason et al., 2014; Myers et al., 2010; Rhéaume, Clément, & LeBel, 2011; Spence Laschinger & Grau, 2012). While research on targeted, tailored and measured interventions for GRN 'transition shock' is limited and, as such, constitutes an area for further research.

Yet despite a solid body of work on 'Transition shock' theory and key areas being identified as contributing to transition shock (Boychuk Duchscher, 2009,

2012; Duchscher, 2008; Duchscher & Myrick, 2008; Kramer, 1974) effective implementation of aligned strategies to effectively manage and prevent 'transition shock' by the education and transition '*nurseries*' remains inadequate. This knowledge is important as it raises awareness that 'transition' shock' together with under preparedness by the '*nurseries*', constitute a 'double risk' indicator for GRNs being unable to effectively enact '*being*' an RN, maintaining their personal sense of wellbeing and remaining in the nursing profession.

Transition shock stems from an under preparedness in life career role education and places the individual at risk of a difficult transition in their new career, placing their wellbeing and retention at risk. Preventing transition shock in new nursing graduates is critical to maintaining their personal health and wellbeing, as well as to ensure their nursing practice remains safe and of high quality and can be achieved. Preventing transition shock in new graduate nurses can be achieved by aligning education and support directly targeted to the areas they are known to be under prepared in. These known areas include managing moral distress, managing their professional role, including managing time effectively, prioritising and delegating, and supporting safe, quality clinical judgements. Equally important in this process, is determining adequate learning outcome measures that signal work readiness. Formal support that offers 'transition shock' early detection by implementing a targeted, tailored and measured intervention by the transition '*nurseries*', can assist to mitigate against the risks of GRN wellbeing decline and thoughts of attrition to promote retention and close the nursing shortage gap.

The important aspect of this study is that Brooke and Diana's transition shock experiences, could have been prevented if their education nursing program and transition support '*nurseries*' had responded effectively to the known 'transition shock' risk factors. For example, by implementing a targeted, tailored and measured education and training and support aligned to the known 'transition shock' areas, would assuage risks of transition shock. Thus, GRNs' transition to effectively enact their RN role can be improved by acknowledging 'transition shock' and responding adequately to preventing transition shock risks. This proactive positioning by the transition support '*nurseries*' will improve GRN personal sense of wellbeing and retention in the profession.

As part of supporting GRNs' additional transition challenges, is also the need to prepare and support them in self-care.

6.4.2.5 Self-care role

Personal self-care roles are the core elements supporting *all* other life roles. Education and transition '*nurseries*' therefore, need to assist GRNs' to keep *all* their life roles 'upright' and to maintain and enhance their sense of wellbeing and retention in the profession. Risk management is a process that can support GRN self-care through early detection of self-care risk indicators. Self-care and care of others are values promoted in the nursing profession's codes of practice. For example, the Australian Code of Professional Conduct for Nurses, principle number seven states "nurses promote health and wellbeing of …their colleagues, …and themselves and in a way that addresses health inequality" (NMBA, 2018, p. 4) and the ICN's Code for Ethics for Nurses states, "the nurse maintains a standard for personal health such that the ability to provide care is not compromised" (ICN, 2012b, p. 3). Thus, preparing and supporting GRNs in the development of this core self-care role by the education and transition '*nurseries*' is critical in mitigating GRNs' risk of declines in personal self-care role reducing GRNs' ill-health and attrition. However, in effectively supporting GRNs' self-care, knowledge about each GRN's personal sense of wellbeing is important in directing tailored strategies to support them. The GRNs', Diana, Brooke and Tina share their self-care practices prior to their GRN transition year, however Anne reflects about her self-care during her transition year. Anne's proactive 'self-care' during her transition year reveals her high level of self-care role salience. Each GRN shares their level of self-care:

> Diana
>
> *"Before starting the graduate nursing program, I used to go out clubbing all the time, used to have a drink, used to have fun with friends, used to go see movies. Shift work massively prevents that."*
>
> Brooke
>
> *"Because I'm on the graduate program and I want to make a good impression, I work weekends. None of my friends work weekends. I see them like once every two months now*

to every second weekend. It really, really suffers. So it sacrificed a lot and it takes its toll definitely."

Tina

"Work balance with kids, enjoying the children and just have a little bit of time for myself…weekends off… [going out] …or go for a barbeque… join the gym."

Self-care role salience is at low levels for Diana, Brooke and Tina, however Anne's self-care role salience is at a high level. Anne shares:

"I find that - well, because of my own personal life this year with the cancer and everything, I re-evaluated everything at that point and decided you need to make time for yourself, because at the end of the day, what good are you at work if you're not looking after yourself?

"So, I do go out of my way to make sure I'm looking after myself. They'll say to me; can you work this weekend? If I can do it because they're short, I'll do it. But if I'm feeling like [I need a day] that night, I really can't, or if I wanted to do something for myself, no, I really can't, because I think it's important to have - I think it's important to have time for yourself as well. It's been less stressful for me in a way that I do have a secure job."

"One thing I have found this year is the importance of having nothing days. Like a day where you don't have to go to work, you don't have to go and do anything at home, you don't have to do housework. Those sorts of days I think are really good for me and my stress levels. That's how I cope. I can go and do what I want to do. I like reading. I can go for a walk to the park. I can go sit outside with my dog, talk to my dog which talks to me and walk the dog. I can do what I want when I want to do it. I think that makes me feel better having a day like that".

Anne's self-care is different to the other three GRNs, due to a significant life stage event of being diagnosed with cancer. Anne is articulate about the self-care that has been effective for her during her transition year which reflects her individual personhood to achieving self-care that is right for her personally.

Tina's reflection is important as it highlights her disappointment in not being able to keep her self-care role 'upright' as a response to needing to place all her efforts into preventing her work/study life roles from 'falling down'. She shares:

> *"I've just gone - like the 12 months without doing anything, you just - with the hubby working away and having the kids and getting them to the school and all that and then working the days and things. I'm thinking, what do I do for myself?"*

Tina's experience is important because it reveals her low positioning of personal self-care is not out of choice, but instead reflective of her instinctive behaviour to compensate for her other life roles of '*being*' a mother, '*being*' a wife and '*being*' a new RN. Additionally, Tina's difficulties in effectively managing all her life roles was noticed by her husband: "…*Hubby said he can notice…my stress level has increased."*

The GRNs however did practice self-care during their "*hard*" transition year, but it was attended to at a conscious, though barely recognised level. Heidegger revealed this as "*Being* is specific and general, enduring and even sometimes fragile; barely felt and yet fully conscious" (Barnett, 2007, p. 28). Diana shared her '*being*' experience.

> *"My sister's also studying nursing as well, so she can relate - she's on practicum as well, so I'm like, oh, yeah, I've been there, I've done that, it's good. But then if I have a bad day, she's like, it's okay, I understand. She's studying psychology as well, so I think that massively makes me feel better, but I couldn't have done it without Brooke."*

Brooke added:

"We often get together outside of that, the four of us as the grad group. We'll go somewhere or we'll go to someone's house and we'll put a movie on. We just vent with each other, vent with food… [laughs]…"

…and…

"It really is a little - it's a little spider web of support. It's incredible. We also have an issue of separating - we always get in so much trouble, especially when we go out with another group of people. We talk and talk and talk and talk. Shut up. Come on. Stop talking about it."

Anne admitted that:

"I have had a particularly stressful unit this year as well. …if I didn't have, yeah, my partner and my sister; my sister doesn't live here, she lives in down Brisbane way. Every day I just needed someone to be there, so my biggest thing this year for getting me through this year was my family for support."

These four GRN experiences about self-care predominantly reveal that they were operating partially from a lack of awareness about the importance of personal self-care. This was exacerbated by their education and transition '*nurseries*' failing to provide support for *all* their life roles. Instead the GRNs responded to their self-care needs instinctively. Predominantly, this self-care was to seek out someone who could truly understand their '*being*' experience. However, due to their sense of agency, they all realised they needed self-care and actively sought out care that suited their personality and '*particular*' context.

Therefore, overall, this study's findings about GRN self-care and managing *all* their life roles alongside their work role stems from an under preparedness in life career role education includes self-care from their education and support '*nurseries*'.

Life career role education is important as it will improve GRNs' preparation in '*becoming*' a nurse and in their ongoing development of '*being*' a nurse. It is also key in its application to their 'other' life roles in '*all* environments and

circumstances'. Broader education and support preparation can raise GRNs' awareness, facilitating their transition and retention in the organisation and profession (Beauregards & Henry, 2009; Holland, 1973; Holmes, 2001; Patton & McMahon, 2006). Life career education should therefore be incorporated in their curricula by the education '*nurseries*'. This will support GRNs to manage their unfolding careers as well as the changing sequencing and combinations of life roles (Super, 1975), for example in their student, RN, CPD, home and leisure roles. This study extends Super's life roles to include the self-care role as the core role supporting *all* life roles. The evidence in this study has demonstrated that GRNs' inadequate self-care role awareness and transition '*nurseries*' ineffectual self-care support constitutes risk indicators for GRNs in maintaining their 'other' life roles and wellbeing during transition. These are new findings.

The identification of these risk indicators is important in implementing reform to mitigate against declines in self-care and negatively impact on its inter-relationships with other life roles to prevent GRNs experiencing life role dissatisfaction and attrition. This inadequate education and support from the '*nurseries*' about self-care has been a consequence of the 'historical epistemologies' still in play regarding the kinds of education and support '*nurseries*' offer. This knowledge can promulgate reform in undergraduate and transition education '*nurseries*' that would encourage nurses to operate with raised awareness about long term effects stemming from the nature and context of their work and the need for proactive self-care.

Proactive education can build GRNs' self-care awareness in relation to two additional transition challenges they are likely to face in their first year. The first are deficiencies in their understanding about potential harsh health environments and employment contexts that can trigger stress for them. The second is lack of knowledge about the personal life contexts/events/stages that may occur and are also known to trigger stress. Action preparation to combat these work and personal stresses can be implemented and include self-care and associated self-determined action strategies. This would signify shifts from a reactive to proactive approaches. In the light of GRNs' evidence, nursing education and transition '*nurseries*' would thus be more effective in improving GRN transition. Previous research by Kelly & Ahern (2008) emphasised that GRNs preparedness needed to include proactive responses to work stresses. Yet

despite these recommendations, a decade later undergraduate and transition education '*nurseries'* have remained static. The lack of broader self-care education preparation reflects the 'historical epistemologies' still in play in the nursing undergraduate and transition education '*nurseries*' and as such, GRN under-preparedness is likely to continue. Consequently, for the GRN first year experience to improve, a disruption to nursing education and training discourses is needed to prepare student nurses in '*becoming',* as well as the transition support into '*being'* a nurse.

These results also stress that a renewed focus on self-care (and care of others) by undergraduate and transition education '*nurseries*' is important for retention. Self-care is the critical life force in '*becoming and being a RN*' and thus needs to mirror (in thinking, behaving and acting) the nursing profession's value system about care of self and others and the broader CPD goals aligned to lifelong learning. The study's findings about undergraduate study and transition CPD can act as '*instruments of thought*', to change the nursing higher education culture, nursing workforce culture and health organisational culture, to one of '*concern and care*' for new nurses. Changes to culture are required including to operate from a broader holistic, GRN-centered approach, framed by risk assessment and management. Such an education approach would be supportive of helping GRNs implement practices that reflect care for self and others. This change to culture would ensure that GRNs are prepared and supported in their work and personal life, with educators factoring these aspects into undergraduate education and transition CPD. This change would also nurture and foster GRNs' study role salience and drive their professional and personal development, including self-care role salience across their life career.

Personal self-care forms a core element in supporting *all* the GRN's life roles and will assist them in maintaining their personal sense of health and wellbeing and retention within the profession. If self-care is included in the broader education and transition support, framed by a risk management process to nurture GRNs in '*becoming'* and *'being'* nurses then identifying GRNs at risk of low self-care role salience early is important. This would help direct a personalised tailored and measured 'on time' response to keep GRNs 'upright' holistically, to promote safe, quality patient care and to retain GRNs in the nursing profession. A proactive approach by the education and transition *nurseries* will assuage GRN attrition by improving GRNs' personal sense of self-care and wellbeing. Supporting GRNs' self-care and

wellbeing, by organising a supportive workplace culture that mirrors nursing values is also essential.

6.4.2.6 Wellbeing and the nexus of culture

The influence of culture can impact a person's sense of wellbeing in either a positive and or negative way and requires new members of these cultures to be aware of the cultural practices and beliefs of the workplace they are entering. Especially being aware about how a negative workplace culture can affect their wellbeing and how to navigate this terrain. Therefore, it is important to provide student nurses with education about the nexus of culture and wellbeing during their undergraduate education and training – the '*becoming*' a nurse stage and adequate transition support during their transition – to '*being*' a nurse stage.

The GRN transition story of '*becoming*' and '*being*' a nurse reflects their experiences in relation to several cultural influences. These include the GRN's '*particular*' culture of high value and the cultural '*webs of significance*' influencing their experiences and dependent on the culture they were situated within. The GRN's reflections reveal their 'eyes opening' (becoming aware) of the nursing cultural '*portrait*' that they were not what they were expecting. Their evidence showed that they felt powerless in response to these '*web of significance*' influences. This powerlessness constituted a response to 'within worlds within worlds'; that is as a GRN in the 'world as a GRN' situated within the 'world of the nursing workplace culture support'. Student evidence demonstrated this. For example, Ann, diagnosed with cancer, believed her sense of personal wellbeing was linked to a 'particular' cultural influence of high value and thus represented her conscious positioning of 'action'.

> *"Time for me. I can go and do what I want to do. I like reading. I can go for a walk to the park. I can read. I can go sit outside with my dog, talk to my dog which talks to me and walk the dog or that sort of thing. I can do what I want when I want to do it. I think that makes me feel better having a day like that."*

Anne's personal wellbeing can be traced to the '*particular*' cultural influence that has high value for her which is to stress less and relax more to enable

her to successfully manage her diagnosis of cancer and her associated treatment plan. Tina's personal wellbeing was very closely linked to her children and then to herself:

> *"Life, work, balance, so I can spend time with my kids, enjoying the children and just have a little bit of time for myself."*

Tina's personal wellbeing can also be traced to her '*particular*' cultural influence of high value and conscious positioning which involves having a balanced life, so she can, finally after all her years of hard work and personal sacrifice, have it all. Having it all to Tina means spending quality of time with her family and friends, having quality time for herself and having a career she loves and can see herself progressing in with the right levels of education and training.

Diana's personal wellbeing was not in the forefront of her of her conscious mind due to the 'throes' of her transition year. Diana's key focus was to succeed in her work role as an RN and this was due to her '*particular*' cultural influence, '*being*' the first in the family to go to university and have a career. Diana describes her life focus for the past 11 months.

> *"My work balance is terrible. I sacrifice so much for the job. God, I just do work and then you're so exhausted from work that you don't want to socialise. Then you get so consumed in work that you don't realise that there is actually a world out there and that actually I'm supposed to have a life outside."*

Researcher's reflexivity comment

Diana's comment "you get so consumed in work that you don't realise that there is actually a world out there and that actually I'm supposed to have a life outside" is a comment I can personally resonate with. I remember having the same thought but not until after I had been working nearly ten years as an RN and was aged 26. Early one morning whilst on night duty, around 2am, I found myself staring out through the hospital ward window looking at the rain falling down and adoring the soft glow of the city's highway lights and thinking, "Oh my gosh, there is a world out there that I don't even know. All I know is this hospital world". My world was simply focused on caring for the people from my community, going home and studying and recuperating ready for my next shift and some phone time with my sister and long-distance boyfriend. It was soon after this realisation that I resigned

my position, moved to Brisbane and worked as an agency nurse Monday to Friday, 7am until 1pm for 12 months. This new life style schedule allowed me for the first time to more effectively control my life balance. This period also assigned me adequate time to review my life to date and to plan for my future, my future life role goals.

Similarly, to Diana, Brook's rotating scheduled shift work also impacted on her sense of life balance – once balanced with work, university study and an active social life – but now one of imbalance with an associated decline in her personal wellbeing being "*so exhausted*" as an GRN.

Brooke

> *"I'm exactly the same. You're so exhausted by the end of it, it's kind of like I really don't want to be doing too much. We found that even a lot of our plans that we've made - like I'll message Diana in the morning and say, are we still going to go do it? We're both too tired or we're both too tired or we're both just absolutely flat. No, it's not going to be happening. I've found, yeah, my social life has gone right down. Everything else, I'm at home. I have a cat - my cat and my dog [laughs]. I still live with my parents. I'm with them. My dad is away during the week. So, I get to be with mum, but other than that, I really don't do anything unless I go over to, Diana's house and chill out over there. We usually watch a movie or something. There's not much else."*

Brooke's life imbalance and decline in her personal wellbeing with its "*so exhausted*" outcomes can be traced to her '*particular*' cultural influences of high value. Like Diana, Brooke was also the first in the family to achieve a university degree and the first in the family to have a career. Consequently, Brooke placed all her effort and energy into succeeding in her work role to ensure her work role as an RN was kept 'upright'. However, work role salience prioritisation was achieved largely at the cost to her overall sense of personal wellbeing. Brooke shares about the 'throes' of her transition year, where her wellbeing was negatively impacted.

> *"I spent lots of times where I'd go home and just stare at a blank wall, because a blank wall doesn't buzz at you. A blank wall doesn't need pain relief. They don't need medications and there's no family berating you about something that you really can't control. I don't know. I went from spending a lot of time with friends - and I had a really good social life at uni, really good - and then it went to my life revolved around these guys and Diana a lot and what we were going through and then going home from work, being completely utterly mentally and physically exhausted, sleeping, getting up and doing it all again kind of thing."*

Brook's reflection revealed gaps in her wellbeing preparedness by her education '*nursery*' and in the wellbeing support offered by her transition '*nursery*'. Together these gaps embody a 'web of significance'. Despite governance bodies and evidence in the literature advocating for wellbeing and self-care education awareness and for self-care support to be included in education programs (Shiparski, Richards, & Nelson, 2011), self-care and support remain largely inadequate. Brooke shared the deficiencies of emotional care she received from her nurse educator.

> *"We were introduced to chocolate and pan-rooms. That's what one of our first educators did to us when she said, pan-rooms, they're there. Use them. Go in there. Take five minutes. Cry. Get yourself together. Come back out and there is always chocolate as well. There's one afternoon we were all stressing and she walked into the treatment room. Patients give us chocolate all the time. She just walked in, grabbed a handful of chocolates, walked out and just handed them to us and said eat, it'll make you feel better."*

The educator's behaviour reflects 'historical influences' of belief, mirroring the support she was offered as a student nurse and the support that had been considered appropriate for decades.

Researcher's reflexivity comment

Being offered chocolate when I was a hospital trained student nurse by my educators and colleagues is certainly an experience of the type of support I also received.

Brooke's evidence underscored the broader educators' often inadequate preparation for the GRN role aligned with the Code of Conduct for Nurses (NMBA, 2018) in providing transition support that includes promoting the health and wellbeing of nurses in a way that addresses health inequities. In addition to operating from an evidence-based platform (NMBA, 2016b), in this case linking self-care research to educators' practice in providing the broader support known to be effective in improving GRNs' wellbeing during their transition year. The need for self-care is increasingly evident within the literature along with needs to build resilience (Shiparski et al., 2011). Consequently, receiving formal wellbeing care is critical for GRNs like Brooke to help them feel supported in all their human dimensions, to be the best nurse (and person) that they can be – part of '*being'* a nurse.

Brooke's evidence additionally revealed that she cares for herself by withdrawing, but she is operating from a reactive platform rather than an awareness, understanding and action platform. At first look, signs of withdrawal may signal a non-coping indicator and a risk to her physical and psychological health (Bhatti & ul Haq, 2017). However, withdrawal also represents one of the self-care strategies proposed by the Green Cross Academy of Traumatology (2011) proposed standards of self-care. Brooke withdrew to rest, relax and recuperate and thus demonstrated a certain level of self-care, but it was an unconscious and reactive strategy. Brooke's instinctive self-care reaction needs to be understood by both formal transition care processes and by Brooke herself. An alternative goal would be to educate Brooke on the importance of self-care, the strategies she can implement and encouragement to raise her understanding and put in place an action plan to enact. This raised awareness would nurture GRNs' self-care, so that they are aware and being able to identify strategies to enact self-care.

A deficit view of the GRN can be signified by being isolated if any signs of weakness are observed. Tina reflection exemplified this: *"It's like if you show any*

signs of weakness, they just pounce on it." The deficit view has been documented in the literature on mental health contexts. Stuhmiller (2010) argued that when mental health diagnoses are made, consequences can be two-fold. Either a negative response occurs, in that it disconnects individuals or communities due to the deficit view held by the members in the group and community. Alternatively, positive response can occur where the diagnosis brings meaning to members in the group/community and members empathise for the suffering experienced. Both views are important to understanding nursing culture and the wellbeing of GRNs. Importantly, deficit views held by members in the group/community are important in recognising the risk indicators to promoting GRNs' wellbeing, as they undermine the personal and collective cultural strength in supporting wellbeing practices.

A deficit view and negative response also occurred from the surgical ward culture towards Diana when she made an error and consequently, negatively impacted her personal sense of wellbeing.

> *"If you made a mistake, you felt like they were staring you down and they were like, oh, you made a mistake. You felt almost inferior and disempowered by that".*

The nursing culture is known for 'eating their young' (Bartholomew, 2006; France et al., 2011) and is another 'web of significance'. However, this study has equally found that nursing culture can also be positive and responsive, demonstrating a 'concern and care' for their 'young' and supporting them in a kind, caring and helpful way that lifts them up during their '*being*' an RN. Diana says:

> *"The staff … so supportive, I think that 150 per cent has changed my outlook. It's brought me back to life again."*

These two GRN experiences highlights the 'portrait of the nursing workforce culture' depicts a divided workplace culture. One half mirrors the 'world of nursing values' with the other half in juxtaposition further constructing 'webs of significance'. Therefore, this positioning of GRNs within a divided workplace culture of values is a main factor impacting GRNs' assent and ascent to wellbeing and stems from the 'particular' and the 'webs of significance' at play. For the GRN, the important 'particular' is not to *be* not knowing and or failing and falling down. While 'webs of

significance' represent those nursing workplace cultures holding a deficit view of GRNs when they are perceived as failing to keep their work role 'upright'.

Raising GRNs and the cultures' awareness about the importance of self-care, being kind to one another and seeking support, is needed if the current culture is to change. This study has found when the nursing culture is kind, caring and supportive, a sense of belonging occurs which helps GRNs to keep their work roles 'upright'. While unsupportive and or unkind cultures generate disconnections and lead to thoughts of attrition. The evidence here shows that some GRNs have to turn to fellow GRNs for 'concern and care' because nursing colleagues did not support them when they were unable to keep their work roles 'upright'.

> *"I had a really, really rough start to it. I think it was week three I had my big emotional breakdown. I think without those guys there [fellow GRNs in the program] I would have been exactly the same. I don't know if I'd still be doing it."*

To prevent GRNs having thoughts of attrition, a 'concern and care' culture needs to be fostered within nursing workplaces. This culture would reflect nursing's professional values.

GRNs' personal wellbeing is closely linked to the 'particular' cultural influences that have high value for them and to the broader, pervasive 'webs of significance' situated in their nursing workplace's cultural 'portrait'. Deficit nursing workplace cultures are based on individual beliefs, mores and norms, rather than operating from evidence-based platforms. Addressing personal wellbeing/self-care requires conscious awareness of the myriad influences at play that inform nursing cultures. Importantly, nursing workplaces exhibiting behaviours that reflect nursing governance values can be used as the 'instrument of thought' – the 'Foucault/Heideggarian turn' – to guide reform that can be applied to all nursing workplaces so that they *all* mirror the values promoted by the Australian and nursing professions governances, including the promotion of wellbeing of self and others. Part of promoting wellbeing is achieving life balance assent and ascent.

6.4.2.7 Life Balance – Life Role Salience

Supporting an individual's assent and ascent towards a life in balance enables them to adequately meet the life roles that are important to them. Workplace

laws and discipline specific standards are there to represent this wellbeing. Individuals who are supported by their organisation in enacting *all* their life roles experience benefits that also extend beyond the individual to their family, organisation, community and society. Therefore, it is important that undergraduate education and training programs provide student nurses with education about life balance and life role salience during their '*becoming*' a nurse stage and adequate transition support during their transition in '*being*' a nurse stage. Education can then assist them in managing risks to life imbalance and a decline in life roles. Preparation in these two areas will help students foster their life balance and life role salience to elevate their wellbeing and retention. However, without a formal risk assessment processes in place to measure GRNs' life balance and associated life role salience status, ensuring positive outcomes would be more challenging. The GRN transition story of '*becoming*' and '*being*' a nurse continues and reflects their experiences in relation to their struggles and successes in their assent and assent towards life balance and life role salience.

GRNs shared their personal life role conflicts they experienced. For example, when Brooke gained a GRN transition program position this came into conflict with her friendship role.

> *"Unfortunately, I lost a couple of friends. I know I lost my best friend from university. I think why I lost her is because I got a graduate position and she didn't. She didn't get a position anywhere. I honestly, think that is why. When I found out I had a position, I kept it a secret. I kept it a secret for months and people asked me why I kept my position secret. It was because you could see the daggers being shoved into your back that you were one of all of the 15 people."*

Life role conflicts can cause individuals stress and feelings of unhappiness and dis-satisfaction with life. They can arise because individuals are unable to adequately meet the demands arising from their life roles (Guest, 2002; Hosie & Sevastos, 2010; Warr, 2007). Participants' reflections revealed their under preparedness during the '*becoming*' a nurse stage largely due to gaps in their life career role education and in the broader goals of lifelong learning. Their education 'nurseries' did not prepare them to assertively manage *all* their life roles with 'confidence, creativity and enjoyment'

in *all* 'circumstances and environments'. The study extends the literature on life balance by identifying a lack of preparedness in life career role education and the broader goals of lifelong learning and how they impact on GRNs' ability to successfully balance their life roles.

