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The experience of new graduate nurses in rural practice in New South Wales

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ABSTRACT

Introduction: The recruitment and retention of health professionals in rural areas is a long-standing concern in Australia. In the context of an ageing rural nursing workforce, recruitment and retention of new graduate nurses is an important issue. Objective: To explore the role transition for new graduate nurses in rural practice in New South Wales (NSW).

Methods: This study utilised a qualitative hermeneutic-phenomenological framework. Participants & Setting: A purposive sample was drawn from eight rural health care facilities in NSW where participants were employed as new graduate nurses in the first year of a graduate nurse transition program.

Results: The ward culture, workload and level of responsibility within rural healthcare facilities were of concern for new graduates and influenced their retention within the rural nursing workforce. Main outcome: There are specific aspects of the transition experience that are unique to graduate nurses in rural practice settings.

Conclusion: The findings have implications for undergraduate curricula in the preparation of graduates for the reality of the rural nursing workforce. Additionally, the expectations that staff have of new graduates as they enter the nursing workforce, and the workplace cultural issues recognised as having a significant impact on the retention of graduates must be addressed locally and at the area health service level if nurses are to be retained in this unique nursing specialty.

Key words: Australia, graduate nurse transition programs, new graduate nurses, recruitment and retention, rural nursing.

Introduction

The recruitment and retention of health professionals in rural areas is acknowledged as a major problem in Australia[1-4] and is a long-standing concern. The rural nursing workforce is an ageing one, and numerous reports focus on the recruitment and retention of new graduate nurses as an important issue for rural healthcare facilities[5,6]. The small number of new graduates who enter rural practice, enter a professional practice vastly different from metropolitan practice and from what they have experienced in their undergraduate preparation. This can be attributed to the scope and diversity of rural nursing practice that results in differences in the level of responsibility and skill when compared with metropolitan nursing practice. Additionally, the diminishing infrastructure of rural towns and the subsequent restructuring of health services have impacted on the staffing ratios and skill mixes within rural healthcare facilities. This has influenced the educational and support services that can be offered to new graduates in transition programs in rural areas.

Much of the existing literature focuses on factors that influence the recruitment of graduates to the rural workforce[4,6,7]. However there is a lack evaluative studies that focus specifically on the new graduate nurse's transition into rural practice settings, or on the experience of employing new graduates in Australian rural healthcare facilities[8]. This study addresses the gap in the literature pertaining to graduate nurse experience of rural nursing practice.

Literature review

The transition process into the nursing workforce is fraught with complexities, and transition-based issues have been well documented[9-13]. The successful assimilation of the new graduate nurse into the nursing workforce is largely dependent on the amount and quality of support that the new graduate receives. This is especially true within the first 3 months of employment when a rapid and major transformation occurs, both professionally and personally, in the new graduate[14]. Various aspects of the transition process in nursing, and the difficulties encountered by beginning registered nurses as they enter the nursing workforce, have been explored in the literature[14-18].

For the new graduate in rural practice the role transition is further complicated by the unique role of the rural nurse. Rural nursing has been referred to as a unique specialty, and is described as a specialist-generalist role[1]. Rural nurses work in areas where there are limited health services, healthcare facilities and medical practitioners. Thus the rural nurse role requires a multidimensional approach, accompanied by a broad range of skills. Rural nurses frequently lack ancillary and medical support, which often results in them being the primary care giver and 'jack of all trades', which means working in all areas and sometimes working beyond their legal boundaries[1,19].

It has been reported[14] that new graduates who enter rural nursing practice feel unprepared because they lack the broad range of skills that are required of rural nurses. Furthermore, the workplace culture in rural areas is a significant issue for new graduates, and common areas of concern unique to rural nursing practice include the clinical environment of rural agencies, the impact of work practices, and stress levels and staffing issues that have impacted on the support programs offered to rural graduate nurses. Workplace barriers such as unprofessional behaviour by more experienced colleagues, competence measured by an ability to cope rather than application of knowledge and skills, and an underestimation of the abilities of new graduates in rural practice have also been identified as significant aspects impacting on the new graduate experience in rural nursing practice[8,19,20]. Hegney[1] and Mosel Williams[8] believe that due to the nature and scope of rural nursing practice which is multi-skilled and takes years of experience, it is unrealistic to expect new graduates to be adequately prepared for such practice.

