Study of Victorian Early Graduate Programs for Nurses and Midwives

Appendices

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1 Appendix A: Research Method

The following appendix outlines the research method and associated procedures used to conduct this project.

1.1 A Staged Approach

A multi-method design was used to ensure a rigorous collection of relevant secondary and primary data. These stages are identified in the following sections.

1.1.1 Stage 1: Identifying Research Parameters

The research process commenced with a consultation with the Department of Health Victoria NMP to discuss the research brief, confirm key questions and the proposed methodology. The key questions which guided the current project and approach to data collection are represented diagrammatically in Table 1-1.

1.1.2 Stage 2: Desk Research Stage

The data collection stage commenced with desk research. This was comprised of two key activities which were a literature review and an environmental scan.

The Literature Review

A concise literature review was undertaken to contribute to the evidence base underpinning the research. The review included examination of scholarly journal articles in peer reviewed journals, unpublished academic thesis, professional papers and government reports. The literature review aimed to provide insight and evidence of best practice in graduate nurse and midwifery transition programs and to explore the issues associated with early graduate transition programs for nurses and midwives.

An Environmental Scan

An environmental scan was undertaken to contribute to the evidence-base available for the current study. It was undertaken to contribute to the background section of
the report providing contextual information related to nursing and midwifery in Australia to inform the study and examination of graduate transition programs from other professions and approaches to graduate nurse and midwife transition in other jurisdictions. The examination of nurse and midwife transition programs within Australia was supported by consultations with representatives from each of the government departments involved in the funding of similar programs.

Table 1-1: Cognitive mapping of key questions

1.1.3 Stage 3: Key Informant Consultations and Site Visits

A significant component of this research involved consultation. This was undertaken to provide primary qualitative data to inform the study. The consultations were undertaken from April to August 2012.
A range of informants were consulted from organisations with an interest in graduate nurse and midwife transition programs including interests in areas such as: program delivery, design and assessment; application processes and selection; undergraduate nurse and midwifery education; alternative models and approaches; and outcomes for health services, graduates and community.

Semi-structured interviews were conducted using a discussion guide approved by the Department. A full list of organisations involved in the stakeholder consultations is provided in Appendix E. The following section contains a description of each of the consultation stage components.

**Consultations with public and private health service site based staff**

Fourteen site based consultations, comprised of multiple interviews were undertaken. These consultations were undertaken to inform the development of best practice case studies by providing a high level of organisational insight into the approaches to delivering EGP in Victoria, the nature and implementation of the EGP, approach to delivery, EGP structure and content, drivers of such approaches, barriers, enhancers and impacts. Other more general issues related to EGPs were also discussed.

A range of public and private health types were included to ensure representation of health services by size and location. Generally, site visits were conducted. The Department of Victoria sent an invitation and information sheet to each health service outlining the nature of the study and inviting participation from a range of stakeholders including CEO’s, HR and organisational development representatives, graduate nurse and midwife program coordinators, clinical educators, preceptors, and facilitators, nurse managers. While the range of stakeholders varied at each location. Consultations were conducted with the following public health services:

- Royal Women’s Hospital
- Alfred Health
- Ballarat Health
- Central Gippsland Sale Health Services
- Bass Coast Regional Health
- North East Health Wangaratta
- Eastern Health
- Northern Health
Colac Area Health
Goulburn Valley Health
St. Vincent's Health.

In order to explore the achievements of private health services representatives from three organisations participated. These were from:

- Epworth Healthcare
- Ramsay Health
- Melbourne Private Hospital.

While the primary focus of the consultations was on the perspectives of those involved in offering the program, a small number of graduates (4) heard about the research and asked to participate. These were included in the consultations.

Consultations were generally undertaken face-to-face during a site visit. However, as stakeholders were not always able to schedule time for a face-to-face consultation, in a small number of cases interviews were conducted over the telephone.

**Consultations with organisational representatives with an interest in graduate programs**

A number of organisations were invited to provide representatives to participate in a series of consultations. These consultations were undertaken to provide insight into EGPs from the perspective of other stakeholders who have an interest in EGPs. Stakeholders were invited to participate by the Department and provided with an information sheet about the project. This group of consultations were undertaken in June and July 2012. Consultations were undertaken with representatives from the following groups:

- Australian Nurses Federation Victoria Branch
- Postgraduate Medical Council of Victoria
- Latrobe Alfred Clinical School
- The Victorian EGP Coordinators Network
- Deakin University-Northern Health Clinical Partnership.
Topics discussed varied according to the focus of the organisation involved. However many provided insights related to:

- The nature of the current working environment which graduate nurses transition into following study
- The issues which pervade the nursing literature on approaches to nurse graduate transition and views on areas of focus (i.e. Should there be a focus on formal educational transition programs or development of educationally supportive learning cultures in clinical contexts?)
- Potential enhancers and barriers to the effective implementation and evaluation of the EGP
- Views on best practice in the EGP
- Other approaches of transitional engagement that could provide learnings for the model
- The possible impacts of EGP on graduates, health services and the community.

**Consultations with representatives from other jurisdictions**

A series of brief consultations were undertaken with representatives from other Australian jurisdictions. These were undertaken in July and August 2012. The key purpose of these consultations was to enhance understanding of approaches to provision of transition programs for nurses and midwives in other Australian jurisdictions. Online desk research provided considerable information about transition programs including program descriptions, application processes, aims and expected outcomes. The consultations were undertaken to obtain further information related to the program purpose from a government perspective, participant numbers and approaches to funding. Consultations were undertaken with official departmental representatives from, New South Wales, Western Australia, Tasmania and Queensland.

**1.1.4 Stage 4: Online Provider Survey**

An online survey of health services with publicly funded EGPs was undertaken in July 2012. The survey was undertaken to provide quantification of a number of issues related to EGP from a provider’s perspective. Targeted at EGP coordinators the questionnaire sought to obtain data related to:

- Aims and objectives of the EGP
- The description of the EGP including the structure and content
Number of graduates and staff engaged in the program
Outcomes for the health service and graduates
Drivers of the approach, barriers and enhancers
Approaches to evaluation.

The EGP for nurses/midwives online survey was sent to n=70 public health services across the state. The Department disseminated discrete links to the survey to each of the potential respondents. The survey was hosted online by TNS on a secure website. A total of n=41 respondents completed the survey, giving a response rate of 59%. All respondents were screened to ensure they were actively involved in the delivery or administration of the EGP for nurses/midwives at the health service where they are employed.

Due to the small sample size of the population involved in this program high level statistical analysis was not appropriate. The survey was always intended as a descriptive strategy to provide quantification of issues which could not be readily collected through interviews alone. As such analysis has been confined to descriptive techniques. The small sample size does not allow for testing of significance. As such where notable differences between sub populations have been identified they are reported.
2 Appendix B: Literature Review

2.1 Introduction

In Australia, few professions have embraced graduate transition programs to the same degree as nursing and midwifery. Over the past two decades, a significant body of literature has emerged related to both the content and structure of these transition programs.

The following chapter contains a concise review of the relevant nursing and midwifery literature related to EGPs including academic journals, government reports and other professional papers. It aims to explore the issues associated with EGPs for nurses and midwives and highlight evidence of best practice.

2.2 Challenges Facing New Graduates

The issue of transitioning from student to professional presents challenges in many disciplines\(^1\). The specific challenges facing recent nursing and midwifery graduates entering the workforce have been prominent in the Australian and international nursing and midwifery literature over the past decade. These challenges can be summarized into three broad categories, professional, organisational and personal (Table 2-1).

Table 2-1: Key categories of challenges faced by graduate nurses and midwives

<table>
<thead>
<tr>
<th>Challenges faced by graduate nurses and midwives</th>
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<tbody>
<tr>
<td><strong>Professional</strong></td>
</tr>
<tr>
<td>General: Issues common to all graduates transitioning to professional practice, such as time management, accountability and communication</td>
</tr>
<tr>
<td>Clinical: Factors specific to clinical practice, such as level of skill and knowledge</td>
</tr>
<tr>
<td><strong>Organisational</strong></td>
</tr>
<tr>
<td>Structure: Challenges associated with working within an organisation, including rostering, understanding the hierarchy and protocols</td>
</tr>
<tr>
<td>Expectations: Matters related to the assumed capabilities of the graduate, including workload and skill levels</td>
</tr>
<tr>
<td><strong>Personal</strong></td>
</tr>
<tr>
<td>Factors of an individual nature that interact and impact on work life. These may include balancing family and work, &quot;fitting in&quot; with the workplace culture and confidence in ability</td>
</tr>
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</table>

Professional literature regarding the challenges faced by graduate nurses and midwives has addressed numerous facets of each of these broad categories. These have included:

**Professional (General):**

- Shifting from an academic to a practical focus\(^2,3\)
- Personal issues, including developing confidence and managing increased stress\(^4,5\)
- Shifting to a higher level of accountability, decision-making and responsibility\(^6,7\)
- Developing a professional identity, attitude and skills\(^8,9\).

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Professional (Clinical):

- Lack of discretionary judgment and stress associated with making clinical decisions
- The application of skills and/or knowledge without adequate support or practice
- An understanding of how and when to apply academic knowledge
- Translating theoretical learning into patient care
- Overcoming practical gaps in knowledge and skills
- Knowing when and how to apply theoretical learning to practical problems
- A lack of opportunity to practice skills and be supported while applying theoretical knowledge of skills into clinical practice
- The disconnection between the values and ideas fostered in the academic context and those experienced in health care facilities


Concerns about patient care\textsuperscript{19}.

\textbf{Organisational (Structure):}

- Learning how to work within a health care facility\textsuperscript{20}
- Working as part of a multidisciplinary team, including effectively communicating with medical practitioners, understanding the role of the nurse/midwife within the team and having the confidence to contribute to decisions\textsuperscript{21}
- Managing shift work, coping with rosters and negotiating appropriate shifts, including reducing exposure to 'unappealing' shifts, such as weekends and evenings, when less support is available\textsuperscript{22}
- Working within a large bureaucratic organisation with multiple and often complex work structures\textsuperscript{23,24}.

\textbf{Organisational (Expectations):}

- A lack of clarity regarding the graduates’ role as beginner professionals\textsuperscript{25}
- The health facility making high demands on graduates inconsistent with a beginner level of practice\textsuperscript{26}


Adjusting to different levels of expectations from co-workers

A lack of cohesion between universities and employers regarding the skills and attributes required of beginning nurses\textsuperscript{27,28}

Work load and working within a context impacted by workforce shortages\textsuperscript{29,30}.

**Personal:**

Socialisation and the development of a sense of belonging to both the organisation and profession\textsuperscript{31,32}

Not feeling accepted, not fitting in and a lack of confidence\textsuperscript{33}

Difficulties with adjustment to the realities of the work environment and the responsibilities of a professional nurse, often referred to in the literature as 'reality shock' or 'transition shock'\textsuperscript{34}

Balancing competing family and professional demands; a factor of increasing prominence as graduates are trending towards entering the nursing/midwifery profession at an older age than previously evident\textsuperscript{35,36}.


\textsuperscript{34} Duchscher, J. (2008) IBID.
The issues facing new graduate nurses and midwives are well documented in the Australian and international literature. This includes considerable commentary and evidence of the impact of these challenges. Notably, high rates of attrition in the first few years following graduation have been documented. International literature estimates this figure to range between 35% and 60% by the end of the first year of practice. In Australia attrition rates have been reported as high as 20%.

35 The average age of a nurse in Australia is 42.2 years and in Victoria it is slightly lower at 41.9 years. (Nursing and midwifery labour force, AIHW 2005). Figures on the average age of new graduates are less reliable, but it is reported as being around 30 years.


Exact rates of attrition have been difficult to quantify due to the lack of systematically collected data at both national and jurisdictional levels\textsuperscript{45}. Despite this, there remains a strong link in the literature, with a large number of small scale studies exploring the link between new graduate attrition and the challenges posed for new professionals in Australia\textsuperscript{46} and internationally\textsuperscript{47}, including concerns regarding patient care and safety\textsuperscript{48,49}.

\section*{2.3 The Australian Context}

Graduate transition programs have become increasingly common in Australian health services. The literature attributes this to the high level of attrition in the early years of nursing/midwifery practice and ongoing nursing and midwifery workforce shortages\textsuperscript{50}. The Australian graduate year requires the new nurse/midwife to make the transition from a student in an academic setting to a nurse employed within the health workforce. While graduate nurses/midwives are fully registered to practice as professionals, to facilitate the transition, many Australian public and private hospitals offer formalised twelve-month graduate nurse programs. These provide graduates with a number of professional development opportunities including rotations through a number of clinical areas,

\begin{thebibliography}{99}
\bibitem{45} Gaynor et al (2006) IBID.
\bibitem{47} Park. M, and Jones, C. (2010) IBID.
\end{thebibliography}
preceptor support and study days\textsuperscript{51}. Reports in the Australian literature suggest however, that graduate programs can vary widely, with inconsistencies between jurisdictions and limited evaluation of program effectiveness\textsuperscript{52}.

Despite this, Australian research indicates that new graduates recognise the value of transition programs\textsuperscript{53} and the role they play in reducing attrition during the early years of nursing practice\textsuperscript{54}. They are seen as critical in shaping the professional identity of nurses and midwives in the initial stages of their careers and fostering the values that shape their nursing practice philosophy\textsuperscript{55}. Specific details and further discussion on the approaches to graduate transition programs within Australian jurisdictions are contained in the following chapters of this report.

\section*{2.4 Positive Impacts of Transition Programs}

Various positive impacts of nursing transition programs have been reported in the literature. These studies have tended to be limited in design, with most descriptive in nature and based on the experiences of individual health services. The findings suggest that multiple interacting factors work to facilitate the transition of new nursing and midwifery graduates into professional practice. Factors commonly cited have included increased confidence and competency, improved patient care, increased job satisfaction and a reduction in attrition rates (Figure 2-1).


Figure 2-1: Factors impacting on the transition of new nursing and midwifery graduates into professional practice

The following key impacts of EGPs for nursing/midwifery have been described in the Australian and international literature:

- Improved retention rates within the profession and at an organisational level\textsuperscript{56,57}
- Heightened competency of graduates including practical skills, knowledge and the ability to perform to prescribed standards\textsuperscript{58}
- Improved graduate self-confidence in terms of capacity to deliver patient care\textsuperscript{59}
- Increased job satisfaction of new graduate nurses\textsuperscript{60}

\textsuperscript{56} Park. M, and Jones, C. (2010) IBID.


\textsuperscript{58} Park. M, and Jones, C. (2010) IBID.


\textsuperscript{60} Park. M, and Jones, C. (2010) IBID.
Improvements in patient care\textsuperscript{61} and reduced patient mortality\textsuperscript{62}.

2.5 Program Characteristics

Empirical research exploring the factors that underpin a successful EGP for nursing/midwifery has been limited. This can be partially attributed to a lack of agreement regarding appropriate aims and objectives of EGPs and how they should be evaluated. Furthermore, studies have tended to focus on small scale, individual health service programs\textsuperscript{63}.

Lack of systematic EGP evaluation has also limited data availability. Many of the studies purporting to examine program strengths and outcomes are largely focused on the results of graduate satisfaction surveys. Such data provides little insight into the capacity of the program to produce outcomes for the organisation and the broader health system. However, within the context of these limitations, a number of studies have explored issues related to specific program attributes including, goals, length of the program, organisational commitment, structured formal arrangements for rotations, preceptorships, study days, supernumerary time and access to clinical and professional support.


2.5.1 Program Goals and Aims

Levett-Jones and Fitzgerald (2005) note that EGPs for nursing/midwifery in Australia have three common goals:

- Development of competent and confident nurses/midwives
- Facilitation of professional adjustment, belonging and socialization
- Development of a commitment to a career in nursing/midwifery

In contrast, other Australian research has placed a stronger focus on the EGP’s capacity to facilitate recruitment and retention. Internationally, the goals and aims of graduate nurse/midwife EGPs are equally varied, but broadly reflect similar themes.

While these goals and aims may be highly functional, there is a lack of systematic, robust evidence available to determine the effectiveness of EGPs in achieving these goals. There is however, a strong reported link between EGPs and positive workforce impacts, including retention.

2.5.2 Program Length

Most Australian EGPs for nurses/midwives are typically 12 months in duration. In a review of international research, Park and Jones (2010) concluded there was a wide variation in program length, ranging from six weeks to 12 months, with most lasting between four and 12 months. They argued that while more research is needed.

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68 Park and Jones (2010).