Participants' evidence showed how life role conflicts emerge from her '*being*' a new nurse. For example, Diana argued:

> *"My work balance is terrible. I sacrifice so much for the job. I don't know if this only applies to me. I was actually thinking about this the other week when this research study came up. But before starting the graduate nursing program, I used to go out clubbing all the time, used to have a drink, used to have fun with friends, used to go see movies. Shift work massively prevents that."*

Diana's work role had a higher value than her life role – her friendship and personal interests. This meant that her life roles and life balance was not in balance. A life in balance is when an individual can spread their energy and efforts between the range of areas in their life that are important to them (Aggarwal, 2012; Nayda & Rankin, 2008). They can thus experience life satisfaction, happiness, wellbeing and improved quality of life because of this balance (Lambert et al., 2006). Life role salience is defined as a person's beliefs, values and attitudes about a role or roles in their life that are important to them (Thoit, 2012). Life role salience includes a person's self-efficacy, knowledge and associated skills and the application of these within broader governance, discipline and personal standards required to perform roles well. It also acknowledges the levels of energy, effort and resources the person is willing to commit to the performance of these role/s (Matzeder & Krieshok, 1995; Rajadhyaksha & Bhatnagar, 2000; Thoit, 2012). Diana's highest life role is her work role of *'being*' a nurse. However, as Diana was unable to balance energy and effort between her work role and her friendship and personal interest life roles, she is at risk of life dis-satisfaction, unhappiness and attrition. Participants' evidence confirms that undergraduate education and transition '*nursery*' inadequately prepares and supports GRNs management of life balance and life role. Participants' under preparedness and the inadequate support offered by the education and transition support '*nurseries*' thus constitute life role/ life balance risk indicators. The study has found risk indicators can

be addressed by aligning targeted and measured interventional strategies to moderate risks of life role/life balance decline, wellbeing decline and attrition.

GRNs' reflections revealed that their lives have not been in balance for the entire transition year in '*being*' a nurse, due to positioning their work roles above *all* other life roles. For example, Brooke struggled in managing her community role as an emergency response trainer:

> *"I also found a lot of people, unless they're in shift work, they don't get it and especially if they don't know that I'm still new at this job. I'm a trainer/assessor through [emergency response organisation] now. I got that appointment last year and so I help the new members come through and train them up. We meet every Tuesday night. …There's one trainer …She got very cranky with me in this one course, because I'd had an absolute crap week at work. I got there and I wasn't prepared. …She kept going on and on and on about me, about being prepared and doing this and doing this and doing this, but she doesn't quite understand. She sits in an office from eight till five and that's what she does. She does this training. That's what she does for work. She was a teacher before she did that, so she knows the drill, where me, we do long hours. Even when our shift is over, it's quite normal to still find us there half an hour later trying to finish off our paper work and all that kind of stuff. This Tuesday night I won't be able to be there, but that's my assessment night for my group and so I've had to find someone else to take over the assessment. They start to get a little bit narky over it and it's like, I can't help that. That's when my shift has fallen. … at this point where our jobs aren't secure and we don't know if we have a job, I'm not going to start saying, can I have every Tuesday night off so I can do this, please? If they want me to work, I'm going to damn well work. Yeah, I think from an outside view, it can get a bit hard…"*

Multifaceted barriers such as these contributed to the difficulties GRNs face in attempting to attain their life role salience within the broader construct of life balance and their workplace transition program discourses. Decisions the GRNs made, worked

against their ascent and assent to a balanced life. For example, they sacrificed social engagements to consider their future job security as a priority over personal feelings of connectedness. The evidence showed that GRNs felt disempowered to do anything against those imperatives. Thus, this study extends current literature about GRN life-balance (Rhéaume, Clément, & LeBel, 2011) by identifying decisions GRNs feel they need to make are based on pragmatic grounds and cultural influences; - the 'particular' and the 'webs of significance'.

Life balance status, however, was very different for other GRNs due to their individual personal role salience goals and life stages. For example, Anne and Tina chose to enact a balanced work/life from the outset to match their personal role salience. Anne's personal role salience reflected her goals of health and wellbeing due to being diagnosed with cancer and having to prioritise quality time to herself and time with her partner, dog and family. For Tina it was about having a quality of life that enabled her to spend time with her children and her husband on weekends when he returned from working away. These differences make it increasingly difficult to determine exactly where to target suitable educational responses which would act to minimise and manage life balance disruptions. This means that focused risk assessments are critical to help GRNs discover and locate precise factors in play to empower them to develop an action plans to respond to and or reduce these factors.

The various and many different responses the GRNs made to the challenges of ascending (assenting) to a balanced life, again reflect the very personal nature of the challenges faced. However, their personal sense of agency about their circumstances only emerged in the part of their life they felt they had some control over – their personal life. The GRNs' acknowledged that they have roles in managing their life balance. Brooke, Anne and Tina share their thoughts about this:

> *"I think you've got to make an effort to it as well."*
>
> *"You definitely do. It's not always like head down at work and just work, work, work, work, work and that's all you want to concentrate about. Then when you get your confidence at work, it's okay to have your life as well."*
>
> *"I know we've got a group of people that we go out for dinner every Wednesday night. They'll always say we'll go out to [this*

place]. If we've both got the evening shift, like if I've got a morning shift or if I've got the night off, I'll go. I get to see them then and Diana is the same. If she's got an evening shift or if she's not exhausted, she'll go as well. We have a bit of a catch-up. But I find you've really got to put a big effort into it. It just doesn't come anymore."

"Yeah, you have to make that time for yourself, like I go nearly every Friday, to a cafe with a girlfriend. She doesn't work in aged care or nursing or anything, but just going and having a chat and just expressing how you're feeling or what things you've done and things like that. It's always good to do that than just letting it boil up."

Life balance and life role salience meant that certain roles are prioritised over others at certain life career stages and life role stages to ensure GRNs' success in meeting their life role goals. This prioritisation is present in the literature, with many life balance tools developed to support individual's awareness about time and energy allocated to different life roles (Byrne, 2005; Super, 1980). The GRNs recognised that an individual effort is required for balancing their personal life, particularly friendships when working as a nurse and experiencing the high physical, mental and emotional burden that is associated with '*being*' a nurse. It is of concern then that their personal life seems to be the only area where they feel some confidence to achieve what seems, to them at least, life-balance and achieving a sense of purpose. This 'ghost' balance is achieved at some personal cost.

Phase 2 findings confirmed the transition year is not balanced due to work being prioritised, followed closely by their study role, with their personal role – friendships coming in last. Phase 2 findings also corroborated that their life balance preparedness to manage work with study and personal life in and beyond their nursing graduate year was inadequate, not helped by gaps exhibited by their undergraduate education and transition education '*nurseries*'. Evidence also suggested several GRNs were confident in supporting themselves to manage any new situations that arose.

These results reveal that GRNs are managing life balance by themselves through their personal sense of agency and without support from their transition programs and or organisations in which they are employed. Whilst this is a credit to GRNs and their

self-reliance, it is concerning to see GRNs who are responsible for caring for the sick and dying being unsupported by their transition '*nurseries*'. Education preparation and support for GRNs' needs to include assisting them to reflect and understand their individual life balance and life role salience and the potential outcomes expected when imbalances occur. It is critical to educate GRNs about the potential outcomes of an imbalanced life position as well as how these can influence life role salience and lead to declines in the quality of life, health and wellbeing, burnout and attrition.

GRN first year experiences denote needs for a disruption to nursing education discourses, workforce and organisational cultures to move towards a broader education and support platform that includes life balance-life role salience. Moving towards a broader life career education platform aligned to lifelong learning goals would assist the acknowledgment of GRN's whole lives, including their various life role stages. It would also assist in directing their preparation to include a broader set of knowledge and skills that are transferable and support the transition between roles. This discourse disruption is important in order to improve the adequacy of GRN life balance and life role salience, including life career role preparation and support by the nursing workforce and organisation cultures in which they will be employed. This change can be achieved through applying formal, measured risk assessment. Additionally, life balance and life role salience risk assessments are important to the early identification of those at risk of life balance and life role declines which place them at further risk of wellbeing decline and attrition. The risk assessments are important to inform aligned, targeted, on time and measured interventional strategies, designed to improve GRNs' life balance and life role salience and their overall life satisfaction, happiness and quality of life. These are new findings.

To effectively support GRNs' individual's assent and ascent towards a life in balance to enable them to adequately meet their life roles, a proactive, evidence-based response is required by the education and transition 'nurseries' to actively apply workplace laws and discipline specific standards promoting GRNs' life balance and wellbeing. It is therefore important that the education nurseries include education about life balance and life role salience during student nurses '*becoming*' a nurse stage, as well as risk management. Furthermore, it is important for the transition support '*nurseries*' to role model and apply these ideas to their support for GRNs in their transition year and beyond. This evidence-based, recursive approach will assist GRNs

to enact their role, '*being*' a nurse in a safe and caring environment that is purposefully designed to nurture them to thrive in their work role and *all* their life roles. As such will assist in mitigating GRNs' risk of life imbalance, life role decline and attrition from the profession.

As part of the education and support disruption to a broader platform, moving to including GRNs as partners in improving the GRN transition experience is also needed.

6.4.2.8 Partnering with GRNs

Partnering with GRNs by involving them in the development and design of quality effective education and transition support will facilitate a more responsive approach to meeting GRN needs and expectations to be work and life ready as RNs in the 21st century. Partnering with GRNs is a concept this study has adopted from the National Safety and Quality Health Service Standards [NSQHSS], Standard 2, Partnering with Consumers. Partnering with Consumers Standard 2 involves "systems and strategies to create a person-centred health system by including patients in shared decision making …and that consumers are involved in the development and design of quality health care" (ACSQHC, 2011; 2017, p. 1). Thus similarly, applying these ideas to partnering with GRNs, would include involving GRNs in the development and design of quality effective education and transition support with the education and support transition '*nurseries*'. This study, by investigating the first year GRN *Load Triad* experiences, essentially 'partnered' with GRNs with the intention of targeting reform in the education and transition '*nurseries*' to improve GRNs' experiences in '*becoming*' and '*being*' a nurse. As the Phase1 focus group concluded, three GRNs offered some advice as part of their 'concern and care' for future GRNs in meeting some of their broader emotional needs in 'being' an RN. Diana shares her personal thoughts about what GRNs need to hear, to feel supported:

> *"To have someone there…one day there…, with chocolate, to sit down and chat to you…honestly explain… I'm not going to lie…[and say]…everyone's going to find the first grad year hard…and I know exactly how you feel."*

This advice resonated with Brooke who added further advice.

"You need someone to understand, not just listen, to understand. Instead of making you feel worse."

Brooke also recommended presenting new graduates with a vision of how they will be feeling once their first 12 months had finished.

"I think that I wish I had have known when we first started that, 11 months down the track, we'd be sitting here feeling okay with ourselves and feeling that we're actually doing it and can do it now…. I wish back in February..." (Brooke's thoughts trail off to within her private mind)."

Anne added her thoughts:

"That there really was a light."

"Yeah, there was. There was the light. It was going to get brighter. I wish I had known that back then, but I suppose we've got to go through all the crap to come out to where you feel okay about it all."

The GRNs in Phase 1 experienced epiphanies about the value of reflecting about their first year of '*being*' a nurse through participating in the research study focus group. They realised that reflecting with other GRNs had galvansised them. Diana:

"It's not really until you sit here like this and reflect to realise how far you've come."

Their epiphany about the value of reflection was surprising because of their previous reluctance as undergraduates in participating in reflections during their education. This irony was evident when Brooke said:

"No!... reflection classes at uni!" [Laughter from all GRNs].

As part of their participation in the focus group, these GRNs realised that reflecting on their experiences helped them in a meaningful way to deconstruct their experiences to achieve a deeper understanding about their transition journeys and their individual paths forward. Reflection is a higher order learning approach (Allan &

Driscoll, 2014) and is supported by the NMBA's Registered Nurse Standards for Practice. Standard 1.2. Standard 1.2 which states "develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice (NMBA, 2016b, p. 3). Thus, the GRNs in Phase 1 understanding about 'the value of reflection to shape future practice' was 'actualised' and assisted in developing them professionally and personally in ways they had not considered prior to the focus group experience. The benefits of their reflections about their first-year experience will extend beyond their individual benefit to also benefit future GRN preparation and transition support in '*becoming*' and '*being*' a nurse. Furthermore, Phase 1 GRNs will also contribute to enabling a more informed and responsive approach by higher education institutions and health organisations in meeting GRN needs and expectations to be work and life ready as an RN in the 21st century.

GRNs reflecting about their transition year are '*being*' a teacher, in that they have '*become*' 'Knowledge Builders Knowledge Creators' (KBKC) and, by participating in this study, have contributed to its outcomes. These outcomes include the development of a new overarching transition theory in '*Becoming and being a nurse*'. This theory is further supported by two new theories, also developed from this study, nurse preparedness theory (where no adequate preparedness theories exist) and life career preparedness theory. Combined, these three theories will inform and guide the transitioning of the person to a nurse by nurturing their personal and professional development in being fully prepared in '*Becoming and being a nurse'*. This approach will build GRNs' capability and adaptability to transition effortlessly in to the workplace as RNs, to 'hit the ground running' and by linking theory to practice in all their life role, with confidence, creativity and happiness and in all circumstances and environments.

6.4.3 Phase 1: Transition journey summary

The Phase 1 GRNs' transition journey experience is critical in providing an improved understanding about the additional transition challenges GRNs encounter to inform the direction of strategies to improve their life career education and support. GRNs are uniquely situated in a range of clinical settings and are a vital link between higher education preparation and industry's expectations of their '*being*' work ready. Therefore, they are qualified to provide insight into the adequacy of their education

and training in '*becoming*' a nurse and transition support to enact '*being*' a nurse. GRNs' performance in these clinical settings shapes the outcomes of their higher education institutions '*nursery*' preparation. Equally their performance in turn produces quality indicators of the effectiveness of the higher education institutions '*nursery*' education preparation and transition support. GRNs' evidence has highlighted areas of weakness in their education and training and transition support that will assist education and transition '*nurseries*' to address these in a more responsive and informed way. The areas of weakness predominantly include neglecting GRNs' preparation for the workplace culture from an evidence-based and measured platform. This encompasses adequate cognitive and constructive alignment to identified areas of weaknesses, including the fundamental knowledge and skills expected of nurses to '*be*' an RN across into their clinical experience. GRN's transition journey experiences revealed a broader curriculum is needed that is based in the nursing epistemologies and aligned to lifelong learning goals to improve GRNs' experiences of working and living life as an RN and to mitigate risks of attrition from the profession. Areas that the GRN first year experience has revealed that need to be included in the GRN's broader curriculum include awareness about cultural influences, the 'particular', 'webs of significance' and beliefs; the nexus of wellbeing and culture; life career role education, including transition and work environments, life balance and life role salience, particularly life role imbalance and the need for self-care; fostering resilience and agency, learning about the development of self and others/reflective practice for CPD to improve life role practice and partnering with stakeholders; and quality improvement processes – risk management and working from a platform based on evidence. Thus, GRNs' transition journey experiences have been found by this study to be critical in providing an improved understanding about nurses' education and training and transition support. These experiences will inform the direction of reform strategies to improve GRN education and training and transition support in '*becoming and being a nurse*'.

The GRN transition story of '*becoming and being a nurse*', continues by moving from Phase 1 focus group GRNs to a larger sample of GRNs, Phase 2 survey findings, to confirm and or deny findings from Phase 1 GRNs' transition journey experience.

6.5 PHASE 2: KEEPING THE BALLS IN THE AIR: HOW GRN'S MANAGE STUDY, WORK AND PERSONAL LIFE

The study's literature review of the contextual factors underpinning the research reveal high GRN attrition rates, concerns about the adequate retention and supply of graduates to meet demands for health service, the paucity of research on GRN's life roles linked to the management of these life roles, and GRNs' attrition intent. These factors combine to improve understandings about GRNs' life role management and considerations about attrition.

The GRN transition story of '*becoming and being a nurse*', continues discussing Phase 2 survey findings. Phase 2 findings incorporate the 6 survey scenarios and are presented in sequential order. The GRNs transition stories in Phase 2 predominantly reflect their life role values and the beliefs that guided their 'particular' choice of action when their life roles came into conflict. Their transition stories also reflect the education and transition support '*nurseries*' values and beliefs in relation to *all* the GRNs' life roles and life balance preparation and transition supports.

The story begins by revealing the life roles GRNs hold most dear, their life role salience in their transition year as a new RN.

6.5.1 Life role salience

Scenario 1 context: Competing life roles (work, study and personal/friendship)

Scenario 1

> You have been working hard all week and feeling tired at the end of each shift. You know your best friend has a BBQ Birthday lunch on tomorrow and you haven't seen her for the last 2 months or so. You have an early shift tomorrow and an in-service training session has also been scheduled first thing in the morning to fit in with your work time.

Life roles are important to individuals, organisations and society to promote 'wellbeing' for all stakeholders. However, when individual life roles and the goals of the organisation and society begin to compete for time, energy and resources, life role conflict can occur. Phase 2 GRNs, in the context of experiencing the broader 'push and pull' influences, found that they needed to balance their work roles against their other life roles, study and personal friendships. The majority of GRNs chose to

prioritise their work roles, followed very closely by their study roles, placing their personal role-friendships last. This study also found that some GRNs worried about how to manage their competing life roles. For example, GRNs in transition programs experienced higher levels of worry compared with GRNs not in a transition program. In addition, the findings revealed that only just under half the GRNs believed they had been prepared by the education institutions for their life role management.

Phase 2 findings confirmed findings Phase 1in that GRNs hold their work and study life roles in high standing, and when faced with competing life roles, choose to sacrifice (in this scenario context) their personal life role in terms of friendship. In addition, Phase 2 findings also confirm Phase 1 findings that some GRNs do worry about the management of their competing life roles and believe their preparation about how to manage competing life roles was inadequate.

Phase 1 and Phase 2 findings have revealed GRNs' broader characteristics also include a high work and study ethic to ensure they are strongly positioned to be successful in enacting their RN role. However, these characteristics also reveal the potential for GRNs to overlook the importance of balance in *all* their life roles. Polt (1999) equates this as the '*absorption*' and '*thrownness*' of *being* a new RN in maintaining their own and their family's overall wellbeing. An excerpt from Phase 2 describes the competing life role challenges, work role salience and the impact on the GRNs and family impact.

> *"I think this year is completely overwhelming and there is no way to balance the work commitment and pressures with the home life routines. I wish my family and partner would be more understanding, instead they think they have put up with my study commitments for the past couple of years and don't think it's fair for them to wait another year for me to try and find my feet."*

The literature is well versed in demonstrating that the first-year in a nurse's career is the most stressful (Martin & Wilson, 2011; Rudman et al., 2014). New nurses are confronted by risks to their health and wellbeing from the health environments and ways of working they are positioned in (Bjerknes & Bjørk, 2012; Freeling & Parker, 2015; ICN, 2006; NSW Nurses & Midwives Association, 2013; Rhéaume, Clément, LeBel, & Robichaud, 2011). In addition, the literature reveals the importance of life role balance to promote wellbeing that benefits the individual, their families,

organisations and society (Magee et al., 2012; Meyer & Maltin, 2010; Longworth & Davies, 2003; Pryor & Bright, 2003a). These findings about GRNs' competing life role values, reinforces the impetus to ensure that life role education and self-management supports are seen as *fundamental* to their journeys '*becoming*' and '*being*' an RN. The inclusion of life role education and self-management will reduce wellbeing decline in GRNs and their families in their first year.

The GRNs' in this study revealed their competing life role value prioritisations. Knowledge is needed to form values (Lewis, 1990) therefore, it can be postulated that the GRNs' life role values reflect their knowledge, their education and their transition support '*nurseries*'. Therefore, to improve the GRNs life role experiences in enacting *all* their life roles in competitive contexts, the education and transition support '*nurseries*' need to be interrelated. Koch (1995) sees these interactions as critical in enacting cultural change.

GRNs competing life role values in their transition year becomes pertinent as 'instrument of thoughts' (Heidegger, 1927, 1962) 'raising awareness' about reviewing current education and transition support offered by '*nurseries*' (Foucault, 1976, 1984). For this to be meaningful and to trigger changes in the education and support '*nursery*' cultures, its members need to undertake 'deconstruction'. Areas targeted for deconstruction include beliefs, ideals, past experiences, culture, history, gender, power struggles, behaviours, how decisions are made and future intentions (Best, 2014; Foucault, 2005; Habermas, 1987; Kock, 1995). Members would be required to *unlearn* "one's bad habits and all the false opinion" (Foucault, 2005, p. 495). In this case, deconstruction of *all* life roles and self-management would be seen as fundamental in facilitating education preparation and transition support during the journey of '*becoming*' and '*being*' an RN.

6.5.2 Work role

Scenario 2 context: Fundamental principles of care preparation

Scenario 2

> You are working in an area/ward well known to you; however today you have been assigned a patient whose presenting condition is new to you.

Graduates have expectations of being work ready in enacting their new career role identities (Dyess & Sherman, 2009). Adequate work role knowledge, skills and clinical experience facilitate work readiness and transitions into workplace role, culture and retention (Holland 1959; 1973; Holmes, 2001; Parsons, 1909; Patton & McMahon, 2006; Pryor & Bright, 2003a; Super, 1990). This study increases understandings about GRN work role preparedness and their confidence in enacting their RN roles.

This study observed GRNs caring for patients whose condition is unfamiliar. Based on fundamental principles of care, Phase 2 GRNs differed in their confidence levels. Additionally, the majority of Phase 2 GRNs revealed they would be worried about causing patient harm. Importantly, the majority of the GRNs also felt confident in their abilities to problem solve, seek supporting resources, including seeking support from experienced nurses.

The findings in Phase 2 confirm the findings in Phase 1: that GRNs hold their work role caring responsibilities in high regard empowering them to provide safe, quality care and are confident to seek support from experienced nurses when needed. In addition, Phase 2 findings also confirm Phase 1 findings: that GRNs do worry about causing patient harm when providing care for a new condition. An excerpt from Phase 2 describes this concern.

> *"I wouldn't feel comfortable nursing a patient with a medical condition I'm not familiar with and prefer to learn from a senior, more experienced nurse."*

This study has also observed that GRNs' lack of preparedness in fundamental knowledge and skills poses a risk to their personhood in terms of valuing their nursing degree and career identity to competently and confidently enact their RN roles.

GRNs' lack of preparedness and transition support are concerns for all stakeholders. The literature confirms the findings that GRNs lack of preparedness in contrast to industry expectations remains an ongoing phenomenon (Grealish & Smale, 2011; Levett-Jones & Fitzgerald, 2005; Romyn et al., 2009). In particular, the findings confirm literature that fundamental knowledge and skills and low confidence remain issues for GRNs. The study also confirms Manley et al. (2011) findings that effective

work place culture and the qualities and attributes that emphasise a commitment to learning, open communication, team work and safety, facilitate a culture of safety and learning. An excerpt from Phase 2 describes this culture of safety and commitment to learning.

> *"This is my job. I need to develop myself to be able to safely care for any patient I am expected to care for. Safe practice doesn't mean avoidance but trial with supervision to develop confidence and competence."*

Furthermore, this study corroborates literature that to improve GRN preparedness, a targeted and aligned evidenced-based approach to overcoming fundamental learning/practice deficiencies (Dyess & Sherman, 2009) causing GRN stress needs to be implemented. Literature identifies that common causes of GRN stress include ineffectively managing their professional roles, making decisions, including clinical judgements, managing time, lateral violence (bullying) and moral distress (Casey et al., 2004; Kelly & Ahern, 2008; Mason, et al., 2014; Myers et al., 2010; Rhéaume, Clément, & LeBel, 2011; Spence Laschinger & Grau, 2012). Other contributing to stress includes prioritising, managing relationships with colleagues and communicating well with physicians (Casey et al., 2004).

The findings confirm that GRNs' lack of preparedness remains a phenomenon that persists. The findings also disclose that education '*nurseries*' and education monitoring bodies are not adequately evaluating and responding to acknowledged issues, shortfalls and recommendations. This suggests that these cultures remain inert in 'historical epistemologies', requiring significant 'disruption' in the nursing education 'discourses' to trigger changed thinking and behaviour and actions to produce graduate nurses who are work ready (meeting industry expectations). That is, GRNs confident and competent in the fundamental knowledge and skills they need to enact their roles as an RN as an outcome of completing their nursing degree.

6.5.3 Study role

Scenario 3 context: Competing life roles (work/study and personal)

Scenario 3

> You are at work and training has been scheduled for you at a time that allows you to participate. However, in the back of your mind you are thinking about a situation that needs attention and resolving.

The value of education is prized by many individuals because of its benefits to empower them to be *all* they can be in *all* their life roles, circumstances and environments, contributing to their life role satisfaction, wellbeing and job retention. The health environment is subject to constant change, including how nurses work and the associated competing push and pull influences on their life roles and wellbeing. This study contributes to knowledge on GRNs' study role salience and *all* their life role self-management education.

Graduate Registered Nurses enter their workplace with the study role salience they gained through completing their nursing degrees. In issues related to scheduled work training competing with a personal issue requiring attention, found the majority of the Phase 2 GRNs prioritised their work training. In addition, Phase 2 GRN's continuous professional development (CPD) requirements had been tailored by their health facility to their work learning needs. However, Phase 2 GRNs differed in their views about the benefits of including CPD assistance with their concerns about managing their life balance with personal issues. The following Phase 2 excerpts presents the low value held by the GRN regarding CPD including topics such as life balance.

