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Registered nurses transitioning from acute care to primary healthcare employment: A qualitative insight into nurses' experiences

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Registered nurses transitioning from acute care to primary healthcare employment: A qualitative insight into nurses' experiences

Abstract

Aims and objectives: To describe the experiences of acute care registered nurses transitioning to primary healthcare settings.

Background: The worldwide increasing demand for primary healthcare services has resulted in skilled acute care nurses transitioning to primary healthcare 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.

Methods: Semistructured interviews were conducted with nurses who had transitioned into primary healthcare employment in the last 5 years. Data analysis was undertaken using Braun and Clarke's (2006) 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 programmes, 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 primary healthcare employment provides unique challenges which must be considered by employers if they are to attract and retain experienced acute care registered nurses.

Relevance to Clinical Practice: Understanding the experiences of nurses who transition from acute to primary healthcare employment can inform the design of orientation programmes 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 primary health care.

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Registered nurses transitioning from acute care to primary health care employment: A qualitative insight into nurses' experiences

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Nil conflicts

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ABSTRACT

Aim

This paper describes the experiences of acute care registered nurses transitioning to primary health care (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.

Methods

Semi-structured interviews were conducted with nurses who had transitioned into PHC employment in the last five years. Data analysis was undertaken using Braun and Clark's (2006) 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 registered nurses.

Relevance to Clinical Practice

Understanding the experiences of nurses who transition from acute to primary health care 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 primary health care.

Key words

Primary health care, transition, role theory, nursing, workforce, nurses

SUMMARY

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

- The international shift towards primary health care necessitates increasing the PHC nursing workforce.
- Transitioning to PHC employment creates unique challenges for acute care registered nurses, who report a range of experiences and varied levels of professional and organizational support.
- Ensuring positive transitioning experiences is important in building PHC nursing workforce capacity and promoting primary health care nursing as a positive career move.

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 (Commonwealth of Australia, 2016). These factors are resulting in a shift from acute care models towards primary health care (PHC) where health services are safely, efficiently and cost effectively delivered in the community (Fealy and McNamara, 2015). The PHC nursing workforce is increasing to meet the demands of these changing models of care, with one in eight of the 271,500 Australian registered nurses, now self-identifying as working in PHC settings (AIHW., 2015). Examples of primary health care 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 relating to the experiences, capabilities and educational preparedness of nurses who transition between acute care and PHC roles (Author's Own).

BACKGROUND

The nursing transition literature remains largely focused on new graduate transitions into the workplace (Higgins et al., 2010, Phillips et al., 2013, Murray-Parahi et al., 2016). Only a small body of literature focuses on other workforce transitions such as within different areas of acute care (Gohery and Meaney, 2013), movements

between levels of clinical seniority (Spoelstra and Robbins, 2010) and into specialty areas of practice including PHC (Author's Own, Zurmehly, 2007). Findings consistently identify the transition experience as stressful, associated with role ambiguity, role strain and role conflict (Chang et al., 2006, Gohery and Meaney, 2013), resulting in low job satisfaction and premature attrition from the workforce (Cortese et al., 2010). A range of factors have been identified as enablers to positive transition experiences. These include: educational preparation (Bryan, 1997, Simpson et al., 2006); opportunities for clinical skills development; access to ongoing continuing education; organisational orientation; a dedicated preceptor; mentoring, and team support in the workplace (Zurmehly, 2007, Rush et al., 2015, Lee et al., 2013).

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 (Holt, 2008); duration of the phases of transition and their association with personal attributes such as flexibility and adaptability (Hartung, 2005); transferability of skills (Zurmehly, 2007); and the experience of working within a new paradigm where benefits such as client relationships and autonomy of practice are identified (Hartung, 2005, Author's Own).

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 registered nurses 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 (Holt, 2008, Zurmehly, 2007), 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 these 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.

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 (Authors Own) and survey findings (Authors Own), 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 (2012). Transcripts were then critically analysed utilising the six phase thematic analysis approach reported by Braun and Clark (2006). As analysis was data-driven, inductive analysis where the researchers code the data without trying to fit it into either a pre-existing coding frame or into preconceived themes, was used. Analysis of themes was initially undertaken by one researcher (XX), a PhD candidate who is an experienced Registered Nurse and Midwife. The data and emerging themes were then discussed with three additional Registered Nurses who are experienced researchers with qualitative research experience. Two of these researchers have significant experience in primary health care 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 Human Research Ethics Committee (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 – 45 minutes in duration. Participant demographics are presented in Table 1.

****INSERT TABLE 1 HERE****

Two themes about the transition experience were identified, namely; Role Learning: the new environment, and Role Socialisation: transition validation (Table 2).

****INSERT TABLE 2 HERE****

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.

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. 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 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"*.

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).

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 ...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 software packages, and understanding appointments, recalls and reminder systems 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).

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“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’ in their first months in PHC. 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 for 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).*

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.”*

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.

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 straight forward. *"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. Being young, 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).

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).

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 (Author's Own, 2016, Arrowsmith et al., 2016). 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 (Holt, 2008, Zurmehly, 2007).

Role theory describes transitioning as a confusing 'zone' of disengaging from old roles and transforming or 'entering' into new roles (Bridges, 2006). Ashforth et al. (2007) 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 (Ashforth et al., 2007). Supporting findings in Holt's study (2008), our participants expressed surprise at the challenges faced as they transitioned to the new role despite most being experienced Registered Nurses. The

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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, and support previous literature (Zurmehly, 2007, Poronsky, 2013). 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 (Ramanan et al., 2006, Price, 2014, Dadiz and Guillet, 2015). These supports have also been shown to be important in developing confidence as an autonomous professional (Price, 2014). In our 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 (Halcomb and Ashley, 2017). Our study supports the need for the investigation of novel models of clinical support to meet the unique workforce needs of this group.

Role socialisation, or the process of internalising the behavioural expectations and adaptations necessary to validate a new role (Murray, 1998) 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 described previously by Holt (2008). 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 (Ashforth, 2000). Unlike graduates who commonly require around twelve months to identify with their new roles (Duchscher, 2009), the participants in our study reported wide variations in how long it took to socialise to their new roles. This supports findings by Holt (2008) and Hartung (2005) who identified personal characteristics, workplace setting and location, level of skill and availability of professional support as factors in the socialisation process. This highlights that a 'one size fits all' approach to providing transition programs in PHC are unlikely to meet the needs of all nurses, and must therefore incorporate flexibility.

Our study identified that most nurses moving to 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 (2000) who identified that professionals are motivated to proactively socialise into 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 primary health care 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 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.

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Table 1. Participant demographics

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

Table 2. Thematic structure

Theme	Role learning: the new environment	Role socialisation: transition validation
Sub-themes	<ul style="list-style-type: none">• Orientation to the workplace• Challenges in the early days• Role ambiguity	<ul style="list-style-type: none">• Role identity and developing confidence• Ongoing professional supports• Role conflict