RESEARCH ARTICLES

Does transition theory matter? A descriptive study of a transition program in Australia based on Duchscher's Stages of Transition Theory and Transition Shock Model

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ABSTRACT

Objective: Explore the impact of transition program policy directives grounded in foundational elements of transition theory.

Background: Within fast-track health service environments nurse leaders remain committed to improving transition programs that support wellbeing and retain new graduate nurses. Duchscher's Stages of Transition Theory and Transition Shock model was the framework chosen by the health service nurse leaders to implement in the clinical environment, however, implementing elements can be problematic without sufficient support and clear policy directives.

Study design and methods: Descriptive study using multiple methods in one major national health service that incorporates a number of private (eight) and public (four) hospitals across Australia. Online surveys were distributed to new graduate nurses at one, five and eleven months into the initial transition year. The survey tool was a synthesised adaptation of the Professional Role Transition Risk Assessment Instrument and Professional and Graduate Capability Framework. At the end of the transition year telephone interviews were conducted with the Nurse Managers who were responsible for implementing transition programs policies and processes. Resulting data were summarised using descriptive statistics for quantitative data and a thematic analysis for qualitative data.

Results: 158 new graduate nurses returned the online survey and eight Nurse Managers participated in the telephone interviews. As a whole the new graduate registered nurses described feeling accepted during their transition and expressed feeling comfortable when approaching senior staff. They managed challenges of shift work and took time for self-care. The clear majority (88%) of participants reported no plans to leave the profession. Nurse Managers were able, in most clinical areas, to apply transition program policy and directives and enable the implementation of Duchscher's Stages of Transition as the framework for the transition support

 https://doi.org/10.37464/2024.412.1050

initiatives. Retention of new graduates on their wards at the end of the program was determined to be a positive outcome for Nurse Managers.

Discussion: A carefully structured Graduate Nurse Transition Program founded on sound theoretically grounded ideology alongside integrated policy directives guided the Nurse Managers implementation of Duchscher's Stages of Transition Theory and Transition Shock model into practice. Additionally, a dedicated Graduate Nurse Coordinator role with a manageable ratio of graduate nurses was an important component included in the transition program at each participating hospital as it facilitated support of both graduates and Nurse Managers. These positions should be costed into any Graduate Nurse Transition Program. An interesting finding was the consistency in smaller units that were unable to provide or mobilise preceptors for the required allocated mirrored shifts and it was felt this workload management issue impacted the success of graduate transition nurse programs on those units.

Conclusions: Implementing policy directives grounded in foundational elements of Duchscher's Stages of Transition theory and Transition Shock model delivered consistent experiences for new graduate nurses across one major health service that incorporates a number of hospitals across Australia. Data suggested some practical challenges to program implementation for Nurse Managers, including unit/ward size, staffing, and varying levels of understanding of preceptor roles.

Implications for research, policy, practice: Introducing formal policy directives that are grounded in strong theoretical frameworks of professional role transition, agreed to and funded by health service nurse leaders are important in guiding a consistent approach across health services in the implementation of evidence-based Graduate Nurse Transition Programs.

Key words: Graduate nurse, newly graduated nurses, stages of transition, transition shock, transition.

What is already known about the topic?

- Duchscher's foundational research on the Stages of Transition theory and Transition Shock model is applied to inform Graduate Nurse Transition Programs on an international level.
- There is a current workforce shortage within Australia and internationally. The importance of retention of newly graduated nurses has become a focus for health care services implementing supportive transition programs to prevent new graduates from leaving the profession in the first year.

What this paper adds

- The inclusion of specific policy directives based on Duchscher's Stages of Transition theory and Transition Shock model provides clear direction to Nurse Managers related to the required implementation steps and time frames to be met during the transition year.
- Additional Graduate Nurse Coordinator positions, with a manageable ratio of New Graduate Registered Nurses (NGRNs), are important supports for both graduates and Nursing Managers to meet policy directives. Additional positions should be costed within transition programs.
- Provides additional evidence that well supported newly graduated nurses are likely to remain within the health service.