Study aims

This study aimed to explore and provide an understanding of new graduate nurses' experience of transition within rural practice settings. Specifically, the researcher sought to identify aspects of the role transition that are unique to rural practice settings and explore the level of support provided to new graduates in rural practice. Issues that can influence the retention of new graduates within the rural nursing workforce were also investigated.

Methods

This study utilised a qualitative hermeneutic-phenomenological framework as described by Annells[21] to provide an understanding of what the first year of practice was like for 10 new graduate nurses in rural practice settings. Individual in-depth interviews of 60-90 min duration were conducted in the participants' homes. Ethical approval for this study was obtained from the University of New England's Human Research Ethics Committee prior to the commencement of the study. To expedite the recruitment process, the University of New England's Human Research Ethics Committee gave permission for the researcher to conduct the interviews in the participants' homes. This avoided the time-consuming exercise of having to obtain ethical approval from several healthcare facilities, and all participants were comfortable with this recruitment process.

Setting

This study was conducted in rural towns of northern New South Wales (NSW) where, at the time of the study, healthcare facilities employed a new graduate nurse in a graduate nurse transition program, and were geographically accessible to the researcher.

Included towns had a population classified as rural, were in a geographical location or at a distance from metropolitan centres considered to be rural according to the Rural, Remote and Metropolitan Areas (RRMA) classification method[22]. The four towns chosen for inclusion in this study were RRMA classified as large rural towns, and the healthcare facilities within these large rural towns provided similar medical and nursing services. For example, the bed capacity ranged between 100 and 150, and staff ratios, skill mixes and graduate nurse programs within these facilities were very similar. The remaining four agencies included in the study were RRMA classified as small rural towns with a bed capacity ranging between 30 and 60. Medical and nursing services within these healthcare facilities were similar, as was the content and structure of their graduate nurse programs.

Population and sampling method

The population for the study were new graduate nurses in area health services within northern NSW, and purposive sampling was used to select a small cohort of new graduate nurses. The inclusion criteria were: being employed as a new graduate nurse in the first year of a graduate nurse transition program in rural agencies located in northern NSW. New graduates who met the criteria were initially approached by the researcher for participation in the study. At the time of the study, the researcher was the clinical coordinator of an undergraduate nursing program in NSW and a regular visitor to rural agencies with access to new graduates and staff at each agency. New graduates who indicated an interest in participating in the study were telephoned at a later date to arrange dates, times and venues for the interviews. In order to facilitate recruitment and ensure participants' privacy and confidentiality, interviews were conducted in the participants' own time and away from their employing facility. This was also intended to reassure the participants that the study was not related to the conditions of their employment, and also to assist them to speak freely about their experiences.

Data analysis

The audiotaped interviews were transcribed verbatim by the researcher immediately after each interview. Transcripts

were mailed to each participant for content validation or change, modification and clarification, as required.

Thematic analysis of the data was undertaken using a highlighting approach, as described by van Manen[23]. Significant statements and commonalities were identified and organised into themes that represented important aspects of the new graduate nurses' experience of transition into rural practice settings.

Results

This article reports on a major theme that emerged from the data: *Socialising to registered nursing in rural practice*. In this theme the findings showed that the new graduates' experience in the first few months of rural nursing practice were significantly influenced by the culture of the ward environment, the workload and level of responsibility, and a lack of structured support during their graduate nurse program. These findings are similar to the findings of previous studies[12,14,24]; however, the experiences of the new graduates in this study differed depending on the size of the agency, and staff ratios and skill mixes within each agency.

The ward culture within rural settings

The findings showed that the new graduates' experience of transition into rural healthcare agencies was influenced and shaped by the effects of the ward culture into which they were trying to assimilate. The social forces at work in the ward environment often resulted in negative ward dynamics, and had an enormous impact on the new graduates. They discussed this in terms of the type of support they received, and from whom they sought support.

For example, a number of instances of horizontal violence operated simultaneously in each ward where the new graduates were rostered. Aggressive behaviour from staff contributed to hostile undercurrents and the negative ward dynamics. Participants indicated that they were exposed to inappropriate and unprofessional behaviour from staff on a daily basis, which resulted in a working climate fraught with distrust, competitiveness and outright 'bitchiness'. The more senior registered nursing staff were identified as the main perpetrators of this hostility and aggressive behaviour. However, participants also acknowledged that individual staff were very supportive of them, if they asked for support. However, this depended on who was working at the time, and the subsequent ward dynamics could ultimately affect the ward climate and, therefore, the treatment of the new graduates.