69 McKenna, L & Newton, J. (2008). IBID.
needed to determine the impact of program length on outcomes, positive results were noted for those of 12 months duration\textsuperscript{70}.

Programs of 12 months duration have been identified as best practice in the US and as such, those supported by the American Association of Colleges of Nursing are 12 months long. Evaluation of the University Health System Consortium and the American Association of Colleges of Nursing program, which is delivered across a large number of health services nationally, showed positive outcomes associated with the 12 month duration. This included improvement in the graduates' communication and organisation skills, higher perceived levels of support, reduced stress and increased rates of retention\textsuperscript{71}.

There has also been support for a program duration of 12 months in the Australian literature. McKenna and Green (2004)\textsuperscript{72} found that graduates largely focused on themselves in the first six months, but by 12 months were able to focus on the bigger picture of patient care. Similarly, Casey et al. (2004) found that while nurses took up to six months to develop time management and organisational skills, a 12 month period was necessary for them to feel sufficiently confident to effectively communicate with doctors, develop clinical judgment and to feel competent working in an acute care setting\textsuperscript{73}.

Several international studies have found EGPs for nursing/midwifery that were 12 months in duration were more expensive to run, given the costs associated with training and support for graduates. However, these costs were mitigated and in fact, saved the health service money when consideration was given to the improved


stability of the graduate cohort, decreased attrition and the associated reduced need to recruit and train new staff\textsuperscript{74,75,76}.

Length of program duration has been the focus of a number of studies examining the changes in graduate needs and their development in the first 12 months of practice. A considerable body of international literature suggests that in the first 12 months of practice, new graduates undergo a series of changes as they develop their professional skills and identity\textsuperscript{77,78}. During this time they require varying levels of support from mentors, preceptors and others as they develop skills and knowledge and subsequently, the confidence to apply these in a clinical setting.

Typical stages of development and the challenges facing new graduates during their first 12 months of practice have been identified and reported in the literature. During the first three months, graduates are adjusting to the bureaucratic and clinical environment of their workplace. They are adapting to the demands of their particular workforce, modifying their lifestyle to the frequent changes in routine and environment and dealing with the loss of their academic lifestyle. During this time they are frequently acting upon the instructions of others and have limited autonomy. They are focused on the new environment, which has a strong focus on the practical application of learning rather than theory\textsuperscript{79,80}.


\textsuperscript{78} Benner P (1984) From Novice to Expert: Excellence and power in clinical nursing practice Addison-Wesley : Menlo Park CA.

Duchscher and Corwin (2006) note that in the first three months, graduates are confronted with values and practices which may conflict with the approaches taught in their undergraduate studies in addition to the need to adjust to a new role and its associated responsibilities. At four to five months graduates typically experience an increase in thinking ability, skills and knowledge. At five to seven months they often experience another developmental shift, as they move to greater consolidation of knowledge and experience and start to focus on enhancing the meaningfulness of work. Concurrently at this point, it is common to experience concerns about their own professional identity and the health system. At around eight months, graduates often experience a shift in thinking and a new awakening. They are reinvigorated, seeking challenges and exploring career goals. By 12 months most are feeling comfortable in the workplace and confident professionally (Figure 2-2).

Figure 2-2: Graduate nurse/midwife progress over 12 months

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Improvement</th>
<th>Consolidation</th>
<th>Progression</th>
<th>Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 months</td>
<td>4-5 months</td>
<td>5-7 months</td>
<td>8 months</td>
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<td>Adjustment to</td>
<td>Increased</td>
<td>Consolidation of</td>
<td>Shift in thinking</td>
<td>Confident</td>
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<td>environment</td>
<td>thinking ability</td>
<td>knowledge and</td>
<td>and a new</td>
<td>professionally</td>
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<tr>
<td>Adapting to new</td>
<td>Improved skills</td>
<td>experience</td>
<td>awakening</td>
<td>Comfortable in</td>
</tr>
<tr>
<td>approaches</td>
<td>Enhanced</td>
<td>Focus on</td>
<td>Reinvigorated</td>
<td>the workplace</td>
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<td>knowledge base</td>
<td>enhancing the</td>
<td>Seeking challenges</td>
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<td>Exploring career</td>
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<td>identity and health</td>
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<td></td>
<td>system</td>
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</tbody>
</table>

(Duchscher and Corwin, 2006)


81 Duchscher, J. and Cowin, L., 2006. IBID.

82 Duchscher, J. and Cowin, L., 2006. IBID.
2.6 Organisational Commitment

The need for organisational commitment to the nursing/midwifery EGP is emphasized in both Australian and international literature. This commitment includes organisational resourcing of program coordinator/s, supernumerary time and study days. Training is also necessary, including orientation to the organisation, structured individual practice settings for graduates and guidance for preceptors and clinical educators. Administrative support must also be provided, including management of rosters and workloads. The importance of a supportive organisational culture is therefore a consistent theme throughout the literature.

While some have contended that a supportive organisational culture could be as effective as a structured graduate nurse/midwife EGP, most literature recognises the need for a specific program to support the transition into nursing/midwifery practice within the context of a supportive organisational culture. This ‘supportive culture’ refers not only to the resources provided to implement the graduate EGP but more broadly, the value the organisation places on learning.

The literature strongly supports the need to develop a positive organisational culture. This is to ensure that those only indirectly involved in the implementation of the program, including Nurse Unit Managers, Directors of Nursing and others, support the learning and development of new graduates and those involved in the provision of the program, such as clinical educators. This includes actively facilitating formal education and training as well as opportunities for experiential learning.

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Nursing/midwifery culture has received a significant amount of negative attention in the Australian and international literature in relation to bullying of early graduates. Bullying behaviour towards early nurse/midwifery graduates reported in the literature includes isolation, intergenerational intolerance, ridicule, discriminatory behaviour, exclusion from formal and informal workplace activities, deliberate assignment of menial tasks, a lack of opportunity, issues with rostering of shifts, lack of positive interaction, poor communication and judgment of the individual. Such behaviour is associated with the organisational culture and is consistently recognised as undermining opportunities for the graduate to work and learn.

2.7 Best Practice Clinical Learning Environments

The Department of Health, Victoria has developed a comprehensive strategy to enhance the capacity and quality of clinical education across Victoria. The emphasis of this strategy is on health students generally, but is also applicable specifically to new graduate nurses and midwives. It resulted in the development of the Best Practice Clinical Learning Environments (BPCLE) project. The project examined the nature of successful clinical placements and developed a model of best practice. It identified key elements of best practice clinical learning environments which underpin a high quality educational environment, irrespective of discipline or setting. These are:

- An organisational culture that values learning
- Best clinical practice
- A positive learning environment
- A supportive health service-training provider relationship
- Effective communication processes

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Appropriate resources and facilities.

Importantly, the report emphasised the need for an organisational context that was committed to teaching and learning. It noted the importance of ensuring that all employees, regardless of their involvement in educational activities, considered education to be beneficial to themselves as well as the learners.

### 2.8 The Nature of Support

Nursing and midwifery EGPs frequently identify the provision of support to new graduates as a key element of the program. The nature of that support often lacks definition. It is widely recognised that support is critical to the graduate nurse/midwife transition from novice to advanced beginner-level practitioner and to the integration of new practitioners into safe and effective organisational processes. The nature of the support, why it is important, who should provide it and the duration it should be available however, have not been systematically investigated.

Johnstone and colleagues (2008) note that support is critical to the process of graduate nurse/midwife transition. They suggest that integration is best provided during the first four weeks of the program and then at the beginning of each ward rotation. Informal teachers and other graduate nurse/midwife colleagues were noted to be amongst the best sources of support. Finally, the importance of organisational culture was raised and untoward attitudes of staff to new graduates noted to be one of the key barriers to successful placement.

Importantly, support must be appropriate to the stage of the nurses’ transition. In a qualitative Australian study, Fox et al. (2005) explored which supportive elements best met the needs of staff as they integrated into an organisation. Results indicated that graduate support needs changed over the course of the 12 month EGP. At two to three months, graduates were particularly concerned with negative interactions with other staff members, inadequate learning assistance and lack of support. At six to nine months graduate needs changed. They discussed being 'self-reliant' and 'getting to know the system' and indicated that support to develop

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organisational 'know how' and resourcefulness would be beneficial, rather than relying on preceptor support that could not always be guaranteed\textsuperscript{92}. Overall, it is noted that support should focus on work competency but, it must also recognise the importance of new graduates developing a sense of belonging and building positive relationships\textsuperscript{93}.

### 2.9 The Role of Preceptors

Preceptors, sometimes referred to as mentors\textsuperscript{94}, are a key element of most graduate nurse/midwife EGPs. Mentorships and preceptorships have been described as the most common form of clinical supervision and support. However, issues associated with contemporary practice such as staffing shortages, increased casualisation of the workforce, the tendency to roster graduates on night and weekend shifts and the increased part time nature of the workforce mitigate against these supportive relationships being sustained\textsuperscript{95,96}.

The concept of preceptorships is entrenched in the nursing/midwifery literature and is commonly regarded as a central feature of graduate EGPs internationally\textsuperscript{97,98}.


\textsuperscript{96} Evans, J. (2008) et al.

\textsuperscript{97} Bain, L (1996) IBID.
According to the Miller-Keane medical dictionary, preceptorships are defined as:

‘A short-term relationship between a student as novice and an experienced staff person (such as a professional nurse) as the preceptor who provides individual attention to the student’s learning needs and feedback regarding performance; students experience relative independence in making decisions, setting priorities, management of time, and patient care activities’\(^99\).

It has been frequently documented that preceptors who encourage engagement with graduates in the workplace, can promote increased job satisfaction in graduates\(^100\).

However, a number of studies caution against reliance on preceptors, indicating that their support is not always available and cannot substitute for self-reliance and resourcefulness\(^101\). These studies note that positive interactions and relationships with a range of staff may also be reduced if preceptors are considered to be primarily responsible for assisting graduates\(^102\).

Despite these potential issues, preceptors are generally considered to provide support, create opportunities for practical learning and guide the learner's review and reflection of progress. Preceptor support is considered to be most valuable when they have volunteered for the role, are able to work alongside the new graduate, are not over burdened by too many graduates and when the


\(^101\) Fox. R. (2005) et al IBID.

Preceptorship continues throughout the entire EGP, not just at the beginning or end of a placement\textsuperscript{103}.

Preceptors also play an important role in reinforcing the values of the organisation by ensuring graduates are able to meet expectations and can function independently. Preceptors should have their own experience to draw upon rather than be beginning practitioners themselves\textsuperscript{104}.

Alspach (2008)\textsuperscript{105} commented that while preceptorships are now common in most health services, the quality of preceptorships offered is often negatively impacted by a lack of resources. Preceptors need to not only have access to organisational support and resources, but also appropriate training and education\textsuperscript{106}. This includes:

- Information required to understand and effectively manage a variety of teaching and learning situations
- Educational strategies for commonly encountered situations
- Diagnosing and troubleshooting learner performance problems
- Suggestions on how to modify strategies for different types of learners
- Alternative approaches to try (when the usual approach is not working)
- Guidelines for managing problematic instructional scenarios
- Solutions for resolving issues not directly related to teaching or learning
- Working more effectively with learners from different cultures.


\textsuperscript{104} Alspach JG. (2000) IBID.


\textsuperscript{106} Alspach JG. (2008) IBID.
2.10 Return on Investment

Research examining the impact of investment into graduate programs is limited. Similarly, there are few business cases determining the value of EGPs. Much of the literature has focused on graduate outcomes and has associated the programs with improved rates of retention. However, few studies have systematically reviewed the return on investment from the perspective of the health service, funding bodies and the community.

Several international investigations have found that while early graduate nurse/midwife EGPs require considerable resources and commitment from the health service and funding bodies, these costs are mitigated by the improved stability of the graduate cohort, lowered attrition and the reduced need to pay for advertising, recruitment and training of new staff\textsuperscript{107,108,109}. In contrast, others have argued that the cost of replacing graduates is higher than the cost of experienced staff because of the need to provide training and support in addition to the usual costs of recruitment and orientation\textsuperscript{110}. Overall however, the literature favours the notion that investment in graduate programs is essential to the retention of new graduates, and that there is a subsequent cost benefit. It is suggested that greater research and awareness of this association could be used to advocate for transition-to-work program funding and the placement of new graduate nurses/midwives in well-staffed units\textsuperscript{111}.


\textsuperscript{111} Scott et al IBID.
An important area for cost savings in healthcare is rates of attrition and the associated costs of replacing staff. The literature reports that the high attrition rates of nursing staff have a considerable impact on health service budgets. It includes direct and indirect costs such as compromised patient care, reduced staff morale and problems with sustainability of the nursing workforce. Ulrich and colleagues (2010) note that investment in graduate programs can improve the retention of graduates and other full time staff who receive the benefits of a better resourced workforce\textsuperscript{112}.

Of the data available, research indicates that EGPs are economically beneficial to health services. Beecroft and colleagues (2001) reported a return on investment of 67\% for a 12 month, acute care, paediatric nurse EGP for 21 participants conducted at a health service in the US. This equated to an annual cost savings of $US 543,131\textsuperscript{113}. Similarly, Pine and Tart (2007) estimated the cost savings resulting from their national EGP for 48 participants to be in the order of $US 823,680 after one year\textsuperscript{114}. Likewise, Halfer (2007) reported that a paediatric graduate nurse program with 17 participants had associated cost savings of $US707,608.

\subsection*{2.11 Limitations of Transitional Programs}

The literature identifies a number of concerns with graduate programs. These can generally be categorised as relating to program content, distinguishing graduates from other nursing/midwifery staff and the relationship between the academic organisation and the health service workplace. Details of each are outlined in the following sections:


Content of the Program

- Transitional programs focus on deficits and address gaps in clinical skills not mastered at university rather than focusing on professional practice\(^{115}\).
- There is a lack of program consistency across jurisdictions in Australia in terms of both content and quality. Variations have been reported in the length, number and type clinical rotations, nature of preceptorships, supernumerary time and formal orientation programs\(^{116}\).
- Graduate programs do not reflect the way nursing competence is acquired, that is, through an ongoing process of integrating theory with practice and reflection\(^{117}\).
- Graduate programs have been criticised for being unnecessarily long, expensive and repetitive\(^{118}\).

Programs distinguish graduates from other nursing/midwifery staff

- Clinical rotations included as part of many programs involve graduates moving to a new environment just when they are beginning to develop skills, confidence and relationships. This can undermine the confidence of the new graduate nurse/midwife and reinforce the notion that they are unable to cope with the work on the wards\(^{119}\). Frequent rotations are also thought to interrupt the process of professional socialisation, which is considered critical in the initial months of professional practice\(^{120,121}\).


\(^{117}\) Butler, K. and Hardin-Pierce, M. (2005) IBID.


Graduates are not seen as permanent staff members and struggle to develop a sense of belonging and informal, supportive relationships\(^{122}\).

Programs can fail to provide new graduates with a challenging work environment and this reinforces their sense of being in a limbo between student and professional nurse\(^{123}\).

**The relationship between academic organisations and the health service workplaces**

- The partnership between academic institutions and nursing/midwifery workplaces is ineffective. There is little accountability taken for the work-readiness demanded of graduates to support them through the transition to professional practice\(^{124}\).
- There is a lack of agreement between the academic organisations and health services regarding the role of a beginning level practitioner\(^{125}\) versus the requirements of new graduates\(^{126}\).
- There are several pathways to becoming a registered nurse or midwife, which vary in terms of theoretical and practical content. As a result, the extent of support required in the first year of practice is variable.

### 2.12 Discussion

The challenges faced by new nurse and midwife graduates are numerous and multifaceted. They can be broadly classified into three key categories; professional, organisational and personal. Although there is a lack of systematically collected data, there are repeated documented links in the literature between the nature and extent of new graduate challenges and rates of development stress and attrition.

\(^{122}\) Evans, J. et al. (2008).

\(^{123}\) McKenna, L & Newton, J. (2008) IBID.


\(^{125}\) Butler, K. and Hardin-Pierce, M. (2005) IBID.

Systematic EGP evaluation has been limited due to a lack of agreement regarding program objectives and how they should be evaluated. Many studies rely on graduate satisfaction survey data, which fails to address the impact of the program on the organisation and the broader health system. Available literature suggests that multiple related factors work to facilitate the transition of new nursing and midwifery graduates into professional practice. Key amongst these factors are increased confidence and competency, improved patient care, improved job satisfaction and a reduction in attrition rates.

