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Practice readiness in very remote hospitals: Perceptions of early career and later career registered nurses

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ABSTRACT

Aim: To understand the practice readiness of the early career registered nurse in their first five years of practice within very remote hospital healthcare provision.
Background: The practice readiness of early career registered nurses is often questioned; this is particularly true of nurses in rural and remote settings where, due to a transitory workforce, adequate support may not be forthcoming.
Method: Qualitative descriptive design using semi structured interviews involving early career (n = 4) and later career (n = 3) registered nurses in very remote hospitals. Data were analysed using Creswell's six-step approach to thematic analysis.
Findings: Practice readiness includes both professional and personal readiness. Early career registered nurse participants felt not ready for remote area employment. Later career registered nurses suggest that critical care placements in an emergency department or intensive care unit are necessary for preparedness to work in rural and remote areas. Key to supporting and developing practice readiness is organisational support, adequate, consistent staffing, and structured orientation across all departments.
Discussion: Early career registered nurses understand their limitations; however, organisational support through appropriate orientation, supernumerary time, and adequate education is often not available.
Conclusion: To support early career registered nurses to be practice ready, it is the organisation's responsibility to provide the adequate support, information, and preparatory education to ensure an effective transition to practice for future proofing of the rural and remote nurse workforce.

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Summary of relevance

Problem or Issue
Higher turnover of nursing staff in rural and remote area requires action to support and retain those who choose to work in these settings.

What is already known
Provision of remote healthcare is challenging, socially isolating, and often confronting. Early career registered nurses require support to assist practice readiness, especially in remote contexts.

What this paper adds
Practice readiness includes both professional and personal readiness. Therefore, specific courses and organisational orientation and support are necessary to optimise practice readiness for remote nursing.

1. Introduction

Australians living in remote and very remote areas experience health workforce shortages despite having greater need for services (Australian Institute of Health and Welfare [AIHW], 2019; Wakerman et al., 2019). The AIHW (2019) data demonstrates people living in very remote areas (see Table 1 for definitions) are hospitalised at twice the rate and have a 1.4 times higher disease burden as compared to their metropolitan counterparts. With the reported difficulties in staffing remote hospitals (Government of Western Australia, 2020; Smith et al., 2019), attracting nurses who are willing to work in remote areas is complex. However, should these willing registered nurses be early career registered nurses (ECRN's) or newly graduated registered nurses, a qualified workforce with limited experience (Juliff, 2017; Mitchell, 2019), the question is then, are they 'practice ready' to handle this unique clinical setting? (Capper et al., 2020).

2. Background

2.1. Remote healthcare provision

Remote healthcare is a unique and challenging environment, with lower staffing levels, high turnover, and more generalised clinical knowledge and capabilities required (Government of Western Australia, 2020; Smith et al., 2019). With ECRNs limited experience and low self-efficacy, a sound understanding of the needs of the practice environment to support the ECRN is imperative (Wang et al., 2018). Challenges to attracting and retaining appropriately skilled nurses to remote locations include access to medical staff, staff development support, and specialist knowledge, the community context, the vast distances to other services, and the ensuing social isolation (Smith et al., 2019; Wakerman et al., 2019).

Hospitals classified as remote, or very remote, have significant barriers to recruitment and retention of registered nurses (RNs) (Australian Institute of Health and Welfare 2019; Government of Western Australia, 2017). Providing healthcare in geographically remote areas is significantly challenging and attracting and retaining appropriately skilled nursing staff proves to be an ongoing issue (Smith et al., 2019; Wakerman et al., 2019). The nature of emergency department (ED) presentations in these locations encompasses the full spectrum of illness and injury, as well as diseases not generally encountered in metropolitan hospitals (Sedgwick & Pijl-Zeiber, 2015). The RN in these settings requires a broad general knowledge base (Sedgwick & Pijl-Zeiber, 2015) and, as the majority of rural hospitals staff both ward and EDs combined, experience in emergency, or critical care nursing is deemed a necessity (Government of Western Australia, 2020).

Positive practice environments with appropriate organisational support and development, coupled with a sound understanding of the ECRN's learning and development needs, has the potential to provide improved job satisfaction, workforce stability and capability to provide safe, quality patient care in the context of remote healthcare provision.