INTRODUCTION

This article contributes to the discourse on transitioning New Graduate Registered Nurses (NGRNs) into the healthcare environment. The transition of NGRNs into their professional careers continues to evolve as health services respond to the challenges posed by rapidly changing social, political, and economic environments. Çamveren et al. suggested that NGRN transition programs will remain ineffective in addressing transition shock unless strategies to improve these programs are undertaken.[1] This posed an issue for nurse leaders in a major national health service in Australia, as they consider the best approach to effectively support NGRNs and mitigate difficulties within the initial transition shock period. To attempt to address this issue a project was initiated that embedded a specific health service policy directive grounded in the theoretical underpinnings of Duchscher's Stages of Transition theory, and Transition Shock model into their health service transition program.[2] The major national health service incorporates a number of private (eight) and public (four) hospitals located across Australia.

BACKGROUND

In the 1974, Marlene Kramer published her seminal research on the experience of 'reality shock' in new nurses.[3] Kramer claimed that this difficult journey into professional practice featured strongly in reasons why nurses leave the profession.[3] Five decades later, high turnover of NGRNs remains a significant issue especially with an ageing nursing workforce

and early retirement.[4] The COVID-19 pandemic has further exacerbated nurse supply shortfalls subsequently placing a spotlight on the importance of both nurse staffing levels and the preparation of new practitioners for this dynamic and highly tumultuous patient care context.[5] In this current healthcare climate, retention of competent NGRNs by virtue of a supportive, evidence-based transition program takes on even more importance.[6]

Bakon et al's integrative review highlighted a lack of consensus on key components of transition programs including aims, content and the type of support provided.[7] It was within this context that the authors chose to design an evidence-based transition program based on the strong theoretical framework offered in Duchscher's Stages of Transition theory and Transition Shock model.[2,8] To implement this program, health service policy directives related to both process and anticipated outcomes were developed that mirrored the theoretical framework described above.

The aim of the study was to examine the effect of implementing policy directives grounded in evidence-based theory on transition into a major national health services NGRN transition programs.[2,8] The primary research question was: Can a formal integration of policy directives, grounded in the constructs of Duchscher's Stages of Transition theory and Transition Shock model, enable the delivery of a successful NGRN support program, with success determined by an increase in retention of new nurses in the healthcare system and a positive experience by Nurse Managers (NM) working with this demographic?

METHODS

OUTLINE OF TRANSITION PROGRAM

The program applies foundational elements critical to the successful transition of NGRNs according to Duchscher's Stages of Transition theory and Transition Shock model (see Table 1).

The health service policy directive was developed from these theoretical constructs to ensure staff and preceptors who worked in the health services different hospitals, consistently applied the NGRN foundational transition elements outlined in Table 2. It was equally important that NMs understood these foundational elements when evaluating evolving clinical expectations of NGRNs in their practice areas.

In each clinical area the NM allocated a preceptor for each NGRN. Preceptors were scheduled to work alongside the NGRNs (this is called mirrored shifts) for four to five weeks, followed by the provision of an additional six months of preceptored support, though not necessarily working the same shift.

Each hospital site within the overarching health service

TABLE 1. FOUNDATIONAL ELEMENTS REQUIRED FOR THE SUCCESSFUL TRANSITION OF NGRNS TO PROFESSIONAL PRACTICE

Ideologies applied to the design of the transition program
Newly graduated Registered Nurses: • have personal and professional lives characterised by stable and supportive relationships; • are afforded roles and responsibilities commensurate with their stage of transition and respectful of their evolving knowledge and confidence; • receive consistent workplace support and constructive feedback; • are familiar with, and successful enacting evolving expectations around care delivery and skill performance; • are provided opportunities to be supported by, consult and collaborate with experienced nurses about increasingly complex clinical decisions; • are consistently successful in responding appropriately to increasingly complex practice scenarios; • are provided with positive review, reinforcement and reassurance about their progress that is evidenced by a strengthening of their knowledge base; • are supported to influence, improve upon and enact quality care policy related to care and practice standards.