Research supports a graduate EGP duration of 12 months. This allows nursing/midwifery graduates sufficient time to move through the necessary stages of development, including adjustment, improvement, consolidation, progression and finally program graduation.

Organisational commitment is essential for resourcing graduate program activities and facilitating the development of a positive culture necessary when supporting new graduate learning. The Best Practice Clinical Learning Environments (BPCLE) project determined how to enhance the capacity and quality of clinical education across Victoria. It determined that several key elements were important for successful clinical placements, including having an organisational culture that values learning, adheres to best practice standards and provides a positive learning environment. Effective communication processes, appropriate resources and facilities and a supportive health service-training provider relationship were also noted as important to ensuring successful clinical placements.

Support for new graduate nurses/midwives has frequently been identified as a key element of EGPs. Research suggests that this support is best provided by informal teachers and graduate colleagues during the first four weeks of the program and then at the beginning of each ward rotation. Importantly, support must be appropriate to the stage of the nurses’/midwives’ transition, with a focus in the first six months on communication and learning and then shifting in the last six months to enhancing independence.

Preceptors are central to graduate nurse/midwife development. They provide support, opportunities for practical learning and guidance to promote learning and confidence. There is some literature to suggest that graduates should depend less on preceptors as this will encourage self-reliance, resourcefulness and positive
interactions with all staff. However, if properly resourced and trained, preceptors are generally viewed as an integral part of graduate nurse/midwife development.

Early graduate nurse/midwife EGPs require considerable resources and commitment from the health service and funding bodies. These costs are however, mitigated by the improved stability of the graduate cohort, lowered attrition and reduced expenses associated with recruitment.

A number of concerns have been raised in relation to graduate nursing/midwifery programs. The most commonly reported issues relate to program content, the artificial distinction between graduates and other nursing/midwifery staff and the ineffective relationship between the academic organisation and the health service workplace.
3 Appendix C: Online Providers' Survey Report

3.1 Introduction

The following appendix contains the findings from the Victorian EGP Providers' survey which was undertaken by TNS to inform the study. These findings have been drawn upon and included throughout the main report.

3.2 Demographic Information: Respondents

The Early Graduate Program (EGP) for nurses/midwives online survey was sent to n=70 public health services across the state. A total of n=41 respondents completed the survey, giving a response rate of 59%. All respondents were screened to ensure they were actively involved in the delivery or administration of the EGP for nurses/midwives at the health service where they are employed.

Almost half (49%) of the respondents were the primary person responsible for co-ordinating the programs, with a further 22% playing a clinical educator role. Management staff (Executive Director of Nursing/Midwifery or other Executive management) accounted for a further 29% (Figure 3-1).

*Figure 3-1: Respondent positions held (%)*

![Respondent positions held graph]

The majority (95%) of respondents were female (Figure 3-2) with approximately 75% having 20 – 39 years of professional healthcare experience (Figure 3-3) and almost half (48.5%) having six to 20 years of involvement specifically in EGPs for nursing/midwifery (Figure 3-4).
**Figure 3-2: Respondent gender (%)**

![Pie chart showing gender distribution]

- Male: 5%
- Female: 95%

**Figure 3-3: Respondent years of healthcare experience (%)**

<table>
<thead>
<tr>
<th>Experience</th>
<th>% Respondents</th>
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<tr>
<td>&lt;10 yrs</td>
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</tr>
<tr>
<td>10-19 yrs</td>
<td>15</td>
</tr>
<tr>
<td>20-29 yrs</td>
<td>32</td>
</tr>
<tr>
<td>30-39 yrs</td>
<td>44</td>
</tr>
<tr>
<td>40+ yrs</td>
<td>7</td>
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</tbody>
</table>

**Figure 3-4: Respondent years of involvement in EGPs for nursing/midwifery (%)**

<table>
<thead>
<tr>
<th>Experience</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6mths</td>
<td>10</td>
</tr>
<tr>
<td>6-12 mths</td>
<td>7</td>
</tr>
<tr>
<td>1-3 yrs</td>
<td>19.5</td>
</tr>
<tr>
<td>4-5 yrs</td>
<td>15</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>24</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>19.5</td>
</tr>
<tr>
<td>16-20 yrs</td>
<td>5</td>
</tr>
</tbody>
</table>
3.2.1 Demographic Information: Respondent Workplace

Approximately one third (32%) of respondents worked in metro based health services, with the remaining two thirds (68%) located regionally or rurally, consistent with the typical demographics of health services in Victoria (Figure 3-5).

Figure 3-5: Health service location

Victorian health service demographics were also accurately reflected in the size of the facilities and the number of campuses. Half of respondents worked in single campus health care facilities (Figure 3-6) and were typically characterised as “Group 4” health services (Figure 3-7).

Figure 3-6: Number of campuses
Figure 3-7: Health service categorisation

Details of health service categorisation are as follows:

**Group 1**
- Alfred Health
- Austin Health
- Eastern Health
- Epworth Healthcare
- Melbourne Health
- Ramsay Health
- Southern Health
- St Vincent's Health.

**Group 2**
- Ballarat Health Services
- Barwon Health
- Bendigo Health Care Group
- Cabrini Hospital
- Latrobe Regional Hospital
- Mercy Hospital For Women
- Northern Health
- Peninsula Health
- Peter McCallum Cancer Centre
- Royal Children’s Hospital
- Royal Women’s Hospital
- St Vincent’s Private
Werribee Mercy Hospital.

**Group 3**

- Albury Wodonga Health
- Bairnsdale Regional Health Service
- Calvary Healthcare Bethlehem
- Central Gippsland Health Service
- Echuca Regional Health
- Goulburn Valley Health
- John Fawkner Private Hospital
- Melbourne Private Hospital
- Mildura Base Hospital
- Northeast Health Wangaratta
- Royal District Nursing Service
- Royal Vic Eye & Ear Hospital
- South West Healthcare
- St John Of God Healthcare
- West Gippsland Healthcare Group
- Western District Health Service.

**Group 4**

- Alpine Health (Myrtleford)
- Bass Coast Regional Health
- Beaufort & Skipton Health Service
- Benalla & District Memorial Hospital
- Boort District Health
- Castlemaine Health
- Cobram District Hospital
- Cohuna District Health
- Colac Area Health
- East Grampians Health Service
- East Wimmera Health Service
- Edenhope & District Memorial Hospital
Gippsland Southern Health Service
Heathcote Health
Hepburn Health Service
Kerang District Health
Kilmore & District Hospital
Kyabram & District Health Services
Lorne Community Hospital
Mansfield District Hospital
Maryborough District Health Service
Moyne Health Services
Nathalia District Hospital
Orbost Regional Health
Portland & District Health
Rochester & Elmore District Health
Rural Northwest Health
Seymour District Memorial Hospital
Stawell Regional Health
Swan Hill District Hospital
Terand & Mortlake Health Service
Timboon & District Healthcare Service
West Wimmera Health Service
Yarram & District Health Service
Yarrawonga District Health Service.

3.3 Characteristics of Nursing/Midwifery EGPs

EGPs for nursing/midwives were co-ordinated by one individual in the majority of cases (77%) (Figure 3-8). The duration of the program being reviewed by respondents in the survey was typically longstanding, with more than two thirds (68%) ranging from six to 15 years (Figure 3-9).
There was some variability in the number of years that respondents had been involved in the EGP for nursing/midwifery at the health service where they were currently employed, although approximately half (48%) had been involved for four to 10 years (Figure 3-10).
3.4 Key Aims and Goals of EGPs

Overall, respondents indicated five key areas of focus for EGPs for nurses/midwives:

- Translating theory to practice (15%)
- Facilitating the transition to professional practice (14%)
- Consolidating skills/knowledge (13%)
- Developing professional skills (12%)
- Providing clinical support (11%).

These and other areas of reported focus are illustrated in Figure 3-11.

Figure 3-11: Key aims/goals of EGPs overall

Further examination of the data indicated a variation in focus between health services located in regional/rural compared to metro areas. Figure 3-12 illustrates that while regional/rural areas have a focus on translating theory to practice (19%) and clinical support (13%) metro areas are focused on the consolidation of skills/knowledge (17%) and facilitating the transition to professional practice (17%). There were however, multiple areas of commonality, including communication skills (2%), reducing risk (4%) and recruitment/retention (9%).
Figure 3-12: Key aims/goals of EGPs by health service location

In addition, Figure 3-12 shows that metro services also have a greater focus on developing professional skills (15% metro compared to 10% regional/rural) and individualising the graduates’ program (11% metro compared to 2% regional/rural). Figure 3-13 further explores how EGPs cater for the individual needs of graduates. Data indicates three key areas of focus:

- Tailored clinical support (97%)
- Reviewing progress throughout the program (94%)
- A program reflecting the interests of graduates (94%).

Figure 3-13: How the EGP caters to individual graduate needs
Segmenting the data into metro and regional/rural categories highlighted that metro health services were typically more able to cater to individual graduate needs, particularly in terms of:

- Training in non-clinical professional skills (75% regional/rural; 90% metro)
- Recognising prior experience (50% regional/rural; 70% metro)
- Tailoring the program to graduates’ educational pathway (29% regional/rural; 60% metro)
- Tailoring the program to graduates’ educational level (8% regional/rural; 20% metro).

In contrast, regional/rural based EGPs were more readily able to provide appropriate support to overseas students (25% regional/rural compared to 10% metro) (Figure 3-14).

![Figure 3-14: How the EGP caters to individual graduate needs](image)

**3.5 Challenges Impacting on EGPs**

There were multiple challenges impacting on EGPs that respondents had experienced (Figure 3-15). Prominent amongst these were:

- Capacity to provide support (16%)
- Access to professional development opportunities (15%)
- Preceptor availability (12%)
- Workplace environment (12%).
Not surprisingly, the challenges encountered by EGPs for nurses/midwives are influenced by the location of the health service (Figure 3-16). Key issues raised for metro and regionally/rurally located EGPs are:

**Regional/rural EGP challenges:**

- Distance (10% regional/rural; 0% metro)
- Preceptor availability (14% regional/rural; 6% metro)
- Access to professional development opportunities (18% regional/rural; 10% metro)
- Cost (13% regional/rural; 7% metro).

**Metro EGP challenges:**

- Poor/variable clinical skills (20% metro; 3% regional/rural)
- Ongoing employment (17% metro; 2% regional/rural)
- Large graduate numbers (7% metro; 3% regional/rural).
3.6 Aspects of EGP Administration

3.6.1 Graduate intakes

Overall, the number of graduate intakes each calendar year was one in more than half of health services surveyed (57%), although as many as four intakes per year was reported (Figure 3-17). Further data drill-down (Figure 3-18) indicated that single yearly intakes for graduates were more common in regional/rural areas (70% compared to 20% in metro regions). Metro regions typically had two intakes per year (50% compared to 19% in regional/rural areas).

Figure 3-17: Frequency of graduate intakes overall (%)
3.6.2 Graduates currently employed at the health service

Overall there was considerable variation in the number of graduate nurses/midwives that were currently employed at respondents’ health services (Figure 3-19). The number of graduates employed was largely dependent on the location of the health service (Figure 3-20) with half (50%) of metro locations employing 101 to 120 graduates and more than half (59%) of regional/rural locations employing less than five graduates.
3.6.3 Professionals responsible for EGP delivery

A number of professionals were responsible for delivering the various components of EGPs for nurses/midwives. The data presented in Figure 3-21 represents the average proportion of the EGP delivered by each type of professional overall. Nursing/midwifery educational staff were typically responsible for the majority, with other nursing/midwifery staff and regional staff and self-directed study also important. Please note that as the data reflects the mean proportion delivered as reported by each respondent, figures do not total to 100% and each mean proportion has a different sample size (provided in brackets).

The prominence of nursing/midwifery educational staff together with other nursing/midwifery staff was clear regardless of health service location (Figure 3-22). However, the data demonstrated that regional/rural health services also relied on regional services and self-directed graduate study/activities.
Figure 3-22: Average proportion of delivery by profession and location

![Bar chart showing average proportion of delivery by profession and location.

3.7 Drivers of Key EGP Delivery Approach

Overall, four key factors were influential in the approach to delivery of EGPs (Figure 3-23):

- Recruitment/retention (17%)
- Resource availability (15%)
- Staff experience (12%)
- Clinical skill levels of graduates (10%).

Figure 3-23: Key factors influencing the approach to delivery of EGPs

![Bar chart showing key factors influencing the approach to delivery of EGPs.

- Research: 14
- Networking: 5
- Formal guidelines: 5
- Resource availability (excl. clinical skill levels): 2
- Clinical skill levels: 10
- Health service: 15
- Management, executive team: 6
- Program evaluation: 4
- Student numbers: 7
- Location: 11
- Time: 3
- Staff experience: 12
- Collaboration other health: 7
- Grad feedback: 5
- Recruitment/retention: 17

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However, there was notable variation in the findings dependent on the health service location (Figure 3-24). Metro based health services were heavily influenced by resource availability (excluding staff, which are explored separately) (25% compared to regional/rural 10%) and graduate feedback (12% compared to regional/rural 12%). In contrast, regional/rural located health services were influenced by recruitment/retention needs (22% compared to metro 9%) and staff experience (15% compared to metro).

Figure 3-24: Factors influencing the EGP approach by health service location

3.8 Factors Related to EGP Structure

Number of days allocated to formal education

The majority of EGPs for nursing/midwifery allocated six to 10 days for formal classes, education sessions or professional development days (Figure 3-25). This finding was generally consistent regardless of health service location, although regionally/rurally located health services reported a marginally higher number of days (Figure 3-26).
Number of allocated supernumerary days

Overall, close to half of respondents (46%) reported supernumerary time between six and ten days and a further quarter (24%) reported allocating 16 to 20 days (Figure 3-27). Examination of the supernumerary days allocated to each graduate by the location of the health service indicated that regional/rural services offered a slightly higher number of days (Figure 3-28).
There was some variation in the number of rotations each graduate typically experienced, although the majority had between two and four rotations (Figure 3-29). The number of rotations was clearly influenced by the location of the health service, with the majority (90%) of metro graduates having two to three rotations, while most regionally/rurally based graduates (81%) had three to four rotations (Figure 3-30).

Figure 3-29: Number of rotations each graduate typically experiences (%)
Figure 3-30: Typical number of rotations by health service location (%)

3.8.1 Number of observation placements typically experienced by graduates

Half (50%) of respondents overall reported that graduates typically had one observational placement, with a further quarter (25%) having two observational placements. It should be noted that a proportion of respondents (17%) felt that the number of placements was largely dependent on the clinical areas the graduate had been assigned to and was therefore ‘variable’ (Figure 3-31).

Figure 3-31: Number of observational placements graduates experience overall (%)

Segmenting the data by health service location indicated that regionally/rurally located graduates were reported to have a marginally higher number of observational placements. Furthermore, the data indicated that the designation of a ‘variable’ number of observational placements was only reported by regionally/rurally located respondents (Figure 3-32).
3.8.2 Usual duration of the EGPs nursing/midwifery overall

Overall, the vast majority (97%) of EGPs for nursing/midwifery were 12 months in duration (Figure 3-33). This was a consistent finding, regardless of whether the health service was metro or regionally/rurally based (Figure 3-34).

Figure 3-32: Number of observational placements graduates typically experience by health service (%)

Figure 3-33: Typical duration of the EGP nursing/midwifery overall (%)
3.8.3 Minimum length respondents consider necessary for an EGP nursing/midwifery

Overall, the majority of respondents (78%) indicated that the minimum length of an EGP for nursing/midwifery was 12 months (Figure 3-35). However, there was some disparity between metro and regionally/rurally located services. While the majority (70%) of metro located respondents indicated that 12 months was the minimum suitable timeframe, the majority of regionally/rurally located respondents (81%) reported that the minimum timeframe was a shorter timeframe at 10 months (Figure 3-36).
Figure 3-36: Perceived minimum length of EGP by health service location

3.9 EGP Content

3.9.1 Program elements

The components of the EGPs, that is, the types of activities the graduates are required to complete, can be divided into five categories:

- Professional skills
- Administrative elements
- Practical skills
- Graduate support
- Structured education.

Each of these five categories has multiple individual elements, utilised with varying frequency (Figure 3-37). The top ten elements most frequently reported were:

- Orientation and induction (97%)
- Clinical support (97%)
- Practical demonstrations (92%)
- Study leave (92%)
- Formal, structured education (92%)
- Supernumerary time (89%)
- Rotations (87%)
- Preceptors (84%)
- Online education (81%)
- Program co-ordinator (78%).
Please note that as this was a multiple response question, proportions do not total to 100%.