2.2. Nursing workforce

The Australian health workforce demand for nurses is expected to increase by 15% by 2025, while it will also experience significant nursing shortages due to ageing and current retention challenges (Hamer & Guilfoyle, 2019). Workforce projections indicate that by 2030, the demand for nurses will exceed supply (Health Workforce Australia, 2014; World Health Organisation, 2016).

Significant research has been undertaken to understand high attrition, especially among junior nursing staff, which combined with the ageing nursing workforce, is projected to have a significant effect on health services' abilities to adequately staff hospitals to ensure safe, quality patient care (Mills et al., 2017; Wang et al., 2018). Rural and remote healthcare is further impacted by an even greater rate of nursing turnover than the metropolitan hospitals (Cosgrave et al., 2018).

Each year, in Australia, thousands of new graduate nurses flood the market, however, Christopher et al. (2015) report significant mismatch between the number of graduate nurses securing graduate program positions and the ongoing nursing workforce shortages. This has a compounding effect, as seen with ECRNs reporting they are unable to secure other positions because they lacked relevant experience, or upon securing a position, did not receive the support necessary to progress their knowledge and skills (Christopher et al., 2015; Mitchell, 2019). Transition to Practice

Table 1
Definitions.

Early career registered nurse	For the purpose of this study, Early career registered nurses are defined as RNs in their first five years of postgraduate practice (Djukic, et al., 2013; Mills et al., 2017; Sedwick & Pijl-Zieber 2015).
Practice readiness	Practice readiness refers to the ability to enter the workforce with the knowledge, skills, and ability to promptly and smoothly become a valued member of the healthcare team; and to be able to transition with minimum stress (Wolsky, 2014).
Later career registered nurse	An RN with greater than five years of experience. According to the Australian Nursing Federation (2019), this classification would equate to RN level 1.5-1.8 or RN level 2 or above.
Very remote	Remoteness in Australia is determined by the Accessibility Remoteness Index Australia (ARIA) whereby the determination is based on measures of distance between populated locations and service accessibility. Towns are given a service centre category, where according to the population size, the indicative services provided to service the population are given one of five categories. Distances from a population size greater than 12000 to the nearest service centres are then indexed with values ranging from 0.00 (highly accessible) to 15.00 (highly remote). (Hugo Centre for Population and Housing, 2020a).

RN, registered nurses.

and Graduate Registered Nurse programes are conducted widely in Australia, however, there are limited quarantined positions available to support the year of transition from student nurse to competent RN. It has been reported that 67% of nursing graduates in Western Australia (WA) were not able to secure a graduate programe in 2018 (Mitchell, 2019). However, permanent positions may not be available at the completion of that transition year, yet with 15% of the WA rural nursing workforce aged over 60, and 40% aged over 50 (Government of Western Australia, 2020), the number of nurses soon retiring exceeds the number of incoming graduates (Fowler et al., 2018). Making the most of the opportunity to increase focus on the recruitment and retention of ECRN's seems pertinent.

The AIHW (2019) report a steady increase in the number of nurses and midwives aged 20-34 between 2013 and 2018, a large proportion of which are in their first five years of professional practice. However, ECRN's have a higher rate of turnover than any other group of nurses, with up to 55% of Australian nurses in their first five years choosing to leave the profession (Capper et al., 2020). The average annual turnover in Australia is approximately 15% among all nurses (Capper et al., 2020). The key to mitigating the risk of the projected nursing shortfall is to employ new nurses, but of great importance, is to retain the nurses already employed (Cosgrave et al., 2018; Onnis & Pryce, 2016).

Considering these issues, this study sought to understand the perspectives of both ECRNs and later career RNs concerning the readiness for practice of ECRNs to work in very remote areas to better support transition and subsequent retention.

3. Aim of the study

The purpose of this research was to explore the meaning of practice readiness from the perspectives of ECRNs and later career RNs in relation to very remote hospital healthcare provision.

4. Methodology

There is a dearth of literature pertaining to the practice readiness perceptions of the ECRN, outside the focus of new graduates and transition to practice, thus the use of a qualitative descriptive approach was deemed appropriate to garner rich narrative of the participants perceptions of their experiences (Doyle et al., 2020). Semistructured interviews focused on the ECRNs' perceptions as to their readiness to work in these settings, plus the insights gained of the perceptions of later career RNs, allowed the researcher to build an understanding of what practice readiness means to the individuals and the organisation (Doyle et al., 2020).

