An ethnographic study of the new graduate nurse's experience when encountering the culture of acute mental health services

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“And what is the use of a book,” thought Alice,

“without pictures or conversations?”

Lewis Carroll

Statement of originality

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

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Acknowledgement of Authorship

I hereby certify that the work embodied in this thesis contains published paper/s/scholarly work of which I am a joint author. I have included as part of the thesis a written declaration endorsed in writing by my supervisor, attesting to my contribution to the joint publication/s/scholarly work. By signing below I confirm that Mary-Ellen Hooper contributed by way of conducting the article reviews, creating the framework of the paper including the bulk of the content included within the paper, and drafting and critical revision of the paper so as to contribute significantly to the final output, to the paper/publication entitled: Hooper, M. E., Browne, G. & O'Brien, A. P. (2016). Graduate nurses' experiences of mental health services in their first year of practice: an integrative review. *International Journal of Mental Health Nursing*, 25, 256-298. This contribution involved

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Publications and presentations from this research

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Abstract

There is a global shortage of mental health nurses at a time of growing demand for mental health care. Several factors explain this shortage including low numbers of nurses entering the discipline, the ageing of the mental health nursing (MHN) workforce and the loss of nurses to early retirement. Research demonstrates that nurses who choose to enter MHN after graduation frequently abandon the discipline after reporting negative clinical experiences and inhospitable work cultures.

The purpose of this thesis was to contribute to new knowledge through a review of the literature and an ethnographic exploration of the experiences of nurses new to MHN to ascertain how these experiences related to their attraction to, and intention to remain in, the field. Schein's (2010) model of organisational culture provided the theoretical framework to explore the new nurses' experiences.

An integrative review of the literature concerning the experiences of new graduate nurses entering mental health nursing was carried out and published in 2016 and the literature was reviewed again in 2020-2021. Results from the literature reviews and the ethnographic study comprise this thesis. For this study, a purposive homogeneous sample was recruited. Participants were the researcher; and 14 newly graduated nurses (NGs) and 12 recent graduate nurses (RGs), working in six mental health units in three metropolitan hospitals in New South Wales, who had graduated from one of 10 Australian universities.

Data were collected using non-participant field observation, semi-structured interviews, and the use of reflexive and field notes. Reflexive thematic content analysis (Braun & Clarke, 2006) was used to determine patterns in the data. Four base themes emerged from the data revealing what can influence new nurses to enter, and remain in, MHN. These were: attraction, transition, entering practice, and assimilation into the culture of MHN. Subthemes associated with attraction to MHN included the amount and quality of undergraduate exposure, with greater exposure and positive clinical experiences more likely to attract nurses to MHN. Other attributes of MHN considered attractive were being able to help people, the holistic, less-task oriented nature of mental health care, and the unpredictability, complexity, and flexibility of MHN which was considered exciting. Conversely, the social stigma associated with mental health consumers, and those who chose this field of nursing, made MHN less attractive.

In respect to transition, the imperfect nature of the new graduate programs (NGPs) was emphasised with some nurses finding NGPs useful in offering opportunities for debriefing and ongoing learning, while others found them to be a waste of time and irrelevant in that they repeated too much of the undergraduate curricula and did not acknowledge new nurses' individual differences in knowledge and experience. Progress through the NGPs was reported to be stressful, apropos to managing NGP requirements at the same time as transitioning into MHN practice and uncertainty related to gaining ongoing employment.

As they transitioned into clinical practice, new nurses described experiencing transition stress. Lack of support during this period was emphasised. While new nurses enjoyed learning new skills and forming both professional and social relationships with other staff and therapeutic relationships with mental health consumers, discord between their expectations and the realities of MHN clinical practice was experienced. Emphasis was placed on how the historically derived role of gatekeeper jarred with the concept of consumer-centred holistic care. Difficulties in defining the role of the mental health nurse and understanding their place in the multidisciplinary team were also experienced by the participants. Communication among cultural members was viewed as an important component of MHN.

New nurse's experiences of assimilating into the culture of MHN centred on moving from the position of outsider to insider. Viewing the experiences of new nurses through the conceptual lens of culture, as found in Schein's model, revealed how the artefacts, values, and assumptions inherent in the MHN culture affect new nurses' assimilation. It was observed and reported that the prevailing culture determined the new member's 'goodness of fit' and rejected those who are not deemed to hold the 'right' values and beliefs. 'Fitting in' was seen as a way to secure ongoing employment, while exclusion from the culture could result in unemployment or the need to 'start again' and train in another field.

This thesis provides, for the first time, the use of ethnography as a novel approach to exploring the experiences of nurses entering the culture of MHN. The findings have implications for the recruitment, training, and maintenance of the MHN workforce. They do this by highlighting the importance of undergraduate exposure to MHN. They outline deficiencies in the ways new nurses currently transition into MHN which can be used to modify existing NGPs and arrangements for the support of new nurses in mental health units. Findings highlighted the discord, experienced by new nurses in many fields, between their ideals of practice and the reality of current philosophies of care which can give rise to transition shock. The cultural characteristics of the organisation were important determinants of new nurses' assimilation into the culture of MHN. Adoption of the recommendations made at the conclusion of this thesis could benefit MHN and mental health care now and into the future, by increasing attraction to, and retention in the field.

Table of contents

Appendices

List of tables

List of figures

Abbreviations

ADL – Activities of Daily Living

AIN – Assistant in Nursing

AWOL – Absent Without Leave

CNC – Clinical Nurse Consultant

CTO – Community Treatment Order

ECG – Electrocardiographs

ECT – Electroconvulsive Therapy

EEN – Endorsed Enrolled Nurse

EMR – Electronic Medical Record

GP – General Practitioner

HASA – Health and Safety Assistant

HETI – Health Education Training Institute

IMI – Intramuscular Injection

IPU – Inpatient Unit

ISBAR – Identity, Situation, Background, Assessment, and Recommendation

MHICU – Mental Health Intensive Care Unit

MHIPU – Mental Health Inpatient Unit

MHN – Mental Health Nursing

MHPOD – Mental Health Professional Online Development

MDT – Multi-Disciplinary Team

NIC – Nurse in Charge

NG – New Graduate Nurse

NGP – New Graduate Program

NUM – Nurse Unit Manager

OOA – Out of Area

OPMHU – Older Persons Mental Health Unit

PECC – Psychiatric Emergency Care Centre

PRN – Pro Re Nata

RG – Recently Graduated Nurse

RN – Registered Nurse

Chapter One
Introduction

"*Begin at the beginning, the King said gravely,*

and go on till you come to the end: then stop."

Lewis Carroll

1.1 Introduction

It has been established that there is a growing shortage of nurses worldwide, with this shortage more pronounced in mental health nursing (MHN) (Drennan & Ross, 2019; McAllister et al., 2014). Several factors have been suggested to explain the shortage of mental health nurses: the ageing of the workforce, nurses retiring early, and the low numbers of nurses entering the discipline – with MHN considered an unpopular choice for nursing graduates (Benjenk et al., 2019; Harrison et al., 2017). In addition to senior nurses retiring early, a number of new nurses leave MHN early in their career (Hercelinskyj et al., 2014). Labrague and De Los Santos (2020) found that up to 60% of new nurses considered leaving the profession during their first year of practice. The literature emerging around the experiences of nurses entering MHN suggests that the organisational culture may play a role in the attraction and retention of nurses to the field (Hooper et al., 2016; Kurjenluoma et al., 2017).

Although the growing shortage of nurses represents a concern globally, with widening gaps between supply and demand, the shortages in MHN continue to be more pronounced (Drennan & Ross, 2019; McAllister et al., 2014). Modelling, conducted by Health Workforce Australia (HWA) in 2014, predicted a shortfall in the mental health nursing workforce of approximately 11,500 to 18,500 full-time equivalents (FTE) by 2030, the largest undersupply (approximately 60%) of all nursing sectors (Health Workforce Australia, 2014). The HWA suggested that the factors contributing to this result included the ageing of the workforce – 57% are aged over 45 years (Australian Institute of Health and Welfare, 2019a), high exit rates - more than 19,000 indicating retirement at age 65 years and with low numbers of new entrants into the workforce in the younger age groups – only 25.4% of the workforce aged between 25 and 34 years (NHWDS: Nurses and Midwives 2012; Health Workforce Australia, 2014). More recent data indicated little progress has been made in attracting nurses to MHN, with employment of mental health nurses essentially unchanged since 2013 at roughly 85 FTE (78 FTE working clinically) per 100 000 population (Productivity Commission, 2020).

Mental health care is becoming more complex with increased economic and health burdens associated with the high prevalence and morbidity of mental illness and disorders in the general community (Australian Institute of Health and Welfare, 2019b). Improving and resourcing mental health care remains a priority, as nearly half the population will experience a mental illness or disorder in their lifetime (National Mental Health Commission, 2014). In the Australian

context, the percentage of people experiencing a mental or behavioural condition rose from 17.5% in 2014-2015 to 20.1% in 2017-2018 (Australian Bureau of Statistics, 2018).

During the last several decades, changes aimed at attracting new members to a career in nursing, such as the move to university-based training in a bid to professionalise nursing, have been made. In the Australian context, nursing education began to move from hospital-based training programs to degree programs in tertiary institutions from 1985 (Dawkins, 1988; Happell & Cutcliffe, 2011). However, there have been consequences of this, including the added difficulty in consolidating undergraduate skills into clinical practice, particularly for MHN (Clinton & Hazelton, 2000; Wynaden et al., 2000). The move to comprehensive nursing curricula – curricula designed to prepare nurses for beginner practice in any nursing specialty, has sparked much debate among academics, with concerns raised that nurses are not being adequately prepared for a career in MHN (Happell & Cutcliffe, 2011; McAllister et al., 2014; Walsh, 2015).

Several initiatives have been developed to support new nurses as they consolidate their undergraduate learning, including implementing transitional programs, and the use of mentoring and preceptorship. These initiatives have been associated with increased satisfaction and increased retention of NGs (Hooper et al., 2016). The exploration of the experiences of new nurses has become a priority of academics, with new nurses describing negative and

challenging experiences as they enter clinical practice, such as burnout and job dissatisfaction, with these experiences increasing the risk of attrition (Dawson et al., 2014; Drennan & Ross, 2019; Mabala et al., 2019). The work environment has been identified as an important factor in the management and presence of workplace difficulties that increase the risk of turnover (Dawson et al., 2014; Kutney-Lee et al., 2012). Moreover, Glisson and Williams (2015) emphasise that positive workplace cultures are associated with job satisfaction and role clarity, whilst limiting role overload and emotional exhaustion.

Outside of the realm of nursing, the concept of organisational culture has been widely studied to explore the satisfaction and commitment of members to the organisation (Schein & Schein, 2017). Organisational culture can be described as the shared beliefs, behaviours, and assumptions within an organisation, represented as the norms and expectations that guide the behaviours of its members (Glisson & Williams, 2015; Schein & Schein, 2017). The premise of this term is that the collective culture, whether reflective of an organisational, religious, or ethnic group, is the essence that binds the group together. This concept provides a basis for understanding the dynamics of a cultural group and the underlying assumptions, values and beliefs held by its members.

In exploring the concept of organisational culture, Schein (2010) presents a model that has been utilised in research in this area. Within this model, understanding the culture of an organisation involves exploring the layers of the culture in order to develop a deeper understanding of the cultural group. Schein

emphasised the need for congruence between the layers of the organisational culture, with this and clarity between the layers of culture reflective of a stronger or positive culture. Weak or negative organisational cultures are described as being associated with reduced commitment of members to the organisation, and loss of members to attrition (Jacobs & Roodt, 2008; Kulkarni, 2014; Schein & Schein, 2017). Organisational culture has been emphasised in the literature as an important determinant in the satisfaction and cohesion of the organisational members (Abu-Jarad et al., 2010; Glisson & Williams, 2015).

1.2 Stating my interest

I have felt passionate about the future of nursing since I joined the profession in 2006. Initially, my interest was around the training and education of nurses. As a graduate of a comprehensive nursing program, I felt inadequately prepared for practice in MHN and noticed a similar sentiment from fellow comprehensively trained nurses working in MHN. This interest has stayed with me, alongside a growing interest in the attraction and retention of future nurses. This interest has led me on a journey in searching through the literature around MHN content – both educational and clinically-based in nature. I have been fascinated with the concept of organisational culture development and change – particularly in improving the commitment of its members to the organisational culture. In wanting to learn about people, I also developed an interest in the development of groups of people – or cultures. As a mental health nurse early in my career, the concern around workforce shortages and the increased complexity and incidence of mental illness have prompted a strong desire to

understand the reasons why nurses may not be attracted to MHN, and for those who are attracted to MHN, exploring the factors that may influence their intention to leave.