*Figure 3-37: Program elements offered by EGPs overall*

<table>
<thead>
<tr>
<th>Professional skills</th>
<th>Professional skill development</th>
<th>54</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Orientation &amp; induction</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Program co-ordinator</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Rotations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Supernumerary</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Clinical support</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Practical demos</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Observational placements</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Web based community</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Peer support gps</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Training for mentors/preceptors</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Preceptors</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
<td>92</td>
</tr>
<tr>
<td>Administration</td>
<td>Pre-employment sessions</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Orientation &amp; induction</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Program co-ordinator</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Rotations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Supernumerary</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Clinical support</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Practical demos</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Observational placements</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Web based community</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Peer support gps</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Training for mentors/preceptors</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Preceptors</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
<td>92</td>
</tr>
<tr>
<td>Practical skills</td>
<td>Pre-employment sessions</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Orientation &amp; induction</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Program co-ordinator</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Rotations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Supernumerary</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Clinical support</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Practical demos</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Observational placements</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Web based community</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Peer support gps</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Training for mentors/preceptors</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Preceptors</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
<td>92</td>
</tr>
<tr>
<td>Graduate support</td>
<td>Pre-employment sessions</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Orientation &amp; induction</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Program co-ordinator</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Rotations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Supernumerary</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Clinical support</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Practical demos</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Observational placements</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Web based community</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Peer support gps</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Training for mentors/preceptors</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Preceptors</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
<td>92</td>
</tr>
<tr>
<td>Structured education</td>
<td>Pre-employment sessions</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Orientation &amp; induction</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Program co-ordinator</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Rotations</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Supernumerary</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Clinical support</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>Practical demos</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Observational placements</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Web based community</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Peer support gps</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Training for mentors/preceptors</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Preceptors</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Mentors</td>
<td>92</td>
</tr>
</tbody>
</table>

Analysis of responses by the location of the health service indicated that the metro based EGPs generally incorporated a larger number of program elements, with 10 elements reported to be part of the EGP for every metro based EGP surveyed (Figure 3-38). These program elements were:

- Orientation and induction (metro 100%, regional/rural 96%)
- Program co-ordinator (metro 100%, regional/rural 70%)
- Rotations (metro 100%, regional/rural 82%)
- Supernumerary time (metro 100%, regional/rural 85%)
- Clinical support (metro 100%, regional/rural 96%)
- Practical demonstrations (metro 100%, regional/rural 89%)
- Training for mentors/preceptors (metro 100%, regional/rural 37%)
- Preceptors (metro 100%, regional/rural 78%)
- Study leave (metro 100%, regional/rural 89%)
- Formal education (metro 100%, regional/rural 89%).
Regional/rural based EGPs emphasised observational placements (37% compared to metro 20%) and mentors (44% compared to metro 20%).

**Figure 3-38: Program elements offered by EGPs by location of health service**

3.9.2 Methods of delivery

A variety of techniques are employed in the delivery of EGPs for nurses/midwives (Figure 3-39). Overall, the most frequently cited methods were:

- Face to face classes (95%)
- Ad hoc informal learning (87%)
- Computer assisted learning (81%)
- Workshops/practicums (73%)
- Self-paced online learning (70%).
This pattern of results was broadly consistent, regardless of the location of the health service providing the EGP (Figure 3-40). Some variations were however noted, where regionally/rurally located services employed the use of video conferencing (33% compared to 0% metro) and more frequently used observational placements (44% compared to 20% metro). In contrast, metro based EGPs used seminars more frequently (50% compared to 22% regional/rural) and had a greater emphasis on ad hoc learning (100% compared to 82% regional/rural).

Figure 3-39: Methods of delivery used by EGPs overall

Figure 3-40: Methods of delivery used by EGPs by health service location
Further analysis regarding the main methods of delivery was undertaken, where respondents listed the top three methods employed by their EGP. Results indicated a pattern of findings consistent with those mentioned above (see Figures 3-41 and 3-42).

**Figure 3-41: Top three methods of delivery used by EGPs overall**

- Observational placements: 100%
- Workshops/practicums: 93%
- Study groups: 83%
- Video conferencing: 56%
- Seminars: 73%
- Self-paced hard copy material: 95%
- Self-paced online: 81%
- Computer assisted: 87%
- Ad hoc informal learning: 94%
- Face to face classes: 97%

**Figure 3-42: Top three methods of delivery used by EGPs by location**

- Observational placements: 100%
- Workshops/practicums: 95%
- Study groups: 88%
- Video conferencing: 67%
- Seminars: 83%
- Self-paced hard copy material: 60%
- Self-paced online: 83%
- Computer assisted: 81%
- Ad hoc informal learning: 91%
- Face to face classes: 96%

**December, 2012**
3.9.3 Content of the EGP’s formal education component

The curriculum for the formal education component of EGPs was diverse, however overall, almost half (47%) of the time was spent on clinical practice. Other important educational elements were clinical theory (17%) and common health conditions (13%), (Figure 3-43). Please note that as the data reflects the mean proportion of time spent on each topic as reported by each respondent, figures do not total to 100% and each mean proportion has a different sample size (provided in brackets).

*Figure 3-43: Topics included in the formal education component of EGPs*

This allocation of time between the various topics typically included in an EGP for nursing/midwifery was consistent regardless of whether the health service was metro or regionally/rurally based (Figure 3-44).

*Figure 3-44: Formal education topics by location of health service*
3.10 Evaluation of EGP Impacts

3.10.1 Impact of EGPs on workforce requirements

EGPs were perceived to have a substantial impact on the quality and number of graduates recruited and retained within public health services. Overall, 63% of respondents ‘Strongly agreed’ (rated 9-10) that the EGP contributed to higher rates of retention at their health service. In terms of recruiting, 73% of respondents ‘Strongly agreed’ (rated 9-10) that the EGP was important to recruiting high quality graduates. Finally, 71% of respondents ‘Strongly agreed’ (rated 9-10) that they were always more likely to hire nursing/midwifery staff who had completed a graduate program (Figure 3-45).

Figure 3-45: The impact of EGPs on health service workforce

3.10.2 Impact of EGPs on professional practice

Overall, the majority of respondents perceived that EGPs assists graduates to work as independent practitioners more quickly (88%, of which 37% ‘Strongly agree’ (rated 9-10) and 51% ‘Agree’ (rated 6-8)) (Figure 3-46).

Respondents reported their EGPs focussed on both clinical and non-clinical professional skills with more than half (51%) of respondents stating they ‘Strongly agree’ (rated 9-10) with this statement and a further 42% reporting that they ‘Agree’ (rated 6-8). A clinical skills/competencies focus was reported however, with
this being an area of strong emphasis for 36% of respondents (rating 9-10) and an important area for a further 46% of respondents (rating 6-8) (Figure 3-46).

The extent to which graduates were focused on new clinical skills rather than reviewing skills previously taught was variable. It was clear that for many; a lot of time was spent reviewing competencies that the graduate should have been taught as a student. This was evident with more than half of respondents in agreement with the statement (56%, of which 17% 'Strongly agree' (rated 9-10) and 39% ‘Agree’ (rated 6-8). In contrast, 39% ‘Disagree’ (rated 3-5) with this statement and a further 5% ‘Strongly disagree’ (rated 0-2) with the statement (Figure 3-46).

**Figure 3-46: Impact of EGP on professional practice**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating 9-10</th>
<th>Rating 6-8</th>
<th>Rating 3-5</th>
<th>Rating 0-2</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>We find that our EGP assists graduates to work as independent practitioners more quickly</td>
<td>7</td>
<td>51</td>
<td>37</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Our EGP is primarily focussed on reinforcing clinical skills/competencies</td>
<td>2</td>
<td>15</td>
<td>46</td>
<td>36</td>
<td>1%</td>
</tr>
<tr>
<td>Our EGP focuses on both clinical and non-clinical professional skills</td>
<td>7</td>
<td>42</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much of our time is spent reinforcing or re-assessing skills/competencies which should have been taught ...</td>
<td>5</td>
<td>39</td>
<td>39</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

3.10.3 Impact of EGPs on the health service as an organisation

Overwhelmingly respondents noted that health service leadership considered the EGP important to the organisation, with 73% ‘Strongly agreeing’ (rating 9-10) and a further 22% ‘Agreeing’ (rating 6-8). Consistent with this finding was the high ratings received for the statement ‘The EGP is part of the learning culture across the entire organisation’. Overall, 51% ‘Strongly agreed’ (rated 9-10) and a further 44% ‘Agreed’ (rated 6-8) with the statement (Figure 3-47).
Despite this perceived strong endorsement from health service leadership and the learning culture of the organisation, respondents were less convinced that the EGP was well understood across the health service, with 29% of respondents ‘Strongly agreeing’ (rating 9-10) and 54% ‘Agreeing’ (rating 6-8) that the EGP was well understood (Figure 3-47).

Finally, the rated impact of the EGP on the use of best practice approaches was mixed. A notable proportion (20%) disagreed (rated 3-5) that the EGP increased the use of best practice approaches. However, the majority of respondents agreed that best practice approaches were increased as a result of the EGP (78%, of which 32% ‘Strongly agree’ (rated 9-10) and 46% ‘Agree’ (rated 6-8)) (Figure 3-47).

*Figure 3-47: The perceived impact of EGPs on the health service organisation*

<table>
<thead>
<tr>
<th>The EGP is well understood across the health service</th>
<th>5</th>
<th>12</th>
<th>54</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service leadership sees the EGP as important to the organisation</td>
<td>5</td>
<td>22</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td>The EGP is a part of the learning culture across the entire organisation</td>
<td>5</td>
<td>44</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>The EGP has resulted in increased use of best practice approaches to professional practice...</td>
<td>20</td>
<td>46</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>DK= 2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DK= Don’t know

**3.10.4 Internal EGP Evaluations**

*EGP evaluation aims, goals and expected outcomes*

Overall, it was clear that the aims, goals and expected outcomes of EGPs had been defined across all health services surveyed (Figure 3-48). Particular areas of strength were:
Clear, well understood aims, objectives and/or goals:

- **90% agreement** (51% ‘Strongly agree’ (rated 9-10) and 39% ‘Agree’ (rated 6-8))

- **10% disagreement** (10% ‘Disagree (rated 3-5))

Clear understanding of the outcomes expected from the EGP:

- **88% agreement** (42% ‘Strongly agree’ (rated 9-10) and 46% ‘Agree’ (rated 6-8))

- **12% disagreement** (2% ‘Strongly disagree’ (rated 0-2) and 10% ‘Disagree’ (rated 3-5))

Linking the EGP to the overall organisational learning and development objectives:

- 86% agreement (44% ‘Strongly agree’ (rated 9-10) and 42% ‘Agree’ (rated 6-8))

- 12% disagreement (2% ‘Strongly disagree’ (rated 0-2) and 7% ‘Disagree’ (rated 3-5)).

Although ratings were generally very high, areas where ratings were comparatively lower were:

- The EGP has Key Performance indicators:

  - **66% agreement** (29% ‘Strongly agree’ (rated 9-10) and 37% ‘Agree’ (rated 6-8))

  - **29% disagreement** (12% ‘Strongly disagree’ (rated 0-2) and 17% ‘Disagree’ (rated 3-5))

- The EGP has Key Performance Indicators (KPIs) which were reported against and used to monitor performance:

  - **61% agreement** (22% ‘Strongly agree’ (rated 9-10) and 39% ‘Agree’ (rated 6-8))

  - **34% disagreement** (12% ‘Strongly disagree’ (rated 0-2) and 22% ‘Disagree’ (rated 3-5))

- The EGP to clearly linked to the overall safety and quality program:

  - **71% agreement** (29% ‘Strongly agree’ (rated 9-10) and 42% ‘Agree’ (rated 6-8))

  - **30% disagreement** (10% ‘Strongly disagree’ (rated 0-2) and 20% ‘Disagree’ (rated 3-5)).
**EGP evaluation data, surveys and assessment**

The majority of respondents reported collecting data on the EGP and tracking it over time (68%, of which 34% ‘Strongly agree’ (rated 9-10) and 34% ‘Agree’ (rated 6-8)) (Figure 3-49). Further analysis to explore the nature of the data collected indicated that data was somewhat more likely to come from the graduates than from those involved in delivering the EGP. This was indicated from the response to the following two statements:

- ‘We regularly undertake graduate surveys on satisfaction and/or performance of the EGP’
  - **73% agreement** (46% ‘Strongly agree’ (rated 9-10) and 27% ‘Agree’ (rated 6-8))
  - **27% disagreement** (7% ‘Strongly disagree’ (rated 0-2) and 20% ‘Disagree’ (rated 3-5))

- ‘We undertake surveys of preceptors, mentors and others involved with the EGP regarding satisfaction and/or performance of the EGP’
  - **56% agreement** (24% ‘Strongly agree’ (rated 9-10) and 32% ‘Agree’ (rated 6-8))


- **44% disagreement** (20% ‘Strongly disagree’ (rated 0-2) and 24% ‘Disagree’ (rated 3-5)).

Undertaking needs assessment activities to ensure the relevance of the EGP was reported by more than half of respondents (61%, of which 29% ‘Strongly agree’ (rated 9-10) and 32% ‘Agree’ (rated 6-8)). In contrast, more than a third of respondents reported that they disagreed with the statement (12% ‘Strongly disagree’ (rated 0-2) and 24% ‘Disagree’ (rated 3-5)) (Figure 3-49).

While the majority of respondents (61%) indicated that regular financial monitoring of the EGP occurred at the health service, others did not have regular monitoring. Approximately one quarter of respondents (24%) reported they either ‘Disagreed’ (7%) or ‘Strongly disagreed’ (17%) with the statement ‘Our service conducts regular financial monitoring and review of the EGP’ (Figure 3-49).

*Figure 3-49: EGP evaluations in terms of data, surveys and assessment*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Rate 0-2</th>
<th>Rate 3-5</th>
<th>Rate 6-8</th>
<th>Rate 9-10</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data is collected in relation to the EGP and tracked over time</td>
<td>7</td>
<td>22</td>
<td>34</td>
<td>34</td>
<td>3%</td>
</tr>
<tr>
<td>We regularly undertake graduate surveys on satisfaction and/or performance</td>
<td>7</td>
<td>20</td>
<td>27</td>
<td>46</td>
<td>15%</td>
</tr>
<tr>
<td>Our service conducts regular financial monitoring and review of the EGP</td>
<td>17</td>
<td>7</td>
<td>24</td>
<td>37</td>
<td>3%</td>
</tr>
<tr>
<td>We undertake surveys of preceptors, mentors and other involved with the EGP...</td>
<td>20</td>
<td>24</td>
<td>32</td>
<td>24</td>
<td>3%</td>
</tr>
<tr>
<td>We undertake needs assessment activities to ensure the relevance of the EGP</td>
<td>12</td>
<td>24</td>
<td>32</td>
<td>29</td>
<td>3%</td>
</tr>
</tbody>
</table>

DK= Don’t know
3.10.5 The EGP evaluation process

More than three quarters of respondents (78%) agreed that they regularly undertook formal evaluation of the EGP (54% ‘Strongly agree’ (rated 9-10) and 24% ‘Agree’ (rated 6-8)). A similar pattern of results was evident when determining whether it was clear who was responsible for EGP evaluation (83%, of which 49% ‘Strongly agree’ (rated 9-10) and 34% ‘Agree’ (rated 6-8)) and whether evaluation was considered an important part of their EGP approach (78%, of which 46% ‘Strongly agree’ (rated 9-10) and 32% ‘Agree’ (rated 6-8)) (Figure 3-50).

Respondents were divided in their perceptions of having adequate resourcing to undertake regular EGP evaluations. More than half of respondents indicated that they did not believe they had adequate resources (53%, of which 24% ‘Strongly disagree’ (rated 0-2) and 29% ‘Disagree’ (rated 3-5)) (Figure 3-50).