This research was guided by El Haddad et al. (2017) substantive theory of *Practice Readiness: A Nebulous Construct* which postulates that "…the nature of practice readiness is nebulous, which denotes it's vague and ill-defined nature" (p. 394). *Practice Readiness: A nebulous construct*, illustrated in Fig. 1, can be applied to any nurse moving into a new environment, where the system drivers decide what is required and the *Inhabiting Disparate Realities* underpin understanding that views may vary between expectations and contextual requirements (El Haddad et al., 2017).

5. Ethical considerations

Ethical approval was granted by the University Human Research Ethics Committee (2021/022) and by the organisation's ethics committee (RGS0000004650). Recruitment was conducted through a third party and interviews were arranged at a time and venue that was mutually agreeable.

Confidentiality and privacy were assured through de-identification of data. Consideration was also made in transcription regarding potentially recognisable language that could identify any participant.

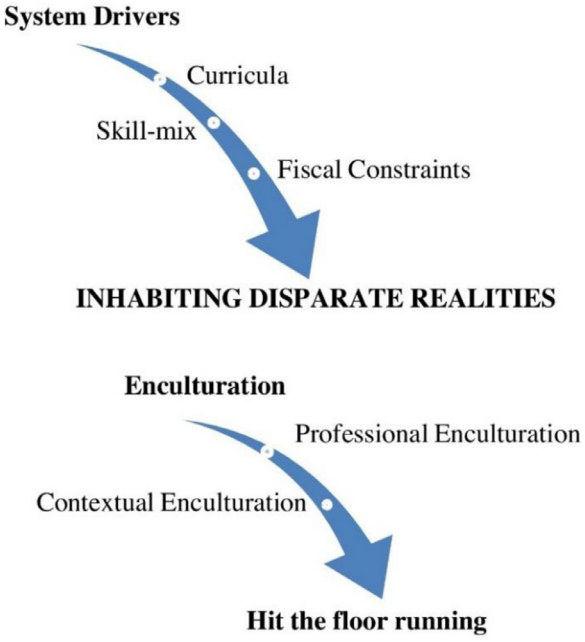

Fig. 1. The El Haddad (2016) substantive theory. Practice readiness: A nebulous construct.

5.1. Setting and participants

Purposeful sampling was used to invite ECRNs, with and without a graduate program, and later career RNs, by email via a third party, to participate in an interview to provide a balanced view of the ECRN's perceptions and those of the nursing staff that manage and support them from within remote hospital sites. The total number of staff meeting the inclusion criteria across the sample sites was 44 (N = 44), 36 later career RNs (N = 36), and nine ECRNs (N = 9).

The research was conducted across two very remote hospitals in one country area health service of WA. Both hospitals are located over 2500 kms from the nearest capital city and have total populations of 4500 people, over 80% of whom identify as Aboriginal (Australian Institute of Health and Welfare 2019). Both hospitals have ED beds and inpatient beds.

5.2. Data collection

Semistructured interviews were conducted one-on-one with each participant. Interview questions were developed from the findings and themes identified from the literature review and concerned self-efficacy, perceptions of practice readiness, and support mechanisms. Interview questions included 'What made you choose a very remote hospital?' and 'Did you feel prepared and capable to work here?' for the ECRNs, and for the later career RNs, 'How do you feel about ECRNs being employed in these very remote locations?' and 'What support do you think is required to support development and provide safe, quality care in these settings?'. Each interview lasted approximately 30 minutes. The interviews were voice recorded to support verbatim transcription. Verbal and written consent was obtained before commencement of each interview. Transcriptions were returned to the participants to verify accuracy.

Table 2
Participant demographics.

Participant	Age group	RN level	Grad programe?	Experience?
ECRN	<25	1.2	No	Metropolitan raised, no remote experience, ho hospital experience after graduation
ECRN	<25	1.3	Yes – tertiary hospital	Metropolitan raised, no remote experience
ECRN	25-30	1.4	Yes – tertiary hospital	Metropolitan raised, 2 years metropolitan experience, no remote experience
ECRN	>35	1.1	Incomplete remote hospital graduate program	Rural raised, previous experience in remote jobs including healthcare
LCRN		1.5	N/A	N/A
LCRN		1.7	N/A	N/A
LCRN		>1.8	N/A	N/A

ECRN, early career registered nurses; RN, registered nurses; LCRN, later career registered nurses

5.3. Trustworthiness

Rigour was demonstrated under the criteria of credibility, confirmability, dependability, and transferability (Bradshaw et al., 2017). These were achieved through establishing rapport and building trusting relationships with the participants, where they felt safe to speak openly and honestly without fear of reprisal. Transcripts were verified and validated by the participants, and an audit trail was established describing the study processes (Bradshaw et al., 2017).