TABLE 2. NATIONAL GRADUATE NURSE TRANSITION PROGRAM KEY POLICY DIRECTIVES

Length of program and contractual arrangements:	
• 12-month contract with re-employment option. • Minimum 1,300 hrs. Worked over 52 weeks.	• Maximum two 6-month rotations. • Minimum FTE – 0.8.
• Paid attendance at Specific Orientation Program. Minimum 37.5 hours (5 day) program. • Includes 3 days theoretical training; • 2 days supernumerary clinical practice with allocated preceptor.	• No relieving for first 4 weeks. • No night duty for the first 12 weeks. • No 'buddying' with undergraduate students or another new graduate during first 6 months.
Resources and support for success	
• Dedicated Graduate Nurse Transition Program Coordinator.	• Minimum 12 months contract • Maximum ratio 1:12 • Facilitator to New Gradate Nurse.
• Graduates roster mirrored with preceptors for first 4 to 5 weeks where possible.	• Two preceptors can be used during this time.
• Graduates may be rostered to work on the weekends with their preceptor after completing two weeks of first rotation only (does not apply to second rotation).	• If graduates required to go relieving during this period, then only to non-specialty areas. Must be provided with a "relief" preceptor for the shift, and/or buddied with a senior staff member.
Professional Development Study Sessions	
• Study Sessions scheduled throughout the program. • In total a minimum of 22.5 hours allocated to this component of the program.	• Consideration given to each session's content to ensure learning needs met, whilst observing the different stages of transition (Duchscher 2008,2009).

supported the introduction of a new Graduate Nurse Coordinator (GNC) role with a specific ratio of 12 NGRNs. This key role oversaw the policy directive of the implementation of the transition stages within the allocated clinical areas throughout the 12-month program. The GNC role involved recruitment of NGRNs, placement into clinical rotations, the facilitation of regular study sessions, ongoing clinical competency assessments, preceptor guidance and clinical bedside support. The GNC was the primary point of contact for NGRNs, preceptors and NMs as it related to their initial 12 months of transition to professional practice.

The NMs were tasked with identifying potential preceptors and ensuring rostering of preceptors on the same shifts as the NGRNs. NMs were required to complete routine performance appraisals on NGRNs as they would for all nursing team members. The Learning and Development teams at each hospital site provided additional educational support to the NGRNs.

RESEARCH DESIGN

The descriptive study applied two separate methods. Phase One consisted of a survey conducted at one, five, and eleven months with NGRNs. These months were chosen to enable comparisons over the transition year and were practical for the health service to facilitate participant recruitment. Phase Two involved semi-structured interviews with NMs at the end of the 12-month transition program, explored their experience (enablers and barriers) of implementing the transition program based on the policy directives.

PARTICIPANTS

Phase One consisted of two participant cohorts who were in the transition program Group 1 included NGRNs (n=86) from across eight private hospitals and Group 2 included NGRNs (n=39) from across four public hospitals. These hospitals are in different geographical areas across Australia but belonged to one major health care group. Participants in Phase Two were NMs from across the different hospitals who were responsible for operationalising transition supports for NGRNs. Prior to commencement of the research, relevant senior nursing staff and NGRNs were informed about the study, through staff meetings and email, which spanned January 2020-July 2021.

ETHICAL CONSIDERATION

This project received ethics approval from Calvary Health Care Adelaide's Human Research Committee (Ethics Protocol 20-CHREC-E002) and from the University of Adelaide's Human Research Ethics Committee (Ethics Protocol 34389). Ethical consideration was given to ensuring informed consent, confidentiality, secure data management and anonymity of the participants. The right to withdraw from the study without any negative impact on their employment was highlighted.

PHASE ONE: QUANTITATIVE SURVEYS

Using work emails, NGRNs were sent a Participant Information Sheet explaining the study and a link to the online questionnaire in March 2020, August 2020, and February 2021. Data collection for each of the three surveys occurred over two weeks with a weekly email reminder.

Survey Monkey™ was the platform used for data collection. The instruments used to assess the NGRNs experience of transition were: 1) the *Professional Role Transition Tool*, (Appendix A) which was a synthesised adaptation of *Duchscher's Professional Role Transition Risk Assessment Instrument*©[2,8] and the *Professional and Graduate Capability Framework*©.[9,10] Permission was granted by the original authors to adapt their instruments for use.

The Professional Role Transition Tool was utilised with the intent to demonstrate that, throughout the 12-month program, NGRNs have incremental improvements across four categories: Category 1: Responsibilities 13 items (plus Emotional Assessment 3 items), Category 2: Roles 12 items, (plus Emotional Assessment 5 items), Category 3: Relationships 13 items (plus Emotional Assessment 10 items) and Category 4: Knowledge Application 16 items. Each item in the survey tool was recorded on a 6-point Likert scale that consisted of Strongly Disagree, Disagree, Somewhat Disagree, Somewhat Agree, Agree, and Strongly Agree. There was also a box to record 'Not Applicable'. The Emotional Assessment questions were added to the survey instrument at the request of the Health Services Ethics Committee to monitor the NGRNs wellbeing throughout the project.

Descriptive statistical analysis was undertaken in Excel™ software using number, mean, and standard deviation. Each item was reviewed to include whether it was positively (+) or negatively worded and assessed for % agreement (sum of SA and A responses for positively worded and SD + D for negatively worded). The total number of respondents for each Likert scale were counted and recorded.

PHASE 2: QUALITATIVE INTERVIEWS

Relevant NMs were invited by email to participate in a semi structured telephone interview. A participant information sheet, which contained a description of the study, the intended interview questions and a contact email of the academic team member who would be conducting the interviews was provided. Upon contact with the academic team member, a consent form was emailed to potential participants to be completed and returned before the interview. Telephone interviews were recorded with participants' permission and transcribed verbatim. Participants' details and locations were removed from transcripts to ensure anonymity. Thematic analysis was undertaken of the transcribed data.[11] Two academic researchers analysed data separately, coming together to agree on final themes and sub-themes.

FINDINGS

DATA QUALITY SUMMARY

Total of completed responses: from the Health Service private and public hospitals (Table 3).

Examination of NGRN quantitative data showed no differences across all three surveys of both public and private institutions.

The highest mean score across all surveys was in Category 3 (Relationships) (13 Items with mean scores of [4.5/ 5.0/ 5.2]) being in the Likert scale of 'agree'. Findings indicate that the graduates felt accepted in the workplace and comfortable approaching senior staff. The lowest score across all surveys was seen in Category 3 relationships in the questions related to Emotional Assessment with an average of [4.2/ 4.0/ 4.0] being in Likert scale 'somewhat agree'. These findings demonstrated that new graduates worries about responsibilities, managing challenges of shift work, being involved in clinical incidents, had difficulty sleeping between shifts and struggled taking time for self-care. However, in the question about whether or not they planned to leave the profession, over 88 % strongly disagreed.

TELEPHONE INTERVIEWS

Eight NMs responded to the invitation for an interview. Each interview lasted approximately 20-30 minutes. Six main themes were developed (Table 4).

Overall, the NMs interviewed for this study were very positive about the policy directed New Graduate Nurse Transition Program (NGNTP) and understood the importance of implementing all elements of Duchscher's Stages of Transition Theory and Transition Shock model in the clinical environment. The NMs clearly recognised the benefits to the organisation of keeping the NGRNs in their ward/unit after the transition program was complete. However, here were a few challenges in meeting the policy directives, particularly for the smaller units.

Theme 1: Unit size

It was revealed that some units/wards were too small to accommodate some components of transition stages, including mirrored shifts with preceptors, because of limited number of available staff;

> *My ward is quite small, I only have three nurses per shift, …* (Int3)

TABLE 3. TOTAL OF COMPLETED RESPONSES FROM THE HEALTH SERVICE PRIVATE AND PUBLIC HOSPITALS

Descriptors	Row labels	Survey 1			Survey 2			Survey 3		
		N	M	SD	N	M	SD	N	M	SD
Responsibility_13 Variable:Confident/responsible/capable	Private	73	4.8	0.5	55	4.7	0.4	22	5.2	0.4
	Public	11	4.8	0.5	20	4.8	0.4	8	5.2	0.6
	Total	**84**	**4.8**	**0.5**	**75**	**4.7**	**0.4**	**30**	**5.2**	**0.4**
Responsibility 3 Emotional Assessment Variable: Responsible/capable	Private	73	4.5	0.8	55	4.1	0.8	22	4.5	0.7
	Public	11	4.5	0.9	20	4.0	0.7	8	4.3	0.8
	Total	**84**	**4.5**	**0.8**	**75**	**4.1**	**0.8**	**30**	**4.5**	**0.7**
Roles_12 Variable: accountability/capable/ confident	Private	73	4.7	0.5	55	4.8	0.5	22	5.0	0.4
	Public	11	4.8	0.5	20	4.9	0.5	8	5.2	0.6
	Total	**84**	**4.7**	**0.5**	**75**	**4.8**	**0.5**	**30**	**5.0**	**0.5**
Roles_5 Emotional Assessment Variable: capable	Private	73	4.2	0.7	55	4.4	0.5	22	4.4	0.5
	Public	11	4.1	0.7	20	4.0	0.6	8	4.2	0.3
	Total	**84**	**4.2**	**0.7**	**75**	**4.3**	**0.6**	**30**	**4.4**	**0.4**
Relationships_13 Variable: confident/capable/accountable	Private	73	4.8	0.6	55	5.0	0.4	22	5.2	0.5
	Public	11	4.6	0.5	20	4.9	0.6	8	5.1	0.6
	Total	**84**	**4.8**	**0.5**	**75**	**5.0**	**0.5**	**30**	**5.1**	**0.5**
Relationships_10 Emotional Assessment Variable:capable/confident	Private	73	4.4	0.6	55	4.1	0.6	22	4.0	0.4
	Public	11	4.4	0.8	20	3.9	0.7	8	4.0	0.4
	Total	**84**	**4.4**	**0.6**	**75**	**4.0**	**0.6**	**30**	**4.0**	**0.4**
Knowledge_16 Variable: Confident/ capable/accountable	Private	73	4.6	0.5	55	4.8	0.5	22	4.9	0.5
	Public	11	4.5	0.6	20	4.8	0.5	8	4.9	0.7
	Total	**84**	**4.6**	**0.5**	**75**	**4.8**	**0.5**	**30**	**4.9**	**0.5**

 https://doi.org/10.37464/2024.412.1050

TABLE 4 SUMMARY OF INTERVIEW THEMES

	Main Themes	Sub Themes
1	Size of ward/unit makes a difference.	1.1 Units that were too small were unable to consistently accommodate preceptor requirements.
2	Appropriateness use of recent graduates as preceptors.	2.1 Staff who were recent graduates of a transition program have not forgotten what it is like to be very new.
3	Access to education support is an important part of the transition program.	3.1. Use of Learning and Development (Clinical Educators) staff on wards as extra support when a response was quickly required proved helpful.
4	Intentional support for newly graduated registered nurses.	4.1 Best outcomes resulted when there were no compromises in following the New Graduate Nurse Transition Program (NGNTP) process. 4.2 When newly graduated nurses were required to help on another ward, support of the newly graduated registered nurses and patient safety was felt to be paramount.
5	Benefits of Graduate Nurse Transition Program to patients.	5.1 Senior staff enjoyed the energy and enthusiasm of younger nursing staff. 5.2 Patients did not mind having a newly graduated registered nurse looking after them, though the importance of their being supported by a senior staff member was identified.
6	Benefits of Graduate Nurse Transition Program to organisation.	6.1 Program enables future staff recruitment. 6.2 Program reduces overall orientation time.

> *Probably one challenge as a manager is having to allocate a specific preceptor this is very difficult* [because the unit is small]. (Int4)

The interviewed NMs were concerned that small ward size and lack of consistency of preceptors may affect the experience of NGRNs. However, this concern seemed unwarranted; although some NGRNs did not have supervision from their specific preceptors, over 90% of the participating NGRNs claimed they felt 'very confident' in approaching their assigned preceptors (See Appendix A, RL9/JS), while 7% of the graduates stated they were 'somewhat confidence' in approaching their preceptors.

Theme 2: Optimising preceptorship

The second theme highlighted the perception by NMs that NGRNs who had recently completed the transition program made good preceptors because they still understood what it was like to transition;

> *A lot of our preceptors we use are Level 1* [Registered Nurse] *because we find Level 2s* [Clinical Nurse] *aren't great…, the Level 1s tend to remember a little bit more about what it was like to be a new grad so we've chosen our senior Level 1s to precept our new grads with the support of our Level 2s and our team leaders.* (Int1)

The value to NGRNs of regularly rostered mirrored shifts with their assigned preceptor was recognised by these participants;

> *If they have the mirrored shifts I think they gain more confidence.* (Int3)

> *I think what works well is definitely when the same preceptors can work consistently with the graduate.* (Int7)

Survey findings did not demonstrate significant differences between NGRNs co-workers, NMs, and even the graduates themselves as to who should precept NGRNs.

Theme 3: Access to education support

The roles of both the Learning and Development staff and the GNCs were identified as key components of the transition program. There was extensive discussion by all NM participants about the positive impact of the GNC roles and the critical influence of supporting NGRNs learning and development.

> *The graduate coordinators… take the grads and they go into one room and just chat about things that they've seen during the week and things that were maybe not so good and things that they thought were really interesting… It is a structured debrief.* (Int1)

This extra support included provision of additional assistance for NGRNs if it was identified that a graduate was struggling with their case load.

> *I asked the LND* [Learning and Development] *person if they could actually spend extra time today on my floor to make sure that* [new graduate nurse] *was properly supported while the other nurses were trying to do their work.* (Int3)

The Learning and Development roles added to the supportive environment for all staff on the unit. Findings related to the relationships between graduates and the hospital staff showed that over 85% of graduates reported feeling they were welcomed and over 75% feeling they were recognised and supported by staff.

Theme 4: Structure of support

Nursing Managers were very committed to providing supportive environments for NGRNs as they progressed through the stages of transition. The best outcomes resulted when there were no compromises on following the transition program policy and process and when a solid theoretical structure underpinned the initiative (See Table 2 for program process):

They're not doing any weekends for the first month. (Int1)

We know in advance that they're coming, we're aware of their rotation dates and we roster in advance so that wasn't a problem… I had four nominated mentors (Preceptors), *so each of the new grads had two each.* (Int2)

When NGRNs were required to help on another ward, NMs considered what was in the graduates and patients best interests:

If we did have to redeploy a grad, the after-hours were told exactly which wards they could go to, they were wards that they had previously rotated through, so no-one was being sent to anywhere that they had never been. (Int1)

No we try not to [redeploy]*… at all, we try and keep them here on the floor* (Int3)

Approximately 1/3 of respondents 'did not agree' that they could deal with their responsibilities/ workload before beginning their shifts. Interviews with the NMs revealed that they were attentive to NGRNs anxieties about being redeployed for a shift.