> *"I don't think that in-service should be wasted on work-life balance topics. This should be encouraged by management but at the initiative of individual nurses."*

In addition, they also differed in their views about their CPD including assistance with strategies about how to improve their learning generally. However, the majority of the Phase 2 GRNs agreed about the benefits of their CPD including information and resources about available training that would help them enhance their work roles.

"I enjoy in-service training and find it relevant to my practice."

The Phase 2 findings confirm those in Phase 1 that revealed that GRNs hold their study role in high standing to support their work role in providing safe, quality care and career development. However, Phase 2 GRNs mixed attitudes towards CPD including life role, life balance and assistance with learning, suggests some GRNs may be aware of the benefits, while others are not. These varying levels of life role/life balance awareness confirms Phase 1 study findings.

GRNs' study role salience and choices about the type of CPD they prefer in their transition support CPD, reflect their values about *all* life role education and all life role self-management education. GRN's choices also reflect the values held by their '*signature nurseries*'. At the nursing governance level, CPD is based on the "foundation of lifelong learning" (NMBA, 2016a, p. 1). Additionally, the CPD definition specifies CPD is required to "…develop the personal and professional qualities needed…" (p.4). At the governance level, the 'cultural CPD portrait' is clear. However, at the organisational education level, the CPD definition is open to interpretation, with CPD outcomes heavily focusing on knowledge and resources to develop nurses' professional nursing practice, rather than their personal capabilities. Hence, the focus from the education and support nurseries reflects only a partially painted 'cultural portrait'.

There is a paucity of literature investigating GRNs' study role values supporting *all* life roles. A study by Zarshenas (2014) revealed GRNs highly value their educational learning. However, nurses generally differed in valuing their study role. Irving, Irving, and Sutherland (2007) found that nurses identified being preoccupied with completing the mandatory CPD 20 hours, rather than valuing the learning outcomes gained for their practice. High regard was observed with nurses valuing learning to improve their work role; however, this value was conditional as the CPD needed to occur in work hours. Additionally, they found that organisational support positively influenced these nurses' attitudes towards participating in CPD (Katsikitis et al., 2014).

There is limited literature on the efficacy of health organisation's CPD as aligned to the broader goals of lifelong learning. Literature however exists on the need to improve CPD guidelines concerning content, implementation and evaluation (Cleary et al., 2011; Ross et al., 2013). The literature within career education also

highlights the need to personalise education for individuals, based on their needs and career goals, with the pedagogy of choice being reflective practice (Freire, 1970, 2005; Parsons, 1909). This approach is used in the chronic health discipline; however, it is applied in the context to achieving patient health goals. A personalised approach is known to assist patients maintain and enhance their health and wellbeing (Karterud & Stone, 2003; McCabe & Holmes, 2009; Rogers, 1959, 1965). This type of approach would also benefit nurses' CPD in supporting *all* their life roles, particularly GRNs entering the health environments and ways of working that pose known wellbeing and attrition risks.

The study's findings extend the knowledge and understanding about GRN's study role salience in supporting *all* life roles, additionally acting as an 'instrument of thought' to guide education and transition reform '*Verstehen*'. Reform is needed to enhance GRNs' and education '*nurseries*' understandings about the value of *all* life role education, including the role of study in supporting self-management strategies, especially their self-care about maintaining their health and wellbeing.

6.5.4 Personal role

Scenario 4 context: Self-care role salience

Scenario 4

> You have been feeling overwhelmed at home for the past few weeks, the dirty clothes always seem to need washing, the house work never seems to get completely done, you haven't done a full week's grocery shop again and you have had an argument with someone close to you. It's lunch time.

Practicing self-care is important in fostering the enactment of *all* life roles to achieve a personal sense of wellbeing. Self-care has been described as the practices individuals implement and maintain to prevent and or manage illness to achieve wellbeing. Practices include managing nutrition, environmental factors, lifestyle and hygiene (WHO, 1998). In the context of GRN's needing to enact their RN role in unsafe work environments and harsh work conditions that pose risks to their health and wellbeing, GRNs' management of their self-care role is essential.

Considering the importance of self-care, Phase 2 GRNs revealed their values about their self-care roles. Self-care strategies identified included making a healthy lunch, phoning a friend and consulting medical and or psychological experts. Less than 10 percent of Phase 2 GRNs were convinced about implementing these self-care strategies. However, the following Phase 2 GRN excerpt revealed additional self-care strategies that included, exercising, engaging in sport and community activities.

> *"I am very organised. Due to shift work and often being on call I do meal preparation in advance, so I stay healthy and fuel my body with good foods. I regularly exercise, at least an hour every day if not 2-3 hours. [The community where I live] offers a lot of sport and I have found it a good way to switch off from work. It's also really important to get involved in the community to keep a healthy mindset."*

Consequently, these additional self-care strategies this GRN is implementing, suggests GRNs are implementing other types of self-care strategies and is an opportunity for further research.

Additionally, this study also observed that Phase 2 GRNs differed in their confidence to determine their own self-care strategies. Only one third of GRNs were certain about feeling happy about this. The following Phase 2 excerpt reveals the GRN is dissatisfied with their personal life due to their work schedule.

> *"Personal life once graduated is non-existent due to working constantly and unable to plan anything due to it being too difficult to get everyone together when you have a day or days off."*

GRNs in Phase 2 suggested their self-care role salience was low, particularly in relation to making a healthy lunch. However, the other self-care strategies identified may also indicate these were not the preferred choices of self-care for the GRNs. This suggests an opportunity for further research to explore GRN's preferred self-care strategies. Overall these results confirm that self-care is an area some GRNs struggle with in their first year.

Phase 2 confirms Phase 1 findings that the implementation of self-care strategies is an area some GRNs struggle with. Phase 2 GRNs revealed differences in

their confidence in implementing self-care strategies, suggesting that some GRNs may be aware of self-care, while others may not.

> *"…I make sure I also find time to exercise, eat healthy, travel and socialise."*
>
> or
>
> *"I think this year is completely overwhelming and there is no way to balance the work commitment and pressures with the home life routines."*

These varying levels of self-care confirm Phase 1 study findings.

Phase 1 and 2 findings revealed some GRNs' potential to overlook the importance of their self-care roles in the '*absorption*' and '*thrownness*' (Polt, 1999). Especially in *being* a new RN and needing to maintain their wellbeing to enact *all* their life roles. This observation reinforces the impetus for education and support 'nurseries' to include self-care management as a fundamental during their GRNs '*becoming*' and '*being*' an RN.

While literature is emerging concerning nurse's self-care behaviours in preventing health risks, there is limited literature on the self-care behaviours of GRNs. Nahm, Warren, Zhu, An, & Brown (2012) found that nurses reported a lack of self-care behaviour, such as not exercising, eating meals at irregular times and were either overweight or obese. Their study noted that these nurses were aware of self-care strategies but were unable to translate these to their own self-care practices. Nahm et al., 2012) recommended improved employer support as well as further research to identify motivators to assist nurses to translate self-care awareness into practice. Furthermore, the benefits of supporting employees in *all* their life roles enhances individuals' and their families' capacities to experience personal happiness and overall satisfaction with the quality of life (Hosie & Sevastos, 2010; Warr, 2007).

This knowledge, combined with the observation that some GRNs potential to overlook the importance of their self-care role in *being* a new RN, becomes pertinent as the 'instrument of thought' (Heidegger, 1927, 1962) guiding education and transition reform '*Verstehen*'. Reform is essential to enhance GRNs' and education '*nurseries*' understandings about the value of self-care management and education to achieve learning that is transformational. Transformational *self-care role* learning will

assist GRNs to confidently enact their roles in their transition year to maintain and enhance their wellbeing, as well as to support their enactment of their other life roles.

6.5.5 Wellbeing and attrition intent

Scenario 5 context: Feeling low, experiencing work stress and thinking about calling in sick, finding another job and or leaving the profession.

Scenario 5

> You have been feeling low at home and you are also feeling stressed about work and right now you are thinking about calling in sick for your next scheduled shift.

An individual's holistic wellbeing is a reflection of their human dimensions; their intellectual, environment, spiritual, sociocultural, emotional and physical qualities working in harmony (Smith, 2014). Health and wellbeing are unique for each individual and are commonly based on how the person feels, their values, beliefs and cultural influences from their family, community and society in general (Baum, 2008). Literature on employee wellbeing adds behaviours such as not calling in sick unless unwell, job satisfaction, high work morale, a sense of wellbeing and retention (Kumar & Paramashivaiah Shivakumaris, 2011; Spence Laschinger & Grau, 2012). Therefore, it is important to acknowledge the individual's perception of their health and wellbeing, with the goal of respecting and supporting their position. Thus, it is essential to seek from GRNs as individuals, their perception of health and wellbeing and support them in their ascent to achieve this.

This study contributes to knowledge and understanding about GRNs' wellbeing. The findings revealed just over half of the Phase 2 GRNs would not call in sick and were not likely to think about finding a nursing position at another place or leave the nursing profession. The following excerpt reveals GRNs values and choices reading their work and or personal/self-care role.

> *"I love going to work."*
>
> *or*
>
> *"Sometimes a 'mental health day' is in order to help you recuperate but I love my job so would never consider leaving."*

In relation to self-care strategies, about one third of the Phase 2 GRNs would implement self-care strategies such as sharing their concerns with a friend and or going for a walk.

> *"I have close friends who I am able to 'vent' to regarding any issues that I might be having."*

Only approximately 10 % of GRNs would implement self-care strategies such as consulting with a doctor and or seeking support from online sources.

These findings suggest that these Phase 2 GRNs' choice of behaviours, reflect their values and cultural influences, including influences from their educational and transition support '*signature nurseries*', and have impacted their personal and employee wellbeing. These findings suggest that for some Phase 2 GRNs, particularly the GRNs not enacting self-care strategies, their personal and employee wellbeing is at risk.

Phase 2 findings confirm Phase 1 findings that personal and employee wellbeing and thoughts of attrition remain individual, however feelings of being anxious, combined with work stress, suggest that this is a risk indicator for some GRNs leading to thoughts of attrition. This study has observed that monitoring GRNs personal mood and work stress is important to detect thoughts of attrition and respond with personalised, timely, measured interventions.

Little is known about Australian GRN wellbeing and thoughts of attrition (Christopher et al., 2018; Cowin & Jacobsson, 2003; Schluter et al., 2011). This study extends this knowledge and understanding about Australian, Queensland GRNs' wellbeing and thoughts of attrition, however further research is needed in both these areas to align education and support. There is literature on international GRN wellbeing decline and attrition (Booth, 2011; Odland, Sneltvedt, & Sorlie, 2014). Causes have been attributed to lateral violence (Beecroft et al., 2001; McKenna et al., 2003), inadequate socialisation (Kelly & Ahern, 2009) and loss of professional identity (Zarshenas, 2014). In effectively responding to these concerns, some literature is emerging (Griffin, 2004; Laschinger, Grau, Finegan, & Wilk, 2010), however a more research exploring intimate, intensive, collaborative, measured relationships between GRNs and the '*nurseries*' is needed.

This study has observed that GRN's inattention to self-care strategies, is a risk to maintaining their personal and employee wellbeing and retention. This knowledge acts as an 'instrument of thought' to guide education and transition reform. Reform to enhance GRNs' and education '*nurseries*' understanding about the value of self-care strategies to supporting overall maintenance and enhancement of holistic wellbeing.

6.5.6 Support

Scenario 6 context: Wellbeing culture

Subtopic: Kindness and caring approach of peers

Scenario 6

> You come to work feeling down and sometime during the shift you make an error. Your nursing peers made some comments that made you feel worse. You start to think about how you care for your patients and wonder why your peers responded to you this way.

In Australia, many hospitals employing GRNs offer support in the first year in the form of structured transition programs to facilitate their transition and retention (Aggar et al., 2017). Despite many hospitals introducing transition programs, GRN attrition continues. In part, this may be attributed to undergraduate and transition support '*nurseries*' not responding in a timely fashion to known causes of GRN stress, such as the health workplace culture, through targeted, measured and quality educational and supportive approaches, that includes access to psychological experts. Psychological experts would be able to assist GRNs to understand the behaviours of others, to better manage their stress and to cope from an improved and informed position (Amirkhan, 2014).

The influence of culture can impact a person's sense of wellbeing in either a positive and or negative way. Cultural effectiveness requires new members to be aware of the workplace cultural practices and beliefs. New members need especially to be aware about how a negative workplace culture can affect their wellbeing and have the skills to navigate this terrain. This study contributes to knowledge on GRN's support within the workplace culture and the impact on their wellbeing.

The study observed that half the Phase 2 GRNs experienced a workplace culture where nurses had been both kind and unkind in response to making an error.

> *"I work in an environment where I am fully supported by my peers."*
>
> or
>
> *"…once graduated you are not prepared for what your about to face and how full on and nasty staff can get."*

In addition, only half of the Phase 2 GRNs received support to help them learn from their error in a positive way. That the support was timely was rated lower. Perceived support from the organisation to manage the personal impact from making an error was rated low, together with offers of extended support to manage future work and personal impacts when an error is made and any other issues related to work, study and personal lives.

The findings in Phase 2 confirm Phase 1 findings. GRNs reported that support from the transition '*nurseries*' focuses heavily on the enactment of the RN role and suggests some '*nurseries*' may be unaware of the broader goals of promoting holistic wellbeing and retention. The findings raise awareness of the need to broaden the support of GRNs by educators and nurses to include other allied health professionals, such as psychologists. The findings also suggest that monitoring GRNs' responses to making an error is important to detect any personal impacts and thoughts of attrition and to respond with personalised, timely, supportive interventions. The findings also suggest that when an error is made an opportunity is lost if the education and support '*nurseries*' fail to engage with GRNs and assess how they are managing with their life roles and advise and implement support if needed.

The nursing shortage stems from a health system's inability to respond to issues using an evidenced based approach (Buchan & Aiken, 2008). Buchan and Aiken (2008) identified a number of concerns, including "…retention ...ineffective use of available nursing resources…poor incentive structures and inadequate career support" (p. 1). Christopher et al. (2017) acknowledged turnover intentions were symbolic of a health system not functioning well and stemmed from inadequacies within the organisational structure in not providing opportunities for effective professional interactions. In addition, Christopher et al. (2017) also found that there was a lack of

strategies in place to develop effective and collegial interpersonal relationships as well as limited support from managers. These studies are important as they raise awareness about the importance of planning for retention by monitoring staff interactions to ensure the workplace culture is supportive and collegial.

The study has observed that health organisations' inattention to workplace culture and strategies constitute risks to GRNs maintaining their personal and employee wellbeing and retention in the profession. Additionally, this study has drawn attention to education and transition support *nurseries'* inattention to education and support aligned with the Code of Conduct for Nurses (NMBA, 2018). This infers that the health and wellbeing of nurses are not promoted in ways that can address health inequities. In addition, they do not operate from evidence-based platforms (NMBA, 2016b), in this case evidence linking research on health and wellbeing and work place culture to practice.

This knowledge acts as an 'instrument of thought' (Heidegger, 1927, 1962) and as Foucault (1998) postulated, raises our awareness about the varying work place cultures and their values, the 'particular' and the 'webs of significance' (Geertz, 2008). Such knowledge also improves our understandings about how decisions are made by individuals in these cultures and where deconstruction needs to occur to trigger changed thinking, behaviour and reform within a culture. Reform should include enhancing GRNs' and education '*nurseries*' understandings about the value of wellbeing support and strategies to support GRNs' maintenance and enrichment of holistic wellbeing, for example, when an error is made.

6.5.7 Thoughts on university education

Graduates have expectations that their university education and associated degree will provide relevant life career role knowledge and skills to enact in their new career role (QILT, 2018a, 2018d; TEQSA, 2017). To support graduate expectations, higher education institutions espouse quality processes to deliver contempory life career education (ASQA, 2017; TEQSA, 2017). Therefore, asking graduates about their first-year experience in their new career roles is important to determine if their university education adequately prepared them to be 'ready' to enact their new life career roles. This determination of being 'ready' is important to acknowledge and respond by directing targeted reform to the education '*nurseries*'.

Therefore, the following Phase 2 GRNs confidence levels reflect their satisfaction about whether their work and life role expectations were met. Phase 2 GRNs differed in the evidence relating to their confidence levels in enacting fundamental nursing knowledge and skills and managing new work situations in and beyond their graduate year. The following two excerpts reflect these differences:

> *"I feel I have been taught well. I have just completed my graduate year with Queensland health in [a rural area] in Queensland. I have felt confident and competent in most aspects of work. I have had a great year. I was often on call, in charge of shifts. ... I have had cardiac arrests, snake bites, heart attacks, car and motorcycle accidents, substance abuse, mental health, snake bites, paediatrics. Everything!"*
>
> or
>
> *"I wish we had an intern year like Dr's. The grad year doesn't give enough support in learning…"*

The differences in confidence levels were also observed in their abilities to manage work with study and personal life in and beyond their graduate year, including any new situations that may arise within their life roles. However, about two thirds of GRNs felt confident in their ability to further their learning to support their nursing practice and personal self-care roles. The following two excerpts reflect these differences in confidence levels to support *all* their life roles.

> *"I have a very healthy balance when it comes to work and personal life. It is so important to have a balance. I love going to work. But I make sure I also find time to exercise, eat healthy, travel and socialise."*
>
> *or*
>
> *"I think this year is completely overwhelming and there is no way to balance the work commitment and pressures with the home life routines. I wish my family and partner would be more understanding, instead they think they have put up with my study commitments for the past couple of years and don't think it's fair for them to wait another year for me to try and find my feet."*

These varying levels of self-care abilities confirm Phase 1 findings.

The study confirms literature about the ongoing differences in GRNs' preparation levels. The responsibility the literature argues lies with the '*signature nurseries*' since the 'historical watershed' decision in 1984-1994, when hospital education and training of nurses (on the job training) was transferred to higher education institutions (Grealish & Smale, 2011). Yet despite the higher education institutions sourcing their curriculum from the National Competency Standards for the Registered Nurse (NMBA, 2006, 2016b), variances in professional preparedness continues to be observed by industry (Levett-Jones & Fitzgerald, 2005; Romyn et al., 2009) and reflects Shulman's (2005) '*signature nurseries*'. Shulman argues that varying professional preparedness stems from inconsistencies in program delivery and in theory and practice, including "how to think, to perform and to act with integrity" (p. 52). This study extends Shulman's work to argue that GRN under preparedness stems from the '*nurseries*' remaining static in 'historic epistemes' in pedagogy, rather than evolving to use pedagogy that 'fits the purpose' suitable to the 21st century health environment and the ways nurses need to work. A pedagogy that is fit for purpose and suitable for the 21st century context is heutagogy. However, for heutagogy to be fully effective, the educator needs to also consciously adopt metacognition and critical thinking to underpin the heutagogy, including how students interact with the content and are assessed. Furthermore, the educator needs to also facilitate the process of reflective practice with the students to empower them as a key active and progressive member within the 'systems' (Freire, 1970, 2005) they are in and will encounter, such as the education and health systems. Together, heutagogy, metacognition and critical thinking knowledge and skills will assist learners to develop their thinking processes, and improve their ability to link theory to practice, as well as adapt to new situations.

Other literature argues variances between GRNs' professional preparedness can be explained by the poor validity and reliability of theoretical and clinical practicum assessment practices (Kako & Rudge, 2008; Ossenberg et al., 2016; Watson et al., 2002). To overcome these concerns the research recommends establishing a national curriculum (Darbyshire & Fleming, 2008; Kako et al., 2008). This study adds to this recommendation by arguing for a 'disruption' to health discourses. This would need to include seeking improved, formal, collaborative, evidence-based practice that involves partnering with GRNs to investigate their

ongoing transition experiences and expectations. The resultant curriculum reform would need to respond to GRNs' needs in a changing health environment.

In Phase 2, *all* GRNs' confidence levels about their life roles were rated as low. The literature confirms that GRNs struggle with balancing their life roles, posing risks for transition shock and attrition from the profession (Boychuk Duchscher, 2009, 2012; Duchscher, 2008; Duchscher & Myrick, 2008; Kramer, 1974). While life career education supports both individuals' transition into their life roles and their retention in the profession (Holland, 1959, 1973; Homes, 2013; McMahon & Patton, 1995, 1999, 2006, Super, 1990) education '*nurseries*' implementation of aligned strategies remains inadequate.

This knowledge about GRNs' professional preparedness levels becomes pertinent as an 'instrument of thought' to 'raise awareness'. It is also timely to reflect and review the education assessment discourses offered by the '*nurseries*'. For this reflection and review to be meaningful and to trigger changed thinking and behaviour and action in the education '*nursery*' cultures, the members need to undergo 'deconstruction' using 'reflective practice' with the aid of a facilitator. Deconstruction includes 'historic education epistemes' and the need to *unlearn* "one's bad habits and all the false opinion" (Foucault, 2005, p. 495). In this case, deconstruction of assessment practices, evidence-based practice and *all* life roles career theory and skills, are fundamental in education preparation during the '*becoming*' an RN stage.

6.5.8 Thoughts on transition education

Graduate Registered Nurses have expectations that the health organisations employing them will provide them with relevant ongoing life career role transition education and support to ensure their safe, transition and retention in the workplace. These expectations align to their study and work role salience values. Equally, health organisations value staff and patient safety and are aware of the general and additional transition challenges GRNs are likely to encounter and consequently implement transition education and support to aid GRN transition and retention.

Differences were observed in Phase 2 GRNs' levels of satisfaction regarding their work abilities, their capacities to manage new work situations and their personal life role and self-care. This suggests that organisational values may differ between organisations influencing the workplace culture in terms of personal and

learning support. The following excerpts reflect differences in workplace the culture in terms of personal life support:

> *"Within my workplace I am able to request unavailable days within each fortnightly roster. I would have requested this day as unavailable so that I was able to balance my work and personal life."*
>
> or
>
> *"It is far from easy to reschedule and socialising is not considered in the work/life balance of the facility I was working in."*

This evidence reflects how varying workplace cultures value learning support:

> *"I was recognised as a graduate but not on the graduate program, so I did not receive the grad program education."*
>
> *"Depending on what area you are working some staff support you and other times it feels like they are wanting you to fail and look like an idiot."*
>
> *"I have the support of the people I work with if something arises that I am unfamiliar with."*

However, the majority of GRNs were very satisfied with their learning abilities to support their nursing practices, including their transition capabilities to further their own learning and to support their personal self-care. However only half the Phase 2 GRNs in a transition program felt confident, compared with three quarters of GRNs not in transition programs. However, GRNs' perceptions of their transition education preparedness to further their own learning and support all their life roles, work, study and personal life, was low.

Phase 2 confirms Phase 1 findings that the transition support '*nurseries*' vary in the theory and skills they provide GRNs in their transition year. They also reveal GRN's decisions to choose their work and study roles over their personal life role/self-care. The differences in *nurseries*' transition support does not align with NMBA (2016a) CPD foundation principles and lifelong learning, including CPD's

requirement to develop the nurses both *personally* and *professionally*…" (p.4). This study confirms that clearer CPD guidelines are needed to ensure the reliability of interpreting content (Shulman, 2005) together with improved equity accessing professional development (Kataoka-Yahiro, 2011), as well as reliability and validity in assessing content knowledge and skills (Kako & Rudge, 2008; Ossenberg et al., 2016; Watson et al., 2002). Additionally, the study argues for improved monitoring of nursing curriculum to ensure the broader goals of life career education remain embedded together with improved, effective assessment practices to improve the work/study/life confidence, competence, wellbeing and GRN retention.

These observations are important in raising awareness about how cultures and their values, the 'particular' and the 'webs of significance' vary (Geertz, 2008). They also improve our understanding about how decisions are made by individuals within transition cultures and where deconstruction needs to occur to trigger changed thinking, behaviour and actions in a culture. Cultures described in this study are cultures of *being* (Heidegger, 1927, 1962) a 'GRN', *being* a 'GRNs in a transition program', and/or 'GRNs not in a transition program'. 'Cultural portraits' (Geertz, 2008) exist in the cultures of 'nursing education' and 'nursing transition support'. However, for deconstruction within these cultures to be effective, the '*nurseries*' need to engage with an educator or career counsellor, to 'facilitate the reflective process' (Freire, 1970, 2005). Furthermore, the '*nurseries*', need to ensure the reflective practice occurs mindfully, as measured against the broader governance goals, as well as the organisation and individual GRN's goals, to promote all stakeholder wellbeing and GRN retention within the profession.

6.5.9 Phase 2: Keeping the balls in the air summary

Phase 2 *keeping the balls in the air* experiences are critical in enhancing understandings about GRNs' transition experiences. Their experiences provide an evidence-base to support educational and support strategies that will facilitate future GRN's transition experiences in '*being*' an RN and in enacting *all* their life roles in balanced ways to improve their wellbeing and retention in the profession. The evidence also revealed education and transition support '*nurseries*' as well as industry and society's expectations about GRNs' capacities to effectively manage their competing life roles. Effectively managing their competing life roles would ensure

their wellbeing, and those of their family, organisation and community. The evidence presented demonstrates that GRNs are qualified to provide insights about the adequacy of their transition education and support in '*being*' a nurse and a person in their other life roles.

GRNs' confidence in performing *all* their life roles shapes the outcomes of their transition '*nursery*'s' ongoing CPD and support. Equally their confidence, in turn, produces quality indicators of the effectiveness of their support. Phase 2 GRNs' varying confidence levels about enacting their work and study roles with their personal roles/self-care revealed that broader transition support is needed. This support would need to be based on nursing governance epistemologies and aligned to lifelong learning goals. This support would improve GRNs' experiences, mitigate risks of any decline in their wellbeing and possibilities of attrition. Phase 2 findings were similar to Phase 1 findings including GRN's awareness about the impact of cultural influences, the 'particular' and 'webs of significance' and beliefs. They also confirmed Phase 1 findings about the nexus between workplace culture and wellbeing and career education, including life role salience and imbalance and the need to develop self-care education management to foster wellbeing. Phase 2 GRN experience has also highlighted the importance for transition '*nurseries*' to evaluate the effectiveness of their practices and to integrate evidence-based reform, including CPD to improve GRNs' life role practices. Phase 2 findings reinforce the needs for transition '*nurseries*' to partner with GRNs in developing quality improvement processes and risk management practices. GRNs' Phase 1 and Phase 2 transition journey experiences are key in strengthening moves to improve nurses' education and training and transition support. These experiences thus inform reform strategies to improve GRN education and training and transition support in '*becoming and being a nurse*'.