Figure 3-50: EGP evaluation process

<table>
<thead>
<tr>
<th>Issue</th>
<th>Strongly Agree (9-10)</th>
<th>Agree (6-8)</th>
<th>Disagree (3-5)</th>
<th>Strongly Disagree (0-2)</th>
<th>DK</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is clarity regarding who is responsible for the EGP</td>
<td>15</td>
<td>34</td>
<td>49</td>
<td>2</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>We undertake regular formal evaluation of the EGP</td>
<td>2</td>
<td>20</td>
<td>24</td>
<td>54</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Evaluation is an important part of our approach to the EGP</td>
<td>2</td>
<td>20</td>
<td>32</td>
<td>46</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>We have adequate resources to regularly evaluate our EGP</td>
<td>24</td>
<td>29</td>
<td>20</td>
<td>24</td>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>

DK= Don’t know

Rate 0-2  Rate 3-5  Rate 6-8  Rate 9-10
3.10.6 EGP outcomes

Overall, EGP outcomes have been very positive (Figure 3-51). Particular areas of outcome strength were:

- The performance of the EGP is important to the organisation:
  - **95% agreement** (63% ‘Strongly agree’ (rated 9-10) and 32% ‘Agree’ (rated 6-8))
  - **5% disagreement** (10% ‘Disagree (rated 3-5))

- Regularly look at ways to improve the EGP:
  - **90% agreement** (70% ‘Strongly agree’ (rated 9-10) and 20% ‘Agree’ (rated 6-8))
  - **10% disagreement** (10% ‘Disagree’ (rated 3-5))

- EGP contributes to services’ productivity
  - **86% agreement** (49% ‘Strongly agree’ (rated 9-10) and 37% ‘Agree’ (rated 6-8))
  - **12% disagreement** (2% ‘Strongly disagree’ (rated 0-2) and 12% ‘Disagree’ (rated 3-5)).

Although ratings were generally very high, an area where ratings were comparatively lower was:

- The EGP contributes to safety and quality performance of less experienced staff:
  - **71% agreement** (39% ‘Strongly agree’ (rated 9-10) and 32% ‘Agree’ (rated 6-8))
  - **27% disagreement** (10% ‘Strongly disagree’ (rated 0-2) and 17% ‘Disagree’ (rated 3-5)).

While ratings were somewhat reduced for the statement ‘Our EGP has a proven track record, is working well and does not need to be reviewed or changed’ (53% disagreement, of which 29% ‘Strongly disagree’ (rated 0-2) and 24% ‘Disagree’ (rated 3-5)) (Figure 3-51) this finding could be reflective of respondents wishing to constantly strive for improvements and refinements.
Figure 3-51: EGP outcomes

- **Our EGP contributes to our services’ productivity**: 212 Rate 0-2, 37 Rate 3-5, 49 Rate 6-8, 9 DK= 3%
- **The performance of the EGP is important to the organisation**: 5 Rate 0-2, 32 Rate 3-5, 63 Rate 6-8
- **We regularly look at ways to improve the EGP**: 10 Rate 0-2, 20 Rate 3-5, 70 Rate 6-8
- **Our EGP… is working well and does not need to be reviewed or changed**: 29 Rate 0-2, 24 Rate 3-5, 34 Rate 6-8, 10 Rate 9-10, DK= 3%
- **Our EGP contributes to the safety and quality performance of our less experienced staff**: 10 Rate 0-2, 17 Rate 3-5, 32 Rate 6-8, 39 Rate 9-10, DK= 2%

DK= Don’t know
4 Appendix D: Environmental Scan

4.1 Introduction

The purpose of the environmental scan is to provide a range of secondary data to facilitate an understanding of the context in which nursing/midwifery EGPs operate. Furthermore, it allows for an examination of different models and approaches to graduate transition. The environmental scan provides a concise review of:

- Comparative models of notable EGPs in other professions and jurisdictions both nationally and internationally
- Victorian graduate nurse programs in mental health
- Similar EGPs for nurses/midwives in other national and international jurisdictions.

The environmental scan was based predominantly on desk research reviewing publically available data including program descriptions, program data, website materials, program reviews, marketing materials and evaluations (to the limited degree that these were available). Information related to nursing and midwifery EGPs in Australian jurisdictions was informed by initial desk research followed by consultations undertaken between July and August 2012 with representatives responsible for the nurse and midwife EGPs.

4.2 EGPs in Other Australian Jurisdictions

The graduate year requires the new nurse/midwife to make the transition from a student in an academic setting to a nurse employed within the health workforce. To facilitate the transition, many public and private hospitals in Australia offer formalised EGPs for nurses/midwives, which provide graduates with preceptor support, study days and rotations through a number of clinical areas\(^{127}\). State and territory governments fund these programs in most public hospitals and some private not-for-profit health services (i.e. Western Australia and NSW). A number of private health services also privately fund EGPs for nurses and midwives with some

of these being nationally consistent (for example the Ramsay Health GradPlus program).

Approaches to funding vary, and not all jurisdictions currently allocate a set amount for each graduate participating in an EGP. Where information on the specific amount of funding provided per graduate was available, it has been provided both in the text and accompanying summary table.

Information was provided via desk research only for the Northern Territory and the Australian Capital Territory. In all other jurisdictions, desk research was undertaken and stakeholders were available for consultation, providing much of the information contained in the following sections.

4.2.1 Australian Capital Territory

Australian Capital Territory (ACT) Health offers a number of graduate programs for new graduate Registered Nurses, midwives and Enrolled Nurses. The program is of 12 months duration and at the completion of the program, all graduate nurses and midwives are offered permanent employment with ACT Health.

- The program includes:
  - Three days orientation
  - Five days of supernumerary time at a Canberra hospital in the first placement
  - Four weeks supernumerary time in the first placement with community health
  - Preceptorship and clinical support on wards
  - Access to free staff professional development education
  - Flexible learning opportunities
  - Access to comprehensive learning opportunities
  - Access to clinical development nurses and midwives who:
    - Are accessible seven days a week
    - Facilitate weekly new graduate meetings
    - Provide hands on clinical support
    - Facilitate learning and the acquisition of new skills
    - Provide feedback on development
    - Conduct competency based assessments
    - Promote evidence based practice.
In addition to this, graduates can access the same additional entitlements as other employees. This includes access to a two day orientation to the health service and two days supernumerary time on new wards.

### 4.2.2 New South Wales

Nurse and midwife EGPs in New South Wales (NSW) are considered by NSW Health as one of a number of programs to assist nurses and midwives who seek to transition to new settings throughout their careers. Other programs are provided to support the transition to work in an ICU, mental health and emergency. A forensic health program is also offered through the Justice Health and the Forensic Mental Health Network.

With recruitment not being a current issue in NSW public health services, the key purpose of the nursing and midwifery EGPs from the NSW Health perspective is to support a smooth transition to practice for recent graduates. In 2012, 2,600 graduate nurses and midwives employed by NSW Health were participating in a 12 month EGP within a public health service.

NSW Health provides $800 for each graduate participating in an EGP. This funding is a contribution towards covering the cost of education activities. The graduates’ salary and any other costs associated with their employment are considered a component of the overall funding of the health service. No further funding specific to the EGP is provided to the health service over its usual operational budget.

Health services within a Local Health District work together to determine the number of graduates required for a particular health service, with consideration given to the specific needs of the district. NSW Health is then advised of the numbers to be employed. Recently graduated nurses and midwives seeking employment apply centrally through an online register.

The structure and content of EGPs for nurses/midwives is developed by the health services. Most contain study days with an educational program, preceptorships, supernumerary time, and additional clinical support.

### 4.2.3 Northern Territory

The Northern Territory (NT) Department of Health offers an EGP for new graduate registered nurses, midwives and Enrolled Nurses. The program is offered through three health services; the Royal Darwin Hospital, Katherine Hospital and Alice Springs Hospital. Opportunities exist for a clinical placement at either the Tennant Creek Hospital or the Gove District Hospital. Both of these hospitals are very
remote and can offer a great insight into remote nursing practice. The programs are open to nurses and midwives who are in their first year of practice.

The graduate nurse/midwife programs are generalist in nature, with clinical placements in a variety of settings, which vary dependent on the health service where the graduate is located.

A 12-month program is offered for Registered Nurses and Enrolled Nurses at Royal Darwin Hospital and Alice Springs Hospital. Enrolled Nurses are asked to complete a six-month program at Katherine Hospital. Full time and part time employment is offered.

4.2.4 Queensland

EGPs for nurses and midwives in Queensland are currently offered throughout all Queensland Health regions. In 2012, 2,000 graduate nurses and midwives participated in EGPs. The key purpose of these programs from a jurisdictional perspective is to support graduates to make a smooth transition into the workforce. A specific aged care EGP is currently being developed to support workforce development and recruitment into this area.

Funding for EGP positions is not directly provided by the state government; rather positions are funded through the health services budget. The state government allocates funds to health services as a component of their budget in the amount of $3,200 for each graduate nursing or midwifery position in a rural or regional position, and $1,600 for each metropolitan position.

Queensland Health and the Queensland Nurses Union (QNU) do not support fixed term temporary appointments to graduate programs. According to HR Policy B3 (June 2010) graduate nurses are appointed to available permanent positions according to the skill mix requirements of the facility.

Information provided by Queensland Health indicates nursing/midwifery EGPs vary according to the region. Some programs are ward based only, while others offer a range of rotations. Rotations may be through a number of wards in one facility or may cover a range of facilities, particularly in rural districts.

Graduate positions are managed centrally through Queensland Health, which currently undertake two graduate registered nurse/midwife recruitments per year, one at the start of the year and a second intake mid-year. Applications for recruitment intakes usually occur four to five months prior to the intake commencement. It is noted that current demand from graduates for positions
exceeds health service vacancies. Vacancy numbers are subject to continual review to ensure that changing workforce needs are responded to in each intake.

4.2.5 South Australia

In South Australia (SA) the state government provides EGPs for nurses and midwives through the Nursing/Midwifery Transition to Professional Practice Program (TPPP). These are offered to nurses and midwives who have successfully completed their undergraduate qualifications, have registered with the Nursing and Midwifery Board of Australia (NMBA) and are commencing their first year of professional practice. In 2012, 537 graduate nurses and midwives were employed in SA Health TPPPs.

The TPPP framework guidelines state that the TPPP aims to facilitate a supportive environment to enable new graduates to undertake a process of:

- Developing positive attributes and attitudes to work
- Skill consolidation
- Building clinical confidence
- Defining their professional responsibilities and boundaries.

Programs are run by most public and some private hospitals within the metropolitan area. In the rural setting, programs are generally run through a regional health service and can be undertaken at one or a combination of hospitals, depending on regional arrangements.

The programs vary in length (six to 12 months) and content, however, all include a theoretical and clinical practice component. Graduates are employed by the health unit/service and work on a rotating roster while completing the program. Graduates apply through a centralised online process. The TPPP offer all graduates:

- A dedicated TPPP Coordinator and education support team
- Professional development study days
- Peer support
- Up to three clinical rotations
- The option of full-time or part-time positions, dependent on the needs of different sites.

The local health units employ the graduates directly, as SA Health has no involvement at all in the employment of any staff at either the local health unit or local health network level. Each health unit runs their own TPPP program and many
share the same program curriculum, however these may be implemented differently based on individual health unit service needs.

SA Health provides funding for the formal TPPP programs through the Nursing and Midwifery Capability Development Grant (previously known as the Case Mix Teaching Nursing and Midwifery Grant). Funding is provided based on a head count quota of $11,000 per participant (capped). The Nursing and Midwifery Capability Development Grant is in addition to health units’ operational budget. Health units may choose to employ new graduates outside the TPPP program, in which case funding is through their operating budget.

Funding through the Nursing and Midwifery Capability Development Grant contributes towards the educational infrastructure of the health service. It includes the provision of the nursing and midwifery TPPP and the salary component of the new graduate participant whilst undertaking approved educational TPPP study days.

4.2.6 Tasmania

The Tasmanian Department of Health and Human Services (DHHS) offers Transition to Practice placements for registered nurses with less than six months full-time experience. In 2012, 110 graduate nurses and midwives were engaged in these EGPs. No specific funding is provided per graduate.

The program aims to provide a supported transition to practise in order to foster recruitment and retention and assist nurses/midwives with less than six months experience. Inexperienced nurses are provided with an extended orientation period and increased professional support for the first three to six months of practice. Transition to Practice positions are available in a wide range of practice settings including metropolitan and rural hospitals and community and mental health settings. Employment of graduates is authorised by DHHS. No specific funding related to EGPs is provided to health services.

The Tasmanian DHHS recommends that EGPs are at a minimum, six months in duration. The Transition to Practice program includes a program coordinator, orientation, study days, rotations, additional professional development, and preceptorship. In 2012, an addition EGP was specifically developed for the aged care sector with the support of Aged and Community Services Tasmania, the peak residential aged care organisation in Tasmania.
The nursing and midwifery EGP offered by the Tasmanian DHHS is underpinned by the Transition to Professional Practice Framework for New Nurses.\textsuperscript{128}

The framework outlines a staged approach to transition which includes:

- **Foundation**: focussing on education, experience, competence and clinical skills
- **On boarding**: concentrating on agency induction, nursing orientation and learning objectives
- **Transition to role**: focussing on critical thinking and reflection, continuing professional development and regular review of learning and professional objectives
- **Consolidation of skills**: concentrating on communication, documentation, time management, prioritisation, clinical risk management, occupational health and safety, medication management and context specific skills
- **Career planning and development**: focussing on ongoing professional development, identifying future career pathways, exploring specialty opportunities and considering postgraduate studies.

The TPP Framework also explicitly identifies benefits for both the participant and the organisation. Specifically:

**For the participant:**

- An individualised transition support process to assist making the new graduate feel welcomed into the team while having time to adjust to a new context and/or role
- Strategies for applying knowledge and skills that are transferable from one setting to another
- The promotion of clinical confidence
- Consolidation of theoretical knowledge and practical skills
- Increased job satisfaction and motivation to improve and develop practice.

For the organisation:

- Patients and clients receiving safe and competent care
- A culture of learning that values critical thinking and inquiry within the workplace
- Acknowledgement of preceptors and their essential contribution to the work environment
- Reducing the risk of adverse incidents
- Increased recruitment and retention of staff.

4.2.7 Western Australia

Graduate programs are available to WA based graduate nurses and midwives in public health services and a number of private health partners. These programs are of 12 months duration and are open to registered nurses and midwives with less than 12 months experience. The state government provides $1,500 per graduate position engaged in an EGP in a public health service and in some private health services.

In 2012, 681 graduate registered nurses and midwives were employed in EGPs funded by WA Health. In addition, 130 graduate enrolled nurses are also participating in EGPs. In WA there is a strong career path from enrolled nurse to registered nurse, with the Department estimating that up to 70% of enrolled nurses will undertake further study to become registered nurses. Graduates are all offered a 12 month fixed contract.

While WA Health does not prescribe guidelines or program content, most EGPs contain preceptorships, rotations, supernumerary time, study days and clinical education support. The primary purpose of the nurse/midwife EGP is to support graduate transition and ensure that graduates are work-ready. EGPs therefore also support the graduates' education through employment of clinical educators and allowing preceptors to work weekends and after-hours alongside graduates.

Following the graduate year program, nurses and midwives who have completed a graduate year are able to apply for several other second year programs. This provides graduates with an extended range of rotations in different health services.
settings and locations\textsuperscript{129}. These include the Ocean to Outback Program, the Country to Coast Program and the Travel and Deliver Program. These extended programs seek to address areas of workforce shortage and provide graduates with ongoing experience.

### Table 4-1: Jurisdictional Summary as at October 2012

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>No. of funded grads.</th>
<th>Funding by position</th>
<th>Purpose of the funding</th>
<th>Is employment authorised by the relevant government department?</th>
<th>Nature of the funding inc. funding of additional inputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>2,600</td>
<td>$800</td>
<td>To support educational activities.</td>
<td>Yes - with input from Local Health Districts.</td>
<td>No additional funding related to the graduate program.</td>
</tr>
<tr>
<td>QLD</td>
<td>2,000</td>
<td>$3,200 for rural/ regional $1,600 for metro</td>
<td>To provide partial support for transition activities provided by the health service. To act as an incentive to health services to employ graduates.</td>
<td>Yes - input at the Hospital and Health (formerly District) Service level.</td>
<td>All other associated costs are met by health services through their input based funding model.</td>
</tr>
<tr>
<td>SA</td>
<td>537</td>
<td>$11,000</td>
<td>To contribute to the educational infrastructure, the provision of the program and the salary component of the new graduate while undertaking study days.</td>
<td>No - Grads are employed at the discretion of the health unit/service. Funding of graduate positions is capped.</td>
<td>Additional activities are funded by the health service’s operational budget.</td>
</tr>
<tr>
<td>Tasmania</td>
<td>110</td>
<td>Nil</td>
<td>N/A</td>
<td>Yes</td>
<td>No specific funding related to the graduate program.</td>
</tr>
<tr>
<td>Victoria</td>
<td>1305</td>
<td>$17,000</td>
<td>To contribute to support and transition activities/costs incurred by the health service above the graduates' salary (including to offset the cost of non-care delivery time of grads (i.e. study days)</td>
<td>No - Employment of computer matched graduates is at the employer’s discretion.</td>
<td>Covered through operational budgets calculated using WIES</td>
</tr>
<tr>
<td>WA</td>
<td>681</td>
<td>$1,500</td>
<td>To support the graduates' education through employment of clinical educators and to allow for preceptors to work weekends and after-hours alongside graduates.</td>
<td>Yes - with health services and regional input.</td>
<td>No specific additional funding related to the graduate program.</td>
</tr>
</tbody>
</table>
4.2.8 Discussion

While the structure and content of EGPs for nurses and midwives appears to be similar throughout Australia, there is considerable variation in the amount of government funding provided. Generally consistent elements included support provided by preceptors, supernumerary time for preceptors and graduates, study days and rotations. While some states provide guidance on the content of programs, other states left this to the health service. Several states based their approach to the program on the Victorian DH EGP Guidelines.