In exploring the experiences of NGs entering the cultural group of MHN, I noted several parallels between this research and my personal and clinical experiences. Firstly, the journey of learning about culture has mirrored my own journey of learning a language – German. Despite having acquired citizenship through birth, without speaking the language I felt as though I was a cultural outsider. Learning the language and the traditions and beliefs inherent to Germany, allowed me to feel more accepted. Secondly, the methods used in this research have similarities to the skills needed in MHN – particularly in my clinical role of conducting mental health assessments. There are elements of looking at the world through the eyes of the person, to develop an understanding of the world as they are experiencing it – *emic perspective*, as well as a more objective outsider view – *etic perspective*. This practice requires a delicate balance between an insider and outsider perspective. My experiences of entering MHN, learning a language and culture, and of my own clinical development have shaped my perspectives. There are similarities to the journey of NGs encountering a new cultural group – in learning the beliefs, attitudes, and behaviours of the group, and moving from outsider to insider.

1.3 Research aim

The aim of this study was to gain a deeper understanding of the NG experience when entering the culture of MHN and how their experiences might relate to their intention to remain in the field. This aim also involves identifying any factors which may relate to the attraction and retention of NGs to MHN, including the process of assimilating NGs into the organisational culture. This study focused on exploring their experiences of assimilation – moving from outsider to insider in the culture, by observing NGs as they engage in the activities in the mental health unit and observing their integration into the cultural group.

1.4 Research questions

The primary research question set out to understand the experiences of NGs entering the culture of MHN.

1. What are the experiences of new graduate nurses when encountering the culture of MHN?

Additional research questions were developed to support the understanding of the primary research question. These additional questions are designed to explore the relationship between the experiences of the NG participants and themes in the literature relating to nurse attrition.

Additional research questions:

2. Are there links between the experiences of NGs and their intention to remain in the field of MHN?

3. What are the processes of assimilating NGs into the workplace?
4. Where do NGs fit into the organisation's hierarchy, and how is this perceived by the NGs?

It was expected that these questions would enable a deeper understanding of how the NGs experience of entering the culture of MHN, might impact on their commitment to the organisation.

1.5 Originality and significance

It was expected that this study would shed further light on the experiences of NGs in the field of MHN, particularly around their experiences within the construct of organisational culture. A review of the literature identified that NGs report negative clinical experiences when encountering mental health services, resulting in an increased risk of attrition early in their career (Hooper et al., 2016; Labrague & De Los Santos, 2020; Mabala et al., 2019). The experiences described by NGs have been associated with the recent changes in the training of mental health nurses; role ambiguity; inadequate clinical preceptorship; encountering the reality of mental health services; and the role of health services in transitioning NGs into clinical practice (Hooper et al., 2016). Research into organisational culture suggests that negative workplace experiences and outcomes are associated with negative organisational cultures (Abu-Jarad et al., 2010; Glisson & Williams, 2015; Kulkarni, 2014). However, there has been limited application of this research in the context of nursing – in particular, exploring NGs entering MHN. Furthermore, there is no research that examines the subculture of the NG experience within the culture of MHN. An

ethnographic research design was applied to explore the experiences of NGs when encountering MHN, with emphasis on the process of assimilating into the organisational culture.

1.6 Outline of the thesis

This thesis is an ethnographic study of the NGs experiences in MHN. Given the complexity of the Australian public hospital system, and the delivery of acute mental health care it was necessary to unpack the experience of the culture of MHN from an organisational context, but also from the participants real-world view of what the natural MHN setting meant to them. This thesis is constructed around the theoretical framework of Edgar Schein's *Model of Organisational Culture* (Schein, 2010). The theoretical framework represents the foundations of the research from which knowledge is constructed (Grant & Osanloo, 2014). Therefore, Schein's (2010) concept of organisational culture will be evident throughout the thesis. Grant and Osanloo (2014) emphasise the importance of the theoretical framework serving to structure and ground the research, including the rationale of the research, the problem statement and the research questions, as well as the literature review, methods and analysis. The following sections provide an overview of each chapter in the manuscript.

1.6.1 Chapter one – Introduction

Chapter one provides a brief introduction to the thesis, with a succinct background providing context to the research, as well as the aims, research questions and methodological issues. This chapter outlines the ongoing issues

of nurse retention in the MHN workforce, with loss of nurses to attrition and low numbers of nurses attracted to MHN. NGs negative clinical experiences were highlighted as a factor contributing to their attrition from MHN. The concept of organisational culture as a determinant of workplace retention was outlined. Schein's (2010) *Model of Organisational Culture* provides a theoretical perspective in exploring the NG subcultural experience of entering the culture of MHN.

1.6.2 Chapter two – Literature review

Chapter two is presented in two parts. Firstly, the literature and policy documentation concerning historical changes to MHN are explored to determine context for the current concerns with MHN training, education, and practice. The concept of exploring the founders of a cultural group are emphasised by Schein (2010) to understand the current cultural context. Secondly, findings from the literature around the development and structure of the new graduate program (NGP) and the experiences of NGs as they enter MHN are presented.

1.6.3 Chapter three – Theoretical framework: organisational culture

Chapter three provides an overview of the theoretical perspective or lens for this research – Edgar Schein's (2010) *Model of Organisational Culture*. This chapter describes Schein's model and the relationship between the levels of culture and the commitment of members to an organisation. This model allows for the

exploration of the organisational culture and the assimilation of new cultural members.

1.6.4 Chapter four – Research design

Chapter four provides the methodological processes and procedures used in this research, with these combined under the umbrella of *research design*. This study utilised ethnography as the methodology as that was most congruent with the research aims, questions, and theoretical perspective. Ethnography is the principal focus with the participants describing their everyday experiences. The methods for conducting the research included: field observations and semi-structured interviews, which are supported by field notes and reflexive researcher notes. This chapter also includes the ethical considerations and limitations of the research design.

1.6.5 Chapter five – Attraction to mental health nursing

Chapter five represents the first of the four finding chapters. This chapter relates to the attraction of NGs to MHN. This finding is important when exploring the concept of attraction and retention of NGs to MHN. Undergraduate nursing education plays an important role in attracting new nurses to the field, particularly in setting expectations around the MHN role and practice. However, new nurses describe a number of challenges when choosing MHN – particularly in encountering stigma associated with MHN and experiencing discouragement in pursuing a career in this field. They also encounter challenges in securing

ongoing employment after completing the NGP, with further challenges in transitioning into general nursing practice if they change their minds about a career in MHN.

1.6.6 Chapter six – The new graduate program

Chapter six represents the second of the finding chapters. This chapter explores the purpose of the NGP for NGs entering the workplace in MHN. The NGP represents the gateway to clinical practice for new nurses and is seen as a rite of passage into the health service. The NGP represented a support structure as well as a stressor for NGs as they navigated the requirements of the NGP, consolidated undergraduate learning, and were socialised and assimilated into the clinical setting.

1.6.7 Chapter seven – Entering mental health nursing practice

Chapter seven represents the third finding chapter and explores the research setting and the cultural context of the research site as well as some of the ethnographic cultural artefacts and symbols that are associated with the culture. This is considered an important component of Schein's (2010) approach to exploring the organisational culture and providing context. The philosophies of care underpinning the units within the research site are explored and how they relate to the artefacts seen within the unit. The chapter then explores the socialisation of NGs into clinical practice within each unit and their role within

the multidisciplinary team (MDT). Within this chapter the tensions between the role of MHN that was envisioned of NGs and the reality of the MHN role as they commenced clinical practice are explored. This is an important finding in examining the experiences of NGs as they enter the culture of MHN, and how these experiences shape their commitment to the organisation.

1.6.8 Chapter eight – Entering the culture of mental health nursing

Chapter eight, the fourth and final findings chapter explores the experiences of NGs in entering the culture of MHN. This is represented as the assimilation of the NG and their socialisation to the cultural group of mental health nurses. The qualities of mental health nurses including the language used and the sought-after attitudes, beliefs and behaviours that are seen as important to the cultural group are explored. The cultural group analysed the qualities of the NG to determine their suitability as a member of the cultural group. The nature of assimilation is time-limited with the NGP spanning one year, requiring the NG to be recognised as a suitable member of the team expeditiously to increase their likelihood of securing ongoing employment after completing the NGP.

1.6.9 Chapter nine – Discussion

Chapter nine provides a discussion of the findings from this research. This discussion is centred around the four findings chapters: *attraction to mental health nursing; the new graduate program; entering mental health nursing*

practice; and *entering the culture of mental health nursing.* These findings represent the journey of transition of the NG from outsider to insider within the cultural group.

Attraction to mental health nursing emphasises the important role of undergraduate learning in setting the expectations of NGs entering the MHN culture, as well as providing skill and knowledge of clinical practice. However, NGs encounter a dichotomy between their expectations and reality of clinical practice.

The new graduate program represents the gateway to the cultural group, with graduate nurses only able to enter the cultural group through the NGP. New members experience socialisation into the organisation with the theoretical and skills components of the NGP setting expectations for practice. The purpose of the NGP represents a challenge with NGs experiencing stress and role overload relating to completing the NGP requirements, in addition to commencing clinical practice. This emphasises the need to clarify the purpose of the NGP in the transition of new nurses from student to clinical practice.

Entering mental health nursing practice outlines the practices that NGs are socialised into within the mental health units. This includes the role that artefacts play in shaping practice within the cultural group and the tension experienced between expectations of MHN as a recovery and holistic practice – with realities of engaging in task-based and risk-averse practices. A lack of

specialist training to provide mental health nursing skills and knowledge and the context of practice within the inpatient setting underpinned by mental health legislation, contribute to this reality.

Entering the culture of mental health nursing represents the deeper levels of entering the cultural group, with NGs socialised into the beliefs, behaviours, and attitudes of the group. The safety discourse within the inpatient MHN practice reinforces the importance of the relationships within MHN, with members perceiving the need to protect the lives of their colleagues and needing that trust in return. New members entering the group need to possess the desired qualities and skills to be accepted. At this level the NG is moving from outsider to insider within the cultural group.

1.6.10 Chapter ten – Conclusion and recommendations

Chapter ten outlines the conclusion and recommendations emerging from this research. The implications of the findings are represented as: *implications for preparation for practice; implications for the transition to practice; implications for mental health nursing culture – cultural identity, cultural practice, and cultural assimilation; and implications for NG nurse retention.* This is followed by a summary of recommendations, strengths and limitations, and a brief autobiographical account of undertaking this research. The findings of this study emphasise the significance of culture, and the complexity of the NG experience of transitioning into the MHN cultural group. These findings allow for further considerations to be made around the undergraduate preparation of nurses, the

structure and function of the NGP, and in the complexity of the MHN culture. Exploring the experiences of NGs sheds light on to the beliefs, behaviours and attitudes held by the cultural group in relation to MHN care and in the assimilation of new nurses to clinical practice.

1.7 Chapter summary

This chapter outlines the background to the thesis and provides an overview of its structure. The following chapter explores the literature around the experiences of NGs in MHN settings. The background discussion of the historical changes to MHN provides context to the nature of MHN as well as in the emergence of the NGP to facilitate transition to clinical practice. The historical focus gives some context to MHN in the present day. According to Schein (2010) it is important to understand the foundations of a culture in order to explore and understand the culture. This then leads to a description of the modern Australian MHN program and emergence of a transitional or NGP to enable the consolidation of learning for NGs entering clinical practice.

Chapter two
Background and literature review

"Sometimes you will never know the value of a moment,
until it becomes a memory…"

Dr Seuss

2.1 Introduction

This chapter presents a review of the literature relating to the experiences of NGs entering MHN. Firstly, the evolution of MHN practice and changes to the training and education of mental health nurses will be explored. This provides cultural context for MHN practice and the experiences of NGs entering MHN. This is followed by examining the literature that has emerged around the use of transitional programs to support the transition of new nurses into clinical practice. Included in this chapter is a published integrative review exploring the experiences of new nurses as they encounter MHN during their first year of clinical practice.

2.2 The evolution of mental health nursing practice

The early treatment of people experiencing mental illnesses and disorders centred around confinement. Mental illness was stigmatised, and people experiencing a mental illness or disorder were perceived as dangerous to society (Slemon et al., 2017; Vrklevski et al., 2017). Institutions were

established to house criminals, people with an intellectual or mental illness or disorder, and the poor, with no distinctions made between these groups – people were confined when they were deemed a risk to society (Vrklevski et al., 2017). People experiencing a mental illness or disorder were also referred to as lunatics or inmates (Sands, 2009; Vrklevski et al., 2017). The profession of Psychiatry developed in response to the growing numbers of people confined to institutions and led to the development of different diagnostic categories for mental illness and disorders.