In terms of theoretical significance, Phase 1 and Phase 2 results generate a new theoretical perspective on the transition from '*becoming to being a nurse'*. Without an external reference point for becoming and being a nurse, understanding to know which way to progress is difficult. Therefore, the GRN's lived experiences has been used in this study to interpret the meaning of '*being'* a nurse and therefore needs to proceed in stages.

6.6 NEW THEORY: BECOMING AND BEING A NURSE

The basis of this theory arises from this study's mixed methodology and the researcher's extensive experience as a nurse working alongside GRNs and in educating student nurses for the past 10 years. It has also been influenced by the existentialist and phenomenologist Heidegger (1927, 1962). A two-stage transition theory is now introduced: *Becoming and Being a Nurse* with stage one '*Becoming a nurse*' and stage two '*Being a nurse*', presented as ways of embodying nursing 'governances' world of nursing' to support the transition to enact the RN role (see Table 6.1).

Table 6.1: *The Two Stage Nursing Transition Theory 'Becoming and Being a Nurse'*

Governance 'World of nursing'	Transitioning	
Portrait	Stage 1	Stage 2
Nursing professional standards, codes and policies.	Becoming a nurse Higher Education setting Environment and culture	Being a nurse Work place setting – environment and culture
	Entering the higher education as a nursing RN student	Entering the workplace as an RN – GRN for the very first time
	This marks the adjustment Phase for stage 1 and is their first major adjustment	This marks the adjustment Phase for stage 2 and is their second major adjustment
	Learning how to '*become*' and '*be'* a nurse - adaption by:	Learning how to adjust to '*being*' the nurse – adaption by:
	Using the nursing governance standards, codes and policies as the overarching guiding curriculum - tool	Using the nursing governance standards, codes and policies as the overarching guiding curriculum - tool
	Using the 'governance world of nursing standards' as the measure (mirror) of	Using the 'governance world of nursing standards' as the measure (mirror) of

	achievement – assessment tool indicators	achievement – assessment tool indicators.
	Setting up - creating and maintaining a personalised bubble of support - nurturing	Setting up - creating and maintaining a personalised bubble of support - nurturing

Table 6.1 encapsulates the ‘governance world of nursing’ as the ‘portrait’ for each new ‘young’ student nurse to aspire to ‘*become*’ during Stage 1 transition into the higher education nursing setting and in ‘*being*’ during Stage 2 transition into the health workplace setting. Stage 1 marks the first major adjustment for each student nurse in mirroring the ‘world of nursing governance’ ‘portrait’. Stage 2 marks their second major adjustment of their transition into ‘*being*’ an RN continually mirroring the world of nursing governance’ ‘portrait’. At each stage the ‘young’ nurses use the nursing governances as a reference point and as signposts to guide and evaluate their ‘*being*’ a nurse.

The theory constitutes a mirror, reflecting the governance of nursing standards and is illustrated in Figure 6.1. Figure 6.1 shows the mirror reflection as an approach that is both top down and bottom up, ensuring that the ‘portrait’ of each education and transition ‘nursery’ and each new nurse as the ‘offspring’ or the ‘young’ of the ‘parent - world of nursing governances’, continually seeks to develop and be a likeness to its ‘parent governance world of nursing’; the act of mirroring. Mirroring ensures the ‘young offspring’ a way to continually guide and evaluate their performances to direct their reciprocal ongoing development to be a likeness to their ‘parent - world of nursing governances’.

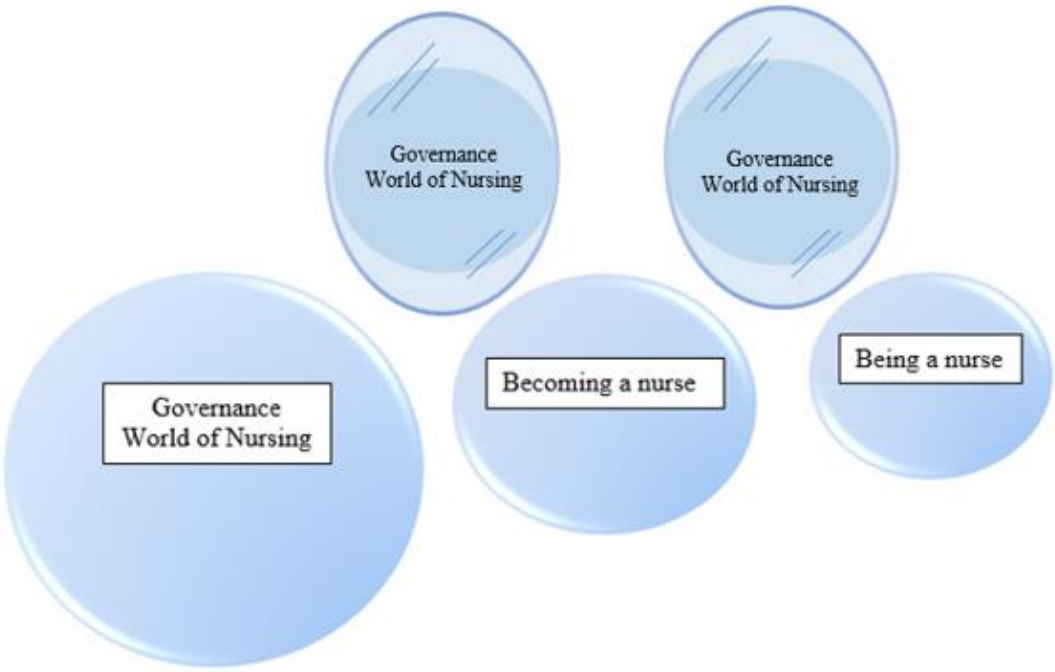


Figure 6.1. Becoming and being a nurse a mirror reflection of the governance 'world of nursing'.

6.6.1 Stage one: 'Becoming a nurse'.

The transition into the RN role begins long before the GRN enters into their professional role and practice as an RN for the first time. The GRN is an individual who, before embarking on their career as a nurse, has been shaped by various cultural discourses which are, in turn are influenced by a number of historical epistemologies. The adjustment process begins when they enter the undergraduate nursing program 'world' as a student nurse. This first stage '*becoming a nurse*', marks the first major adjustment process for them both individually and professionally. The undergraduate stage is typically a 3-year period where they are enculturated and socialised to reflect the professional qualities and attributes of a nurse. During this enculturation and socialisation stage, they are *being* transformed to '*become a person and nurse as one*' and reflect the overarching nursing governance 'world of nursing'. This occurs through two key paths. Firstly, through their exposure to deliberate learning opportunities, including self-awareness – implementing reflection and deconstruction of prior and current cultural beliefs and norms. Secondly, by observing how educators and members of the '*nursing education and training discourse world*' think, behave and act, then by imitating and demonstrating these practices for

themselves. The learning process is non-linear, with students' experiencing disruptive shifts, enabling them to respond more effectively to the new environment, make new meaning and evolve to meet the expectations of the new '*discourses*'. During their undergraduate education, student nurses learn to internalise these '*discourses*': the nursing standards and associated values, norms and ideologies, and begin to think, behave and act in a way, that is acceptable to the expected standards established by the undergraduate '*nurseries*' – adaption. In essence, the higher education '*nursery*' becomes the student nurses' 'bubble of safety', a place where they feel safe and supported in becoming a nurse. Thus, this stage is known as '*Becoming a nurse*'.

6.6.2 Stage two: 'Being a nurse'

The second stage of the transition experience is known as '*Being a nurse*' and begins the moment the student nurse graduates, receives their qualification and enters the health work setting for the first time, employed as an RN. This second stage '*being a nurse*', marks the second major adjustment process for them personally and professionally and is a stage that never ends. In this period, the GRN transitions from their previous '*undergraduate nursing education and training discourse world*' to a new 'world', a living organism offspring to the parent, the overarching governance 'world of nursing'. This new 'world of work' has its own nuanced culture, which in turn, can demand a disruptive shift as GRNs learn how to respond and socialise in their 'being there in the new world' (environment) as a new RN. The GRN either decides to accept or reject this new '*world of work cultural portrait*' based on how they perceive that the portrait mirrors the governance 'world of nursing' – adaption.

Accepting and or developing a belief that they can change the 'world of work culture portrait' or reject, is a critical moment in the GRN's 'being there'. Their determination here will impact GRN retention and wellbeing and thus constitutes a critical area were education and support are required. '*Being a GRN in this new world of work culture*' is when the GRN makes new meanings and evolves in response to their decision to 'being' in this new world culture. A decision of acceptance sees the GRN seeking to accomplish the expectations of this new '*world discourse*' and being socialised within it. In doing so, the GRN feels supported and develops a sense of belonging. A decision of rejection sees the GRN either feeling empowered to influence the workplace culture to change or feeling powerless to influence the culture and risk

being alone, unsupported and perhaps decide to leave. If the GRN decides to stay whilst positioned in an unsupportive 'workplace culture of support', they face challenges and may require intensive recursive support.

Therefore, the first few months is a critical period for the GRN in this second stage adjustment process. This period is where a heightened critical alert can ensue, if the GRN is positioned in a 'workplace culture of support' that is in juxtaposition to the overarching governance 'world of nursing'. It is therefore critical to recognise the heightened vulnerability of the first 3 to 6 months. Supporting the GRN in their successful adjustment and retention is facilitated by two main key strategies. Firstly, positioning them in a 'workplace culture of support' which is a mirror reflection of the governance 'world of nursing' and generating a personal 'bubble of safety' for each GRN. The personal 'bubble of safety' may include supportive fellow GRNs, colleagues, senior mentors, family, expert counsellors and a physical 'place of safety' and always needs to be available. A physical place of safety needs to be available in the GRN's area of work and designed for supporting the GRN holistically.

The development of this new overarching transition theory in '*Becoming and being a nurse*' is supported by two new practice theories also developed in this study and informed by pre-existing key, nursing, educational and career theories and existentialist and nursing philosophies. The two supporting theories include Nurse Preparedness theory (where there are no preparedness theories) and 21st century life career preparedness theory (where this discourse is updated to be relevant for the 21st century).

6.7 NEW THEORY: NURSE PREPAREDNESS THEORY

The nursing preparedness theory (NPT) was originally presented in Section 3.5 and was based on preparing GRNs, during their undergraduate nursing program, to develop the necessary knowledge and skills for their ascent/assent in achieving life roles salience and an overall personal sense of life balance. As an outcome of this study, the NPT is illustrated in Figure 6.2 and has been updated since its first conception in Section 3.5.2 by utilising this study's findings. Figure 6.2 demonstrates the study's responsiveness to GRNs' needs and expectations to be prepared for the realities of work and life as a nurse. The elements 1 to 7 have been identified as

comprising the GRN's personhood and are included to raise awareness about the elements that require attention when preparing student nurses for their lives, working as RNs.

1. Self-Care life role salience – as the core to nurture all other life role saliences
2. Transition capabilities – underpinned by qualities and attributes of a nurse; including the qualities and attributes of adaptability and critical thinking.
3. Transferability knowledge and skill sets – from previous and current life roles to the workplace context and work role as an RN, as well as to future contexts and life roles
4. Agency – to seek support and implement support strategies.
5. Adopting reflective practice to identify new knowledge and skill sets and direct future life role (including career) preparation needs and requirements (see Section 6.6 - 21st century life career preparedness theory).
6. Governance 'world of nursing portrait'
7. Cultural nursing workplace support portrait – 'Dr Jekyll/Mr. Hyde'
    - Creating and shaping the cultural nursing workplace support portrait – to mirror the 'world of nursing portrait' – particularly to be holistic in nature and inculcate advocacy for the broader 'portrait' – by being inclusive with the GRNs as partners. Partnering with GRN in the role of the nurse (ICN, 2012a):
        - promoting a safe environment (for all)
        - research

- participation shaping health policy and in-patient and health systems management
- education and support (both at the undergraduate and organisational levels in transitioning GRNs into the workplace - programs, CPD, etc.)

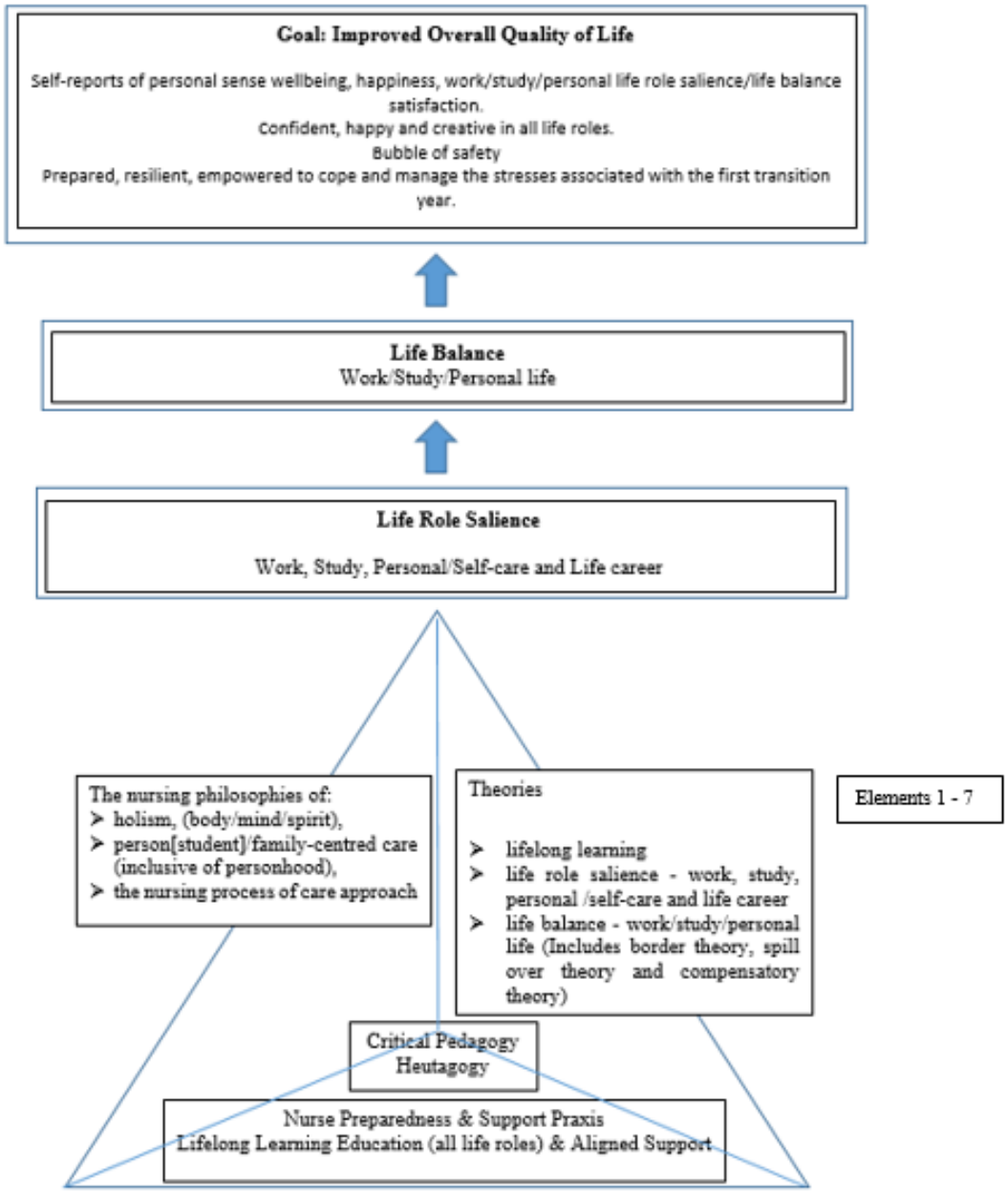


Figure 6.2. Nurse preparedness theory.

The seven elements of GRNs' personhood now shape and guide broader nurse preparedness. They are based on the philosophies of holism, person [student]/family centred care (inclusive of personhood) and the nursing process of care as well as theories of lifelong learning, life role salience and life balance. A necessary component is the adoption of the pedagogical approach emerging from critical pedagogy and heutagogy.

This NPT is a practice-based theory to expand education and support for student nurses from a broader lifelong learning platform. The design of the broader lifelong preparedness is to produce GRNs who will be work and life ready, that is to be fully prepared and supported, resilient and empowered to cope and manage the stress associated with the first transition year and beyond. Additionally, it also encompasses being able to influence recursive reform to GRN preparedness to ensure it is responsive to the changing world and its changing needs and expectations.

NPT is important as it enables an improved understanding of these concepts to empower a conscious awareness by both the student nurse and the educator to 'problematize', 'solutionise (new word)' and evaluates GRN preparedness and support. NPT also supports a recursive reflective process that will assist in revealing whether the education and supports currently in place are ignoring these concepts. It, further, facilitates the identification of student nurses and GRNs who may be at risk by being under prepared and having support for their life roles – work, study and personal (including self-care). Importantly, NPT priorities reform in the nursing education and transition support 'nurseries': by its incorporation by nursing education and support so that the GRN is placed back into the centre of the nursing profession's 'concern and care' for its 'young' and to be fully prepared and supported. Nursing preparedness theory, however, only underpins part of the preparation and support for student nurses in '*becoming and being a nurse*'. The evidence presented in the chapter also verifies the introduction of a 21st century life career preparedness theory.

6.8 NEW THEORY: 21ST CENTURY LIFE CAREER PREPAREDNESS THEORY

21st century life career preparedness theory (21st CLCPT) is a direct outcome of this study (see Figure 6.3) and works in conjunction with the nursing preparedness theory to underpin the two-stage transition theory, '*becoming and being*

a nurse'. The 21st CLCPT values and respects each individual's personhood and with this knowledge supports the preparation of individuals to empower them to effectively respond to and adapt to the changing nature of the work environment and career demands. Underpinning this support and preparation are the capacities to reflect on and raise self-awareness about the essential knowledge and associated skills, qualities and attributes that GRNs need for their life careers. Preparation also includes support so that GRNs are able to implement and evaluate strategies to guide their ongoing development and ascent (and assent) towards achieving their life career goals. Life career preparedness theory also promotes the individual's sense of life role salience, life balance, health and wellbeing; and the wellbeing of organisations and society. Figure 6.3 shows the 21st CLCPT is guided by the research paradigm post-positivism, and several philosophies and theories. The philosophies include Geertz's (2008) 'culture portrait', Heidegger's '*Dasein'* and '*Verstehen'* (1927, 1962), Husserl's life-world (1931, 1962), van Manen's lived experience (2017), beliefs (Argyris & Schön, 1974, 1978; Borg, 2001), Foucault's *care for the self* (McNeill, 1998), *discourse* (Foucault, 1972), '*Foucault's Heideggarian turn*' (Rayner, 2004),), *culture* (Rabinow, 1991), knowledge, discourse and power, and Gidden's (1984) duality of 'agency and structure'. Additionally, this theory includes the nursing epistemology and education epistemology with life-long learning as the main focus. As a central working mechanism to this theory, is Freire's (1970, 2005) critical pedagogy to assist the educator with the tool to support individuals (stakeholders) to deconstruct their lived experiences to inform change that is responsive to the changing nature of the work environment and life role careers.

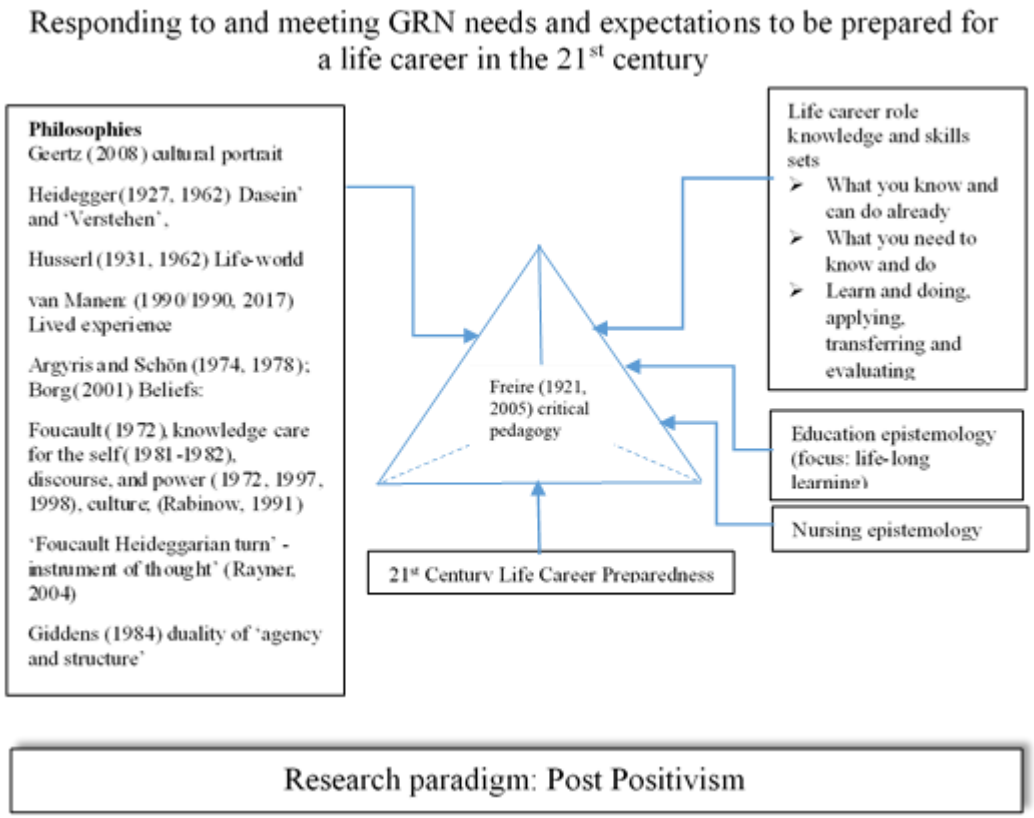


Figure 6.3. 21st Century life career preparedness theory.

The GRN participants in this study revealed their first-year experiences in relation to work, study and their personal lives. The evidence disclosed that they were under prepared and under supported in managing their energy and efforts across their life roles of importance, including their self-care and their life career roles. The new knowledge about these areas of weakness contributes to the construction of three inter-related theories to overturn these weak areas in curriculum and support, and to convert them into strengths. The overarching transition theory is '*Becoming and being a nurse*' and to be effective requires two underpinning theories also emerging from this study. These are NPT and the 21st CLCPT. Combined, the three theories inform and guide a student nurse's transitions from a person, to a 'person and nurse as one'. For the transition to be effective, the three new theories nurture the GRN's professional, study and personal personhood development, so that they are 'fully prepared'. Being fully prepared is defined as transitioning effortlessly in to the workplace as an RN, 'hitting the ground running', with the capabilities to link theory to practice, in all their life roles, with confidence, creativity and happiness and in all environments and circumstances.

6.9 THEORETICAL AND PRACTICAL IMPLICATIONS

This section summarises the theoretical and practical implications of improving the GRN experience from the broader life career preparedness platform.

6.9.1 New contributions to theory

1. Nursing two stage transition theory – '*Becoming and being a nurse*'.
2. *Nursing preparedness* theory (NPT)
3. *21st century life career preparedness* theory (21st CLCPT)

6.9.2 Methodologies

1. Philosophical bricolage: drawing on a number of philosophers to build understandings about the lived experience and life worlds of becoming and being a nurse.

6.9.3 Extensions to existing theories

1. Work/life balance to - Work, Study, Personal, Life Balance
2. Life role salience – extension to Super's (1990) life roles – adding the core role: self-care role.

6.10 CHAPTER SUMMARY

GRNs' evidence in relation to the *Load Triad* comprise quality indicators to direct reform in the education and transition support '*nurseries*', including improved alignment to the goals of lifelong learning and the associated goals of lifelong education and life career education to effectively enable GRNs to enact all their life roles and improve their first-year experiences. This study has found that GRNs are uniquely positioned as a link between the education '*nurseries*' and the transition support '*nurseries*' to provide insight into problems in their preparation and transition support processes. GRNs' experiences form an invaluable core component in ensuring a healthy and functioning education and transition support 'education and health system' to close the gap in GRNs' lack of work/study/personal life readiness (preparedness) and risks of attrition. The GRNs' evidence verifies that reform is required in their preparation for '*becoming*' a nurse and transition support for '*being*'

a nurse. The main meta message is that the GRNs' revealed they had expectations of being adequately prepared for the '*world of work and life as a nurse*' – to 'hit the ground running', as an outcome from successfully completing a Bachelor of Nursing program and attaining the associated qualification.

GRNs' evidence however also established that their preparation for working in a range of clinical health facilities across metropolitan, regional and rural areas in Queensland Australia was both proficient and deficient. This inconsistency impacted GRNs' personal sense of wellbeing, life role salience, life balance and thoughts about attrition and retention and was the consequence of both positive and negative experiences. These experiences emanated from education and transition support 'nurseries' responsiveness in meeting GRNs' needs. Additionally, the qualities, attitudes, attributes and behaviour of the 'workplace culture support portrait', and the level of involvement that GRNs had in determining their education and support needs also featured. The positive features were associated with positive GRN experiences, while negative features were associated with negative experiences.