Consultations with the jurisdictional representatives highlighted a number of issues which reflect discussions held in Victoria. These included:

- Concern about the work readiness of graduates and the appropriate role of the EGP. Reflecting this, in one state graduates are not counted within the EFT for registered nurses and midwives but are considered separate.

- The need for rotations and whether the continued inclusion of multiple rotations was based on the notion that the graduate year aimed to expand graduates’ experiences and that graduates benefited from having a wide range of exposure during their graduate year. Conversely, some felt there was a lack of evidence to support the value of rotations and that these often came at the expense of both the graduate and health service. According to those holding this view, rotations reinforced the notion that graduates were students needing clinical placements rather than professionals. Furthermore, there is evidence to indicate that graduates have increased benefits from remaining in a consistent setting.

- The language used to describe graduates and graduate programs reinforces the view that graduates are not fully qualified to work. Terms such as 'early graduate', 'preparation to practice' and 'junior staff' were examples provided, implying that graduates are not yet fully qualified to practice. It was also argued that the term 'Early Graduate Program' tended to ignore the broader context in which nurses transition across settings throughout their careers, with a number specific programs designed to support such transitions.

- Concern that the increased focus on EGPs reinforced in the minds of graduates and co-workers that graduates are in need of high levels of support and 'hand-holding', limiting the contribution they can make to the health service.

- Concern around graduates requiring specialised education and clinical support from designated personnel associated with the program when this should be provided by all nurses, not just specialists.
4.3 Victorian Mental Health EGPs

The Department of Health Victoria provides funding for EGPs for graduates in mental health settings. Examination of these approaches provides insights into opportunities for nursing and midwifery graduate programs including the use of learning networks, increased study days, collaborations with universities and cross-health service collaborations which have resulted in sharing of educational sessions and online resources.

As a stream within the Victorian Graduate Nurse Program, most EGPs in mental health contain similar elements to nursing and midwifery EGPs including access to preceptors, clinical education support, study days and rotations. Mental health nursing in Victoria continues to experience challenges in workforce distribution, recruitment and retention. Funding of specialist nurse graduates is therefore provided by the Department as part of a recruitment and retention strategy.

A number of area mental health services offer EGPs within the mental health stream and consultations were undertaken with representatives of Eastern Health and the Alfred to provide insight on these models. The Eastern Health approach provides graduates in the program with additional study days (15) and access to opportunities for post graduate study. As a part of the North East Victoria Innovative Learning, Training and Professional Development Cluster (NEVIL), graduates have access to an expanded range of professional development activities, opportunity to achieve credits towards a university post graduate qualification and opportunities for intra health service networking.

Similar to the Eastern Health Graduate Mental Health Nurse Program, the Alfred Health case study below demonstrates the development of a model to address the specific needs of graduate nurses working in mental health settings as well as the workforce needs of the health service. Both programs have a strong educational focus which seeks to address the often limited exposure of undergraduates to mental health settings. Provision of educational opportunities is also seen as important to building the workforce skills of mental health nurses and encouraging commitment to ongoing learning and post graduate study.
Case Study: Mental Health Nursing at Alfred Health

The Alfred Mental Health Graduate Nurse Program currently employs eight graduate nurses within the specialist mental health area. The number of positions for the 2013 intake is capped at 10.

The purpose of the EGP is to provide a supportive environment, assisting newly registered nurses to consolidate and further develop their knowledge and skills in mental health nursing. The emphasis is on working in collaboration with a multi-disciplinary team to develop skills as a beginning level Mental Health Nurse.

The program provides supernumerary time and clinical education support. Reflecting the need to provide graduates with a stable environment to develop a sense of competency and belonging, there is only one rotation and one observational placement. In order to retain high quality mental health nurses, an ongoing employment contract is offered upon completion of the program.

The program has a strong educational focus with study days reflecting the Australian Nursing and Midwifery Council National Competency Standards. The educational program is externally accredited and evaluated by University of Melbourne, RMIT and LaTrobe University. It provides an overview of the major theoretical foundations of psychiatric nursing and enables graduates to develop their conceptual understanding of practice. Reflecting the multi-disciplinary approach to care provided at the Alfred, graduates undertake the educational elements of the program with other graduate allied health professions. Completion of The Alfred Mental Health Graduate Nurse Program provides up to four credited subjects towards a Postgraduate Diploma of Mental Health Nursing at the University of Melbourne, RMIT or Latrobe University. The program offers an optional second year, designed to promote retention and further study. During this year, graduates are supported with increased study leave to complete the Diploma. Approximately 85% of first year graduates will complete a second year.

In recognition of the challenges facing mental health nurses and the need to address retention issues, the program includes a structured reflection component. It seeks to provide graduates with reflective skills that will equip them to deal with challenges throughout their nursing career. It supports the development of graduates’ protective skills and promotes resilience. This is achieved by teaching graduates to reflect upon the challenges they encounter and the impact this may have both personally and professionally. The program includes compulsory fortnightly reflection and support sessions for all graduates.
4.4  EGPs in other Professions

The value of early graduate programs is well recognised across a broad range of professions in Australia, assisting the transition from education to professional practice. Often these programs are driven by employers, professional associations or government and seek to address issues associated with workforce capacity and retention. Most focus on goals for both the employer and the graduate. They often contain common elements such as development of professional skills, application of practical skills and opportunities for a range of professional experiences.

The following section outlines a number of EGPs in other professions in Australia. Firstly, EGPs in dentistry are explored, with particular attention on the Commonwealth funded Voluntary Dental Graduate Year Program. Following this there is an examination of graduate programs driven by peak professional bodies, specifically, Engineers Australia and the Australasian Institute of Mining and Metallurgy (AusIMM). The alternative approaches in law and psychology are also presented.

4.4.1  EGPs in Dentistry

A number of programs exist to assist recent dentistry graduates in the transition to professional practice. They are administered by both jurisdictions and at a Commonwealth level and aim to alleviate dentist workforce shortages in the public sector. The largest of these schemes is the Commonwealth Voluntary Dental Graduate Year Program (VDGYP) detailed below. This program is primarily aimed at addressing issues associated with workforce shortages and distribution.

Program Background

The Voluntary Dental Graduate Year Program (VDGYP) is an initiative of the Australian Department of Health and Ageing (DoHA). Funding of $52.6 million over four years from 2011-12 to 2014-15, was announced in the 2011-12 budget. This measure aims to support the introduction of voluntary dental graduate placements and commencing from 2013, the program will be offered nationally.

The VDGYP was introduced to address the misdistribution of the dental health workforce, where 83% of dentists currently practice in the private sector and 81%
practice in metropolitan locations\textsuperscript{130}. This is not meeting population needs, with approximately 400,000 people currently on public dental waiting lists\textsuperscript{131} and with public dental patients suffering significantly worse oral health compared to the overall Australian population\textsuperscript{132}. To address these issues, and the geographic misdistribution of dentists, the VDGYP aims to supplement the public health workforce, while developing the skills of new graduates, prior to their entry into private practice\textsuperscript{133}. Furthermore, the tendency for graduates to move directly to private practice results in them missing the opportunity to work with the more challenging cases, which are more common in public dental health services.

A further targeted Commonwealth initiative, the Dental Training Expanding Rural Placements (DTERP) program, has also been introduced by DoHA. The DTERP program works to improve the availability of rural dental care and strengthen the rural dentist workforce. This is achieved by funding Australian university dental faculties to administer full-time equivalent clinical placements annually for dentistry students in established rural training settings.

\textit{Program Outcomes}

A number of expected program outcomes have been identified by DoHA\textsuperscript{134}. Aimed at increasing recruitment into the public sector and enhancing the public dental sector as a longer term career option, the impact of the VDGYP is expected to be concentrated on those who depend on the public system for access to dental.

\begin{tabular}{l}
\textsuperscript{131}Brennan DS 2008. Oral health of adults in the public dental sector. AIHW Dental Statistics and Research Series no. 47. \\
\textsuperscript{133}Australian Institute of Health and Welfare, 2011, Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006; AIHW Dental Statistics and Research Series No. 53. \\
\textsuperscript{134}DoHA (2012) ATM. Development of an Evaluation Framework for the Voluntary Dental Graduate Year Program. ATM ID: DoHA/270/1112.
\end{tabular}
services. It is anticipated that the program will help reduce waiting times, avoid preventable procedures and ultimately, help address the oral health needs of the community.

Program Administration

External parties from both public and private dentist services will be appointed as program administrators through a competitive funding process. The appointed administrator will then be responsible for advertising, participant selection and implementation of individual graduate programs. The funding process is currently underway, with the potential of additional administrators being engaged for further placements in 2015\textsuperscript{135}.

A number of jurisdictions have already developed some form of dental graduate program, however, it is expected that the VDGYP will build upon these and complement them, rather than replace or duplicate existing measures. Similarly, the VDGYP is expected to support the employment of additional dental graduates into the public sector, rather than replacing existing jurisdictional recruitment efforts.

Funding

In addition to dental graduate salaries, the VDGYP will finance appropriately qualified and experienced staff to provide mentor and preceptor support to dental graduates during their placement. The program will also provide infrastructure funding for participating dental services to purchase necessary equipment (such as dental chairs) and/or refurbish existing facilities in order to support a VDGYP placement.

Graduate Placements

The program will support 50 dental graduate placements per annum from February 2013. It is expected that the placements will be distributed in public sector facilities and other areas of need across Australia, including rural and regional areas, aged care settings and Aboriginal medical services. However, it is noted that the

\textsuperscript{135} DoHA Voluntary Dental Graduate Year Program website:  
geographical distribution of placements will be influenced by factors including jurisdictional and local capacity, resourcing and advice from relevant stakeholders.

Participating dental graduates will have access to theoretical and practical continuing education and training opportunities. The program will provide practice experience and professional development opportunities which build on the skills, knowledge and experience gained through entry to practice courses. In addition to the increased support and opportunities, participants will also receive a $15,000 bonus payment on completion of their placement.

A curriculum is currently being developed specifically for the VDGYP. The final program content will be informed by key stakeholders to ensure its value and appropriateness for dental graduates. It is expected to include both practical and theoretical components.

Graduate eligibility for the program includes a number of factors. Participants must be an Australian citizen or permanent resident of Australia and have completed an Australian approved course of study in dentistry in the academic year prior to the year of the VDGYP placement. Furthermore, all participants must have general registration as a dentist with the Dental Board of Australia with no restrictions, or the ability to gain this registration prior to the placement.

**Performance Measurement**

The program will be subject to evaluation with DoHA commissioning projects to develop an evaluation framework and conduct the evaluation. The VDGYP evaluation framework will set out the activities, data and key performance indicators required to undertake a rigorous and comprehensive evaluation of the program. This will enable the continuous assessment of the outcomes, effectiveness, efficiency and appropriateness of the program in meeting its objectives. More definitively, the evaluation of the program will measure:

- The outcomes delivered by the VDGYP
- The extent to which the VDGYP has achieved its objectives
- The appropriateness of the VDGYP in addressing the dental graduate and workforce needs, particularly in the public dental sector
- The VDGYP’s efficiency, including consideration of the extent to which the outputs are maximised for a given level of input
The effectiveness of the VDGYP based on the degree its outputs positively contribute to the specified outcomes and the level of success in achieving the outcomes.

**Discussion**

In comparison to the nursing and midwifery EGP, the VDGYP has a national focus and a primary mandate to provide exposure to public dental health settings experiencing workforce shortages. The program is based on the theory that graduates are more likely to commit to and be retained in public dental health services if given positive learning experiences and support early in their careers.

Fifty places are offered (in the first 12 months) with funding covering graduate salaries and infrastructure and/or equipment required to accommodate the graduate. The program has an evaluation plan in place, which includes the development of an evaluation framework. As an additional incentive, graduates are provided with a payment of $15,000 at the completion of the year. The approach to funding of places is competitive.

Consistent with the nursing and midwifery model, the program is 12 months in length, graduates volunteer to participate and are provided with preceptorship, mentoring and rotations though diverse settings. It has a similar focus on participatory learning, however, more emphasis is placed on the provision of consistent educational content across the program.

**4.4.2 Engineers Australia Graduate Program**

**Program Background**

Engineers Australia, the largest professional membership body for engineers in Australia, offers a graduate program for engineers with up to four years’ experience. The program facilitates the professional development process that graduate engineers must undertake in order to obtain ‘professional formation’ which leads to ‘Chartered Engineer’ (CEng) status. The program is delivered over a two year period, with a framework including professional development workshops, online resources and a Community of Professional Practice (CoPP).

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Program Structure

Privately funded by participants, the program costs graduates or their employers $5,940 (inc. GST) for Engineers Australia Members or $6,600 (inc. GST) for Engineers Australia Non-Members.

The Program model combines a series of ten professional development workshops, on-line resources, professional workplace mentoring, structured reporting, reference materials and attendance certificates recognised by Engineers Australia for continuing professional development.

Graduate Development

Rather than technical engineering training, the emphasis of the graduate program is on improving professional, cultural and self-management skills within the professional engineering environment. This is evident in the ten professional development workshops (full and half-day sessions). Examples of these workshops have been detailed below:

- **Planning Your Career**: Focused on the ‘role of the engineer’ both within the organisation and externally. This includes career planning tools and a self-evaluation exercise using an ‘engineering skills matrix’.

- **Mentoring**: Focused on ‘how to get the best out of being mentored’ and highlighting the two-way commitment required from both the graduate engineer and the mentor (usually from their place of employment). This includes a half day instructional workshop for the mentors and practical tips and ideas on how to implement mentoring programs.

- **Understanding Self & Others**: Focused on how to identify and work with different personality types within the workplace. This includes cultural, gender and age differences as well as other common interactions, such as dealing with seniority within the organisation.

- **Managing Your Career**: Focused on skill development activities for career management. There is an emphasis placed on factors that guide people and understanding how this can be incorporated and managed when mapping a career pathway.
Online Program

For the online component of the program, Engineers Australia in conjunction with their subsidiary, Engineering Education Australia, offer access to the Harvard ManageMentor. This is a management training tool developed by a third party.\footnote{Source: Engineering Education Australia, Harvard ManageMentor: \url{http://www.eeaust.com.au/harvard-manage-mentor.html} accessed - 17/06/12.} It includes a wide range of modules which concentrate on day-to-day management issues such as budgeting, crisis management, team management and performance measurement.

Discussion

The model for the Engineers Australia Graduate Program differs substantially from the Victorian nursing and midwifery EGP. Importantly, it is a privately funded program offered through a professional association. A key differentiating factor is the content of the program. Engineering specific skills and competencies are assumed and the emphasis is therefore on professional skills. There is a strong focus on structured formal learning through the use of targeted workshops and online resources. Topics covered are of broad value for professional development, with multiple educational methods utilised. However, the program offers little opportunity for learning in expanded settings.

The program duration is 24 months and seeks to provide a customised, structured program of professional development to meet the needs of engineers who have graduated in the last four years. Similar to the Victorian nursing and midwifery EGP, the program has a significant focus on the development of transferrable professional skills and encouraging review and self-reflection. Furthermore, the program encourages the use of mentors and offers structured training for those undertaking a mentoring role.

4.4.3 Minerals Industry

Initiative Background

The peak body for professionals in the minerals industry, the Australasian Institute of Mining and Metallurgy (AusIMM), provides best practice guidelines for companies implementing graduate training programs. The guidelines were developed following
research indicating that participants were unsure of their expectations at the start of the graduate program. They were designed to assist companies, especially smaller companies, consultancies and contractors, who generally do not have dedicated human resource departments.