The evolution of Psychiatry as a profession rose from their dominance as health professionals in the context of care of people experiencing a mental illness or disorder in the early 19th century. The advent of Psychiatry allowed for the shift towards treatment of mental illness as opposed to purely custodial practices (Vrklevski et al., 2017). Through government sanctions, Psychiatrists were endorsed to both define madness or mental illness, and to determine an individual's admission to and discharge from facilities, allowing them a monopoly on the treatment approaches and systems. The Institutions themselves were also viewed as a method for treating people experiencing a mental illness or disorder (Slemon et al., 2017; Vrklevski et al., 2017). The term 'asylum' was used for institutions in the late 18th century with earlier terms including madhouse (Parry-Jones, 1988) poor house, workhouse and prison (Sands, 2009). Later the term mental hospital was used, reflecting legislative changes to mental health care and to distance from negative connotations of the lunatic asylum.

The first known (mental) institution, The Bethlem Royal Hospital – also known as “Bedlam”, was established in London, England in 1247 (Vrklevski et al., 2017). In the Australian context, the first institution was built in 1811 at Castle Hill, New South Wales (NSW) (Rosen, 2006). This was the first of many institutions to open in Australia, with similarities found with other psychiatric or mental institutions in the Western world, with the policies and structure of the asylum transported from Britain (Gooding, 2016; Rosen, 2006; Vrklevski et al., 2017). The structure of the institution was legislated by Australian Lunacy policy in the 1800s (Gooding, 2016) and was adopted from the original British Lunatics Asylum Act and Lunatics Act (Gooding, 2016). The establishment of Asylum Acts related to the origins of the institutions as treatment facilities and the subsequent evolution of Psychiatry and Psychiatric Nursing – more recently MHN, the results of which are evident in Australia today. From the time the first institution was opened in Australia, the number of beds continued to expand reaching peak capacity of 30,000 beds in the 1960s (Gooding, 2016; Hudson, 2016; Vrklevski et al., 2017).

The treatment of people with a mental illness in institutions evolved over time and reflected the changing beliefs held about mental illnesses and disorders. Vrklevski et al (2017) suggest that the historical view of mental illness as resulting from bad blood, weakness of character or supernatural forces rather than physiology, shaped how mental health care was delivered. The initial institutions centred around a custodial framework designed to segregate people experiencing a mental illness or disorder from the wider community to minimise

the perceived or potential risks they posed (Vrklevski et al., 2017). Despite attempts to provide care, the reality of many institutions were over-crowding, substandard conditions and brutal containment practices (Rosen, 2006). Behaviour was managed through punitive or restrictive custodial practices such as removal of privileges with the earlier institutions reflecting barbaric and cruel conditions (Junior et al., 2017; Slemon et al., 2017; Vrklevski et al., 2017). Once admitted to an institution, people had little chance of ever being released (Vrklevski et al., 2017).

With the establishment of institutions controlled by the Psychiatrists, came the early attendants who were male and acted as assistants to the medical professionals (Martyr, 2010). The attendants were untrained and held a similar social rank to ‘inmates’ and were referred to as lunatic attendants, keepers, caretakers or wardens (Vrklevski et al., 2017) and were largely hired based on their size and strength (Vrklevski et al., 2017). Being an attendant was not seen as a discipline, in its own right, and the role centred around caretaking as determined by the needs of the institution and the Psychiatrists who oversaw those institutions. Later when female staff were introduced into the institutions, they were referred to as nurses, while the male staff retained the title of attendant (Martyr, 2010). It is suggested that at this time the foundations of the relationships between nurses and medical professionals in the mental health care context were established (Gooding, 2016; Vrklevski et al., 2017). Subsequent changes to the legislation governing mental health care resulted in changes to both the names of institutions to mental hospitals, and the names of

attendants to mental nurses. This reflected a shift in ideology with attendants were viewed more as professionals rather than just keepers (Sands, 2009).

2.2.1 The deinstitutionalization movement

Worldwide, there have been many reforms to mental health care, from the establishment of mental institutions in the 13th century; the changes in treatment approaches including the recovery movement; and the eventual move to depopulate standalone psychiatric or mental institutions (Gooding, 2016). In the Australian context, there have been various social, political, and economic factors that contributed to the hastened closure of the large standalone institutions, beginning in the 1960s (Gooding, 2016; Holyoake, 2014; Hudson, 2016; Rosen, 2006). With the focus of treatment designed to be delivered in the least restrictive environment – largely the community (Gooding, 2016). These reforms began to acknowledge the civil rights of persons experiencing mental illness and disorders, as well as public criticism of the institutions and the antipsychiatry movement of the 1950s (Gooding, 2016; Nolan & Hopper, 2000).

The social drivers for deinstitutionalisation were the reported poor conditions inside the institutions leading to further changes to the service delivery and philosophies of care (Holyoake, 2014). The advent of antipsychotic medications in the 1950s also coincided with the deinstitutionalisation movement which led to major changes in mental health treatment and care practices (Holyoake, 2014; Vrklevski et al., 2017). Additionally, there were exorbitant costs in

maintaining large institutions prompting economic incentives in moving to smaller or mainstreamed services (Hudson, 2016; Rosen, 2006).

The premise of deinstitutionalisation was the de-population of standalone institutions and the ‘mainstreaming’ of mental health services into general hospital settings (Gooding, 2016; Hudson, 2016). These changes led to the development of short-term specialist inpatient services for care and treatment of the acute illness or situation, and the development of community-based services for longer-term community-based care (Gooding, 2016). The process of depopulation involved reducing the number of psychiatric beds in Australia from 30,000 in the 1960s down to 6000 beds in 2005, which has steadily risen again to 12,467 beds in 2017 (Australian Institute of Health and Welfare, 2019b; Senate Select Committee on Mental Health, 2006). However, these figures have not taken into account population growth over the last half century. Most people living with a mental illness in Australian now reside in the community and their care is primarily managed by General Practitioners in the primary healthcare setting and community-based mental health services. This reflects the shift towards protecting the rights and dignity of people accessing mental health services. Reflecting person-centred and recovery principles, there has been a shift in the terms used to refer to people accessing mental health services. The original terms used were *patient* or *inmate,* with contemporary terms including: mental health consumer, or person with a lived experience/person experiencing a mental illness or disorder (Gooding, 2016; Lakeman, 2013).

Although the population of institutions began to decline in the 1960s, the conditions inside the institutions and the quality of care continued to be viewed negatively by the public, resulting in multiple investigations and reports. A prominent report into psychiatric facilities was the *Inquiry into health services for the psychiatrically ill and developmentally disabled* known also as the Richmond Report, commissioned by the NSW Government and chaired by David Richmond (New South Wales Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled et al., 1983). Several recommendations were made including improving the community-based resources for consumers now living outside of the asylums, and to bridge the gaps in legislation relating to mental health care between the Australian States and Territories (New South Wales Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled et al., 1983). Later, an additional enquiry, *The Burdekin Report: Human rights and mental illness: Report of the National inquiry concerning the human rights of people with mental illness,* explored the human rights of people living with a mental illness and outlined the effects of inadequate mental health and welfare services, particularly in the community (Rose et al., 1993). Despite these recommendations, Hazelton et al (2011) highlighted the link between a lack of community-based supports and policy shortfall in the community-based recovery approaches for people experiencing mental illness or disorders.

Although there has been a movement towards closing institutions, there are still 17 public standalone psychiatric or mental hospitals in Australia, whilst there are

144 general hospitals which have a designated mental health unit or ward attached (Australian Institute of Health and Welfare, 2019b). Additionally, a criticism of deinstitutionalisation was the movement of 90% of the consumers into the community by 1984, while 90% of the staff and funding were retained within the inpatient hospital setting (Senate Select Committee on Mental Health, 2006). This remains an ongoing issue for mental health care provision in Australia, with funding and care largely focused on people with more acute and complex needs, rather than prevention, early intervention, and community-based care (Mental Health Commission of NSW, 2014). Although the care of people in the community is designed to reflect recovery approaches, a consequence of deinstitutionalisation has been surges in the number of people experiencing homelessness, requiring nursing home care or entering the criminal justice system (Hudson, 2016).

2.2.2 Contemporary mental health care in Australia

There have been significant changes to Australian mental health services over the last half century including the philosophy of care, policies, and associated funding. The majority of psychiatric institutions have closed down, with mental health services generally *mainstreamed* with general health services (Roche & Duffield, 2007). There has been a shift towards community-based care as opposed to inpatient care – with inpatient care reserved for those deemed unable to be cared for in the least restrictive setting (Hudson, 2016). Within the inpatient setting, the focus has shifted towards short-term care aimed at addressing symptoms posing a risk to the individual or society. With a least

restrictive philsophy to care, the focus is in reducing the length of stay within mental health facilities. Kurjenluoma et al (2017) highlight the challenges of this approach with consumers largely experiencing greater symptom severity with shorter hospital admissions with a focus on addressing the acute symptoms and managing the risks.

In comparison to the original institutions, mental health care in Australia is delivered in a range of facilities – public and private psychiatric hospitals, mental health units in general hospitals, community-based services, and care through Non-Government Organisations (Australian Institute of Health and Welfare, 2019b). In Australia in 2017, there were 161 public hospitals and 68 private hospitals providing specialised mental health services. These facilities provided 12,467 beds of which 3,011 beds were in the private sector. Of the public hospital beds, 76.5% were in specialised mental health units in general hospitals with the remainder in public psychiatric hospitals (Australian Institute of Health and Welfare, 2019b).

The shift in service approach and the emphasis on community-based care has resulted in changes to inpatient mental health care and the parameters for admission. Currently the admission to public mental health facilities is governed by individual State and Territory-based mental health legislation (Australian Institute of Health and Welfare, 2019b). An example of legislation in Australia relating to inpatient care in mental health services is the *Mental Health Act 2007* (NSW) which stipulates the legislation guiding the admission criteria. The legal

definition of mental illness under the *Mental Health Act 2007* (NSW) differs from the formal or clinical definition of mental illness described in the Diagnostic and Statistical Manual of Disorders V (DSM-V) (American Psychiatric Association, 2013). According to mental health legislation, a person must meet specific criteria to be considered legally mentally ill or disordered – including presenting as a risk to themselves or to others, with no care of a least restrictive kind available *Mental Health Act 2007* (NSW). Under these legal frameworks, a person may be detained against their will to receive mental health care (Hewitt, 2009). The focus on detaining people into mental health care is arguably a matter of considering the safety of the public as well as the safety of the individual.

Holyoake (2014) acknowledges the role history plays in the construction of current mental health nursing practices, and highlights the importance the practice of gatekeeping held within the cultural group – a practice which is evident currently. Loukidou (2010) emphasises that the practices of MHN have largely been shaped by the institutions in which they performed. Despite the move towards community-based and least restrictive practices, safety and risk aversion remain values that underpin contemporary mental health care in Australia and around the world. Slemon et al (2017) highlight gatekeeping and restrictive practices as identifying and managing the risks to consumer as well as the use of seclusion, locked units, medications and close observations. With these reflective of the safety discourse that has evolved from the original psychiatric institutions.

Harrington et al (2019) explored the emphasis on observation and risk aversion in the mental health setting and noted that despite these practices, consumers of mental health services still engaged in harming themselves or absconding from mental health facilities. They further argued that the practice of observation was linked to identifying overtly risky behaviour as opposed to engaging with consumers. This focus on observation and risk management is contradictory to a recovery-focus of care that acknowledges the consumer as an equal partner as opposed to passive recipient of care (Harrington et al., 2019; Holyoake, 2013). This safety discourse is arguably powerful in shaping the practices seen within contemporary mental health care, with Slemon et al (2017) and Lakeman (2013) outlining that this legitimises practices that may be physically or psychologically harmful.

Lakeman (2013) emphasises the challenges of practicing based on evidence as mental health care has evolved. He considers the historical treatment approaches which were considered effective at their time but were later rebuked as ineffective or harmful, citing the use of lobotomy to treat certain conditions or disorders. This perspective draws attention to practices such as observation and risk management, and whether these practices are considered effective and constitute treatment in mental health care (Slemon et al., 2017). Despite the consideration that restrictive practices may not promote recovery, this may follow societal expectations for mental health care as well as reflect defensive rather than therapeutic practices to avoid litigation or blame in relation to the responsibility of patient safety (Hewitt, 2009; Slemon et al., 2017).

The shift towards restrictive practices within the inpatient admission detracts from the focus on therapeutic engagement. Alchin (2010) argues that despite the shift towards more therapeutic practices in the 1970s, current approaches are largely based around the medical model of care. He further argues that this focus, alongside the diminishing knowledge base in MHN, is shaping the mental health nurse back into the role of handmaiden to medical professionals. This concern was also outlined by Nolan and Hopper (2000) and Hein and Scharer (2015) who argued that this reflected a deviation from the role of the mental health nurse in building interpersonal relationships with, and counselling, consumers.