Positive features of the GRN transition experience contributed to their improved sense of role enactment and role satisfaction. For example, positive experiences eventuated when members of the organisation, nurse managers, educators or experienced colleagues, mirrored the 'world of nursing values', providing support through effective, responsive communication. When such a positive culture was in play, GRNs felt a sense of 'concern and care' with a therapeutic, interpersonal relationship established that assisted them to enact their RN role. Relationships like these assisted GRNs to feel safe and supported. They also enabled them to readily seek assistance from these members when they required and not to be judged when they didn't possess key knowledge and skills to provide patient care and or when they made errors. Likewise, regarding study support, positive experiences were experienced when GRNs could readily and easily access organisational CPD and or were supported in gaining further education and training to grow professionally. Personal support from their organisation to assist them to achieve life balance, elevating their wellbeing and fostering their life roles aside of work, also contributed to a positive experience. However, the positive experiences most valued by GRNs emanated from their patients' acknowledgement that they indeed had made a positive difference to their lives and

when their patients thanked them. Cumulatively, these positive features encouraged GRNs to thrive.

Other positive features included GRNs' acknowledgement of the positive personal characteristics they possessed that helped them sustain their transition and retention. These personal characteristics included possessing a strong personal life role salience and agency in their work role, including deep 'concern and care' for their patients. Additional characteristics included possession of strong study role salience in their undergraduate and transition studies, and 'concern and care' for their personal friendship role, their fellow GRNs and their families. These characteristics were identified as key indicators of resilience and commitment to the nursing profession and GRN retention. Key educational stakeholders and health organisations employing GRNs need to recognise the positive personal characteristics GRNs' possess and harness and nurture these to propel GRNs forward to be all they can be, in all their life roles. Nurturing these positive personal characteristics will benefit the GRN's individually, their families, their patients and the families they care for, the organisation and society.

GRNs' negative experiences and their associated influences were also present in the evidence. They contribute to the risk indicators and thus guide recommended reform in terms of implementing recursive risk management processes. Negative GRN transition experiences were associated with a lowered sense of ability and a lack of confidence in enacting their role as well as reduced satisfaction in their work role. Negative experiences included being aware that they were under prepared to transition easily into the 'world of work' and largely unaware of the need for a broader preparation for a 'life working as a nurse'. Other negative experiences emerged from the undergraduate and transition '*nurseries*' largely overlooking the GRN's personhood reflected in a lack of a broader education and support to nurture the GRN's personhood. For example, education and support is key in nurturing GRNs' life balance including their life roles, self-care and career-care. Additional negative experiences emanated from '*cultural workplace support portraits*' being in juxtaposition to the nursing governance standards, values and principles that advocate 'concern and care' for not only patients, their families, and the public but also for one another. These negative experiences were the result of historical epistemologies still being in play in undergraduate and transition '*nursery*' cultures. These influences

prevent effective education and training and support being responsive and evolving in response to the changing needs of GRNs working and living life as nurses in the 21st century. Importantly these features and influences interrelate in the GRN first year transition experience. The evidence presented here confirmed that it is important to address shortcomings to ensure that GRNs are well equipped for a successful transition. Even if all shortcomings are not addressed, negative consequences will remain for GRN's overall experience, satisfaction and retention in their first year and beyond.

Overall, the evidence presented has illustrated the positive and negative experiences that impact on GRNs' successful transitions in relation to work, study, personal life and their ascent (assent) to achieving life role/life balance satisfaction that is right for them personally. Awareness about these factors improves understanding about the GRN experience and position key stakeholders to be responsive in actively and targeted ways, to promote GRNs' personhood, personal sense of wellbeing and retention in the nursing profession. Conclusions drawn, recommendations and opportunities for further research to improve the GRN first year experience from a broader, holistic approach are presented in the next chapter.

Chapter 7: Conclusions and Recommendations

7.1 CHAPTER INTRODUCTION

The nursing profession is experiencing a nursing shortage globally. Compounding this shortage is high GRN attrition. In Australia, the nursing shortage has been predicted to begin this decade, while specific GRN attrition remains unspecified. This study utilised the first-year experiences of GRNs working and living life as new RNs in Queensland during the period 2013-2015. Evidence presented in the study has improved understandings about GRNs' broader work, study and personal life experiences and how these might impact on attrition. Gaining a broader and improved understanding is key in reforming nursing education and transition support.

This chapter presents a summary of my study and includes the research outcomes, strengths and limitations of the study and the conclusions drawn – addressing GRNs' retention risks. Important implications for practice are also offered, followed by recommendations to initiate reform in GRN education and support. Future plans to extend the study are also outlined.

Chapter 1 introduced the thesis entitled 'Becoming and being a nurse: A research informed theory to guide contemporary university and industry approaches to preparing and supporting graduate nurses. A mixed-methodology design as advocated by Creswell (2011) guided the research investigation of GRNs' first year experiences about how they managed their work, study and personal life (the *Load Triad*).

Chapter 2 outlined the philosophical and theoretical stances adopted to guide this research study. A range of philosophies were included to explore lived experience, power and self, agency, pedagogies of higher education and nursing epistemologies. Several theories were presented and included life career and life balance theories. These philosophies and theories were merged to establish the study's ontology, epistemology, axiology and praxis.

Chapter 3 reviewed the key literature pertaining to the focus of this study to gain insights about the previous research conducted and the evidence-base already

developed. This included the historical background – consisting of the global nursing shortage, Graduate Registered Nurse (GRN) attrition and Australia's historical education and move to the higher education system. Also reviewed was the literature investigating GRNs' first year experiences – GRNs' preparedness and transition support as well as nurses and graduate nurses' life balance.

Chapter 4 detailed the research design, its mixed-methodology design positioned within a post-positivism paradigm. The method implemented encompassed a mixed methods exploratory design that demonstrated two ontological oscillations: Phase 1: Interpretive and Phase 2: Positivist. The chapter described the participants, Graduate Registered Nurses (GRNs) in their first 12 months. Data selection and analysis processes used for Phase 1 – qualitative data, manual thematic analysis and Phase 2 – quantitative data and SPSS descriptive statistics. Ethical considerations were provided detailed and research limitations identified.

Chapter 5 presented the results: Phase 1, the focus group and Phase 2, the survey to answer this research study's question:

> *What are the factors impacting GRN's first year experience to manage work, study and personal life and to what degree do these factors and possible relationships between them, impact on their overall life balance and attrition intent?*

Chapter 6 discussed, interpreted and evaluated the results with reference to the literature. A preliminary conceptual model was developed mirror the stages involved.

Chapter 7 summarises how the research addressed the study's research question. It overviewed the factors affecting GRNs' first year experiences in managing work, study and personal life and the inter-relationships between these domains that impacted on their overall life balance.

7.2 RESEARCH OUTCOMES

The research outcomes associated with the stated research question and the study's objectives are now presented. These outcomes encapsulate the original contributions to knowledge made by this study.

7.3 RESEARCH QUESTION

The primary question guiding this research was:

> What are the factors affecting the graduate registered nurses' first year experience in managing work, study and personal life and to what degree do these factors and the possible relationships between them, affect their overall life balance?

GRNs are faced with a diversity of challenges throughout their education in relation to 'becoming and being a nurse'. These challenges, whilst sometimes confronting, also act as opportunities as they provide vital clues to what is important to nurses (GRN's personhood) in their preparation for their RN role and transition into the nursing profession as a 'nurse and person as one'.

This research took place in the second decade of the 21st century, a pivotal point in history where the gaps between the supply of new nurses and rising demands for health care in Australia and the world have begun to widen. The main causes for these gaps are that older nurses are retiring and GRN attrition rates are escalating. The study focussed on improving the supply of nurses in a sustainable way by seeking understandings about the GRN experience to, in turn, develop strategies to instigate reforms to both improve the GRN experience and reduce GRN attrition. The study found that the GRN experience is an invaluable tool that can be harnessed as a quality indicator to inform what is working well in nursing education and transition support. The study also identified areas of weakness that require bolstering if GRNs' experiences, their preparedness and overall retention are to be improved.

The study group methodology (GRNs reflecting on their first-year experience from a broader work, study, personal life and life balance approach) provided useful evidence to help determine whether their overall life balance status was positive, what the associated risks were and the strategies that need to be developed to guide future reform in a targeted and informed way. The findings revealed that GRNs' experiences of working and living life as RNs, included many challenges. Firstly, there was the challenge of being able to effectively manage their self-care and personal friendship roles alongside their high work and study life role salience. Secondly, there were the challenges of being able to effectively manage a 'workplace culture of support' in juxtaposition to the 'governance world of nursing'.

The GRNs disclosed low intentions of attrition, even though experiencing dissatisfaction about work and having personal concerns. However, the low rate of intentions to leave (18.2%) is not to be dismissed as it is above the average documented (Cresswell, A., 2011). In the context of nursing shortages, the 18.2% finding is of concern and constitutes a risk indicator, suggesting that intervention and support for GRNs is imperative. Interventions, for example, could comprise the implementation of institutional risk management (ACSQHC, 2014), audited through independent commonwealth bodies. These findings raise concerns for GRN wellbeing and without a thoughtful, evidence-based implementation of aligned, targeted and measured strategies to improve the education and support of GRNs, including those in relation to workplace culture, the wellbeing of GRNs will remain problematic and attrition will continue.

7.4 RESEARCH OBJECTIVES

The main objectives of this research were to:

a. Establish the relationship of the impact of *Load Triad* on GRN life balance and attrition intentions.

This study established that there is a clear relationship between *Load Triad* impacts and GRNs' life balance. The study found the life domains of GRNs were imbalanced, due to their prioritisation of their work and study roles over their other personal life roles, particularly their self-care and friendship roles. This prioritisation was a compensatory mechanism due to their lack of awareness about the importance of self-care, life role salience and life balance caused by gaps in their education by their transition '*nurseries*' as these were not aligned to the broader goals of lifelong learning. This lack of awareness negatively impacted the GRN's personal assent and ascent towards life balance, wellbeing and overall life satisfaction.

b. Investigate GRNs' experiences to identify GRNs' lack of preparedness and vulnerability as first year nurses, causing their transitions to be problematic and risking attrition.

Several weaknesses were identified in the evidence which meant that GRNs acknowledged that they felt under prepared and vulnerable in their first year. Despite this, GRN attrition was low at 18.2% but still significant. The main areas of weakness encompassed life career transition, transition shock, harsh work

environments, deficiencies in fundamental knowledge, skills and clinical experience, harsh workplace cultures, inadequate self-care and disruptions in the nexus between culture and wellbeing and life balance. Vulnerabilities emerged from their personal levels of worry and their low confidence in their ability to effectively enact their RN role and their other life roles. The GRN evidence also identified areas of weakness and vulnerabilities in their educational preparation and transition support.

c. Explore the requirements underpinning the design of a preliminary *Load Triad* Assessment tool that uses behavioural indicators to represent GRN preparedness and resilience and these factors' relationships with retention.

The preliminary design for the Load Triad Assessment tool was designated as an outcome of the study. The tool identified behavioural indicators that represent wellbeing (see Section 7.8.4). These indicators were extended to include wellbeing behavioural indicators informed by current literature. These wellbeing behavioural indicators were also linked to the study's three new theories, also developed as outcomes from this study. These comprised the two-stage nursing transition theory 'Becoming and being a nurse', the nurse preparedness theory and the life career preparedness theory. The outcome from objective 1 above demonstrated the link between GRNs' lack of broader preparedness and thoughts of attrition which constitute risks of actual attrition. This link is important as it is the foundation for the Load Triad Assessment tool.

The indicators of resilience that emerged in the evidence are linked to strong role salience in work, study and personal role salience of '*concern and care*' for each other. The links between resilience and role salience are core indicators for GRN retention in their first year. The link between preparedness, attrition and resilience is established in the study, supporting the development of the Load Triad Assessment tool.

d. Outline and recommend preventative education support that targets the individual domain within the Load Triad identified to be at risk, as well as the Load Triad as a whole, to promote balance and retention.

GRNs' evidence identified areas of weakness in the Load Triad that are core in instigating reform in undergraduate and transition education and support. Reform to overcome these areas of weakness are most appropriately located in the

GRNs' life balance domain Study where GRNs' life roles of work, study and personal care can be targeted. Thus, the list of preventative education presented below, are closely aligned with the areas of weaknesses identified in Phase 1 and 2):

Study Domain

Work Domain – inter-related with the personal domain

1. Life career role education and strategies to foster career role development within the transition year as a GRN and beyond.
    a. Transition shock knowledge, early recognition of signs and symptoms and supportive strategies to implement to prevent and or overcome if transition shock occurs.
2. Transition capabilities (underpinned by qualities and attributes of a nurse; including the quality and attribute of adaptability and leadership) education and strategies to foster role transition to enact RN role and other life roles.
    b. Awareness and development of transferable knowledge and skill sets (from previous and current life roles to the workplace context and work role as an RN, as well as to future contexts and life roles).
3. Cultural health workplace 'portraits' being two sided – the mirroring portrait and the portrait in juxtaposition to the governance 'world of nursing' as well as strategies empowering GRNs to thrive in positive workplace cultures and strategies to survive in negative workplace cultures. This includes knowledge and strategies to foster workplace cultures to be mirror reflections of the governance world of nursing with the end goal benefiting all members in the culture.
4. Aligning fundamental knowledge and skills with clinical experiences to ensure fundamental knowledge and skills are mapped against nursing competencies and applied in clinical setting. For example, competencies in relation to showering, sponge baths, pre-operative care and post-operative care, including managing patients who are diabetic; care of dying patients, including airway management and care of deceased patients; and delegating competencies.

5. Strategies to manage high and demanding workloads, including enacting delegation and scope of practice knowledge for other team members and negotiating with management to effectively manage work load.
6. Palliative care
7. Peritoneal Dialysis
8. Care and co-ordination of the patient's family, especially when families become increasingly distressed.
9. Work place violence prevention, management, reporting and the process on how to report.

Personal Domain – interrelated with the work domain

1. Life roles – work role salience (includes life career role), study role (includes learning knowledge and skills to develop and support all other life roles, personal role saliences).
2. Self-care life roles – as the core to nurture all other life roles, knowledge, self-care strategies and self-care support.
    a. Personal self-care to manage personal negative effects (stress pertaining to responsibilities and moral distress) from experiencing harsh work environments and or as a response to caring within stressful and challenging environments
    b. Personal self-care to manage nature of work – shift work, including strategies for quality sleep, exercise and healthy eating and maintaining and nurturing personal relationships.
    c. Personal self-care to manage negative effects from experiencing verbal and or physical abuse from patients and or their families.
    d. Personal self-care to manage negative effects from experiencing verbal harassment from colleagues, such as work place gossip and bullying.
3. Agency and strategies to implement support plans.
4. Reflection to raise awareness and development of strategies to not only survive (manage, cope and be resilient) but to thrive (development of belief and confidence in one's own values, knowledge and skills mirroring the nursing governances) and to be successful in 'being a

nurse' and evolving the workplace culture to mirror the nursing governances (to be nurturing, holistic and evidence-based).

Life Balance Domains - A Whole Approach

1. Life balance theory and life role salience.
2. Strategies to manage competing life roles, for example work with study and personal life, and maintaining personal wellbeing, self-care.
3. Reflection to raise awareness about the need for and development of life balance (ascent/assent) to work with harmony with the life roles in each life domain.

Preventative education can reduce GRNs' risks of feeling under prepared in effectively enacting all their life roles and ensure that they thrive in their first year and not simply survive. It is important for educators to implement targeted intervention approaches to improve GRNs' ability to enact all their life roles confidently and competently, in all environments and circumstances, to ensure their retention in the profession.

7.5 STRENGTHS AND LIMITATIONS OF THIS STUDY

Acknowledging the research study's strengths and limitations can facilitate its strengths whilst also managing its limitations. This acknowledgement enhances research rigor because it augments readers' understanding of the parameters of the research and provides opportunities for further research to address the limitations. The strengths allow readers to accept and acknowledge the rigor of research outcomes. The steps taken to harness the study's strengths and minimise its limitations are outlined next.

7.5.1 Strengths

Several strengths were integral in the design of Phases 1 and 2 of the study. In Phase 1, a strength was the capacity to explore GRNs' experience in a regional city in deep and rich ways that were not previously present in the literature. That the GRNs were working in clinical settings, hospital and residential health care facilities was also representative of where most GRNs were working (AIHW, 2015). A Phase 2 survey strength emanated from focus group findings being validated by a larger sample of

GRNs in a wider range of geographical areas and clinical settings, as well as including male respondents.

Another research strength emanated from the role played by participant observation through the inclusion of the researcher's experience. These experiences are extensive and include the following settings. Firstly as a student nurse with a hospital trained certificate RN (1987-1990). Secondly as a university educated RN (1994-1988). Thirdly as an RN working in both hospital and aged care settings, working alongside GRNs during the period (1990-2008). Fourthly as a lecturer teaching nurses as a practicing nurse educator supporting GRNs' transition into rural and remote areas in Queensland as a District Nurse Educator (2005-2006). Fifthly as a Health Teacher teaching into EEN programs (2009-2010). Lastly, as a Nursing Lecturer in Higher education teaching many courses in undergraduate and post graduate nursing programs (2011-2018 continuing). The researcher's experience adds strength to the study (not generally evident in such research) by her knowledgeable and informed analysis of the factors impacting GRNs' first year experience. The researcher (as the research instrument) employed her experiences to ensure any biases were acknowledged and, through processes of reflexivity, play an intrinsic role in the research methodology.

Overall, the trustworthiness of data from the Phase 1 focus group and the reliability and validity of the survey data from Phase 2 were demonstrated in the analysis chapter. It is important however to acknowledge that the study's findings are not representative of the larger GRN Australian population. However, the findings provide 'instruments of thought' to guide further research to improve GRNs' first year preparedness and experiences.

7.5.2 Limitations

Several limitations were identified and acknowledged in both Phases 1 and 2 of this study. Phase 1 limitations included (mainly due to requirements to complete the research in a timely manner) the focus on GRNs' experiences in a regional city, in a private hospital setting and an aged care facility. The clinical areas encompassed medical, surgical and palliative care as well as aged care in high and low care settings. It is recognised that these experiences may not reflect the experiences of GRNs working in metropolitan and or rural and remote locations and or in other health

settings. These include hospitals and clinical areas, such as theatre, paediatrics, emergency and intensive care, and aged care settings including dementia and community care. Future research could focus on a larger range of geographical areas both within Queensland and in other Australian states. Future research could be inclusive of more clinical settings to enhance the exploration Phase. Other Phase 1 limitations included a lack of gender diversity, as all participants were female. While Phase 1 did approach male GRNs they did not volunteer (see Section 4.5.4.6). Gender diversity, however, was more capably attended to in the Phase 2 survey. The GRNs in the focus group provided valuable, in-depth, detailed and relevant rich data to enable the research to not only to proceed but to arrive at evidence-based conclusions, implications and recommendations.

Limitations were evident within Phase 2 survey. These included a low response rate, a narrowed representation and the age of respondents. Phase 2 GRN response rate was low at 2% (n = 71), representing a small percentage of the Australian graduate nurse population (3570 nurses at the time of this study) and thus the results are not generalisable outside this study, nor have they been presented as such. Online survey response rates are known to be lower than paper-based surveys (Nulty, 2008, p. 302), with online survey response rates averaging at 33% compared with 56% for paper-based surveys. However, strategies to boost numbers were incorporated as suggested by Nulty (2008). These strategies included keeping the survey brief (with an expected completion time of 10 minutes); an extension of six months – with the total availability being seven months (November 2014 to end of June 2015); and additional reminders disseminated through the QNU online newsletter and via emails to recently graduated nursing alumni.

The survey sample was limited to Queensland and so is not representative of GRNs in other states of Australia. Another limitation of Phase 2 was the omission of GRNs age demographic. Maturity, life experience and life stage may have been a characteristic influencing a GRN's capability to manage the Load Triad factors, the type of support needed to achieve life balance, and the effectiveness of their transition strategies. However, a range of ages and life stages was none-the-less present in Phase 1 focus group data with the evidence suggesting similarities in the lived experiences in the GRN/parent/partners role.

Acknowledging strengths and limitations add to the study's rigor by establishing the parameters for research. The strengths were based on utilising evidence-based philosophies and theories and methods to underpin the research process. The limitations were acknowledged and managed to minimise their effects on the research outcomes. Harnessing strengths and acknowledging and managing weaknesses facilitated valid evidence-based conclusions which emerged from the analysis and discussion. These conclusions are outlined next.

7.6 ADDRESSING GRADUATE REGISTERED NURSES' RISK

Addressing the risks to GRNs' life role, declines in wellbeing and increased attrition requires a quality, sustainable and meaningful response that is GRN centred, holistic in nature and inclusive of the whole education and transition support system. For this whole-of-system approach to be effective, each stakeholder within the system need to implement reiterative feedback loops, in the form of reports back to the education institution nursing programs and the nursing governance education accrediting bodies, ANMAC and AHPRA. For example, key stakeholder reports include the QILT survey and the implementation of a GRN first year experience survey that would act as a quality indicator reporting GRNs' education and support preparedness as well as GRNs' perceptions about health organisations' effectiveness in supporting GRN transition. In supporting these initiatives, the study provided a snap shot of GRNs' first year Load Triad experiences that can be utilised to support broader 'concern and care' reform strategies. An additional strategy to further support GRNs, would be the implementation of risk management approaches by the transition '*nurseries*'. These would facilitate the development of a broader life role risk assessment tool to assist transition 'nurseries' to recognise GRNs at risk of declines in their life roles, life balances, personal sense of wellbeing and their retention. These aspects are presented next.

Assessing GRN risks of being unable to effectively enact their RN roles with their other, sometimes higher life roles, is important in promoting their life role satisfaction, life balance, wellbeing and retention within the profession, as well as their safety and the safety of others, including the patients in receipt of their care. Risk management practices are governed and guided by the National Safety and Quality Health Service Standards (ACSQHC, 2014) and implemented by organisations in their

daily practices to promote the safety of employees, contractors, consumers and visitors. Hence, the applicability of similar practices for the 'concern and care' of GRNs is both important and relevant.

An outcome of this study is the identification of issues of concern in GRNs' education and transition support. These need to be harnessed as part of a risk management approach to improve the 'concern and care' of GRNs. These areas of concern have been classified as risk factor categories. Risk factor categories build on the pool of knowledge about the factors contributing to GRNs' risks of under preparedness and attrition (Bjerknes & Bjørk, 2012; Duchscher, 2008; Rhéaume, Clément, & LeBel, 2011; Romyn et al., 2009). Risk factor categories include education and clinical under preparedness and individual, workplace and the higher concerns life role transition preparedness risk factors identified in Tables 7.1 to 7.4.

Table 7.1

Education and Clinical Preparedness Risk Factors

Education and clinical under preparedness risk factors
Verbalising worry and low confidence to enact RN roles. Indicator examples: - I haven't showered anyone before. - I have only practiced on a mannequin. - I have only had clinical experience in one setting, for example: Aged care.
Verbalising worry and low confidence to enact competing life roles. Indicator examples: - I haven't exercised for the past month or more. - I haven't seen my friends for the past month or more. - I am eating unhealthy food most days and putting on weight.

Table 7.2

Individual Risk Factors

Individual risk factors
Adverse life event Indicator examples: - I have a life threatening condition. - I have a concerning health condition.

No personal ‘safety bubble’ – a person you feel safe to go to for support and to openly express concerns Indicator examples: - I have no-one I feel I can trust and or relate to here at work that can support me effectively. - I have no close friend or colleague here at work.
No social network
Living alone
Partner works away
Carer - caring responsibilities (for example children)
Verbalising worry and low confidence to enact RN role Indicator examples: - I am worried how to my role within the time allocated. - I don’t feel I can give an injection confidently.
Verbalising worry and low confidence to enact competing life roles

Table 7.3

Workplace Risk Factors

Workplace risk factors
Positioned within a harsh work environment
Verbalising concern about unkind treatment by colleagues
Bullying, office gossip, lack of team
Lack of work role support: no buddy, no preceptor, no after business hours GRN support
Lack of life role support: access to expert counsellors
Lack of broader life role education and support, including access to resources

Table 7.4

Higher Concerns - Life Role Transition Preparedness Risk Factors

Higher concerns - life role transition preparedness risk factors
RN role transition shock signs and symptoms Indicator examples: - I’m feeling stressed here at work most days - I am lying awake at night worrying about work - Crying

- I am doubting myself and my abilities to do my role as a nurse
- I am feeling overwhelmed with the work I need to do and little time to do it in

No work 'safety bubble' – a person at work you feel safe to go to for support and to openly express one's concerns

Repeated bullying and repeated subject of office gossip.

Repeatedly verbalising being unhappy and dis-satisfied with ability to enact life roles.

Life roles not balanced

Indicator examples:

- I'm not doing the things I used to do before I came a nurse. For example, not socialising with friends regularly (weekly/fortnightly).
- I don't bother to take a meal break
- I don't see the value of a counsellor or doctor to help me.

Life imbalance

Indicator examples:

- I feel I have no energy to do things I enjoy. For example, going for a walk or going to the movies or the gym.

Minimal life role CPD and resources

Expressing intent to leave

Indicator examples:

- I'm feeling frustrated that my life career role needs are being repeatedly ignored.

Understanding these risk indicators is important in supporting and equipping the nurse educators and nurse managers in frequent contact with GRNs, with a set of preliminary warning cues to aid in the early detection of GRNs at risk of declines in their life role and wellbeing and those at risks of attrition. Broader life role risk management by the 'nurseries' is important to foster and nurture GRNs to be all they can be in all their life roles, environments and circumstance. However, more can and should be done, including understanding the ways in which institutional support can actively prevent new ways of approaching 'concern and care' for GRNs.

This study has contributed improved understandings about GRNs' first year risks of effectively and confidently enacting their RN role together with their other competing life roles. Essentially this study identified that the contributing factors stem from three main veins:

1. A lack of adequate responses by the education and transition 'nurseries' in providing broader life role preparedness and support.

2. ‘Nurseries’ remaining to a large degree static in historical ways of education and support.

