Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

Christine Ashley

University of Wollongong

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Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

Abstract

Background: Internationally, the health needs of communities are changing as a result of the ageing population and the complexity associated with providing care to people with chronic conditions. This has resulted in the need for a sustainable health workforce skilled in the provision of primary health care (PHC). In Australia, there is evidence that registered nurses (RNs) are being recruited from acute care employment in order to meet nursing workforce shortages in PHC. However, little is known about how and why RNs transition, how efficiently they are able to transfer their skills, their transitioning experiences between settings and their future career intentions. This study provides new knowledge to inform recruitment and retention strategies, workforce policy and nursing education.

Aim: To investigate the transition experiences and future career intentions of Australian RNs who move from acute care to PHC employment.

Methods: A sequential mixed methods design was selected based on pragmatic underpinnings. Role theory provided the theoretical framework to inform the research design. The study consisted of a national online survey of RNs who had transitioned from acute to PHC employment within the previous five years (n=111), and semi-structured interviews with thirteen purposefully selected survey respondents.

Findings: Reasons why nurses chose to transition to PHC were most commonly cited as relating to personal rather than professional issues. Improved work/life balance, better work hours and flexible work arrangements were highly rated, and made up for lower remuneration in the PHC sector. Barriers and enablers to successfully transitioning were also identified, with the nature of orientation and access to other supports such as preceptors and mentors varying greatly across the PHC sector. Availability of funding and/or time to undertake professional learning and knowledge development, and performance review opportunities varied according to the nature of PHC settings and factors such as geographic location and size of the workplace. Despite the positive attitudes of study participants towards the PHC environment and PHC nursing, a reasonable number were unwilling to commit long term to a career in PHC. Reasons cited included concerns about loss of clinical skills and availability of career paths in PHC.

Conclusion: This study has highlighted the need to improve the professional profile of PHC nursing in order to attract nurses to this sector. If nurses are to be retained in PHC employment, they must be professionally supported by preceptors and mentors within a positive work environment throughout their transition. Opportunities to retain clinical skills, access to professional development and equitable remuneration are likely to encourage nurses to remain in PHC employment.

Degree Type
Thesis

Degree Name
Doctor of Philosophy

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Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

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A thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

School of Nursing
Faculty of Science, Medicine and Health

UNIVERSITY OF WOLLONGONG AUSTRALIA
Thesis Certification

I, Christine Margaret Ashley, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Nursing, Faculty of Science, Medicine and Health at the University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. This document has not been submitted, either wholly or in part, to any other educational institution.

Signed: _________________________       Date:
Verification

This statement verifies that the greater part of the work in the named manuscripts is attributed to the candidate. Christine Ashley conceived and designed the study, and undertook data collection and analysis. She prepared the first draft of each of the manuscripts for publication, and responded to editorial suggestions of co-authors. Christine Ashley then prepared articles for submission to the relevant journals and responded to reviewers’ and editors’ comments in order to finalise the manuscripts.

Professor Elizabeth Halcomb, Principal Supervisor
School of Nursing, Faculty of Science, Medicine & Health
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I would also like to thank my other two supervisors, Associate Professor Angela Brown and Associate Professor Kath Peters whose wisdom, support and collegiality have made my supervision meetings not only constructive, but also fun. I am also grateful for the support provided by Dr. Rosemary Bryant during the early stages of my candidature, and prior to her retirement.

My sincere thanks goes to Marijka Batterham for her guidance and advice on statistical aspects of the study, and to Elizabeth Smyth for sharing her expertise in statistical data analysis.

A big thank you to all the primary health care nurses who willingly shared their experiences, and thank you also to everyone in the School of Nursing who were so helpful to me as I navigated the intricacies of academic life as an external student. Research Week each year was a great opportunity to network and learn from academics and students, and was much appreciated.

An unexpected bonus of undertaking my doctoral studies was the opportunity to meet with other students in the School of Nursing. What a great source of friendship and support this provided. Special thanks goes to Sue McInnes for sharing her own student experiences with me throughout our candidature over an occasional glass of wine…

Sadly, neither of my beloved parents lived long enough to see my work completed, but I know they would have been enormously proud. A huge thank you goes to my children and other family members and friends for their encouragement and willingness to show genuine interest in my study. In particular, words don’t describe how much I have appreciated my husband Norman’s ongoing support. Apart from supplying endless coffees and sandwiches, he has attempted to share the passion for my study, and has personally sacrificed so much to enable me to achieve my dream.

Finally, I would like to dedicate this thesis to my beautiful extra-special granddaughter, Bailey. Nothing is insurmountable. I know you too will follow your dreams in the years ahead.
Publications and presentations

Peer reviewed journal publications


Other publications


Conference presentations and posters


Abstract

**Background:** Internationally, the health needs of communities are changing as a result of the ageing population and the complexity associated with providing care to people with chronic conditions. This has resulted in the need for a sustainable health workforce skilled in the provision of primary health care (PHC). In Australia, there is evidence that registered nurses (RNs) are being recruited from acute care employment in order to meet nursing workforce shortages in PHC. However, little is known about how and why RNs transition, how efficiently they are able to transfer their skills, their transitioning experiences between settings and their future career intentions. This study provides new knowledge to inform recruitment and retention strategies, workforce policy and nursing education.

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Barriers and enablers to successfully transitioning were also identified, with the nature of orientation and access to other supports such as preceptors and mentors varying greatly across the PHC sector. Availability of funding and/or time to undertake professional learning and knowledge development, and performance review opportunities varied according to the nature of PHC settings and factors such as geographic location and size of the workplace.

Despite the positive attitudes of study participants towards the PHC environment and PHC nursing, a reasonable number were unwilling to commit long term to a career in PHC. Reasons cited included concerns about loss of clinical skills and availability of career paths in PHC.

**Conclusion:** This study has highlighted the need to improve the professional profile of PHC nursing in order to attract nurses to this sector. If nurses are to be retained in PHC employment, they must be professionally supported by preceptors and mentors within a positive work environment throughout their transition. Opportunities to retain clinical skills, access to professional development and equitable remuneration are likely to encourage nurses to remain in PHC employment.
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# Abbreviations

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<th>Description</th>
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<tr>
<td>ACMHN</td>
<td>Australian College of Mental Health Nurses</td>
</tr>
<tr>
<td>ACN</td>
<td>Australian College of Nursing</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>ANMF</td>
<td>Australian Nursing and Midwifery Federation</td>
</tr>
<tr>
<td>APNA</td>
<td>Australian Primary Health Care Nurses Association</td>
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<tr>
<td>CoNNMO</td>
<td>Coalition of National Nursing and Midwifery Organisations</td>
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<tr>
<td>CHC</td>
<td>Community health centre</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HDR</td>
<td>Higher degree research</td>
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<td>HREC</td>
<td>Human Research Ethics Committee</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<tr>
<td>IWS</td>
<td>Index of Work Satisfaction</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PHN</td>
<td>Primary Health Network</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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# Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Acute care nursing</strong></td>
<td>The provision of nursing services in hospitals or other inpatient settings, usually within a medical model of care.</td>
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<tr>
<td><strong>Clinical Supervision</strong></td>
<td>Clinical supervision relationships, commonly associated with mental health and psychology clinical practice, provide a structured forum for professional support(^1), with the goal of improving clinical practice and the transmission of knowledge through personal reflection and self-evaluation(^2).</td>
</tr>
<tr>
<td><strong>General practice</strong></td>
<td>The Royal Australian College of General Practitioners describes general practice as providing:</td>
</tr>
<tr>
<td></td>
<td>“person centred, continuing, comprehensive and coordinated whole person healthcare to individuals and families in their communities. As a sector, general practice, its practice teams and their PHC relationships comprise the foundations of an effective health care system”(^3) p.16.</td>
</tr>
<tr>
<td><strong>Mentor</strong></td>
<td>A personal development relationship in which a more experienced or knowledgeable person helps a less experienced or less knowledgeable person over time, and in which mutual learning, sharing and growth occur in an atmosphere of respect, collegiality and affirmation(^4). Mentoring is distinct from preceptoring, which is generally more prescriptive(^1).</td>
</tr>
<tr>
<td><strong>Preceptor</strong></td>
<td>A preceptor is an experienced clinician who provides role support to new employees. In the nursing profession the preceptor is often considered to have an educator role, and is assigned to a learner. Preceptoring usually takes place within a structured framework based on specified learning objectives and outcomes(^1).</td>
</tr>
<tr>
<td><strong>Primary care</strong></td>
<td>The provision of healthcare to communities in Australia has traditionally been medically focused, providing ‘primary care’ delivered by general practitioners usually in privately owned practices, utilising a biomedical model of care. Funding systems and resource allocation have favoured this approach(^5). Primary care, however, should be considered a subset of the broader concept of PHC(^6).</td>
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Primary health care

The World Health Organisation defines PHC as:

“essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community ... the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work”\(^{(7)}\).

Primary health care settings

Registered nurses in Australia work in a range of PHC settings\(^{(8)}\). These include: community settings including the community controlled health services and the community health sector; general practice (where nurses are commonly referred to as Practice Nurses); residential aged care; custodial/detention settings; outreach to homeless people; educational settings, and occupational settings.

Primary Health Networks

Primary Health Networks (PHNs) are primary health care organisations established by the Australian Government in 2015 to replace previous organisations that were branded Medicare Locals. PHNs were established with the key objectives of increasing the efficiency and effectiveness of health services for patients, and improving coordination of care to ensure patients receive the right care in the right place at the right time. This is achieved by understanding the health care needs of local PHN communities through analysis and planning, and by providing general practice support services so that GPs are better placed to provide care to patients. PHNs also support other health care organisations which provide care to patients with complex chronic conditions or mental illness\(^{(9)}\).
Chapter 1: Introduction

“The best time to plant a tree was 20 years ago… the second best time is now”

Chinese proverb. Source unknown.
Background

Reforms in health service delivery are occurring around the world. For much of the 20th century health care has been focused on the provision of specialist tertiary care in hospital settings. The forces which have driven this include professional traditions and interests, and the economic weight of the health industry, led by technological and pharmaceutical interests. More recently, industrialised countries have demonstrated that hospital centrisism provides poor value for money, and the unnecessary medicalisation of health care.

Concurrently, a complex web of factors including increasing urbanisation, the ageing population and global lifestyle changes have resulted in significant increases in morbidity and mortality associated with chronic and non-communicable diseases (NCDs). The ageing of the population has also impacted on service delivery with increasing co-morbidities. One quarter of those aged 65–69 years and 50% of those aged 80–84 years are affected by two or more chronic conditions. To respond to these changes, health systems are refocusing from tertiary centred, acute care services to the provision of comprehensive care across PHC settings. This movement reflects the core values initially articulated by the PHC movement at Alma Ata in 1978. These values, including equity, people centredness, community participation and self-determination, are now, more than ever exemplified in community expectations of health systems throughout the developed world.

Global primary health care

Internationally, health systems are adapting to the increased demand for patient centred PHC services across macro (policy), meso (organisation) and micro (patient/practitioner) levels. Despite differing levels of infrastructure and
resources from country to country, there are similar trends in the provision of PHC across the globe\textsuperscript{(10)}. Whilst these trends vary in response to local contexts, they reflect shared objectives of redefining health system functioning and processes to improve population health outcomes and increase service efficiency. In addition, approaches to ensure a sustainable PHC health workforce are being addressed\textsuperscript{(12)}.

In the United States of America (USA), a major policy initiative to increase the provision of PHC has resulted in the introduction of the Patient Centred Health Care Home model. This approach has demonstrated improvements in the quality of care received, lower costs, better access and enhanced patient experiences\textsuperscript{(13)}. In the United Kingdom (UK), and elsewhere in the western world, new workforce models of care have also been introduced to encompass team approaches and evolving health professional roles in PHC\textsuperscript{(10)}. Advanced nursing roles in the UK and physician assistants in the USA compliment general practitioner (GP) roles in the management of chronic conditions\textsuperscript{(10)}. Other initiatives include the introduction of integrated models of care where health and community based social services work together, such as in the UK polyclinics\textsuperscript{(10)}, Canadian family medicine clinics\textsuperscript{(14)} and New Zealand’s integrated family health centres\textsuperscript{(12)}. These team-based approaches have shown reductions in hospital admissions, improvements in the outcomes and quality of life for those with chronic conditions, and improved support for elderly populations\textsuperscript{(10)}. Similar efforts are being made in developing countries, such as Pakistan and the Pacific Islands, where shortages of trained and experienced PHC health professionals have started to be addressed through the introduction of new specialty PHC training programs\textsuperscript{(15)}.
**Primary health care in Australia**

PHC is a vital component of the comprehensive health care system in Australia, and shares the pressures experienced worldwide\(^{16}\). In 2010, the Australian Government committed to delivering PHC tailored to meet consumer needs and preferences, and appropriate to meet the needs of specific population groups\(^{16}\). Its vision for PHC stated:

*A strong, responsive and sustainable primary health care system that improves health care for all Australians, especially those who currently experience inequitable health outcomes, by keeping people healthy, preventing illness, reducing the need for hospital services and improving management of chronic conditions*\(^{16}\)(p.11).

Over the last decade, PHC services have been introduced across Australia to meet the changing health care needs of communities. The nature and operation of these services differ depending on location, socio-economic factors and population demands\(^{16}\). PHC is largely delivered through two parallel funding systems at federal and state levels. Commonwealth Government funding for PHC is provided through Medicare, the universal health scheme in Australia. Non-government agencies, GPs operating general practices as small businesses, and GP super clinics providing multidisciplinary integrated care are able to access funding to provide a range of PHC services and programs\(^{17}\). Individual patients can claim Medicare rebates towards the cost of accessing some PHC services\(^9\). At state level, funding is provided by state and territory governments to operate community health services. These include community based clinics, remote health services, public school health programs and correctional health centres\(^{18}\).
A significant development in coordinating PHC services was the establishment of Primary Health Networks (PHNs) by the Australian Government in 2015 to increase the efficiency and effectiveness of primary health services for patients. PHNs support PHC providers, including GPs, PHC nurses and allied health care workers, to ensure patients receive the right care in the right place at the right time. They also provide professional learning development and support local PHC research.

**Australian PHC nursing workforce**

The recent growth in the delivery of PHC together with estimates that by 2025 as much as 70% of health care may be provided in the community, requires an exponential growth in the size of the health workforce. As nurses are the largest profession by number within the health workforce, additional nurses will be needed to ensure the sustainability of these health services.

In 2012 the Australian Government noted that almost 36,000 nurses identified themselves as working in clinical positions within PHC settings, with a further 3,000 working in other PHC roles including administration and education. This was a significant increase from around 10,000 nurses identifying themselves as working in PHC a decade ago. Further, the report found that 65% of the PHC nursing workforce was aged over 45 years, indicating that nurses were likely to have several years of experience. Many were also reported to have transitioned from acute settings to take up PHC employment. As the delivery of PHC becomes more complex, it is important to attract experienced nurses to the sector, and retain those who transition in order to provide seamless, co-ordinated health promotion and care to communities.
How this can be addressed requires an understanding of the transition process experienced by nurses moving from acute to PHC employment.

**Transitioning**

Transitioning, described as moving from one state, condition or place to another\(^{(26)}\), has been conceptualised as exhibiting characteristics relating to process, time, perception and patterns of response\(^{(27)}\). Transition is a component of change, and is not experienced uniformly by individuals or across society\(^{(28)}\). The process of transition may be influenced by factors such as personal characteristics, the context of the change, and the environment to which the transition is being made\(^{(29)}\). The challenges of career transitions are widely reported across professions and occupations\(^{(28; 29; 30)}\). Most notably, high profile sports professionals\(^{(31)}\) and members of the military report a range of difficulties in adjusting to new careers\(^{(32; 33)}\). These challenges include a lack of confidence, professional disconnection, difficulties adjusting to new routines, loss of identity and team “mateship”\(^{(30; 31)}\). Similarly, health professionals transitioning from student to new graduate roles report comparable experiences in adjusting to a new role or employment setting\(^{(34; 35; 36)}\).

Nursing roles, like any professional roles, are located within a broader societal or organisational context. Nursing transition research describes the challenges associated with new graduate nurses entering the workforce following completion of their studies\(^{(37; 38)}\), and the content of programs which are designed to assist the transitioning process\(^{(39)}\). There are also studies of RNs transitioning between general and specialty areas within acute care settings, such as from surgical wards to intensive care or emergency departments\(^{(40; 41; 42)}\).
Adapting to changing environments are likely to affect both personal and professional behaviours and impact on factors such as professional performance and role satisfaction\(^{(29)}\). Yet little is known about how nurses have been prepared for, or experience the transition from acute to PHC employment\(^{(43; 44; 45)}\). This transition may be particularly challenging as the nurses’ roles change from working under a medical model in a highly regulated environment to autonomous or semi-autonomous roles in a range of often smaller PHC settings. An evidence base is required to identify how transferable acute care skills may be in PHC settings, how scopes of practice may change and what difficulties are faced when transitioning to PHC. Further, it is important to identify what is required to assist these nurses to transition in a way that facilitates the provision of safe and effective PHC as quickly as possible.

**Conceptual framework**

In order to conceptually understand the transitioning experiences of nurses, role theory has been adopted as a framework. Role theory provides an explanation for the way individuals respond to the transitioning process, and the interactions and behaviours which may occur\(^{(46)}\). The way in which role theory provided a framework for this study is described further in Chapter 3.

**Motivation for undertaking the study**

Having been involved in various national nursing projects relating to PHC, I have observed firsthand the significant impact which nurses have on improving the health of the community. I have also worked clinically in both acute and PHC settings, which has provided direct experience of the significant differences between sectors, and the skills required to practise safely in PHC. An invitation to prepare a report on graduate nurse transition programs created
a personal and professional interest in the broader application of knowledge relating to nurse transitioning. Combining this interest with my experience in researching PHC issues, I was surprised to discover the limited information available about the transitioning experiences of nurses moving from acute to PHC employment. It raised several questions for me. How relevant are undergraduate curricula in preparing nurses for PHC nursing employment? What attracted nurses to move from acute to PHC? How were nurses preparing themselves for the transition from acute to PHC? How were they being supported by their employer to function in their new roles, and were there any safety or cost factors related to transitioning? The lack of published research about all these factors motivated me to explore this topic further.

**Statement of the problem**

The increased demands on the Australian PHC system over the last decade has resulted in a corresponding increase in size of the PHC workforce to provide care to Australian communities. In order to meet requirements, experienced nurses are transitioning from acute to PHC roles. Little is known about why nurses decide to transition, the personal and professional impact this transition has on individuals, or how their experiences may impact on their future career intentions. By exploring these issues, this study provides new knowledge that will inform nurses, managers, employers, educators and policy makers. Nurses will gain an insight into the experiences of others allowing them to be better prepared for experiences they may encounter in PHC. In addition, the findings provide guidance to PHC employers, education providers and policy makers in ensuring that nurses moving to PHC employment are educationally prepared, appropriately supported and aware of the challenges
they may face. By ensuring that nurses are clinically competent and safe in the provision of PHC, they will be able to practise safely within their full scope within a short period of time, providing a range of existing and additional services to their PHC communities.

**Purpose**

The purpose of this study was to investigate the transition experiences and future career intentions of Australian RNs who move from acute care to PHC employment.

**Aims**

The aims of the study were:

1. To explore why Australian RNs transition from employment in acute care to PHC settings.
2. To describe the experiences of RNs who transition from acute care to PHC.
3. To explore RNs’ reflections on transitioning from acute care to PHC employment, and their future career intentions.

**Significance to nursing and health care**

The new knowledge generated from this study will be of significance to multiple audiences involved in the transition of nurses to PHC employment. By understanding nurses’ experiences of transitioning, policy makers will be better able to plan and finance processes to attract nurses to PHC employment, and to develop long term strategies to retain nurses. This will assist in ensuring a sustainable PHC nursing workforce able to meet the predicted demands in PHC provision over the coming decades.
Employers will be provided with new evidence to guide recruitment and retention strategies in order to attract and retain experienced RNs to PHC and to create working environments which meet the professional and personal expectations of the PHC nursing workforce. Academics and educators will also benefit by having the opportunity to use the findings to inform curriculum development for undergraduate and post graduate PHC courses.

In order to function competently and safely, acute care nurses considering transitioning to PHC employment must be prepared for the professional and personal challenges associated with the new environment. This study will provide new evidence to guide them in their decision making about making a career change, and will enable them to identify supports which should be available to them in their new employment.

**Thesis structure**

This thesis has been prepared in accordance with the University of Wollongong Higher Degree Research (HDR) Thesis by Compilation Rules. It consists of nine chapters, incorporating six peer-reviewed publications. These papers are placed within the thesis to maintain logical flow of the content, with additional chapters providing supporting commentary and linkages between the publications.

This first chapter has provided an introduction to the background of the study and discussed the research problem and the study aims. The chapter also describes the significance of the research to nursing and health care.

Chapter 2 presents Paper 1, an integrative review of the literature, published in the Journal of Clinical Nursing, entitled “Transitioning from acute to PHC
nursing: An integrative review of the literature"\textsuperscript{(47)}. This review synthesised current evidence and identified gaps in the literature which this thesis sought to address.

The conceptual framework for the study is presented in Chapter 3 in a publication entitled: "A study exploring the protean responses of nurses transitioning to PHC"\textsuperscript{(48)}. This publication demonstrates how role theory informed the design of the data collection.

The methodology employed in the study is described in Chapter 4. The first part of the chapter describes the survey design, data collection processes and analysis methods. This is followed by a description of the qualitative data collection and analysis. The chapter also describes the process of data integration, and considers the ethical aspects of the research.

The research findings are presented in Chapters 5, 6, 7, and 8, and follow chronologically the stages described by the study participants (Figure 1.1).

**Figure 1.1** Overview of findings

In Chapter 5, Paper 3 entitled “Exploring why nurses transition from acute care to PHC employment”\textsuperscript{(49)}, describes the reasons why Australian RNs choose to move to PHC. The publications within Chapters 6 (Paper 4) and 7 (Paper 5) describe the quantitative and qualitative findings relating to the transition,
including their orientation experiences, socialisation into the new role and ongoing support provided by employers. The remaining findings are described in Chapter 8. This chapter examines the reflections of nurses who have transitioned, and their future career intentions. These findings are presented in Paper 6 entitled “Work satisfaction and future career intentions of experienced nurses transitioning to PHC employment”(50).

The last chapter, Chapter 9, critically synthesises the findings of this study from the perspective of role theory, describing the significance of the findings, and the study’s limitations. The recommendations for policy, practice and further research that emanate from this study are also presented.
Chapter 2: Literature review

“Read not to contradict and confute, nor to believe and take for granted... but to weigh and consider”.

Francis Bacon

(51)
Chapter introduction

Whilst the transition experiences of new graduate nurses entering the workforce have been widely reported\(^{(52; 53; 54)}\), there has been much less attention given to experienced nurses transitioning to new practice environments\(^{(47; 55)}\). This chapter presents Paper 1, an integrative review which explored the experiences of RNs who transitioned from acute to PHC employment. Permission to include this publication in the thesis has been granted by the publisher, John Wiley and Sons.


Abstract

**Aims and objectives:** This paper seeks to explore the transition experiences of acute care nurses entering employment in PHC settings.

**Background:** Internationally the provision of care in PHC settings is increasing. Nurses are moving from acute care settings to meet the growing demand for a PHC workforce. Whilst there is significant research relating to new graduate transition experiences, little is known about the transition experience from acute care into PHC employment.

**Design:** An integrative review, guided by Whittemore and Knafl’s\(^{(56)}\) approach, was undertaken. Following a systematic literature search 8 studies met the inclusion criteria.

**Methods:** Papers which met the study criteria were identified and assessed against the inclusion and exclusion criteria. They were then subjected to
methodological quality appraisal. Thematic analysis was undertaken to identify key themes within the data.

**Results:** Eight papers met the selection criteria. All described nurses transitioning to either community or home nursing settings. Three themes were identified: (1) a conceptual understanding of transition, (2) role losses and gains, and (3) barriers and enablers.

**Conclusion:** There is a lack of research specifically exploring the transitioning of acute care nurses to PHC settings. To better understand this process, and to support the growth of the PHC workforce, there is an urgent need for further well-designed research.

**Relevance to clinical practice:** There is an increasing demand for the employment of nurses in PHC settings. To recruit experienced nurses it is logical that many nurses will transition into PHC from employment in the acute sector. To optimise retention and enhance the transition experience of these nurses it is important to understand the transition experience.

**Introduction**

The health environment in which nurses practise is constantly evolving to meet changing societal needs. This provides ongoing challenges to ensure workers are equipped with the appropriate knowledge and skills to meet these changes. Whilst hospitals continue to focus on the provision of acute healthcare, health systems are undergoing a period of significant reform globally to meet the needs of the ageing population and chronic diseases burden\(^{57}\). Over the last decade there has been a corresponding shift and re-design of health care towards the provision of care in PHC settings\(^{25; 57}\) such as in general practices, schools, correctional settings, community health centres and within the home.
Aligned with this has been the need to develop a skilled PHC nursing workforce able to provide appropriate care in these settings, including health promotion and assisting people to self-manage existing conditions\(^{(16; 58)}\). This can best be achieved by recruiting new graduate nurses, and by encouraging experienced nurses to move from employment in acute care settings to PHC.

In 2011, a national review of the Australian nursing workforce found that two thirds of RNs (first level nurses) and almost half of enrolled nurses (second level nurses) worked in acute settings, with nearly half providing direct patient care in surgical, medical, critical care or emergency settings\(^{(20)}\). The same report also noted that most nurses commence their careers in hospitals, but as they age they are likely to consider moving to other care settings. Reasons for this include a desire to work autonomously, practice in less physically demanding roles, and to avoid shift work. These findings are supported by evidence that nurses are increasingly being attracted to take up positions in PHC, with numbers of nurses working in Australian general practices increasing from around 8000 nationally in 2009 to almost 12,000 in 2012\(^{(21)}\). Similar trends of a growing PHC nursing workforce have also been reported internationally\(^{(43)}\).

There is a considerable body of knowledge relating to the difficulties experienced by new graduates transitioning to the workplace, however little research has explored the transitioning of nurses from acute care to PHC settings\(^{(59; 60)}\). Yet as more acute care nurses move to employment within PHC, it is timely to explore their transitioning experiences in order to ensure processes are in place to safeguard a sustainable PHC workforce into the future.
Background

Understanding the transition process and the impact this may have on the experiences of nurses moving to new work environments has led to the development of transitioning theories to explain the stages of transition\(^{26, 52, 61, 62}\). Theorists claim that when a change occurs, there will be a period of time associated with stress and dislocation as well as the need for additional skills acquisition\(^{26}\). Much of the recent role transition research in the nursing literature focuses on the experiences of new graduates transitioning to the workplace\(^{62, 63}\), and builds on Kramer’s\(^{61}\) sentinel work in which the term ‘transition shock’ was first used. Boychok Duchesser et al.’s\(^{52}\) model identifies the transition process of new graduates as occurring through three phases – doing, being and knowing, with each phase being marked by increasing confidence. New graduates commonly experience these phases over a twelve month period.

Role transition amongst experienced nurses has not been widely explored. The applicability of such models to these nurses is not clear, and the literature that is available tends to focus on evaluating educational strategies and transition programs which have been designed to meet local workforce needs and the needs of the transitioning nurses\(^{64}\). Other studies focus on nurses transitioning to new areas within acute care settings\(^{40, 65, 66}\). In their interviews with clinical nurses who were rotated to new wards, Fujino and Nojima\(^{65}\) were able to identify a range of role stresses including role overload, role ambiguity and role incongruity experienced at differing levels by nurses. A key factor associated with positive transition experiences was a high desire for career development. Gohery and Meaney\(^{40}\) used a phenomenological methodology to explore the
experiences of nurses moving from hospital wards to intensive care units in Ireland. Their research identified four key themes which included: the highs and lows of changing roles; the need for support; the theory – practice gap, and fear associated with feeling unprepared and inexperienced in the new area. In another phenomenological study in the United Kingdom (UK), Farnell and Dawson\(^{66}\) similarly described themes of support, knowledge and skills, socialisation and culture as factors which have a direct impact on positive or negative transitioning experiences amongst nurses moving into critical care units. Their study also noted that by making work environments attractive and supportive to transitioning nurses, recruitment and retention cost savings could be made which may be associated with increased patient safety\(^{67}\).

Internationally, the increased provision of care in PHC settings has led to many nurses transitioning from acute care nursing to PHC. In these new settings, scopes of practice, employment status, and the clinical skills required to function effectively are likely to vary from previous roles\(^{19}\). Acute care nursing is usually associated with working rotating shifts in either a public or private facility, usually with an established hierarchy within teams of health professionals and an associated infrastructure of staff support systems. In contrast, many PHC employers have competing priorities, for example general practices operate as small businesses, whilst employers such as schools and prisons are primarily set up for a purpose other than health care. As such, these organisations may have limited access to professional support services for nurses. Nurses in PHC may also work in geographically and/or professionally isolated settings or, for example in prisons and schools, where the range of skills and working environments are significantly different to acute settings\(^{19}\).
The proliferation of care provision in PHC settings, and associated increases in nurses moving from acute settings into diverse PHC roles requires a better understanding of how these nurses can be supported during their period of transition. It is important to explore their transitions and identify strategies which could assist in achieving positive experiences, potential cost savings through recruitment and retention strategies and improved patient outcomes. This integrative review of the literature will attempt to build on existing knowledge by critically examining and evaluating what is currently known about the experiences of acute care nurses who have transitioned to PHC settings, and identify areas for future research.

**The Review**

**Aims and method**

The aim of this integrative review is to critically synthesise primary research findings relating to the transitioning experiences of acute care nurses who move to roles in PHC settings. Due to the varied and limited literature available, an integrative review design was selected as most appropriate. This method may address new or emerging topics, and allows for mature topics to be re-conceptualised by building on the existing knowledge base\(^{(68)}\). It also allows for inclusion of a broad range of evidence, including experimental and non-experimental research\(^{(56}; 69)\).

**Search method**

A three phase strategy was adopted which consisted of an initial structured search of the literature followed by a search of references identified in the initial search, and finally hand searching for relevant papers. Data sources included: CINAHL; MEDLINE; Pubmed; Scopus; Web of Life; The Cochrane Library;
Joanna Briggs Institute; Google Scholar, and Trove databases. Key search terms, relevant synonyms, and use of Boolean operators OR and AND (as appropriate), are identified in Figure 2.1. The terms relating to PHC roles were selected based on the descriptors provided below.

| primary health care; community nurs*; practice nurs*; school nurs*; remote area nurs*; forensic nurs*; prison nurs*; military nurses*; refugee nurs*, office nurs* |
| transition to practice; role transition; role change, knowledge and skills; transferable skills. |

**Figure 2.1 Search terms**

Papers eligible for inclusion included primary research papers published in the English language from 1997 – 2014, which related to nurses transitioning their employment from acute care workplaces to PHC settings (Table 2.1). For the purposes of this review, the term ‘primary health care settings’ is used in a broad context to encompass any setting that provides frontline health services within the community\(^{70}\). The term ‘acute care settings’ refers to the provision of nursing care within a hospital clinical setting.

Papers were excluded if they referred to student placements or new graduate nurse transitions to PHC practice. These were excluded as students and new graduates are subject to a unique issues related to transitioning to a beginner level practitioner\(^{71}\) (Table 2.1).
CHAPTER 2: LITERATURE REVIEW

Table 2.1 Study eligibility criteria

<table>
<thead>
<tr>
<th>Included</th>
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<tbody>
<tr>
<td>Paper described RNs transitioning from acute to PHC settings</td>
</tr>
<tr>
<td>Published between 1997 - 2014</td>
</tr>
<tr>
<td>Published in English language</td>
</tr>
<tr>
<td>Peer reviewed journals or doctoral theses</td>
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<tr>
<td>Primary research</td>
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<th>Excluded</th>
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<tr>
<td>Studies which described transition experiences of undergraduate students, new graduates (except where findings were compared with experienced RNs), and studies which described transition between acute settings.</td>
</tr>
<tr>
<td>Synthesis of the literature, opinion pieces, editorials</td>
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</tbody>
</table>

Search outcome

An initial search identified 442 papers (Figure 2.2). The vast majority of papers were descriptive in nature, and/or focused on student and new graduate transitions. When these were removed and duplicate papers discarded, 74 papers remained. These were downloaded to Endnote© Version 7(72) for further analysis. Abstracts of each of these papers were examined, with a further 35 discarded as, on further examination, they did not meet the inclusion criteria. The remaining papers were examined in full text against the inclusion criteria. Of the 39 papers examined, 8 were scrutinised independently by two authors and were found to fit the inclusion criteria. A summary of these papers is provided in Table 2.2.