> *I think the hardest is that you used to always hear about horizontal violence that goes on. Being a student you are only in the ward for a period of time and then you go out again… Now it's* [bitching] *in your face and you're always there and comments eventually get back to you. It just always goes on, everyone's bitching about everyone and it's a real eye opener.* (Emma)

The hostile undercurrents meant that participants did not trust some colleagues, and so would not seek their support, or would do so grudgingly if there was no-one else available. Additionally, while most staff were able to display supportive actions, that is they would help out when asked, participants felt that their manner or attitude was not always supportive and so they were initially unsure of whom to turn to for support. They also found it difficult to ask for support from the more dominant senior staff members because their 'bitching' and hostile attitude toward other staff meant the participants were not able to trust them.

> *The management are really close friends and the morale at work is really poor. It's really hard to approach them* [senior nurses]. *They'd have their coffee of a morning and you would hear them run down every single person in the hospital. I have found they are my biggest problem since I have been at work. I think it is a much bigger problem than what most people see on the surface. I think that's why I don't go to them* [senior staff] *for support because I don't trust them.* (Hannah)

The participants stated that when they tried to address their problems with management, many experienced very little support. While it is acknowledged that this problem is not specific to rural practice, it is not surprising given that a lack of support from management has been reported[25] to influence a person's decision to report such behaviours. In addition, because senior nurses are often the main perpetrators of horizontal violence, these problems are often overlooked or dismissed by management[25]. When participants approached more experienced nurses for advice regarding clinical decisions they believed to be beyond their scope of knowledge and experience, participants experienced the staff as intimidating, and often felt rebuked for not being able to make the clinical decisions of a more experienced nurse in that situation.

The new graduates also found it hard to be socially accepted and to form friendships within some of the rural healthcare facilities because of the social clique that had developed over time. Staff in rural communities often have worked together for a number of years, may have trained together, may have partners who work together and even have children who play together, leading to social cliques forming around their work relationships. This unique element of rural nursing is uncommon in larger healthcare facilities. For newcomers, dealing with such social issues while living and working in a very small community can create an extra barrier to assimilation into the rural nursing workforce. Related to this, the lack of anonymity that occurs on several levels for rural nurses[26] can cause discomfort for new graduates. They are not used to the lack of privacy in their day-to-day nursing practice that occurs in the close working environment with small numbers of staff that characterises rural healthcare facilities. For the new graduate there was no escape from the hostile undercurrents prevailing in the wards. Due to the small size of some of the rural agencies, the graduates would be working with these people, as well as sharing coffee and meal breaks with them on a daily basis.

> *Having to realise that people who have grown up in the same community, they have gone to school together, they have gone through nursing together and they are working together. So there is that element of the pecking order, and as a grad you fit into the pecking order right at the bottom end of the scale. And you have to comply with everybody else's expectations and you might jeopardise your position in that pecking order if you overstep those boundaries that are set by those people.* (Sally)

Workplace conflict in nursing is not a new phenomenon, but it is only recently that this problem been acknowledged as an important factor in the recruitment, retention and career satisfaction of nurses and, in particular, of new graduate nurses[24,25]. The problems of horizontal violence and workplace aggression in nursing, the factors that influence such behaviour, and its impact on organisational culture and the nursing workforce have been explored recently[25,27-31]. Numerous studies identify horizontal violence in the nursing workplace as a major cause of anxiety and extreme work-based stress for many nurses[25,27-30].

Horizontal violence refers to overt and covert non-physical hostility, and includes workplace conflicts, aggression and bullying. Farrell[27] states that this type of violence can take many forms, the most common of which include gossiping, infighting, rudeness, criticism, scapegoating, and an unwillingness to speak up for others. These negative behaviours by nurses toward other nurses are attributed[25,27-30] to power relations and oppressed group behaviour, resulting in the inward expression of dissatisfaction. Jackson et al[25] reported such hostile undercurrents, violence and hostility to be part of the day-to-day lives of most nurses. The findings of this study reveal that rural nursing practice is no exception.