Another challenge is the role of MHN within the MDT. Contemporary mental health care is largely delivered by the MDT using a common model of care (Carlyle et al., 2012). The disciplines in mental health care primarily comprise of nursing, occupational therapy, psychiatry, psychology, and social work (Australian Institute of Health and Welfare, 2018). Vrklevski et al (2017) emphasise the challenges of blurring of boundaries between the professional groups with an added concern of genericism within the MDT, and the effect on the professional identity of each discipline. With challenges acknowledged in the MHN borrowing skills and identity from other professions (Holyoake, 2014).

Defining the role of MHN is considered a challenge affecting the recruitment and retention of nurses to the field (Hercelinskyj et al., 2014). Cutcliffe et al (2013) emphasises that challenges exist within the MHN identity and

demonstrates that even from the perspective of lack of consistency in the nurse identity, with the terms mental health and psychiatric nurse frequently interchanged. This is also linked to the argument that there is a difference between psychiatric and mental health care (Cutcliffe et al., 2013). In attempts to define MHN and differentiate it from psychiatric nursing, Lakeman (2013) outlines that variation relates to skillset, preparation for practice, and context of practice. The title of the nurse is linked to the places and period they have worked and to the historical construct of the MHN identity – with psychiatric nursing associated with the practice of psychiatry (Cutcliffe et al., 2013; Lakeman, 2013).

Barker and Buchanan-Barker (2011) outline challenges in the title of mental health nursing, with difficulties in defining or describing the role beyond vague terms. The term MHN was argued to reflect a shift in ideology and to reflect idealistic mental health care – nurses who engage in holistic care, working in partnership with people experiencing mental health issues and their family and community, and working towards recovery as defined by the person (Barker & Buchanan-Barker, 2011). This is contrasted to the more bio-physically orientated approach of the general nurse (Happell & Platania-Phung, 2005; Prebble, 2001). However, the practice of MHN is arguably constrained within mental health institutions with an emphasis on safety creating tension between idealistic and realistic MHN practice.

Ambiguity in the role and definition of MHN and the association of MHN with the practices of psychiatry are related to recruitment and retention challenges, especially for nurse graduates (Barker & Buchanan-Barker, 2011; Harrison et al., 2017). This is exacerbated by the criticisms of psychiatry and practices within the institutions affecting the perception of MHN (Nolan & Hopper, 2000). Despite the changes to mental health care including reforms, there remains ongoing stigma with low expectations of MHN – with mental health nurses perceived as being mere custodians of people (Harrison et al., 2017; Nolan & Hopper, 2000). This is also reflected in a lack of specialist training for nurses working in mental health settings in the Australian context (Nolan & Hopper, 2000). Hercelinskyj et al (2014) highlight the importance of defining the MHN role and considering this from the perspective of training and education of the next generation of MHNs.

2.2.3 Changes to mental health nursing education and training

In addition to exploring the way the mental health facilities have been shaped, it is also important to explore the training and preparation of mental health nurses. MHN education in Australia has undergone significant change over the last 50 years with this influenced by national inquiries and international trends in nursing education (Happell, 2015; Henderson & Martyr, 2013). This is important in providing context to the development of the modern NGP.

As we have already explored, the historical origins of MHN differ from those of general nursing. General nurses are depicted by the Nightingale era as virtuous carers, whereas mental health nurses, within the context of institutions, are depicted as asylum caretakers or attendants. The original mental health nurses – attendants / caretakers, did not receive formal training and fell under the jurisdiction of the medical professionals, who determined their training and development, depending on the needs and preferences of the medical staff.

The formal education for Psychiatric Nursing did not begin until 1887 in Australia – at Kew Asylum, Victoria, with caretakers in NSW and Victoria institutions receiving training from the late 1880s onwards (Martyr, 2010). The training spanned three years – much like contemporary nursing programs. Despite the advent of training, there was no recognition of the qualification until the passing of the *Victoria Nurses Act* (1958). This reflected the resistance to formally recognise Psychiatric Nursing in Australia and in other parts of the western world at that time. Prior to the transfer of nursing education in Australia to tertiary institutions from 1984, Registered Nurses (RNs) completed a three-year training program within the hospital setting in their chosen specialty area. With nurse graduates only permitted to work within their field of training, unless they undertook further training in another specialty. The Psychiatric Nursing student was employed within the hospital and completed various theoretical and practical components in blocks of several weeks over the three-year period, moving from beginner level to proficient nurse (Moxham et al., 2011). This was designed to apply theory to the ongoing skills being developed. Henderson and

Martyr (2013) gave a historical overview of the nurse training in Western Australia at Claremont hospital for the insane, which resonated with other documented accounts of hospital-based training. In this context nurse training was conducted from 1903 onwards with the program spanning three years. Twelve lectures a year were delivered by medical professionals with learning entirely based on the UK's Handbook for Mental Nurses, commonly known as the 'red book' (Henderson & Martyr, 2013).

Similarly to the Australian reports conducted on psychiatric institutions resulting in service changes, there have been numerous reports exploring the training and education of nurses in Australia. The 1988 Dawkins White Paper (Dawkins, 1988) made recommendations to shift nursing education into the higher education sector – although the transfer of nursing education had already begun. As well as shifting the training of nurses, it was also recommended that ongoing collaboration occur between health institutions and higher education institutions to prepare nurses for practice. This was outlined in the 1978 Sax Report (Tertiary Education Commission, 1978). In reference to nursing in a global sense, the UK's 'Shape of caring' report (2015) also recommended that the relationships between health and regulatory bodies and universities be strengthened, with particular emphasis on supporting new nurses entering the clinical setting (Willis, 2015).

In Australia in 1984, the transition of hospital-based nursing training to tertiary educational institutions began, coinciding with the deinstitutionalisation of

psychiatric institutions in Australia (Henderson & Martyr, 2013; Holyoake, 2014; Martyr, 2010; Vrklevski et al., 2017). Those changes to nursing education were intended to elevate the status of nursing in a bid towards professionalisation, but also to improve the skills and knowledge within the profession (Cunich & Whelan, 2010; Dawkins, 1988; Hazelton et al., 2011).

Although there are various pathways to achieving registration as a nurse, in the Australian context nurses generally complete a three year qualification or equivalent from an approved program of study to register with the Australian Health Practitioner Regulation Agency (AHPRA) (Australian Institute of Health and Welfare, 2019a). With the changes to training, the modern mental health nurse is defined by AHPRA as an: 'RN who indicates that their principle place of work is in mental health' (Australian Institute of Health and Welfare, 2019a). There is no longer a formal recognition or requirement to have specialist training to work as a mental health nurse, with this differing from the earlier requirements for registration as a specialist mental health nurse (Henderson & Martyr, 2013).

In contemporary nursing educational programs, nurses complete practical and theoretical learning designed to prepare graduates for beginner practice in any nursing specialty. It is noted that educational content and practical experiences vary between universities (Warelow & Edward, 2009). It has been argued that despite the merging of a three-year specialist mental health program into a comprehensive program in the Australian context, MHN content continues to be

under-represented in curricula (Henderson & Martyr, 2013; McAllister et al., 2014; McCann et al., 2010; McKeown & White, 2015). This has been argued to affect the ability of NGs entering the mental health field to provide high quality care, reflecting a gap between theory and practice (McAllister et al., 2014; Nolan & Hopper, 2000). A lack of MHN knowledge and skills was argued to prevent mental health nurses from practicing comprehensively, with erosion of specialist knowledge over time (Happell, 2015; Hazelton et al., 2011; McAllister et al., 2014). Fear concerning the progressive dilution of specialist skills and knowledge has sparked concern over the future of MHN (Clinton & Hazelton, 2000; Hazelton et al., 2011). McAllister et al (2014) further iterate that without a specialist knowledge base, MHN is likely to follow the lead of the medical model in the provision of mental health care, representing a shift towards historical practices of the nurse in the attendant or caretaker role.

There have been ongoing professional calls for an increase in MHN content in the curriculum, including increased clinical exposure to mental health settings (Curtis, 2007; Happell & Cutcliffe, 2011; Neville & Goetz, 2014). Some authors report that exposure in the undergraduate curriculum to mental health theoretical and practical learning was associated with more favourable attitudes to MHN and increased preparedness for practice (Edward et al., 2015; Happell & Gaskin, 2013; Moxham et al., 2011). Mental health nurse academics argue that the current comprehensive, rather than focused, education program contributes to new nurses not being prepared for clinical practice in mental health and not being attracted to a career in this field (Benjenk et al., 2019;

Happell & Gaskin, 2013; Hazelton et al., 2011). Graduates who do pursue a career in MHN continue to be criticised in the clinical setting for a lack of sufficient knowledge and skills for practice in the MHN domain (Harrington et al., 2019; Hazelton et al., 2011; Kim & Yeo, 2019; Walsh, 2015). Kunst et al (2017) argue that the nursing curriculum should be based on the best evidence to ensure nursing graduates have the skills and capability to provide high quality and holistic care.

Addressing preparation for practice remains a priority as graduates who feel unprepared are less likely to pursue a career in MHN (Neville & Goetz, 2014). The focus in the literature has been on exploring the educational preparation of nurses entering MHN, particularly within the context of deinstitutionalisation of mental health services and the movement towards comprehensive-based nursing curricula (Happell & Cutcliffe, 2011; Neville & Goetz, 2014). However, the focus in the literature has begun to shift towards exploring the transition of nurses from student to clinician and exploring their experiences of entering clinical practice. This is especially in the context of graduates reporting feeling unprepared for clinical practice and reporting negative experience when entering clinical practice in mental health settings. The literature exploring the transitional experiences of NGs entering clinical practice is outlined in the remainder of this chapter.

2.3 Preparation for practice – the emergence of the new graduate program

In response to the changes to MHN training and practice outlined in this chapter, transitional or NGPs have been developed to support new nurses as they consolidate their skills, knowledge and to provide support as they integrate into the workforce, and transition from student to clinician (Pearson, 2019; Walsh, 2018). The NGP is described as important for the successful transition of new nurses to the clinical setting, particularly in allowing for their socialisation and development of their professional identity (Meyer, 2019; Tingleff & Gildberg, 2014). According to the literature, NGPs have been found to be effective in attracting and retaining new nurses to the field (Pelletier et al., 2019; Rush et al., 2013; Walsh, 2018). Despite the benefits of the NGP, there appears to be variations in the aims, duration, supports and educational focus of NGPs internationally (Pearson, 2019; Walsh, 2018). This includes variations in the names for NGPs such as – internships, residencies, mentorships, preceptorships and programs (Rush et al., 2013). The exploration of the NGP within the literature will be explored here as well as the socialisation of NGs into clinical practice.

In the Australian context there are currently no regulations on how a NGP should be delivered, therefore there are wide variations in the structure, content, and duration of NGPs. There is variation on the length, number, and type of clinical rotations in addition to the program components (Missen et al., 2014; Pearson, 2019; Rush et al., 2013). Though the program components

could include a combination of mentorship, education, supernumerary time, formal or informal preceptorship, and orientation (Rush et al., 2013). Overall, the aim of the NGP was seen as consolidating the skills and knowledge of NGs in a supported manner (Parker et al., 2014; Pearson, 2019). There are a number of ways that NGs can enter a transitional program – largely managed within each Australian State and Territory. In the NSW context, NGs applying for a public hospital new graduate position need to apply through the state-level online portal (NSW Health, n.d.). In reviewing this process, each State and Territory has similar but differing criteria for applicants. Despite the common online portal for applications, in NSW it is recommended that NGPs are locally developed and adapted to suit the requirements of each health service and clinical area, resulting in differing program structure, content, and duration. In exploring the entry point of the NGP, all States and Territories emphasise that newly graduated applicants are not guaranteed their clinical specialty preference for the NGP, and it they declined their offer, they may not receive another offer. This highlights the competitive process with a large number of applicants and the possibility of not gaining a position in the NGP. It is also emphasised that the NGP was beneficial for new nurses but not mandatory to gain employment as an RN (NSW Health, n.d.). The challenges of securing the desired NGP specialty was also highlighted by Walsh (2018) who stated that in the Australian context, NGs might not be able to secure their chosen specialty and may need to accept the offer of the program they have been provided.