Quality appraisal

As there was considerable variation in methodologies and analytical processes across papers, application of a comprehensive quality appraisal process was difficult(56). Methodological rigour was addressed with the development of a concept matrix based on the work of Webster et al.(73), and quality appraisal criteria selected using a modified version of the scoring system developed by Pluye et al.(74). This system allocates a score of 1 for ‘present’ and 0 for ‘not present’ using predetermined qualitative and quantitative criteria.
The eight papers were then critically appraised against these criteria. Whilst Pluye et al.\textsuperscript{(74)} exclude the lowest methodological quality studies, in this review no studies were removed due to the small number of studies and the relatively minor methodological flaws noted. Qualitative and quantitative studies were awarded scores based on the presence of a statement relating to the aims and/or objective, descriptions of design or methodology, the context and the sample. In addition, quantitative scores were awarded based on justification of measurements (validity and standards) and details of controls used for confounding variables. The one mixed methods study was also scored according to its justification for using of a mixed methods design, data collection and analysis techniques, and details relating to integration.
## Table 2.2 Summary of included papers

<table>
<thead>
<tr>
<th>Citation</th>
<th>Country</th>
<th>Focus</th>
<th>Method</th>
<th>Sample</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>Adams(75)</td>
<td>USA</td>
<td>Transition from acute care to home care settings</td>
<td>Semi-structured interviews (thematic analysis)</td>
<td>Pilot - 13 nurses. Main study – 20 nurses employed in a variety of home health care nursing settings</td>
<td>Data findings revealed five categories with related themes: • Autonomy with themes of independence, confidence, competence, being alone or by oneself and being responsible; • Relationship with patient and family with themes of time, continuity of care, extension of family and involvement; • Patient in control with themes of patient teaching and education, setting as the patient's home, acceptance of living conditions; • Home care as work with themes of flexibility, organization, paperwork, traveling and perceptions as a real nurse; • Home care as an industry with themes of restraints, constraints, company changes and absence of nursing in health care policy.</td>
</tr>
<tr>
<td>Bryan et al.(76)</td>
<td>USA</td>
<td>Nurses’ perceptions of the skills required to practice in PHC settings and transition needs</td>
<td>Survey. Three part 56 item tool</td>
<td>879 nurses working in critical care, medical surgical and oncology units</td>
<td>• Proficiency in certain skills in acute care settings predicted feelings of proficiency in home care settings. • Top predictors and differentiators of proficiency in non-acute settings were wound care, knowledge of community resources, diabetic education, patient and family advocacy, communication with third party payers and neonatal care.</td>
</tr>
<tr>
<td>Hartung(45)</td>
<td>USA</td>
<td>The process of transition into home health nursing and the factors which influence success in transition</td>
<td>Mixed methods - survey and semi-structured interviews (grounded theory)</td>
<td>14 RNs who had transitioned into home health settings within the previous 6–20 months</td>
<td>• Nurses proceeded through three phases of transitioning: information marathon, closing the gaps, and crossing the goal line. • No absolute beginning or end to each phase. The duration of each phase was dependent on individual factors • Author concluded that successful career transition went beyond adaptation to encompass a life change that included perceptual, conceptual, and philosophical changes.</td>
</tr>
<tr>
<td>Citation</td>
<td>Country</td>
<td>Focus</td>
<td>Method</td>
<td>Sample</td>
<td>Key Findings</td>
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| Holt(26)       | UK      | How nurses who are engaged in advanced practice adapt to new roles in PHC settings | Semi-structured interviews / focus groups (grounded theory); observation; content analysis of job descriptions | 11 nurses in 3 district nurse centres and 2 community NHS trusts | - Theory of role transition proposed through a model which represents 4 concepts: (1) centring identities; (2) focusing roles; (3) enacting roles; (4) shaping roles  
- Model could have relevance to other settings and other health professionals |
| Murray(77)     | USA     | Nurses' transition experiences; the adaptations required of nurses; the effectiveness of orientation and the value of continuing education | Semi-structured interviews (phenomenology)                            | 25 nurses who transitioned to home nursing in previous 6 months                                                                 | - All nurses experienced stress when changing roles  
- Need for continuing education programs focused on transitioning nurses was identified  
- Recognition that nurses new to PHC settings are novices and will require experience to progress along the continuum to expert  
- A need for peer support systems, networking opportunities, additional learning resources  
- Need to establish standards for practice and competencies which reflect roles |
| Pearson et al.(78) | Canada | How selected provinces in Canada have prepared acute care nurses for their new roles in community health centres (CHCs) | Semi-structured interviews (grounded theory)                           | 11 representatives of key stakeholder groups involved in the strategic planning and implementation of CHCs | - 5 key themes: focus of care; stakeholder involvement; transitional strategies; continuing education; organizational support  
- The main role differences between acute care and CHC nurses relate to focus of care and skill level  
- Such differences necessitate the development of several key organisational and individual strategies to enable successful transition |
<table>
<thead>
<tr>
<th>Citation</th>
<th>Country</th>
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<th>Method</th>
<th>Sample</th>
<th>Key Findings</th>
</tr>
</thead>
</table>
| Simpson et al. | Saudi Arabia/Australia | The use of the Transitional Practise Model to guide the transition of acute nurses to a community setting | Focus group; case study     | 2 experienced acute care nurses transitioning to community nursing | • Model consisted of 3 components: dimensions; domains of practice; and evaluation  
• Model was effective at bridging the gap for participants to transition from acute to PHC settings  
• Substantial medical/surgical clinical practice assisted in transitioning by providing a grounding to understand different disease processes  
• Preceptors provide an understanding of the nature of professional practise through learning opportunities, mentoring and support |
| Zurmehly       | USA              | To describe existing community nursing practises and to explore factors associated with transition of clinical practice from acute care settings to community care settings | Semi-structured interviews (thematic analysis) | 48 community nurses                         | • 4 key categories identified: autonomy; client and family; education; community nursing as work  
• All participants felt they had transitioned successfully and felt they were making a difference  
• All reported that they were unlikely to return to acute care nursing  
• Participants reported feeling empowered, autonomous, and independent in their new roles |
Four papers scored the maximum of five\(^{(26; 43; 75; 77)}\), three scored four\(^{(45; 76; 78)}\), and one paper scored three\(^{(79)}\). The lower score awarded to one paper reflected the limited information provided relating to the design and methodology, and the limited description of the data collection and analysis techniques. The remaining seven papers which scored four or more were assessed as methodologically rigorous.

**Data abstraction and synthesis**

Content relating to each of the eight papers was abstracted into a summary table and reviewed independently by two of the researchers. As the number of papers identified was small and the type of data diverse, meta-analysis was not appropriate. Findings from the papers were therefore synthesized into core themes.

**Results**

**Included papers**

The eight papers describe experiences of acute care RNs transitioning to PHC settings in five countries. The majority of papers were from the USA (n=5, 62%) with others from the UK (n=1), Canada (n=1) and a joint paper from Australia and Saudi Arabia (n=1). Despite the diversity of existing PHC settings, the included papers examined the transition experiences of acute care nurses moving exclusively to ‘community health settings’ or ‘home health care’. The authors were unable to identify any relevant literature which explored transition experiences of nurses into other PHC settings.

The sample sizes of the included studies varied from the application of a transition model for two RNs\(^{(79)}\) to the use of large surveys to review perceptions relating to skills required to transition to PHC\(^{(76)}\). Most studies used
qualitative methodologies\(^{(26; 43; 75; 77; 78; 79)}\), with exceptions being Bryan et al.'s\(^{(76)}\) quantitative survey and Hartung's\(^{(45)}\) mixed methods study. The qualitative studies used a range of methodological approaches, including: phenomenology\(^{(77)}\); grounded theory\(^{(26; 78)}\); case study\(^{(79)}\), and thematic analysis\(^{(43; 75)}\).

**Key themes**

Three key themes emerged from the literature: (1) a conceptual understanding of transition; (2) role losses and gains; and (3) barriers and enablers.

**Theme 1 - A conceptual understanding of transition**

Moving from one practice setting to another is experienced by all nurses at various stages in their careers. However, to move from an institutional setting to a community based setting is likely to influence professional identity\(^{(43)}\). The PHC context of practice has been reported as quite different, and skill sets used in acute care are unlikely to be sufficient to meet the needs of the practising PHC nurse\(^{(43)}\). Whilst none of the papers defined the PHC nursing role, two authors described the specific roles of nurses practising in community or home health settings\(^{(75; 76)}\), and emphasised the autonomous or independent nature of PHC nursing practice compared with acute care\(^{(45; 75)}\).

To understand how nurses were able to successfully transition between settings, three studies explored theory and model development\(^{(26; 45; 79)}\). Holt\(^{(26)}\) describes how the rapid pace of change within health systems in the UK has resulted in many nurses and other health professionals experiencing role, context and cultural changes. Holt\(^{(26)}\) argues that the role transition experience may range from identification of factors relating to a single event through to a series of significant experiences which may have long term professional
implications, depending on the nature of the new role and associated responsibilities. His theory proposes a model based on four integrated concepts. The first, ‘centring identities’, relates to changes associated with old and new roles, self-identity associated with personal factors such as personal attitudes and values and individual social characteristics, and how the individual interacts as part of a new group. The second concept is entitled ‘focusing roles’, with Holt\textsuperscript{(26)} describing this as relating to an active process of planning current and anticipated activities to achieve the requirements of the new role. Holt\textsuperscript{’s}\textsuperscript{(26)} third concept ‘enacting roles’ was described as the dominant theme which emerged in the development of his theory, and related to the practical elements (‘the doing and delivering care’) of the new role and the capacity of the transitioning nurses to fulfil the role. The fourth concept ‘shaping role(s)’ identifies the losses and/or expansion of roles associated with the transition. Holt\textsuperscript{(26)} describes these as having a positive or negative impact on the transition experience, and thereby having the potential to redefine the new role for the transitioning nurse. The author claims that by conceptualising the transition process, individual nurses and employers will benefit by having a better understanding of role transition, and appropriate initiatives can be developed to support nurses in transition.

Whilst Hartung’s\textsuperscript{(45)} theory has similarities to the work of Holt\textsuperscript{(26)}, it also explored why nurses decided to transition and how this may impact on the transitioning process. Hartung\textsuperscript{(45)} draws on comparisons between the different work environments in acute and community settings, including health care structures, care delivery and economics, and how these factors may impact on the decision of a nurse to undertake a career move. Hartung\textsuperscript{(45)} also reported on how
different personality traits such as flexibility and adaptability affect the transition process. The study identified three phases in the transition process: information marathon, closing the gaps and crossing the goal line. The duration of these phases was not clearly defined with each phase varying according to the ability of the nurse to utilise or access external, internal and joint strategies such as an orientation to the role, access to preceptors, and identification of personal learning needs.

The third study, reported by Simpson et al.\textsuperscript{(79)}, described the application of the Transitional Practice Model in assisting two Saudi Arabian nurses to transition from acute nursing to a community setting. This model was developed to provide an educational learning program for transitioning nurses, and incorporated three components: dimensions, domains of practice, and evaluation. The dimensions component, based on Benner’s\textsuperscript{(80)} novice to expert concept, recorded progress across 5 stages as the nurses moved from Stage 1 (novice) to Stage 5 (expert). The domains of practice related to the growth and development of the nurses across the stages, and the evaluation component included the nurses demonstrating their skills through interview, presentation of case studies and undertaking research. The authors claim that the three components were effective in easing the transition process for the nurses. However, as the results were presented in a descriptive format, assessment of the methodological rigour was not possible.

\textit{Theme 2 - Role losses and gains}

\textit{a) Loss of role familiarity}

Most nurses entering the workforce are employed in acute care settings and will gain additional skills and expertise over time within the sector\textsuperscript{(75)}. The work of an
acute care nurse is as part of a multidisciplinary team with organisational support available when needed. The work frequently involves shift work, and nursing care is provided based on a medical diagnosis. Adams\(^\text{(75)}\) notes that there is often little opportunity for nurses to practise autonomously in these settings.

Most nurses who have practised for years in acute settings are unlikely to have received recent formal education or experience in PHC nursing. Graduate nurses are also largely socialised into hospital clinical experiences with limited exposure to community health settings during their undergraduate years\(^\text{(43)}\). Transitioning to PHC nursing, therefore, may entail the loss of familiarity of their acute care roles and lack of clinical or educational preparation in PHC nursing. This loss of role familiarity can be particularly stressful when the transition process occurs as a result of organisational restructure rather than by individual choice\(^\text{(78)}\).

\textit{b) Transferability of skills}

Bryan et al.\(^\text{(76)}\) reported that nurses from various acute specialities perceived themselves as being proficient in their clinical nursing skills regardless of their work settings. However, participants in several studies were shown to have unrealistic expectations relating to the transferability of their skills\(^\text{(43; 45)}\). Whilst having appropriate theoretical knowledge and understanding of various diseases and conditions, transitioning nurses were found to be ill prepared, have limited knowledge about the scope of PHC nursing, and lacked the clinical or communication skills to function autonomously or effectively in the PHC setting\(^\text{(43; 45; 76)}\). Participants also reported feelings of isolation, concerns relating
to personal safety, loss of confidence in their ability to make decisions, and a sense of dislocation and confrontation \(^{(45; 75)}\).

c) **Gaining autonomy and empowerment, and establishing client relationships**

Whilst the earliest phase of transition is described as associated with role losses as nurses leave their familiar surroundings in acute care settings, over time a role shift occurs which begins the process of transformation \(^{(43; 45; 75)}\). Hartung \(^{(45)}\) associates this transformation with the process of gaining knowledge and skills which results in closing the gap between the old and new roles. Zurmehly \(^{(43)}\) and Adams \(^{(75)}\) describe role gains as being related to feelings of empowerment. Examples cited included: the autonomous nature of the PHC role; more control over personal lives with regular working hours replacing shift work; the development of rewarding relationships with clients; being able to integrate a patient education focus into their role, and flexibility to organise workloads to best meet the needs of clients. Adams \(^{(75)}\) also describes how nurses who transition to PHC roles experience a new paradigm with clients ‘in control’ of their care, both within the context of the nature of care, and the location in which the care is provided (for example, the client’s home or community).

**Theme 3 - Barriers and enablers**

Barriers or enablers in facilitating positive transitions to new work settings identified in the studies were: relevant educational preparation; skills development; access to ongoing continuing education, and availability of support systems such as organisational orientation, preceptoring, mentoring, and team support in the workplace.
a) Formal educational preparation and skills development

Bryan et al.\textsuperscript{(76)} identified gaps in PHC theory and practice in some undergraduate curricula. They noted that, in general, curricula and competencies were acute care focused, there was a lack of clinical placements in PHC settings and that curricula needed to incorporate specific aspects of PHC nursing practice. Gaps in PHC knowledge of acute care nurses were specifically noted in Simpson et al.’s\textsuperscript{(79)} study which identified that a sound knowledge base of disease processes led to improved transition experiences.

b) Importance of support

Various supportive strategies throughout the transition period were identified as vehicles for assisting nurses moving into new roles. These included workplace and/or organisational orientation which introduce nurses to the philosophy, policies and procedures of the new workplace, provide information about role expectations and competencies, and planned clinical experiences\textsuperscript{(45; 77; 78)}. Hartung\textsuperscript{(45)} described how rushed orientations due to staff shortages resulted in nurses feeling overwhelmed and sufficiently stressed to consider quitting. Availability of preceptors during the first days and weeks of transition, and ongoing mentorship by team members was identified as critical to the integration of information and contextualisation of the new role\textsuperscript{(45; 77; 79)}. Trained preceptors were also described as important in ensuring that nurses were not overloaded with complex patients or responsibilities too soon\textsuperscript{(43; 45; 77; 78; 79)}. Formal mentorship and team support was found to facilitate the process of ‘closing the gap’ between old roles and new, with Hartung\textsuperscript{(45)} describing frequent consultations with managers, supervisors and other team members as valuable in assisting in the transition process, and Pearson et al.\textsuperscript{(78)} noting that
mentoring was a viable and cost effective tool in preparing nurses for their new roles.

Access to relevant continuing professional development (CPD) was identified as being critical in fostering new role identities by developing the additional skills and knowledge required in PHC settings\(^{43; 75; 76; 77; 79}\). The availability of CPD in PHC settings was noted by Pearson et al.\(^{78}\) as also needing to target the context of practice, be self-directed and accessible during work hours, with responsibility shared between organisations and individuals.

**Discussion**

To meet the growing workforce need for skilled PHC nurses it is important that nurses are supported during their transition into PHC from acute care employment. Despite the importance of the issue and the awareness of the impact of transitions on nurses in other settings\(^{59; 60}\), a limited amount of research focusing on the transition experiences of nurses moving from acute care to PHC was able to be identified in this review.

Even though a systematic search strategy was used to identify relevant papers, those papers which met the review criteria were drawn from only a few categories of PHC settings. Given the variations in the PHC work environments, it is difficult to combine research from across various settings in meaningful comparisons. However, the commonalities of the PHC settings provide a conceptual link that underpins the comparisons. Additionally, the impact of the specific health system in which the research had been undertaken is unclear.

Whilst this review provides a critical synthesis of the available literature, it also highlights the urgent need for more research in this area. The review has found evidence that the conceptualisation of nursing transition between employment
in acute and PHC settings shares some common characteristics with new
graduate nursing transition experiences\(^{(52; 61)}\). Nurses moving into PHC
employment were found to experience a similar range of stresses associated
with their dislocation, such as lack of confidence, loss of familiarity associated
with role and place, and comparable stages of progression to becoming
confident and competent PHC practitioners. There were similar to those
described by Boychuk Duchscher et al.\(^{(52)}\) in relation to new graduate nurses
experiencing "transition shock" (p.1105). Boychuk Duchscher et al.’s\(^{(52)}\)
research identified that new graduates progress at their own pace through the
transition stages, with most being confident professionally, and feeling
encultured into the profession by the end of a year of supported practice.

Of concern were Bryan et al.’s\(^{(76)}\) findings that there were unrealistic
expectations reported by some participants relating to the transferability of
acute care skills to PHC nursing, and that generally, transitioning nurses were
not adequately prepared for the change in context of practice\(^{(43; 45; 75; 77)}\). Bryan
et al.’s\(^{(76)}\) findings are supported by Boychuk Duchscher et al.’s\(^{(52)}\) work with
new graduates which found that study participants were ill-prepared for the
change in work relationships, roles, responsibilities and knowledge associated
with the move from academia to the work environment. Forbes et al.\(^{(81)}\) also
noted similar findings among experienced RNs who move from an area of
expertise to a new clinical area. They stated that experienced nurses in their
study described the apparent dichotomy between the effective provision of
clinical care as opposed to being proficient in, and confident to prescribe patient
care in a new environment. In contrast, Farnell et al.\(^{(66)}\) reported that nurses
moving from a surgical ward to critical care were aware they lacked specific
skills in caring for critically ill patients, but were still surprised by the level of
knowledge and skill required to function effectively in their new roles. These
findings are important as nurses seeking to move to PHC settings need to be
advised about the likely course of transition, offered support to prepare for the
new role, and be provided with appropriate ongoing support as they gain skills
and knowledge in PHC nursing.

A limited focus on PHC nursing in some undergraduate programs was identified
by Bryan et al.\(^{(76)}\). More recently, Betony et al.\(^{(82)}\) found that a range of barriers
limited the theoretical and practical exposure of undergraduate nursing students
to PHC in New Zealand. Barriers included variable understanding of the PHC
model, a lack of clarity about a team's role in PHC delivery, and difficulties in
sourcing clinical placements. Yet the value of incorporating theoretical and
practical components of PHC into undergraduate nursing programs was
reported by Bennett et al.\(^{(83)}\) to have positive impacts on the development of
skills, knowledge, attitudes and confidence. In Bennett et al.'s\(^{(83)}\) cohort,
students undertook an intensive structured learning program complimented by
well-designed clinical experiences in rural and remote settings in Australia.
Given the current health environment and the shortage of experienced nurses in
PHC, these findings warrant further investigation.

An important aspect which was identified in this review was the satisfaction that
PHC nurses stressed about their roles over time\(^{(43; 45)}\). Whilst conceptual\(^{(26)}\) and
emotional adjustments\(^{(77; 78)}\) were required when transitioning, the studies also
identified increased autonomy, empowerment and rewarding multi-level holistic
interactions with clients, families and communities. Promotion of these positive
aspects of nursing in PHC settings may encourage nurses to consider moving
to PHC, and assist in meeting future workforce needs. Whilst this review was unable to identify any reliable evidence demonstrating a correlation between successful nursing transitions to PHC and the impact on organisational costs and health outcomes, there is evidence from acute care nursing literature that positive work environments, such as those evidenced in Magnet hospitals, may contribute to cost savings and improved patient safety\(^{44; 66; 67}\). Robust data from PHC studies is required in order to explore these potential correlations.

**Conclusion**

This integrative literature review has explored the transitioning experiences of nurses moving from acute care to PHC employment. It has highlighted challenges faced by transitioning nurses at both personal and professional levels. It also identified that, despite the growing demand for nurses in PHC settings, there has been limited attention paid to the transitioning of nurses into PHC employment. Further research is urgently required to inform organisational policy development as well as clinical and academic support programs in facilitating optimal transition experiences and enhance the recruitment and retention of nurses in PHC settings.
Chapter 3: Role theory: a conceptual framework

“All theories are legitimate, no matter. What matters is what you do with them”

Jorge Luis Borge\(^{(84)}\)
Chapter introduction

In this chapter, Paper 2 describes how role theory provides a theoretical framework to inform the study. The paper also provides examples of how the theory informed the study design. Permission to include this publication in the thesis has been granted by RCNi.


Abstract

**Background:** Healthcare systems are faced with changing community health profiles and ageing populations. Together with economic considerations, these factors have influenced the increased provision of care in primary rather than other health care settings. Many nurses are electing to move from acute care to meet demands for a skilled primary healthcare workforce. Little is reported, however, about these nurses’ experience of transition.

**Aim:** To describe how role theory provides a theoretical framework to inform the design of a mixed methods study exploring the transition of acute care nurses to roles in PHC.

**Discussion:** The paper explores the relevance of role theory and its components as a validated framework for informing the design of the quantitative and qualitative components of the study. The methodology consisted of a national survey of recently transitioned nurses, with questions that explored their experiences in relation to role exit/role entry, role enactment, role ambiguity, role stress/strain and rites of passage. The qualitative
component of the study incorporated semi-structured interviews with selected participants, to further explore aspects of the role transition.

**Conclusion:** There are few published reports on the value of theoretical frameworks in the design of nursing research. This paper describes one example of the value of selecting an appropriate theoretical framework for a national study of experiences of transition.

**Introduction**

Contemporary life is characterised by fragmentation, uncertainty and perpetual change which affects individuals, organisations and society. Healthcare systems provide a good example of this flux, because they constantly transform in response to changes in economic realities, community health profiles and an ageing population. Organisations and individuals need to adapt to respond to these changes.

Nurses are often the first to have to adapt to the evolving healthcare environment, and are likely to change their roles frequently throughout their careers. Examples include transitioning from student to new graduate, moving between different areas of clinical practice, and advancing to specialist, nurse practitioner, educator, researcher or management roles. How these changing roles affect personal and professional behaviours has not been widely reported in the literature other than in relation to new graduates entering the workforce\(^{71}\);\(^{85}\) and RNs transitioning to nurse practitioner roles\(^{86}\).

In Australia, the shift in the provision of health care from secondary acute hospitals to PHC settings has resulted in nurses relocating from acute care
roles to meet the demand in PHC\(^{(21)}\). This has resulted in changes in scopes of practice, and new and evolving professional challenges and opportunities\(^{(46;47)}\).

How individuals cope with significant change has been referred to as proteanism, a reference to the Greek god Proteus, who was able to change shape in response to a crisis\(^{(87)}\). Ashforth\(^{(29)}\) describes the protean person as flexible, able to seamlessly transition into new roles, and manage change by abandoning ‘old’ roles. A recent integrative review of the literature has identified that there is a paucity of knowledge about how nurses experience the transition to PHC roles, why they transition, and how they cope with the professional and personal changes associated with their new roles\(^{(47)}\). The limited evidence available indicates that a protean response, characterised by flexibility and adaptability, is required to transition successfully to new PHC nursing roles\(^{(46)}\).

Yet a broader and deeper understanding of the experience of transition is required, to provide direction to those contemplating career changes, and to organisations and employers wanting to engage and retain nurses new to PHC.

Designing and operationalising research that explores such a complex phenomenon requires consideration of all aspects of the transition experience in order to generate valid outcomes and recommendations. The selection of an appropriate theoretical framework provides an important road map for guiding such research\(^{(88)}\). As a result, a mixed methods doctoral study undertaken by the lead author (CA) assisted by authors (EH, AB) used role theory as a framework to study the transitioning of RNs from acute care to PHC settings. This enabled a detailed exploration of the experience to be undertaken, and ensured that the study remained focused.
CHAPTER 3: ROLE THEORY

Transition

The transition of nurses between different healthcare settings is defined as “a passage from one fairly stable state to another fairly stable state … triggered by a change. Transitions are characterized by different dynamic stages, milestones, and turning points and can be defined through processes and/or terminal outcomes”(27)(p.11). Role transitions require that a person new to a role must incorporate new knowledge, and ‘reinvent’ or redefine themselves according to the new role or social context(27).

Using role theory to understand transitioning

A role is neither a unitary concept nor a systematically organised theory(89), but a configuration of behaviours and attitudes which are linked to an identity or social position(90); these are contextually bound(46). Role theory, which was first proposed by theorists such as Mead et al.(91), states that the social behaviour of people in different roles is not random or meaningless(92). The theory is a collection of concepts, definitions and hypotheses that predict how individuals may react in given contexts, and what behaviours may be expected(93). It provides a framework for the collection of generalisations about the organisation of roles within societies and groups, how interaction and behaviour occurs between people in different roles and how individuals manage the different and often competing roles in their personal and professional lives(29; 94). Some role theorists have also noted that during a lifetime, as individuals assume different and new roles, there is a corresponding need to ‘unlearn’ old roles in order to effectively transition to new situations(90). This “unfreezing” is associated with individuals mentally disengaging from their previous roles as they prepare for the transition(29).
Approaches to role theory are broadly classified in the sociological literature as structural functionalist or symbolic interactionist. The structuralist view is that roles are made up of a series of behaviours common to specific contexts or positions in organisations or society which shape the individual’s behaviour (29; 46). Examples include gender specific behaviours such as the ‘role’ of a woman or mother and how it differs from the ‘role’ of a man or a father, or profession specific role differences such as those between police officers and priests or doctors and nurses. Roles are therefore viewed as fixed and largely taken for granted (29).

In contrast, symbolic interactionists take a subjective view, focusing on the way individuals interpret and/or behave in a new role as they personally experience the transition from a previous role (95). Unlike structuralists, symbolic interactionists view roles as fluid, and are negotiable based on shared understandings (29).

**Concepts associated with transition**

As with any theory, role theory includes a number of interrelated abstract representations of specific parts of the theory (96). In the context of nurses transitioning from acute care nursing to PHC, role theory provides a useful approach for exploring adjustment to the new setting or “role entry” (29) and the associated unfreezing from the old role or “role exit” (29; 97). As well as role entry and role exit, there are several concepts in role theory which are associated with the role adjustment nurses are likely to experience (98). These are detailed in Table 3.1.
Table 3.1 Summary of key concepts associated with role theory

<table>
<thead>
<tr>
<th>Concept</th>
<th>References</th>
<th>Description</th>
<th>Nursing examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role entry</td>
<td>Ashforth(99)</td>
<td>Usually begins before role exit, as an individual mentally prepares for the transition to a new role. Role entry may continue for an undetermined period whilst confidence and experience is gained.</td>
<td>The transitioning nurse actively seeks information about the new role, and identifies actual/potential knowledge gaps and strengths. Discussing a learning plan with the new employer. Participates in orientation, works with preceptors or mentors in the new workplace in order to develop confidence and skills.</td>
</tr>
<tr>
<td>Role exit</td>
<td>Ebaugh(97)</td>
<td>“The departure from any role that is central to one’s self-identity”(97). The physical and social – psychodynamics of ‘unlearning’ or disengaging from the old role –and preparing to move on to the new role. Described by Holt(26) as being “like bereavement”.</td>
<td>Packing up possessions in the old work place and preparing for the first day in the new job. Saying final farewells, returning identity pass. Actively seeking information and undertaking professional development relating to the new role.</td>
</tr>
<tr>
<td>Role enactment</td>
<td>Squires(100)</td>
<td>“The process by which nurses apply, modify, and utilize the existing situation, resources, and variables in a specified context to perform their nursing role”(100). Role enactment is more than specific tasks required to do the work, but includes multiple dimensions and the influence of those dimensions.</td>
<td>Fulfilling the requirements of the role – the “doing” or delivery of care to clients(26) interactions with other work colleagues, and responding to the needs of clients and others. Role enactment also determines the quality of the performance of the nurse, and is frequently associated with the frustrations of wanting to do more for the client but being restricted by limited resources.</td>
</tr>
<tr>
<td>Role conflict</td>
<td>Brookes et al.(94)</td>
<td>Role conflict exists when an individual has two or more role requirements that work against each other. Conflict is often associated with role ambiguity leading to personal and interpersonal conflict. Role conflict has been associated with burnout and reduced retention rates.</td>
<td>Nurses transitioning to their new role may be unclear about their scope of practice and organisational expectations. Other health professionals do not provide the support and mentorship necessary during the transitioning period leading to feelings of resentment and interpersonal conflict.</td>
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<tr>
<td>Concept</td>
<td>References</td>
<td>Description</td>
<td>Nursing examples</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Role stress and role strain</td>
<td>O’Shea(^{[101]})</td>
<td>Role stress and role strain are often used interchangeably, although role stress normally precedes role strain. The term(s) describe a subjective or phenomenal state of tension and/or discomfort resulting from inability to perform a role or anxiety about being able to perform it(^{[90]}). Often resulting from or associated with existing role conflict, and role overload. The level of intensity of the strain will vary depending on various moderating factors such as personal characteristics and social context.</td>
<td>Acute care nurses new to PHC are anxious initially as they feel unprepared to fulfil aspects of their role, such as undertaking pap smears, or administering immunisations. A moderating factor would include the provision of a structured orientation program, and support offered through a preceptor and an ongoing mentor.</td>
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<tr>
<td>Role ambiguity</td>
<td>Brookes et al.(^{[94]})</td>
<td>A lack of clarity or confusion about a role, leading to disagreement about the expectations associated with the role.</td>
<td>Nurses transitioning to a new role such as PHC may discover that they are unable to practice to their full scope due to restrictions in place through the medical benefits system, or lack of understanding of the nursing role by other health professionals.</td>
</tr>
<tr>
<td>Rite of passage</td>
<td>Ashforth(^{[29]})</td>
<td>Rituals or acts which assist and acknowledge the movement of individual(s) from one role to another.</td>
<td>Nurses transitioning to a new role may experience various rituals or acts associated with the move. These may include a farewell event, exit interview, presentation of a gift from ‘old’ employer and colleagues, followed by a welcome morning tea, and informal introductions to staff in the new workplace. It is likely to also include a formal orientation to the new workplace. Over a period of time, a rite of passage may include the employer enabling the new nurse to progress from working with a mentor to practising autonomously as new skills or competencies are demonstrated.</td>
</tr>
</tbody>
</table>
Designing the study

The limited research conducted into the transition from acute care to PHC, has shown that contrasts between the sectors are complex and nurses’ experiences are multifaceted \(^{(47)}\). Role theory was identified as a useful framework that could inform the research design. It was also recognised that no individual source of data was likely to be able to capture both the macro view of nurses transitioning to various PHC settings as well as the micro view of individual nurses’ transitioning experiences\(^{(103)}\). In addition, we could not explore the complexity of human phenomena and deeper insights into the protean responses of nurses in transition through the limitations of a solely structuralist or symbolic interactionist paradigm\(^{(104; 105)}\).

A sequential explanatory mixed method design provided an opportunity to gain a rich insight into transition experiences. Quantitative data was gathered using a national survey, with qualitative data gathered in a series of semi–structured interviews with purposefully selected survey participants representing a range of PHC settings. Study participation required meeting pre-determined criteria including being a RN who had transitioned from acute care to PHC in the previous five years. We chose this timeframe to ensure that transition experiences could be realistically recalled, and because of changes in Australian government policy relating to PHC in the last five years, which have resulted in increased numbers of nurses transitioning\(^{(106)}\).

**Quantitative phase**

The purpose of the quantitative phase was to gain a broad macro view of nurses who had transitioned from acute care to a range of PHC settings. A
survey was deemed the most appropriate tool to broadly understand the various constructs that may influence the experience of transition.

An extensive literature review found no validated survey tool that met all of the investigation’s requirements. We therefore designed one using the concepts of role theory, and validated components of other surveys. Face validity of the survey was established before distribution by testing and re-testing with a group of experienced PHC nurses. The survey used questions designed to explicate a range of information relating to: role exit; role entry; role enactment; role ambiguity; role stresses; role strains; role conflict, and rites of passage as experienced by the nurses. Data gathered included: demographic information; reasons for leaving acute care; prior knowledge of PHC; preparation for the new role; support systems provided by PHC employers; personal and professional difficulties encountered following transition; how the transition could have been made easier, and intentions to stay working in PHC. Examples of survey questions and their relationship to role theory are detailed in Table 3.2.