Workload in rural practice settings

Initially, all the participants believed their time management skills to be problematic, especially given the patient load they said they were expected to manage almost immediately upon entering the nursing workforce. Expectations regarding student-nurse patient load and what was allocated to them as a beginning registered nurse patient load were quite

different. Participants acknowledged their initial inexperience in carrying a full workload and associated responsibilities, and felt there was no recognition of this by the healthcare agencies.

They also perceived no difference between their workload at the commencement of their graduate program and the workload of more experienced staff, believing the workload allocations to be unfair and a reflection of the hostile attitudes to university graduates of more senior staff. The graduates felt that coping with their workload was a test that could confirm their acceptance as a registered nurse, and that having a lighter workload was a reward for hard work, rather than a support measure for new graduates.

> *After 3 days of orientation you sort of get left to your own devices. I was thrown in at the deep end.* (Sally)

> *They don't see you as a new grad here. They see you as having RN next to your name, you can have the full patient load, don't talk to me unless you have a problem.* (James)

A full patient load in rural agencies can mean one registered nurse and one enrolled nurse working together, expected to care for up to twenty patients between them. The registered nurse is responsible for the management of the ward, the dispensing of medications and management of intravenous therapies, and is also responsible for monitoring the care delivered by the enrolled nurse. Participants stated that before being given full workload responsibility they thought they would be given more support to allow them time to settle in, adjust to the role change and become familiar with the workplace environment. Overall, the new graduates found the workload allocation extremely stressful and overwhelming because they had not been exposed to this type of workload and ward management during their undergraduate education.

> *I had two days orientation and then they said 'right this is you' and I had 14 patients to look after and I nearly died. I was shocked. I had to walk up and down for ten minutes trying to get my head around it. I think fourteen patients for a new grad without any other RNs around is too much.* (Anne)

> *I asked for help and they gave me another EN. I said this is not what I need. I need another RN to break up the medication load and the RN specific skills such as managing the IV therapies and blood transfusions.* (Anne)

The level of responsibility and the role that the new graduates were expected to fulfil was a significant issue for these new graduates. Several studies[12,13,24] have identified the level of responsibility as one of the main issues that causes new graduates extreme stress and nervousness in their graduate year. However, there are differences in the level and type of responsibilities new graduates in rural practice settings are expected to assume, due to the size of the healthcare agency, the services it provides and the staffing ratios. These factors were identified in this study, and influence not only workload expectations, but also the level of responsibility and the extended role the new graduates are expected to undertake. For example, the downsizing and rationalisation of rural health services in larger regional centres in NSW means that individual wards may accommodate a mix of patients, including paediatric, maternity and medical patients accommodated in one area. Alternatively, one ward may be allocated to long-stay medical, psychiatric and geriatric patients, and one ward for acute patients of differing types.

Also, it is not uncommon in rural healthcare agencies for accident and emergency areas to be left unattended until a patient arrives. This means that the registered nurse working at that time not only manages a patient load and coordinates the activities of the enrolled nurses, but also attends to patients who arrive in accident and emergency. The participants who worked in smaller rural agencies were expected to assume extra responsibilities, often with very limited supervision or guidance. They were almost immediately placed in charge of whole wards and also expected to attend the accident and emergency area should

the need arise. As beginning registered nurses, they believed they were not prepared for these roles that generally required experienced registered nurses. This was a cause for concern to the graduates who found it stressful and as a result also experienced self-doubt and loss of confidence regarding their practice ability.

> *When I first started, there was the aged care unit and the registered nurse was in charge of the aged care unit, so you are in charge straight away. It has its certain level of responsibility which you are not trained to fulfil. Yet that's what your responsibility is!* (Sally)

> *I was the only RN for the emergency and surgical ward and I usually had one enrolled nurse. I was a postgrad, I had every key to the hospital in my pockets and at lunch, my lunch break would be, I'd go outside under the tank stand and smoke. The ambulance would come and I would have to leave because there would be no one else to collect the ambulance.* (Hannah)

The new graduates felt that the expected level of responsibility was beyond their level of competence, knowledge and experience at this beginning stage of their nursing careers. Most stated that they had very limited exposure to emergency nursing in their undergraduate preparation and lacked experience with ward management and the responsibilities of being in charge. However, in the smaller rural agencies, staffing practices and staff expectations necessitated the beginning registered nurse to frequently overstep the boundaries of their knowledge and skills.