3. Governing health bodies lack of assessment of the:

- health system components individually,
- inter-connectedness between individual components and their contributions to an effective whole.

These three veins of risk were confirmed to be important as they impact GRNs’ overall ability in achieving their personal assent and ascent towards life role salience and associated life balance and personal wellbeing.

The analysis revealed these three veins of risk occurred as a result of the education and health system predominantly working from historical epistemologies, rather than from an evidence-based platform that embraces being inclusive to all stakeholders, including GRNs. In addition, the analysis identified that power imbalances were present and that ways of working, especially in determining GRN personhood and when communicating to GRNs, were not always respectful and or not operated from a shared decision and consensual platform. If the education and health systems continue to operate from such historical epistemologies, then current education and health systems will remain unchanged. Thus, problems that have been plaguing the nursing profession such as GRNs experiencing declines in wellbeing soon after entering the workforce and then leaving the profession, will be highly likely to continue and the supply of GRNs will fall short of filling predicted nursing shortage gap. This is of concern in light of current nursing shortages in meeting and increasing demands for health care services. Together they will place organisations’ and society’s wellbeing at risk.

The risk of declines to GRN wellbeing and increasing (or at least sustained) attrition from the profession can be reduced by a change in education and support practice to improve GRN preparedness for all their life roles and by adopting an holistic quality improvement, risk management approach. For this new approach to be realised, changes of cultural thinking, behaving and acting need to occur. Changes to culture can be realised through a new way of working that is based on reflective critical pedagogy and uses the nursing epistemologies as the guiding philosophy, together with other relevant philosophies such as those drawn upon in this thesis.

Relevant philosophies are those that support open mindedness and being responsive to evidence in a concerned and caring way.

To do this well, the development of active, respectful partnerships with all stakeholders and respective formal processes of communication with each stakeholder, such as in the form of reports (reiterative feedback loops back to the nursing programs and transition 'nurseries') as part of strategic plans are needed to improve the preparedness of GRNs in all their life roles. These relationships between stakeholders and their respective feedback loops to higher education nursing programs to improve their ongoing responsiveness to improve GRN preparedness are illustrated in Figure 7.1. Stakeholders include those at the governance level, the nursing discipline governance bodies AHPRHA and NMBA, and higher educations' discipline governance body, the Tertiary Education Quality and Standards Agency [TEQSA]. At the educational organisational level, stakeholders include the higher education system and institutions, and their respective Executive Deans of Health, Heads of Nursing Schools, research co-ordinators and academics delivering nursing programs and courses. At the health organisational level, stakeholders include their respective executive managers, research co-ordinators, Directors of Education, nurse educators and staff development officers, nurse unit managers and members of the nursing ward team. Importantly at the individual level, the stakeholder is the GRN.

Additionally, each stakeholder needs to develop strategies that are consensually implemented and evaluated for their effectiveness in improving GRN preparedness from the broader platform – work, study and personal life, including self-care. Key evaluation measures would need to be incorporated at governance, organisational and individual GRN levels. Key outcomes could include increased GRN retention rates; improved GRN work place readiness; enhanced transition experiences for both industry and GRNs; value-added patient experiences; and improved QILT survey data. GRNs' outcomes could include self-reports of improved confidence, competence and happiness levels, as well as self-reports of amplified satisfaction in all their life roles, including their personal sense of wellbeing and life balance. Adopting approaches based on nursing epistemologies that are inclusive of all stakeholders and centres and 'concern and care' around the GRN experience, could frame potential strategies 'with a risk management framework of the GRNs' Load Triad' to promote GRN holistic wellbeing and life role salience sustainably and

responsively. GRN retention would be increased, thus closing the loop on the GRN attrition and the nursing shortage.

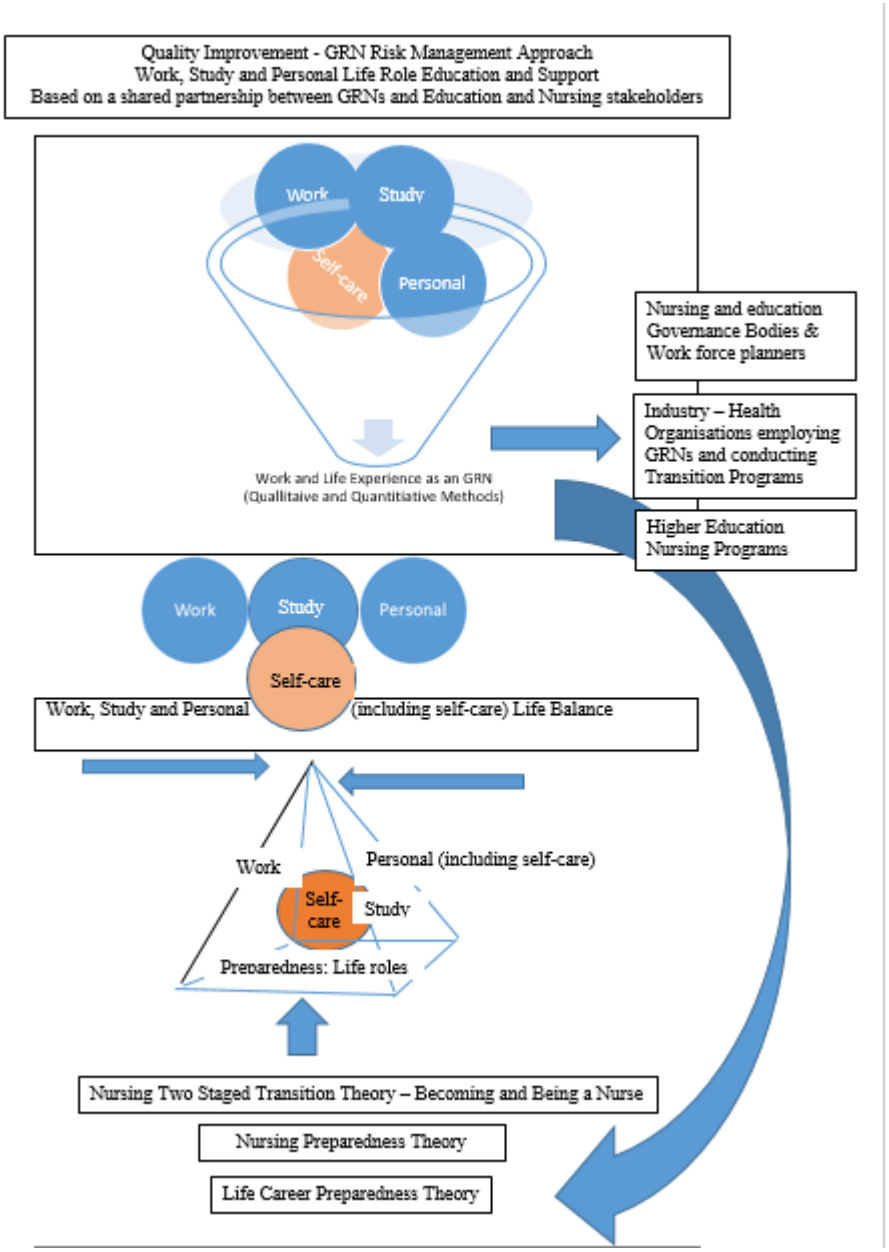


Figure 7.1. Whole system quality improvement GRN risk management approach to work, study and personal life education and support.

7.7 IMPLICATIONS

This section outlines the implications of not addressing issues and shortfalls emerging from the study. These implications are categorised into three levels: individual - GRN, organisational – higher education and health facilities, and system includes the education and health systems and are detailed next.

7.7.1 The GRN

Overall, GRNs evidence revealed that their preparedness levels remain problematic. This is partly because the move from hospital to higher education preparation in some ways still negatively impacts GRNs' ability to achieve an enduring and resilient personal sense of overall wellbeing and life balance. Addressing GRN preparedness is important to empower their agency to exert their energies and efforts across all their life roles of importance. While GRNs remain under prepared and under-supported by their education providers, they will continue to compensate for this by focusing most of their efforts into their work and study role salience and foregoing their self-care role salience. This compensatory action by the GRNs is assisting them to cope and to succeed in their first year and to be seen as not failing or 'falling down'. To help GRNs achieve a more sustainable balance in their lives, it is critical to incorporate GRN agency and 'self' (this includes self-care role salience) into higher education as the core driver of preparedness and support reform.

7.7.2 For higher education and health care institutions

Implications for the higher education institutions and health organisations employing GRNs, stem from recognising their needs to reflect the relevance and effectiveness of their current beliefs, values and practices and to deconstruct any negative historical and cultural influences at play. Undertaking these practices as usual and accepted 'ways of working' will promote improved understanding about current practices and guide reform that is in alignment with nursing governance values. These new ways of working will also help ensure GRNs' successful transition into the world of work and life as nurses. If the needs for reflection and responsive action from a broader holistic preparedness platform are not recognised and understood by the 'nurseries' and the 'nursing workplace culture' and not considered in education programs, including CPD and the type of broader support offered, GRNs' under preparedness and declines in wellbeing and retention will continue at least at the current rates. Additionally, these same 'nurseries' need to adopt reflective processes underpinned by nursing epistemologies to deconstruct historical epistemologies and associated cultural beliefs at play, including any associated 'systems of power'. Reflective practice would raise awareness and understanding, galvanising 'ways of

working' to facilitate equal power relationships between members, with the goals of establishing positive reciprocal relationships.

7.7.3 For the 'system'

The concerns and threats to GRNs' personhood revealed by this study have provided several practical opportunities to improve the GRN experience. Having a clear 'portrait' of the nurse and the nursing profession as one 'portrait' (that is as two portraits are inseparable from one another), affords a clear vision of how all members in the 'system' need to operate to build and maintain gestalt and thus enhance the functioning and wellbeing of the whole. Members operating in the 'system' need to actively engage with one another. A key focus needs to be on engaging with GRNs respectfully regarding their personhood. Engaging with GRNs within the 'system' recognises they have a vital role to play in improving the GRN transition experiences and in guiding responses to evolve current practices to meet their needs and expectations. Employing the transactional model of communication presents an approach to engaging effectively with GRNs within the education and health systems. This can be accomplished at four key levels: the experiential, education program, organisational and environmental levels.

1. The *experiential level* incorporates GRNs' transition experiences in relation to their work, study and personal life, life role salience, overall life balance and personal sense of wellbeing. At this level, GRNs need to be communicated with in ways that reflect nursing governance standards and values and organisational risk management goals. GRNs need to be treated with respect and open and active 'concern and care' for their personhood, communicated by experts so that they are fully educated from a broader platform, one that supports and encourages their participation and feedback.
2. The *education program level* invites GRNs to participate in focus groups by routinely provide feedback about the overall design of education and training programs. This would provide feedback to enhance curriculum revitalisation at the higher education level.
3. The *organisational level* includes understanding how education and health organisations operate, including all the departments in these two

systems, their services and programs. At this level, the individual departments need to invite GRNs to participate as full members in department committees, for example providing feedback about GRN quality improvements/ risk safety management, facility design to facilitate GRN transition and transition education and support, and research.

4. The *environment level* invites GRNs' to share their educational and transition support experiences with nursing accrediting, health and educational regulatory bodies to further inform policy and reform to nursing education and transition support programs. These regulatory bodies need to monitor and evaluate GRN participation in the education and health systems and offer strategies to improve GRN participation.

This proposed 'way of working' will lead to improved GRN preparedness and transition support experiences based on respect for each other as human beings and with human rights that actively support GRNs in a positive way in '*becoming and being a nurse*' in the 21st century.

7.8 RECOMMENDATIONS

Current nursing epistemology advocates for person/family-centred care based on holism and human rights and includes a recursive nursing process of care approach to ensure the care needs of patients and their families are adequately being met. It is notable that nurses need to care for themselves and each other in this current epistemology. However, it is apparent this same nursing epistemology is not being transferred in education preparation and care of student nurses and GRNs. Based on the GRNs' experience it is apparent some higher education undergraduate nursing programs and health organisations employing GRNs remain static in their education and support approach in not actively and routinely engaging GRNs to evaluate the effectiveness of their programs and support to inform reform to their programs and support.

This section outlines recommendations which stem directly from the study and highlights strategies that governance bodies, their standards and policies, and managers and educators in higher education and health organisations need to consider to actively engage student nurses throughout their three undergraduate education and

training and engage GRNs in their transition year as RNs. Section 7.8.1 proposes changes in thinking, behaviour and action for GRN preparedness and support. Section 7.8.2 considers moves to monitor and measure nurse preparation performances employing student nurses, GRNs and employer feedback to close the loop. Section 7.8.3 considers the main issues in redefining GRN preparedness from a focus on work discourses to a broader more holistic platform discourse. Section 7.8.3 considers the issue of competency and the levels that can assure readiness for the workplace. Section 7.8.4 includes recommendations pitched at the department level to ensure the systems in place are student focused with the GRN at the centre, thus are actively facilitating more holistic student and GRN preparations, through quality service, education, clinical experiences, and support. Section 7.8.5 indicates the importance of implementing the new Life Career Preparedness Theory to address GRN attrition. Section 7.8.6 highlights the need for future research on education and support programs to effectively prepare and support GRNs. These recommendations acknowledge that the education facilities and organisations employing GRNs need to consider how best to implement these recommendations considering their individual contexts, challenges and changeable factors.

7.8.1 Making a change towards quality GRN preparedness and support

Making a change to the current GRN preparedness and support from a student/GRN centred approach would mean a change in thinking, behaviour and action by education and nursing governance regulators in terms of measuring student and GRN preparedness and support outcomes. In relation to a student/GRN centred approach, a broader set of measures would need to be included. For example, if nursing epistemology is more closely focussed on what quality care is (Dempsey, 2014) and applied to the nursing context, measures would include GRN personhood, which means incorporating a broader set of measures accounting for all human dimensions.

The broader set of GRN measures need to include their personhood, which includes what interests them, what they hold dear, what concerns them and what threatens them in relation to all their human dimensions and associated life roles. Measures also need to include recognised negative preparation factors affecting GRN safety such as entering harsh work environments with a high work and emotional burden, complex care, complex decision making and lateral bullying. It would also

include GRNs' stress levels, morale and intentions to leave and or stay in the profession. Other measures identified as an outcome from this study include GRN personhood, self-care, life role salience (including their study and life career development), life balance and their perception of the workplace culture of support in aligning to the nursing governance 'world of nursing'.

Incorporating the shift to a student/GRN centred approach would comprise a disruptive shift to the control and power of education and support providers and instead generate a more equal balance of power based on mutual trust and respect. This new approach means the student nurse and GRN would share in knowledge construction, decision making and direction for education preparedness and support with education and support providers. The impetus for this disruption needs to begin at the governance level by agreeing and including student/GRN centred education preparedness and support as a core element of quality safety, education and support. Positioning student/GRN centred safety, education preparedness and support as a core element of quality education and support would also improve concern and care for students and GRNs. Such positioning necessitates adopting risk management strategy approaches to improve the safety, wellbeing and quality preparedness and support for nursing students and GRNs.

7.8.1.1 Recommendation 1

That education and nursing governance regulators include student nurse/ GRN-centred education and support as new quality measures to improve GRN safety, education and support and that need to be registered in strategic reports and policies.

7.8.1.2 Recommendation 2

That higher education nursing programs and health organisations employing GRNs include the student/GRN-centred (personhood) education and support as a quality element in strategic education and support approaches and policies.

7.8.1.3 Recommendation 3

That GRN personhood, self-care, life role salience and life balance 'concern and care' comprise a core component embedded throughout the undergraduate and health organisations education programs, practices and evaluated for its effectiveness.

7.8.1.4 Recommendation 4

That undergraduate education and health organisations, including those that offer formal transition programs to engage GRNs as partners and to collaborate with them, actively respond to the changing education and support needs and expectations of GRNs entering the work force in the 21st century.

7.8.1.5 Recommendation 5

That student nurse and GRN centred concern and care be incorporated in undergraduate and health organisations' education and support programs.

7.8.2 A move to monitor and measure nurse preparation level and close the loop

A move to monitor and measure nurse preparation expectations and performance based on student nurses, GRNs and employer feedback will act to close the loop on the adequate preparation levels required to effectively and safely enter the work setting and life as RNs. This would include monitoring and measuring student nurse preparation expectations and performance and needs to begin at the undergraduate level. The first transition stage of the two-stage nursing transition theory 'becoming a nurse', (as an outcome of this study and outlined in Section 6.5) needs to be implemented at the end of each year of the undergraduate degree (at a minimum). Secondly, the monitoring and measuring of GRN preparedness expectations and performance need to also occur at the second stage of this transition theory, 'being a nurse', so that GRNs are progressing in their work and life roles an RNs at the completion of their first year. This monitoring and measuring of the nurse education and support would improve and maintain the quality of nursing education and support in Australia. It is also critical that this information is communicated and accessible for the public and used to inform nursing education and support reform.

QILT data is already publicly available that outlines measures of student and graduate satisfaction about their preparation, the quality of teaching and employability knowledge and skills exists. However, QILT (2018b, 2018d, 2018e) data contains several limitations. Firstly, QILT uses a single method, surveys. Secondly, it does not consider that participants may vary in their understandings of interpreting the questions. Thirdly, the QILT survey does not measure student values, including historical epistemologies at play, broader life role salience, life balance and

personal wellbeing or considers the contextual or and or geographical challenges and nuances. For example, it is recognised, especially in the discipline of nursing, that student nurses do not value theory as much as the practical skills and may also not value new pedagogical approaches (Greenwood, 2000). They may also lack the knowledge to adequately judge teaching quality. Thus, students' views may rate nursing quality of teaching negatively. There is always the aspect that a person does not know what they don't know, and this is not factored into QILT survey questions and as such are not reported. This is a significant QILT limitation. Addressing these limitations needs to be considered to improve the validity and reliability of the data and any conclusions and accountabilities derived from their reports.

It is primarily the individual higher education institution's responsibility to respond to QILT data, however nursing governance bodies and organisations employing graduates also have responsibilities to respond to the data. Currently, higher education institutions actively investigate QILT (2018b, 2018c, 2018d, 2018e) claims utilising their own student experience surveys, focus groups and one on one interviews to improve their understanding of the contextual issues, challenges and historical epistemologies at play. However, nursing governance bodies and health organisations employing GRNs largely do not actively respond to QILT data to implement processes of their own, such as GRN feedback through surveys, focus groups and GRN retention data that would equally monitor and measure the effectiveness of the graduates' readiness and organisational programs and workplace supports. There are moves by the Department of Education and Health and national nursing governance bodies to fund a national survey in combination with GRN focus groups across all geographical areas and clinical settings. Such a survey, focussing on GRNs' preparedness education and support outcomes for work and life, is needed. This approach is one initiative at the governance level that places student nurses and GRNs at the centre of the nursing education and support system and thus leads to further recommendations offered by this study.

7.8.2.1 Recommendation 6

Development of a national quality body to assess the adequacy of student nurses' and GRNs' preparedness for work and life as an RN via qualitative and quantitative methods. The assessment would then feed into institutional accreditation.

7.8.2.2 Recommendation 7

Development of nationally endorsed survey questions and focus groups across Australian states and in particular geographical locations, metropolitan, regional, rural and remote, and in a range of clinical settings to provide insights into the current issues impacting on GRNs' life roles.

7.8.2.3 Recommendation 8

Nationally endorsed survey questions and focus groups to assess student nurses' and GRNs' preparedness experiences to include questions specifically addressing personhood including life role salience, life balance, sense of health and wellbeing. In addition, questions need to be including ascertaining how well their expectations are being met in their work, life, including life career preparedness and satisfaction.

7.8.3 Revisiting competency and level that assures readiness for the workplace

The traditional approaches by higher education nursing programs and organisations employing GRNs, predominantly focus on preparing and supporting nurses in work psychomotor knowledge and skills development and assessing these through 'competency' measures. However, the competency measures in the higher education setting are not the same measures previously implemented in the hospital nursing education setting.

In the hospital education and training setting, as I can personally account for as a hospital trained nurse, competency was assessed and measured in actual clinical practice. To be competent the hospital-trained student nurse had to achieve 100% in each of the clinical psychomotor knowledge and skill assessment indicators. Additionally, they also had to achieve 65% to pass written theory assessments. Whereas in the higher education setting, 'competency' in clinical practice and theory is now measured against a criterion referenced rubric and a clinical assessment tool, both of which can vary from institution to institution. The passing grade for clinical assessment using a criterion reference is 50% and is the agreed 'capable' level. This is a shift from competency to capability and represents a dilution in the transformation of knowledge and skills into authentic practice. This passing grade level of achievement is determined by the higher education setting as adequate in preparing of

student nurses' psychomotor knowledge and skills that will enable them to transition smoothly into their work places and work roles as RNs. Likewise, theory to inform practice is delivered in a manner that is heavily teacher-directed and is again assessed through either discerning criterion and or an exam consisting of predominantly multiple-choice questions and a smaller component of short answers, with 50% being determined as being adequate in preparatory theory knowledge appropriate for the world of work. This represents a marked dilution of competency and preparation capability and what it means for safe, effective, work-ready practice. The GRNs world of work and the public may regard such measures as incomplete and inadequate at best or dangerous at worst.

7.8.3.1 Recommendation 9

Effective, close working partnerships need to be established and maintained and or strengthened between universities, industry, student nurses and GRNs in joint initiatives. The joint initiatives need to work towards achieving quality education, quality clinical practice, authentic assessment and effective support for student nurses. Such partnerships would help to ensure a responsiveness to the needs and expectations of all stakeholders in fully preparing student nurses for the world and life as an RN.

7.8.3.2 Recommendation 10

Nationally endorsed, evidenced based clinical assessment tools need to be developed and implemented to accurately measure levels of competence and capability and students' capacities to link theory to authentic practice. In addition, it would be critical to also ensure the validity, reliability and transparency of assessment tools and assessment practice. Nationally endorsed pedagogical approaches and assessment need to be developed and implemented to accurately and effectively assess students' progression from theory to authentic practice as well as their levels of preparedness for clinical settings. A key recommendation would be to move away from exams to the authentic clinical environment.

7.8.3.3 Recommendation 11

Student nurses' clinical experiences in their degree and GRN first year experience need to be included as indicators of quality in GRN education preparedness

for work, study and personal life and need to be reflected in education and nursing governance standards and reporting.

7.8.4 A move to develop whole health system wellbeing standards to assure whole health system solutions.

Currently, any problems within the education and health system are managed in isolation and or compartmentalised without due consideration about how individual problems within the system impact other compartments within the system and vice versa. These individual problems decrease the strength of the system as a whole. Within the epistemology of nursing, for health and wellbeing to be achieved, the whole person, in all their many and various dimensions, need to be supported and attended to respectfully and in shared partnership consensual approaches. Yet this same approach is not evident in how problems are managed within the health system. For an effective, sustainable solution, a whole system approach is needed to ensure the whole system is functioning well. All sections of the system need to be measured and monitored to determine if they are 'functioning well' and or exhibit the wellbeing status to effectively support the wellbeing status of the system as a whole. For this to occur effectively, each section needs to interrelate with the others. The most effective way to achieve this integration is for all components to form reciprocal relationships with one another. Such relationships would promote a systems approach to sharing their monitoring and measurement outcomes together with their strategies with one another to ensure a whole approach to wellbeing standards are adopted. To address GRN attrition sustainably, it is not adequate to solely focus on GRNs but to also focus on promoting the wellbeing status for all members and components within the system. To do this adequately, a top down, bottom up approach is offered, operationalised through recommendations to facilitate measures at top down, organisational, departmental and individual levels and then bottom up, from individual outcomes measured against wellbeing standards.

Thus, the rationale for wellbeing standards as a research outcome is the protection of the whole societal system and the components (stakeholders) in this system to ensure components are all working in harmony and not in isolation. Thus, the standards serve to protect and nurture the health system as a whole and the members within it. While these standards were developed initially to improve the

safety and quality of care of GRNs, the standards are broad and applicable to all members and all organisations and to their associated broader systems.

The study acknowledges that the preliminary national wellbeing standards presented here are based on a similar design format – the National Safety and Quality Service Standards (ACSQHC, 2012) as the benchmark in a linear, top down communication model. It is recognised that these preliminary national wellbeing standards require further research to comprehensively identify the quality indicators in each wellbeing standard as well as the description, strategies and systems that will further facilitate what needs to be measured and monitored in the education and health systems. This encompasses patients, nurses and all members of the systems, nursing bodies like AHPRA/NMBA & HWA, health organisations employing nurses and higher education systems to ensure that the system is functioning well and safely. Preliminary standards comprise the beginnings of a quality improvement process to ensure that wellbeing standards are met and evolve to reflect new evidence-based knowledge as it emerges. These standards, once fully developed, can also be used in accreditation processes to demonstrate inter-professional stakeholder collaboration. The wellbeing standards are designed to complement existing Australian national nursing codes of practice standards and Commonwealth legislative laws.

7.8.4.1 Recommendation 12

Three National Wellbeing Standards describe the system and strategies, including partnering, to promote holistic wellbeing of the components within the system and the system as a whole, including being responsive to meeting stakeholders' needs and expectations.

As an outcome from this study:

1. Individual Wellbeing – describes the system and strategies to promote effective holistic individual functioning and needs:
    i. Individual Work Wellbeing – describing the system and strategies to promote effective work role functioning.

Indicators

Positive affective measures:

- Individual self-reports of feeling happy and feeling well, physically and psychologically
- Individual observations and self-reports of positive professional functioning, demonstrated by an alignment of thought, behaviour and actions with discipline professional standards

- Individual self-reports of positive functioning personally, with the individual effectively meeting their personal roles and responsibilities (Meyer & Maltin, 2010; Warr, 2007).