**Qualitative phase**

The qualitative phase also used role theory and its interrelated concepts as a theoretical lens to explore in depth the transition experiences and issues raised during the quantitative phase of the study. The semi-structured interviews were informed by a symbolic-interactionist approach, to investigate behaviours of individuals during their transition to PHC\(^{107}\). A series of questions and prompts based on initial analysis of the survey findings was designed to gather personal stories and reflections on transition, and to identify how transitioning to PHC had affected the nurses’ professional and personal aspirations. Examples of questions and their conceptual basis in role theory are displayed in Table 3.3.
Table 3.2 Examples of survey questions

<table>
<thead>
<tr>
<th>Examples of questions</th>
<th>Type of question</th>
<th>Role theory concept</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which of the following influenced your decision to seek employment in PHC:</td>
<td></td>
<td></td>
<td>Personal and professional reasons for transitioning to new roles and expectations of new role have been identified as impacting on positive/negative transitioning experiences(26).</td>
</tr>
<tr>
<td>- opportunity to advance my career</td>
<td>Multiple choice</td>
<td>Role entry/role exit</td>
<td></td>
</tr>
<tr>
<td>- opportunity to increase my level of work satisfaction</td>
<td>tick options</td>
<td>Role enactment</td>
<td></td>
</tr>
<tr>
<td>- salary and employment benefits</td>
<td>were relevant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- balancing my life and work responsibilities</td>
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<td></td>
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<tr>
<td>- Improved working hours which suited my lifestyle</td>
<td></td>
<td></td>
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<tr>
<td>- to pursue my interest in PHC</td>
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<tr>
<td>- to stop working shift work</td>
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<tr>
<td>- consolidating my nursing and midwifery knowledge</td>
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<tr>
<td>- the autonomous nature of the work</td>
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<td>- wanted a change from the acute sector</td>
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<tr>
<td>- was the first employment opportunity</td>
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<tr>
<td>- location was closer to home</td>
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<tr>
<td>When you transitioned from an acute setting to PHC, how difficult was it for you to adjust to the following in your new role:</td>
<td></td>
<td></td>
<td>Gaps between expectations and reality are linked to positive/negative transitioning experiences(108).</td>
</tr>
<tr>
<td>- Changes in the amount of responsibility</td>
<td>5-point Likert</td>
<td>Role entry/role exit</td>
<td></td>
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<tr>
<td>- Increased autonomy</td>
<td>scale:</td>
<td>Role enactment</td>
<td></td>
</tr>
<tr>
<td>- Confidence in clinical skills</td>
<td>Very difficult</td>
<td>Role ambiguity</td>
<td></td>
</tr>
<tr>
<td>- Clinical knowledge</td>
<td>to</td>
<td>Role stress/strain</td>
<td></td>
</tr>
<tr>
<td>- Organisational knowledge</td>
<td>Very easy</td>
<td>Conflict</td>
<td></td>
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<tr>
<td>- Prioritising workload</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Concerns relating to personal safety</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- New technologies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples of questions</td>
<td>Type of question</td>
<td>Role theory concept</td>
<td>Rationale</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
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<tr>
<td>Workplace familiarization</td>
<td></td>
<td></td>
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<tr>
<td>How satisfied were you with the following aspects of your role in the first 6 months working in PHC?</td>
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<td></td>
<td></td>
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<tr>
<td>- Interaction with patients and families</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Workload</td>
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<tr>
<td>- Professional nursing role</td>
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<td></td>
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<tr>
<td>- Management of the workplace (eg. rostering)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Workplace environment</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Respect from colleagues</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Orientation (eg. preceptors, level of feedback)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Being involved in the team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-point Likert scale: Completely dissatisfied to Completely satisfied</td>
<td>Role entry</td>
<td>Role enactment</td>
<td>Job satisfaction associated with lack of support during the transition phase, role ambiguity and scope of practice issues are associated with increased turnover (109) and decreased quality of relations with patients/clients (110).</td>
</tr>
<tr>
<td>Please compare how you feel NOW about your role in PHC compared with your previous role in acute care.</td>
<td>Open ended item</td>
<td>Role entry/exit</td>
<td>Opportunity to gather additional data relating to personal and professional transition experiences.</td>
</tr>
</tbody>
</table>
Table 3.3 Examples of questions used in gathering qualitative data

<table>
<thead>
<tr>
<th>Question/prompt</th>
<th>Role theory concept</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me what it was like for you when you first started in your PHC Role</td>
<td>Rite of passage</td>
<td>Opportunity to explore specific issues raised in survey such as lack of</td>
</tr>
<tr>
<td>Prompts:</td>
<td>Role entry/exit</td>
<td>orientation/work overload.</td>
</tr>
<tr>
<td>- What was it like leaving your old role?</td>
<td>Role enactment</td>
<td></td>
</tr>
<tr>
<td>- How did you feel in those first few days?</td>
<td>Role stress/strain</td>
<td></td>
</tr>
<tr>
<td>- In the survey people told us they had issues with their orientation – tell me about yours.</td>
<td>Role conflict</td>
<td></td>
</tr>
<tr>
<td>- What resources did you receive before/during orientation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you tell me what you found to be the most challenging aspects of the new role?</td>
<td>Role ambiguity</td>
<td>Identification of specific examples of transitioning difficulties.</td>
</tr>
<tr>
<td>Prompts:</td>
<td>Role stress/strain</td>
<td></td>
</tr>
<tr>
<td>- What about autonomy, confidence, working relationships, communication,</td>
<td>Role conflict</td>
<td></td>
</tr>
<tr>
<td>professional/personal isolation, availability/access to professional development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you describe how you managed or overcame these challenges?</td>
<td>Role enactment</td>
<td>Identification of specific strategies to overcome challenges associated with</td>
</tr>
<tr>
<td>Prompts:</td>
<td>Role entry</td>
<td>transitioning.</td>
</tr>
<tr>
<td>- Professional supports. eg. access to CPD, mentor, staff meetings, performance review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Personal supports</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Discussion

To meet the increasing demand in Australia for nurses to work in PHC settings, there is likely to remain a significant movement of nurses from acute to PHC\(^{(21)}\). To ensure this transition is as seamless as possible, more information is required about the experiences of these nurses and their protean response to the change in role. To fully explore such a complex phenomenon requires the careful selection of a methodology that will capture the range of experiences. Although there are few recent published examples of the application of specific frameworks\(^{(88)}\), selecting and using an appropriate theoretical framework is an important part of research\(^{(109)}\), and provides a valuable lens to guide the design and implementation of both quantitative and qualitative studies\(^{(111)}\).

This study selected role theory as the theoretical framework to guide and inform the development of the research methodology, as it has been empirically verified and widely used in a range of studies relating to transitioning from one work area to another\(^{(112)}\). Models based on role theory have provided a basis for research into the transition experiences of nurses in various settings\(^{(26; 43; 46; 78)}\). At least two differing philosophical perspectives of role theory exist, but together with the main concepts identified in the role theory literature, these ensured that the design and content of this study reflected the full scope of issues relating to transitioning. Survey items were designed based on these concepts, exploring previously reported aspects relating to new nurses in PHC contexts, such as increased autonomy, concerns about isolation, and clinical competence. The items also provided the opportunity for new information to be obtained, using open-ended responses from survey participants.
Similarly, the design of the qualitative phase drew on role theory concepts, using probing questions and prompts to build on significant findings from the survey. The use of semi-structured interviews provided flexibility in obtaining information about the objective and subjective world of the participants in order to fully explore the protean response of the cohort to transitioning\textsuperscript{(113)}.

**Conclusion**

The purpose of this paper has been to demonstrate that role theory provided a valuable theoretical framework to inform the design of a study into the transition experiences of nurses moving from acute care to PHC. When undertaking research into complex phenomena, the use of an appropriate theoretical framework provides guidance about the scope of the project, and explanations about how variables may be related. Although many texts exist about the use of theories in nursing research, we discovered that there are few papers that explicitly discuss how theoretical frameworks have been used in research design and application.
Chapter 4: Research design and methods

“In much of society, research means to investigate something you do not know or understand. Research is creating new knowledge”.

Neil Armstrong(114)
Chapter introduction
The previous chapter identified how role theory provided the theoretical framework which guided the design of the study. This chapter describes the methodology and methods used to discover new knowledge about the research problem to investigate the transition experiences of nurses moving from acute care to PHC settings.

The methods of qualitative and quantitative data collection and analysis are described. These include the development and distribution of the survey tool, the process of conducting the semi-structured interviews, and the analysis of both data sets. Ethical considerations are discussed, and issues of reliability/validity and rigor are presented.

For clarity, in this thesis, the term ‘respondent’ refers to those individuals who completed the survey, and the term ‘participant’ is used to describe those who were interviewed during the qualitative component of the study.

Aims
The aims of the study were to:

1. To explore why Australian RNs transition from employment in acute care to PHC settings.

2. To describe the experiences of RNs who transition from acute care to PHC.

3. To explore RNs’ reflections on transitioning from acute care to PHC employment, and their future career intentions.
Methodology

Pragmatism

In selecting which methodology best suited the nature of the study, careful consideration was given to the philosophical assumptions underpinning the research. Some purists argue that there are only two world views or paradigms, one supporting quantitative and the other supporting qualitative research\(^\text{(115)}\). These paradigms are considered to be diametrically opposed except in the goal of generating discipline specific knowledge\(^\text{(115)}\). Such dogmatism was considered unhelpful in this study, where exploration of the complexity of human phenomena and individual insights into the transition process are required to fully explore the transition experience. A pragmatic approach was therefore selected, as this is not tied to either paradigm, and has strong associations with mixed methods research\(^\text{(115)}\). Pragmatism has been referred to as the interface or bridge between philosophy and methods\(^\text{(116; 117)}\), shedding light on how findings from different data sources can be mixed fruitfully\(^\text{(116; 118)}\). In this study, these characteristics enabled the blending of different knowledge claims, enquiry strategies and research sources\(^\text{(105; 119)}\).

Mixed methods

Stemming from the pragmatic underpinnings, it became clear that mixed methods research was the most appropriate methodology for investigating the transitioning of acute care nurses to PHC settings. Mixed methods is broadly defined as “research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches”\(^\text{(120)(p.3)}\). It provides a more complete and comprehensive understanding of the area of research than any one method\(^\text{(111)}\):
and can highlight differences and similarities between aspects of a phenomenon. This approach has been widely used in health research due to the complexity of human behaviour and experiences. Mixed methods research draws on the strengths of both quantitative and qualitative approaches, as well as minimising the limitations of both. For example, ‘closed ended’ data gathered by quantitative methods such as the survey used in this study, has the advantage of being able to study large numbers of people over a short period of time, provides precise numerical data, and is considered relatively independent of researcher bias. A limitation of this approach, however, is that an in-depth understanding of a phenomenon from an individual perspective may be missed, and data may be too broad. In contrast, qualitative data gathered during semi-structured interviews is useful for studying issues in-depth and for describing complex contextual phenomena such as transition experiences. Limitations associated with this approach however, need to be considered such as generalising findings from individual interviews, concerns relating to credibility of data analysis techniques used by some quantitative researchers, and the time taken to gather and analyse the data. The results are also potentially subject to researcher bias.

In this study, the contrasts between acute care and PHC were expected to be complex, and the transitioning experience known to be multifaceted. It was considered unlikely that any individual data source would capture both the macro view of nurses transitioning to various PHC settings, and the micro view of individual nurses’ transitioning experiences to specific PHC employment. Selection of a mixed methods approach was therefore considered to add value
to the research by highlighting shortcomings in each of the individual methods and by compensating for them\(^{(126)}\).

Whilst the limitations of mixed methods research were taken into account, including the additional time required to gather two sets of data, and the skills required of the researcher to be competent in both methodologies, these were not considered barriers to using this approach\(^{(127)}\).

**Study design**

A sequential explanatory design was adopted, in which collection and analysis of the quantitative and qualitative data occurred in consecutive phases with one source of data building on the other\(^{(111)}\). This design has been widely reported as having application in social and behavioural sciences research, as the qualitative data helps to explain in more detail significant statistical findings from the quantitative data\(^{(111; 125; 128)}\). The sequential explanatory design was considered to have advantages which were relevant to this study. These include that it is considered methodologically straightforward\(^{(111)}\), and following exploration of quantitative results, provides the opportunity to further explore and expand upon results arising from the data\(^{(128)}\).

In this study analyses of the quantitative data gathered via a national survey provided a ‘world view’ understanding of the research problem. This was then refined by analysing qualitative data gathered during semi-structured interviews with purposively selected survey respondents\(^{(128)}\). During the analysis and interpretation phases the quantitative and qualitative data were given equal priority. This approach is illustrated in Figure 4.1.
CHAPTER 4: RESEARCH METHODS

Figure 4.1 Study Design
Adapted from Creswell et al.\textsuperscript{(125)}, Halcomb and Hickman\textsuperscript{(103)}, and Ivankova et al.\textsuperscript{(128)}.

The mixed methods approach was also mapped, showing how the sources of data addressed the study’s aims (Table 4.1)

Table 4.1 Map of Study Aims and Data Sources

<table>
<thead>
<tr>
<th>Aim</th>
<th>Phase 1 Survey</th>
<th>Phase 2 Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To explore why Australian RNs transition from employment in acute care to PHC settings.</td>
<td>Section 1: • demographic data including years in nursing / PHC, current role, location of practice</td>
<td>Question 1: • demographic information</td>
</tr>
<tr>
<td></td>
<td>Section 2: • reasons for transition</td>
<td>Question 2: • what influenced participants to move from acute care nursing to PHC?</td>
</tr>
<tr>
<td></td>
<td>Section 3: • free text data relating to why nurses transitioned</td>
<td></td>
</tr>
<tr>
<td>2. To describe the experiences of RNs who transition from acute care to PHC.</td>
<td>Section 2: • support during orientation</td>
<td>Questions 3 – 9: • descriptions of transition experience</td>
</tr>
<tr>
<td></td>
<td>• difficulties encountered during first weeks</td>
<td>• challenges experienced and strategies implemented</td>
</tr>
<tr>
<td></td>
<td>• most and least satisfying aspects of transition</td>
<td>• developing confidence</td>
</tr>
<tr>
<td></td>
<td>Section 3: • free text data related to orientation and supports</td>
<td>• descriptions of professional errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• how the transition could have been made easier</td>
</tr>
<tr>
<td>3. To explore RNs’ reflections on transitioning from acute care to PHC employment, and their future career intentions.</td>
<td>Section 2: • Current role and job satisfaction</td>
<td>Questions 10 -13: • reflections on moving to PHC</td>
</tr>
<tr>
<td></td>
<td>• future career intentions</td>
<td>• participants’ suggestions to employers for improving transitioning experiences</td>
</tr>
<tr>
<td></td>
<td>Section 3: • free text data related to positive and negative aspects of working in PHC</td>
<td>• future career intentions</td>
</tr>
</tbody>
</table>
Phase 1 - Survey (quantitative) phase

Survey method

An online descriptive survey was selected as the most appropriate method to gather quantitative data from RNs who had transitioned to various PHC settings within the last five years. Surveys are one of the oldest methods of data collection, with historical records indicating their use over 2,500 years ago by the Romans to conduct population censuses for the purpose of taxation and military service\(^{(129)}\). They provide a cost-effective means to elicit characteristics, beliefs and attitudes of large and small populations\(^{(129; 130; 131)}\), and are therefore ideally placed to explore the transitioning experiences of PHC nurses employed across a range of settings.

Improved access and familiarisation with the internet has led to increasing use of online surveys\(^{(132)}\), and are a convenient efficient way of accessing information from a defined population sample\(^{(133)}\). In Australia, nurses have increasingly embraced online communications, with the Nursing and Midwifery Board of Australia (NMBA) noting that annual online professional registration renewals jumped from 54% in 2010 to 98% in 2016\(^{(134)}\). There have also been many online nursing surveys circulated via professional nursing organisations as a means to gather data over the last decade. These have included surveys of the PHC nursing workforce\(^{(135; 136)}\), indicating that this form of accessing information is now a reliable means to gather data, and is familiar and accessible to the target group\(^{(137)}\).

Apart from convenience, online surveys have additional advantages which were relevant to this study. They may be anonymous, enabling feedback which may otherwise be withheld, are less costly than paper based surveys,
environmentally friendly, and more time efficient, particularly for geographically dispersed participants\(^{(129;131)}\). Links to the survey can easily be forwarded to other potential respondents, thus increasing participation in a diverse population such as the PHC nursing workforce surveyed in this study. Data entry by the researchers is not required and data can be continuously analysed during data collection\(^{(132)}\). This was of particular value in this study as it enabled ongoing analysis by the researcher as survey responses were received to inform areas where targeted recruitment was required. The availability of relatively accessible online survey software such as SurveyMonkey\(^{(138)}\) also increased the accessibility and feasibility of an online survey.

There are, however, some disadvantages in using online surveys to collect data. These include the lack of direct contact between the researcher and the participant, the time taken for respondents to complete surveys and the potential for fraudulent responses\(^{(139)}\). These disadvantages were considered of limited relevance in this study, as Australian nurses have willingly embraced similar workforce surveys, participation was voluntary, and the time taken to complete the survey was clearly articulated at the commencement of the survey. Accessibility to the internet or lack of computer skills has also been reported as impacting on response rates\(^{(132)}\). However, the PHC nursing workforce is required to routinely use computers in the workplace\(^{(140)}\), and has been shown to be responsive to online surveys previously\(^{(141)}\). As such, this limitation was considered unlikely to impact significantly on recruitment. There is also the potential for bias if surveys are purposefully circulated to select populations\(^{(142)}\). In this study this was avoided where possible by utilising snowballing techniques to recruit participants. Snowball sampling, which
consists of a series of referrals between likeminded individuals or groups who become ‘champions’ for the research\(^{143}\), was particularly useful for reaching those PHC nurses who were geographically and professionally isolated.

**Survey tool**

Despite an extensive review of the literature\(^{47}\), no tool was identified which specifically explored the nature of transitioning from acute to PHC nursing. The survey tool was therefore designed by drawing on validated tools used in new graduate transition studies\(^{144}\), studies of nurses’ career intentions\(^{145}; 146\), role transition studies in other settings\(^{86}; 107\) and previous PHC nursing surveys\(^{145}; 147; 148\). In planning the study, the appearance and layout were selected cognisant of evidence indicating that length, graphic appearance, comprehension of questions and ease of progression through the survey may all impact on the response and completion rate\(^{133}\). The design was also influenced by the capacity of the SurveyMonkey\(^{138}\) software to host the survey.

The final survey tool (Appendix C) included an information sheet which detailed the purpose of the research, ethical considerations and how to participate. This was followed by three distinct parts. Part 1 sought demographic information such as age, gender, level of education, years in nursing, professional experience, work location, and questions relating to the reasons why nurses moved to PHC employment. Part 2 asked questions relating to respondents’ transition experiences, barriers and facilitators to transition, and degrees of satisfaction with the new role. This part included modified questions from the Index of Work Satisfaction (IWS)\(^{149}\), which measures occupational satisfaction of health professionals both in institutional and non-institutional settings, and the Casey–Fink Graduate Nurse Experience
Survey\textsuperscript{(150)} which measures new graduate experiences in hospital settings. Questions also explored current work status and career intentions drawing on items from the Nurses’ Retention Index\textsuperscript{(145)}, which measures nurses’ intention of staying in their nursing job or leaving to find other work (career intentions). Part 3 comprised two open ended items relating to the positive and negative aspects of working in PHC compared with acute care nursing.

Closed questions in the survey were structured in various forms to promote responses. These included dichotomous (yes/no) responses; Likert scales; and the use of filter questions requiring respondents to answer only if they answered a previous question in a certain way. Open ended items were spread throughout the survey providing opportunities for respondents to explain their response and provide additional information.

After completing the survey tool, respondents were asked to provide their contact details should they wish to participate in a subsequent interview. At the end of the survey all participants were taken to a “thank you” page to acknowledge their participation.

\textit{Pilot testing}

The survey was pilot tested before being disseminated\textsuperscript{(130; 131)} in order to identify any problems with the survey design or structure. This was undertaken in two stages: first, a pre-test consisted of the draft questions being circulated to a purposefully selected sample of sixteen experienced PHC nurses and research experts. Feedback was requested regarding content, appropriateness of language, time required to complete, and ease of comprehension\textsuperscript{(131)}. The revised tool was then loaded onto the SurveyMonkey platform\textsuperscript{(138)} and the same
group were asked to complete the survey online and provide feedback including technical aspects of the survey and ease of navigation\(^{(131)}\). Feedback received related to clarifying the wording of some items, corrections of minor grammatical errors and the formatting of responses. This feedback was used to modify the items to improve clarity and presentation prior to final dissemination of the survey.

**Study setting**

This study took a broad national focus, with the intention of gaining insights into the experiences of RNs who transitioned from acute care employment to any PHC setting across Australia.

**Sample**

This study focussed on RNs who had previously worked in acute care and had transitioned to PHC employment within the last five years. RNs were identified as the target group as they comprise the largest proportion of the Australian PHC nursing workforce\(^{(151)}\). Australian RNs are baccalaureate educated, or equivalent. They have varying scopes of practice depending on their previous experience, competence and capacity, enabling them to be employed in a range of PHC roles and settings\(^{(152)}\). As newly graduated RNs have been identified as requiring unique support needs relating to their transition into the workplace\(^{(39; 54)}\), they were not included in this study. Additionally, diploma educated Enrolled Nurses (ENs), who are required to work under the direct or indirect supervision of an RN\(^{(153)}\), and Nurse Practitioners (NPs) who practice autonomously were excluded.
Since there is no accurate database of PHC nurses in Australia\((154)\), the numbers of nurses who met the inclusion criteria or indeed who were actually employed in PHC at the time of data collection was unknown. This precluded us from having a response denominator and calculating a true response rate. This issue has previously been cited as a limitation in the literature\((154)\).

**Recruitment**

Recruitment to surveys is generally recognised as being challenging\((154; 155)\). As well as being considered an intrusion into peoples’ lives, potential respondents are likely to be put off by surveys which require considerable time to complete or do not appear to provide relevant response options for the respondent\((131)\). Survey recruitment by nurse researchers has been identified as particularly difficult\((156)\), with some nurses reporting being over-burdened with repeated surveys\((155)\), lack of time, limited access to professionally circulated emails, and ‘gatekeeping’ by practice managers in general practices\((157)\). However, various strategies to improve response rates have been reported including making personal contact with potential participants\((158)\), and offering financial\((159)\) or other incentives\((160; 161)\). Whilst financial incentives were not offered in this study, as a professional incentive, nurses were encouraged to record their participation in the research in their professional portfolios as evidence towards meeting annual regulatory professional development requirements\((152)\).

Initially, the research was widely promoted by email through established professional networks, and through the personal contacts of the researcher. Information about the study was also distributed by national nursing organisations such as the ACN, APNA, ANMF and the Coalition of National Nursing and Midwifery Organisations to their members, and also circulated to
PHNs\(^{(9)}\) nationally. In order to ensure that as many of the target group were informed of the study as possible, snowballing techniques were used to reach difficult to access PHC nursing groups\(^{(129; 143)}\) such as those working in isolated roles in schools and industry. Other recruitment strategies included presentations at nursing and PHC conferences and professional meetings, as well as publication of articles about the study in nursing newsletters and journals. Social media was also utilised with information circulated via Facebook, Twitter and LinkedIn. All promotional material included a direct link to the survey tool.

### Data collection

The survey opened on 1 July 2015 and closed on 14 September 2015. Reminders were circulated via email to organisations and individuals at intervals after the launch of the survey and prior to closure to encourage participation.

### Data management

Survey data were exported directly from SurveyMonkey\(^{(138)}\) into SPSS Version 22\(^{(162)}\). Free text responses were subsequently imported into NVivo Version 10\(^{(163)}\). In order to ensure accuracy, cleaning and checking of all data was undertaken by the primary researcher and a research assistant, and checked by the principal supervisor. Surveys found to have missing demographic or transition experience data, or where data indicated the respondent did not meet the inclusion criteria, were removed prior to analysis.

### Data analysis

The quantitative data was subjected to a range of descriptive and inferential statistical analyses. Descriptive analysis was used to measure categorical
variables (including frequencies and percentages) and continuous variables (means, standard deviations and ranges). Relationships between variables were explored using the independent sample t-test and Pearson’s chi-square test. Examples included comparing demographic variables such as age and geographic location with factors influencing the decision to transition and difficulties experienced. Statistical significance was attributed to results where $p<0.05$.

Open ended responses were analysed using Braun and Clarke’s inductive thematic analysis approach. This approach was selected due to its flexibility in providing accessible and systematic procedures for generating codes and themes from qualitative data. Data were coded, re-coded and grouped into themes using NVivo Version 10. These themes were further strengthened and validated through discussions with other members of the research team. This method was similar to that used in the interview analysis and is described in further detail below.

**Validity and reliability**

Various approaches were incorporated into the design, navigation and operationalisation of the survey in order to ensure content validity and face validity. An extensive review of the literature, selection of role theory concepts, and discussions with nurse researchers and a statistician were utilised to ensure the survey measured the concepts under investigation, and was presented in an unambiguous clear format. The two stage process of pilot testing provided a final confirmation for content and face validity of the survey tool.
As the survey consisted of categorical items and was designed for information gathering rather than a tool developed for assessing different constructs, assessment of reliability using Cronbach’s alpha internal consistency reliability was considered inappropriate\(^{(139)}\). Instead, the process of testing and re-testing during the pilot phase assured reliability\(^{(164)}\).

**Phase 2 – Interview (qualitative) phase**

The qualitative phase commenced following completion of the survey data analysis, and comprised semi-structured interviews with a purposive sample of survey respondents. Interviews are frequently used to collect qualitative data, and contrast to quantitative approaches such as surveys. Interviewees become participants in the process of interpretation of the data, rather than a conduit from which information is retrieved when responding to surveys\(^{(168)}\).

In this study, semi-structured interviews were used as they provide a flexible and versatile approach for collecting data\(^{(113)}\) than a structured interview, and more control than a unstructured interview\(^{(169)}\). As in most semi-structured interviews, predetermined open ended questions were developed with prompts to assist in promoting dialogue between the interviewer and participant\(^{(168)}\). This approach enabled the researcher to participate in the discussion by structuring questions to reveal multidimensional streams of data, such as moving from fully open ended to theoretically driven questions\(^{(169)}\). Semi-structured interviewing also enables participants to raise their own questions and explore these further. This was of particular value in revealing personal aspects of the transition experience which had been forgotten, and reconstructing perceptions of events and experiences associated with the change in employment\(^{(168)}\). This also added to the richness of the data gathered\(^{(170)}\).
**Reciprocity**

Reciprocity, described as the ‘give and take’ of social interactions\(^{(169)}\), is an essential characteristic of qualitative research in order for the interviewer to fully engage with participants during the interview process\(^{(171)}\). By judicious use of self-disclosure, rich descriptive data may emerge from interviews which become conversations based on trustworthiness between the two parties\(^{(169)}\). In order to achieve reciprocity in this study, the researcher engaged with participants by self-disclosing her own professional nursing background\(^{(172)}\).

By achieving reciprocity with the interview participant the researcher was able to focus the conversation on issues of importance\(^{(113)}\), with the researcher acting as an ‘instrument’ using prompts, and re-phrasing questions according to the interview situation\(^{(169)}\). This approach enabled clarification of issues raised which was instrumental in adding meaning and depth to the data. Reciprocal engagement also enabled the researcher to engage in meaning generation from the stories described, seeking "below the surface" meanings from words and expressions used by the participant\(^{(169)}\).

**Interview process**

The purpose of the interviews was to explore and clarify meanings from the survey data\(^{(125)}\), and to elicit experiences from the interview participants to add additional dimensions to the survey data. The open ended questions and probing prompts (Appendix E) drew on findings from the literature review\(^{(47)}\) and preliminary survey findings\(^{(173)}\). Whilst the structure of the interviews were loosely organised around the research questions, there was considerable flexibility to enable participants to speak freely about their experiences. These strategies sought to assist participants in recalling their experiences of the
transition\(^{40}\). Following an initial “ice breaker” question to open the interview, subsequent questions were designed to be easy to understand and to respond to, non-threatening, yet probing enough to yield a rich body of data\(^{169}\).

**Sampling and recruitment**

Interview participants were selected by purposeful sampling from survey respondents who had indicated their willingness to be interviewed and had provided contact details. Purposeful sampling was used to enable the researcher to maximise variation in participant demographics\(^{174}\). To identify potential interview participants, the researcher developed a matrix including names and demographic factors such as employment setting, age, geographic location, and nursing experience. This matrix was then used to select potential participants who represented a cross section of these characteristics. Identified potential participants were then telephoned by the researcher to provide information about the interviews, confirm their willingness to participate, and to organise a mutually convenient time to conduct the interview. When an individual declined or was not contactable, an individual with similar demographic characteristics was contacted. Confirmed participants were emailed a study information sheet and a consent form (Appendix D) which they were asked to sign and return prior to the interview.

**Sample size**

The inductive nature of qualitative research requires sampling to be undertaken until data saturation is achieved\(^{170}\). How saturation is reached, however, is hotly debated by researchers who question whether the “richness” of the data or the “thickness” of the data is the critical point\(^{175; 176; 177}\). In this context, the richness of the data refers to the many layered, nuanced and detailed
information obtained in contrast to the quantity (or thickness) of data revealed\(^{176; 177; 178}\). It was planned for interviews to be conducted until data no longer provided new insights\(^{111}\). As the data was collected, rich new data enabled new codes to be identified until the eleventh interview. A further two interviews were undertaken to confirm saturation had been achieved.

**Data collection**

In this study, where participants were geographically dispersed and costs prohibited extensive travel\(^{179}\), telephone interviews proved a reliable and convenient alternative to face to face interviews. All but one interview, which was conducted face to face, were conducted by telephone. Whilst face to face interviews enable observation of body language and eye contact\(^{174}\), they can be time consuming and are likely to involve travel and associated expenses\(^{174}\). Telephone interviews enable conversations to occur simultaneously, although no visual observation of the participant can occur. This has been identified as a disadvantage, as intended meaning may be lost since the researcher is unable to observe non-verbal cues or body language. However, telephone interviews have many reported advantages, resulting in greater acceptability to participants and researchers\(^{113; 174}\). These include being less intrusive on time as they are generally shorter in duration resulting from the inability to visually interact with the participant\(^{179}\). They can also be perceived as less intrusive, as the interviewer is not visible, and are convenient for the participant in terms of avoiding the necessity to travel\(^{179}\). In addition, this method is cost-effective, and readily available, as almost everyone has access to a telephone\(^{113; 174}\).

Each interview in this study was preceded by the researcher outlining the interview process, and confirming agreement to record the interview. To
overcome the challenge of interviewing via the telephone the researcher introduced herself and shared her professional background as a nurse to assist in developing rapport. Participants were reminded that interviews could be paused or terminated at any time if they wished. Telephone participants were encouraged to locate themselves in a private, quiet location to minimise interruptions. The researcher conducted all telephone interviews from a private office, and the face to face interview was conducted in a suburban coffee lounge conveniently located for both the researcher and participant.

Following completion of the interviews, each participant was emailed a letter of thanks and acknowledgement of participation. This provided evidence of the participants’ contribution to the research, and could be included in their professional development portfolios. Participants were also subsequently sent emails with links to publications emanating from the study for their interest.

To incorporate participants’ availability the interviews extended over a ten week period from February to May 2016. Review of the transcriptions of the first two interviews led to minor modifications to the questions and additional prompts added to improve the flow of the discussion. A further eleven interviews were then conducted. All interviews were digitally audio-recorded and later professionally transcribed verbatim. The researcher also took field notes during and immediately after each interview in order to record personal reflections and nuances, and to highlight key points.

**Rigour**

Seminal work in developing criteria for ensuring quality in qualitative research has identified credibility, dependability, confirmability and transferability as
important strategies in determining rigour\(^{181; 182}\). In this study, credibility relating to the value and believability of the findings\(^{181}\) was assured by conducting the research in accordance with established interview processes used in previous mixed methods PHC nursing studies\(^{183; 184}\). Processes to ensure dependability of data included outlining decisions made throughout the research process, and providing an audit trail at each step of planning, conducting the interviews and analysis of data\(^{185}\). Confirmability, which is closely linked to dependability, is described as the neutrality and accuracy of the data\(^{185}\). It was essential to ensure accuracy when transcribing the interviews, and that the information recorded was true to its original intent – including ensuring punctuation was accurately recorded\(^{166}\). A professional transcription service provided verbatim transcriptions, which accurately reflected every word and nuance within the audio-recording, including ‘ums’ and ‘ahs’, repeated words, emotions, background noises and prompts\(^{186}\). These were checked for accuracy by the researcher, after which each transcript was given a unique identifier and imported into NVivo\(^{163}\). Basic survey demographic data was also linked to the unique identifier and considered in the analysis. The use of NVivo\(^{163}\) provided a record of codes, themes and sub-themes throughout the analysis process, ensuring an audit trail of decisions made\(^{163}\). This audit trail, as well as the use of the participants voice in the findings enables readers to assess the transferability of the findings to another context\(^{185}\).