> *Because of the* [rural] *environment you are put into a setting where you don't have any experience, such as the emergency department. You might have only minimal exposure to that through your course. It* [working in emergency] *requires certain levels of further training to qualify for that area. You know the intolerance of other staff members. You know you're a registered nurse therefore you perform at registered nurse level.* (Sally)

In one ward Sally was expected to be in charge and fulfill RN duties, yet on another ward she was expected to function at the EN level and was told she had to 'take on an extra load if you want to do RN specific duties'. Sally describes what happened when she tried to initiate taking on more specific RN duties, and consequently more responsibility:

> *I was called into the office. I was informed that I was not pulling my load. So I felt rather agitated and I wanted to know specific areas, issues that they felt I was not fulfilling. They couldn't comply with that. I addressed the RNs. If they were concerned that I wasn't pulling my load I wanted them to let me know. One of them said, 'Perhaps it's your time management' and I thought, 'OK, time management in what capacity? In what role? What specific role are you referring to? Is it my registered nursing role or is it my general duties role?'* (Sally)

This role ambiguity becomes evident when the new graduate's role is unclear, vague and ill-defined and there is a lack of clarity as to other staffs' expectations of that role. Added to this is role incongruity: in one area of the hospital, Sally was expected to be in charge and function at the level of more experienced colleagues, while in the other ward she was not expected to do any more than an enrolled nurse would.

Anne also believed that she experienced role ambiguity and role conflict because she was being treated differently from another beginning registered nurse who was not part of a graduate nurse program.

> *There was this big thing on the medical ward that ENs don't sign medications with the new grad RNs. And I just cleared that up. I said to the RN in charge, who I thought was really uncooperative, 'Oh well if that is your rule then it is not very good for this person* [casual RN] *and I to sign and check each*

> *others medications because we went to uni together. They are a new grad too!' And she* [the in-charge RN] *said 'they are employed as an RN, you are a grad.* (Anne)

According to Hardy and Conway[32], role stress and strain are to be expected in the transition to professional practice, because these elements of role transition are manifest in any social organization. Role stress is prevalent in nursing because of the multiple sub-roles in the professional nurse role, the organisation and delivery of health care, and the prevailing economic conditions that impact on the nurse's role. The most prominent feature of role stress during the socialisation process of new graduate nurses has been identified as role overload and ambiguity, where the graduate's role is not specifically delineated or there is a lack of understanding of what is expected[17,24]. However, the high levels of role stress or role strain that Sally and Anne experienced can occur when an organisation puts very difficult, conflicting or impossible demands on individuals, and this was certainly the case in this rural setting. The incidents experienced by the participants are also consistent with a new graduate's enculturation process, imposed by more experienced clinicians as a means to control and restrain the new graduate[8].

Discussion

For most of the participants in this study, socialisation into the rural nursing workforce had occurred quickly. The workload and workforce issues that strongly impact on rural health services had forced the new graduates to either cope with the expected workload and level of responsibility or leave rural practice. However, leaving rural practice was not an option for most of the participants because of ties to the rural area relating to partners, families or financial commitments, as has been reported elsewhere[7].

The influence of ward culture on the socialisation of the new graduate nurse was significant in shaping and influencing their experience of transition into rural practice. It appeared from the data that the behaviour of other staff and the undercurrents in the ward were operating to shape the behaviours of the new graduates to conform to the expectations of a registered nurse. This is not unique to rural practice settings; however, what is different in rural settings is the effect of the close working environment on ward culture. The new graduates have to adjust to working with people they know socially in a small rural community. They also have to work with the same people everyday because of the small number of staff in rural agencies, which means there is no escape from the aggressive and hostile undercurrents that can prevail in the rural wards. Because the unprofessional behaviours came from staff who were supposed to be supportive role models, the graduates were reluctant to seek out support. This left the graduates unable to trust some staff members and without anyone to turn to for support in dealing with these issues.

Important to this cohort of new graduates was the culture of the rural ward environment which meant they had to adjust to and deal with role diffuseness and the lack of anonymity that comes with working in rural communities. This was a significant aspect of the graduates' socialisation to registered nursing practice because they were continually struggling for acceptance as part of the team, yet feeling self-conscious and intimidated by the unprofessional behaviour of staff.