5.4. Data analysis

Analysis was undertaken through interpretation of the findings and sorting them into themes by coding the data using the six steps described by Creswell (2014, p.198). Coding is a major component of this process and is used in developing categories and sub-categories gleaned from the interview transcriptions (Creswell & Poth, 2018). Themes were developed using thematic analysis (Creswell & Poth, 2018). To attain dependability and confirmability of the data, the analysis process was reviewed by two qualitative expert supervisors. The thematic analysis was supported by verbatim excerpts from the transcribed interviews Data saturation was achieved.

6. Findings

Seven participants consented to participate in the study, four ECRNs and three later career RNs (LCRNs) across both sites. Basic demographics are outlined in Table 2. The key question posed was regarding the perception of whether ECRNs were practice ready to work in these very remote hospitals. Three of the four ECRNs interviewed felt they were not practice ready, each citing they had no concept of the hospital or environment they were going to work in. Three main themes emerged through analysis: practice readiness; professional development and support; and remote health service staffing and education. Subthemes were also found, and each will be discussed to follow.

7. Theme 1: Practice readiness

Practice readiness as a term delivered two subthemes. These were with reference to knowledge and skill, or clinical practice readiness, versus the personal readiness for practice and the local environment.

7.1. Subtheme: Clinical practice readiness

When asked about their university preparation in terms of being practice ready to work in a very remote hospital, one participant responded:

> "No, no, I don't think so…there had been only one unit on indigenous health over the three years." (E4)

Two of the ECRN participants had undertaken a graduate registered nurse program of one year and continued to work in large metropolitan tertiary hospitals before being employed in a remote area. These participants did not feel practice ready for this remote setting, however participant E3 had previous experience in a remote hospital, a passion for remote healthcare, and despite having only completed six months of a 12-month graduate program, felt practice ready.

> "I would say yes. Whether that's as much from a practice perspective or a personal perspective, in myself, I was ready." (E3)

Later career RN participants asserted that ECRNs require a graduate program to be clinically practice ready for remote nursing. Participant L1 did not feel that having 'just any' graduate program makes the ECRN practice ready, rather, that they required a critical care placement in the ED or Intensive Care Unit in that programe. The rationale would be assessment skills developed in these environments may translate to safer care in the very remote hospital ED. This participant states:

> "… when you lack the confidence in your assessments or how you interact with the patients in that emergency setting then you obviously miss out on the critical things that you have got to look at when the person is really sick." (L1)

7.1.1. Whereas participant L3 responded

> "I don't think the answer is yes or no… some nurses are definitely ready…and some … are definitely not."

Notably, participant L2 felt that ECRNs were not practice ready with or without a graduate program and required a much wider nursing experience.

> "In a regional hospital, it's you! There's so much responsibility put on you. … for safety reasons, I don't think a [RN level] 1.2 or 1.3 should be out there." (L3)

7.2. Subtheme: Personal preparedness

The ECRN participants cited that they would have felt better prepared if they understood the environment, the community, and the health service before commencement. However, as E4 explained, they had been given a rundown of the hospital and where it was and that it was predominantly an indigenous population however:

> "I really didn't know what to expect. I think in my first three months, I really didn't think that I was able to do it, I really struggled…" (E4)

One participant asked for an outline of the health service and an explanation of the hospital before accepting a position which gave them a little more confidence. However, when researching the town this participant stated:

> "I looked it up and thought, wow, that's really in the middle of nowhere…" (E1)

The ECRNs were further surprised by the number of other duties that are normally undertaken by different staff in a large hospital such as pathology tests, patients' laundry, reception, organise Patient Assisted Transport Service, and the restocking of pharmacy were undertaken by nursing staff.

All participants cited cultural awareness and culturally appropriate care as an integral part of being ready to practice providing safe quality care in the remote setting.