**Data analysis**

Thematic analysis was used to analyse the interview data. Braun and Clarke\(^{166}\) argue that thematic analysis provides a flexible research approach which organises, and provides an insightful account of the data. Thematic analysis
can be used to explore themes and patterns across a data set to reflect reality\(^{(166)}\). Further, themes and patterns may be identified by taking either an inductive ("bottom up", grounded in the data) approach or a deductive ("top down" influenced by existing literature or theoretical perspectives) approach. In this study, whilst interview questions were developed from the literature review and survey data through the lens of role theory, the dominant approach to analysis was inductive, coding the data without trying to fit it into a pre-existing coding frame or preconceived themes.

**Table 4.2 Stages of thematic analysis**

Adapted from Braun and Clarke\(^{(166)}\)

<table>
<thead>
<tr>
<th>Steps</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1:</td>
<td>• Importing transcripts to NVivo(^{(163)})</td>
</tr>
<tr>
<td>Familiarisation with data</td>
<td>• Initial reading of transcripts and checking for accuracy using digital recordings and notes</td>
</tr>
<tr>
<td></td>
<td>• Re-checking, familiarisation, note taking</td>
</tr>
<tr>
<td>Step 2:</td>
<td>• Generation of descriptive and interpretative codes using NVivo(^{(163)}) nodes</td>
</tr>
<tr>
<td>Generating initial codes</td>
<td>• Ongoing generation and comparison of codes during interview phase</td>
</tr>
<tr>
<td></td>
<td>• Initial development of themes</td>
</tr>
<tr>
<td></td>
<td>• Development of concept map</td>
</tr>
<tr>
<td>Step 3:</td>
<td>• Consultation with supervisors who reviewed data set, and concept map independently</td>
</tr>
<tr>
<td>Searching for themes</td>
<td>• Revision of themes</td>
</tr>
<tr>
<td>Step 4:</td>
<td>• Continued revision of themes</td>
</tr>
<tr>
<td>Reviewing themes</td>
<td>• Classification of sub-themes</td>
</tr>
<tr>
<td></td>
<td>• Written description of each theme and sub-theme</td>
</tr>
<tr>
<td></td>
<td>• Selection of extracts to present each theme/sub-theme</td>
</tr>
<tr>
<td>Step 5:</td>
<td>• Findings and analyses reported in four results papers</td>
</tr>
<tr>
<td>Defining and naming themes</td>
<td></td>
</tr>
<tr>
<td>Step 6:</td>
<td></td>
</tr>
<tr>
<td>Final analysis and reporting</td>
<td></td>
</tr>
</tbody>
</table>
In order to ensure rigour and credibility in the data analysis process\textsuperscript{(187)} Braun and Clarke’s\textsuperscript{(166)} approach to thematic analysis was adopted (Table 4.2). The first step identified by Braun and Clarke\textsuperscript{(166)} describes the importance of familiarisation with the interview data. The familiarisation process commenced immediately following each interview. Field notes were reviewed against audio recordings, and transcripts were checked for accuracy. De-identified transcripts were exported into NVivo\textsuperscript{(163)}. The second and third steps described by Braun and Clarke\textsuperscript{(166)} consist of identifying early patterns and meanings, generating these into initial codes, and later into broader themes and sub-themes. In this study, data were aggregated into initial codes and groups as an ongoing process during the interview phase, building systematically on information gained as each interview was conducted. An initial concept map assisted in this process. Further refinement of these codes into broader themes took place as more data was analysed\textsuperscript{(188)}.

The process of reviewing the data set to ensure codes and themes are coherent and supported by the data is the fourth step described by Braun and Clarke\textsuperscript{(166)}. The researcher consulted extensively with the supervisors as an additional strategy for ensuring credibility in the analysis. Further refinement of the themes, and the development of sub-themes took place, reflecting Braun and Clarke’s\textsuperscript{(166)} fifth step. These were accompanied by a written analysis and selection of verbatim extracts of the participants’ voice to support the narrative.

The concluding step described by Braun and Clarke\textsuperscript{(166)} is the final reporting process which includes drawing on extracts and examples from the data to add to the merit and validity of the analysis. As can be seen in the subsequent findings papers, verbatim quotations have been used to illustrate key themes.
Integration
The process of data integration in a mixed methods study involves synthesising the two different paradigms to gain a deeper understanding of the research phenomenon, without compromising the unique nature of each paradigm\(^{189}\).

Selection of a procedure for ‘mixing’ the quantitative and qualitative aspects of the data in this study has drawn on Creswell’s\(^{111}\) ‘connection’ model of integration where the findings from one data set are used to reveal further information in the second data set. This aligns with the selection of a sequential study design.

Integration commenced at the research conceptualisation stage, where the literature review revealed factors relating to role theory which guided the decision to select a mixed methods approach for exploring the research questions. In this study, data gathered from the quantitative survey identified aspects which required further in depth exploration in the subsequent semi-structured interviews. Interviews did not commence until initial analysis of quantitative data had been completed and initial codes and themes had been identified from the open ended survey questions. These data informed the questions asked in the interviews. Demographic data obtained from the quantitative analysis also informed the selection of interview participants. The final stage of integration involved merging the two data sources into a combined dataset\(^{189}\). From this data set a more sophisticated response to the research questions evolved than would have been possible from either the quantitative or qualitative data in isolation.

Different methods, should, in theory yield comparable results in relation to the same topic and the same research setting\(^{142}\). However, as noted by others\(^{190}\):
191), data contradictions can and did occur in our study. This required further analysis by introducing probing overarching questions during interviews to explore the complexities of the findings from the survey. Inconsistencies in interpretation of data between the two sources were also discussed with the supervisors in order to ensure different perspectives were reflected during the refining of themes and sub-themes from both data sets.

**Ethical considerations**

**Ethical approval**

Approval to undertake the study was granted by the University of Wollongong and the Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee (HREC) in May 2015 (approval number HE15/179) (Appendix A). The study was conducted in accordance with national and international standards of research integrity, respect and beneficence.

**Consent**

The information provided at the start of the survey explained the study purpose and what was required of participants. It was also explained that participation was voluntary, and that consent was implied by completing the survey (Appendix D). Participants were also invited to provide contact details if they were willing to be interviewed. Those who agreed to be interviewed were provided with an information sheet and consent form (Appendix D) prior to the interviews. The consent form was returned to the researcher before the interview. Prior to commencing interviews each participant was further advised about the study and given an opportunity to ask questions. Participants were provided with contact details of the researcher if further information was required.
**Beneficence**

Closely aligned with reciprocity is the concept of ethical research\(^{(181)}\), where studies are carried out respectfully, and with honesty and empathy, acknowledging the collaborative connection between the researcher and participant\(^{(194)}\). In this study, as well as demonstrating respect and reciprocity, ethical dimensions of the qualitative research included explicitly informing participants about processes and procedures associated with the interview and the broader study.

As an additional ethical consideration, the researcher considered participants’ welfare during the interview process\(^{(194)}\). Whilst the risks of harm or discomfort were considered minimal and unlikely to be more than would be felt discussing professional issues with colleagues, information was provided about how to seek support if required (Appendix D). As most interviews were not conducted face to face, this included providing instruction about accessing national 24 hour counselling help lines. As a risk management strategy, the researcher also reiterated prior to commencing the interview that it could be ceased at any time if participants became distressed. Contact details were provided if participants wished to voice any concerns about the study, including how to contact the HREC.

**Confidentiality**

Survey participation was anonymous and voluntary. However, information was provided which explained that if respondents were willing to be contacted for the second part of the study, their personal contact details would be required.

Completion of that section implied consent for the sole purpose of being contacted by the researcher to take part in an interview. These contact details
and basic demographics were immediately removed from the larger survey dataset. All interview participants were reassured that information they provided was confidential. Any potential identifiers were removed from transcripts (for example, names, location, place of work), and each individual participant was allocated a pseudonym to protect their identity in publications, presentations and reports. Only the research team had access to de-identified data and transcripts.

**Data storage**

All data emanating from the survey and interviews were stored electronically on the researcher's laptop using password encrypted security, and were backed up on the University of Wollongong’s secure network. Any hardcopy study documents were stored in a locked filing cabinet where they will remain for five years following the publication of results\(^{(192)}\).

**Conclusion**

This chapter has provided a description of the design and methods utilised in the quantitative and qualitative phases of the study. As well as providing justification for selecting a mixed methods approach, the chapter describes the process of undertaking the survey, selection of interview participants, ethical considerations and conduct of the interviews. Management of the data, methods for ensuring rigour during data collection and analysis, and a description of how the findings from the two data sources were integrated are presented. Finally, ethical considerations of the study have been discussed.
Chapter 5: Reasons for transitioning

“What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from”.

T.S. Eliot\(^{(195)}\).
Chapter introduction

In this chapter findings from both the survey and interviews regarding why participants chose to transition to PHC are presented within Paper 3.

Permission to include this publication in the thesis has been granted by Elsevier Ltd.


Abstract

**Aim:** To explore why Australian acute care RNs transition to PHC employment.

**Background:** PHC models of service delivery are recognised internationally as pivotal in meeting increases in chronic and complex conditions. One approach to meeting demands for PHC nurses is to employ acute care nurses. Transitioning into new areas of practice is stressful and may impact on recruitment and retention strategies. Understanding what attracts acute care nurses to PHC will inform future workforce planning.

**Design:** A sequential explanatory mixed methods study using the theoretical framework of role theory.

**Method:** Phase 1 consisted of a survey of RNs who had recently transitioned from acute to PHC settings. Descriptive statistics were used to describe data, whilst relationships between variables were explored using Pearson’s Chi-square test. Semi-structured interviews were conducted with a purposeful sample of survey respondents (Phase 2). Interviews were transcribed and analysed using thematic analysis.
**Results:** One hundred and eleven respondents completed the survey, and thirteen interviews were conducted. Responses indicated that improved work/life balance, family-friendly work hours, increased work satisfaction and autonomy were the most important factors influencing decisions to transition.

Interview participants stated PHC models of care, better work/life balance, feeling unsupported and the physical demands of acute nursing as reasons for transitioning.

**Conclusions:** This study has revealed important information relating to why acute care nurses transition to PHC. This information will provide guidance to employers/managers seeking to recruit and retain experienced RNs in PHC settings.

**Background**

The ageing population and increases in chronic conditions have led to a re-evaluation internationally of how and where healthcare is best accessed and delivered\(^{57}\). PHC models of service delivery are recognised as pivotal in providing a cost effective and accessible approach to care provision as well as promoting the continuity of care between acute health services and the community. Whilst nurses meet the health needs of people in all settings and throughout the lifespan\(^{196}\), rising demand has necessitated an increase in the size of the PHC nursing workforce internationally. A review of the Australian nursing workforce found that almost ten percent of nurses identified themselves as working in PHC settings, including general practice, schools, refugee health, correctional settings, community health centres and remote communities\(^{197}\). This represented a fivefold increase in Australian PHC nurses over the last
decade\textsuperscript{(154)}. Similarly, studies from North America\textsuperscript{(198; 199)} and Europe\textsuperscript{(200)} have also identified increasing numbers of nurses recruited to PHC in the same timeframe.

Recruiting and retaining nurses across clinical settings remains challenging within the developed world due to workforce shortages, maldistribution of human resources and the ageing nursing population\textsuperscript{(201)}. Employers in large government funded or private acute health services use a range of recruitment strategies to entice nurses, including career advancement opportunities, attractive salary packages and flexible working arrangements\textsuperscript{(202)}. To attract nurses to PHC, however, different strategies are likely to be required, as many PHC employers operate as small businesses or non-government agencies.

Nursing in PHC settings has not generally been viewed as a positive career move, with previous studies reporting negative aspects associated with nursing in PHC and their influence on job satisfaction\textsuperscript{(184)}. These include perceived skill loss, poor wages, and sub-optimal professional opportunities compared with acute care roles\textsuperscript{(154; 203)}. There is also limited literature which specifically explores the reasons why nurses disengage from often long held acute care roles to transition to PHC employment\textsuperscript{(47)}. It is timely, therefore, to develop an evidence base relating to the process of transition from acute to PHC employment to inform future recruitment strategies and transition support programs.

**Aim of the study**

To explore why Australian RNs transition from employment in acute care to PHC settings.
Design

Role theory was selected as the theoretical framework to inform the research design, since the theory has been empirically validated and widely used in workplace studies\(^{29}\). The theory consists of several interrelated concepts which are relevant to the transition experience, as they suggest how individuals are likely to react in certain circumstances. Concepts of relevance in the transitioning of nurses from acute to PHC employment include the processes of role exit (leaving the “old role”) and role entry, role ambiguity, role conflict and “rites of passage”\(^{29; 48}\). Due to the complexity of the transition process, a sequential explanatory mixed methods design was adopted\(^{204}\) as this was considered the most appropriate approach to capturing both the macro and micro aspects of transitioning. The design consisted of a national survey (Phase 1), followed by a series of semi-structured interviews with a sub-group of survey respondents to further explore the quantitative results (Phase 2).

Given the large amount of data generated, this paper reports on a subset of the data. The remaining aspects of the data focus on the reflections and transitioning experiences of study participants, and are discussed elsewhere\(^{173; 205}\).

Sample

Survey respondents were RNs who had previously worked in acute care settings and had transitioned into PHC employment within the last five years. In Australia. An RN is a baccalaureate prepared, or equivalent, individual who has satisfied the requirements of the NMBA\(^{206}\). RNs were specifically selected as they represent the largest proportion of the Australian nursing workforce\(^{206}\).
The difficulties of undertaking research within the PHC nursing workforce have been widely reported and, in Australia, particularly relate to the lack of a national register of nurses working within PHC and the diverse settings in which they work\(^{154; 207; 208}\). Therefore, a multifaceted approach to survey recruitment was employed, combining snowball and convenience sampling. Emails containing an electronic link to the survey were disseminated via relevant professional nursing organisations, PHC networks and key stakeholders. Individual nurses who expressed an interest were also sent the email, and the survey was widely promoted through social media outlets (Facebook, LinkedIn).

Survey respondents were asked to provide their contact details if they were willing to participate in the interviews. Individuals were purposefully selected for interview based on their PHC roles, geographic location, age and years of nursing experience.

**Survey tool**

Despite an extensive review of the literature, no existing validated tool was identified which adequately addressed the research question. A survey tool was therefore developed based on a critical literature review of both transition and role theory, and by seeking expert opinion. The survey consisted of forty items divided into three sections. Each question was designed by drawing specifically on those concepts of role theory which are relevant to the transitioning experience. These are described elsewhere\(^{48}\).

Section one consisted of twenty-six items exploring respondents’ demographics, acute care experience and reasons for moving to PHC. Section two explored how nurses were orientated to their new roles, support systems
provided, barriers and facilitators to transition, and satisfaction with their new role. Section three included questions relating to current status and career intentions. Findings from Section One are described in this paper.

The survey, which was hosted by Survey Monkey\(^{138}\), was open for two months between July and September 2015. Reminders were disseminated after one month, and again one week before survey closure.

**Interviews**

Semi-structured interviews were conducted with survey respondents until data saturation was achieved\(^{175}\). Due to time, distance, cost and participant availability factors, most interviews were conducted by telephone, with one carried out face to face. Interviews were digitally audio-recorded and professionally transcribed verbatim.

**Ethical considerations**

Approval for the study was granted by the University HREC prior to commencing data collection (Approval no. HE15/179). All data was de-identified prior to publication and interview participants were allocated pseudonyms to protect their identity and to maintain confidentiality.

**Data analysis**

Survey data were downloaded into SPSS Version 22\(^{162}\). Descriptive statistics were used to describe the data. Relationships between variables were explored using Pearson’s Chi-square test\(^{164}\). Statistical significance was attributed to results where \( p<0.05 \)\(^{164}\). Responses to open ended items were separated from the main data set and downloaded into NVivo\(^{TM}\) Version 10\(^{163}\). Data were coded by two researchers using a process of thematic analysis\(^{166}\). Interview
transcripts were also imported into NVivo™ Version 10\(^{(163)}\). Whilst inductive thematic analysis predominated utilising Braun and Clark’s\(^{(166)}\) six-phase open coding process, the theoretical construct of role theory was used to undertake limited deductive analysis.

**Integration of data**

The quantitative and qualitative data collected in this sequentially designed study were integrated at several stages. Integration took place by analysing the survey data from Phase 1, and using findings to inform the interview questions and identification of participants for Phase 2\(^{(204)}\). Integration of findings from both phases enabled a deeper understanding of the phenomena which occurred before, during and after the transition of RNs from acute care roles to PHC\(^{(204)}\).

**Results**

**Survey respondents**

One hundred and seventy one survey responses were received and of these one hundred and eleven (64.9%) provided both demographic and response data and so were included in the analysis. Whilst it is not possible to calculate a response denominator, as the number of potential respondents is unknown, this sample size is consistent with other recent surveys of Australian PHC nurses\(^{(137}; 154)\).

The majority of respondents were female (n=106, 96.4%) and aged between 40–59 years (n=74, 66.6%, mean 45 years) (Table 5.1). Just over half of the participants worked in city / metro areas (n=67; 60.9%).
### Table 5.1 Survey respondent demographics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (yrs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23-29</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>30-39</td>
<td>18</td>
<td>16.2</td>
</tr>
<tr>
<td>40-49</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>50-59</td>
<td>35</td>
<td>31.5</td>
</tr>
<tr>
<td>60-67</td>
<td>9</td>
<td>8.1</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>106</td>
<td>96.4</td>
</tr>
<tr>
<td><strong>Years worked as an RN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean: 18.9 SD: 11.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Years in PHC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean: 3.6 SD: 3.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHC location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/metro</td>
<td>67</td>
<td>60.9</td>
</tr>
<tr>
<td>Rural</td>
<td>26</td>
<td>23.6</td>
</tr>
<tr>
<td>Remote</td>
<td>17</td>
<td>15.5</td>
</tr>
<tr>
<td><strong>Previous acute experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical wards</td>
<td>23</td>
<td>20.9</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>17</td>
<td>15.5</td>
</tr>
<tr>
<td>Maternity</td>
<td>16</td>
<td>14.5</td>
</tr>
<tr>
<td>Other</td>
<td>42</td>
<td>38.2</td>
</tr>
</tbody>
</table>

Most respondents were employed in general practice (n=71, 64.5%), with others (n=39, 35.5%) working in settings including community health, community based palliative care services, maternal and child health, schools, correctional centres, sexual health services, Aboriginal and Torres Strait Islander health services, primary health networks, workplace health services and refugee health.

**Interview participants**

Thirteen survey respondents participated in the interviews. Interview participants ranged in age from 23–62 years (mean 48.2 years), and worked in various PHC settings, including general practice (n=6, 46.1%), school nursing
(n=3, 23.0%), and one each from refugee health, community health, sexual health and remote area mental health. There was considerable diversity in the years of experience as a RN prior to moving to PHC, with participants having from 12 months (n=3, 23.0%) to over 30 years (n=5, 38.4%) experience.

**Reasons for transitioning to PHC**

**Survey responses**

Survey respondents rated the importance of 12 factors relating to their decision to transition, using a 5-point Likert scale (1 ‘unimportant’ to 5 ‘very important’). Balancing life and responsibilities (n=105, 95.4%), improved work hours which suited personal lifestyles (n=102, 93.6%) and the opportunity to increase work satisfaction (n=102, 93.6%) were the most important factors affecting their decision to transition to PHC (Table 5.2). In response to the open ended question, respondents stated:

> “Enjoyed my private hospital job but PHC job fits in better with family. I hated shift work”

> “My current role is far more satisfying, gratifying and much less stressful than my role in acute care. The work/life balance is also much better now and my workplace is very flexible and supportive…a far cry from the operating theatres…”

For some moving to PHC employment was unplanned but beneficial:

> “It was a job I stumbled upon and never really sought out. However, it fits perfectly with my family with young children”.
Table 5.2 Factors influencing the decision to move to PHC

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mod. important to Very important</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Balancing my life and work responsibilities</td>
<td>105</td>
<td>95.4</td>
</tr>
<tr>
<td>Improved working hours that suited my lifestyle</td>
<td>102</td>
<td>93.6</td>
</tr>
<tr>
<td>Opportunity to increase work satisfaction</td>
<td>102</td>
<td>93.6</td>
</tr>
<tr>
<td>To stop working shift work</td>
<td>91</td>
<td>82.0</td>
</tr>
<tr>
<td>The autonomous nature of the work</td>
<td>85</td>
<td>77.3</td>
</tr>
<tr>
<td>Wanted a change from the acute sector</td>
<td>78</td>
<td>70.9</td>
</tr>
<tr>
<td>To pursue my interest in PHC</td>
<td>71</td>
<td>66.3</td>
</tr>
<tr>
<td>Consolidating my nursing/midwifery knowledge</td>
<td>66</td>
<td>62.3</td>
</tr>
<tr>
<td>Opportunity to advance my nursing career</td>
<td>67</td>
<td>59.0</td>
</tr>
<tr>
<td>The salary and employment benefits</td>
<td>62</td>
<td>56.3</td>
</tr>
<tr>
<td>The location was closer to home</td>
<td>48</td>
<td>43.6</td>
</tr>
<tr>
<td>Was the first employment opportunity that came up</td>
<td>32</td>
<td>29.1</td>
</tr>
</tbody>
</table>

Many respondents (n=85; 77.0%) also described the autonomous nature of PHC nursing as a factor in changing employment:

“*The diversity of the PHC role, the autonomy. Never looked back*”.

“*Much greater accountability and autonomy in PHC than in the hospital environment*”.

Salary and employment conditions (n=62, 56.3%), location of the work closer to home (n=48, 43.6%) and being the first job opportunity that arose (n=32, 29.1%) were identified as the least important factors influencing the decision to seek PHC employment.

Application of the Chi-square test for independence indicated that there was no significant association between age and the factors influencing the decision to move to PHC (p>0.05), or in relation to choice of PHC employment. However,
respondents with less than 15 years acute care experience were more likely to report that stopping shift work was an important or very important factor in their decision (p=0.02). Chi-square testing for independence also indicated that balancing life and work responsibilities was more likely to be rated as moderately or very important amongst respondents working in metro or city settings (p=0.04).

**Interview findings**

Supporting the survey findings, interview participants cited both personal and professional reasons for moving to PHC. Only three interview participants reported having specifically planned a career in PHC, with the others describing “falling into” PHC employment:

“I didn’t necessarily want to leave the acute field. For me it was more that this opportunity presented itself……” (Vanessa, remote area mental health nurse).

Exposure to PHC settings through education, clinical placement or casual work prompted some participants to make the move into PHC. These experiences were described as triggers which had created an interest to move to a PHC setting:

“I did my elective in my bachelors in PHC. So I thought it was just an interesting topic that [I] don’t know much about. This opportunity came along and I thought perfect, it combines everything” (Alex, general practice nurse).

“I was doing my Masters in Public Health working casually at a women’s clinic. I was quite interested in HIV when I was working
in intensive care. Well, I made a decision to do it [move to PHC]...

(Mieken, sexual health nurse).

“I fell into it...I mean I knew about it [school nursing] but I didn’t know much… the employment agency asked me to do a few shifts...” (Margaret, school nurse).

Others identified that PHC employment fitted with their professional goals:

“I was probably always geared towards PHC, but...it seemed to be a pathway [to PHC] through ICU” (Sue, refugee health nurse).

For some participants, however, it was a combination of factors which resulted in their decision to transition from acute care nursing to PHC employment:

“I decided that I would try practice nursing because I felt that it was local, the hours suited me, it seemed a combination of all my professional experience, and I could still work with all ages from babies through to the elderly” (Natalie, general practice nurse).

Personal reasons beyond age alone were also cited by participants as motivators to transition to new employment. For Francine, a trigger to move related to feeling unsupported by her employer:

“[I] required surgery and I was working in the operating theatres which is an incredibly unforgiving environment...management [were] incredibly unsupportive, so I was off work for three months. I just happened to see a job for the position I’m in now and applied and haven’t looked back since. ..I’d never thought of general practice” (Francine, general practice nurse).
CHAPTER 5: REASONS FOR TRANSITIONING

An older nurse, Liz, described the physical demands associated with acute care employment, and how PHC nursing provided a way of continuing to nurse:

“Shift work and ward work is really quite harrowing on the body especially when you’re not a young thing...a rotating roster is hell, as I’m sure all nurses know.....with a heavy heart I left the ward and transitioned into PHC for the purpose of continuing to earn a living and of course continue to hopefully have contact with nursing” (Liz, general practice nurse).

Moving to PHC also provided an escape from the stress of acute care nursing for some participants:

“Where I am now...they’re not acutely ill. So I am really out of that stress situation. I don’t come home from work and worry and worry. I don’t have nightmares about it...” (Margaret, school nurse).

“The trepidation for me [in] ICU was the bells, the whistles, the technology – it’s a very high pressured stressed environment...life and death. This role [refugee health], it can get stressful...but it’s a gentler stress, because generally most people are well. It’s a positive environment” (Sue, refugee health).

For others, like Suzanne, PHC nursing was a stepping stone to retirement after a long career:

“I was the director of nursing ...I was associated with them [previous employer] for 25 years. So I saw this...as my semi-retirement role” (Suzanne, school nurse).
However, for participants with young families, PHC nursing provided an improved work/life balance:

“I’ve got young children. Shift work over a period of time, [working] a lot of night shifts, I was doing weekend work missing out on children’s sporting activities and so forth….” (Barb, school nurse).

Even potential disincentives such as lower salaries were overlooked in favour of the benefits of a better work/life balance:

“School nurses I don’t consider are paid particularly well…Look, it doesn’t worry me. I’m happy with what I’m doing” (Suzanne, school nurse).

Discussion

Findings from our study provide insight into the reasons influencing nurses to transition from acute care nursing to PHC employment. The interrelatedness of professional and personal factors support explanations for role transitions cited by Ashforth\(^\text{(29)}\) and Curtis et al.\(^\text{(203)}\), who identified that the situational relevance of roles influenced how and why new positions were selected. Consistent with other research into the PHC workforce\(^\text{(24; 154)}\), our study identified that survey respondents were older than the Australian nursing workforce national average\(^\text{(206)}\). As discussed by Norman et al.\(^\text{(209)}\) and Duffield et al.\(^\text{(210)}\), this finding has implications for the PHC sector by providing a pool of experienced acute care nurses who may otherwise leave the profession. However, it also has consequences for future skill mix in the PHC workforce as older nurses are likely have shorter career spans than their younger peers. This highlights future potential shortfalls in the PHC workforce at a time when demands are
increasing for skilled nurses to work in PHC. In order to ensure a sustainable workforce, it becomes clear that efforts must be made to attract younger nurses to consider careers in PHC. In particular, the physical demands of shift work, long hours, and emotional stresses associated with acute care nursing were all cited by participants as prompting the decision to move from that environment. This supports previous findings that workplace physical and emotional stresses have generational characteristics which affect job satisfaction and career planning\(^{(211; 212)}\). Staff turnover in acute settings has also been associated with the stresses of “compassion fatigue”\(^{(213; 214)}\) as described by participants in our study.

Of all the personal reasons cited for moving to PHC, family friendly work arrangements and balancing work and home life were identified as the most important. Our findings are congruent with previous literature which identified these factors as major contributors to job satisfaction\(^{(47; 203)}\). Balancing personal life and work responsibilities was also found in our study to be significantly more important for those living in urban/metro settings. This is consistent with Kulig et al.’s\(^{(215)}\) exploration of nurses’ job satisfaction across rural and urban settings, which concluded that nurses from rural communities were more satisfied with their work life arrangements than their urban colleagues. It also supports findings that whilst rural nurses may have little separation between their personal and professional lives, small community living creates a sense of belonging, informal networks play a role in providing professional support, and rural nurses demonstrate greater self-efficacy than those in urban settings\(^{(216)}\). These are important considerations for employers when developing location specific recruitment and retention strategies.
Some participants indicated that they had little idea about the PHC role for which they were applying. This is consistent with previous studies of pre-registration nurses, who acknowledged little or no understanding of PHC nursing or models of care\textsuperscript{(217)}. The lack of awareness of PHC career opportunities suggests that, in order to attract nurses to PHC settings, strategies need to be implemented to raise awareness of this area of clinical practice. Whilst the professional practice standards for PHC nurses in both Australia\textsuperscript{(183)} and the UK\textsuperscript{(218)} identify the importance of PHC nurses advocating for and promoting their role, this will take some time to be fully realised. By contrast, most interview participants who purposefully selected PHC employment, made their decision following previous exposure to a PHC environment. The positive impact of exposure to PHC in guiding career paths was also reported in McInnes et al.'s\textsuperscript{(217)} study of pre-registration nurses undertaking clinical placement in PHC settings. This finding highlights the importance of promoting the positive aspects of PHC nursing, and the inclusion of PHC experiences in both undergraduate and postgraduate nursing education.

Despite the literature which has linked poor remuneration with low levels of job satisfaction\textsuperscript{(47; 148)}, in our study participants indicated that salary and employment conditions were of low importance in influencing their decision to transition. A possible explanation may relate to findings from other disciplines that work values shift over the life course, and that generational differences account for differences in attitudes to work/life balance and salary and conditions\textsuperscript{(219; 220; 221)}. 
CHAPTER 5: REASONS FOR TRANSITIONING

Limitations

This study has some limitations. The lack of a national database of PHC nurses\(^{(154)}\) or accurate data relating to nurses who transition from acute care settings to PHC means that it is not possible to calculate a response rate. However, recruitment methods used were similar to other national surveys of the Australian PHC nursing workforce\(^{(137; 154)}\). Whilst efforts were made to recruit RNs working in a range of PHC settings, respondents were not spread across all of these, and numbers were small in some PHC settings. This may limit the generalisability across all areas of PHC nursing. The lack of differences in this study relating to age, which contrasts with other studies where generational effects have been shown, may be related to the sample size of the study. This warrants investigation in future research, particularly given the small sample sizes in the younger and older age groups.

An additional limitation of this study was that survey data were based on reflective self-report, rather than from longitudinal data collection. Therefore, findings may be subject to bias or inaccurate recollection of the transition experience.

Conclusion

This study has provided an insight into the reasons why nurses transition from acute to PHC employment. It highlights the value placed on family friendly working conditions, the attraction of working autonomously and the positive impact that prior education and clinical experiences in PHC may have in influencing nurses to transition to PHC employment. Armed with this knowledge, the role of PHC nurses can be better promoted as a satisfying area of professional practice. Our findings will assist in workforce planning and the
development of recruitment and retention strategies, by providing evidence about what attracts experienced RNs from acute care nursing into PHC. Our findings are also of significance for policy makers seeking long term solutions to increase and retain the PHC workforce, and for educators in the design and delivery of programs focused on PHC models of care.
Chapter 6: Orientating to PHC

“Tell me and I forget. Teach me and I remember. Involve me and I learn”.

Xun Kuang(222).
Chapter introduction
In this chapter, paper 4 describes survey findings relating to how nurses were orientated to their new roles in PHC, and the supports that assisted them to adjust to the new work environment. Permission to include this publication in the thesis has been granted by the publisher, John Wiley and Sons.


Abstract

**Aim:** To describe the experiences of RNs who transition from acute to PHC employment.

**Background:** Internationally the provision of health care in PHC settings is increasing. Nurses are moving from acute care employment to meet the growing demand for a PHC workforce. However, little is known about the transition experiences of these nurses.

**Design:** A sequential mixed methods study comprising a survey and semi-structured interviews. This paper reports on survey findings relating to the transition experience.

**Methods:** Convenience and snowballing techniques were used to recruit one hundred and eleven RNs who had transitioned from Australian acute settings to PHC employment within the last 5 years. An online survey gathered data relating to personal and professional demographics, type of PHC setting and transition experiences.
**Results:** Most respondents (n=90, 81.1%) reported receiving some orientation, although the length and content varied considerably. Those working in metropolitan locations were more likely to report concerns associated with their orientation, with respondents from rural or remote locations more likely to have access to a preceptor than city/metropolitan respondents. Just under half of respondents found prioritising workload (n=47; 42.7%) or organisational knowledge (n=45; 40.9%) difficult or very difficult, and 47.7% (n=53) felt isolated or unsupported. Almost half (n=55, 49.5%) reported being overwhelmed with their new role, either sometimes or regularly. Barriers to transitioning successfully included limited employer support to attend professional development activities.

**Conclusions:** Availability of specific support measures may assist in the transition process. Findings from our study should be considered by employers when recruiting nurses new to PHC, and when designing orientation and ongoing education programs.

**Relevance to clinical practice:** This study highlights the challenges faced by nurses who transition from acute care into PHC employment. Understanding the barriers and facilitators to successful transitions enhances the process for future recruitment and retention of PHC nurses. This evidence can inform managers, educators and policy makers in developing support programs for nurses moving into PHC.
CHAPTER 6: ORIENTATING TO PHC

Introduction

Health care provision in PHC settings has been rapidly evolving over the last decade in order to meet the needs of an ageing population and increases in the prevalence of chronic conditions\(^{(196; 223)}\). In Australia approximately 90% of the population seek PHC services annually\(^{(224)}\), and 35% have a chronic condition requiring multiple visits to a doctor during the course of a year\(^{(223; 225)}\). Reforms have included placing an increased focus on the integration of health care service provision between health providers, and between tertiary and PHC settings\(^{(226)}\).

Associated with the expansion of PHC services has been a growing demand for a skilled nursing workforce to fill new roles in PHC settings\(^{(227)}\). PHC nurses provide care in general practices, community health, schools, correctional facilities, remote indigenous communities, and numerous other settings\(^{(228; 229)}\). However, PHC nursing has traditionally suffered as a career choice by being associated with lower remuneration than acute care nursing, often perceived as a ‘pre-retirement’ choice and lacking the professional challenges of acute care nursing\(^{(140)}\). In order to increase recruitment and retention of nurses in PHC, professional organisations, PHC groups and education providers in Australia offer various programs and support systems to assist nurses to transition into these settings\(^{(230; 231)}\). There is, however, limited research investigating the experiences of nurses who have transitioned from acute to PHC nursing employment and exploration of what has assisted or hindered this transition\(^{(47)}\).

Background

In line with international trends, the Australian PHC nursing workforce has increased significantly over the last decade\(^{(154)}\). There is also evidence that
many nurses are transitioning from acute care settings to PHC to meet the growing workforce needs\(^{(197)}\). This move requires changing from acute care roles focused on acute and episodic care, to PHC models of care centred on the ongoing care of individuals and families within a community setting. Such PHC roles require both the acquisition of new clinical skill sets, and adjusting to different and often complex work environments\(^{(47)}\). For example, while acute hospitals are often highly regulated and operate under a hierarchical medical model, Australian general practices are frequently small businesses in which the general practitioner has the dual role of clinician and owner\(^{(157)}\).

International literature suggests that workforce re-configuration and the interaction between macro-level influences (for example, government policy) and micro level practice (such as adaption to new professional roles), require a range of factors to ensure the successful transition from old roles to new\(^{(232)}\). Experiences during the early transition period are also recognised as critical in shaping an understanding of any new role\(^{(46)}\). The process of transitioning has been reported as stressful, and associated with a lack of confidence, role ambiguity and role conflict as the requirements of the new role become clear\(^{(233; 234)}\). These phases may be followed by periods of readjustment as workers ‘unfreeze’ from the old role and acquire the skills and confidence needed to fulfil their new role\(^{(26; 29; 48)}\). The association between these phases of transition and the impact they may have on job satisfaction, patient/client safety and retention in the workforce have not been widely researched in the PHC sector\(^{(48)}\). However, evidence from other sources, in particular new graduate nurses entering the workforce, suggests that negative transitioning experiences have
been associated with increased staff turnover\textsuperscript{[233; 235]} and patient safety concerns\textsuperscript{[54; 59; 236]}. 

As acute care nurses are likely to continue to move into PHC employment in order to meet growing shortages of nurses and increasing demand for a skilled workforce, an understanding of the challenges associated with the transition is essential. This evidence base will inform nurses, managers and employers how to optimise transitioning experiences, and assist policy makers planning long term solutions to workforce shortages.

**The Study**

**Aim**

This paper describes the experiences of RNs who transition from acute care to PHC employment.

**Methods**

The lack of available data relating broadly to transitioning of nurses to PHC settings and specifically to individual nurses’ transitioning experiences has been previously described\textsuperscript{[47]}. A mixed methods sequential design was therefore selected to capture both macro and micro aspects of the transitioning experience. Role theory was adopted as a theoretical lens to explore the transition\textsuperscript{[89]}. This provided opportunities to explore relevant concepts such as role exit and entry, role ambiguity, role conflict and ‘rites of passage’\textsuperscript{[237]}. Data were collected via an online survey and subsequent semi-structured interviews\textsuperscript{[205]}. Due to the large amount of data generated, this paper reports on a subset of the survey data relating to the transition experience. The reasons
why nurses transitioned to PHC employment, qualitative experiences of transition and future career intentions are described elsewhere\(^{(49; 205)}\).

**Data collection**

Following an extensive literature search, no existing validated survey instrument was identified which met all the requirements of the study. A survey was therefore purposefully designed by drawing on a critical review of the literature\(^{(47)}\), expert input and the concepts of role theory\(^{(48)}\). The tool was subjected to a two stage process of validation for content and design: first, questions were circulated to a purposefully selected sample of experienced PHC nurses and two research experts, seeking feedback regarding content, time required to complete and ease of comprehension. The revised tool was then loaded onto SurveyMonkey\(^{(138)}\) and piloted by the same group. Additional feedback was used to make minor modifications to the wording and layout of the survey prior to final dissemination.

The final survey was divided into three sections. The first section explored demographic attributes and reasons for transitioning (19 items). The second section explored transition experiences (15 items), and the third comprised open ended items which explored the positive and negative aspects of working in PHC. This paper reports on data drawn from the demographic items and section 2 items, with other findings reported elsewhere\(^{(49; 205)}\).

**Respondents**

Respondents were Australian baccalaureate prepared RNs who had previously worked in acute care settings and had transitioned to PHC employment within the previous 5 years. This group was selected because RNs are the largest
group in the nursing workforce\textsuperscript{(22)}, and having transitioned within five years facilitated recall of the experience.

A multifaceted approach to recruitment was employed. The study was promoted through emails sent to national PHC organisations and professional networks, National and State/Territory based nursing organisations, State/Territory Chief Nurses and senior nurses, and through universities with dedicated post graduate PHC nursing courses. In addition, social media (Facebook, LinkedIn and Twitter) was utilised to promote the survey, and information was circulated at two national PHC nursing conferences. Individuals were directed to an online link to access further information and to participate in the survey, which was open between July and September 2015. Reminder emails and postings were sent to the stakeholders after a month and again a week before the survey was closed.

\textbf{Ethical considerations}

The University HREC granted approval to conduct the study before data were collected (Approval No. HE15/179). In accordance with the National Health and Medical Research Council\textsuperscript{(193)}, completion of the survey implied consent to participate.

\textbf{Data analysis}

Data were exported from SurveyMonkey\textsuperscript{(138)} directly into SPSS Version 22\textsuperscript{(162)}. Surveys missing either demographic or transition experience data, or where data revealed that the participant did not meet the inclusion criteria, were removed from the analysis\textsuperscript{(164)}. Descriptive statistics were used to summarise the data for both categorical (using frequencies and percentages) and
continuous variables (mean, standard deviations and ranges)\(^{(164)}\). Relationships between variables were explored using the independent sample t-test, Pearson's chi-square test\(^{(164)}\). As large numbers of variables were generated, this was managed by grouping interrelated items. Statistical significance was attributed to results where \(p<0.05\)\(^{(164)}\). Thematic analysis was used to analyse responses to open ended items\(^{(166)}\).

**Results**

**Demographics**

One hundred and seventy one survey responses were received, and of these one hundred and eleven (64.9\%) provided complete demographic and response data, met the selection criteria and so were included in the analysis. Of these, 96.4\% (\(n=106\)) were female and nearly three quarters were aged over forty years (\(n=83, 74.7\%)\) (Table 6.1).

The mean duration worked as an RN was 18.9 years (SD: 11.2). Most respondents were employed in a permanent capacity (\(n=83, 75.5\%)\), although over half worked part-time (less than 38 hours per week)(\(n=70, 63.0\%)\). Less than a third of respondents (\(n=32, 28.8\%)\) reported having a second job in nursing and only 16 (14.4\%) respondents reported ongoing acute care employment.

Respondents reflected a broad geographic spread across States and Territories and a mix of capital cities / metropolitan areas (\(n=67, 60.9\%)\), rural (\(n=26, 23.6\%)\) and remote settings (\(n=17, 15.5\%)\). Most respondents were employed in general practice (\(n=72, 65\%)\), with the remainder (\(n=39, 35\%)\) working in various PHC settings including community based palliative care services, maternal and child health, schools, correctional centres, sexual health services,
Aboriginal and Torres Strait Islander health services, primary health networks, workplace health services and refugee health. Medical units (n=23, 20.7%), emergency departments (n=17, 15.3%) and maternity (n=16, 14.4%) were identified as the most common acute clinical areas from which respondents had transitioned, followed by surgical wards, critical care, paediatrics/child and family nursing, operating theatres and mental health.

Table 6.1 Participant demographics

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23-29 years</td>
<td>10</td>
<td>9.0</td>
</tr>
<tr>
<td>30-39 years</td>
<td>18</td>
<td>16.2</td>
</tr>
<tr>
<td>40-49 years</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>50-59 years</td>
<td>35</td>
<td>31.5</td>
</tr>
<tr>
<td>60-67 years</td>
<td>9</td>
<td>8.1</td>
</tr>
<tr>
<td>State/Territory of Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Queensland</td>
<td>12</td>
<td>10.9</td>
</tr>
<tr>
<td>Victoria</td>
<td>30</td>
<td>27.3</td>
</tr>
<tr>
<td>Western Australia</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>New South Wales</td>
<td>37</td>
<td>33.6</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>South Australia</td>
<td>9</td>
<td>8.2</td>
</tr>
<tr>
<td>Tasmania</td>
<td>5</td>
<td>4.5</td>
</tr>
<tr>
<td>Location of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/metro</td>
<td>67</td>
<td>60.9</td>
</tr>
<tr>
<td>Rural</td>
<td>26</td>
<td>23.6</td>
</tr>
<tr>
<td>Remote</td>
<td>17</td>
<td>15.5</td>
</tr>
<tr>
<td>Mean SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total years since graduation</td>
<td>20.25</td>
<td>11.5</td>
</tr>
<tr>
<td>Years worked as an RN</td>
<td>18.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Years since transition to PHC</td>
<td>2.8</td>
<td>1.7</td>
</tr>
<tr>
<td>Actual years worked in PHC</td>
<td>3.4</td>
<td>3.5</td>
</tr>
</tbody>
</table>
Support

When commencing employment in PHC, most respondents (n=90, 81.1%) reported receiving some orientation to the new workplace (Table 6.2), although there were differences in its structure and duration. Of those who described their orientation, 53.0% (n=30) of respondents had between 2-5 days orientation, whilst 33.9% (n=19) reported having 8 hours or less orientation.

Access to a nurse to discuss a clinical problem (n=80, 72.0%), provision of a role description (n=75, 67.5%) and access to another nurse to assist with a workplace issue (n=75, 67.5%) were the most frequently provided supports during transition. Just under half of the respondents (n= 55, 49.5%) reported having a supernumerary period without a client load. However, only 45.0% (n=50) reported having access to funding for external professional development.

Table 6.2 Orientation and supports provided

<table>
<thead>
<tr>
<th>Support</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received orientation to workplace and role</td>
<td>90</td>
<td>81.1</td>
</tr>
<tr>
<td>Access to a nurse preceptor to assist with clinical skill development</td>
<td>80</td>
<td>72.0</td>
</tr>
<tr>
<td>Role description provided</td>
<td>75</td>
<td>67.5</td>
</tr>
<tr>
<td>A nurse preceptor who assisted with organisational/management skills development</td>
<td>75</td>
<td>67.5</td>
</tr>
<tr>
<td>Encouragement to complete specified professional development</td>
<td>71</td>
<td>63.9</td>
</tr>
<tr>
<td>Leave/time to attend external professional development</td>
<td>65</td>
<td>58.5</td>
</tr>
<tr>
<td>Physical learning resources (eg. books, manuals)</td>
<td>54</td>
<td>48.6</td>
</tr>
<tr>
<td>Period of being supernumerary without own client load</td>
<td>55</td>
<td>49.5</td>
</tr>
<tr>
<td>Funding to support external professional development</td>
<td>50</td>
<td>45.0</td>
</tr>
</tbody>
</table>
In response to this item one respondent commented:

“all the above processes would have made my introduction to

PHC better. Now I have tried to introduce an orientation folder for

all the new nurses that start at the clinic...”

Despite the small number of participants who reported having access to a

nominated preceptor (35.1%, n=39), the perceived value of preceptorship and availability of mentors was identified in several free text responses:

“would have been great to have a mentor that I could call or email

about something I needed help with...I'm the only nurse and so I

had no access to someone who had experience”.

“continuing professional development in respect to education

sessions is encouraged, however, preceptors and mentorship is

non-existent”.

The Pearson chi–square test for independence indicated that those working in city/metropolitan locations were more likely to report issues associated with their orientation such as lack of resources or support than those in rural or remote settings (p=0.01). However, respondents working in rural or remote locations were more likely to have access to a preceptor than those working in city/metropolitan locations (p=0.02). Those respondents who were employed part-time were less likely to report receiving physical learning resources, such as manuals and learning packages, than full-time respondents (p=0.004).

**Difficulties in transitioning**

Over half of respondents (n=62, 56.4%) identified that they had experienced orientation difficulties such as information overload, issues with organisational
knowledge and workplace familiarisation, and learning new technology. Slightly less than half of respondents (n=47, 42.7%) reported difficulties relating to unclear role expectations. Few respondents reported experiencing a lack of confidence (n=29, 34.1%), workload concerns (n=24, 28.2%) and fears such as safety issues (n=17, 15.5%).

**Adjusting to PHC**

Respondents rated the level of difficulty in adjusting to aspects of PHC employment on a 5-point Likert scale (5 being ‘very difficult’ to 1 being very easy’) (Table 6.3). While mean scores for these items were between ‘easy’ and ‘neither difficult nor easy’, over a third of respondents rated organisational knowledge (n=4, 40.9%) information overload (n=37, 33.9%), and around a quarter identified new technology (n=28, 25.6%) and workplace familiarisation (n=28, 25.4%) as ‘difficult’ or ‘very difficult’. Conversely, just over half of respondents found the increased autonomy (n=68, 62.9%), prioritising workload (n=63, 57.3%) and changes in the amount of responsibility (n=61, 55.5%) to be ‘easy’ or ‘very easy’.

A Pearson chi-square test for independence indicated a significant association between location and adjustment to new technology, with significantly more respondents in city/metropolitan settings reporting it to be ‘easy’ or ‘very easy’ to adjust to new technology compared to those working in rural or remote areas (p=0.03). Respondents from city/metropolitan settings were also significantly more likely to report unclear role expectations than rural or remote nurses (p=0.03).
Approximately half of respondents reported feeling isolated or unsupported (47.7%, n=53) and/or overwhelmed with the new role (49.5%, n=55) either sometimes or regularly.

Table 6.3 Difficulties adjusting to PHC employment

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Very Difficult</th>
<th>Difficult</th>
<th>Neither difficult or Easy</th>
<th>Easy</th>
<th>Very Easy</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Information overload</td>
<td>7</td>
<td>6.4</td>
<td>30</td>
<td>27.3</td>
<td>46</td>
<td>41.8</td>
</tr>
<tr>
<td>Organisational knowledge</td>
<td>7</td>
<td>6.4</td>
<td>38</td>
<td>34.5</td>
<td>28</td>
<td>25.5</td>
</tr>
<tr>
<td>Workplace familiarisation</td>
<td>4</td>
<td>3.6</td>
<td>24</td>
<td>21.8</td>
<td>39</td>
<td>35.5</td>
</tr>
<tr>
<td>New technology</td>
<td>4</td>
<td>3.7</td>
<td>24</td>
<td>22.0</td>
<td>34</td>
<td>31.2</td>
</tr>
<tr>
<td>Confidence in clinical skills</td>
<td>3</td>
<td>2.8</td>
<td>20</td>
<td>18.3</td>
<td>29</td>
<td>26.6</td>
</tr>
<tr>
<td>Clinical knowledge</td>
<td>2</td>
<td>1.8</td>
<td>15</td>
<td>13.8</td>
<td>36</td>
<td>33.0</td>
</tr>
<tr>
<td>Prioritising workload</td>
<td>0</td>
<td>0.0</td>
<td>23</td>
<td>20.9</td>
<td>24</td>
<td>21.8</td>
</tr>
<tr>
<td>Changes in the amount of responsibility</td>
<td>2</td>
<td>1.8</td>
<td>9</td>
<td>8.2</td>
<td>38</td>
<td>34.5</td>
</tr>
<tr>
<td>Increased autonomy</td>
<td>2</td>
<td>1.9</td>
<td>14</td>
<td>13.0</td>
<td>24</td>
<td>22.2</td>
</tr>
<tr>
<td>Concerns related to personal safety</td>
<td>0</td>
<td>0.0</td>
<td>7</td>
<td>6.4</td>
<td>47</td>
<td>43.1</td>
</tr>
</tbody>
</table>

Making the transition easier

Respondents indicated that an improved orientation (n=42, 38.2%), workplace specific skills practice (n=37, 33.6%) and greater preceptor support (n=35, 31.8%) were the three most important factors which could have assisted during the transition (Table 6.4).
Transitioning between workplaces has been described as complex and multidimensional\(^\text{(26; 41; 238)}\). It includes a period of closure from the old role, a period of adjustment, followed by socialisation or settling in to the new role\(^\text{(239; 240)}\). Experienced nurses moving to new cultural and clinical environments face issues relating to confidence and competence\(^\text{(24)}\). This is described by Disch\(^\text{(241)}\) as moving from ‘expert to novice’. We identified a range of factors which impacted on RNs’ immediate and ongoing transitioning experiences from acute care to PHC environments, and how the transition process could have been improved.

The impact of demographic factors (age, years in nursing, previous experience) and situational contributors (location of practice, type of work, access to supports) in influencing transition experiences have been previously identified.

<table>
<thead>
<tr>
<th>Additional support factors to assist transition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
</tr>
<tr>
<td>Improved orientation</td>
</tr>
<tr>
<td>Workplace specific skills practice</td>
</tr>
<tr>
<td>Greater preceptor support</td>
</tr>
<tr>
<td>Improved mentorship</td>
</tr>
<tr>
<td>Opportunity for team meetings</td>
</tr>
<tr>
<td>Increased support from other nurses</td>
</tr>
<tr>
<td>Longer orientation</td>
</tr>
<tr>
<td>Increased support from manager</td>
</tr>
<tr>
<td>Improved communication between nurses</td>
</tr>
<tr>
<td>Improved communication with medical staff</td>
</tr>
<tr>
<td>Enhanced workplace socialisation</td>
</tr>
<tr>
<td>Greater opportunities for staff socialisation</td>
</tr>
<tr>
<td>Better workload division</td>
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<tr>
<td>Improved rostering</td>
</tr>
</tbody>
</table>
across different workplaces\textsuperscript{28; 40; 242} and amongst new graduates\textsuperscript{60; 243}. In our study, age and years in nursing did not significantly impact on the transition experience. This differed from Longo’s\textsuperscript{244} study which reported that older workers described negative stereotypes, multigenerational issues and disempowerment when moving jobs. However, difficulties experienced by some of our respondents in adjusting to the technological aspects of PHC aligns with research which has identified that younger age groups are less threatened by technology\textsuperscript{245}. The relationship we found between adjusting to technology and the location of respondents in rural or remote areas also highlights the inequities which exist between exposure to technology, data access, and mobile coverage in rural and metropolitan centres in Australia\textsuperscript{246}.

Many studies relating to structured workplace orientation programs indicate their importance in influencing job satisfaction\textsuperscript{247} and safety in the new workplace\textsuperscript{248}. In our study we found considerable diversity in the length and content of orientation programs and other support systems, with a third of our respondents reporting eight hours or less orientation, and nearly half having no supernumerary period. There was also diversity relating to information overload, time to practice new skills, and a lack of learning resources. Our respondents identified that an improved orientation and additional time were the most important factors which would have assisted in their transition, and supports similar research relating to new graduate orientation programs\textsuperscript{249}.

Preceptoring and mentoring have both been described as a means to assist workers to transition between different roles\textsuperscript{250}. Ellis et al.\textsuperscript{19} describe preceptoring as a formal arrangement where experienced clinical preceptors assist less experienced nurses to develop clinical skills and confidence, and
achievement of their professional goals. In contrast, mentoring is usually less formal, and relies on the interpersonal relationship between the mentor and mentee to provide professional support and guidance\(^{(19)}\). In this study respondents who had access to preceptors and/or mentors described these supports as extremely beneficial in assisting in the transitioning process. These findings align with previous literature which links preceptoring and mentoring with increased skills development, access to professional and personal learning, attainment of professional goals, job satisfaction and personal support\(^{(1;251)}\). For those respondents who did not have access to preceptors or mentors, such support was identified as an important factor which might have assisted in their transitioning. Free text responses indicated frustration with the lack of preceptors and/or mentors available to provide professional support in environments where nurses often work alone. However, the shortage of skilled nurse preceptors is not unique to PHC, and has been identified across other health care settings\(^{(252)}\). In PHC, lack of available preceptor training, time factors and the nature of many PHC nursing roles create barriers to implementing these supports\(^{(253)}\). Our findings support the need for employers and managers to prioritise availability of trained preceptors, and to encourage access to mentors who can provide ongoing support to PHC nurses.

Less than two thirds of respondents identified that they had access to study leave and/or financial support to undertake professional learning in PHC. Ellis et al.\(^{(19)}\) describe several reasons why nurses in PHC settings are likely to experience such barriers, including the size and nature of the organisation, its location, time, rostering issues and costs. However, return on investment should be considered by employers. Studies indicate that PHC nurses with relevant
education are better prepared to increase their scope of practice to include additional roles in preventive health and chronic disease service provision, as well as support new nurses in PHC\textsuperscript{(254)}. Findings from this study therefore support the need for PHC employers, policy makers and the profession, to prioritise the provision of incentives such as study leave, scholarships and alternative modes of course delivery. Access to professional development is likely to create an environment conducive to fulfilling nurses’ professional learning ambitions as well as develop a skilled future PHC nursing workforce.

**Limitations**

The lack of national PHC nursing workforce data precluded the use of representative sampling techniques. Sample sizes from PHC settings were also variable. Therefore it cannot be assumed that our sample was representative of the broader PHC nursing workforce. Our recruitment techniques, however, were comparable with other Australian PHC workforce studies\textsuperscript{(137; 154)}.

An additional limitation was that survey data were based on self-report, and therefore potentially subject to bias. It is also possible that the experiences and perceptions of non-responders may differ from those who participated.

**Conclusions**

This study has provided an important snapshot of the experiences of a cohort of acute care nurses who have transitioned to PHC employment. Transitioning requires adjustment to new models of care and work environments. It has also identified the diversity in orientation programs and supports available during transition. Access to a preceptor, ongoing support from mentors, a culture of good communication and employer support to undertake professional learning, rated highly as key contributors to successful transition experiences.
Chapter 7: Experiences of transitioning

“Not in his goals but in his transitions, man is great”.

Ralph Waldo Emerson(255)
Chapter introduction
This chapter presents Phase 2, the interview data, which expands on the survey findings reported in Chapter 6. These data are described in Paper 5. Permission to include this publication in the thesis has been granted by the publisher John Wiley and Sons.


Abstract

Aim: This paper describes the experiences of acute care RNs transitioning to PHC settings.

Background: The worldwide increasing demand for PHC services has resulted in skilled acute care nurses transitioning to PHC settings to meet workforce requirements. Little is known about the experiences and challenges associated with the transition. Knowledge of this will enable employers to design appropriate support processes and transitioning nurses can make informed choices about their career moves.

Methods: Semi-structured interviews were conducted with RNs who had transitioned into PHC employment in the last five years. Data analysis was undertaken using Braun and Clarke’s(166) thematic analysis approach.

Results: Thirteen nurses were interviewed, and two themes identified: Role learning: the new environment, and Role socialisation: transition validation. Role learning was influenced according to the quality of orientation programs,
previous experience, clinical knowledge and professional support. Support and professional respect from mentors and/or employers greatly assisted with role socialisation and the transition experience.

Conclusions: Transitioning to PHC employment provides unique challenges which must be considered by employers if they are to attract and retain experienced acute care RNs.

Relevance to clinical practice

Understanding the experiences of nurses who transition from acute to PHC employment can inform the design of orientation programs and ongoing professional supports to address barriers and challenges. Targeted orientation and support has the potential to enhance recruitment and retention of experienced nurses in PHC.

Introduction

Throughout the developed world, there is a convergence of increasing health costs and service demands associated with the ageing population and rise of chronic diseases in the community\(^{(223)}\). These factors are resulting in a shift from acute care models towards PHC where health services are safely, efficiently and cost effectively delivered in the community\(^{(200)}\). The PHC nursing workforce is increasing to meet the demands of these changing models of care, with almost 36,000 Australian RNs now self-identifying as working in PHC settings\(^{(20; 197)}\). Examples of PHC settings include general practice, community nursing, schools, remote area nursing, corrective centres and refugee health centres.
To grow the PHC nursing workforce, employers are actively seeking both new graduates and experienced acute care nurses prepared to move to the PHC sector. Whilst there is a need to ensure a skill mix of clinically experienced nurses, limited empirical evidence is available regarding the experiences, capabilities and educational preparedness of nurses who transition between acute care and PHC roles\(^{(47)}\).

**Background**

The nursing transition literature remains largely focused on new graduate transitions into the workplace\(^{(54; 85; 256)}\). Only a small body of literature focuses on other workforce transitions, such as moving between different areas of acute care\(^{(40)}\), movements between levels of clinical seniority\(^{(257)}\) and into specialty areas of practice including PHC\(^{(43; 47)}\). Findings consistently identify the transition experience as stressful, associated with role ambiguity, role strain and role conflict\(^{(40; 107)}\), resulting in low job satisfaction and premature attrition from the workforce\(^{(110)}\). A range of factors have been identified as enablers to positive transition experiences. These include: educational preparation; opportunities for clinical skills development; access to ongoing continuing education; organisational orientation; a dedicated preceptor; mentoring, and team support in the workplace\(^{(39; 43; 243)}\).

From the few studies exploring transitions to PHC, key issues reported in the transition process have included: professional and personal losses and gains associated with old and new roles\(^{(26)}\); duration of the phases of transition and their association with personal attributes such as flexibility and adaptability\(^{(45)}\); transferability of skills\(^{(43)}\), and the experience of working within a new paradigm.
where benefits such as client relationships and autonomy of practice are identified\(^{45, 47}\).

In light of the evolving importance of care delivery in PHC settings and the need to ensure a stable workforce, it is timely to build on existing evidence of nurses’ transition experiences from acute to PHC employment. Such data can allow nurses to better prepare for their transition, inform employers when designing orientation and support programs and advise policy makers to assist in planning future recruitment and retention strategies. This paper reports on qualitative data from a mixed methods study which explored the transition experiences of acute care RNs moving to employment in PHC settings.

**Methods**

*Design*

A two-phase sequential mixed methods study explored the transition experiences of acute care nurses to PHC. Role theory, which has previously been reported to provide a valid basis for researching transitioning between nursing workplaces\(^{26, 43}\), was selected as the theoretical framework to inform the design and analysis of findings. Phase 1 consisted of an online survey of 111 PHC nurses who had transitioned from acute care employment within the previous 5 years. Survey respondents were asked to indicate a willingness to participate in subsequent semi-structured interviews (Phase 2). This paper describes the findings from those interviews. Due to the volume of data collected and the various aspects of the transition experience explored, findings from other aspects of the larger study are reported elsewhere\(^{49, 173, 205}\).
Data collection

Potential interview participants were purposefully selected according to their PHC setting, age, years of nursing experience and geographic location. Based on participant availability and their location, interviews were conducted by one researcher, either by phone (n=12) or face to face (n=1). None of the participants were known to the researcher. All were conducted in locations selected by the participants. A semi-structured interview schedule was developed from the literature review\(^{(47)}\) and survey findings\(^{(173)}\), with additional prompts used where necessary. The suitability of this schedule was tested in a pilot interview, as well as being evaluated in the first few interviews of the data collection. This resulted in some very minor changes to the wording and order of some questions. Interviews were digitally audio-recorded and professionally transcribed verbatim. Due to resource limitations and the nature of the interviews, transcripts were not returned to participants. Field notes were recorded by the researcher during and immediately after each interview.

Analysis

Transcripts and recordings were cross-checked by two researchers for accuracy, and were de-identified before being imported into NVivo Version 10\(^{(163)}\). Transcripts were then critically analysed using the six phase thematic analysis approach reported by Braun and Clark\(^{(166)}\). As analysis was data-driven, inductive analysis was used, where the researchers code the data without trying to fit it into either a pre-existing coding frame or into preconceived themes. Analysis of themes was initially undertaken by one researcher (CA), a PhD candidate who is an experienced RN. The data and emerging themes were then discussed with three additional RNs who are experienced researchers with...
qualitative research experience. Two of these researchers have significant experience in PHC nursing. Together, the four researchers discussed the possible interpretations and reached consensus on the final themes.

**Ethical considerations**

Approval for the study was granted by the University HREC (Approval No.HE15/179) prior to commencing data collection. Anonymity, confidentiality and security of participants’ details and responses were assured, and included the use of pseudonyms to protect identities.

**Results**

Thirteen interviews were conducted over a ten week period until saturation of data was achieved. Interviews ranged from 30 to 45 minutes in duration. Participant demographics are presented in Table 7.1. Two themes about the transition experience were identified, namely; Role learning: the new environment, and Role socialisation: transition validation (Table 7.2)

**Role learning: the new environment**

Role learning, or the process of ‘entering’ the new environment, included sub-themes relating to the orientation provided, the early challenges experienced and role ambiguity relating to the new role.

**a) Orientation to the workplace**

Most participants described receiving an orientation to their new workplace, although these varied considerably in length, quality, availability of resources and content.
### Table 7.1 Participant demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>PHC Setting</th>
<th>Previous acute nursing experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex</td>
<td>23</td>
<td>General practice</td>
<td>New graduate year - various acute settings</td>
</tr>
<tr>
<td>Nicky</td>
<td>26</td>
<td>General practice</td>
<td>Acute aged care unit</td>
</tr>
<tr>
<td>Mieken</td>
<td>30</td>
<td>Sexual health</td>
<td>Intensive care</td>
</tr>
<tr>
<td>Vanessa</td>
<td>32</td>
<td>Remote area mental health</td>
<td>Acute metropolitan mental health unit</td>
</tr>
<tr>
<td>Sue</td>
<td>39</td>
<td>Refugee health</td>
<td>Intensive care</td>
</tr>
<tr>
<td>Barb</td>
<td>45</td>
<td>School</td>
<td>Intensive care</td>
</tr>
<tr>
<td>Natalie</td>
<td>46</td>
<td>General practice</td>
<td>Medical ward</td>
</tr>
<tr>
<td>Denise</td>
<td>52</td>
<td>Community health</td>
<td>New graduate year – various acute settings</td>
</tr>
<tr>
<td>Francine</td>
<td>52</td>
<td>General practice</td>
<td>Operating rooms</td>
</tr>
<tr>
<td>Liz</td>
<td>56</td>
<td>General practice</td>
<td>Pool – mainly medical/surgical wards and high dependency</td>
</tr>
<tr>
<td>Suzanne</td>
<td>57</td>
<td>School</td>
<td>Acute patient transport setting</td>
</tr>
<tr>
<td>Christine</td>
<td>58</td>
<td>General practice</td>
<td>Operating rooms and education</td>
</tr>
<tr>
<td>Margaret</td>
<td>62</td>
<td>School</td>
<td>Paediatrics</td>
</tr>
</tbody>
</table>

### Table 7.2 Thematic structure

<table>
<thead>
<tr>
<th>Theme</th>
<th>Role learning: the new environment</th>
<th>Role socialisation: transition validation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-themes</strong></td>
<td>• Orientation to the workplace</td>
<td>• Role identity and developing confidence</td>
</tr>
<tr>
<td></td>
<td>• Challenges in the early days</td>
<td>• Ongoing professional supports</td>
</tr>
<tr>
<td></td>
<td>• Role ambiguity</td>
<td>• Role conflict</td>
</tr>
</tbody>
</table>

For some, orientation was extremely brief: “*I was lucky to have two hours I think with the previous staff member that was going on maternity leave*” (Barb). Others described having more time to adjust, where new staff were ‘buddied’ with preceptors or experienced staff until they were familiar with the new role:
“There was always someone there. I didn’t get left on my own until I was comfortable and confident in what I was doing” (Francine).

There were also differences in orientation within a workplace, depending on the level of experience of the transitioning nurse. Alex, who had transitioned from a new graduate program to general practice, described having a structured orientation designed specifically to identify knowledge gaps and meet her needs:

“the first couple of weeks in fact was mostly shadowing the practice nurses here...learning about diabetes health checks and what to look for, using the spirometry. .... and things that I've just never had to do before, nor learnt before....”

This contrasted with the unstructured orientation provided to more experienced nurses coming into her practice:

“They got nothing when they transitioned. ..., thrown much more in the deep end. They just sort of were expected that [as experienced RNs] you should know what to do” (Alex).

Participants who reported minimal, or no formal orientation, described feeling isolated and lacking support:

“I was there on my own and I guess I didn’t realise the comfort that the hospital had provided ... I guess which I’d taken for granted. Here I was by myself in this role and I was like...so what am I supposed to do? I wasn’t sure of what their expectations were at all” (Barb).
Similarly, Margaret commented:

“I just turned up and found the key under the mat so to speak because the other person had already left. It was very poorly managed. The booklet with the information in wasn’t very clear or up to date. It was very vague and I had not much idea”.

Some participants indicated that their negative experience had positively influenced them to support future new staff:

“I didn’t [have an orientation] but I put an orientation program together for the future…I am very supportive of orientation programs. I think it’s very important in any workplace. If you orientate well, you’ll have satisfied and content staff” (Suzanne).

b) Early Challenges

PHC was described as “a whole different ball game to working in the acute setting where you’ve got a controlled environment” (Vanessa). Availability of peer support was highly valued at this time:

“I will never forget my first day…it was just a very different environment. I remember thinking oh boy, how am I ever going to remember any of this? …[but] they were very good at making sure that I was okay …and not feeling overwhelmed” (Alex).