2.3.1 Socialisation of new nurses

Socialisation into cultural group has been described as stressful for new nurses. It is described as more than just consolidating skills and entering the workforce in their chosen specialty, it describes the change of state that NGs encounter involving identity formation, ability, and behaviour (Cleary et al., 2009; Meyer, 2019; Procter et al., 2011). The process of socialisation for new nurses is expected to take at least 12 months, with NGs developing core skills as they socialise into the organisation (Hayman-White et al., 2007). Whereby their communication, attitudes, and perceptions are influenced through social approval and feedback from their colleagues and superiors (Stevens, 2014; Waegemakers Schiff, 2009). Dyess and Sherman (2009) describe NGs as moving through the stages of ‘doing’, to ‘knowing’ and then to ‘being’ in their first twelve months of clinical practice. This process reflects the NGs socialisation both into clinical practice and into the cultural group. The primary goal for NGs is to integrate into the organisation and into their collegiate network (Duchscher, 2009). This process is associated with shock and stress, with an increased risk of attrition during the first 12 months for NGs entering clinical practice (Mabala et al., 2019). Clinton and Hazelton (2000) emphasise that it can take longer for graduates to socialise and develop proficiency if their educational preparation has been inadequate.

The process of socialisation and transition experience has been explored in the literature. With Kramer (1974) coining the term ‘reality shock’ to describe the conflict experienced as hospital-based nursing students transitioned from the

structure, expectations and values of student nurses within the educational setting, to the differing values and world views inherent to the clinical practice. The key component of this experience was the disparity between values in the clinical setting and their own resulting in the NG abandoning their own values or abandoning the clinical setting altogether (Kramer, 1974). The process of transition has been identified as occurring over four phases – honeymoon, shock phase, recovery, and resolution (Kramer, 1974). According to Kramer (1974), NGs enter the workplace in the honeymoon phase, but move to the shock phase when the reality of clinical practice is realised (Cleary et al., 2011; Kramer, 1974). Nurses then progress to the recovery phase where they start to experience reduced anxiety and are better able to cope with the reality of the workplace. In the resolution phase, the nurse experiences a successful transition into the clinical setting or experiences symptoms of burnout and leaves the clinical setting or professional altogether (Cleary et al., 2011; Kramer, 1974).

Duchscher (2009) coined the term ‘transition shock’ through further research based on Kramer’s original theories. Duchscher (2009) emphasised the need to bridge the undergraduate curricula with workplace expectations. Labrague and de los Santos (2020) outlined that as many as 60% of NGs want to leave within their first year of practice in response to the stress of transition. Kim and Yeo (2019) acknowledged that many NGs experience some form of transition shock but noted differences in the severity of the experience. They further emphasise that the transition shock may be worse if the NG is entering a poor or negative

work environment. Mabala et al (2019) also highlight those challenges for new nurses when they are entering an environment perceived as high risk or unsafe.

One of the challenges outlined for new nurses was in assimilating into the cultural group and not being seen as incompetent by their peers (Wakefield, 2018). Feng and Tsai (2012) also acknowledged these challenges for the NGs in their study. They noted that the adaptation to the cultural context of the workplace and the organisation to be the biggest challenge – particularly in the clash between their own values of person-centred nursing and the organisations values of task-based nursing (Feng & Tsai, 2012). One of the challenges in the process of socialisation was in determining the focus of the NGP – with challenges between the organisations goals in orientating the NG versus the NGs individual transition to practice needs (Malouf & West, 2011; Pearson, 2019).

2.4 Transition experiences of new graduate nurses

Although this literature review seeks to explore the NGP in the context of mental health settings, there are commonalities found in the literature with NGPs across other clinical settings. There are similar patterns of difficulty in recruiting and retaining nurses in all settings as well as work-related challenges and experiences for nurses. One of the shared agreements across the literature was in the need to explore transitional experiences to retain NGs in the workforce (Labrague & De Los Santos, 2020). Successful or positive transitional experiences were associated with improved attraction and retention of NGs to

the workplace (Phillips et al., 2014). In exploring the experiences of NGs, transition shock, described in the preceding sub-theme, was a commonly described experience for new nurses. Shock and stress when transitioning to new clinical areas were evident for more experienced nurses as well as NGs (Hussein et al., 2017; Kinghorn et al., 2017). This experience can be exacerbated depending on the personal characteristics of the NG and the workplace they were assimilating into (Kim & Yeo, 2019).

The workplace was described as an important factor in the satisfaction and experience of NGs. Read and Laschinger (2015) emphasised the link between positive and empowering work environments and the improved retention of nurses. These positive experiences were linked with the NGs access to resources, leadership, and relationship with colleagues (Phillips et al., 2015; Read & Laschinger, 2015; Rush et al., 2013). In contrast, negative experiences such as horizontal violence and challenging workloads were associated with burnout and increased risk of attrition (Dawson et al., 2014; Kutney-Lee et al., 2012). One of the challenges outlined by NGs is in navigating the workloads as well as feeling unprepared for the demands of clinical practice with a gap described between their theoretical preparation and the clinical expectations (Kinghorn et al., 2017; Labrague & De Los Santos, 2020). NGs experienced challenges in adapting to new clinical areas and developing the necessary skills (Kinghorn et al., 2017). The shock of the transition and encountering variance from expectation also presented a challenge for NGs (Parker et al., 2014).

Research concerning support for NGs as they enter clinical practice in various clinical areas was also a commonality. Kinghorn et al (2017) noted the value of support systems, however noted that there was inconsistency in their implementation across clinical areas. Within the literature, transitional programs were seen as necessary to create a work environment that supports new nurses with this resulting in increased job satisfaction and improved retention rates (Missen et al., 2014). Walsh (2018) explored the benefits of the NGP for NGs particularly around skill development related to communication, organisational, critical thinking and stress management, with these factors associated with improved job satisfaction and retention. Phillips et al (2014) and Parker (2014) noted that the experience of transitioning can be improved through supportive practices and fostering collegial respect. This is supported by Laschinger and Grau (2012) who noted that supportive collegial relationships are important for organisational productivity and retention outcomes. Labrague and de los Santos (2020) and Jackson (2018) suggest that preceptorship can improve the retention of NGs to clinical practice. Successful transition was demonstrated by the nurse building confidence and orientating to the role (Powers et al., 2019).

2.4.1 Publication one: Hooper, Browne & O'Brien (2016). The experiences of new graduate nurses entering mental health nursing: an integrative review. *International Journal of Mental Health Nursing, 25,* 286-298.

The brief overview of the history of MHN in the Australian context provided background context to the modern educational preparation of mental health nurses. Additionally, the understanding of the origins of MHN culture provided an insight into the practice cultures that are evident today. The focus of the literature review is around the experiences of NGs within mental health services. The findings of the literature review specifically pertaining to the experiences of NGs in mental health services has been published as an integrative review (Hooper et al., 2016). This literature review represents a broader and more detailed review of the literature. This includes the comparison of 22 studies exploring the experiences of NGs entering MHN. The primary review findings highlighted negative clinical experiences and increased risk of attrition early in the mental health nurses' career. These were primarily attributed to the changes to MHN education, role ambiguity, inadequate clinical preceptorship, encountering the reality of mental health services, and the role of mental health services in the transition of NGs into clinical practice (Hooper et al., 2016)

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Review Article

Graduate nurses' experiences of mental health services in their first year of practice: An integrative review

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ABSTRACT: *New graduate nurses have reported negative experiences in mental health settings, particularly during the transitional period of practice. Previous research has focused on addressing the undergraduate preparation of nurses for practice instead of the experiences and outcomes of the transitional period. Recently, there has been growing interest in exploring the experiences of graduate nurses in transition and the implementation of promising interventions to facilitate new graduates' assimilation to practice. Despite these initiatives, the overall shortage of mental health nurses continues to rise, and graduates still report negative experiences in the mental health setting. The purpose of this study was to identify and explore the experiences of new graduate nurses in mental health services in their first year of clinical practice. An integrative review was conducted with 22 studies sourced from the CINAHL, PubMed, Scopus, and PsychINFO electronic databases, as well as through hand-searching the literature. Literature review findings have highlighted negative clinical experiences and increased attrition from mental health services for graduate nurses. These experiences were closely linked with the changes in the training of mental health nurses, role ambiguity, inadequate clinical preceptorship, encountering the reality of mental health services, and the role of health services in transitioning graduate nurses into clinical practice. Established research into organizational cultures demonstrates that negative organizational outcomes result from negative workplace experiences. Therefore, further research into new graduate nurses' experiences of mental health nursing and its culture might clarify the reasons why they might not be attracted to the discipline and/or are leaving early in their career.*

KEY WORDS: *culture, experience, graduate nurse, mental health service, transition programme.*

INTRODUCTION

It has been widely documented that the global nursing shortage is increasing, with the workforce paucity being more pronounced in modern mental health services (Cunich & Whelan 2010). The shortage of mental health nurses in Australia, for example, is further impacted by an ageing workforce, with nurses approaching retirement age. This factor correlates negatively with the smaller numbers of nurses attracted to and retained in the field (Stuhlmiller 2005). In New South Wales, Australia, between 2008 and 2012, the average age of nurses and midwives increased from 44.1 to 45.3 years of age, with the number of nurses over the age of 50 years practicing in public health services increasing from 35.9% in 2008 to 42.2% in 2012 (Australian Institute of Health and Welfare 2013). The ageing workforce is more pronounced in the mental health field, with the average age of mental health nurses at 47 years in 2012 (Australian Institute of Health and Welfare 2013).

Australia, commensurate with other countries, is currently experiencing a health and economic burden related to the increased incidence and morbidity of mental illness in the general community (McCloughen & O'Brien 2005;

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Department of Health 2009; Australian Institute of Health and Welfare 2014). It is estimated that in any given year, 20% of the Australian population experience mental illness, with nearly half the Australian population experiencing mental illness in their lifetime (National Mental Health Commission 2014). Thus, addressing critical and perpetual nursing workforce shortages remains a priority for mental health services in this country, as it is with other developed countries. There has been a substantial body of research exploring the educational preparation of nurses, particularly within the context of deinstitutionalization, and the change to comprehensive tertiary models of educational preparation as a means for explaining the deskilling and shortage of mental health nurses in practice (Happell & Cutcliffe 2011; Neville & Goetz 2014). Nevertheless, despite the protracted publication of research findings surrounding the educational preparation of nurses for mental health practice, and often critical discussion, very little has changed in the educational preparation, recruitment, and retention of new graduates in the past decade.

There is now an emerging body of literature detailing the experiences of new graduate nurses in mental health services, with particular emphasis on graduate or transitional programmes to support and prepare nurses for clinical practice in their first year out of university as a registered nurse (Cleary *et al*. 2009a; Procter *et al*. 2011). Although transitional programmes have been shown to be necessary in the process of transitioning for graduates, there is still a high risk of attrition early in the career of mental health nurses (Hazelton *et al*. 2011; Procter *et al*. 2011). Further exploration into the experiences of new graduate nurses when first encountering mental health services is warranted, given the increasing workforce shortages, increased incidence of mental illness, and the risk of attrition. Despite good intentions to facilitate the transition of graduate nurses into mental health nursing, these efforts do not appear to be ameliorating the problems.

Education and training of mental health nurses

The historical origins of mental health nursing differ from those of general nursing; the former originating from the custodial origins of the asylum, while the latter depicted as originating in the Nightingale era (Prebble 2001; Holyoake 2014). These contrasting origins have been recognized within the historical specialty training programmes, whereby graduate nurses were only allowed to work within their field of training unless they undertook additional training in another specialty field.

Interestingly, from 1985, the transition of nursing education from hospital training to tertiary education began, but the nursing specialities were eventually dropped in preference for a comprehensive approach to education (Dawkins 1988; Russell 1990; Happell & Cutcliffe 2011; Department of Health 2013;). The graduates of the modern comprehensive training programme are intended to be prepared as a beginner clinician in any nursing specialty, rather than trained as specialist graduates (Warelow & Edward 2009; Wynaden 2010; Happell & Cutcliffe 2011). The move to generic training has sparked much debate among academics, with the dilution of specialist knowledge and skills in the mental health sector cited as a primary concern (McKeown & White 2015).

The Sax report conducted in 1978 identified issues relating to the education and training of nurses, with emphasis on differing standards of training and the inadequate preparation of nurses to meet health-care challenges (Department of Education Training and Youth Affairs 2001). Then in the chronology of events, the Dawkins 1988 white paper recommended nursing education shift to the higher-education sector. One of the relevant recommendations of the Sax report was the need for improvement in the collaboration between health services and tertiary education institutions in order to provide for the educational preparation of nurses (Department of Education Training and Youth Affairs 2001). A similar recommendation also made in the more recent UK's 'Shape of caring' report to strengthen the relationships between universities and regulatory and professional bodies, but with a focus on providing adequate preceptorship to nursing graduates (Willis 2015).