Theme 5: Benefits for patients

Benefits of a Graduate Nurse Transition Program in the provision of quality patient care was identified by all NMs. In particular, the energy and enthusiasm of NGRNs was seen as fostering a positive attitude:

The new grads that we have had through here are young, they are enthusiastic, because we are team nursing they learn the ropes, so they're more effective, and I think the patients really benefit from that. (Int2)

New grads they do offer the latest research don't they …I love new grads coming in and offering some new evidence and suggestions for change I think it's amazing. (Int7)

All preceptors and MNs acknowledged the importance of introducing NGRNs to their patients, which appeared to reassure the patients that there was a supportive supervision process (team approach) in place, and that the patients would receive optimum care:

When we do our bedside handover, we usually go as a team. And I say this is one of our NGRNs who is looking after you and they're working with our facilitator (Preceptor) *today, so it gives them* [patients] *reassurance when they see us as a team.* (Int4)

One benefit of the program to patients was the rapid increase in confidence of NGRNs as they evolved through the transition stages and were empowered to provide safe care. For instance, almost all the NGRNs felt confident talking to their team leader about their patients, over 70% were confident calling medical doctors about their patients, and over 80% were confident in escalating patient care concerns. Although the provision of care to patients with complex needs requires a high level of nursing skill, over 40% of the respondents were confident they could deal with these patients, and over 50% were confident in looking after patients with changes in their clinical status.

Theme 6: Benefits to organisations.

The retention of the graduate registered nurses who went through the transition program was seen as a significant benefit to organisations participating in a supportive transition program for NGRNs. In this study, the majority of graduates expressed plans to return to the units where they had transitioned. For many reasons, including these now experienced nurses not needing to be re-orientated, was received by NMs as beneficial from a unit cohesion as well as fiscal perspective:

I think it's retention of well-trained staff is the big one from a managerial point of view because it's so hard to find staff that … really do fit into the culture of each ward. (Int1)

We've been able to recruit from grads which is very beneficial… but the grads that we've had that have stayed I find they're even better with the grads as well because they've been there, done that, they're young and fresh. (Int3)

Think we retain nurses through having that supportive environment… and input our values into them. (Int4)

We've got brilliant new registered nurses already hitting the ground running. (Int2)

The high retention of NGRNs at the end of the transition program was attributed to a good 'cultural fit' by NMs. This was reflected in less than 15% respondents stating they considered leaving their current workplace, and only 3% of the respondents stating they considered leaving the nursing profession.

DISCUSSION

The transition program was specifically modelled on Duchscher's Stages of Transition theory and Transition Shock model. Policy directives were incorporated into the program design to instruct NMs on each stage with the intent to maximise implementation of the key theoretical foundations. This approach aimed to provide a supportive environment where NGRNs became confident, capable, accountable, and responsible practitioners by the end of the year.

SUPPORTED IN THEIR PROCESS OF TRANSITIONING

The survey findings supported this aim, providing evidence of positive responses to feeling supported in transitioning as registered nurses within the first five months of their program.

The affirmative results from survey data, particularly about questions relating to feeling accepted, comfortable, and confident in their role support the initiative of providing a dedicated GNC with a manageable ratio of nursing graduates. The valued contribution of the GNC role in supporting NGRNs was consistently reported by NM. One regular issue raised by NM in supporting NGRNs was the importance of a regular feedback loop from GNC to the Nursing Manager about the progress of NGRNs. Nurse Managers who were unable to regularly connect with the NGRNs relied on feedback from the GNC to determine whether or not to increase patient workload and acuity, when to roster night duty, or when a preceptor was no longer required.

BENEFITS OF A STRUCTURED GRADUATE NURSE TRANSITION PROGRAM

Overall, NMs were very positive about the benefits to patients and the organisation of a structured transition program. There was a strong sense of commitment to the theoretical framework and meeting at each stage of the policy directive allowed NMs and GNCs to communicate and troubleshoot as needed. Survey responses indicated that the foundational elements of Duchscher's theory were being implemented such that GNCs were supporting the stages of transition appropriately and, as a result, NGRNs felt welcomed, comfortable with the expectations of the workplace, and accepted by their colleagues.

The NMs recognised the organisational impact of the transition program, which included recruitment of NGRNs back to their ward/unit at the end of the program. This greatly reduced subsequent orientation time because of familiarity with both the ward environment/culture and case mix of patients. This outcome is an important fiscal consideration for health services.