As an outcome of this study

Individual positive functioning needs to also include:

Indicators

- Individual self-reports and observation of positive self-care functioning encompassing a healthy BMI, being clean and well groomed, eating a nutritious well-balanced diet, drinking adequate water, achieving adequate hours of sleep, making time for self-interests and social/friendship and family connections and presence of a 'support bubble'.
- Individual's self-reports and observation of feeling a sense of belonging at work and not being judged but, alternatively, feeling supported
- Individual self-reports of feeling happy and feeling well emotionally, mentally, intellectually (study and life career role), socially and environmentally.

ii. Individual Study Wellbeing (including responsiveness to meeting immediate, short, medium and long-term learning needs, including work, study and personal life role development. This includes life career development roles and describing the system and strategies to promote effective study role functioning.

As an outcome of this study

Indicators

- Individual self-reports and observation of positive professional and personal functioning, with the individual effectively meeting all their life roles and responsibilities, including being enabled to direct and control own learning directions and life career roles aspirations.
- Responsive pedagogical approach – self-reports and observation by individuals (for example GRNs and educators) of expectations being met and with satisfaction.

iii. Individual Personal Wellbeing describes the system and strategies to promote effective personal role functioning.

As an outcome of this study

Indicators

- Individual's self-reports in effectively managing multiple life role saliences.
- Individual's self-reports on quality of life satisfaction.
- Individual's self-reports of happiness associated with their quality of life and life role satisfaction. (For example, time for self, such as time to pursue interests and personal goals, time to relax, time for family, sports and exercise, friendships, etc).
- Individual's self-reports about having an honest, social-emotional connection with someone who listens and truly understands (for example, in this study's context a fellow GRN and or close family member).
- Individual's self-reports of shared power and decision making and sense of feeling in control.

iv. Individual Life Role Salience Wellbeing - describes the system and strategies to promote effective life role salience functioning.

As an outcome of this study

Indicators

- Individual Work Wellbeing indicator number i is met.
- Individual Study Wellbeing indicator number ii is met.
- Individual Personal Wellbeing indicator number iii is met.
- Individual's self-reports of life role salience expectations met.
- Individual's self-reports of life role salience satisfaction.

v. Individual Life balance ascent (assent) describing the system and strategies to promote effective life balance functioning.

As an outcome of this study

Indicators

- Individual Work Wellbeing indicator number i is met.
- Individual Study Wellbeing indicator number ii is met.
- Individual Personal Wellbeing indicator number iii is met.
- Individual's Life Role Salience Wellbeing indicator iv is met
- Individual's self-reports of life balance ascent (assent) satisfaction.

vi. Individual Health and wellbeing describing the system and strategies to promote effective health and wellbeing functioning.

Indicators

- Individual's positive affect - a feeling of happiness (Hosie & Sevastos, 2010; Warr, 2007).

- Individual's self-reports and reports from the family perspective that their quality of life improves (Magee, Stefanic, Caputi, & Iverson, 2012; Meyer & Maltin, 2010; Siu et al; 2010; van Steenbergen et al., 2007; Wayne et al., 2006).

As an outcome of this study

Indicators

- Individual Work Wellbeing indicator number i is met.
- Individual Study Wellbeing indicator number ii is met.

- Individual Personal Wellbeing indicator number iii is met.
- Individual's Life Role Salience Wellbeing indicator iv is met
- Individual's Life Balance Ascent (Assent) Wellbeing indicator v is met.
- Individual's self-reports of health and wellbeing satisfaction.

vii. Individual Support wellbeing - describes the system and strategies to promote effective support (responding to and meeting expectations) functioning.

Indicators

- Indicator numbers i to vi are met.
- Individual self-reports that they feel supported in all their holistic human dimensions and associated enablement to reach their full potential in all their life roles and feel happy and satisfied.

2. Organisational Wellbeing – describes the system and strategies to promote effective organisational functioning and needs to include firstly as an outcome from this study:

Indicators

viii. Standards 1 to 2 - includes the outcome measurements of the system and strategies in place to promote individual wellbeing.

ix. Employee self-reports of happiness, improved morale and life satisfaction levels (Goetzel & Ozminkowski, 2008),

x. Employee attrition and turnover is reduced (Beauregard & Henry, 2009; Frone, 2003; Greenhaus & Powell, 2006; Haar & Bardoel, 2008).

xi. Outcomes of services delivered - describes the system and strategies to respond to and meet consumers expectations

xii. Consumers' satisfaction levels - describes the system and strategies to respond to and meet consumers expectations (ACSQHC, 2017, pp. 14-19).

xiii. Organisational productivity - describes the system and strategies to meet organisational goals of improved productivity, efficiency and growth (Goetzel & Ozminkowski, 2008).

3. System wellbeing – describes the system and strategies to promote effective organisational functioning and needs.

As an outcome from this study:

Indicators

Indicators

xiv. Standards 1 to 9

xv. Partnering with stakeholders - describes the system and strategies to promote effective inter-system functioning.

Indicators

- Flexible and adaptive to the changing nature of the world and world of work and life to remain relevant and responsive (Amundson, 2005; McMahon & Patton 1995, 1999, 2006; Watson & Stead, 2006). For example:
- Implementation of research,
- Implementation of evidence-based practice,
- Evidence of constructivism and social constructionism, to guide behaviour, thinking and action; praxis; valuing the 'other' as an instrument of thought (Olanike, 2010; Rayner, 2004) - use of critical pedagogy (Freire, 1970, 2005).

- Evidence of shared goals between the organisation, the individual employee and higher education about career development that are responsive and reflective of the needs of individuals and counsellors.

7.8.4.2 Recommendation 13

All health organisations employing GRNs collect broader wellbeing standards data to report to education and nursing governance bodies, organisation managers and educators and to be made publicly available on education and nursing governance body's websites. Additionally, these health organisations should also provide a report that includes an analysis of their data, with a corresponding quality improvement action plan and associated action timelines.

7.8.5 Life career preparedness: A moving guiding philosophical lens

Life career preparedness developed during GRNs' undergraduate nursing program, their transition year and beyond are key strategies to improve students' employability, life role salience satisfaction, health and wellbeing and retention within the nursing profession.

As an outcome of this study:

Implement the responsive and sustainable new Life Career Preparedness Theory (21stCLCPT) (see list of terms and definitions and Section 6.7).

7.8.5.1 Recommendation 14

All higher education and health organisations employing GRNs implement the new 21st century life career preparedness theory (21st CLCPT) to underpin their undergraduate and post graduate programs, including transition programs. This would ensure students and professionals are supported and enabled in successfully '*becoming and being*' the professional they set out to achieve, as well as ensure their future life career development goals.

7.9 FURTHER RESEARCH

To improve the responsiveness to meeting GRNs needs and expectations to be work and life ready as RNs, future research on how education and support programs effectively prepare and support GRNs is needed. Further research is also needed to measure and monitor GRNs' 'concern and care' ensure the education and support strategies are being adequately responsive in meeting the expectations and needs of GRNs and industries employing GRNs. This study recommends that a key focus be directed towards data collection methods that include a combination of both GRNs' self-reports of their broader work, study, personal, including life role salience, wellbeing and life balance experience, as well as objective data evaluating the effectiveness of education and support programs.

Future research is needed to evaluate how education and support programs are measuring and monitoring the effectiveness of implementing a risk management approach. The approach would be based on the study's two stage transition theory 'Becoming and Being a Nurse', its nurse preparedness theory (NPT) and the 21st century life career preparedness theory (21st CLCPT). These theories combine to

present methods to overcome GRNs' lack of broader work, study and life preparedness and their associated impacts of stress, burnout and attrition.

Additional research is needed to underpin the development of the preliminary Load Triad Assessment tool to identify the indicators representing GRN preparedness, resilience and their relationship to retention and or their under-preparedness, low resilience coupled with vulnerability and attrition.

These targeted areas of research provide opportunities to improve the responsiveness of higher education institutions and industry employing GRNs to meet GRNs' needs and expectations to be work and life ready as RNs.

7.9.1 Research opportunity to extend this study

The further research opportunity would build on this study's findings to construct the *Load Triad* Assessment tool by implementing a third oscillation to this study's methodology, such has critical interpretative. Critical interpretivism is appropriate to providing rich, thick data needed to achieve quality research outcomes. It is suggested that this extension use a qualitative method, one on one, semi structured interviews. It is expected the data from these interviews will provide insight on the preparedness indicators forming the basis of the *Load Triad* Assessment tool. This future research opportunity is a recommendation from this research study.

Figure 7.2. Oscillating trilogy of ontologies as a post-positivist researcher.

7.10 CHAPTER SUMMARY

This chapter documented the key findings and insights garnered from the analysis and findings, applying them to enhance GRNs' transition to healthcare contexts. The chapter also explained how the study addressed the research question by supplementing the research exploring GRN attrition. The chapter also advanced the implications of failing to address the gaps identified in the literature review. Recommendations were presented on specific courses of action that, if adopted, could address GRNs' attrition as well as presenting opportunities for future research.

Finally, the chapter introduced new and expanded ways of thinking about GRN attrition, offering new insights and creative approaches for framing, contextualising and resolving the research problem. It presented three inter-related theories to promote a broader GRN preparedness to sustainably address GRN attrition. These three theories represent an original and important contribution to knowledge made by this study. In doing so, the chapter reiterated the strengths of the study, positioning the research within the larger contexts of risk management and associated assessment and identifying the need for independent auditing bodies to address short comings in GRN preparation. As such, this chapter is not simply a repetition of the findings, rather it offers the researcher's reflections on the evidence presented and the study's central research problem – GRN attrition. The chapter highlighted the importance and value of this study through its original contributions to scholarship and meanings derived about GRN education and their lived experiences in '*becoming and being a nurse*'.

Chapter 8: Reflections and Final Thoughts

8.1 WHY THIS RESEARCH WAS IMPORTANT TO ME

This research inquiry emerged from my professional practice as a GRN, RN, District Nurse Educator and as an academic. A further impetus were the escalating concerns raised by Australian nursing governance bodies and researchers. These concerns included a global nursing shortage and high global GRN attrition rates, an imminent nursing shortage predicted for Australia within the decade, and concerns that Australian GRN attrition rates were remaining largely unexplored. In addition, were ongoing industry's concerns about the under preparedness of GRNs to confidently and competently enact their RN roles. These concerns had particular personal relevance because I was a practicing academic (nursing lecturer) in a university when I began this project. In undertaking this exploration of the GRN first year Load Triad experience and transition support, several findings presented themselves to persuade me to implement reform in the education and transition support 'nurseries', as well as to the education and health system as a whole to close the loop on GRN under preparedness and attrition intentions. These reforms target all levels of the health system including individual, organisational and governance levels. The research has shed light on a whole of education and health system approach to improve GRNs' development of '*becoming and being*' a nurse to improve GRNs' first year experiences, preparedness and their retention within the profession.

My intention was to explore the factors impacting the GRN's Load Triad experience, the relationships between these and the impact these had on their overall life balance. The purpose of this exploration was to identify strengths and weakness, but particularly, to illuminate areas of weakness to align targeted interventional strategies to assist GRNs to improve the first year Load Triad experiences and life balance and thus contribute to GRNs' personal sense of life role satisfaction to aid their retention and contribute to closing the loop on the nursing shortage.

The existing literature was heavily focussed on the GRN experience in relation to their under preparedness to enact their RN role. However, there was a lack

of literature on GRNs' broader life role preparedness, including life career preparedness. However, I did not know at the beginning of this study whether there were relationships between GRNs' Load Triad experience, their personal sense of preparedness for their RN roles and their broader life roles, including their life career preparedness and how GRNs' manage challenges and adversity, as well as their intentions to remain in the profession. This meaning-building has signified that the preparedness-practice nexus is much more complex than suggested in the literature, setting a foundation for further research. This nexus is also closely linked to how educators respond to the changing needs and expectations of nursing students and GRNs in challenging 21st century education and health care contexts. However, the education and health institutions while enduring, do so with values either deeply embedded in evidence-based practice or are at risk of being anchored by historic epistemologies and workplace cultures that do not always mirror overarching governance standards, thus preventing these institutions' ability to be responsive and evolve. Hence, just like any institution, higher education organisations may also require assistance to evolve and respond to changing contexts by adopting reflective practice as a way of working. Adopting reflective practice can contribute to a meaningful deconstruction of current ways of operating, if grounded in evidence-based practice and or beliefs. With this raised awareness, organisations can pursue practice reforms that are evidence-based and outcomes-based, rather than based on personal beliefs or folk pedagogy. Marginson (2010) was insightful about institutions:

> Is there any other institution (except possibly government) that combines so many different social functions? Is so clear about its primary values, so diffuse and unreadable in its core objectives? So self-serving and other-serving at the same time? So easily annexed to a range of contrary agendas: conservative and radical, capitalist and socialist, elite and democratic, technocratic and organic? The university is like the 'public good', in that it becomes what we want it to be. But the university rarely holds to a single course. It continually disappoints. It always falls short of potential. But we defend it. We sense that if it were lost then something quite fundamental, and probably essential, would be lost. (p. 14)

Higher education and health institutions are solid foundations guiding and caring for members of society. These institutions have a serious responsibility to be

credible and reliable and to direct societal change informed by evidence. My realisation of the role I play in contributing to these institutions' credibility and the broader' concern and care' of educating nurses in providing safe, quality care to patients has been deepened as result of my doctoral journey. Just how deeply affected I became as my doctoral journey progressed is only discernible now, at its completion. Especially relevant here is "How do I want to define myself at the end of my doctoral journey?"

8.2 HOW THE PROCESS CHANGED ME OR HOW I WANT TO DEFINE MYSELF WHEN I COMPLETE

I have now become essence of the word, an academic or even a scholar (Rice, 1990). I have always been interested in the difference between being a nurse (of 23 years 'floor' experience) and being accepted as an academic. Now, to me the distinction seems less blurred. The practice of nursing research has always intrigued me and now through the process of developing new knowledge – developing understandings about a phenomenon previously unexplored, I see the academic nursing community with more clarity.

8.3 PERSONAL DEVELOPMENT AND CAREER GOALS

I consider a doctorate not simply as a capstone to my career as a student but importantly as an entry point to a new career where I can succeed through passion, a desire and a determination to learn more and advance my field and to advance professionally in my field (the concern and care *Dasein* of my field of interest). I want to belong to and to be seen to belong to a vigorous nursing community of sceptical scholars engaged in work that makes real differences to GRNs' lives across all their roles, their communities and the broader world.

8.4 PERSONAL CHALLENGES

I am much more focussed, efficient, resilient and motivated – I found these qualities essential to successfully working through the doctoral program. The challenges I faced at the commencement of the program concerned dividing my time successfully between work, study and family – getting the mix right so each of these key areas of my life were in balance. I soon realised that balance was not possible all the time. I had to choose one domain over another as priorities shifted, but importantly,

I needed support of others to keep my other domains ‘upright’. In particular, my personal life domain – family – required intensive support in my final year to keep ‘upright’. I also realised this was appropriate for short periods of time and to not feel guilty for not balancing all my domains perfectly.

I was also constantly challenged and stressed academically in my doctoral writing to produce work that could meet my supervisors’ expectations, my peers’ expectations, and of course, my own expectations. However, I soon realised the mix between challenge and stress is important. Stress motivates me, while the academic challenges assist me to produce work that is robust and tightly focussed.

8.5 HOW UNDERTAKING THIS RESEARCH HAS ENRICHED ME

Producing quality publishable work through original writing that contributes to knowledge about academic teaching and learning practice was rewarding. GRN preparedness as a form of learning, informed by scholarly inquiry into how GRNs make meaning, was also a personally enriching and fulfilling journey.

8.6 FINAL THOUGHTS

GRNs are complex, intelligent and varied about how they approach life and its problems. They have families and friends and interests away from their work yet are always ‘*being*’ a nurse. They confront the large and small triumphs and tragedies most of us face. However, they are still human and their humanity shines brightly, especially in their ‘*becoming and being*’ a nurse. I am very proud of them all.

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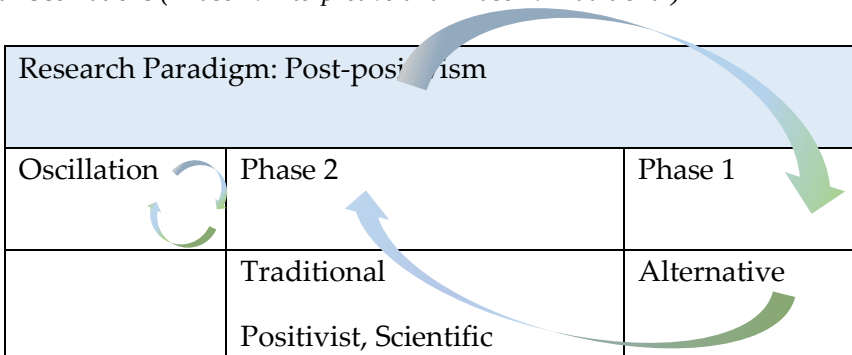
Appendices

Appendix A: Research paradigm

Table A.1

Research Paradigm: Post-positivism - Demonstration of Mixed Methods Exploratory Design

Ontological Oscillations (Phase 1: Interpretive and Phase 2: Traditional)



Research Paradigm: Post-positivism		
Oscillation	Phase 2	Phase 1
	Traditional Positivist, Scientific Rationale, Hypothetic deductive	Alternative (Naturalistic, Constructionalist Interpretative
Data Type	Survey	Focus Group
Quantitative		
Qualitative		

	Traditional	**Constructionalist Interpretive**
Ontology (Nature of reality)	Reality is singular and independent of observer. It is controlled by fixed rational laws based on cause and effect.	There are multiple realities that are individually and socially constructed. We can only talk about our construction of reality than reality as an independent entity.

Epistemology (Theory of knowledge and truth)	Truth is a set of statements that reflect reality. The knower and the known are independent. Truth is objective and value free.	Truth is a sophisticated construction on which there is local consensus. Truth is a function of finding out. Truth subjective and value laden.
Methodology (How do we find out?)	Strip the phenomenon under study from its context. Inquiry always converges on truth. Observer does not change the phenomenon studied.	Phenomenon can only be studied in context. Researcher tries to see reality from the insider point of view. Observations may change the phenomenon studied.
Value of Research (How do we evaluate the research?)	Concern about validity and reliability of measures and of designs. Aims to generate correct measures and statements about reality.	Concern about if the story generated is reasonable and credible. Concerned about multiplicity of data sources to obtain a more complete picture.
Aims of research	Research aims to generate knowledge that is generalizable to other situations. Knowledge helps us to control and predict.	Research aims to generate knowledge of the particular cases. Sometimes the particular helps in understanding the general. Research assists in developing understanding situations.
	Phase 2	Phase 1
Methods	Quantitative: **Survey**	Qualitative: **Focused Group**

Research question	**What are the factors impacting the Graduate Registered Nurses first year experience as they make decisions about work, study (continuing professional development) and personal life and to what degree do these factors and the possible relationships between them, impact on their overall life balance?** (Atweh, 2009; Creswell, 2011, Crotty, 1998)

Appendix B: Ethics approval letter

OFFICE OF RESEARCH
Human Research Ethics Committee
PHONE +61 7 4631 2690| FAX +61 7 4631 5555
EMAIL ethics@usq.edu.au

UNIVERSITY OF SOUTHERN QUEENSLAND AUSTRALIA

18 October 2013

Ms Natasha Reedy
C/- School of Health, Nursing & Midwifery
Faculty of Health, Engineering & Sciences
University of Southern Queensland
TOOWOOMBA QLD 4350

Dear Natasha

The USQ Human Research Ethics Committee has recently reviewed your responses to the conditions placed upon the ethical approval for the project outlined below. Your proposal is now deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and full ethical approval has been granted.

Approval No.	**H13REA200**
Project Title	Keeping the balls in the air: How graduate nurses manage study, work and personal life
Approval date	18 October 2013
Expiry date	18 October 2016
HREC Decision	**Approved**

The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC
(b) advise (email: ethics@usq.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project
(c) make submission for approval of amendments to the approved project before implementing such changes
(d) provide a 'progress report' for every year of approval
(e) provide a 'final report' when the project is complete
(f) advise in writing if the project has been discontinued.

For (c) to (e) forms are available on the USQ ethics website:
http://www.usq.edu.au/research/ethicsbio/human

Please note that failure to comply with the conditions of approval and the *National Statement (2007)* may result in withdrawal of approval for the project.

You may now commence your project. I wish you all the best for the conduct of the project.

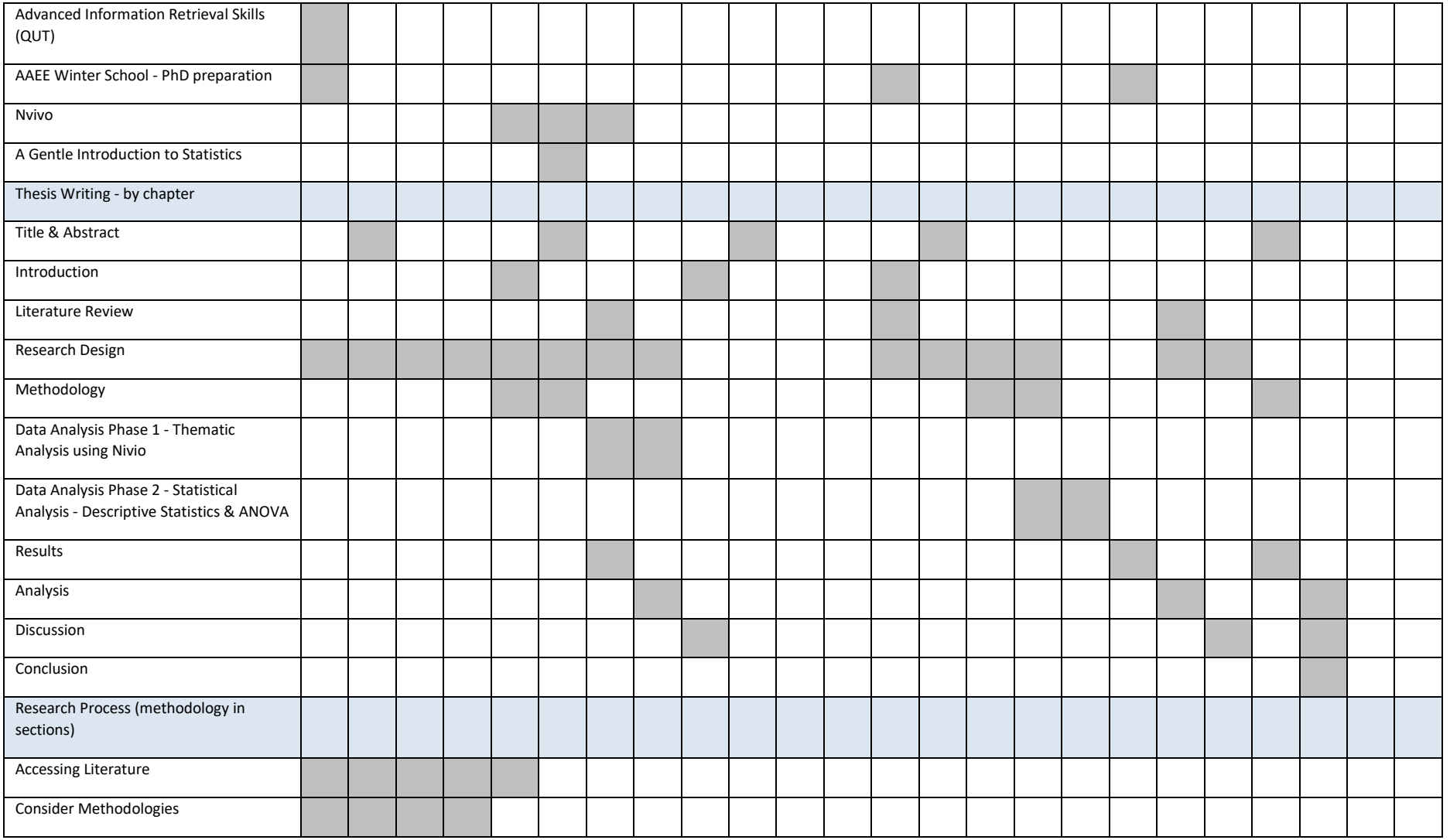
Annmaree Jackson
Ethics Committee Support Officer