The evolution of training relocation from hospitals to universities and the changes to mental health care being deinstitutionalized in the 1980s were largely influenced by social, political, and economic factors (Holyoake 2014). The deinstitutionalizations of people living with a mental illness and the integration of services to general hospitals were believed to reduce stigma and improve the physical health care of consumers (Warelow & Edward 2009; National Mental Health Commission 2014). The Carpenter Report conducted in New Zealand suggested that mental health nursing as a specialty would eventually no longer be required, and that general nurses would then fulfil this function within the general nursing setting (Department of Health 1971; Prebble 2001); however, this has not happened.

Despite good intentions, there is little evidence to suggest that the comprehensive model of training improves stigma or the physical health care of consumers, and mental health nursing certainly has not gone into extinction. In fact, the incidence of mental illness has continued to rise globally, despite the major changes to training and health-care service provision (Australian Bureau of Statistics

2007; Wynaden 2010; World Health Organization 2013). The changes to mental health care and training in Australia have subsequently fuelled research into and continuous debate about the preparation of graduate nurses for clinical practice. The overall consensus has been that graduate nurses are largely not prepared for, or even attracted to, a career in mental health nursing (Cleary *et al.* 2009a; Happell & Gaskin 2013), while those who do pursue a career in mental health nursing continue to be criticized for a lack of sufficient knowledge and skills for practice in the mental health nursing domain (Hazelton *et al.* 2011).

METHOD

Search strategy

Although the focus of this review is to explore the experiences of graduate nurses in the Australian context, the review of literature internationally will give the research findings further depth, as this review intends to synthesize data on the experiences of new nurses in the clinical environment, irrespective of the modality of educational preparation. Similarly, the findings of this review would then be applicable in the international context.

The computerized databases of CINAHL, PubMed (Medline), PsychINFO, and Scopus were searched using the following key words: graduate nurse, mental health, psych*, experience, transition, clinical practice, culture, mental health services, orientation, reality. The first author conducted all literature searches. The inclusion criteria included articles published in peer-reviewed journals; written in the English language; and had content pertaining to the search terms, with the aim of the literature review to explore the 'experiences of graduate nurses of mental health services'. There were no date restrictions on the literature; however, the earliest relevant article retrieved was published in 1997. There were no restrictions to the country of origin, as long as the article was available in the English language, to allow for a range in the literature of experiences and opinions. Articles were excluded if they focused on the undergraduate nursing experiences in the mental health setting or did not pertain to graduate nurse experiences or transition to mental health.

Each of the databases searched produced different results; the majority of articles were found through CINAHL, with a total number of 22 articles retrieved. The first retrieval considered the title, abstract, and keywords using the search terms. Sourced literature was then excluded if they did not meet the inclusion criteria. The remaining articles were then comprehensively reviewed, and those that did not address the aims of the review were excluded. This resulted in a total number of 22 papers included in the review. There were additional papers included that did not solely address the experiences of graduate nurses, but added further depth to the paper (Table 1).

RESULTS

The results of the integrative review are outlined in Table 2.

Transition of graduate nurses in mental health services

The purpose of the graduate or transitional year of practice is to consolidate the learning attained through undergraduate training and to provide support during the period of transition into clinical practice (Cleary *et al.* 2009b; Hayman-White *et al.* 2007). This period of transition involves a change of state within the graduate nurse over time, involving identity formation, ability, and behaviour (Cleary *et al.* 2009a; Procter *et al.* 2011). The transition period is known to be characterized by shock and stress, with this reaction not only attributed to a change in the individual's state of mind, but also to the process of acculturation into the complex and confronting nature of mental health nursing itself (Hayman-White *et al.* 2007; Martin *et al.* 2007). It is posited that the development of core clinical skills, as well as adaptation and socialization into the organization, can take at least 12 months (Hayman-White *et al.* 2007). Therefore, new graduates will require adequate support and guidance in mental health nursing for adequate socialization to occur.

Many of the research papers reviewed detailing the experiences of graduate nurses focus on identifying a correlation between undermined educational and clinical preparation of graduate nurses and the associated workforce and clinical expertise deficits (Hayman-White *et al.* 2007; Patterson *et al.* 2008). In response to these findings, various schemes have been devised to remedy this issue, such as the use of transitional support programmes and the mentoring and/or preceptorship of undergraduate and graduate nurses. Unfortunately, despite these schemes, there is still a high proportion of negative experiences described by graduate nurses in mental health settings. The majority of these experiences are compounded by negative and seemingly preconceived ideas about mental health services (Arnold *et al.* 2004; Warelow & Edward 2009), and inadequate educational preparation for practice (Hayman-White *et al.* 2007). Such experiences have been associated with a decreased attraction to mental health services and difficulty in retaining the newly-

TABLE 1: *Search methodology*

Search method	Search terms	No. retrieved	Excluded titles/ abstracts	Duplicates removed	Excluded full articles	No. studies that met inclusion criteria	Articles
CINAHL	Mental health and nurs*and New grad*	55	34	-	4	17	Tingleff & Gildberg 2014; Hazelton *et al.* 2011; Procter *et al.* 2011; Cleary *et al.* 2011; Patterson *et al.* 2008; Cleary *et al.* 2009a,b; McCloughen & O'Brien 2005; Nadler-Moodie & Loucks 2011; Hayman-White *et al.* 2007; Wright *et al.* 2011; Schwartz *et al.* 2011; Rungapadiachy *et al.* 2006; Charleston *et al.* 2007; Puntil 2005; Waite 2004;
	Mental health and nurs* and transition	91	82	7	1	1	Cleary & Happell 2005
PubMed	Mental health and nurs*and graduate	184	183	-	-	1	Khankeh *et al.* 2014
	Mental health and nurs* and transition	55	55	-	-	-	
Scopus	Mental health and nurs*and new grad*	308	291	13	2	2	Martin *et al.* 2007; Prebble & McDonald 1997
	Mental health and nurs* and transition	237	225	12	-	-	
PsychINFO	Mental health and nurs*and graduate	70	64	6	-	-	
	Mental health and nurs* and transition	27	22	5	-	-	
Hand Search	Reference lists of included articles	-	-	-	-	1	Karlowicz & Ternus 2009;

Search terms: mental health OR psychiatric; nurs* OR nursing, nurse, nurses; graduate OR new graduate OR new graduate nurs*; and transition OR program OR orientation OR clinical.

graduated nurse to the field of mental health nursing beyond the transitional year of practice (McCloughen & O'Brien 2005;Hazelton *et al.* 2011; Tingleff & Gildberg 2014). It can be postulated that a new graduate entering the workplace with positive expectations in their first year of practice, who encounters a negative experiential culture, will develop an ambiguity about mental health nursing being a career prospect.

Role ambiguity

Role ambiguity can be described as a lack of clear definition and boundaries of what is expected of a role (Patterson *et al.* 2008). The issue of role ambiguity is not limited to the experiences of graduate nurses, but also to the profession of mental health nursing, whereby the definition of skills and practice are constantly evolving and the overall direction unclear (McKeown & White 2015). Graduate nurses report

TABLE 2: *Methodological review of literature.*

Study	Focus/aim	Method	Participants/setting	Themes/findings
Qualitative studies of graduate nurse experiences				
Khankeh *et al.* (2014)	Describe the experiences of newly-graduated nurses in a mental health setting in Iran.	Descriptive phenomenology. Unstructured individual in-depth interviews.	*n* = 14. Participants with <6 months' clinical experience. Razi Hospital inpatient unit, Iran.	Negative experiences and perceptions of mental health worsened by inadequate preparation for practice. Mental health setting described as frightening and unsupportive. Self-doubts to practice as a mental health nurse.
Hazelton *et al.* (2011)	Evaluation of a group mentorship programme for NG nurses in a public mental health service.	Participatory action research. Thematic analysis of findings.	*n* = 18 NG, *n* = 5 CNC. 3 mentorship groups meeting fortnightly for 6 months, then monthly for 6 months. Australia.	Fitting in to difficult work environments, maltreatment, abuse and neglect of service users, troubling clinical encounters and duty of care.
Cleary *et al.* (2011)	Elucidating the insights of NG nurses in a mental health service.	Semistructured interviews. Qualitative analysis.	*n* = 13 participants with 3–24 months' experience in mental health. Australia.	Teamwork important to NG to promote belonging and learning. Further effort needed to promote teamwork for NG transitioning into mental health.
Wright *et al.* (2011)	Investigating successful integration into mental health services by graduate nurses.	Qualitative study. Semistructured interviews	*n* = 10 graduates with <18 months' experience. Quebec, Canada.	Relational experience determinant of NG satisfaction with transition experience. Quality relational experiences with consumers as the primary motivation to pursue career in mental health nursing.
Schwartz *et al.* (2011)	Exploring new nurses' experience of their role within interprofessional health-care teams in mental health.	Semistructured interviews. Qualitative, descriptive design. Convenience sampling.	*n* = 10 graduates with 3–18 months' experience. Canada.	Adopting a passive role to 'fit in' and engaging in an active role to influence consumers care. Interpersonal and organizational factors impact on transition process. Promote workplace that encourages interprofessional collaboration.
Karlowicz and Ternus (2009)	Exploring work experiences that influence retention within the first year of employment in mental health.	Case analysis – grounded theory approach. Structured telephone interviews. Snowball sampling.	*n* = 14 current and former NG from four different inpatient mental health facilities. South-eastern region of USA.	Issues influencing NG decision to cease employment include nursing role limited and task-orientated, inadequate education and training, team dynamics, and organizational support. Role clarity identified as a critical factor influencing retention.
Patterson *et al.* (2008)	Identifying the competencies	Phenomenological approach. Purposive	*n* = 8 mental health nurses –	NG to have similar competence to mental health workforce at conclusion

(*Continues*)

TABLE 2: Continued

Study	Focus/aim	Method	Participants/setting	Themes/findings
	expected of newly-graduated mental health nurses.	sampling. Semistructured interviews.	not all NG. Regional NSW, Australia.	of transitional programme. Main competency themes: communication, safety, self-awareness, and treatment.
Martin *et al.* (2007)	Assessing the suitability of a forensic setting to provide a NGP.	Semistructured interviews. Qualitative content analysis approach to organize and classify data.	3 participant groups – $n = 3$ NG, $n = 5$ RN who had completed GNP and remained employed, $n = 6$ RN who had completed GNP, but not employed. Forensicare, Melbourne, Australia	NG report positive experiences from the specialized forensic programme, and deny feeling disadvantaged by its specialist nature. Forensic setting is suitable for a NGP, although there is a need for sufficient numbers of competent and satisfied nurses to support NG.
Charleston *et al.* (2007)	Examining mental health GNP in Victoria, Australia, in order to make improvements.	Thematic analysis from individual and focus group interviews. Purposive sampling.	$n = 21$ area mental health services in Victoria, Australia. Participants included non-graduate nurses.	Effective orientation crucial to NG confidence and learning. Formal, structured, and supportive orientation need in the mental health setting.
Rungapadiachy *et al.* (2006)	Determining whether the perception of the mental health role changes post-graduating.	Semistructured interviews 6 months' post-registration. Grounded theory for data analysis.	$n = 11$ NG recruited from a tertiary institution. University of Leeds, UK	Participants report little change in their perception of the mental health nursing role post-graduating. The role is still regarded as ambiguous secondary to the diversity of required unction and tasks.
Waite (2004)	To describe and explore the transitional experiences of advanced beginner nurses in mental health settings.	Phenomenological study, audio-taped interviews.	$n = 15$ NG. Mental health setting, USA.	Variance in NG experiences – expectations, orientation, responsibility, and support. Integration of education and clinical experience deemed inadequate.
Prebble & McDonald (1997)	To explore the experiences of comprehensive nurse graduates as they adapted to the mental health setting.	Qualitative, descriptive study.	$n = 4$ participants.	Themes identified: transition to practice, conflict, contradiction, structural constraints, and 'reality' of the mental health setting. Concern with the quality and quantity of transitional programmes,

(*Continues*)

TABLE 2: Continued

Study	Focus/aim	Method	Participants/setting	Themes/findings
				and inadequate educational preparation for practice.
Quantitative studies of graduate experiences				
Cleary *et al.* (2009a,b)	Assessment of NG satisfaction with NGP and its impact on their perceived knowledge, confidence, and self-concept.	Quantitative evaluation design. Questionnaire for data collection	3 groups (n = 44) of participants completed pre- and post-surveys (total: n = 45 participants in programme). Australia.	Improvement in knowledge and confidence post-transition. Future research could ascertain benefits of NGP on retention.
Cleary and Happell (2005)	Evaluation of the satisfaction of a NGP to determine its effectiveness.	Survey – post-first clinical placement and after completion of course. Data analysed – SPSS spreadsheet.	NGP in Central Sydney Area Health Service. n = 39 who commenced the programme, n = 37 who completed the programme.	Recruitment and retention difficulties in mental health. Availability of clinical support main contributor to positive experience with lack of support contributing to attrition. Increased emphasis on preceptorship needed.
Literature and programme reviews				
Tingleff and Gildberg (2014)	Review of the literature pertaining to transition programmes and experiences in mental health.	Thematic analysis of the literature.	14 papers analysed	Nursing education. Transition programmes and evaluation. Working environment. NG nurse role.
Nadler-Moodie and Loucks (2011)	Description of a NG residency training programme directly into mental health nursing.	Case study.	Sharpe Healthcare 'new-grad' programme, Sharp Mesa Vista Hospital, USA.	Programme could be implemented in other settings to address recruitment and retention difficulties. Programme has a structured approach, with a focus on education, clinical experience, and professional development.
Procter *et al.* (2011)	Identify patterns of broader issues faced by newly-graduated mental health nurses when entering the workforce.	Thematic analysis of literature.	9 papers analysed.	Collaboration needed between health services and universities to improve transitional experience and decrease role ambiguity and the uncertainty of NG. Preceptors essential to assist in preparing, supporting, and retaining NG, and to assist in building resilience and self-development to manage clinical experiences.