> "You get an online module to do but you don't get much cultural advice. You just learn as you go from other nurses, which is huge because you are just gung-ho, you just go in to do stuff up here." (E2)

In discussing practice readiness with the later career RNs, reference was made to the individual's attitude, calibre, experience, and goals as supporting whether they are practice ready or not to work in these very remote locations. One participant stated:

> "I've seen people [nurses] get off the plane have a look around and get straight back on the plane." (L3)

8. Theme 2: Professional development and support

8.1. Two subthemes emerged under this theme

8.1.1. Subtheme: Essential courses

Advanced Life Support (ALS) and Paediatric Advanced Life Support (PALS) courses before starting or very soon after employment was noted by the ECRNs as necessary. Without this advanced education they felt they were unsafe in ED, and that their ability to provide quality care for patients was compromised.

> "If I'd done the [ALS] course, I would have had the knowledge. Even if I had the skills, mentally I was just standing back – 'I don't know, this is way out of my comfort zone'." (E2)

> "Maybe just even your ALS and PALS, … but maybe having that... so you get more of an understanding." (E1)

ECRNs stated they were 'chucked in the deep end' to sink or swim. They said:

> "There was no sort of, like system…. or systematic approach to ward or ED. I was chucked in the deep end. Either there was an 8-patient load on the ward, which was always, or just getting hammered in ED, a sort of sink or swim sort of situation." (E4)

> "I'm being put in ED as the ED nurse when you're not just picking up the bits and pieces that you can do, but actually taking full care of the patient." (E3)

When asked about working in ED E2 stated

> "It was pretty much immediate, because I remember I wasn't too chuffed about it." (E2)

Another course identified by both groups of nurses that had major impact on managing ED presentations and admissions, concerned family and domestic violence. Participant L1 outlined that '*some of these things are very disturbing*.' Participant E4 reflects

> "The things I saw were quite traumatic. A lot of domestic violence and family violence, I was just so shocked." (E4)

Both remote hospital settings deliver the ambulance service for the local areas. Every ECRN felt unprepared or ready to work on the ambulance callouts as they had not undertaken the preparatory course making them feel very unsafe and scared, placing their patients at risk. Participant E2 spoke of just having completed the ambulance course over two years after commencement saying:

> "I wasn't used to the ambulance at all, I was freaking out….I've only just done [the ambulance course] it last week, 2 years after I started...I think you are supposed to do it in the first three months" (E2)

8.1.2. Subtheme: In-house support

Across both ECRNs and later career RNs, the theme of in-house support was recognised through the availability of structured orientation, a designated mentor or preceptor. Later career RNs suggested that all ECRNs have someone allocated to them for six months.

Both cohorts discussed the need for learning to be self-directed and each ECRN was happy to ask questions when they felt they needed to. However, as one participant pointed out that a mentor/educator/clinical preceptor available to support learning on a shift-by-shift basis would be helpful because:

> "…you don't know what you don't know." (E1)

Participant E1 felt that a structured orientation would have assisted to support the integration into the small hospital setting where caring for the patient is not just the clinical care. They said:

> "I don't think anything is going to prepare you for [the town]. She [my mother] was right, it [the university] really didn't, it is really different. I've never seen anything like it!" (E1)

8.2. ECRNs also felt there should be a proper ED orientation. E3 said of their experience

> "We had really good supernumerary time on the ward, but nothing in ED. There needs to be more ED development, more ED supernumerary time and training." (E3)

9. Theme 3: Remote health service staffing and education

Both the ECRN and later career RN participants spoke of staffing as being a major limitation and having the biggest impact on being able to support the ECRN to learn and to provide safe patient care in the remote setting.

When asked did they feel they had senior support to learn, the ECRNs felt that adequate senior support was not available.

> "One of our more senior nurses made a point of sitting down and saying, 'how do you feel that you've been supported and what can we do better?' and took what I said on board. Unfortunately, she's not here anymore." (E3)

> "I think it is pretty hard because most of the staff are agency staff… There was some you could tell knew what they were doing, and there was some …. who weren't." (E4)

> "They try in a way, but it really doesn't work because we are always understaffed, always minimally staffed. Unfortunately, it's one of those environments where you sink or swim. I just don't really know how to change that without saying we need all the staff that metro does." (E2)

Some later career RNs raised concerns there was no suitably qualified staff to provide ongoing education and lack of support from regional and district staff, with these participants stating:

> "…They actually need support to be able to train." (L3)

"…Having someone coming out to go through a few scenarios and spend time with new staff would be beneficial... I just had to wing it." (L2)

10. Discussion

Very remote hospitals are challenging and complex environments for the provision of health care (Smith et al., 2019; Wakerman et al., 2019). Both sample sites are in very remote Aboriginal communities with significant socioeconomic, intergenerational trauma, and chronic disease issues that impact hospital presentations and the ability to build rapport (Gwynne & Lincoln, 2017). Participants undeniably asserted that their clinical skills and knowledge did not meet the requirements of practice readiness in these environments. Practice readiness was as much about their clinical capability as it was about the remoteness and the cultural context of the community that had most impact on their nursing.