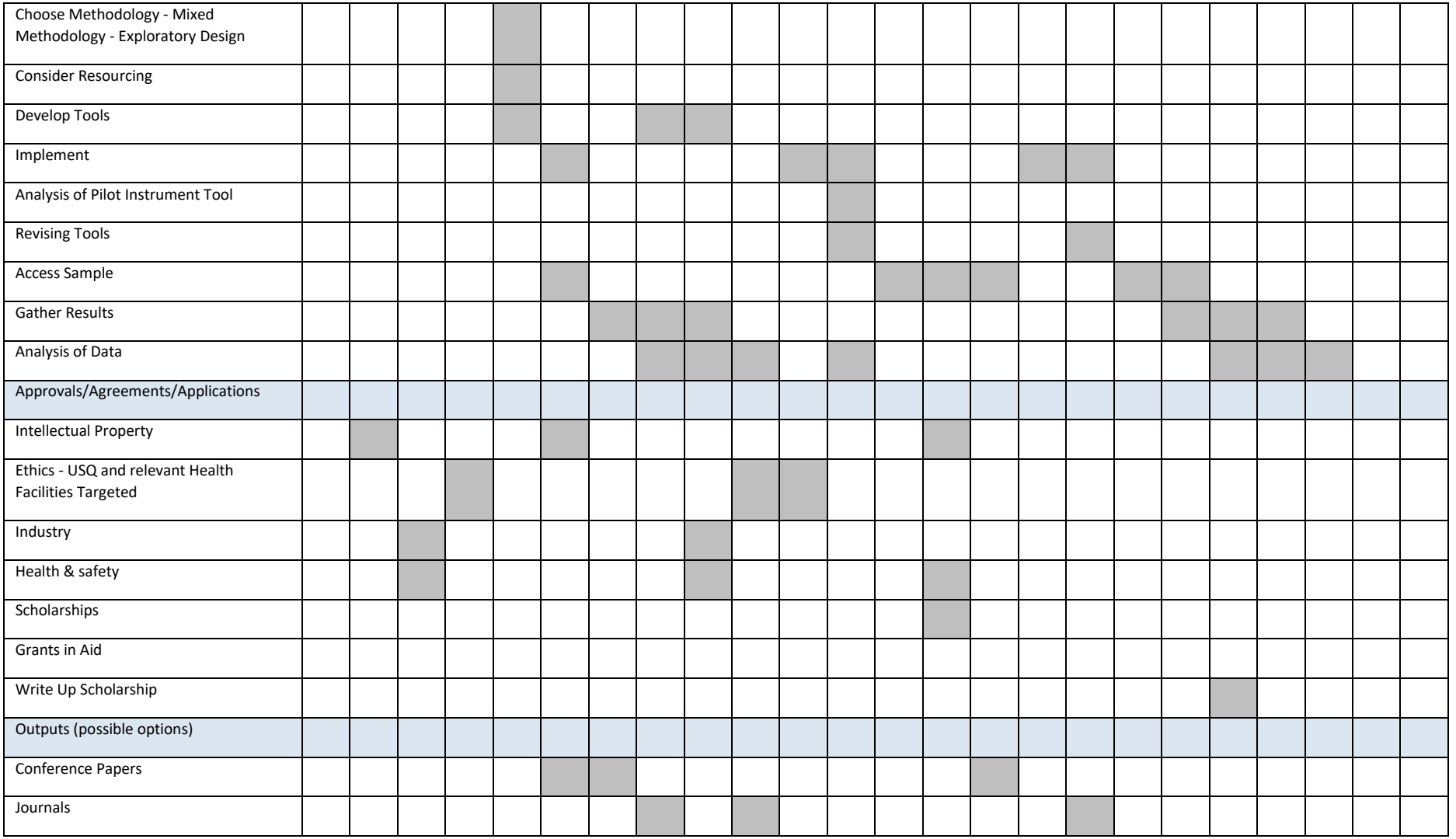
Copies to: natasha.reedy@usq.edu.au

Appendix C: Research timeline

Proposed timeline for research: Investigating the GRN experience to manage work, study and personal life.

by Natasha Reedy	July 2012 - June 2013				July 2013 - June 2014				July 2014 - June 2015				July - 2015 - June 2016				July 2016 - June 2017				July - 2017 - June 2018			
Time Elapsed (in months for 3 yr study)	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	53	56	59	62	65	67	70
Phase 1 - Qualitative (Focus Group) - 4 Graduate Registered Nurses																								
Phase 2 - Quantitative (Survey - Pilot) - (Aim to test with the 4 GRNs from Focus Group)																								
Phase 2 - Pilot (200 Graduate Registered Nurses)																								
Phase 3 - One on One Interviews (6 Graduate Registered Nurses - sample from Survey Participants)																								
Confirmation																								
Annual Progress																								
Final Seminar																								
Draft Lodgement to supervisors																								
Lodgement																								
Coursework																								


Advanced Information Retrieval Skills (QUT)
AAEE Winter School - PhD preparation
Nvivo
A Gentle Introduction to Statistics
Thesis Writing - by chapter
Title & Abstract
Introduction
Literature Review
Research Design
Methodology
Data Analysis Phase 1 - Thematic Analysis using Nivio
Data Analysis Phase 2 - Statistical Analysis - Descriptive Statistics & ANOVA
Results
Analysis
Discussion
Conclusion
Research Process (methodology in sections)
Accessing Literature
Consider Methodologies


Choose Methodology - Mixed Methodology - Exploratory Design
Consider Resourcing
Develop Tools
Implement
Analysis of Pilot Instrument Tool
Revising Tools
Access Sample
Gather Results
Analysis of Data
Approvals/Agreements/Applications
Intellectual Property
Ethics - USQ and relevant Health Facilities Targeted
Industry
Health & safety
Scholarships
Grants in Aid
Write Up Scholarship
Outputs (possible options)
Conference Papers
Journals

Product Development																							
Notes:																							
Mixed Methodology - Exploratory Design																							
Phase 1 - Qualitative - Focus Group - 4 Graduate RN's: Create 4 - 5 Semi Structured Interview Questions. + Ask about - "Is there a burning topic you would like to add to this Focus Group discussion?"																							
Phase 2 - Quantitative (Survey - Pilot) - (Aim to test with the 4 GRNs from Focus Group)																							
Phase 2 - Pilot (200 Graduate Registered Nurses)																							

Date: 28th November 2013

Appendix D: Phase 1 focus group data collection interview/resource management plan

Title of project: Keeping the balls in the air: How graduate nurses manage work, study and personal life

Ethics Project ID: H13REA200

Plan	Time	Information/ Resources
INTRODUCTION Part one Principal researcher will attend: Welcome Icebreaker Housekeeping Research Title	1600	Focused Group Interview Guide – 2 hours Personal Introductions (researchers and participants) Seating/ Speak about the weather; traffic; parking;

Overview of research topic Parking Lot Explanation of the purpose of the focus group Clarification of terms Study Work Personal Life	1605	Toilets; fire exits; water & nibbles availability. Duration of Focussed Group Session (2hrs) 'Keeping the balls in the air: how graduate nurses manage study, work and personal life'. To explore what the graduate nurse's first year experience is like. To explore any burning thoughts on the Graduates mind that they would like to speak about and discuss with the other Graduates. **Plain language statement** will be handed out to interested graduates who have presented to participate in the research focused group discussion. All participants will be asked to read this. Full explanation will be provided by the principal researcher.

Focused Group Procedures Explained Audio Recording De-identification process		**Study** (continuous professional development; ***formal study*** – Post Graduate Certificate, Post Graduate Diploma, Masters*;* ***informal study*** – In-services, reading journals, attending conferences and work-shops related to professional nursing development); **Work** (working in the position as a registered nurse in a nursing role in a health facility); **Personal Life** (life outside of nursing work and nursing study, that is - does not include work as a graduate nurse or study involving professional nursing development). Details about the focussed group being **audio recorded** by using an iPhone will be explained. Further explanation will be given about how the audio recording will downloaded and saved onto a hard drive and be kept for five years as per USQ's ethics requirements. The audio file will be secured electronically by a username and password only known to the principal researcher. De-identification process will be explained (to protect the respondents anonymity) and consent for this obtained initially verbally and formalised by the consent form.

Note Taking Session summary Accuracy checks of notes by participants	1610	De-identification process will be attended by giving each participant a choice of a pseudonym for the focus group, however in any publications, pseudonyms will be replaced by: for example: Participant One, Participant Two, etc. For the focus group, each participant will be referred to as their pseudonym of choice. For example: Jane, John. Pseudonyms will be placed on each participant's chair by a paper label and by a sticker on their shirt. Pseudonyms from data collection will further be transformed when undergoing data analysis to be known as Participant One, Participant Two, etc. Principal researcher may write notes regarding the topic area under discussion and note the time on the audio recorder that may assist the researcher when manually transcripting the audio data later. Additional research assistant will act as an additional note taker. The research assistant will note which participant is speaking by their pseudonym, regarding their topic and their observed feelings at the time of speaking. This process is to ensure the audio recording transcription of data is accurate.

Revisiting Original Purpose		This summary will occur in the last 20 minutes of the session and will include: a recall/recount of what was discussed & shared, by both the principal researcher and assistant researcher. Researcher will provide opportunity for participants to check notes taken by researchers for accuracy of the notes and to correct misinformation.
Invitation & or Farewell		Lastly, the researcher will revisit the focus groups original purpose to ask the participants if they would like to add further information to the discussion to ensure the purpose goal has been achieved: Research title: 'Keeping the balls in the air: How graduate nurses manage study, work and personal life'. Opening statement: "What has your first year working as a Registered Nurse been like?" Opportunity for questions will be provided. Invitation to stay and participate in the research: will be announced and to inform people who have decided not to participate… a formal thank you and goodbye.

	1620	

Plan	Time	Information/ Resources
INTRODUCTION Part two Consent forms		

	1621	**<u>Consent forms</u>** will be **handed out** to interested graduates who have stayed on and would like to stay and participate in the research focused group discussion. Consent forms will be **collected** and placed in a sealed envelope.
Pseudonym selection by participants.		Pseudonym selection by participants, followed by paper labelling on the table and by a sticker on their shirt. Instructions will be provided to each participant to introduce themselves as their pseudonym of choice the first time they speak. For example: "Jane here…or John here…"
Further explanation will be provided to the group		Further instructions will be provided to participants (both verbal and written (via a white board and written handout) when speaking for the very first time to include in addition to their pseudonym, their age, gender, marital status, dependents, length of time working, full time, part time and or casual, areas they have worked in their first year as a graduate registered nurse, their current area of work, current study and key personal commitments. The researcher will provide a broad opening statement to start the discussion: "Let's talk about your experiences in your first year as a graduate registered nurse".

Group etiquette will be explained: Session Summary Timeframe Opportunity for Questions will be provided.	1630	Additional questions may be posed during the course of the discussion to expand topics or to cover topics not yet mentioned. Each member of the group is to talk freely as in a conversation. Each member is to be aware of sharing the time speaking equally, to ensure the data collected reflects all group members' experiences, rather than one or two dominant speakers. Members of the group who have not spoken during the conversation will be encouraged by the researcher to share their experiences. Explanation regarding session summary will be explained by the researcher. Session summary will be attended 20 minutes before the two hour session finishes. Opportunities for questions given.

Plan	Time	Question/Statement	Notes from Graduate Nurses Focused Group Discussion
BODY Press recording button on researchers iPhones. Focused group discussion will be opened by the following general statement.	1631	Press recording button on researchers iPhones. "Let's talk about your experiences in your first year as a graduate registered nurse".	Press recording button on researchers iPhones.

Questions posed during focused group **if required**:	1700hr	Can you discuss any issues or challenges that you experienced in your first year related to your work or perhaps tell me a story about this? Can you discuss any issues or challenges that you experienced in your first year related to your study or perhaps tell me a story about this? Can you discuss any issues or challenges that you experienced in your first year related to your personal life or perhaps tell me a story about this?	

		What does life balance mean to you? How would you describe the relevance of self-care in your first year working as a Registered Nurse or perhaps tell me a story about self-care practices that have impacted on your first year working as an RN?	
Plan	Time	Question/Statement	Notes from Graduate Nurses Focussed Group Discussion
CONCLUSION Session Summary	1730 1740	Session a summary of what was discussed will be shared by both the principal researcher and assistant researcher.	

Checking Accuracy of Notes Revisiting Original Purpose	1750 1755	An opportunity will be provided for participants to check the accuracy of the notes taken by the researchers and for corrections to be made or for further additions of information. Principal researcher will revisit the focus groups original purpose to ask the participants if they would like to add further information to the discussion to ensure the purpose goal has been achieved:	

		Research title: 'Keeping the balls in the air: How graduate nurses manage study, work and personal life'. Opening Statement: "What has your first year working as a Registered Nurse been like?" Formal Feedback/ Thank you/ Invitation to stay on and socialise while have a light snack/Farewell.	
Notes from Graduate Nurses Focused Group Discussion – Participant 1 – Name:_____			

Researcher _____ Date_____
Notes from Graduate Nurses Focused Group Discussion – Participant 2 – Name:_____
Notes from Graduate Nurses Focused Group Discussion – Participant 3 – Name:_____
Notes from Graduate Nurses Focused Group Discussion – Participant 4 – Name:_____

Appendix E: Phase 1 participants demographic characteristics

Table E.1

Phase 1 Participants Demographic Characteristics

Participant Number	Participant Pseudonym	Age	Gender	Marital Status	Previous Nursing Experience	Work Context	Transition Program	Employment Status/Fortnight	Dependents
1	Diana	21	F	S	Undergraduate	Private Hospital (Rotated through surgical, medical & palliative)	Yes	Part-time 0.8 to 0.9	0
2	Brooke	21	F	S	Undergraduate	(Rotated through orthopaedic, medical & palliative)	Yes	Part-time 0.8 to 1	0
3	Anne	22	F	S	Undergraduate Assistant in Nursing (AIN)	Private Aged Care	No	Part-time 0.9	0

4	Tina	41	F	S	Undergraduate AIN & Endorsed Enrolled Nurses (EEN)	High Care Private Aged Care Hostel	No	Part-time 0.8	2	

Appendix F: Phase 2 critical nursing colleague qualifications and experience

Table F.1

Phase 2 Critical Colleague Characteristics

Critical Colleague Number	Nursing Qualifications
1	General Certificate Nursing RN; Bachelor of Nursing; Grad Certificate Acute Care; Credentialed Psychiatric Nurse
2	Bachelor of Nursing; Masters of Midwifery
3	Bachelor of Nursing; Bachelor of Education; Master of Science

Appendix G: Phase 2 survey instrument

Keeping the balls in the air: How graduate nurses manage study, work and personal life.

Principal Researcher: Natasha Reedy

About this Research: All nurses are invited to participate in this research project that focuses on how Graduate Registered Nurses manage work, study and personal life and to what degree this is affecting Graduate Registered Nurses life balance and wellbeing. Current graduates and recent graduates are encouraged to participate.

Benefits:

1. An increased awareness about you as a Graduate Registered Nurse and how you are managing your work with study and personal life and to what extent this is having an impact on your sense of life balance and well-being.
2. Caring and supporting you, the Graduate Registered Nurse, focuses in on you as a priority; potentially helping you personally and helping to position you better when caring for your clients, improving their overall care experience from you.

Main Outcome:

- The research outcomes will help inform the right type of support for you as a Graduate Registered Nurse in your first year, to improve your overall sense of managing your life balance and wellbeing.

Risks: There are low risks for participants: time imposition.

Method: Anonymous Survey
What would you do?... Typical scenarios

The following survey is broken into two sections.
The first section: (Duration 5 to 8 minutes)
5 brief scenario questions with set responses for you to rate in relation to:

1. Life balance
2. Work
3. Personal
4. Study
5. Support And....
6. Your thoughts on your University Nursing Education & Nursing Graduate Year

There are no right or wrong responses here.

1

A comment box has been included for each section to allow you to elaborate on your choices and will help the researcher to have a deeper understanding of your individual situation.

The second section: (Duration 2 minutes) Questions in relation to your personal work experience, participation in a nursing graduation program or not, general demographics and study.

Section 1: (Duration 5 to 8 mins)

5 brief scenarios: Please respond to each scenario by putting yourself in the picture and then choose the response that best fits your individual response.

1. Life balance

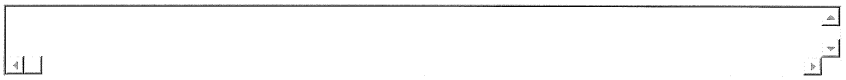
You have been working hard all week and feeling tired at the end of each shift. You know your best friend has a BBQ Birthday lunch on tomorrow and you haven't seen her for the last 2 months or so. You have an early shift tomorrow and an in-service training session has also been scheduled first thing in the morning to fit in with your work time.

From the list below, rate the following statements

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree
1. Work is a priority, so I would go to work as scheduled.	○	○	○	○	○
2. My best friend is important, so I would let her know I will be there.	○	○	○	○	○
3. In-service training is important, so I would go to work so I could attend.	○	○	○	○	○
4. I would feel I could easily reschedule, to fit them all in.	○	○	○	○	○
5. I would feel worried if I had to best manage this situation.	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Life Balance and this scenario.*

2



2. Work

You are working in an area/ward well known to you; however today you have been assigned a patient whose presenting condition is new to you.

From the list below, rate the following statements

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree
1. I can care for this patient quite well based on principles of care.	○	○	○	○	○
2. I'm worried that I might do something wrong to the patient.	○	○	○	○	○
3. I can check and verify with my senior nurse my plan of care and seek further advice as required.	○	○	○	○	○
4. As the situation evolves itself, I would refer to an experienced colleague in my work area and ask them to talk me through the care needed.	○	○	○	○	○
5. If time permits, I would refer to resources in my work to help me care for my patient.	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Work and this scenario.*

3

3. Study (Continuing Professional Development)

You are at work and work training has been scheduled for you at a time that allows you to participate. However, in the back of your mind you are thinking about a situation at home that needs attention and resolving.

From the list below, rate the following statements

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree
1. Even though I have a personal issue, I will attend this training session as it is just right for my work learning needs.	○	○	○	○	○
2. This training session has resulted from an experienced colleague at my facility speaking with me to find out what my work learning needs are.	○	○	○	○	○
3. I wish these training sessions covered topics to help me with my personal life too. Like to help with my work, life balance, for example, like my situation that needs resolving at home.	○	○	○	○	○
4. I wish these training sessions would give me information to help me with how to improve my learning generally.	○	○	○	○	○
5. I wish these training sessions could provide me with resources about available training on different topics that would help me as a graduate nurse generally.	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Study and this scenario.*

4

4. Personal

You have been feeling overwhelmed at home for the past few weeks, the dirty clothes always seem to need washing, the house work never seems to get completely done, you haven't done a full weeks grocery shop again and you have had an argument with someone close to you. It's lunch time.

From the list below, rate the following statements

	No chance	Very little chance	Some chance	Very good chance	Unsure
1. Generally I feel unhappy with my personal life.	○	○	○	○	○
2. I make myself a healthy lunch from what is available and/or go grocery shopping and buy something like that on the way there.	○	○	○	○	○
3. I phone my friend or someone close to me and chat about my situation.	○	○	○	○	○
4. I make an appointment to see my local Doctor to chat about my situation and how I am feeling.	○	○	○	○	○
5. I would think about strategies that can help me with this situation, that perhaps I could action.	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Personal and this scenario.*

5

5. Personal Wellbeing

You have been feeling low at home and you are also feeling stressed about work and right now you are thinking about calling in sick for your next scheduled shift.

From the list below, rate the following statements

	No chance	Very little chance	Some chance	Very good chance	Unsure
1. You ring in sick.	○	○	○	○	○
2. You think about finding another nursing job at another place.	○	○	○	○	○
3. You think about finding a different job other than nursing.	○	○	○	○	○
4. You don't tell anyone how you feel.	○	○	○	○	○
5. You seek support from your local doctor.	○	○	○	○	○
6. You seek support from an online support group for strategies on how to manage these feelings.	○	○	○	○	○
7. You go for a walk or similar and or/plan to do something nice for yourself.	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Personal Wellbeing and this scenario.*

6

6. Support

You come to work feeling down and sometime during the shift you make an error. Your nursing peers made some comments that made you feel worse. You start to think about how you care for your patients and wonder why your peers responded to you this way.

From the list below, rate the following statements

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
1. I have had similar situations at work.	○	○	○	○	○	○
2. I have had similar situations at work but I felt my peers responded with empathy.	○	○	○	○	○	○
3. I have had similar situations at work and I felt I received support that helped me learn in a positive way.	○	○	○	○	○	○
4. I have had similar situations at work and I felt I received support right on time.	○	○	○	○	○	○
5. I have had similar situations at work and I felt I received support prior to such situations that helped me manage both the work and personal impact from making such an error.	○	○	○	○	○	○
6. I have had previous similar situations at work and I felt I received support that offered help with other issues related to work, study and personal life.	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic Support and this scenario.*

7

Thoughts on: University Nursing Education & Nursing Graduate Year Education

Thinking back to your nursing education and thinking about your graduate year as a nurse...

From the list below, rate the following statements

1. I am confident in my nursing work abilities generally (knowledge and practical skills).

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic* *University Nursing Education and Graduate Year Education*

2. I am confident in my ability to further my own learning, to support my nursing work.

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic* *University Nursing Education and Graduate Year Education*

8

3. I am confident in my ability to support my personal life in caring for myself.

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic* *University Nursing Education and Graduate Year Education*

4. I believe I have been prepared in regard to how to learn so I can feel confident in how to manage new work situations in and beyond my nursing graduate year.

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic* *University Nursing Education and Graduate Year Education*

9

5. I believe I have been prepared in regard to how to manage work with study and personal life in and beyond my nursing graduate year.

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic University Nursing Education and Graduate Year Education*

6. I am confident in my abilities to support myself to manage any new situations that may arise, whether it is work, study or personal life related.

	Strongly Disagree	Disagree	Somewhat Agree or Disagree	Agree	Strongly Agree	N/A
University Nursing Education	○	○	○	○	○	○
Nursing Graduate Year Education	○	○	○	○	○	○

Comments: *Please add further thoughts and or responses below related to this topic University Nursing Education and Graduate Year Education*

Section 2. (Duration 1 min)

Experience, Demographics and Study *(This next section is very important to complete; ensuring the research can be successfully analysed and interpreted. Your continued support to complete the survey is appreciated).*

Type of Nurse

Please specify below (e.g., Surgical, Medical including Pallitive Care)

Please mark (tick or cross) the relevant box that best describes you.

- ○ Graduate Registered Nurse - 0 to 3 months
- ○ Graduate Registered Nurse - 4 to 6 months
- ○ Graduate Registered Nurse - 7 to 9 months
- ○ Graduate Registered Nurse - 10 to 12 months
- ○ Registered Nurse - 13 months +
- ○ Graduate Enrolled Nurse (0 – 12months)
- ○ Graduate Registered Midwife - 13 months +

- ○ Registered Midwife - 13 months +
- ○ Enrolled Nurse (13months +)
- ○ Graduate Assistant in Nursing (0 – 12 months)
- ○ Assistant in Nursing (13 months +)

Highest Undergraduate Qualification

- ○ Bachelor of Nursing
- ○ Bachelor of Midwifery
- ○ Diploma of Nursing
- ○ Aged Care Certificate III
- ○ Assistant in Nursing
- ○ Other (please give details) _____

Work Experience in the above Undergraduate Qualification

- ○ 0 – 12 months
- ○ 13 – 24 months
- ○ 25 – 36 months
- ○ 3 – 4 years
- ○ 4 – 5 years
- ○ 5 – 10 years
- ○ 10 years and one month or more

12

Transition

- ○ Graduate Program
- ○ No Graduate Program
- ○ Not Applicable
- ○ Other (please give details) _____

Work Place (no specific names please), tick as many boxes as you like.

- ☐ Private Hospital
- ☐ Public Hospital
- ☐ Aged Care
- ☐ Community
- ☐ General Practice Clinic
- ☐ Mental Health
- ☐ Other (please specify below)

Current Geographical Work Location Please write the location/s here... (for example: Ipswich, QLD)

13

Current Employment Status

- ○ Full Time
- ○ Part Time (Specify hours per fortnight below)
- ○ Casual (Specify hours per fortnight below)

Completed Post graduate studies (Tick as many boxes as you require).

- ☐ Post Graduate Certificate
- ☐ Post Graduate Diploma
- ☐ Master Degree
- ☐ PhD
- ☐ Not Applicable

Current Post graduate studies (Tick as many boxes as you require).

- ☐ Post Graduate Certificate
- ☐ Post Graduate Diploma
- ☐ Master Degree
- ☐ PhD
- ☐ Not Applicable

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Informal (Tick as many boxes as you require).

- ☐ Workplace In-services
- ☐ Online training courses

(Please specify "training course/s" below if known)

- ☐ Reading Nursing Journals
- ☐ Other

Please specify "other" below

- ☐ Not Applicable

Gender

- ○ Male
- ○ Female

Ethnicity (Please specify)

Relationship Status

- ○ Married
- ○ Defacto

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- ○ Single
- ○ Other (Please specify 'Other' below)

	0	1	2	3	4	5	6	7	7 or more
Number of Dependants	○	○	○	○	○	○	○	○	○

Age of Dependants (Tick as many boxes as you require).

- ☐ N/A
- ☐ 1 day to 5 years
- ☐ 6-12 years
- ☐ 13-17 years
- ☐ 18-24 years
- ☐ 25-64 years
- ☐ 65 years and over

Personal Commitments (Tick as many boxes as you require).

- ☐ Team Sport
- ☐ Gym
- ☐ Hobby/Interest
- ☐ Caring for parents

- ☐ Caring for children
- ☐ Nil
- ☐ Other (Please specify 'Other' here and or elaborate on personal commitments below)

Submit Survey

Appendix H: Queensland Nurses Union approval letter for Phase 2 survey

Natasha Reedy

From: Liz Todhunter <ltodhunter@qnu.org.au>
Sent: Thursday, 9 October 2014 1:30 PM
To: Natasha Reedy
Subject: RE: PhD student Natasha Reedy Seeking permission to conduct research - Graduate Registered Nurses

Natasha,

The QNU receives many requests from researchers to participate in surveys. While we do not contact members directly, we can offer you an item in our next online newsletter, Qnews. To do this we need to know that Ethics Committee has approved your research and a 300-350 word article outlining the study with a link to the survey. We expect that Qnews will be published within the next 3-4 weeks.

Kind regards

Liz

Dr Liz Todhunter
Research and Policy
Queensland Nurses' Union
Phone: 07 3840 1444
Direct: 07 3840 1473
Web: www.qnu.org.au

From: Natasha Reedy [mailto:Natasha.Reedy@usq.edu.au]
Sent: Thursday, 9 October 2014 11:30 AM
To: Wendy Lawrence
Subject: PhD student Natasha Reedy Seeking permission to conduct research - Graduate Registered Nurses

Dear Wendy,

I am seeking formal approval from you in writing regarding permission to recruit Graduate Registered Nurses (100 to 200) via QNU's contacts to participate in a research study titled 'Keeping the balls in the air: How graduate nurses manage study, work and personal life'.

The survey has a duration of only 20 minutes and is low risk to participants. Participation is entirely voluntary and participants may withdraw at any time (up until data collection – as the participant will be de-identified, making withdrawal after this time impossible to determine their individual data).

This research is designed to help inform how to support Graduate Registered Nurses in their first year to help with their personal satisfaction and well-being as well as to help improve retention of Graduate Nurses in the nursing workforce.

Attached is my: