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# Experiences of registered nurses transitioning from employment in acute care to primary health care - quantitative findings from a mixed-methods study

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# Experiences of registered nurses transitioning from employment in acute care to primary health care - quantitative findings from a mixed-methods study

## Abstract

**Aims and objectives:** To describe the experiences of registered nurses who transition from acute to primary health care (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 study reports on survey findings relating to the transition experience.

**Methods:** Convenience and snowballing techniques were used to recruit 111 registered nurses 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. 49.5% (n = 55) reported being overwhelmed with the 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 programmes.

**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 policymakers in developing support programmes for nurses moving into PHC.

## Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

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## TITLE

**Experiences of registered nurses transitioning from employment in acute care to primary health care – quantitative findings from a mixed methods study.**

## RUNNING HEAD

***Transitioning to primary health care***

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**Conflict of Interest**

Nil conflicts

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## **ABSTRACT**

### **AIM**

To describe the experiences of registered nurses who transition from acute to primary health care (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 111 Registered Nurses 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. 49.5% (n=55) reported being overwhelmed with the 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 enhance 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.

## **SUMMARY BOX**

### **What does this paper contribute to the wider global clinical community?**

- This paper provides a new insight into the experiences of acute care nurses who have transitioned to primary health care employment.

- There is evidence that orientation and ongoing professional support for experienced nurses transitioning to PHC roles should be purpose designed to address individual gaps in knowledge and skills of the new employees.

## KEYWORDS

- Transition, primary health care, nursing, orientation, preceptor, mentor

## INTRODUCTION

Health care provision in primary health care (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 (Primary Health Care Advisory Group. 2015, WHO 2016). In Australia approximately 90% of the population seek PHC services annually (Carey *et al.* 2013), and 35% have a chronic condition requiring multiple visits to a doctor during the course of a year (Connelly 2011, Primary Health Care Advisory Group. 2015). Reforms have included placing an increased focus on the integration of health care service provision between health providers, and between tertiary and primary health care settings (Oandasan *et al.* 2010).

Associated with the expansion of PHC services has been a growing demand for a skilled nursing workforce to fill new roles in PHC settings (Bloomfield *et al.* 2015).

PHC nurses provide care in general practices, community health, schools, correctional facilities, remote indigenous communities, and numerous other settings (APNA. 2015, McCarthy *et al.* 2012). However, PHC nursing has traditionally suffered as a career choice 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 (Halcomb *et al.* 2016). 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 (APNA. 2016a, Australian College of Nursing. 2016, Halcomb *et al.* 2016). 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.

## **BACKGROUND**

In line with international trends, the Australian PHC nursing workforce has increased significantly over the last decade (Halcomb *et al.* 2014). There is also evidence that many nurses are transitioning from acute care settings to PHC to meet the growing workforce needs (AIHW 2015). 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 (Authors Own). For example, while acute hospitals are often highly regulated and operate under a hierarchical medical model, Australian general practices are frequently small businesses where the general practitioner has the dual role of clinician and owner (McInnes *et al.* 2015).

International literature suggests that workforce re-configuration and the interaction between macro-level influences (ie. government policy) and micro level practice (i.e. adaption to new professional roles) require a range of factors to ensure the



successful transition from old roles to new (Currie *et al.* 2010). Experiences during the early transition period are also recognised as critical in shaping an understanding of any new role (Murray 1998). 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 (Kramer *et al.* 2013, Parker *et al.* 2014). 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 (Authors own) (Ashforth 2001, Holt 2008). 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 (Authors own). 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 (Parker *et al.* 2014, Yeh & Yu 2009) and patient safety concerns (Gaynor *et al.* 2006, Murray-Parahi *et al.* 2016, Rush *et al.* 2013).

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 registered nurses who transition from acute 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 (Halcomb *et al.* 2014)(Author's Own). 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 (Hardy & Conway 1988) . This provided opportunities to explore relevant concepts such as role exit and entry, role ambiguity, role conflict and 'rites of passage' (Ashforth 2001). Data were collected via an online survey and subsequent semi-structured interviews. 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 (Authors own).

### 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 drawing on a critical review of the literature (Authors own), expert input and the concepts of role theory (Authors own). 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<sup>®</sup> and piloted by the same group. Further 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 exploring 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 (Authors Own).

### **Respondents**

Respondents were Australian baccalaureate prepared Registered Nurses who had previously worked in acute care settings and had transitioned to PHC employment within the previous 5 years. This group was selected as Registered Nurses are the largest group in the nursing workforce (Health Workforce Australia 2012), 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 in September and October 2015. Reminder emails and postings were sent to the stakeholders after 1 month and again 1 week before the survey was closed.

### **Ethical considerations**

The University Human Research Ethics Committee granted approval to conduct the study before data were collected (Approval no. HE15/179). In accordance with the National Health and Medical Research Council (2015), completion of the survey implied consent.

### **Data analysis**

Data were exported from Survey Monkey<sup>®</sup> (2015) directly into SPSS Version 22 (IBM Corp. 2013). Surveys missing either demographic or transition experience data, or where data revealed that the participant did not meet inclusion criteria were removed from the analysis (Field 2013). Descriptive statistics were used to summarise the data for both categorical (using frequencies and percentages) and continuous variables (mean, standard deviations and ranges)(Field 2013).

Relationships between variables were explored using the independent sample t-test, Pearson's chi-square test (Field 2013). As large numbers of variables were generated, this was managed by grouping interrelated items. Statistical significance was attributed to results where  $p < 0.05$  (Field 2013). Thematic analysis was used to analyse responses to open-ended items (Braun & Clarke 2014).

## RESULTS

### Demographics

One hundred and seventy one survey responses were received, and of these 111 (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 40 years (n=83; 74.7%)(Table 1). The mean duration worked as a Registered Nurse 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 (<38 hours/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.

## Support

When commencing employment in PHC, most respondents (n=90, 81.1%) reported receiving some orientation to the new workplace (Table 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 (n= 55; 49.5%) of the respondents reported having a supernumerary period without a client load. However, only 45.0% (n=50) reported having access to funding for external professional development.

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 -'very difficult' to 1 -'very easy') (Table 3). While mean scores for these items were between 'easy' and 'neither difficult nor easy', over a third of respondents rated organisational knowledge ( $n=45$ ; 40.9%) and 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.

### **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 4).

## **DISCUSSION**

Transitioning between workplaces has been described as complex and multidimensional. It includes a period of closure from the old role, a period of adjustment, followed by socialisation or settling in to the new role (Ashforth *et al.*



2007, Meleis *et al.* 2000). Experienced nurses moving to new cultural and clinical environments face issues relating to confidence and competence (Keleher *et al.* 2007). This is described by Disch (2002) as moving from 'expert to novice'. We identified a range of factors which impacted on Registered Nurses' 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 (eg. 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 across different workplaces (Bridges 2004, Burns *et al.* 2011, Gohery & Meaney 2013) and amongst new graduates (Lee *et al.* 2013, Missen *et al.* 2014). In our study, age and years in nursing did not significantly impact on the transition experience. This differed from Longo's (2013) 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 (Murray 2011). The relationship we found between adjusting to technology and 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 (University of Canberra 2016).

Many studies relating to structured workplace orientation programs indicate their importance in influencing job satisfaction (Tabvuma *et al.* 2015) and safety in the new workplace (Curcuruto *et al.* 2016). 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 factor which would have assisted in their transition, and support similar research relating to new graduate orientation programs (Strauss *et al.* 2016).