The staff expectation that new graduates would have 'to hit the decks running' proved to be very much the case for the cohort of new graduate nurses in this study, who entered rural practice with expectations of being eased into the rural workforce. Staff shortages and the casualisation of the workforce was identified by Levitt-Jones and Fitzgerald[33] as mitigating against a supportive environment for new graduates. For the new graduate nurse in rural practice, restructuring and relocation of health services out of rural towns to regional centres has resulted in reduced staff : patient ratios and skill mixes. Additionally, the new graduates often had to work beyond their level of experience and knowledge immediately, and were also expected to become a productive member of the rural nursing team in a very short time.

It is important to note that not all the findings from this study are specific to rural nursing practice. For example, the researcher believes the graduates may have had unrealistic expectations of and assumptions about their graduate year for several reasons. First, several of the younger participants had not been employed previously in an organisation. Because of this, they entered the workforce with a minimum level of work experience, which included a knowledge deficit regarding workplace cultural issues and the role transition processes. As a result, graduates experienced a fear of the unknown in their graduate year because of the unpredictability of the nursing environment and the change in their role from student to that of registered nurse. This was evidenced by graduates in this study who stated they felt as well prepared as possible given the unpredictability of nursing practice and their lack of experience in the workforce.

However, the findings of this study suggest that undergraduate nursing students need to be better prepared to deal with ward culture and social interactions in rural practice settings that may significantly influence their transition experience. Nursing in the higher education sector should also address health management topics when preparing graduates for the reality of the rural nursing workforce. These suggestions are supported by the Commonwealth Department of Education, Science and Training[34], which identified interpersonal skills and management as two areas in undergraduate nursing education that need to be taught in a rural context. Programs offered by the higher education sector could assist rural health staff to understand the beginning level skills and knowledge of new graduate nurses. Such programs could assist staff with planning and implementing appropriate support strategies to ensure that graduates are effectively integrated into the rural workforce. In the long term, this could assist with the recruitment and retention of graduates to rural areas.

Limitations of the study

While the generalisability of the findings is limited, it was not the intention of the researcher to generalise the findings to the graduate nurse population. Rather, this study seeks to identify and explore the experience of role transition for a small group of graduate nurses in order to generate an awareness of issues specific to rural nursing practice.

Conclusion

The findings of this study show that more work is needed in order to address the retention and recruitment problems of rural nurses in Australia. All new graduates need to be nurtured by the nursing profession, and rural registered nurses are doing the profession a grave disservice if they do not perform as professional, caring role models. It is hoped that these research findings will assist rural nurses and rural health facilities to address the expectations that staff have of new graduates as they enter the nursing workforce. The workplace cultural issues that were recognised in this study as having a significant impact on the retention of graduates need to be addressed, not only by individual rural agencies, but also at the area health service level.

References

1. Hegney D. The status of rural nursing in Australia: a review. *Australian Journal of Rural Health* 1996; **4:** 1-10.

2. Bell P, Daly J, Chang E. A study of the educational and research priorities of registered nurses in rural Australia. *Journal of Advanced Nursing* 997; **25:** 794-800.

3. Courtney M, Edwards H, Smith S, Finlayson K. The impact of rural clinical placement on student nurse employment intentions. *Collegian* 2002; **9:** 13-18.

4. Playford D, Larson A, Wheatland B. Going country: rural student placement factors associated with future rural employment in nursing and allied health. *Australian Journal of Rural Health* 2006; **14:** 14-19.

5. Cowin L. The effects of nurses' job satisfaction on retention: an Australian perspective. *Journal of Nursing Administration* 2002; **32:** 283-291.

6. Gum L. Studying nursing in a rural setting: are students adequately supported and prepared for rural practice? A pilot study. *Rural and Remote Health* **7:** 628. (Online) 2007. Available: http://rrh.deakin.edu.au (Accessed 21 May 2007).

7. Lea J, Cruickshank M. Factors that influence the recruitment and retention of graduate nurses in rural health care facilities. *Collegian* 2005; **12:** 22-27.

8. Mosel Williams L. New graduates in rural practice: a place for the novice nurse? In: *Proceedings, Infront–Outback Australian Rural Remote Health Scientific 5th Biennial Conference*. 24-26 February; 2000; Toowoomba, QLD. 2001.

9. Winter-Collins A, McDaniel A. Sense of belonging and new graduate job satisfaction. *Journal for Nurses in Staff Development* 2000; **6:** 103-111.