Mieken described her frustration at feeling like a novice again:

“I felt like I had to ask all my very much more skilled colleagues that have been in the area for a long time, even just about the basic stuff…I felt like I should know more and I didn’t, and I was
very skilled in ICU so I felt like I just started afresh and I’m the new person again and it’s a bit annoying”.

Several participants described the challenges associated with the administrative and structural aspects of PHC, such as working in a small business context, learning new computer software packages, and understanding appointments, recalls and reminders in general practice:

“You’ve got to pick up a patient load very quickly because there’s the need for the business” (Liz).

“Having to watch the money and having your day put into 15 minute blocks...getting used to the appointment system” (Francine).

“The biggest difference is the type of paperwork...the intensity of the record keeping was probably the most overwhelming thing at the beginning, not the clinical stuff, not interacting with patients, or the blood pressures or the ECGs...none of that...it was how to work efficiently with the paperwork” (Natalie).

Some participants described how their acute care experience assisted them in the transition:

“There was less trepidation in actually going into PHC than there was working in ICU... I was excited about what opportunities were available” (Sue).
“I didn’t feel out of my depth, I needed to just feel comfortable liaising with the [school] boys really, but as far as the clinical side, it just all naturally came back” (Suzanne).

Eleven participants recalled making clinical errors or having ‘near misses’ during their first months in PHC employment. These included giving the wrong vaccination to a child, misdiagnosis of a child following an injury, and misreading blood test results. Despite the potential risks to patient safety, most participants seemed less concerned with the impact of potential adverse events: “Often there is nothing critical. If you put the wrong dressing on, it’s not going to really do any damage” (Denise). Similarly, Mieken said: “I would have made errors. I guess the beauty is where I’m working now is that you can’t really kill anybody”. However, some participants acknowledged the risks associated with having to undertake clinical tasks independently in a time pressured environment:

“I was very, very concerned and worried about the immunisation component... That, I found was very, very stressful having to work by yourself... having to learn in a short period of time when you’re under the pump and you’re very busy. Those are the times that those things are going to happen” (Liz).

**c) Role ambiguity**

Several participants described a lack of role clarity and a sense of professional isolation: “Making sure I was informed enough to know what was my actual legislative requirements,… because I felt so isolated on my own” (Barb).

Similarly, Alex commented: “I guess it’s the thing that I struggle with...the
viewpoint of what I am as a health professional and what my health professional role is in general practice”.

Christine highlighted how lack of role clarity and conflicting advice from other professionals led to confusion:

“It was a bit of a surprise to me that I had somebody say to me, well, you can’t make a diagnosis. As a health professional I should be offering them some sort of help…[Another nurse] went oh that’s not our role…so I had a chat with a couple of GPs …It depends on the GP…it depends on what they say. I thought, well that’s a bit wishy-washy.”

Vanessa reflected that she initially had a poor understanding of her new role and highlighted the professional isolation and lack of oversight in the PHC environment: “in hindsight I was very unprepared…you don’t always know, you can slip under the radar and just try to fumble your way.” Further contributing to the role confusion in general practice were the funding models that required medical input for services to be billed.

“My scope of practice has changed quite considerably…here in general practice everything is overshadowed by a doctor…it’s not so much they don’t trust that we can do it, it’s just that to be able to get billed…a doctor has to be present. That’s very hard to comprehend…to be able to say you’re not really worth your opinion because a doctor’s opinion is the one that gets billed for” (Alex).
Role socialisation: transition validation

Role socialisation, or ‘settling in’ to PHC encompasses the sub-themes of role identity and role conflict. Developing confidence in the new position and the availability of ongoing professional supports were associated with role identity, whilst unrealistic expectations and lack of professional respect were found to influence the development of role conflict.

a) Role identity and developing confidence

Adjusting to new roles and feeling confident to practise safely took participants varying lengths of time. Margaret, who had many years of acute care experience, found adjusting to school nursing was straightforward:

“So by the end of the second week I was fine because I ended up doing quite a few shifts by myself… When I was on my own I had to make sure I knew what I was doing, and that turned out to be a really good thing.”

For Alex, being confident meant being able to undertake clinical and technical activities independently. She stated:

“As a young nurse I learn fast, and the technology is my friend. Probably after about eight weeks I thought, okay, I can do this. I’m confident to be able to call in on a patient and do a health assessment, do a wound dressing whatever it is…and don’t need to ask someone where is this or how do I do this or what’s the next step”.

Barb described being “always happy” in her new role, but her confidence took six months to develop as she adjusted to the PHC environment. Vanessa
identified that, as well as being inexperienced at the time of transitioning, gaining confidence working in the geographic remoteness of the Outback took time. “I think it takes a couple of years at least... to gain confidence as opposed to feeling comfortable in going out there”. The level of confidence felt by participants was noted to fluctuate over time as they were exposed to different situations. Natalie described:

“when you feel that everything’s under control and you’re feeling okay about things then something happens… and then suddenly you think well I wasn’t quite as sure as I thought I was”.

Several participants described the development of role identities as being closely associated with positive workplace cultures and open communication. Francine described a supportive and collegial environment:

“We do a lot of bouncing off each other, we all get together. Our doctors are very good. They rely on us a lot…the doctors will always [say to patients] well, these girls are the experts, go talk to them”.

Others described how transitioning to a PHC model aligned with their personal and professional philosophies of nursing:

“There are some people that just find one area that they love and they’ll stay there forever. I think for me that refugee health is that area, because theoretically and intellectually it stimulates me in so many different ways. I think just having the passion for PHC can make the transition better…it’s very rewarding” (Sue).
b) Ongoing professional support

Participants described varying levels of ongoing workplace support, and personal strategies adopted to establish themselves in their new roles when support was limited. Access to either a mentor or clinical supervisor was highly valued. Sue described how all nurses in her workplace participated in clinical supervision, and how over time she developed a valuable relationship with her clinical supervisor: “She’s a wonderful woman and it’s very easy to talk to her”.

Mieken also recognised the value of clinical supervision, describing how once a month she reflected on her work and clinical role with other team members and found: “the staff are super-supportive”.

Several participants recognised that there was also a need to take personal responsibility for learning. Liz stated:

“It was a bit full on…wonderful people, wonderful doctors, wonderful manager, wonderful support from that point of view, but there was just so much still to have to learn myself”.

Access to various external contacts and educational resources, such as social media (Natalie), and primary health organisations (Christine), were described as helpful. However, resistance by employers to provide either financial support or leave to facilitate professional development was a source of discontent:

“Trying to get education is extremely difficult. We have to ask every single time and plead our case and virtually prove it would be beneficial. Just getting my CPR done…it’s going to be up to me financially …to pay for all these things…” (Margaret).
“I don’t even ask them to pay for me to study. I just asked them to have study leave and my manager emailed me back saying, sorry we’re not interested” (Nicky).

Natalie described difficulties accessing leave when working in a practice with only one other nurse: “I would be made to feel that I was letting the practice down for not being on the floor, and then they wouldn’t cover it”. For those working in larger organisations there was more support available:

“Brilliant…I’ve been very fortunate. It’s always supportive” (Sue).

“We’ve been lucky about that sort of thing. The funding has been available and they’ve been very supportive” (Vanessa).

The availability and effectiveness of a performance review process in which nurses could raise issues of concern, discuss knowledge gaps or professional support needs varied. A barrier to effective performance review included being managed by non-nurses.

“The challenging aspect is dealing with the practice manager that doesn’t have a clinical background” (Natalie).

“They don’t do it. You have to ask….it’s hard for her [practice manager] to do a performance review. She doesn’t know what you do, and the GPs wouldn’t have the time…it’s not their area” (Christine).

In Natalie’s general practice, the only time her performance had been discussed was when she had done something wrong: “Just a negative comment [from the doctor] that I was employed as an RN and I’m to do what I’m told to do”. School
nurses also identified issues relating to the structure of reviews: “It’s really difficult because they’ve given us the same paperwork that they give the teachers…It was a waste of time…nothing was going to change” (Margaret).

c) Role Conflict

Role conflict was described by participants in terms of other professionals placing unrealistic expectations on them or challenging their practice. Alex felt conflicted by the ongoing expectations placed on her with little support for skill development:

“It wasn’t to say that my mentor wasn’t around…[but] when I was in the hospital surgical setting there’s only a set amount of things that a surgical nurse needs to do, whereas here in primary health I’m an immunisation nurse, a paediatric nurse, I’m a geriatric nurse, I’m a palliative care nurse, asthma, diabetes etc.”

Natalie described how a non-clinical practice manager created conflict when she insisted on double checking and challenging clinical activities: “If she had approached me in a different way I would have felt more respected, but right now I just feel disrespected”.

Christine identified the significance of role conflict for inexperienced nurses transitioning to PHC roles:

“That’s what concerns me about a new practitioner going into that [PHC] position. Unless they’re really really sure of their scope of practice, to be able to push back and have the confidence…to say no, sorry… because the expectation is that you can do it all. I actually was asked to do something. It was by the practice owner,
who's a GP. I said I can't do that. I said I've never done it. She went, oh really? I said, yep, so I'm sorry but I won't do that”.

Discussion

Our study describes the transition experiences of acute care nurses who moved into PHC nursing employment. Participants identified issues common to nursing transitions in other settings such as lack of confidence, role ambiguity and role conflict, lack of professional supports, and information overload\(^{47, 258}\). However, the diversity of PHC environments created unique challenges for participants. At the point of role entry, role learning was influenced by orientation to the new role, availability of preceptors, and clarity relating to the PHC environment. During the role socialisation phase, role validation was affected by availability of ongoing professional support, role conflict and role identity\(^{26, 43}\).

Role theory describes transitioning as a confusing ‘zone’ of disengaging from old roles and transforming or ‘entering’ into new roles\(^{259}\). Ashforth et al.\(^{240}\) note that new workers are most receptive to adaption at the role entry phase. As well as personal characteristics influencing adaption, the new role identity is likely to be strongly influenced by the socialisation practices to which the new employee is exposed in the early days\(^{240}\). Supporting findings in Holt’s\(^{26}\) study, our participants expressed surprise at the challenges faced as they transitioned to the new role despite most being experienced RNs. The differences in the environment, pace of work and expectations relating to individual scopes of practice between acute care nursing and PHC, were described as immense, which supports previous literature\(^{43, 260}\). Whilst participants’ existing clinical and interpersonal skills were mostly transferable to PHC, the approaches applied in the acute care setting had to be modified to fit
with the new environment. Adjusting successfully to these changes was dependent on a number of factors including: access to structured orientation programs relevant to the clinical setting; availability of preceptors, mentors and/or clinical supervisors; clarity relating to the PHC role, and other socialisation aspects such as team meetings and good communication. Professional support was identified as particularly important throughout the orientation period. Availability of preceptors, mentors and clinical supervisors has been widely reported as enhancing career satisfaction, improving clinical expertise and facilitating staff retention\(^{(250; 261; 262)}\). These supports have also been shown to be important in developing confidence as an autonomous professional\(^{(250)}\). In this study few participants reported access to a dedicated preceptor or mentor. This is likely due to the nature of PHC settings where nurses frequently work in small numbers or in isolation\(^{(184)}\). These findings support the need to investigate alternative models of clinical support to meet the unique workforce needs of this group, such as Skype or videoconferencing.

Role socialisation, or the process of internalising the behavioural expectations and adaptations necessary to validate a new role\(^{(46)}\) was described by our participants as occurring over varying timeframes. The process of ‘settling in’ to the PHC environment included learning the values, beliefs, norms and skills required to function effectively in the new role as described previously by Holt\(^{(26)}\). It also involved recovering a sense of self determination and control for participants, and regaining recognition as an ‘expert’ after relinquishing this title when leaving their acute nursing roles. Adjustment to the new role was also described as being associated with developing a sense of belonging by
connecting with peers in the new environment and receiving feedback on performance.

Role identity is described as the sense of oneness within a role or with a group, entailing both perception and valuing of that oneness (29). Unlike new graduates who commonly require around twelve months to identify with their new roles (38), the participants in our study reported wide variations in how long it took to socialise into their new roles. This supports findings by Holt (26) and Hartung (45) who identified personal characteristics, workplace setting and location, level of skill and availability of professional support as factors in the socialisation process. It also highlights that a ‘one size fits all’ approach to providing transition programs in PHC are unlikely to meet the needs of all nurses.

This study identified that most nurses moving into PHC were adaptable to the range of new challenges facing them. As professionals they reflected on their personal capabilities, developed networks to meet gaps in their knowledge, and were cognisant of their individual and professional scopes of practice. This aligns with Ashforth (29) who identified that professionals are motivated to proactively socialise into their new roles. There was evidence, however, of insufficient ongoing support from employers, with participants expressing frustration at performance review processes and lack of constructive feedback and encouragement to undertake professional learning.

**Limitations**

Participants in our study represented a small convenience sample of nurses who have transitioned into PHC employment within the last five years. Due to the geographic dispersion of participants, all except one interview was conducted by phone. Despite the rich data that was gathered, this may have
impacted on the quality of data gathered. Given the qualitative nature of the study, assumptions cannot be made that the sample represents the broader PHC nursing population. Additionally, the range of different PHC settings was unequally represented and may not accurately reflect experiences of all PHC nurses.

Conclusion

This study has provided unique insights into the experiences of acute care nurses transitioning into PHC employment. Despite their often considerable clinical experience, participants were clearly challenged by the transition. Supports, such as structured orientation programs, availability of preceptors and mentors and collegial supportive environments, were highly valued and reportedly enhanced the transition experience. This study highlights the need for PHC employers and policy makers to implement evidence based strategies to support nurse transition in order to promote role clarity, optimise job satisfaction and enhance retention of these nurses.
Chapter 8: Reflections on transition and career intentions

“The future depends on what you do today”

Mahatma Gandhi(263)
Chapter introduction
This chapter describes the reflections of study participants on their transition experiences, their satisfaction with working in PHC and their future career intentions. These findings are presented in Paper 6. Permission to include this publication in the thesis has been granted by the publisher, John Wiley and Sons.


Abstract

Aim: To explore RNs’ reflections on transitioning from acute to PHC employment, and future career intentions.

Background: Reforms in PHC have resulted in increasing demands for a skilled PHC nursing workforce. To meet shortfalls, acute care nurses are being recruited to PHC employment, yet little is known about levels of satisfaction and future career intentions.

Method: A sequential mixed methods study consisting of a survey and semi-structured interviews with nurses who transition to PHC.

Results: Most reported positive experiences, valuing work/life balance, role diversity and patient/family interactions. Limited orientation and support, loss of acute skills and inequitable remuneration were reported negatively. Many respondents indicated an intention to stay in PHC (87.3%) and nursing (92.6%)
for the foreseeable future, whilst others indicated they may leave PHC as soon as convenient (29.6%).

**Conclusion:** Our findings provide guidance to managers in seeking strategies to recruit and retain nurses in PHC employment.

**Implications for nursing management**

To maximise recruitment and retention, managers must consider factors influencing job satisfaction amongst transitioning nurses, and the impact that nurses’ past experiences may have on future career intentions in PHC.

**Background**

Health systems internationally are being re-designed to meet changing demographics and population health needs, resulting in increasing levels of service provision in PHC settings\(^7\). A key factor in ensuring that these services are sustainable is a stable skilled health workforce able to provide communities with accessible quality services. An approach used in many countries has been to recruit health professionals from acute care settings to fill shortfalls in the PHC workforce\(^{196; 223}\).

As in many countries, nurses are the largest health professional group in Australia, with approximately 36,000 (9% of the total nursing workforce) now working in PHC employment\(^{151}\). The workforce in some PHC settings has grown exponentially, for example the number of nurses in general practice has grown from 2,349 to over 13,000 nurses in the last decade\(^{151}\). To facilitate this exponential workforce increase, experienced nurses are being recruited from acute care settings to take up PHC employment\(^{229}\).
Transitioning causes career disruption, and requires nurses to adapt to a new role and establish new professional identities\(^{(48; 264)}\). The experience of transitioning between employment settings is known to influence job satisfaction and may impact on staff retention\(^{(110; 265)}\). In order to enhance satisfaction and optimise retention within PHC, employers and managers need to be cognisant of the impact that transition experiences may have on future workforce sustainability and turnover\(^{(172)}\). Armed with this knowledge, appropriate orientation and professional support systems can be designed and implemented to meet the needs of these nurses.

This paper reports a subset of findings from a larger mixed methods study exploring the transitioning experiences of RNs moving from acute care to PHC employment. The aim of this paper is to report on respondents’ satisfaction with their new roles, personal reflections, and future career intentions. Other aspects of the study, namely; the reasons that nurses transition to PHC and their transition experiences are reported elsewhere\(^{(49; 173; 205)}\).

**Methods**

**Design**

Ethics approval to undertake the study was obtained from the University of Wollongong HREC. This sequential explanatory study, undertaken between July 2015 and April 2016, consisted of an online national survey (Phase 1) and semi-structured interviews (Phase 2). The research was informed by the theoretical framework of role theory\(^{(29; 48)}\).


Data collection

Survey respondents were RNs (baccalaureate prepared, or equivalent) who had previously worked in acute care (hospital) settings and had transitioned into PHC employment within the last five years.

Difficulties associated with researching the PHC nursing workforce have been widely reported due to the diversity of settings in which they work, and the lack of a national database of PHC nurses. Recruitment to the survey (Phase 1) was therefore multifaceted combining snowball and convenience sampling. The survey was promoted via a link included in emails which were distributed by national professional nursing organisations, including the ACN, ANMF and APNA, as well as PHNs in each state and territory. Additional promotion occurred via social media such as Facebook, LinkedIn and Twitter. Survey respondents who indicated willingness to be interviewed were purposefully selected for the second phase based on factors such as the PHC employment setting, geographic location, age, and nursing experience.

Survey tool

As no validated survey tool was identified which met the study criteria, a tool was developed from a critical review of relevant literature, input from PHC experts and using the principles of role theory. This tool was subjected to a two phased piloting process. A purposefully selected group of experienced PHC nurses and research experts provided initial feedback on question content, structure, and survey design. Subsequent feedback related to the functionality of the survey in the online context. The survey consisted of three sections: section 1; demographic characteristics, acute care experience and reasons for moving to PHC, section 2; how nurses were orientated and supported in their
new roles, and their levels of satisfaction with PHC nursing, and section 3; about their current status and career intentions. Free text options were included throughout the survey. This paper reports on section 2 and section 3 data relating to reflections on PHC as a career move, satisfaction with PHC employment and future career intentions.

The survey, which was hosted online by SurveyMonkey\(^{(138)}\), was open from July-September 2015, with reminders circulated at intervals prior to survey closure.

**Interviews**

Semi-structured interviews were conducted by one researcher between February and May 2016, to expand and explore survey findings\(^{(205)}\). Questions were informed by existing literature, survey findings and role theory concepts\(^{(48)}\). Interviews, which ranged in length from 30 to 45 minutes continued until data saturation was achieved\(^{(175)}\). Twelve interviews were conducted by telephone due to the geographic spread of participants, and one conducted face to face. Interviews were digitally audio-recorded and professionally transcribed verbatim, and then checked by the researchers for accuracy. Pseudonyms have been used to protect identities and maintain confidentiality.

**Data analysis**

Survey data were exported from SurveyMonkey\(^{(138)}\) into SPSS Version 22\(^{(162)}\) and were analysed descriptively. Pearson’s chi-square test was conducted to compare demographic characteristics with levels of job satisfaction. A p value greater than 0.05 was considered significant.
Open ended responses from the survey and interview data from Phase 2 were imported into NVivo Version 10\(^{(163)}\) and analysed using Braun and Clarke’s\(^{(166)}\) thematic analysis approach. Integration of the data took place at several points, with survey responses informing selection of interview participants and the structure of interviews. Final integration involved merging the two data sources into a combined dataset.

**Results**

*Demographic characteristics*

One hundred and eleven respondents representing every Australian state and territory completed the survey, and thirteen interviews were conducted. A full description and analysis of the demographic data of survey respondents and interview participants are reported elsewhere\(^{(49; 173; 205)}\), however, a demographic summary is provided in Tables 8.1 and 8.2 to provide context. Survey respondents had worked in PHC for a mean of 3.4 years and just over half worked in city or metropolitan areas \((n=67, 60.9\%)\). Respondents reported previously working in a diverse range of acute care settings, including general wards, critical care, child and family health and mental health. The largest sub-group in both the survey respondents \((n=71, 64.5\%)\) and interview participants \((n=6, 46.0\%)\) were employed in general practice.

*Satisfaction with PHC employment*

Respondents were largely satisfied with their PHC roles in the first six months following transition, with all aspects scoring a mean >3 indicating a mean rating of ‘somewhat satisfied’ \((Table 8.3)\).
### Table 8.1 Survey respondent demographic characteristics

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-29</td>
<td>10</td>
<td>9.0</td>
</tr>
<tr>
<td>30-39</td>
<td>18</td>
<td>16.2</td>
</tr>
<tr>
<td>40-49</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>50-59</td>
<td>35</td>
<td>31.5</td>
</tr>
<tr>
<td>60-67</td>
<td>9</td>
<td>8.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>106</td>
<td>95.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years worked as an RN</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.9</td>
<td>11.2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years worked in PHC</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4</td>
<td>3.5</td>
<td></td>
</tr>
</tbody>
</table>

### Table 8.2 Interview participant characteristics

<table>
<thead>
<tr>
<th>PHC setting</th>
<th>Geographic location</th>
<th>Pseudonym</th>
<th>Age</th>
<th>Years in nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health</td>
<td>Rural</td>
<td>Denise</td>
<td>52</td>
<td>13</td>
</tr>
<tr>
<td>Community mental health</td>
<td>Remote</td>
<td>Vanessa</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>General practice</td>
<td>City/Metro</td>
<td>Alex</td>
<td>23</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Natalie</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>City/Metro</td>
<td>Francine</td>
<td>52</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>Christine</td>
<td>58</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nicky</td>
<td>26</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liz</td>
<td>56</td>
<td>23</td>
</tr>
<tr>
<td>Refugee health</td>
<td>City/Metro</td>
<td>Sue</td>
<td>39</td>
<td>4</td>
</tr>
<tr>
<td>School</td>
<td>City Metro</td>
<td>Barb</td>
<td>45</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suzanne</td>
<td>57</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Margaret</td>
<td>62</td>
<td>28</td>
</tr>
<tr>
<td>Sexual health</td>
<td>City/Metro</td>
<td>Mieken</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>
Interaction with patients and families (mean 4.64), the professional nursing role (mean 4.27), workload (mean 4.27) and respect from colleagues (mean 4.25) were rated highest in terms of satisfaction. Free text survey comments confirmed these findings.

“I felt highly valued in the practice in a very short space of time” and “I love my role in PHC and the interaction with my patients, we are an advocate for our patients by providing active team care and preventative health care”.

Satisfaction was also confirmed by interview participants; “It’s not as scary as it [first] seemed – it’s actually a lot of fun” (Alex, practice nurse).

Ongoing learning (mean 3.65) and orientation (mean 3.59) were rated as the least satisfactory aspects by survey respondents, with a mean of ‘neither satisfied nor dissatisfied’. Free text comments explained: “There is no financial support for professional development and acceptance of ideas of new strategies into the work place” and “I was obliged to learn on the go”. Interview participants provided further insights: “professional development…that’s the biggest stand out [challenge]…not being able to access anything” (Alex, practice nurse).

Pearson’s chi-square test failed to demonstrate a statistically significant relationship between age, previous acute care experience and aspects of satisfaction with PHC employment.

**Reflecting on transitioning**

Eighty nine (80.2%) survey respondents provided free text reflections on their transition experiences. Data were grouped according to positive, negative or mixed role experiences.
Table 8.3 Satisfaction in first six months

<table>
<thead>
<tr>
<th>Category</th>
<th>1 Dissatisfied</th>
<th>2 Somewhat dissatisfied</th>
<th>3 Neither satisfied or dissatisfied</th>
<th>4 Somewhat satisfied</th>
<th>5 Satisfied</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction with patients and families</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>23</td>
<td>82</td>
<td>73.9</td>
<td>4.64 0.70</td>
</tr>
<tr>
<td>Professional nursing role</td>
<td>2</td>
<td>7</td>
<td>10</td>
<td>32</td>
<td>60</td>
<td>54.1</td>
<td>4.27 0.99</td>
</tr>
<tr>
<td>Workload</td>
<td>0</td>
<td>10</td>
<td>9</td>
<td>32</td>
<td>59</td>
<td>53.2</td>
<td>4.27 0.96</td>
</tr>
<tr>
<td>Respect from colleagues</td>
<td>3</td>
<td>8</td>
<td>8</td>
<td>31</td>
<td>61</td>
<td>55.0</td>
<td>4.25 1.05</td>
</tr>
<tr>
<td>Workplace management (eg. rostering, human resources)</td>
<td>2</td>
<td>9</td>
<td>19</td>
<td>29</td>
<td>52</td>
<td>46.8</td>
<td>4.08 1.06</td>
</tr>
<tr>
<td>Being Involved in the team</td>
<td>4</td>
<td>11</td>
<td>9</td>
<td>34</td>
<td>53</td>
<td>47.7</td>
<td>4.09 1.13</td>
</tr>
<tr>
<td>Workplace environment (eg. facilities and equipment)</td>
<td>5</td>
<td>11</td>
<td>9</td>
<td>37</td>
<td>49</td>
<td>44.1</td>
<td>4.02 1.16</td>
</tr>
<tr>
<td>Ongoing learning (eg. workplace role models, mentorship)</td>
<td>8</td>
<td>18</td>
<td>19</td>
<td>24</td>
<td>41</td>
<td>36.9</td>
<td>3.65 1.32</td>
</tr>
<tr>
<td>Orientation (eg. preceptors, feedback)</td>
<td>9</td>
<td>17</td>
<td>18</td>
<td>33</td>
<td>34</td>
<td>30.6</td>
<td>3.59 1.29</td>
</tr>
</tbody>
</table>
**a) Positive experiences**

Forty nine respondents (55.6%) described having positive experiences. Positive comments referred to the rewarding relationships with clients and families, the autonomous and diverse nature of PHC nursing, opportunities to develop new skills, and the excellent work life balance. Interview participants confirmed and expanded these findings, with participants giving examples of the value of close client relationships in providing better care:

“I've got more time to know my patients, compared with the hospital. In primary health settings you will see the same patients all the time which I really enjoy...you become very close to the patient which is good as it means they trust you and you can provide better care to them” (Nicky, practice nurse).

The diversity and autonomy of the role and opportunities for professional growth were also positively described:

“I've learned so much more – chronic disease management, one on one with patients. I love the range. ..You get great exposure to all sorts” (Liz, practice nurse).

*It’s definitely more autonomous...the advice that you’re giving to people is really between you and them...ICU was fantastic in that you were constantly developing your skills...[but] I do enjoy my [PHC] work. There’s a lot more room I feel here for growth”* (Mieken, sexual health nurse).
Others described the value placed on the work life benefits of PHC:

“I loved my acute care [but] it was great to change and I love the position I’m in at the moment. The hours are far more family friendly and much nicer” (Barb, school nurse).

Sue also referred to the opportunity to have a global view of health:

“I think PHC is more interesting because of those social determinants...you see the bigger picture” (Sue, refugee health nurse).

b) Negative and mixed experiences

Nine (10.2%) of the free text survey responses reported their experiences as negative or a mix of negative and positive, with remuneration, loss of skills and negative comments from colleagues identified as adverse aspects of PHC nursing. Lower levels of remuneration in PHC nursing were described as impacting on the perception of the role:

“It kind of makes you feel that you aren’t as important as the RNs in clinical (acute) settings because they are covered under an award...we’re out on the sideline here. We’re falling behind everyone else and I think it’s really important that community nurses are equally recognised” (Denise, community nurse).

“They won’t consider a pay rise. I didn’t get even a dollar extra an hour for getting my immunisation certificate. We’re not on an award...we’ve just been offered this money, and that’s it” (Natalie, practice nurse).
The lower levels of remuneration were however, offset by some survey respondents who stated that this was balanced by the improved work life balance in PHC employment:

“I thoroughly enjoy the variety of PHC and I enjoy nursing people across the lifespan. The best things about PHC are the sociable hours – the salary though is not enticing” (survey response).

Another concern identified by over 12% of survey respondents as well as interview participants related to the potential loss of acute clinical nursing skills when employed in PHC:

“I’m only 23 years old – how will I ever get back into acute care because I’ve lost my basic [acute] nursing skills. I don’t do neurological assessments and things like that...it’s so easy to lose those acute care skills” (Alex, practice nurse).

“I am concerned about my clinical skills, so this year I’m working casually back at the hospital to maintain those skills” (Barb, school nurse).

Associated with the loss of skills were concerns relating to the capacity of PHC nurses to practice to their full scope:

“I often feel my skills are not utilised fully but remind myself that I left the stressful public health service due to continued stress and burnout” (survey response).

Some survey respondents reported experiencing a degree of negativity from their acute care peers in response to their move to PHC employment:
“the general population of nurses don’t have a great amount of knowledge about the role of PHC… I remember when I was ward nursing everyone [said] ‘oh god you’re going to GP nursing. It’s like the graveyard that nurses go to” (survey response).

“They’d say things like, oh, that’s such a waste of a good nurse to move into community nursing. A lot of them said, you know, that’s what you do just before you retire. They look down on community nurses as people that just can barely do nursing...all the negative stuff was from the acute setting really. I don’t think there was one person that was particularly positive” (survey response).

**Future career intentions**

Most survey respondents (90.0%, n=100) agreed or strongly agreed that they intended to continue their nursing careers for the foreseeable future, with 85.5% (n=95) agreeing or strongly agreeing that they planned to remain working in PHC for the foreseeable future (Table 8.4). Despite these positive findings, only 55.1% (n=59) of respondents agreed or strongly agreed that they would still be working as a PHC nurse in the next five years. Additionally, 20.4% (n=22) of respondents were undecided and 9.4% (n=10) agreed or strongly agreed that as soon as convenient they intended to leave PHC nursing. One third (n=36; 33.6%) indicated that they were undecided and 11.5% (n=12) disagreed or strongly disagreed that they would still be working as a PHC nurse in the next 5 years. This represented a sizeable group of respondents who were either uncertain about their future in PHC or intended to leave.
### Table 8.4 Future career intentions

<table>
<thead>
<tr>
<th></th>
<th>1 Strongly Disagree</th>
<th>2 Disagree</th>
<th>3 Undecided</th>
<th>4 Agree</th>
<th>5 Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I intend to continue my nursing career for the foreseeable future</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>I intend to continue my nursing career in PHC for the foreseeable future</td>
<td>1</td>
<td>0.9</td>
<td>11</td>
<td>37</td>
<td>58</td>
</tr>
<tr>
<td>As soon as it is convenient I plan to leave the nursing profession</td>
<td>47</td>
<td>44.3</td>
<td>20</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>As soon as it is convenient I plan to leave PHC nursing</td>
<td>42</td>
<td>38.9</td>
<td>22</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>I am actively looking for another job outside the nursing profession</td>
<td>71</td>
<td>66.4</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>I am actively looking for another job outside PHC</td>
<td>62</td>
<td>57.4</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>I will still be working as a nurse in PHC next year</td>
<td>3</td>
<td>2.8</td>
<td>9</td>
<td>33</td>
<td>60</td>
</tr>
<tr>
<td>I will still be working as a nurse in PHC in the next five years</td>
<td>7</td>
<td>6.5</td>
<td>36</td>
<td>18</td>
<td>41</td>
</tr>
</tbody>
</table>
Age, years in nursing and previous experience did not predict future career intention. However, those working in city/metro areas indicated that they were less likely to be working in PHC in the next 5 years compared to those working in rural or remote areas ($\chi^2 = 6.79, p = 0.03$).

All interview participants spoke of their intentions to stay in PHC, with some speaking of the diverse opportunities available within the various PHC settings:

“…you have to go in [to PHC] with an open mind, but once you get there it sort of sucks you in and you can’t leave! It’s a good job and very interesting. Yes…I’m planning to stay in PHC …”
(Margaret, school nurse).

“I'll be here probably … next year and then I'll see, but I think even the other roles that I've been looking at are more public health - infection control, community health aspects. I don’t know whether I'll go back to the hospital system and shift work again” (Mieken, sexual health nurse).

**Discussion**

The experience of transition has been described in the literature as being personally and professionally challenging\(^{[148, 199, 232]}\). This study has provided new data to explore the work satisfaction of experienced nurses new to PHC and their future career intentions. Work satisfaction has been found to be a significant predictor of staff retention\(^{[266, 267]}\). This study highlighted a number of areas in which respondents were highly satisfied, and also identified consistent areas of low satisfaction. Our findings that respondents were satisfied with their
interactions with patients and families in the PHC environment, are similar to those reported in the literature\(^{268;269}\). Similarly, the relationship between manageable workloads and satisfaction found in our study resonates with previous work in acute care\(^{184;270}\). The less satisfactory aspects of transitioning, such as the quality and nature of orientation programs and availability of ongoing educational support, concurs with previous broader studies of the PHC workforce\(^{184;271}\). The findings of these issues in the newly transitioned cohort indicates a need to focus on improving access to structured orientation and education programs across the sector.