Preceptoring and mentoring have both been described as a means to assist new workers to transition between different roles (Price 2014). Ellis and Chater (2012) 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 (Ellis & Chater 2012). In our 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 (Carlson 2013, McCloughen *et al.* 2006). 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 health care settings (Pickens & Fargotstein 2006). In PHC, lack of available preceptor training,

time factors and the nature of many PHC nursing roles create barriers to implementing these supports (DeCicco 2008). 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 in our study identified that they had access to study leave and/or financial support to undertake professional learning in PHC. Ellis and Chater (2012) 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, with studies indicating 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 (Hallinan & Hegarty 2016). Our findings 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 different 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 (APNA. 2016b, Halcomb *et al.* 2014).

An additional limitation of the study 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-respondents may differ from those who participated in the study.

## **CONCLUSIONS**

Our 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.

Our study has 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.

## **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 enhance 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.

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**Table 1.** Demographics

<b>Demographic Characteristic</b>	<b>n</b>	<b>%</b>
Age	Range: 23–67 years; Mean 45.44; SD 10.45	
23-29 years	10	9.0
30-39 years	18	16.2
40-49 years	39	35.1
50-59 years	35	31.5
60-67 years	9	8.1
State/Territory of Employment		
Queensland	12	10.9
Victoria	30	27.3
Western Australia	4	3.6
New South Wales	37	33.6
Northern Territory	2	1.8
Australian Capital Territory	11	10
South Australia	9	8.2
Tasmania	5	4.5
Location of practice		
City/metro	67	60.9
Rural	26	23.6
Remote	17	15.5
	<b>Mean</b>	<b>SD</b>
Total years since graduation	20.25	11.5
Years worked as an RN	18.9	11.2
Years since transition to PHC	2.8	1.7
Actual years worked in PHC	3.4	3.5



**Table 2.** Orientation and supports provided

	n	%
Received orientation to workplace and role	90	81.1
Access to a nurse preceptor to assist with clinical skill development	80	72.0
Role description provided	75	67.5
A nurse preceptor who assisted with organisational/management skills development	75	67.5
Encouragement to complete specified professional development	71	63.9
Leave/time to attend external professional development	65	58.5
Physical learning resources (eg. books, manuals)	54	48.6
Period of supernumerary working with another nurse without own client load	55	49.5
Funding to support external professional development	50	45.0

**Table 3.** Difficulties adjusting to PHC employment

	Very Difficult		Difficult		Neither difficult or Easy		Easy		Very Easy		Mean
	n	%	n	%	n	%	n	%	n	%	
Information overload	7	6.4	30	27.3	46	41.8	19	17.3	7	6.4	3.10
Organisational knowledge	7	6.4	38	34.5	28	25.5	26	23.6	11	10.0	3.04
Workplace familiarisation	4	3.6	24	21.8	39	35.5	34	30.9	9	8.2	2.82
New technology	4	3.7	24	22.0	34	31.2	30	27.5	17	15.6	2.71
Confidence in clinical skills	3	2.8	20	18.3	29	26.6	35	32.1	22	20.2	2.51
Clinical knowledge	2	1.8	15	13.8	36	33.0	35	32.1	21	19.3	2.47
Prioritising workload	0	0.0	23	20.9	24	21.8	44	39.1	19	17.3	2.46
Changes in the amount of responsibility	2	1.8	9	8.2	38	34.5	42	38.2	19	17.3	2.39
Increased autonomy	2	1.9	14	13.0	24	22.2	51	47.2	17	15.7	2.38
Concerns related to personal safety	0	0.0	7	6.4	47	43.1	34	31.2	21	19.3	2.37

**Table 4.** Additional support factors which could have assisted during the transition

	<b>n</b>	<b>%</b>
Improved orientation	42	38.2
Workplace specific skills practice	37	33.6
Greater preceptor support	35	31.8
Improved mentorship	30	27.3
Opportunity for team meetings	28	25.5
Increased support from other nurses	25	22.7
Longer orientation	23	20.9
Increased support from manager	22	20.0
Improved communication between nurses	20	18.2
Improved communication with medical staff	19	17.3
Enhanced workplace socialisation	16	14.5
Greater opportunities for staff socialisation	15	13.6
Better workload division	12	10.9
Improved rostering	5	4.5