10. Chang E, Daly J. *Transitions in nursing, preparing for professional practice*. Sydney, NSW: Maclean & Petty, 2001.

11. De Bellis A, Longson D, Glover P, Hutton A. The enculturation of our nursing graduates. *Contemporary Nurse* 2001; **11:** 84-94.

12. Goh K, Watt E. From 'dependant on' to 'depended on': the experience of transition from student to registered nurse in a private hospital graduate program. *Australian Journal of Advanced Nursing* 2003; **21:** 14-19.

13. Casey K, Fink R, Krugman M, Propst J. The graduate nurse experience. *Journal of Nursing Administration* 2004; **34:** 303-311.

14. Madjar I. *Project to Review and Examine Expectations of Beginning Registered Nurses in the Workforce 1997*. (Online) 1997. Nurses Registration Board of New South Wales. Available: www.nmb.nsw.gov.au/expectations-brns/default.aspx (Accessed December 2004).

15. Kramer M. *Reality shock: why nurses leave nursing*. St Louis: Mosby, 1974.

16. Pigott H. Facing reality: the transition from student to graduate nurse, *Australian Journal of Nursing* 2001; **8:** 24-26.

17. Chang E, Hancock K. Role stress and role ambiguity in new nursing graduates in Australia. *Nursing & Health Sciences* 2003; **5:** 155-163.

18. Parker V, Plank A, Hegney D. Adequacy of support for new graduates during their transition into the workplace: a Queensland, Australia study. *International Journal of Nursing Practice* 2003; **9:** 300-305.

19. Bridgewater R. The importance of the graduate nurse program in the small rural hospital. In: *Proceedings, The Graduate Year: Visions and Realities Conference*. Melbourne, Vic. 1998.

20. Reddick J. How understanding of the transition can improve preceptor support to new graduates. In: *Proceedings, The Graduate Year: Visions and Realities Conference*. Melbourne, Vic. 1998.

21. Annells M. Evaluating phenomenology: usefulness, quality and philosophical foundations. *Nurse Researcher* 1999; **36:** 5-9.

22. Handley A. Setting the scene: rural nursing in Australia. In: *Education, Training and Support for Australian Rural Nurses*. Monograph series, volume 1. Wyhalla, SA: Association for Australian Rural Nurses University of South Australia, 1998.

23. van Manen M. *Researching lived experience: human science for an action sensitive pedagogy*, 2nd edn. Ontario: Althouse Press, 1997.

24. Kilstoff K, Rochester S. Hitting the floor running: transitional experiences of graduates previously trained as enrolled nurses. *Australian Journal of Advanced Nursing* 2004; **22:**13-17.

25. Jackson D, Clare J, Mannix J. Who would want to be a nurse? Violence in the workplace - a factor in recruitment and retention. *Journal of Nursing Management* 2002; **10:** 13-20.

26. Taheri-Kennedy B. Cultural rurality: Implications for nursing in rural cultures. In: Proceedings, *Rural Nursing Celebrating Diversity. The Association for Australian Rural Nurses 5th National Conference*. Ballarat, Vic. 1997.

27. Farrell G. Aggression in clinical settings: nurses' views. *Journal of Advanced Nursing* 1997; **25:** 501-508.

28. Farrell G. Aggression in clinical settings: nurses' views - a follow-up study. *Journal of Advanced Nursing* 1999; **29:** 532-541.

29. Farrell G. From tall poppies to squashed weeds: why don't nurses pull together more? *Journal of Advanced Nursing* 2001; **35:** 26-33.

30. Freshwater D. Crosscurrents against cultural narration in nursing. *Journal of Advanced Nursing* 2000; **32:** 481-484.

31. Deans C. Who cares for nurses? The lived experience of workplace aggression. *Collegian* 2004; **11:** 32-36.

32. Hardy M, Conway M (Eds). *Role theory: perspectives for health professionals*. Norwalk: Appleton & Lange, 1978.

33. Levett-Jones T, Fitzgerald M. A review of graduate nurse transition programs in Australia. *Australian Journal of Advanced Nursing* 2006; **23:** 40-46.

34. Commonwealth Department of Education, Science and Training. *Rural nurses: knowledge and skills required by to meet the challenges of changing work environment in the 21st century*. Canberra, ACT: Commonwealth Department of Education, Science and Training, 2003.