When reflecting on their old acute and new PHC roles, participants in the study revealed a range of professional and personal gains and challenges associated with their transition. Participants placed great importance on a positive workplace culture, including encouragement to be innovative in utilising new and existing skills. These positive findings are important as associations have been identified between staff satisfaction and better patient outcomes, increased safety, and improved retention rates\(^{203;272}\).

Consistent with recent literature\(^{147;184}\), our study identified remuneration as a negative aspect of working in PHC. However for some, the benefits of family friendly hours and the convenience of the practice location outweighed this. Previous literature has also reported that remuneration alone was rarely the chief source of dissatisfaction\(^{221;267}\). Other negative aspects such as loss of acute nursing skills, barriers to practising to their full scope, and lack of support to undertake professional learning, emphasise the need for organizational commitment to promote ongoing professional development. Employers need to be innovative and supportive in identifying opportunities for PHC nurses to
maintain existing skills and develop new skills, to facilitate a sustainable skilled PHC workforce. Such approaches may include providing educational opportunities, supporting attendance at educational activities, and encouraging participation in professional development.

Like Henderson et al.\(^{(273)}\), our cohort described a lack of understanding amongst their acute care peers about the career opportunities available in PHC.

Similarly, Murray-Parahi et al.\(^{(54)}\) identified the limited understanding of PHC nursing amongst newly graduated nurses. These findings suggest that promotion of careers in PHC has been inadequate. To meet the growing demand for nurses in PHC, and to fill the increasingly complex nursing roles, it is vital that PHC nursing is positively promoted, and PHC career pathways be developed\(^{(183, 231)}\). Whilst organisations such as APNA are seeking to address this, there remains an urgent need for employers and policy makers to strategically plan recruitment campaigns which focus on the unique opportunities and benefits available to PHC nurses.

The majority of participants indicated their intention to remain in nursing and PHC for the foreseeable future. This is an important consideration for employers, as intention to leave is often used as a proxy for turnover, strongly predicting actual departure from a job\(^{(274)}\). We identified that rural nurses were more likely to intend to stay working in PHC in the long term than urban/city nurses, possibly relating to the positive levels of community and social supports found in rural settings\(^{(215)}\) or due to the decreased employment opportunities in rural communities.
Conversely, the group of respondents (29.6%) who were either undecided or indicated an intention to leave so soon after moving to PHC provides evidence of the need for managers to give close consideration to implementing strategies to support workforce retention. Whilst improved work life balance and other personal reasons are cited as reasons initially triggering the move to PHC\(^{173;184}\), these benefits seem insufficient to retain a proportion of the PHC workforce. This finding highlights the need for managers, educators and employers / policy makers to constantly review support and retention strategies.

Limitations

Undertaking research relating to PHC nursing in Australia is subject to difficulties due to the lack of a national database of the PHC nursing workforce\(^{154}\). It is not possible, therefore to be sure how representative our survey cohort was of the broader PHC workforce. In acknowledging the limitations of the size of our survey sample, the techniques used, however, were similar to other recent studies of the Australian PHC nursing workforce\(^{147;229}\). An additional limitation was that participants were self-selected, and responses may represent personal agendas.

Conclusion

This study provides evidence about nurses’ satisfaction with PHC employment, their reflections on the career move, and future career intentions. As the demand for a sustainable PHC workforce increases, our findings confirm that the benefits of a career in PHC need to be disseminated. Additionally, an increased emphasis on orientation and ongoing learning is required to enhance
levels of satisfaction. The sizeable group of participants who were undecided or negative about their future career intentions also suggests that attention is required to implement retention strategies to address the negative aspects raised by participants and provide support to encourage their retention.

**Implications for nursing management**

To maximise PHC recruitment and retention of nurses, managers must be aware of factors which influence satisfaction amongst nurses transitioning from acute care to PHC. In particular, well designed orientation programs and access to ongoing learning are important considerations for employers, educators and managers. The amalgamation of individual work values and organisational management processes in PHC are also essential in order to enhance work satisfaction and minimise workforce turnover.
Chapter 9: Discussion and conclusion

“PHC nursing has made me a better person with more awareness and a less judgemental approach to caring for people”

Survey respondent.
Chapter introduction

This final chapter draws together the findings presented in Chapters 5 – 8 and discusses them from the perspective of role theory, and in relation to their significance for future PHC workforce planning. The discussion also identifies areas for further research, and makes recommendations for future action in policy, education and clinical practice. The strengths and limitations of the study are presented, and the chapter concludes with a final summary of the key outcomes from the research.

Key findings

This study has generated new knowledge relating to the interplay of personal and professional drivers prompting the move by acute care nurses to PHC employment\(^{(49)}\). It has also reported the experiences of those who have transitioned between acute and PHC settings\(^{(173; 205)}\) and has explored the participants’ satisfaction and future career intentions\(^{(50)}\). These data build on previous research relating to transitions in nursing, and to other PHC nursing workforce research\(^{(52; 147; 184; 199; 275)}\).

Work by role theorists\(^{(28; 29)}\) describing the different stages of adjusting to life transitions and transitions in the workplace\(^{(48)}\) also assisted in explaining the transitioning experiences reported by study participants. The stages which reflect the transition process of participants and the interrelated role theory stages and concepts are summarised in Table 9.1.
Table 9.1 Transition stages and related role theory concepts

<table>
<thead>
<tr>
<th>Stage</th>
<th>Role theory stage</th>
<th>Related role theory concepts$^{(48)}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Why nurses chose to move to PHC</td>
<td>Role Exit and Entry: making the move</td>
<td>Disengaging from the old role, crossing role boundaries, establishing a new role identity</td>
</tr>
<tr>
<td>2. Orientation</td>
<td>Role Learning: the new environment</td>
<td>Role enactment, role ambiguity, role stress and role strain</td>
</tr>
<tr>
<td>3. Settling in and ongoing support</td>
<td>Role Socialisation: transition validation</td>
<td>Role identity, role conflict</td>
</tr>
<tr>
<td>4. Reflections and future career intentions</td>
<td>Self-Continuity</td>
<td>Role identity, rites of passage</td>
</tr>
</tbody>
</table>

**Role exit and entry**

Participants reported various reasons for disengaging from their acute care nursing employment, but significantly the reasons cited related more to personal rather than professional drivers$^{(49)}$. These were important regardless of participants’ age. Associated with both personal and professional drivers were opportunities to increase work satisfaction. Previous research has explored the drivers leading to work satisfaction amongst nurses in various settings$^{(148; 276; 277)}$. Lack of autonomy or professional recognition, poor work environment and increasing demands are frequently cited as barriers to satisfaction, resulting in staff turnover$^{(267)}$. In a time of global change, the old world view of a career has evolved from a long term mutual commitment with opportunities for promotion within an organisation to short-term ‘mutually convenient’ interactions between employers and employees$^{(278)}$. In Kanter’s$^{(279)}$ seminal work on organisational socialisation he describes contemporary careers as events which are dynamically connected with economic, social or political issues within a society. Similarly, role theorists argue that role transitions are influenced by macro and micro level factors which lead to workforce reconfiguration$^{(29)}$. Within the
complexity of the PHC environment, both macro and micro level factors\(^{(280)}\) were found to have considerably influenced the transition experiences of participants. From a macro perspective, the shift in health policy and funding towards a focus on the provision of care in PHC settings has been demonstrated in health systems throughout the world\(^{(7)}\). In Australia over the last fifteen years, government funding has been significantly increased to support PHC initiatives\(^{(106)}\). Associated with this has been the growth in the Australian PHC nursing workforce, and an increased presence of multidisciplinary health professionals working together to improve health\(^{(106)}\). This has resulted in a range of associated stakeholders influencing the PHC environment, such as professional organisations, regulatory bodies and accreditation authorities\(^{(280)}\). Within nursing, these macro level changes have created new opportunities to function in largely autonomous nursing roles in PHC settings, removed from and contrasting with the medically dominated paradigm associated with acute care nursing\(^{(281)}\). However, as revealed in this study, issues of role ambiguity need to be addressed in order for nurses to practise to their full scope and capacity in the PHC setting. The dichotomy of practising nursing within a business model, where health becomes a commodity rather than focusing on the best interests of the patient, is likely to impact on the employee/employer relationship, and ultimately on job satisfaction\(^{(282)}\).

At the micro level it is argued that, in recent times, nursing roles in acute care have been fragmented as a result of increasing technology and specialisation, and changing scopes of practice for health professionals\(^{(232)}\). Consequently, nurses have been required to undertake new tasks traditionally performed by
others\textsuperscript{(281)}. This has been reported to undermine the core attributes of nursing, which initially attracted individuals to the profession\textsuperscript{(281)}. Examples of this include RNs’ increasing responsibilities for undertaking various administrative tasks\textsuperscript{(283)}. These activities have been reported as being at the expense of the provision of patient/family care\textsuperscript{(283)}. The literature also describes the decreased job satisfaction experienced by acute care nurses who report having limited ability to practice to their full scope, or to autonomously make decisions within the medically dominated paradigm of acute care facilities\textsuperscript{(281; 284)}.

In contrast, PHC models of collaboration between multidisciplinary health professionals and consumers\textsuperscript{(280)} have been reported to provide increasing opportunities for nurses to realise their full potential in delivering improved health outcomes\textsuperscript{(284; 285)}. This would support the importance reported in the literature\textsuperscript{(184; 269)} and by study participants in achieving greater work satisfaction through autonomous practice and the development of collaborative patient/family relationships in PHC nursing. From the perspective of recruitment and retention of nurses, these are key factors to promote as positive aspects of PHC nursing.

This study revealed a perceived lack of knowledge about PHC, and PHC nursing by nurses working in acute care settings\textsuperscript{(49)}. This was expressed in the reported negative behaviours and attitudes of acute care peers hearing of their colleagues’ decisions to transition to PHC. The ambivalent attitudes of some acute care nurses towards PHC employment may be explained by role theorists who emphasise the importance placed by workers on socialisation or ‘familiarisation’ with their existing roles\textsuperscript{(29; 286)}, and the characteristics, norms
and values associated within a specific role (94). The negative attitudes also demonstrate a lack of knowledge and understanding about the PHC environment and PHC models of care (273) which needs to be addressed by the profession if the personal and professional opportunities associated with PHC nursing are to be promoted (183; 287).

From the participants’ perspective, lack of a clear vision about the new work environment was secondary to the desire to move to something new. Role theory explains this need to ‘move on’ as relating to the inability to continue to find value in being competent and confident in the ‘old’ (acute care) role (48).

Familiarisation with the acute care role in this study was replaced by a stronger motivation to find personal meaning in work and a better work/life balance, regardless of the nature of work in PHC employment (28). Bridges (28) notes that typically this shift in work attitudes takes place in the 35 – 50 years age group, which is congruent with the mean age of participants in this study.

**Role learning and role socialisation**

This study found that the transitioning process following ‘role exit’ from acute nursing into PHC nursing employment consisted of two distinct but interrelated phases – role learning, and socialisation. These findings are consistent with both social structuralist role theorists, and symbolic interactionists (48).

From the social structuralist role theorists’ perspective, the PHC nursing role is made up of a series of behaviours common to the specific context of practice which shape an individual’s behaviour (46). In the context of the current study, transitioning to PHC nursing required participants to learn a new skill set, adjust to new work arrangements and identify their new scopes of practice (26).
Adjusting to the new role was, however, frustrated by barriers such as varying levels of support from peers and employers, levels of trust between employee and employer, lack of organisational knowledge, information overload, role ambiguity and role conflict\(^{(48)}\). From the social structuralist role theorists’ perspective these social environment factors are more influential on patterns of behaviour of employees than individual responses of nurses challenged by their new roles\(^{(48; 94; 286)}\). Identification of these barriers and development of strategies to overcome them should therefore be prioritised by employers, managers and policy makers to assist in supporting nurses transitioning into PHC employment.

Through the lens of symbolic interactionism, the socialisation phase of transitioning is illustrated by the individual actions of some participants who were self-motivated to undertake additional learning and to develop resources to help other future transitioning nurses\(^{(48)}\). The innovative approaches described by some participants to enhance the services provided in their workplace also illustrate the symbolic interactionist approach to role theory\(^{(48)}\). These proactive approaches support Ashforth’s\(^{(29)}\) findings that the traditional passivity associated with entry to new roles has been replaced by highly motivated individuals supporting their own role learning and engaging in role innovation. The variable timeframes taken to feel confident within the PHC environment also exemplified the individual differences in role adjustment associated with symbolic interactionist explanations for role behaviour\(^{(48)}\).

The difficulties in transitioning both in the role learning and socialisation phases were described by participants as being associated with the levels of support provided in their work place\(^{(48; 288)}\). The lack of direct support resulting from
working alone on shifts that was reported by some participants, impacted on their ability to learn and to socialise into the new role. Previous studies have also identified professional isolation\(^{(24; 289)}\) as a negative aspect of PHC nursing, with the lack of professional guidance leading to errors being made by unsupervised or inexperienced nurses\(^{(106; 290)}\).

The critical importance of providing appropriate types of support has been reported in the literature with authors arguing that support is required across the three structural tiers in PHC – at the clinical level, by the team, and systemic strategic support\(^{(232; 291)}\). Using this tiered approach, ‘clinical support’ is described as using interventions aimed at facilitating clinical work. In the PHC setting this could mean extended periods of preceptorship and professional mentorship to develop clinical competence, access to training manuals and dedicated time to attend workshops. The team plays an important part in the transition process at the second level by creating and supporting learning opportunities, providing performance feedback and by ensuring an inclusive team approach to care planning. Support at the systemic level relates to how organisations are strategically prepared for employing new employees\(^{(291)}\). Organisations need to ensure there are financial resources to meet the costs associated with employees transitioning to PHC, that policies support new employees, communication is facilitated across the organisation and that roles of the multidisciplinary team are clearly articulated\(^{(291; 292)}\).

The barriers to successful transitioning described by participants, illustrates the investment needed by some employers to support nurses new to PHC. Employers need to ensure availability of appropriate resources such as access
to preceptors during the initial orientation phase, availability of ongoing mentors and/or clinical supervision as well as opportunities for performance review in the long term\(^{(269)}\). Strategically, PHC employers can also assist in enhancing transition experiences by investing in the development of a climate of learning, and by ensuring a positive work environment where professional respect and good communication are embedded in policies and practice\(^{(184; 272)}\). Such strategies will positively impact on the socialisation aspects of transitioning, promote job satisfaction and assist in staff recruitment and retention\(^{(240)}\).

**Self-continuity**

Self-continuity in this study can be described as that period of time when transitioning nurses identify themselves foremost as PHC nurses, and are able to reflect back on their career path from acute care nursing. Many participants described how over time any tensions associated with the move to PHC were dissolved, and high levels of job satisfaction achieved\(^{(148; 293; 294)}\). Indeed, most interview participants reported being unlikely to return to acute nursing\(^{(205)}\). However, approximately a third of survey participants reported that they were undecided or uncertain if they would remain in PHC nursing in the long term\(^{(50)}\). These findings indicate that participants, regardless of age, were uncertain about their future career intentions, even when reporting high levels of satisfaction with PHC nursing and socialisation into PHC roles\(^{(294; 295; 296)}\). PHC employers, educators and policy makers therefore, all play a critical role in creating positive working environments conducive to reducing staff turnover in the short term\(^{(213; 297; 298)}\), and introducing career structures to support future career planning in PHC employment\(^{(299; 300)}\). Role theorists also argue that short
term intention to stay, and long term career intentions are influenced by the inability of some individuals to completely relinquish their ‘old’ role, regardless of exemplary supports during transition, and evidence of socialisation into the new role\(^{26; 28; 29}\). It is possible that this may explain why some participants were unwilling to commit to long term careers in PHC, having been unable to totally relinquish their acute care identity. This may have been influenced by views expressed by acute care peers that ‘real’ nursing only happens in acute care\(^{54}\).

Optimal workforce retention in PHC is essential in order to provide efficient and safe delivery of care, as well as to ensure positive patient outcomes\(^{7}\). Likewise, employee longevity is critical as it takes time to develop clinical expertise, to develop trust between employer and employee, and to establish effective workplace interactions\(^{301}\). Staff retention also reduces the time required to orientate and support new staff, thus reducing the burden on resources\(^{210}\). This, in turn, enhances workforce stability and job satisfaction across the workplace, increases productivity, and is associated with increased patient satisfaction and lowering of costs\(^{210; 301}\). In contrast, high turnover is linked to reduced productivity and burnout of other staff required to ‘fill in’ until vacant positions are filled\(^{301}\). Flowing on from this are restrictions on an organisation’s ability to implement new programs or to fulfil program goals\(^{301}\).

Whilst PHC employers may wish to develop retention strategies to minimise avoidable premature departure of staff, optimising retention does not imply an indefinite length of service in one location\(^{296}\). Across a lifetime and in today’s dynamic health care environment, career progression invariably necessitates movement between positions and organisations, and relocation including
between rural and urban settings\textsuperscript{(28)}. Traditionally, increased turnover in rural and remote clinical settings has created unique challenges such as additional recruitment costs and the availability of suitably qualified employees\textsuperscript{(301; 302; 303)}. The finding in this study that nurses working in rural or remote PHC positions were more likely to commit to a long term career in PHC than their urban peers is significant\textsuperscript{(173)}, and contrasts with findings from other studies\textsuperscript{(301; 302)}. This finding will be reassuring to rural and remote employers since sustainability of PHC services in these locations is often dependent on the maintenance of a skilled nursing workforce, and the pool of nurses from which to recruit is limited.

**Implications**

Nurses, like all health professionals, have a duty to provide optimal evidence based care to their patients. Implicit in this is the responsibility of individual nurses to ensure they practise safely and competently\textsuperscript{(152)}. Nurses moving to new areas of practice need to take responsibility for planning self-directed learning and professional development relevant to their new roles. However, when nurses make significant changes in employment such as moving from acute care to PHC environments, they must also be professionally supported to develop new knowledge and the skills to practise competently. Without this, both during the transitioning process and over time, findings from this study indicate that there is likely to be an impact on levels of job satisfaction, and by association, on staff retention. The literature also indicates that these may impact on patient safety and health outcomes\textsuperscript{(203)}.

This study has demonstrated that orientation programs, and access to ongoing professional support in PHC settings vary considerably, and are provided in an
ad hoc manner. This indicates a need for employers to have a more structured approach in place to assist nurses transitioning to PHC. Such an approach requires focusing on promoting PHC nursing as offering an exciting and varied career choice. Support processes need to be flexible in order to meet the needs of a diverse workforce presenting to PHC with a range of skill levels and capabilities\(^{238}\). They will also require the capacity to be adaptable to different geographic locations\(^{199}\), and to varying PHC settings\(^{304}\). Such an approach would also provide guidance to education providers, administrators and policy makers in planning for future workforce needs in PHC settings.

**Strengths and limitations**

Although research into the experience of transitioning within nursing is increasing, a key strength of this study was its unique focus, and the addition of new knowledge relating to the transition from acute to PHC employment\(^{47}\). Using role theory as a lens through which to view the transitioning experience was undoubtedly a strength of this study. Role theory provided a theoretical framework to inform the study design\(^{48}\), provided guidance about the scope of the research, and assisted in informing the analysis.

The sequential mixed methods approach was also a study strength\(^{111}\). Survey findings enabled the researcher to gain a worldview of the transitioning experiences and from analysis of these, to design interviews with the purpose of exploring specific issues in greater depth. It is unlikely that any one data source could have generated the richness of data or depth of insight into the transitioning experience that was achieved by integrating the two datasets in this study.
The lack of a national database of the PHC nursing workforce has been previously identified as a barrier when undertaking research in the field, since the accurate size of the PHC workforce and the source of nurses moving to PHC is unknown\(^{(154)}\). This limitation precludes the use of representative sampling techniques\(^{(154)}\). However, by taking a national approach and by using snowballing techniques to widely promote the research, the study was strengthened by the geographic and workplace diversity of respondents. This enabled analysis to be undertaken on a range of variables such as differences experienced by urban and rural PHC nurses, and nurses employed in several different PHC settings. The varying levels of participation across work settings, unequal representation of genders and self-selection of participants means that it cannot be assumed that the sample in this study was representative of the entire PHC nursing workforce. Further, as interview participants self-selected their willingness to participate, their responses may represent personal agendas. Methods of recruiting nurses for this study were however comparable with other studies undertaken into the broader Australian PHC nursing workforce\(^{(137;154)}\), and the sample size comparable.

**Recommendations for practice**

Recommendations for clinical practice emerging from the study are twofold. First, individual nurses who plan to move from acute care nursing to PHC employment need to consider the adjustments in roles and the clinical environment that accompany the change in workplace. They need to explore factors such as service funding, the transferability of existing clinical skills and the supports offered by potential new employers. By accessing relevant practice
standards they will be able to identify gaps in knowledge and clinical skills, and the impact this may have on their scopes of practice\textsuperscript{(140; 183)}. Given the mainly privatised nature of many PHC settings, the infrastructure to provide education and professional support varies from larger public health systems. Nurses therefore need to consider developing negotiation skills to gain access to additional professional supports and to manage wage negotiations\textsuperscript{(147)}.

Secondly, stakeholders including employers, education providers and professional organisations need to promote PHC nursing widely as a valued career choice. PHC models of nursing care need to be embedded across the RN curricula, with students being provided access to a breadth of experiential PHC clinical practice as well as learning opportunities to develop negotiation and business skills suited to PHC environments.

It is also essential for employers to create transition and orientation programs which are cognisant of the challenges faced by staff moving into PHC settings. This includes the need to provide professional development opportunities, learning resources in the workplace, and for skilled preceptors and mentors to be available to support nurses new to PHC. Employers must also be committed to supporting nurses either financially and/or by providing work release to undertake relevant professional learning\textsuperscript{(24)}. This will assist in maximising recruitment and retention of nurses, influencing levels of job satisfaction and may impact favourably on future career intentions\textsuperscript{(295)}.

**Recommendations for policy**

PHC is the frontline of Australia’s health care system\textsuperscript{(106)}, and having a stable and skilled PHC nursing workforce is therefore essential in order to ensure a
sustainable PHC system. However, PHC is not a homogeneous sector, and there are a range of important variables related to the context in which PHC services are delivered which may significantly influence the provision of care by nurses\(^{(106)}\). These contextual variables relate to the type of provider (for example, a general practice ‘small business’, a state funded school, a Commonwealth funded Aboriginal community controlled health service), the education and training of the health professional, and the geographic location of the care setting\(^{(305)}\). These variables require the implementation of evidence based policies which recognise the complexity of the PHC workforce and environment. Most Australian state governments have already developed policies relating to the establishment and support for new graduate transition to practice programs\(^{(306; 307)}\). However, there is an urgent need for similar policies to be developed relating to PHC nursing. Findings from this study provide an evidence base for national and state based policies promoting awareness of PHC nursing, and state policies which address disparities in salary and conditions for PHC nursing\(^{(6; 137)}\). At an organisational level policies are required which address confusion relating to roles and responsibilities. These should focus on re-designing traditional professional roles in PHC to maximise the skills and capabilities which PHC nurses bring to their roles\(^{(205)}\). Despite the predominance of small business and non-government employers in PHC, this study has also identified the importance of establishing local workplace polices which articulate the nature of transition programs, and other professional supports for PHC nursing employees. These are essential in order to ensure safe work practices and employment of competent clinicians. A means to achieve this could be through the provision of support by PHNs\(^{(9)}\). A structured
workplace will also assist in promoting job satisfaction, staff retention and reduced turnover.

**Recommendations for further research**

This study has identified a number of areas in which further research is warranted. The limited understanding of nursing in the PHC sector described by participants highlights the need to further explore attitudes relating to careers in PHC nursing amongst students and the broader nursing community. Findings from such research will enable targeted and evidence based promotional campaigns to be designed to better inform the wider nursing community about the diverse opportunities for PHC employment. Further research is also required to explore various models of support required in specific PHC settings, the types of support currently provided, and the impact of different approaches to transition support. Such research could include testing orientation and support interventions for their impact on transition, job satisfaction and retention of staff. Longitudinal studies could also be undertaken to explore the transition experience of nurses over time, and what factors, if any, impact on the long term career plans of the PHC nursing workforce. This could inform the development of robust recruitment, retention and workforce development strategies. From another perspective, research into the impact that transitioning nurses may have on employers, could inform the development of programs that are feasible and sustainable within the health system and political context.

**Conclusion**

The complexity of the PHC environment and its rapid growth over the last decade has highlighted the importance of having a highly skilled, adaptable and
sustainable nursing workforce. Creating such a workforce requires an evidence base of the barriers and enablers to successfully transition, as well as establishment of mechanisms to promote the positive characteristics and to address negative aspects of PHC nursing employment. By utilising a mixed methods approach, and using role theory to inform the study design, this study provides new insights into the experiences, perceptions and intentions of Australian nurses who have transitioned to PHC employment. Findings have highlighted the reasons why nurses are attracted to PHC, the negative attitudes expressed by peers, and the initial challenges associated with the transition. The differing levels of support provided to transitioning nurses by employers, and the personal experiences and future career plans of the cohort have also been identified. Nurses are likely to consider leaving PHC prematurely unless policy makers and employers ensure that their working environment reflects the issues nurses consider to be conducive to retention.

Nurses will play a pivotal role in the future in ensuring that the PHC sector is able to meet the evolving needs of the Australian community. This study has illustrated how there is still work to be done by policy makers, educators and employers to ensure that nurses moving to PHC are appropriately supported to function effectively in the PHC environment.
Reference list


Appendices

Appendix A: Ethics Committee Letter of Approval

Appendix B: Recruitment Letters

Appendix C: Survey Tool

Appendix D: Interview Participant Information & Consent Form

Appendix E: Semi-Structured Interviews Schedule

Appendix F: Peer Reviewed Publications
Appendix A: Ethics Committee Letter of Approval
APPROVAL after review
In reply please quote: HE15/179
Further Enquiries Phone: 4221 3386

12 May 2015

Prof Elizabeth Halcomb
Building 41
School of Nursing
University of Wollongong

Dear Prof Halcomb

Thank you for your letter responding to the HREC review letter. I am pleased to advise that the Human Research Ethics application referred to below has been approved

Ethics Number: HE15/179
Project Title: Exploring the Transition of Registered Nurses from Acute Care to Primary health Care Settings
Name of Researchers: Prof Elizabeth Halcomb, Ms Christine Ashley, Ms Angela Brown
Documents Approved:
- Initial Ethics Application
- Participant Information Sheet - Survey V3
- Participant Information Sheet - Interviews
- Participant Consent Form - Interviews
- Transcript of email to organisations about the survey
- Letter to survey participants
- Consent Form
- Letter to interview participants
- Survey V2

Approval Date: 12 May 2015
Expiry Date: 11 May 2016

The University of Wollongong/SLHD Health and Medical HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research. The HREC has reviewed the research proposal for compliance with the National Statement and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at http://www.uow.edu.au/research/rso/ethics/UOW009385.html. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.
As evidence of continuing compliance, the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email reo-ethics@uow.edu.au.

Yours sincerely

[Signature]

Professor Colin Thomson
Chair, UOW & ISUHD Health and Medical Human Research Ethics Committee
Appendix B: Recruitment Letters
Dear Colleague

I am writing to seek your assistance in promoting a study being conducted by the University of Wollongong entitled **Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings**. Ethics approval for the conduct of this project has been obtained from the Human Research Ethics Committees (HREC) of the University of Wollongong (UOW), approval number HE15/179. The investigators for this study are Christine Ashley, PhD candidate, and Liz Halcomb, Professor of Primary Health Care Nursing.

Transitioning from one area of nursing to another has previously been found to be stressful, and may be associated with personal, professional and organizational challenges. Increasingly, more and more healthcare is being provided in primary health care settings, resulting in many nurses moving from acute settings to primary health care (PHC) roles. Little is known about how easy or difficult this transition is, and what could be done to ensure positive experiences. **This study is seeking feedback from nurses who have moved in the last 5 years from acute care to any PHC role in order to learn more about this experience.**

We are therefore seeking your assistance in promoting this study amongst your professional nursing colleagues who may be willing to participate in the study by completing a confidential online survey. This survey should take no more than 15-20 minutes of the participant’s time. Participants will also be invited to indicate if they would be willing to be interviewed during the next stage of the study.

We would be most grateful if you could circulate this information through your usual professional networks, eNewsletters and social media, and invite nurses to access the survey at: [https://www.surveymonkey.com/r/TransitiontoPHC](https://www.surveymonkey.com/r/TransitiontoPHC)

Please feel free to contact Professor Halcomb or myself for any further details relating to the study, and many thanks in anticipation of your support

Kind regards

Christine Ashley  
cma130@uowmail.edu.au

Professor Liz Halcomb  
ehalcomb@uow.edu.au
Primary Health Care Nurses – we need your help!

Dear Colleague

Are you a registered nurse working in one of the many areas of primary health care (PHC)? Did you move from acute/hospital based nursing to PHC within the last 5 years? If so, we need your help! Researchers from the University of Wollongong are undertaking a study entitled Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings. Would you be willing to participate in the study by completing a confidential online survey, which should take no more than 15 – 20 minutes of your time? If so, you can access more information, and the survey at https://www.surveymonkey.com/r/TransitionintoPHC.

The survey will close on 1 September 2015, so please hurry! Your input, and that of your PHC nursing colleagues is very important, so please feel free to forward this email to others working in PHC!

Many thanks in anticipation

Kind regards

Christine Ashley (PhD candidate)
cma130@uowmail.edu.au

and

Professor Liz Halcomb
ehalcomb@uow.edu.au
Professor of Primary Health Care Nursing
School of Nursing, Faculty of Science, Medicine & Health
University of Wollongong
Good afternoon

Thank you for previously promoting our study being conducted by the University of Wollongong entitled **Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings**. Ethics approval for the conduct of this project has been obtained from the Human Research Ethics Committees (HREC) of the University of Wollongong (UOW), approval number HE15/179. The investigators for this study are Christine Ashley, PhD candidate, and Liz Halcomb, Professor of Primary Health Care Nursing.

We would be most grateful if you could send out a reminder through your networks that the survey closes on **1 September 2015**. Wording we ask you to use is as follows:

**Primary Health Care Nurses – we need your help!**

Dear Colleague

Are you a registered nurse working in one of the many areas of primary health care (PHC)? Did you move from acute/hospital based nursing to PHC within the last 5 years? If so, we need your help! Researchers from the University of Wollongong are undertaking a study entitled **Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings**. Would you be willing to participate in the study by completing a confidential online survey, which should take no more than 15 – 20 minutes of your time? If so, you can access more information, and the survey at: https://www.surveymonkey.com/r/TransitiontoPHC.

**HURRY!** The survey will close on **1 September 2015**. Your input, and that of your PHC nursing colleagues is very important, so please feel free to forward this email to others working in PHC!

Many thanks in anticipation

Christine Ashley  
cma130@uowmail.edu.au

Professor Liz Halcomb  
ehalcomb@uow.edu.au
Appendix C: Survey Tool
Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

Survey Information Sheet

What is the Purpose of the Research?
Translating from one area of nursing to another has previously been found to be stressful, and may be associated with personal, professional and organizational challenges. Increasingly, nurses are moving from working in acute hospital settings to a variety of primary health care (PHC) roles in settings such as general practice, community health, schools, refugee health centres and correctional centres. Little is known about how easy or hard this transition is, and what could be done to improve the transitioning process for nurses.

Investigators
Christine Ashley, PhD candidate - cma130@uowmail.edu.au
Professor Liz Halcomb, Primary Supervision - ehalcomb@uow.edu.au

Study Participants
This study is seeking feedback from Registered Nurses who have moved in the last 5 years from working in an acute hospital setting to PHC.

What would you like to do
If you choose to participate we ask you to complete the online survey. This survey should take no more than 15-20 minutes of your time. Questions will ask you a bit about yourself and your professional experience, and explore your perceptions about transitioning from working in an acute hospital setting to PHC. There will be a combination of tick box questions and short answers.

If you are willing to contribute further and participate in an interview, at the end of the survey, you will be able to provide your contact details and the researcher will contact you to arrange a time to discuss this aspect of the project. Contact data will be separated and not stored with your survey responses.

Will the study benefit me?
Whilst there may be no direct benefits to you as an individual, disclosing your transition may raise your awareness or make you think about how you may assist others in the future who are planning to move into PHC. It is expected that there will be broader benefits for nurses moving to PHC in the future, in terms of providing structured approaches to transitioning for individual nurses, and raising awareness of transition issues for organisations.

Will the study involve any discomfort for me?
It is not anticipated that the survey would cause any more discomfort than experienced in a conversation about such issues with a colleague. However, if you have had a negative transition experience, raising the issue may cause some distress. If the research has raised distressing issues, you can contact the researchers. Alternatively, counselling and support may be obtained 24 hours a day from Lifeline Australia on 13 11 14 or the Salvo Care Line 1300 36 36 22.

How is this study being paid for?
Christine Ashley is a full-time PhD candidate supported by an Australian Postgraduate Award scholarship.