**Graduate Program Guidelines**

The AusIMM graduate program guidelines provide best practice knowledge and full documentation for companies to develop their own graduate program. The AusIMM emphasises that the guidelines need to be adapted to individual companies and graduates.

Central to the initiative is the Graduate Program Best Practice Guidelines document\(^{138}\). Section A of this document outlines the overarching elements which should be common to all graduate development programs in the industry, regardless of the size or specialism of the company. Section B outlines elements for inclusion in graduate programs which are specific to the various professional disciplines found within the mineral industry including metallurgy, geology, mining engineering, and geotechnical engineering. The document also includes sections on business/management skills, personal development skills, statutory requirements, further education and continuing professional development. Rather than providing detailed instruction for the implementation of a graduate training program *per se*, the document functions as a check list of participant requirements for use by both the employer and graduate (see Figure 4-1).

*Figure 4-1: The AusIMM Graduate Program Best Practice Guidelines Checklist*

<table>
<thead>
<tr>
<th>2.4.01 Health and Safety/Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be aware of company policies</td>
</tr>
<tr>
<td>• Take part in incident/accident investigation</td>
</tr>
<tr>
<td>• Job hazard analysis</td>
</tr>
<tr>
<td>• Take part in safety meetings and committees</td>
</tr>
<tr>
<td>• Take part in inspections, audits and risk assessments.</td>
</tr>
</tbody>
</table>

**Future Training: Lead investigation and demonstrate positive safety behaviour.**

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\(^{138}\) See the full Graduate Program Best Practice Guidelines document:

The AusIMM Logbook

Graduates wishing to be admitted to the mineral industry’s Register of Chartered Professionals must complete the AusIMM log book, located in the final section of the guideline document. The logbook charts graduates’ personal achievements in continuing professional development throughout the graduate program and beyond. Such continuing professional development activities include undertaking formal coursework relevant to the member’s area of practice, attending relevant technical conferences, undertaking a structured program of job training and active participation in mentoring. The details and time spent completing each activity are logged, with a time weighting factor given to each activity in accordance with its importance.

Discussion

Similar to the Department of Health’s relationship to the nursing and midwifery EGP, the AusIMM acts as a central body guiding graduate programs, but allows substantial autonomy for implementation. The key difference between the programs is the form of guidelines provided. For The Department, this takes the form of a broad set of principles and recommendations underpinned by empirical evidence. Contrastingly, the direction provided by the AusIMM is more tightly structured. It gives practical direction for administrators, preceptors, mentors and graduates on how programs should be implemented and completed.

It could be argued that the AusIMM model lacks a framework of principles that can function as a referential tool for employers and employees. The program also differs in its approach to experiential learning, with the EGP for nurses/midwives providing opportunities for rotations which is not a component of the AusIMM model.

4.4.4 Psychology

There are several pathways to becoming a qualified psychologist, all of which require both academic and practical training (Figure 4-2). The minimal length of academic training is four years. The student may then obtain provisional registration only with further study and/or supervised practice required. As such, early graduate training in the workplace forms a necessary component of learning in order to become a qualified professional. The model assumes a ratio between the extent to which academic training (including student placements) and the professional setting takes responsibility for graduate training and acknowledges that, to a certain degree; one can be offset by the other.
**Program Background**

The Australian Psychological Society (APS) was the body responsible for accreditation of psychology training programs for approximately 30 years until 2005 when the Australian Psychology Accreditation Council (APAC) assumed this role, co-ordinating training across all states and territories to provide a uniform approach to registration as a psychologist, accreditation of training programs and membership with the APS.

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APAC is the government appointed authority ensuring that the knowledge and skills of registered psychologists are at an appropriate standard. In 2008 APAC was formally assigned the role of psychology accreditation under the National Registration and Accreditation Scheme for Health Professions from 01 July 2010 to 01 July 2013. This scheme regulates multiple health care professions in addition to psychologists.\textsuperscript{141}

Consistent with this role, accreditation standards have been explicitly defined by APAC. This incorporates detailed and comprehensive information on academic, research and practicum requirements.\textsuperscript{142} A focus on professional skills and practice is evident from the start of training, as documented in the requirements for the initial three year undergraduate sequence.\textsuperscript{143}

**The 4 + 2 Year Internship Program**

The 4 +2 year internship sequence follows a model of practical professional training outside of an academic institution. Detailed guidelines for the program are provided


Program objectives are defined and can be summarised as:

- Develop knowledge and understanding of psychological principles and their application
- Provide experience and instruction in psychological practice with a variety of clients and presentations
- Develop competency in administration and interpretation of psychological tools, enhance differential diagnosis skills and formulating appropriate interventions
- Support professional development and awareness of the importance of ongoing professional development and supervision
- Instil ethical and professional standards of conduct
- Teach self-evaluation and promote awareness of professional limitations
- Protect clients, employers and provisional psychologists while skills are being learnt.

The core capabilities must be achieved by the provisional psychologist under a Board-approved internship. The internship must adhere to guidelines outlining minimum time requirements, the degree and nature of supervision and the amount of professional development. Additional requirements include minimum levels of direct client contact and client related activities, regular progress reports (including log books recording a daily record of practice), the completion of case studies, supervisor completion of Assessment of Capabilities and from July 2013, the completion of an examination. Provisional psychologists must plan their proposed practice program, which must be submitted to the Board for approval. The practice requirements are extensively defined and a reproduction of the Board guidelines summary is provided in Table 4-2.

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Table 4-2: Summary of 4+2 yr. psychology internship requirements

<table>
<thead>
<tr>
<th>Training</th>
<th>Minimum requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>2 yrs (3080 hours). Maximum time to complete is 5 years.</td>
</tr>
<tr>
<td>Supervision</td>
<td>176 yrs overall with 117 hrs of individual supervision. Ratio of 1 hr supervision to 17.5 hrs of supervised practice. 1 hr per week of supervision. 1 hr per fortnight of individual supervision.</td>
</tr>
<tr>
<td>P.D.</td>
<td>Ratio of 60 hrs per full-time year, 120 hrs overall.</td>
</tr>
<tr>
<td>Practice</td>
<td>Board approved workplace settings. Direct client contact: 1232 hrs.</td>
</tr>
<tr>
<td>Method of Supervision</td>
<td>66 % individual face to face with an approved supervisor. 33 % group supervision and 25 % secondary supervision.</td>
</tr>
<tr>
<td>Frequency of Supervision</td>
<td>One hr of supervision per. 17.5 hrs supervised practice. One hr per week of supervision. One hr per fortnight of individual supervision.</td>
</tr>
<tr>
<td>Direct Observation</td>
<td>An approved supervisor must conduct 2 assessments and 2 interventions every 6 months on clients in an approved workplace.</td>
</tr>
<tr>
<td>Core Capabilities</td>
<td>Achieve proficiency in 8 core capabilities meeting specific training objectives and assessment tasks.</td>
</tr>
<tr>
<td>Supervised Practice Plan</td>
<td>Must be submitted and approved by the Board before time spent in the role(s) can be counted. Changes in work require a new plan. The principal supervisor must be a recognised supervisor.</td>
</tr>
<tr>
<td>Log Books</td>
<td>Must contain a daily record of practice, record of professional development and record of supervision</td>
</tr>
<tr>
<td>Progress Reports</td>
<td>Must be submitted every 6 months and must be submitted within 28 days from the due date.</td>
</tr>
<tr>
<td>Transition Reports</td>
<td>To be completed by the ex-supervisor within 14 days and provided to the new supervisor and Board for approval within 28 days.</td>
</tr>
<tr>
<td>Assessment of Capabilities</td>
<td>Principal supervisor completes Assessment of Capabilities forms and approves 3 case studies for submission to the Board.</td>
</tr>
<tr>
<td>Case Study Requirements</td>
<td>A provisional psychologist must write 6 case studies during the internship program of which 3 of these must be submitted with an application for general registration.</td>
</tr>
</tbody>
</table>
**Postgraduate Professional Courses**

Postgraduate courses in psychology include fifth year Graduate Diploma of Professional Psychology courses, Masters courses (six years), Professional Doctoral courses (typically seven years) and Certificate and Diploma courses which serve to bridge from one psychology specialty area to another. Practicum, together with coursework and research (thesis or dissertation) are the main components of fifth and sixth year masters programs and the professional doctorates. Detailed and specific guidelines for the course work curriculum are provided by APAC, with an increasing emphasis on professional skills.\(^{146}\)

**Practical Placements for Masters and Doctorate Students**

The practicum component for the postgraduate professional courses has the same core objectives for each course stream, although the length of practicum required and the expected skill level at completion varies according to the qualification obtained. Guidelines are focussed on ensuring students have the required experience and skill to practice as registered psychologists. At this stage, there is a prerequisite assumption that students have sufficient knowledge and professional skills to conduct themselves appropriately on placement and therefore the focus is on developing experience and ensuring adequate translation of theory to practice. A summary of the guidelines as presented by APAC\(^{147}\) are provided in Table 4-2.


Discussion

Consistent with the nursing and midwifery profession, there are a variety of pathways to become a registered psychologist. The option most consistent with the nursing 3 yr + graduate year approach is the professional internship (4 + 2 year internship program). These programs are similar in their reliance on the professional clinical environment to provide the necessary training for graduates. In both programs, guidelines are provided to facilitate and standardise this process.

The psychology practicum differs to nursing practicum in the degree to which the specific type of training is mandated. The psychology program is highly structured and uses an independent board to verify the successful completion of all requirements. Supervisors must also be approved by the Board. The nursing and midwifery program is less rigid, which allows it to accommodate a wider range of practical experiences, but decreases the extent to which training is standardised.

A further difference between the nursing and midwifery and psychology approaches is evident when reviewing the psychology Masters and Doctoral programs. Rather than allocating responsibility for clinical training to the professional workplace, these programs make the academic institution more responsible for ensuring graduates are ready for professional practice. Although students are required to undertake practicum, these are closely monitored and complemented with further formal academic tuition. In contrast, nursing and midwifery programs allocate a greater degree of responsibility to the professional environment to ensure graduates are ready for clinical practice. This may reflect the difference in clinical skills required in each profession, but does raise the question regarding allocation of the responsibility for training and where it should lie.
Table 4-3: Summary of guidelines for Masters and Doctorate programs

<table>
<thead>
<tr>
<th>Training</th>
<th>Minimum requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior knowledge</td>
<td>Adequate education and training in professional skills and knowledge including ethics prior to the first placement. Ongoing class contact.</td>
</tr>
<tr>
<td>Amount/ type of experience</td>
<td>Masters, or Masters/PhD degree, minimum 1000 hours, professional doctorate min 1500 hrs. Experience appropriate to the area of specialisation. Generalist courses must ensure a range of placements undertaken. APS Course Approval requirements should be met.</td>
</tr>
<tr>
<td>Range of settings</td>
<td>Placements must provide experience and skill development in a range of settings and include casework involving 66% face-to-face work with clients. At least 3 placements in different settings.</td>
</tr>
<tr>
<td>Placements setting and log book</td>
<td>1 placement can be conducted within the AOU and supervised by suitably qualified academic staff provided the facilities provide practical experience with “real life” issues. A log book of casework and supervision must be maintained. Supervisors are required to endorse the log book.</td>
</tr>
<tr>
<td>Supervisor qualifications</td>
<td>All external placements must be supervised by field supervisors recognised by the AOU offering the course. Supervisors must submit a CV vitae with details of qualifications and experience for consideration by the course coordinator.</td>
</tr>
<tr>
<td>Co-sign of documentation</td>
<td>All reports and case notes written by the student on placement must bear the signature of the responsible supervisor.</td>
</tr>
<tr>
<td>Supervisor qualifications</td>
<td>All supervisors should be eligible for APS membership and hold current full registration and have at least two years relevant full-time experience as a psychologist.</td>
</tr>
<tr>
<td>Nature of supervision</td>
<td>Supervision must be 1hr of direct contact for each full day of placement (7.5 hrs). If supervision is a mix of individual and small group formats, no less than 50% can be individual supervision.</td>
</tr>
<tr>
<td>Placement co-ordinator</td>
<td>A placement co-ordinator from the AOU eligible for APS college membership should be responsible for liaising with all field supervisors and ensuring students have a range of experiences.</td>
</tr>
<tr>
<td>Supervision contract</td>
<td>At the beginning of each placement the student and supervisor must complete and sign a supervision contract stating objectives, including activities to be covered and skill base to be developed.</td>
</tr>
<tr>
<td>Interim reports</td>
<td>An interim review mid-placement should be conducted reviewing progress, student’s performance and the extent the placement objectives are being met.</td>
</tr>
<tr>
<td>Assessment of Capabilities</td>
<td>At placement end the supervisor must complete a final assessment and recommend whether the student has passed, failed or will pass with additional time to meet requirements. The final decision is made by the placement coordinator in consultation with the supervisor.</td>
</tr>
<tr>
<td>Placement location</td>
<td>No more than 33% of external placement may be undertaken at any workplace where the student is employed.</td>
</tr>
</tbody>
</table>
4.4.5 Law

Historically the approach to preparation for employment as a lawyer in Australia evolved more from tradition, reaction and compromise than from a cohesive and logical strategy. However, in recent years the process has undergone change to promote increased consistency between Australian jurisdictions and ensure that graduates are provided with a structured foundation upon which to enter practice as a legal practitioner. These changes were also designed to provide a process for ensuring the quality of the workforce as the number of students completing undergraduate requirements and seeking employment was projected to rise.

Previously in Victoria, the pathway for admission as a legal practitioner was informed by the Legal Practice (Admission) Rules 1999. It involved the candidate firstly completing a Law Degree, then either a year of ‘articles’ as an articled clerk (generally with a legal firm or legal practitioner) or completing a course of practical legal training (PLT) at an accredited PLT provider for a period of at least six months. The candidate was instructed in ethics and professional responsibility, work management, legal writing and drafting, interviewing and communication skills, negotiation and dispute resolution, legal analysis, research and advocacy. This approach was reviewed following increased concerns about the potential lack of consistency between employers and the need to ensure that graduates received high quality preparation for independent practice.

The current approach to admission into the legal profession was enacted in the Legal Profession Act, 2004. Requirements for admission to the legal profession in Victoria are set out in the Legal Profession (Admission) Rules 2008 and now include specific requirements for both academic and practical legal training.

The academic qualifications involve completion of a course of study at an approved academic institution that includes subjects approved and determined by the Law Admissions Consultative Committee (LACC), together with a sufficient knowledge of written and spoken English.

During the course of study, students are able to apply for clerkships with legal firms. The clerkships are designed to provide a broad overview and real, practical experience. Each firm has different structures for exposing students to various

practice areas. Subsequently, clerkships provide a pathway to potential traineeships post study.

Following successful completion of a course of study at an approved institution, the candidate is eligible to undertake PLT. There are two options for completing PLT: an approved PLT course or supervised workplace training (SWT).

An approved PLT course is successfully completed by acquiring and demonstrating an appropriate understanding of and competence in each element of the following:

- **Compulsory skills:**
  - Lawyer’s skills
  - Problem solving
  - Work management and business skills
  - Trust and office accounting.

- **Practice areas:**
  - Compulsory areas: Civil litigation practice, commercial and corporate practice, property law practice;
  - Optional areas: One of administrative law practice, criminal law practice, or family law practice; and one of consumer law practice, employment and industrial relations practice, planning and environmental law practice, or wills and estates practice; and

- **Compulsory values:**
  - Ethics and professional responsibility.

In order to successfully complete SWT, the candidate must complete a period of at least 12 months under the supervision of an eligible person, with the training plan to be approved by the Board of Examiners. A supervisor for the purposes of undertaking SWT must be an Australian lawyer engaged in legal practice working principally in Victoria for a total of at least five years. Supervision can be conducted by more than one person. In addition, the candidate must:

- Acquire an appropriate understanding of and competence in each element of the compulsory skills, practice areas and compulsory values (described above)

- Acquire an appropriate understanding of and competence in the areas listed below through a course of instruction and program assessment conducted by a PLT provider. This includes satisfactorily completion of assessment requirements:
  - Ethics and professional responsibility
Upon completion of the PLT or SWT the candidate must apply to the Supreme Court for admission. Not less than one month prior to the appointed day of Supreme Court sittings in which the candidate intends to apply for admission, the candidate must serve on the Board of Examiners a notice of intention to apply, and post a copy of the notice in the Supreme Court. In support of the application for admission, and to satisfy the Board of Examiners that the candidate is a fit and proper person to be admitted to practice, the candidate is required to provide:

- An Affidavit of Disclosure
- Two affidavits as to character, each made by an acceptable deponent
- A criminal record check by the Chief Commissioner of Police
- Academic conduct reports from each approved academic institution or PLT provider at which the candidate studied.