Wang et al. (2018) use the term 'self-efficacy' as the mechanism by which the ECRN would believe they were ready to perform in the practice environment. Only one participant felt they were practice ready based on their previous experience, yet clinical skill did not form part of their perception as being practice ready. Newcomers of any experience go through an adjustment period which effects their practice readiness both personally and professionally (Cosgrave et al., 2018). By understanding the definition of practice readiness as a self-efficacy measure of the ECRN, organisational support can be prioritised to ensure self-efficacy can be improved for nursing staff (Wang et al., 2018).

In aligning with El Haddad et al.'s (2017) ubstantive theory of *Practice Readiness: a nebulous construct,* the system drivers of skill-mix effect the level of educational support and impact on the staffing numbers that remain. *Inhabiting Disparate Realities* (El Haddad et al., 2017) is reflected in the newcomer's expectations and lack of understanding of the remote nursing context, where all ECRNs felt they were 'chucked' or 'thrown' into ED before they were prepared both personally and clinically.

In juxtaposition to the organisations' expectations of the newcomer to be able to 'hit the floor running' (El Haddad et al., 2017, p. 394), this study found staffing levels and high staff turnover had significant impact on the perception and experience of senior support, mentoring and clinical education. Rural and remote healthcare is impacted by a greater rate of nursing turnover than the metropolitan and larger hospitals (Cosgrave et al., 2018; Onnis & Pryce, 2016).

To grow our own nursing workforce, organisations need to deliver adequate support to ECRNs to stabilise, and hopefully, ensure the nursing workforce of the future (Gwynne & Lincoln, 2017; Sedgwick & Pijl-Zieber, 2015). Provision of support mechanisms would improve the capability of the ECRN to practice safely whilst developing skills over time (Murray et al., 2020; Spence Laschinger et al. 2016). Secondment to regional hospitals could further support ECRN clinical development. Provision of the preparatory ambulance course, ALS/PALS courses, and a cultural safety course in addition to a thorough orientation to rural and remote health and ED should be delivered to all ECRNs upon commencement of employment.

Establishing a mentor program for nurses, whether on-site or available elsewhere in the region that can support both their clinical and personal journeys, as well as structured supernumerary time in ED, and a structured overarching orientation program are required. Senior nursing staff also requires education to provide effective mentorship and support to new staff. There is also need for dedicated education staff that are available either on-site or on an ad-hoc basis through teleconferencing to support staff of all levels.

11. Limitations

The small sample size of this study is acknowledged and focused on two small hospitals in one Australian state. Further research is required of other like services where remoteness, similarities in size and purpose of the health services align, to provide deeper insight into the experience of ECRNs.

12. Conclusion

Attracting and retaining appropriately skilled nursing staff is an ongoing issue for geographically remote areas. ECRN are a valuable resource, armed with the latest evidence-based skills and knowledge, and a willingness and enthusiasm to put these skills into practice. Healthcare organisations are responsible for providing appropriate and timely support to all staff, especially those new to the setting as preparedness is related to nursing context. Senior nurses and managers need to have the capacity to provide adequate and appropriate orientation, supported supernumerary time, and/or context specific education to support ECRN transition for safe practice, professional development, and culturally appropriate quality nursing care.

Authorship contribution statement

All authors have contributed to the concept and design of this research. This research was based upon a paper required for partial completion of a Master of Health Care Management degree conducted by the first author. Therefore, the first author recruited the participants, collected and analysed the data. All authors assisted with the formation of the original concept, provided input and advice in the data analysis, and were responsible for proofreading and editing

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Ethical statement

Ethical approval was granted by the Murdoch University Human Research Ethics Committee (2021/022) and by the Western Australian Country Health Service Human Research Ethics Committee (RGS0000004650). Ethical approval was granted May 2021.

Conflict of interest

This article is the authors original work, the article has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted and the authors abide by the copyright terms and conditions of Elsevier and the Australian College of Nursing.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.colegn.2022.07.003.

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