(*Continues*)

TABLE 2: Continued

Study	Focus/aim	Method	Participants/setting	Themes/findings
Cleary *et al.* (2009a,2009b)	Examining how transition programmes meet the expectations of stakeholders and participants.	Literature review.	Broad review of available literature – number of papers and criteria not stipulated.	Lack of published evaluations of transitional programmes, particularly from the consumers of mental health services. Consumers' expectations should contribute to the design of transitional programmes.
Hayman-White *et al.* (2007)	Review of the literature - transitional experiences of mental health programmes.	Literature review.	Broad review of the available literature – transition programmes in general, and then the purpose, structure, and content.	Inadequate orientation and support might impact on NG ability to adapt and learn in the clinical environment. Inadequate undergraduate preparation for practice. Further research needed to identify factors promoting positive experiences for NG in mental health.
Puntil (2005)	Identify methods to attract, orientate, and mentor NG nurses in a geriatric mental health setting.	Case study	Geriatric inpatient mental health setting, USA.	Orientation influences the function and competence of the NG. Investment into orientation, education, supervision, and support is likely to result in greater job satisfaction and commitment.
McCloughen and O'Brien (2005)	To describe the development of a mentorship programme for NG nurses in a mental health setting.	Case study	University and 3 separate mental health services. NSW, Australia.	Mentorship promotes the retention of NG, which is identified as a useful strategy to address recruitment and retention difficulties in mental health nursing.

CNC, clinical nurse consultant; GNP, graduate nurse programme; NG, new graduate; NGP, new graduate programme; NSW, New South Wales; RN, registered nurse.

that the role of the mental health nurse is unclear and dependent on the clinical environment, with the wide range of tasks contributing to the diffuseness and uncertainty of their role (Schwartz *et al.* 2011; Rungapadiachy *et al.* 2006). The impact of role ambiguity appears to affect the graduate nurse more intensely, with graduates feeling uncertainty with their role and unprepared for the sudden increase in responsibility when commencing clinical practice (Procter *et al.* 2011; Rungapadiachy *et al.* 2006). Commencement anxiety is compounded in some settings by a lack of clinical support, education, and horizontal violence, which reportedly contributes to an increase in attrition rates (Hayman-White *et al.* 2007; Wright *et al.* 2011). Aside from increased attrition from mental health nursing, nurses report increased anxiety, difficulty coping, lack of confidence, and conflict with the dichotomy of theoretical and clinical learning expectations (Hayman-White *et al.* 2007). Graduate nurses also report a conflicting state of being 'put in their place' while being challenged to demonstrate competence in clinical practice (Hazelton *et al.* 2011). Addressing role ambiguity is essential in the retention of graduate nurses to the field of mental health; it involves identifying the culture, values, roles, and approaches to practice, as defined by the profession, and where the graduate fits into this (Karlowicz & Ternus 2009; Schwartz *et al.* 2011). Role ambiguity can be partially ameliorated through clinical supervision and preceptorship by experienced clinicians in the company of new graduates in clinical practice.

Preceptorship

The recent emphasis on implementing preceptor and mentorship models within mental health services aims to provide support and to aid the integration of graduate nurses as they enter clinical practice. They are also intended to assist in the development of competent mental health nursing skills, while alleviating the stress of the transition process (Curtis 2007; Hayman-White *et al.* 2007; O'Brien *et al.* 2014). The benefits of preceptorship include access to the expertise of experienced nurses, role modelling, and socialization into the organization (Cleary & Happell 2005). Graduate nurses are dependent on their colleagues, particularly in the process of acclimatizing to the clinical environment and for social and emotional support.

They require the availability and time of skilled clinicians, as well as reciprocal inclusion, trust, and acknowledgement as they develop professionally and integrate into the organizational culture (Martin *et al.* 2007; Wing *et al.* 2013). This requires the health services to additionally support, nurture, and facilitate the professional development of preceptors in order to provide adequate professional support effectively (Hayman-White *et al.* 2007; Rungapadiachy *et al.* 2006). The reality of some mental health services, however, is of inconsistency in the provision of support in the preceptorship for graduates (Wright *et al.* 2011; Wynaden *et al.* 2000). Inadequate social and clinical support is linked to feelings of incompetence, powerlessness, and psychological distress (Wing *et al.* 2013; Tingleff & Gildberg 2014). There is a strong correlation between preceptorship and workforce stability and clinical outcomes, with this reflected in the level of perceived support of the new graduate, their overall skill development, as well as their intent to remain in the mental health nursing domain (Charleston & Happell 2006; Karlowicz & Ternus 2009).

Reality of mental health services

Graduate nurses have reported low levels of confidence as beginner clinicians in the field of mental health nursing, with this exacerbated by the negative experiences they have had in clinical practice during their training practicum events (Hazelton *et al.* 2011; Moodie & Loucks 2011; Khankeh *et al.* 2014; Nadler- Neville & Goetz 2014). These negative experiences have included horizontal violence (Cleary *et al.* 2009a), lack of clinical support and guidance (Hazelton *et al.* 2011), rostering onto shifts with limited supervision and support (Cleary *et al.* 2009a), negative attitudes of experienced staff towards students and graduate nurses (Wynaden *et al.* 2000), and unrealistic expectations from other team members (Hazelton *et al.* 2011).

These experiences are in addition to some graduates working in services that are characterized by a defensive work culture, and are understaffed, overworked, and ill-prepared to consolidate the graduate's learning (Wynaden *et al.* 2000; Wright *et al.* 2011; Spence *et al.* 2012;). They have also reported shock when faced with the reality of the working conditions, expectations, and stress of mental health nursing itself, where the clinical environment is often described as difficult and hostile (McCloughen & O'Brien 2005; Hazelton *et al.* 2011; Procter *et al.* 2011).

The demonstration of power relations and coercive practices towards consumers was a reality of some mental health settings, as well as a focus on security and safety measures, which have been described as confronting and distressing. (Hazelton *et al.* 2011; Procter *et al.* 2011; McAllister *et al.* 2014; Tingleff & Gildberg 2014). Such situations highlight the dichotomy between ideal practice and the reality of practice in some mental health settings, which can create confusion between what is taught and what is an apparent clinical practice reality. The consequences of nurses encountering negative clinical experiences include absenteeism and attrition (McKenna *et al.* 2003).

Those graduate nurses who undertake clinical experience or pursue a career in the field of mental health nursing might experience the remnants of the evolution of a negative and hostile mental health nursing culture. Unfortunately, new nurses have reported feeling devalued by society and fellow nursing colleagues for pursuing a career in mental health nursing, in addition to feeling devalued and isolated by established mental health nurses (Charleston & Happell 2005). This finding indicates that a negative portrayal of mental health nursing exists, with this implicated in the existing stigmatization of mental illness and mental health care (Hayman-White *et al.* 2007). Despite this reality, there are graduate nurses interested in pursuing mental health nursing as a career, yet are impacted by a multitude of negative experiences, which add to the already stressful nature of acculturating and assimilating into mental health nursing. It is clear that graduate nurses need positive experiences and opportunities to gain proficiency, feel supported, and become indoctrinated positively into the profession (McCloughen & O'Brien 2005). The attitudes of mental health clinicians are influential on whether graduates perceive their clinical experiences to be positive or negative, with positive experiences more likely to lead to the graduate remaining in the field of mental health (Arnold *et al.* 2004; Cleary & Happell 2005).

Health services in the transition process

There is ambiguity and controversy about the role of health services in the process of transitioning nurses into practice. It is unclear and inconsistent what the transition programme entails, given the diversity in structure and programme content across health services. The varying functions of a transition programme could include an educational programme, recruitment and retention strategy, or simply a process to make up staffing numbers. Therefore, the function of the programme should theoretically determine the outcome and the appropriate resources implemented (Hayman-White *et al.* 2007). Health services that mismanage the process of transitioning risk attrition of nurse graduates not only negatively affect the profession in the long term, but also result in high costs to the service and has detriment to consumer outcomes (Charleston *et al.* 2007; Wright *et al.* 2011).

Without a clear direction and purpose of the programme, the nurse who undertakes the programme faces an increased stress of role ambiguity and a commensurate increase in the described negative experiences of clinical practice, resulting in burnout, difficulty coping, and increased attrition (McCloughen & O'Brien 2005). It is posited that graduate nurses hold a similar level of competence as the majority of mental health nurses by the end of their first 12 months of practice, through attainment of the skills, knowledge, and behaviours acceptable to the organization and field of mental health nursing (Martin *et al.* 2007; Patterson *et al.* 2008). If this outcome is to be achieved, there needs to be an effective transitional programme in effect. There is an emphasis on the importance of empowering workplace structures, with clear and concise support processes. It is more likely that the graduate will report more favourable attitudes towards mental health nursing and intention to remain in the profession when they have had adequate support and positive experiences during their period of transition (Charleston *et al.* 2007; Procter *et al.* 2011).

DISCUSSION

It has been established that there is ongoing difficulty in attracting and retaining graduates to the field of mental health nursing – the more problematic being the difficulty in retaining staff. While difficulty attracting graduates is expected, given the apparent unpopularity of mental health nursing, those who do elect to enter the profession are still at a high risk of attrition (Hazelton *et al.* 2011). A high attrition of new staff is alarming, given the imminent retirement and ageing of the workforce, overall dilution of expertise in the clinical setting, and the increasing incidence of mental illness (Hazelton *et al.* 2011). Through this review of the literature, it has been identified that new graduate nurses have reported negative experiences during transitional periods in mental health nursing, with this emphasized by role ambiguity and inconsistent preceptorship.

Yet mental health services still need new graduates who can 'hit the floor running' (Hayman-White *et al.* 2007), which is hardly a solution to this issue, especially given the evidence that this only exacerbates the negative experiences graduates already face, resulting in them learning to cope instead of developing professionally, or even leaving the profession altogether (Hayman-White *et al.* 2007). In response to the negative experiences described by new graduates and the need for effective professional development, there is an emphasis on the provision of clinical supervision in addition to preceptorship within the health setting (Cleary *et al.* 2010; Health Workforce Australia 2014). It is established that there are ongoing challenges and inadequate emphasis on implementing and establishing clinical supervision into mental health settings, despite

the organizational and professional benefits of its practice (Cleary *et al.* 2010). This is acknowledged as a further complicating factor in the overall negative experiences of graduate nurses in clinical practice.

The health services cite criticism towards universities for the inadequate preparation of nurses, despite existing literature identifying that mental health nursing is a less favoured specialty area (Clinton & Hazelton 2000). Nevertheless, there are still a proportion of nurses who pursue a career in mental health despite its unpopularity, and do not elect to remain in that field after completing clinical experience (Cleary *et al.* 2011). Further investigation into these phenomena is imperative given that the current focus in the literature has been on the universities' inadequate preparation of graduate nurses for practice, with this taking precedence over the ability of health services to reciprocate or continue the process of preparation, and in essence, retain graduate nurses to the field.

Increasing nursing attrition in the field of mental health is a current reality. There are promising findings in the literature emphasizing the ability to influence the negative attitudes of undergraduate and graduate nurses towards mental health nursing (Happell & Gaskin 2013), with a resultant increase in the likelihood of pursuing a career in this field. Despite these efforts by universities to improve the preparation of graduate nurses for beginner practice and to encourage them to pursue a career in mental health nursing, there is still a high attrition of nurses within 1–2 years of graduation (Procter *et al.* 2011).