If SWT has been completed, the candidate must provide affidavit by the person who executed the candidate’s training plan, a certificate by an approved PLT provider that the candidate has completed the compulsory skills, practice areas and compulsory values and an affidavit executed by each person who acted as a supervisor of the candidate.

With the application having passed the scrutiny of the Board of Examiners, the candidate must then attend the Supreme Court for admission. The ceremony is presided over by three Judges of the Supreme Court and involves the recital of oaths and affirmations, after which each candidate signs the Roll and receives the signed and sealed Order of Admission from the Prothonotary.

Despite the changes to the Legal Practice (Admission) Rules from 1999 to 2008, what remains is the focus on practical training. Former Law Institute of Victoria CEO John Cain stated that ‘The feedback we get from the profession is that articles is highly regarded and well thought of and there is a strong desire to retain some form of articles for admission to practice.’ He noted the impetus for the review in 2004 came from two main factors: the National Profession Project and the desire for consistency across Australia in graduate admission requirements. He believed
that with the increase in potential legal graduates, the system would come under tremendous strain in 2008\textsuperscript{149}.

The Law Council of Australia states that ‘the overall goal is to move towards a more functional and efficient Australian legal services market. The approach is to establish an integrated regulatory framework in each State and Territory that is underpinned by uniform legislation. This approach is expected to facilitate the seamless delivery of legal services throughout Australia. At the same time, the project aims to improve the overall level of protection for consumers of legal services’\textsuperscript{150}.

\textit{Discussion}

The approach to the preparation of lawyers following their undergraduate year is considerably different to approach to the graduate year for nurses. Lawyers are not considered to be fully registered to practice until they have completed a PLT or SWT, even though they have fully completed the undergraduate requirements. While practical experience is valued by the legal profession, as evidenced by clerkships, and the previous Articles training process, concerns regarding quality and standardisation of content have resulted in a pronounced shift to a structured training program.

\subsection*{4.5 International Nursing and Midwifery Models}

The challenge of supporting new graduate nurses to make the transition from academia to professional practice is common to health services across the world. As such, a plethora of different models have been devised to facilitate this process. The goal remains largely the same, namely to support, train, develop and assist nurses through a demanding stage in their careers. However, the systems put in place to accomplish this, including the structures and administration, funding mechanisms, principles and guidelines, eligibility, quality assurance and evaluation vary heavily across jurisdictions on local, national and international levels. There are currently no agreed international standards of best practice in nursing/midwifery graduate program development and implementation.


While graduate transitional models can vary greatly, some commonalities remain. For example, the need to foster a supportive environment for graduates, the requirement of organisational and professional orientation procedures and the need for knowledgeable and considerate preceptors are all regularly cited as important aspects of any graduate program. Table 6 below outlines a number of international graduate transition initiatives and highlights variations and commonalities found in models internationally.

The following section examines graduate nurse transition initiatives. This includes the national model implemented in New Zealand, the provincial model adopted in Ontario, Canada and the approach to nursing EGPs in the United States.

4.5.1 New Zealand

Background

The New Zealand Ministry of Health (the Ministry) developed the Nursing Entry to Practice Program (NETP Program) in 2005 following a review of nursing education and practice. A structured and consistent program was developed with guidelines explicitly outlined, including the provision of a learning framework and utilisation of optimal teaching methods. If an individual program meets the required specifications, standards and quality assurance, it may then apply for funding from the Ministry of Health.

Funding

Start-up costs were funded by the National Ministry of Health with further ongoing costs of $NZ 12,000 per graduate funded jointly by the Ministry’s Clinical Training Agency (CTA) and each local District Health Board (DHB).

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Eligibility

Eligible graduate nurses must hold an approved nursing degree, have graduated in the last 12 months, not practiced as a Registered Nurse for longer than six months and be employed as Registered Nurses at a minimum of 0.8 FTE within a DHB.

Program Delivery

It is the individual responsibility of the DBHs to develop, implement and administer the NETP programs. As such, graduate programs may vary in their organisation, length and content. Each DHB program is led by a program co-ordinator with experience in clinical nursing practice and clinical education. The Ministry stipulates that DHB programs must include two rotations of five-six months each in different service areas, or one 10-12 month placement.

All funded programs adhere to the NEPT Learning Framework to ensure national consistency of content, processes and outcomes of individual DHB programs.

NETP Evaluation

The NETP program underwent a national, independent evaluation in 2009. The findings of the evaluation were very positive, reporting that the program specifications reflected “the most successful and effective qualities of new graduate nursing programs as identified by international literature from the past decade”.

Discussion

The NEPT Program was developed to address the inconsistencies in the structure and quality of early graduate programs administered by regional Department of

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Health Boards. Taking into account the findings of the evaluation, this structure has provided a successful means of standardising EGPs, whilst guarding the autonomy of healthcare providers. The NEPT Program could therefore provide a valuable model for the regulation of EGPs in Victoria.

4.5.2 Ontario, Canada

Background

The Nursing Graduate Guarantee (NGG) is an initiative developed by the Ontario Ministry of Health and Long-Term Care\(^ {156} \). It aims to provide all new Ontario nursing graduates with the opportunity to work full-time in the province\(^ {157} \) and is designed to build nursing capacity within the Ontarian health care system.

Funding

Overall funding and control of the NGG rests with the Ministry of Health. However, HealthForceOntario (HFO), a subsidiary body functioning to identify and address Ontario’s health human resource needs\(^ {158} \), provides funding for temporary, full time, supernumerary positions for 26 weeks for NGNs. It is expected that these bridging positions will lead to permanent, full-time employment. If the employer terminates employment early, they must return the balance of funds to HFO. Employers commit to funding an additional six-week, full time position for the graduate if the NGN is not bridged into permanent full time employment within 26 weeks.

Eligibility

NGNs must have graduated from an Ontario accredited nursing program and be matched with an employer within six months of course completion. Additionally,

\(^{156}\) Under Canadian administration, the administration and delivery of health care services is the responsibility of the each province or territory (see Health Canada website: [http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/ptrole/index-eng.php](http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/ptrole/index-eng.php)).


NGNs must receive temporary registration with the College of Nurses of Ontario before commencing employment.

**Program Delivery**

Implementation of the program is managed by HFO. Guidelines for program delivery include extended orientation, the provision of an explicit definition of the role, a graduate learning plan and a variety of teaching and learning strategies. Central to the program is facilitating the transition of NGNs into fulltime positions with their matched program employers, or assistance in finding an appropriate alternative position.

**Evaluation**

The NGG was independently evaluated in 2009/10. The evaluation was commissioned to determine the impact of the NGG on full time employment of new nurse graduates in Ontario. Overall, the evaluation found that the NGG had resulted in an upward trend in full-time employment among NGNs in Ontario. It was recognised that a number of factors affect the employment trends of NGNs, including existing labour market conditions and the overall supply of graduating nurses in a given year. However, it was concluded that the three-year evaluation data “demonstrated the overall effectiveness of the NGG in integrating new graduates into the health care system”. 159

**Discussion**

In providing a guarantee of employment to graduating nurses, the Ontarian model differs from the other graduate schemes discussed in this review and indeed with approaches reviewed in other professions. While the NGG Program evaluation shows that this approach has succeeded in its main goal of increasing full-time nursing capacity in the workforce, question marks still remain over its impact on the autonomy of employer healthcare providers in the selection and retention of graduates.

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4.5.3 United States

**Background**

In the United States nursing transition to clinical practice varies depending on the setting and level of nurse education\(^{160}\). The National Council of State Boards of Nursing (NCSBN), the peak body for Boards of Nursing\(^{161}\) identified a number of issues associated with this high degree of program variation leading to a call for a national standardisation of the programs\(^{162}\). In addition, the Joint Commission\(^{163}\) recommended “a nursing equivalent of the Accreditation Council for Graduate Medical Education and funding to support this training.”\(^{164}\) Since 2002 the NCSBN noted that several EGPs have been very successful\(^{165}\). Key amongst these is accreditation with the Commission on Collegiate Nursing Education (CCNE).

**Funding**

Participation in accreditation with the CCNE is voluntary and attracts fees from the healthcare provider for both undertaking the accreditation process and ongoing

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\(^{161}\) In the United States, at state level, Board of Nursing license and approve qualified individuals and adopt and enforce legal standards for nursing education and nursing practice.

\(^{162}\) The term Nurse Residency Program is used in the United States rather than Early Graduate Program.

\(^{163}\) An independent, not-for-profit organization, The Joint Commission accredits and certifies health care organisations and programs in the United States: [http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx](http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx).


annual membership dues. Individual nurse residency programs are typically internally funded, or receive government grants for key initiatives being undertaken.

**Eligibility**

Only new graduates of baccalaureate degree nursing programs or entry-level post-baccalaureate\(^{166}\) degree nursing programs are eligible to participate in the residency program. Additional criteria, such as a cumulative minimum grade point average and nursing registration vary dependent on the state.

**Program Delivery**

Accredited programs must adhere to standards outlined by the CCNE. They include a curriculum that facilitates the transition to professional nursing, develops effective clinical decision making, incorporates research based evidence into practice, promotes leadership and formulates an individual career plan.

**Evaluation**

The CCNE accreditation evaluation consists of a review of the program’s mission, goals, and expected outcomes. A performance assessment of the program’s ability to achieve its goals through effective utilisation of available resources, programs, and administration is undertaken. The evaluation process also requires a review of evidence relating to the application of resources in assisting NGNs in attaining their educational goals.

**Discussion**

The CCNE Nurse Residency Programs Accreditation system provides a prescriptive approach to certifying standards in graduate residency program delivery. Providers provide a wide array of documentation and data, including the curriculum, resident evaluations, post-residency retention rates and employee surveys to attest to

\(^{166}\)There are three educational pathways that can be followed to become a registered nurse in the United States. The first is a three-year diploma program; another is an associate degree, most often offered by a community college; the last is a four-year baccalaureate degree offered at four-year colleges and universities: [http://www.peoriamagazines.com/ibi/2009/apr/importance-baccalaureate-degree-nursing-education](http://www.peoriamagazines.com/ibi/2009/apr/important-baccalaureate-degree-nursing-education). Baccalaureate programs must receive accreditation from the CCNE.
program quality. In practice, such requirements would likely be too onerous for most healthcare services in addition to the provision day-to-day patient care. It may be for this reason that since its introduction in 2008, only nine health care organisations (mainly hospital facilities) have gained CCNE accreditation\textsuperscript{167}. However, the CCNE Accreditation process does highlight various strategies that can be implemented to improve and standardise the provision of EGPs in Australia.

\textsuperscript{167} See list of CCNE accredited facilities: 
Table 4-4: Summary of International Graduate Transition Initiatives

<table>
<thead>
<tr>
<th>Jurisdiction and Initiative</th>
<th>Description</th>
<th>Elements</th>
<th>Performance measures</th>
<th>Status/Results</th>
<th>Length</th>
<th>More info.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Achieving Excellence in Professional Practice: Canadian Nurse Association’s Guide to Preceptorship and Mentoring.</td>
<td>General guide for setting up a mentoring and preceptorship for novice nurses.</td>
<td>Relevant terms defined</td>
<td>Reviewed literature</td>
<td>N/A</td>
<td>[Click here]</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Benefits cited</td>
<td>From literature identified increased graduate satisfaction, confidence, retention, and improved patient care.</td>
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<td></td>
<td></td>
<td></td>
<td>Costs explored</td>
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<td></td>
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<td></td>
<td>Steps for developing a successful program identified</td>
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<td></td>
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<td></td>
<td>Preceptor/mentoring</td>
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<td></td>
<td></td>
<td></td>
<td>Competencies identified</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The Scottish Executive</td>
<td>Flying Start in Scotland, NHS Scotland</td>
<td>Web-based program launched in January 2006. Over 1,200 new nurses have taken part in the program. Approximately 200 hours of didactic content, taking about 2-5 hours per week. Uniqueness in being a Web-based program.</td>
<td>Peers &amp; mentors meet online. Online modules include: Communication</td>
<td>Program evaluation.</td>
<td>1 yr</td>
<td>[Click here]</td>
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<td></td>
<td></td>
<td></td>
<td>Clinical skills</td>
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<td>Teamwork</td>
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<td>Safe practice &amp; policy</td>
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<td>Research for practice</td>
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<td>Equality and diversity</td>
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<td>Reflective practice</td>
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<td>PD &amp; career pathways</td>
<td></td>
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<tr>
<td>Ireland</td>
<td>Background available online with document entitled: &quot;Report of the Commission of Nursing,&quot; 1998.</td>
<td>Transferred from 3 yr apprenticeship program to a 4-yr program in 2002.</td>
<td>Students are paid during the EGP. During this period the students are still in their education program. This is accomplished through regulatory mandate.</td>
<td></td>
<td>36 wks</td>
<td>[Click here]</td>
</tr>
<tr>
<td>The State of Mississippi</td>
<td>Mississippi Office of Nursing Workforce Nurse Residency Program</td>
<td>6-month residency/internship program Implemented through the Mississippi Office of Nursing Workforce.</td>
<td>Coordinator Weekly meetings/seminars 2 weeks of a general orientation Unit orientation (or specialty content) Work up to a full patient load Preceptors mentor 1-2 residents/interns</td>
<td>Savings of $4 M through elimination of agency nurses &amp; $1.1 M through decreased turnover Reduction of vacancy by 47% Patient satisfaction increased 10% 80% completion rate</td>
<td>3-6 mths</td>
<td>[Click here]</td>
</tr>
<tr>
<td>Jurisdiction and Initiative</td>
<td>Description</td>
<td>Elements</td>
<td>Performance measures</td>
<td>Status/Results</td>
<td>Length</td>
<td>More info.</td>
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</tbody>
</table>
|**The State of Wisconsin**<br>Wisconsin Nurse Residency Program (WNRP)| State-wide with 40 plus hospitals, including a large rural group, which is a unique aspect of this program. They have enrolled over 300 new graduates in this program. | • Clinical coach  
• Learn to think professionally  
• Meet once a month  
• Reflection and feedback  
Focus on:  
• Critical thinking  
• Best practice  
• Delegation | Review job stress, organisation commitment, clinical decision-making, & professional behaviour. Tools include:  
• Porter and Steers  
• Organizational Commitment  
• Professional Nursing | Increase of retention; rural settings found it highly beneficial. | 12 mths | [Click here] |
|**New Zealand**<br>The Nursing Entry to Practice Program (NEPT)| National program regulated by the NZ Ministry of Health with programs administered by the 17 regional Department of Health Boards. NEPT aims to bring all EGPs in NZ to a national recognised standard while guarding local autonomy. | • Two rotations of 5-6 mths in different service areas, or one, 10-12 mth placement.  
• Clinical preceptor support, sharing the clinical load for 6 wks total  
• 12 group learning/study days | Program Evaluation | Enhanced trainees confidence and competence though a supported first year of practice  
Positive impact on recruitment and retention | 10-12 mths | [Click here] |
|**Ontario, Canada**<br>The Nursing Graduate Guarantee Initiative| The Nursing Graduate Guarantee (NGG) aims to ensure every new Ontario nursing graduate who wishes to work full-time in the province has that opportunity. (see details below) | • Orientation - 12 wks  
• Extended orientation 14 wks,  
• Employer-Funded - 6 wks  
• Employer expected to make all efforts to appoint the graduates into full time positions | Program Evaluation | Upward trend in full-time employment among newly graduated nurses in Ontario | 12-32 wks | [Click here] |

5 Appendix E: Contributors

This research project was made possible with input from the following contributors:

Alfred Health
Australian Nursing Federation
Ballarat Health Services
Bass Coast Regional Health
Benalla Health
Bendigo Health
Central Gippsland Health Service
Colac Area Health
Deakin University-Northern Health Clinical Partnership
Department of Health and Human Services, Tasmania
Department of Health, Victoria
Eastern Health
EGP Coordinators Network
Gippsland Health Services Consortium
Goulburn Valley Health
Latrobe University Alfred Clinical School
Latrobe Regional Hospital
Melbourne Private Hospital
Mercy Mental Health
Northeast Health Wangaratta
Postgraduate Medical Council of Victoria
Queensland Health
Ramsay Health Care
Royal Women’s Hospital Melbourne
South Australian Health Department
Western Australian Health Department