BARRIERS TO PROGRAM IMPLEMENTATION

Not all practice areas were able to follow the program directive of scheduling the same preceptor on mirrored shifts with the graduate nurse for the entire 4-5 weeks. When mirrored shifts were able to be achieved it was noted by NM that the NGRNs' clinical confidence increased more rapidly. The smaller units found it more difficult to organise mirrored shifts due to a minimum number of suitable senior preceptors. It could be suggested that smaller units are not ideal for transition programs because of their inability to comply with key strategies despite their best of intentions.

PRECEPTORSHIP ROLE VARIATION

This study highlighted differing views on the skills required for a preceptor. Some NMs preferred having experienced nurses with training in preceptorship because they understood the requirements of their role in supporting graduated nurses and focusing on stage-specific strategies. Others thought that recent graduates (who had just finished their transition year) were sufficient in the role of preceptor because they could still relate to what it was like to be new. The idea of utilising recent graduates because of their proximity to the transition experience alone suggests an undervaluing or lack of understanding of the broader purpose of preceptorship/mentoring. The critical nature of tacit knowledge transfer from experienced nurses to new practitioners is one of the most important underpinnings of the preceptor/mentor role. If the definition of preceptorship, at least in part, is the sharing of relevant experience and knowledge for the purpose of enhancing clinical judgement and appropriate decision-making, then experience (time spent practicing) in that clinical context is important to the role.[12-14] Preceptorship, in the context of this study, was determined to include the modelling of positive values and tenets of professional practice as well as the transferring of knowledge and the application of practice ethics within the healthcare context.

BUILDING A CULTURE OF SUPPORT

When considering the allocation of NGRNs to a particular patient demographic, one important strategy that NMs regularly employed was to introduce the NGRN to patients as part of the clinical team looking after them for the shift. The emphasis on 'team' reduced pressure on the NGRN to manage on their own and reassured patients that the novice practitioner was well-supported by other clinical experts. NMs reported positive feedback from patients who ultimately enjoyed the NGRNs energy and confident approach to providing their nursing care.

LIMITATIONS

The number of participant responses reduced over the three surveys. The high number of questions that resulted from a melding of two distinct tools may have contributed to question exhaustion and the subsequent reduction in survey response over time. It is noted that one question not included in this series of questions was related to registered nurses' salaries, which could be a factor for NGRNs to consider if they want to continue their nursing profession. This may be worth considering in future surveys. The study also occurred during COVID-19 and the negative impact on the hospitals staff, staffing levels and the NGRNs may have contributed to the reduced response rate as well as the respondent views and study findings.

It was not feasible for the study design to incorporate an 'experimental' control group because a significant number of nursing staff across all of the hospitals had previously attended workshops based on Duchscher's Stagoes of Transition© theory and Transition Shock© model.[2,8] Though some hospitals were not included in the new Graduate Nurse Transition Program, it is possible that the underpinnings of transition theory had already been incorporated into the graduate nurse programs run at each hospital.

CONCLUSION

A carefully structured Graduate Nurse Transition Program founded on sound theoretically grounded ideology alongside integrated policy directives that reflect best practices for professional role transition provides a supportive environment for NGRNs. Inclusion of a dedicated GNC role with a manageable ratio of NGRNs to senior nurse preceptors is important in supporting both graduates and nursing managers to meet the program's policy directives. This component should be costed into any Graduate Nurse Transition Program. Smaller wards/units unable to provide preceptors for the required allocated mirrored shifts may require further human resource support to be suitable for participation in Graduate Nurse Transition Programs. More education is required for senior nursing staff to really understand the nuances of the preceptor role and the stages of transition for NGRNs.

Acknowledgements: Thank you to the nursing staff who took the time to respond to the surveys and interviews who work in the Calvary Health Care study sites.

Funding Support: Little Company of Mary Health Care Ltd funded a small research grant to allow the study to be undertaken. Funding contributed to data collection (interviews), transcribing recorded interviews and quantitative and qualitative data analysis.

Declaration of conflicts of interests: The authors declare that they have no conflicts of interest pertaining to this work.

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