Will anyone else know the results? How will the results be disseminated?
All presentations of the results will use de-identified data. Therefore, no individual participant will be able to be identified. Results will be disseminated in conference presentations, journal publications and in a doctoral thesis.

Can I withdraw from the study?
Participation is entirely voluntary: you are not obliged to be involved. As survey responses will be entered anonymously online it is not possible to withdraw your responses. Participation in this study will not affect any current or future association with the University of Wollongong.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator’s contact details or the link to the survey.
What if I require further information?
If you would like to know more at any stage, please feel free to contact either Christine Ashley via email on cma130@uowmail.edu.au or Professor Elizabeth Halcomb via email on ehalcomb@uow.edu.au or phone 02 4221 3764.

What if I have a complaint?
This study has received Human Research Ethics approval from the University of Wollongong Research Ethics Committee (Approval Number HE15/179). If you have any complaints or reservations about the ethical conduct of this research, you may contact the UOW Ethics Officer on (02) 4221 3586 or email research@uow.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in the interviews, you will be asked to sign the Participant Consent Form. Completion and submission of the survey form will be assumed to imply informed consent.
Participant Criteria

Primary health care nurses work in a range of settings, providing primary health care which is appropriate to the needs of the community being served.

* 1. Are you a registered nurse currently employed in primary health care?
   - Yes
   - No

* 2. Have you changed employment from an acute hospital setting to primary health care role in the past 5 years?
   - Yes
   - No

* 3. Have you read and understood the information sheet?
   - Yes and I agree to participate in this research.
   - No and/or I do not wish to participate in this survey.
Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

Disqualification

Thank you for your interest in the survey. However your response indicates that you do not meet the criteria for inclusion in this study. Thank you again for your interest.

4. Would you be interested in receiving further information about the study as it progresses? If so, please record your email address below:

[Blank space for email address]
* 5. In what year did you first qualify as a registered nurse (YYYY)?

   

6. How long, in total (excluding absences from the workforce >6 months), have you worked as a registered nurse?

   Years
   
   Months

7. How long, in total (excluding absences from the workforce >6 months), have you worked in a primary health care setting?

   Years
   
   Months

8. How long ago did you move from a nursing job in an acute hospital setting to employment in primary health care?

   Years
   
   Months

9. In which clinical area were you working in prior to commencing work in PHC?

   Medical
   Surgical
   Critical Care (ICU / CCU)
   Emergency Department
   Other (please specify)
10. Do you currently still work in acute (Hospital) care as well as PHC?
   - Yes
   - No
   - If Yes (please specify setting)

* 11. What is your current age? (please round to the nearest year)

  

* 12. Are you:
   - Male
   - Female
   - Other

13. Have you completed a Postgraduate University course?
   - Yes
   - No
   If yes, please provide the title of all post graduate university courses you have completed (e.g. Masters of Aged Care Nursing)

14. Would you consider undertaking Post Graduate University study in the future?

<table>
<thead>
<tr>
<th>Definitely Not</th>
<th>Unlikely</th>
<th>Undecided</th>
<th>Possibly</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Why / Why not? (please specify)
The following questions ask you about your main / primary job.

* 15. In which state / territory are you currently employed?

- QLD
- VIC
- WA
- NSW
- NT
- ACT
- SA
- TAS
- Multiple states / territories

Please specify

* 16. Which term best describes the locality covered by your current primary workplace?

- Capital City
- Other metropolitan centre (urban population > 100,000)
- Large rural centre (urban centre population 25,000-99,999)
- Small rural centre (urban centre population 10,000-24,999)
- Other rural area (urban centre population < 10,000)
- Remote centres (urban centre population > 4,999)
- Other remote areas (urban centre population < 5,000)
- Unknown

Unknown (please specify postcode)
17. What term best describes the setting of your main nursing job?

- General practice
- Specialist rooms
- Correctional services/prisons
- Refugee health
- Community health
- Aged care facility
- Community residential care (eg young disabled, group home)
- Other (please specify)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practice</td>
<td>Various settings across healthcare facilities</td>
</tr>
<tr>
<td>Specialist rooms</td>
<td>Specialized medical or professional services</td>
</tr>
<tr>
<td>Correctional services/prisons</td>
<td>Institutions dedicated to handling offenders or prisoners</td>
</tr>
<tr>
<td>Refugee health</td>
<td>Organizations providing aid and support to refugees</td>
</tr>
<tr>
<td>Community health</td>
<td>Health services within a community, often with wide scope</td>
</tr>
<tr>
<td>Aged care facility</td>
<td>Services designed for elderly people</td>
</tr>
<tr>
<td>Community residential care (eg young disabled, group home)</td>
<td>Settings providing care for specific groups of individuals</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Customized environments based on the specific needs of patients</td>
</tr>
</tbody>
</table>

* 18. What is your employment status in this main job? (please choose one only)

- Permanent
- Fixed term or temporary contract
- Self employed contractor
- Casual
- Unsure
- Other (please specify)

* 19. On what basis are you currently employed in this main job? (please mark one only)

- Full time (average 38 hours per week)
- Part time
- Casual
- Unsure
- Other (please specify)

20. How many hours (on average) do you work each week in this main job?

[box for input]
* 21. Do you currently have a secondary job?
   - Yes - in nursing
   - Yes - outside of nursing
   - No - only work in one job
## Secondary Employment

The following questions ask you about your **secondary** job.

22. What term best describes the setting of your **secondary** job?

- [ ] General practice
- [ ] Specialist rooms
- [ ] Correctional services/prisons
- [ ] Refugee health
- [ ] Community health
- [ ] Aged care facility
- [ ] Community residential care (eg. young disabled, group home)
- [ ] Aboriginal and/or Torres Strait Islander health services
- [ ] Social Services
- [ ] Boarding house / Outreach to homeless
- [ ] School / pre-school
- [ ] University / TAFE
- [ ] Other (please specify)

![Image]

* 23. What is your employment status in this **secondary** job? (please choose one only)

- [ ] Permanent
- [ ] Fixed term or temporary contract
- [ ] Self employed contractor
- [ ] Casual
- [ ] Unsure
- [ ] Other (please specify)
24. On what basis are you currently employed in this secondary job? (please mark one only)

- Full time (average 38 hours per week)
- Part time
- Casual
- Unsure
- Other (please specify)

25. How many hours (on average) do you work each week in this secondary job?
### Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

#### Your transition to primary health care

The following questions relate to the time when you transitioned from an acute nursing role to a primary health care role for the first time.

26. Please indicate the extent to which the following influenced your decision to seek employment in primary health care.

<table>
<thead>
<tr>
<th>Influence</th>
<th>Of Little Importance</th>
<th>Moderately Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity to advance my nursing career.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity to increase my level of work satisfaction.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The salary and employment benefits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balancing my life and work responsibilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved working hours that suited my lifestyle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To pursue my interest in primary health care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To stop working shiftwork.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolidating my nursing/medicinal knowledge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The autonomous nature of the work.</td>
<td></td>
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<tr>
<td>Wanted a change from the acute sector.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the first employment opportunity that came up.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The location was closer to home.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. Were you provided with a role description when you inquired about the primary health care position?

- Yes □
- No □
- Unsure □
28. When you first started in your job in PHC, please indicate whether you received any of the following as part of your introduction to your role.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse preceptor who assisted with clinical skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse preceptor who assisted with organisational / management skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical learning resources (e.g. booklets, manuals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leave / Time to attend external professional development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding to support external professional development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encouragement to complete specified professional development</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

29. When you first commenced working in PHC did you receive orientation to the workplace and/or role?

- Yes
- Unsure
- No

If you please specify the number of days of orientation:

30. When you first commenced working in PHC did you have a nominated preceptor / mentor?

- Yes
- Unsure
- No

If you please specify the duration of this:

31. When you first commenced working in PHC did you have a supernumerary period (period working with another nurse without your own patients/clients)?

- Yes
- Unsure
- No

If you please specify the number of days of supernumerary work:

222
32. In the first six months of working in PHC, did you have access to another nurse with whom you could discuss:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a clinical problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a professional issue?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a workplace issue?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

33. What difficulties, if any, did you experience with the transition from an acute care nurse to working in PHC (please tick any which apply).

- [ ] unclear role expectations (eg. autonomy, more responsibility)
- [ ] lack of confidence (eg. communication skills, knowledge deficit, critical thinking)
- [ ] workload (eg. organising, prioritising, feeling overwhelmed)
- [ ] fears (eg. safety issues)
- [ ] orientation issues (eg. workplace familiarisation, learning technology, relationship with multiple preceptors, information overload)

Please add any other difficulties you experienced:

|
34. When you transitioned from an acute setting to working in PHC, how difficult was it for you to adjust to the following in your new role?

<table>
<thead>
<tr>
<th></th>
<th>Very Difficult</th>
<th>Difficult</th>
<th>Neither Difficult or Easy</th>
<th>Easy</th>
<th>Very Easy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in the amount of responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence in clinical skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical knowledge</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Organisational knowledge</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Prioritising workload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns related to personal safety</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>New technology</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Workplace familiarisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information overload</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Comments:

35. What could have been done to help you feel more supported or integrated into your PHC workplace? (please tick any which apply).

- Improved orientation
- Greater preceptor support
- Longer orientation
- Workplace specific skills practice
- Increased support from manager
- Increased support from other nurses
- Improved mentorship
- Enhanced workplace socialisation
- Greater opportunities for staff socialisation
- Better workload division
- Improved rostering
- Opportunity for team meetings
- Improved communication between nurses
- Improved communication with medical staff

Please add any other suggestions of how you could have been supported:
36. How satisfied were you with the following aspects during the first six months in your PHC job?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Somewhat satisfied</th>
<th>Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction with patients and families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional nursing role</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Management of the workplace (e.g. rostering, human resources)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace environment (e.g. facilities and equipment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect from colleagues</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Orientation (e.g. preceptors, level of feedback)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Being involved in the team</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing learning (e.g. preceptors, workplace role models, mentorship)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Comments: ____________________________

37. Did you ever feel isolated, alone, or lacking support from other nurses / midwives in your workplace?

- Regularly  
- Sometimes  
- Rarely  
- Never

38. Did you ever feel overwhelmed with the demands of your new role in PHC?

- Regularly  
- Sometimes  
- Rarely  
- Never
### Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

**Your Role Now**

The following questions refer to your current feelings about working in PHC.

39. Indicate your level of agreement with the statements below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I intend to continue with my nursing career for the foreseeable future.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I intend to continue with my nursing career in PHC for the foreseeable future.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As soon as it is convenient for me I plan to leave the nursing profession.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As soon as it is convenient for me I plan to leave PHC nursing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am actively looking for another job outside the nursing profession.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am actively looking for another job outside PHC.</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>I will still be working as a nurse in PHC in the next year.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will still be working as a nurse in PHC in the next 5 years.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40. Please compare how you NOW feel about your role in primary health care (positive and/or negative aspects) with your previous role in acute care

Thank you for taking the time to complete this survey.

Your assistance will be invaluable in helping others transitioning to primary health care.
Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

Contact Details

41. Would you be interested in receiving further information about the study as it progresses? If so, please record your email address below:

42. Would you be willing to be interviewed about your transition experience? This could either be by phone, internet or face to face, at a time and place convenient for you. All information obtained will be treated confidentially, and will be de-identified. If you are willing to speak to the researcher, please record your email address and/or phone number so that we can contact you.

Name

Email Address

Phone

Best time / day to call
Appendix D: Interview Information and Consent Form
Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings

What is the study about?

Transitioning from one area of nursing to another has previously been found to be stressful, and may be associated with personal, professional and organizational challenges. Increasingly, more and more healthcare is being provided in primary health care settings, resulting in many nurses moving from acute settings to primary health care (PHC) roles. Little is known about how easy or difficult this transition is, and what could be done to ensure positive experiences. This study is seeking feedback from nurses who have moved in the last 5 years from acute care to PHC roles in order to learn more about this experience.

Investigators

Christine Ashley, PhD candidate. cma130@uowmail.edu.au
Professor Liz Halcomb, Supervisor. ehalcomb@uow.edu.au

What we would like you to do

If you choose to participate we would ask you to agree to be interviewed by the researcher. This will be either face to face at a location and time convenient for you, or by telephone or Skype. Interviews will be informal, and of approximately 20 to 45 minutes in duration. The interview will consist of asking you some questions about your transition experience to PHC. All information you provide will be held in strictest confidence, and will be de-identified.

Will the study benefit me?

Whilst there may be no direct benefits to you as an individual, discussing your transition may raise your awareness or make you think about how you may assist others in the future who are planning to move into PHC. It is expected that there will be broader benefits for nurses moving to PHC in the future, in terms of providing structured approaches to transitioning for individual nurses, and raising awareness of transition issues for employers and organisations.

Will the study involve any discomfort for me?

It is not anticipated that the interviews would cause any more discomfort than a conversation about such issues with a colleague. However, if you have had a negative transition experience, raising the issue may cause some to feel distressed. If this is the case, the interview can be ceased at any time, and support will be offered. Alternatively, counselling and support may be obtained 24 hours a day from Lifeline Australia on 13 11 14 or the Salvo Care Line 1300 36 36 22.
How is this study being paid for?
Christine Ashley is a full-time PhD candidate supported by an Australian Postgraduate Award scholarship.

Will anyone else know the results? How will the results be disseminated?
All presentations of the results will involve aggregated or de-identified data. Therefore, no individual participant will be able to be identified. Results will be disseminated in conference presentations, journal publications and in a doctoral thesis to be written by Christine Ashley.

Can I withdraw from the study?
Participation is entirely voluntary: you are not obliged to be involved. Consent to withdraw from the interviews can be withdrawn at any time. Participation in this study will not affect any current or future association with the University of Wollongong.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator's contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?
When you have read this information, the researcher will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact either Christine Ashley via email on cma130@uowmail.edu.au or Professor Elizabeth Halcomb via email on ehalcomb@uow.edu.au or Phone 02 4221 3137.

What if I have a complaint?
This study has received Human Research Ethics approval from the University of Wollongong Research Ethics Committee (Approval Number HE15/179). If you have any complaints or reservations about the ethical conduct of this research, you may contact the UOW Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in the interviews, you will be asked to sign the Participant Consent Form.

Thank you!
I, ............................................................................. consent to participate in the research project titled:

**Exploring the Transition of Registered Nurses from Acute Care to Primary Health Care Settings.**

I acknowledge that:

- I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
- The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
- I consent to the audio taping of my telephone interview with the researcher. I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.
- I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Signed: ____________________________________________

Name: ____________________________________________ Date: ___________/ ____________/ ____________

Return Address:  Professor Elizabeth Halcomb  
Building 41 - School of Nursing, University of Wollongong, Northfields Ave  
Wollongong NSW 2522

This study has received Human Research Ethics approval from University of Wollongong Human Research Ethics Committee (**Approval Number HE15/179**). If you have any complaints or reservations about the ethical conduct of this research, you may contact the University of Wollongong Human Research Ethics Committee through UOW Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix E: Semi-Structured Interviews Schedule
1. General introduction:
   - Outline of project
   - details of ethics approval provided to participant (explanatory documents provided as detailed in ethics approval)
   - explanation and confirmation of confidentiality – ie. the data will be de-identified and only the researchers will have access to the data.
   - completion of consent form
   - agreement obtained to audio record interview for data analysis purposes
   - details provided for following up with supervisors any concerns post-interview (as in ethics approval)

2. What influenced you to move from acute care nursing to Primary Health Care?
   Prompts:
   - Which would you say were most important - personal or professional reasons?
   - Could you enlarge on the reasons e.g. physical/health aspects of previous/current role, emotional aspects, family reasons

3. Tell me what it was like for you when you first started in your Primary Health Care Role
   Prompts:
   - How did you feel in those first few days?
   - In the survey people told us they had issues with their orientation – tell me about yours.
   - What resources did you receive before/during orientation?

4. After you had had a few weeks or so in your new role, tell me about how you felt then.
   Prompts:
   - Describe when you started to feel confident in the role.
   - What aspects of your role did you feel most/least confident about?
   - More than 50% of the survey participants described feeling isolated, alone, or lacking support from other nurses in their workplace. Tell me how you felt in relation to this.
   - More than 50% of the survey participants described feeling overwhelmed in their workplace. Tell me how you felt in relation to this.

5. Can you tell me what you found to be the most challenging aspects of the new role?
   Prompts:
   - What about autonomy, confidence, working relationships, communication, professional/personal isolation, availability/access to professional development
6. Can you describe how you managed or overcame these challenges?
   Prompts:
   - Professional supports. eg. Access to CPD, mentor, staff meetings, performance review
   - Personal supports.

7. Can you give me an idea of how long it took you to feel that you were functioning to the full capacity of your nursing abilities?

8. Do you recall if you made any clinical or professional misjudgements in the first few months in your new role?
   Prompts:
   - How could these have been avoided?

9. What could have been done to make your transition easier?

10. Looking back now and with the benefit of hindsight, would you still have moved to Primary Health Care nursing? Why/why not

11. Do you plan to stay in Primary Health Care nursing? In your current role?
    For how long? Why/why not

12. If you were an employer and were going to employ a nurse new to Primary Health Care to work in your organisation, what would YOU do before the person commenced employment, during the first few weeks and in the long term to assist them to transition effectively?

13. Is there anything else you would like to tell me about your transition experience, or about your work in Primary Health Care?

Summarise the interview, and recap on the expected completion process of the project. Thank participants for their time and contribution.
Appendix F: Peer Reviewed Publications
Exploring why nurses transition from acute care to primary health care employment

Christine Ashley, RN, RM, BlHlSc, MN, FACN⁎, Elizabeth Halcomb, RN, BN (Hons), PhD, FACN⁎, Kath Peters, RN, BN (Hons), PhD⁎, Angela Brown, RN, BSc (Hons), Cert Ed PG Dip, MA, PhD⁎

⁎ School of Nursing, Faculty of Science, Medicine and Health, University of Wollongong, Northfields Ave Wollongong, NSW 2522, Australia

1. Background

The ageing population and increases in chronic conditions have led to a re-evaluation internationally of how and where healthcare is best accessed and delivered (Domsavisri et al., 2015). Primary health care (PHC) models of service delivery are recognised as pivotal in providing a cost effective and accessible approach to care provision as well as promoting the continuity of care between acute health services and the community. Whilst nurses meet the health needs of people in all settings and throughout the lifespan (WHO, 2016), rising demand has necessitated an increase in the size of the PHC nursing workforce internationally. A review of the Australian nursing workforce found that almost 10% of nurses identified themselves as working in PHC settings, including general practice, schools, refugee health, correctional settings, community health centres and remote communities (Australian Institute of Health and Welfare, 2015). This represented a fivefold increase in Australian PHC nurses over the last decade (Halcomb, 2016; Halcomb et al., 2014, 2017). These include perceived skill loss, poor wages, and sub-optimal professional opportunities compared with acute care roles (Cuesta & Gluckman, 2014; Halcomb et al., 2014; Halcomb & Ashley, 2017). There is also limited literature which specifically explores the reasons why nurses disengage from often long held acute care roles to transition to PHC employment (Ashley et al., 2016). It is timely, therefore, to develop an evidence base relating to the process of transition from acute to PHC employment to inform future recruitment strategies and transition support programs.

2. Aim of the study

To explore why Australian registered nurses transition from employment in acute care to PHC settings.

2.1. Design

Role theory was selected as the theoretical framework to inform the research design, since the theory has been empirically validated and widely used in workplace studies (Ashforth, Kreiner, & Fugate, 2000). The theory consists of several interrelated concepts which are relevant to the transition experience as they suggest how individuals are likely to react in certain circumstances. Concepts of relevance in the transition of nurses from acute to PHC employment include the processes of role exit (leaving the ‘old role’) and role entry, role ambiguity, role conflict and ‘rites of passage’ (Ashforth et al., 2000; Ashley, Halcomb, & Brown, 2017). Due to the complexity of the transition process, a sequential explanatory mixed methods design was adopted (Creswell, Plano Clark, & Smith, 2013) as this was considered the most appropriate approach to capturing both the macro and micro aspects of transitioning. The design consisted of a national survey (Phase 1) followed by a series of semi-structured interviews with a sub-group of survey respondents to further explore the quantitative results (Phase 2).

Given the large amount of data generated, this paper reports on a
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The majority of respondents were female (n = 106, 96.4%) and aged between 40 and 59 years (n = 74, 66.6%, mean 45 years).

Table 1 Survey respondent demographics.

<table>
<thead>
<tr>
<th>Demographic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
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<td></td>
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<tr>
<td>20–29</td>
<td>10</td>
<td>9</td>
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<td>30–39</td>
<td>18</td>
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<td>40–49</td>
<td>39</td>
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<td>50–59</td>
<td>31</td>
<td>29.1</td>
</tr>
<tr>
<td>60–67</td>
<td>9</td>
<td>8.1</td>
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</table>

<table>
<thead>
<tr>
<th>Gender</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Female</td>
<td>106</td>
<td>96.4</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>4.6</td>
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Year worked as an RN

<table>
<thead>
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<th>Year in PHC</th>
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<td>1–5</td>
<td>67</td>
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<tr>
<td>6–10</td>
<td>66</td>
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<tr>
<td>11–15</td>
<td>26</td>
</tr>
<tr>
<td>16–20</td>
<td>17</td>
</tr>
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</table>

Previous acute experience

<table>
<thead>
<tr>
<th>Phase</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical wards</td>
<td>20</td>
</tr>
<tr>
<td>Emergency</td>
<td>17</td>
</tr>
<tr>
<td>Remote</td>
<td>16</td>
</tr>
<tr>
<td>Other (eg. surgical, critical care, mental health, child and family health, operating ward)</td>
<td>42</td>
</tr>
</tbody>
</table>
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(Table 1). Just over half of the participants worked in city/metro areas (n = 85, 77.0%). Most respondents were employed in general practice (n = 71, 64.5%), with others (n = 39, 35.5%) working in settings including community health, community based palliative care services, maternal and child health, schools, correctional centres, sexual health services, Aboriginal and Torres Strait Islander health services, primary health networks, workplace health services and refugee health.

3.2. Interview participants

Thirteen survey respondents participated in the interviews. Interview participants ranged in age from 23 to 62 years (mean 48.2 years), and worked in various PHC settings, including general practice (n = 6, 46.1%), school nursing (n = 3, 23.0%), and one each from refugee health, community health, sexual health, and remote area mental health. There was considerable diversity in the years of experience as a registered nurse prior to moving to PHC, with participants having from 12 months (n = 3, 23.0%) to over 30 years (n = 5, 38.4) experience.

3.3. Reasons for transitioning to PHC

3.3.1. Survey responses

Survey respondents rated the importance of 12 factors relating to their decision to transition, using a 5-point Likert scale (1 ‘unimportant’ to 5 ‘very important’). Balancing life and responsibilities (n = 105, 95.4%), improved work hours which suited personal lifestyle (n = 102, 93.6%) and the opportunity to increase work satisfaction (n = 102, 93.6%) were the most important factors affecting their decision to transition to PHC (Table 2). In response to the open ended question, respondents stated:

“Enjoyed my private hospital job but PHC job fits in better with family. I have shift work.”

“My current role is far more satisfying, gratifying and much less stressful than my role in acute care. The work/life balance is also much better now and my workplace is very flexible and supportive...a far cry from the operating theatres…”

For some moving to PHC employment was unplanned but beneficial:

“It was a job I stumbled upon and never really sought out. However, it fits perfectly with my family with young children”.

Table 2: Factors influencing the decision to seek employment in PHC

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mod. important</th>
<th>Very important</th>
<th>Mean</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balancing my life and work responsibilities</td>
<td>105</td>
<td>85.4</td>
<td>4.90</td>
<td></td>
</tr>
<tr>
<td>Improved working hours that suited my lifestyle</td>
<td>102</td>
<td>83.6</td>
<td>4.32</td>
<td></td>
</tr>
<tr>
<td>Opportunity to increase work satisfaction</td>
<td>102</td>
<td>83.6</td>
<td>4.18</td>
<td></td>
</tr>
<tr>
<td>To stop working shift work</td>
<td>81</td>
<td>82.0</td>
<td>3.61</td>
<td></td>
</tr>
<tr>
<td>The environment of the work</td>
<td>65</td>
<td>77.3</td>
<td>3.32</td>
<td></td>
</tr>
<tr>
<td>To stop working in the acute sector</td>
<td>78</td>
<td>70.9</td>
<td>3.05</td>
<td></td>
</tr>
<tr>
<td>To pursue my interest in PHC</td>
<td>75</td>
<td>66.3</td>
<td>3.36</td>
<td></td>
</tr>
<tr>
<td>Consistently meeting my earning/equity knowledge</td>
<td>64</td>
<td>62.3</td>
<td>2.98</td>
<td></td>
</tr>
<tr>
<td>Opportunity to advance my nursing career</td>
<td>67</td>
<td>70.8</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td>The salary and employment benefits</td>
<td>62</td>
<td>56.3</td>
<td>2.82</td>
<td></td>
</tr>
<tr>
<td>The location was closer to home</td>
<td>48</td>
<td>43.8</td>
<td>2.51</td>
<td></td>
</tr>
<tr>
<td>Want the first employment opportunity that came up</td>
<td>52</td>
<td>29.2</td>
<td>2.15</td>
<td></td>
</tr>
</tbody>
</table>

Many respondents (n = 85, 77.0%) also described the autonomous nature of PHC nursing as a factor in changing employment:

“The diversity of the PHC role, the autonomy. Never looked back.”

“Much greater accountability and autonomy in PHC than in the hospital environment.”

Salary and employment conditions (n = 62, 56.3%), location of the work closer to home (n = 48, 43.6%) and being the first job opportunity that arose (n = 32, 29.1%) were identified as the least important factors influencing the decision to seek PHC employment.

Application of the Chi-square test for independence indicated that there was no significant association between age and the factors influencing the decision to move to PHC (p > 0.05), or in relation to choice of PHC employment. However, respondents with < 15 years acute care experience were more likely to report that stopping shift work was an important or very important factor in their decision (p = 0.02). Chi-square testing for independence also indicated that balancing life and work responsibilities was more likely to be rated as moderately or very important among respondents working in metro or city settings (p = 0.04).

3.3.2. Interview findings

Supporting the survey findings, interview participants cited both personal and professional reasons for moving to PHC. Only three interview participants reported having specifically planned a career in PHC, with the others describing “falling into” PHC employment.

“I didn’t necessarily want to leave the acute field. For me it was more that this opportunity presented itself…”

(Vanessa, remote area mental health nurse)

“Exposure to PHC settings through education, clinical placement or casual work prompted some participants to make the move into PHC. These experiences were described as triggers which had created an interest to move to a PHC setting.”

(Varsha, refugee health nurse)

“I did my elective in my bachelors in PHC. So I thought it was just an interesting topic that I don’t know much about. This opportunity came along and I thought perfect, it combines everything!”

(Alex, general practice nurse)

“I was doing my Masters in Public Health working casually at a women’s clinic. I was quite interested in HIV when I was working in intensive care. Well, I made a decision to do a PHC Masters…”

(Adria, sexual health nurse)

“I fell into it… I mean I knew about it [school nursing] but I didn’t know much… the employment agency asked me to do a few shifts…”

(Mieken, school nurse)

Others identified that PHC employment fitted with their professional goals:

“I was probably always geared towards PHC but it seemed to be a pathway (to PHC) through ICU” (Vanessa, refugee health nurse)

“Since joining my practice in 1991, I’ve always been interested in PHC.” (Margaret, general practice nurse)

For some participants, however, it was a combination of factors which resulted in their decision to transition from acute care nursing to PHC employment. For Francine (general practice nurse), a trigger to move related to feeling unsupported by her...
4. Discussion

Findings from our study provide insight into the reasons influencing nurses to transition from acute care nursing to PHC employment. The interrelatedness of personal and professional factors support explanations for role transitions cited by Ashforth et al. (2000) and Curtis and Glacken (2014), who identified that the situational relevance of roles influenced how and why new positions were selected.

Consistent with other research into the PHC workforce (Halcomb, 2014; Kolosker, Joyce, Parker, & Pietzmann, 2007), our study identified that survey respondents were older than the Australian nursing workforce national average (ANHA, 2016). As discussed by Norman et al. (2005), and DuFeld et al. (2015), this finding has implications for the PHC sector by providing a pool of experienced acute care nurses who may otherwise leave the profession. However, it also has consequences for future skill mix in the PHC workforce as older nurses are likely to have shorter career spans than their younger peers.

This highlights future potential shortfalls in the PHC workforce at a time when demands are increasing for skilled nurses to work in PHC. In order to ensure a sustainable workforce, it becomes clear that efforts must be made to attract younger nurses to consider careers in PHC.

In particular, the physical demands of shift work, long hours, and emotional stressors associated with acute care nursing were all cited by participants as prompting the decision to move from that environment. This supports previous findings that workplace physical and emotional stressors have generational characteristics which affect job satisfaction and career planning (Andrews, Manthorpe, & Watson, 2005; Lampe-Tremblay, Trépanier, Fernet, & Bonneville-Roussy, 2014). Staff turnover in acute settings has also been associated with the stresses of “compassion fatigue” (Kelle, Range, & Spender, 2015; Lampe, Cummings, & Probert-Migot, 2014) as described by participants in our study.

Of all the personal reasons cited for moving to PHC, family friendly work arrangements and balancing work and home life were identified as the most important. Our findings are congruent with previous literature which identified these factors as major contributors to job satisfaction (Curtis & Glacken, 2014; Ashforth et al., 2016). Balancing personal and work lives is especially important for those living in urban/metro settings. This is consistent with Ridg et al.’s (2009) exploration of nurses’ job satisfaction across rural and urban settings, which concluded that nurses from rural communities were more satisfied with their work life arrangements than their urban colleagues. It also supports findings that while rural nurses may have little separation between their personal and professional lives, small community living creates a sense of belonging, informal networks play a role in providing professional support, and rural nurses demonstrate greater self-efficacy than those in urban settings (Baussadaini et al., 2013). These are important considerations for employers when developing location specific recruitment and retention strategies.

Some participants indicated that they had little idea about the PHC role they were applying for. This is consistent with previous studies of pre-registration nurses, who acknowledged little or no understanding of PHC nursing or models of care (Halcomb, Perth, Hardy, & Ashley, 2014). The lack of awareness of PHC career opportunities suggests that in order to attract nurses to PHC settings strategies need to be implemented to raise awareness of this area of clinical practice. Whilst the professional practice standards for nurses in PHC in both Australia (Halcomb, Stephenson, Brys, Foote, & Ashley, 2018) and the United Kingdom (General Practice Foundation Nursing Sub-group, 2012) identify the importance of PHC nurses advocating for and promoting their role, this will take some time to be fully realised. In contrast, most interviewee participants who purposively selected their role in PHC employment, made this decision following previous exposure to a PHC environment.

The positive impact of exposure to PHC in guiding career paths was also reported by Melzak et al. (2013) in their study of pre-registration nurses undertaking clinical placement in PHC settings. This highlights the importance of promoting the positive aspects of PHC nursing, and the inclusion of PHC experiences in both undergraduate and postgraduate nursing education.

Despite the literature which has linked poor remuneration with low levels of job satisfaction (Dobosz et al., 2011; Ashley et al., 2016), in our study participants indicated that salary and employment conditions were of low importance in influencing their decision to transition. A possible explanation may relate to findings from other disciplines that work values shift over the life course, and that generational differences account for differences in attitudes to work/life balance and salary and conditions (Egan, 2012; Ross, Lyon, Schouten & Eddy, 2015; Procurtus, 2015).

4.1 Limitations

This study has some limitations. The lack of a national database of PHC nurses (Halcomb et al., 2014) or accurate data relating to nurses
who transition from acute care settings to PCH means that it is not possible to calculate a response rate. However, recruitment methods used were similar to other national surveys of the Australian PCH nursing workforce (Australian Primary Health Care Nurses Association, 2016; Halcomb et al., 2014). Whilst methods were made to recruit registered nurses working in a range of PCH settings, respondents were not spread across all PCH settings, and numbers were small in some PCH settings. This may limit the generalisability across all areas of PCH nursing. The lack of differences related to age when group differences in the other studies may be related to the sample size of the study and warrants further investigation in future research, particularly given the small-sample size in the younger and older age groups.

An additional limitation of the study was that survey data were based on reflective self-report, rather than from longitudinal data collection. Therefore, findings may be subject to bias or inaccurate recall of the collection experience.

5. Conclusion
Our study has provided an insight into the reasons why nurses transition from acute to PCH employment. It highlights the value placed on family friendly working conditions, the attraction of working autonomously and the positive impact that prior education and clinical experience in PCH may have in influencing nurses to transition to PCH employment. Armed with this knowledge, the role of the PCH nurse can be better promoted as a satisfying area of professional practice. Our findings will assist in workforce planning and the development of recruitment and retention strategies, by providing evidence about what attracts experienced registered nurses from acute care nursing into PCH. Our findings are also of significance for policy makers seeking long term solutions to increase and retain the PCH workforce, and for educators in the design and delivery of programs focused on PCH models of care.

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Conflicts of interest
Nil conflicts.

References