Arguably, this rate of attrition could be the result of their clinical experiences after graduation, and not necessarily as a consequence of inadequate preregistration training (Procter *et al.* 2011). As the literature demonstrates, the majority of the preparation and retention deficits occur in the clinical setting. The focus of research needs to shift towards the clinical environment and the experiences of graduate nurses when encountering the reality of mental health services. Further investigation is warranted into the cultural nuances of mental health nursing, and how this impacts graduate nurses when they enter the clinical setting.

The impact culture of mental health nursing culture on new graduates has not been well documented in the literature, although has been alluded to in existing studies. Previous studies on organizational culture have demonstrated a correlation with negative workplace culture and recruitment and retention difficulties, as well as an overall decrease in the success of the organization.

It is interesting that this phenomenon has not been explored in mental health nursing, given the projected future of mental health nursing itself and the concerns with the diminishing capacity of the workforce to address the increased prevalence and complexity of mental illness. Exploring the culture of mental health services and how graduate nurses experience this culture is an important direction for the future of mental health nursing.

CONCLUSION

A review of the literature found that the experiences of graduate nurses transitioning through mental health services resulted in a high risk of attrition associated with negative clinical experiences. The emphasis in the literature has shown some of the causes of this high attrition to be: (i) the recent changes to the educational preparation of mental health nurses; (ii) the issues regarding role ambiguity; (iii) inadequate preceptorship of graduate nurses; (iv) the reality of mental health services; and (v) the health services' role in the transitioning of graduate nurses to clinical practice.

The experiences within these themes were shown to contribute to the overall attrition of graduate nurses from mental health. Although negative experiences were described in the literature, without further investigation into the cultural nuances of mental health nursing and how graduates experience this culture, there is little gain to be made. An understanding of the culture of mental health nursing cannot be elicited from the existing literature, and therefore only a hypothesis can be drawn from the literature review findings. However, extensive research has been made in the field of organizational culture and the effects of positive and negative workplace cultures on workforce and clinical outcomes. This then outlines the need for further research into the experiences of graduate nurses when encountering the culture of mental health nursing.

LIMITATIONS

The primary limitation of the present review is the paucity of literature existing that investigates the experiences of graduate nurses encountering mental health nursing culture. The literature search itself was not strict in its inclusion and exclusion due to the need to find literature pertaining to mental health nursing culture and graduate experiences. This literature review is certainly not the first to review graduate nurses' experiences in mental health; however, this review differs by its emphasis on the need to explore mental health nursing culture as a way of addressing nursing attrition. The present study included other pertinent literature that did not explore the graduates' experiences of mental

health services, but added to the overall research findings and aim of the review. This included some non-mental health graduate research papers and the experiences and opinions of those who are not graduate nurses.

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2.4.2 Additional papers published since this review

The preceding integrative review was published in 2016, and additional papers, relating to the experiences of NGs entering MHN, have been published since then. The themes found within the more recent literature follow a similar trend to the findings of the published integrative review (Hooper et al., 2016).

Kurjenluoma et al (2017) explored the experience of the workplace for NGs in Finland using survey methods. They noted that the increased complexity and severity of symptoms and the use of coercive measures such as restraint in mental health care was associated with decreased satisfaction among NGs. Sorensen, Tingleff and Gildberg (2018) published similar findings when they explored the experiences of NGs as they transitioned into a forensic mental health inpatient setting. They noted two main themes – *feeling safe* and *taking on responsibility*. NGs held more positive views on their responsibilities when they felt safe and supported. Mabala et al (2019) explored the perceptions of NGs working in mental health facilities using semi-structured interviews. Their study emphasised that NGs experience fear and concerns for their safety when entering the mental health unit. This has been also noted in previous studies outlined in the integrative review (Hooper et al., 2016). They noted that encountering stressful or demanding clinical situations were linked with a higher risk of attrition within one to two years of entering clinical practice (Mabala et al., 2019).

White et al (2019) explored the challenges faced by NGs in developing therapeutic relationships with consumers in mental health settings due to a workplace focused on risks and task-based practices as well as deficits in supports. A similar focus was taken by Padagas et al (2021) who explored the experiences of NGs during their transition, with their two main findings around transitional challenges and coping mechanisms. Several studies identified that the workplace played an important role in NGs satisfaction, with stress relating to the practice environment, workloads, relationships with colleagues and conflicts in the workplace associated with decreased satisfaction (Kurjenluoma et al., 2017; Mabala et al., 2019; Pearson, 2019). Pelletier et al (2019) emphasised that the risk of attrition was enhanced through job distisfaction and inadequate supports in the clinical setting.

In exploring strategies to support NGs entering clinical practice, Jackson (2018) explored a peer support program in the initiaitive to retain newly qualified nurses. Jackson's (2018) paper supports the existing literature exploring the difficulty of transitioning for NGs and the increased risk of attrition. Pearson (2019), Padagas et al (2021) and Sorensen et al (2018) also emphasised the need for NGPs to support new nurses with an emphasis on measures such as preceptorship, mentorship and debriefing during the early experiences of NGs entering the clinical setting. Pelletier et al (2019) explored the effectiveness of a transitional program on retention of new nurses by measuring turnover rates using quantitative methodology. They found that overall NGP's are effective in attracting and retaining competent and capable NGs to MHN.

Despite further research into the experiences of NGs and the relationship to increased risk of attrition, no studies have explored the subcultural experiences of NGs entering the mental health setting, with the focus currently limited to the use of surveys or interviews to capture the experiences of NGs. These findings reinforce the need to explore the NGP and the subcultural experiences of NGs as they enter the culture of MHN.

2.5 Chapter summary

This chapter provided an overview of the historical changes to MHN practice to provide context for the nature of modern MHN practice. According to Schein (2010) it is important to understand the foundations of a culture to then explore and understand the culture. His model provided cultural context for MHN practice and the experiences of NGs entering MHN. This then led to a description of the changes to MHN training in the Australian context and the emergence of a transitional or NGP to enable the consolidation of learning for NGs entering clinical practice. This was followed by a review of the literature that has emerged exploring the use of transitional programs to support the transition of NGs into clinical practice. Included within this chapter was a published integrative review exploring the experiences of new nurses as they encounter mental health nursing during their first year of clinical practice. The experiences of nurses largely relate to their educational preparation, role ambiguity, inadequate or inconsistent preceptorship, encountering the reality of mental health services, and the health services role in the transition of new nurses. In the next chapter, the theoretical framework – Edgar Schein's (2010)

Model of Organisational Culture used in this study is explained and discussed in relation to the ethnography methodology. The theoretical framework represents the theoretical perspective of this research and allows for the meaning of research findings to be elicited.

Chapter three
Theoretical framework:
Organisational culture

"The lens we look through will determine what we see"

Renee Swope

3.1 Introduction

To address the research aims of exploring the experiences of new nurses entering the culture of mental health nursing, Edgar Schein's (2010) *Model of Organisational Culture* provided the theoretical framework. This chapter provides the justification of this framework, its relevance is in its explanation of organisational culture and how this shapes the practices, experiences, and commitment of members of the organisation. The justification of the theoretical framework will be outlined followed by an overview of culture and culture formation. The concepts of culture formation, the socialisation of new members, and organisational culture in relation to retention will also be explored.

3.2 Justifying the theoretical framework

The theoretical framework provides a lens through which to view and interpret the research data and provides a foundation from which knowledge is constructed (Grant & Osanloo, 2014). The primary issue identified at the

beginning of this research was the difficulty in attracting and retaining nurses – particularly to MHN. An important component of this study is to understand the everyday experiences of NGs and to explore factors which might relate to their attraction and retention to MHN.

In considering a theoretical framework or perspective, I Initially wanted to examine the NG experience through their eyes to determine what affected their choice to stay or leave MHN. However, as the research design evolved it became apparent that there may be aspects of the NG experience that might not be evident to them, or that this lens may not shed light on the broader issues affecting NGs such as the organisational culture and its impact on retention. During the literature review, and when reflecting on the aims of this study, it became evident that there were more appropriate theoretical frameworks I might use, such as Edgar Schein's (2010) *Model of Organisational Culture*, which has been used to explore organisational culture. Patnaik (2011) also argues that exploring the organisational culture can allow the researcher to understand the challenges experienced by new members assimilating into a cultural group. The choice of Schein's (2010) model as an interpretative theoretical framework for this study was further supported with the established use of this framework in a variety of organisational constructs to help understand the organisational culture and the commitment of its members to the organisation (Dauber et al., 2012).

Schein (2010) outlines that there are four ways to investigate the culture of a group: analyse the process and content of socialisation of new members; analyse responses to critical incidents in the organisation's history; analyse beliefs, values and assumptions of a culture creators or carriers; and jointly explore and analyse with insiders the anomalies or puzzling features observed or uncovered in interviews. To address both the investigation of culture and the experiences of NGs entering the cultural group, the first method of *analysing the process and content of socialisation of new members* presented itself as relevant approach, further justifying the use of this theoretical framework in this study.

3.3 Understanding organisational culture

There are a number of theories, models and frameworks that aim to explain organisational culture. Dauber et al (2012) explored several models of organisational culture and noted that Schein's (2010) *Model of Organisational Culture* is one of the most widely cited models, with his model reducing the complexity and abstraction of understanding organisational culture (Dauber et al., 2012). To understand the significance of Schein's (2010) model, it is important to explore what an organisational culture is. It is emphasised that organisational cultures are socially constructed over a period of time by members of the organisation and is the most difficult attribute to change – outlasting the founders, leadership and physical attributes of the organisation (Patnaik, 2011; Schein, 2010). Schein defines organisational culture as:

> *"The accumulated shared learning of that group as it solves its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, feel, and behave in relation to those problems. This accumulated learning is a pattern or system of beliefs, values, and behavioural norms that come to be taken for granted as basic assumptions and eventually drop out of awareness"* (Schein, 2010, p. p. 6)

In 1952, Krober and Kluckhorn (1952) completed a review on the concepts and definitions of culture and noted more than 160 different definitions of culture. Incorporating their findings, Kroeber and Kluckhorn (1952) defined culture as:

> *"Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consists of transitional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, and on the other as conditioning elements of further action"* (Kroeber & Kulckhorn, 1952)

Although there are a number of definitions of organisational culture, there are general commonalities, such as the culture representing the norms and expectations that guide the behaviour of its members and guides the way organisational members approach their work and direct their priorities (Glisson & Williams, 2015). The culture also serves as a boundary for the organisation by defining the standards of behaviour, but it also creates a sense of identity for

its members (Patnaik, 2011). The inherent nature of culture within an organisation is that it is dynamic and comprising of individual and organisational values (McLaren et al., 2013; Stevens, 2014; Waegemakers Schiff, 2009). Despite these definitions of culture, they arguably fail to convey the dynamic and holistic nature of culture, or the influence that the shared ideational systems influence the structural or social relationships within a culture.

Organisational culture is socially constructed over time, and is the product of groups – not individuals, based on the shared experiences (Bellot, 2011; Bitsani, 2013; Whitehead, 2005). Bellot (2011) acknowledges that culture is not a surface phenomenon but is infused with symbols and symbolism and is undetectable most of the time. Patnaik (2011) notes that culture change can also be challenging. Although the surface aspects of the culture can be shifted and changed, this will not shift the underlying values or assumptions (Patnaik, 2011).

In acknowledging the complexity of defining culture, Bitsani (2013) explores the concept of organisational culture and climate. They acknowledge that there are challenges in defining culture but also in differentiating culture and climate. They define climate as a reflection of the interactions of individual members of the cultural group. Initial studies of organisations focused more on the climate with use of quantitative methods of investigation, with these methods not capturing the holism of the culture or work environment (Bellot, 2011; Bitsani, 2013; Ross, 2015; Schein & Schein, 2017). Further research into organisational

cultures adopted anthropologic epistemology to the study of the organisational climate, with a shift towards qualitative methods to explore organisational cultures (Bellot, 2011; Schein & Schein, 2017).

3.3.1 Model of Organisational Culture – Edgar Schein

Although there are different organisational culture models available, the *Model of Organisational Culture* developed by Schein (2010) has been adopted for this inquiry as it has been used previously in exploring the culture of healthcare organisations. One of the elements of this model is in exploring how new members are assimilated into the cultural group. Schein (2010) had developed the *Model of Organisational Culture* to make culture more visible within an organisation, noting that it is the culture of a workplace that determines how individuals interact with one another.

Schein (2010) outlined three levels within an organisational culture, these are outlined from the most superficial to the deeper levels of the culture: artefacts; espoused beliefs and values; and basic underlying assumptions – this is represented in *Figure 1*. Within this model, Schein (2010) describe the surface level aspects of the culture as being visible and tangible and represented as the artefacts, with the deeper layers of the culture hidden and representing the deeper level assumptions and values that are not easily seen. Despite the various layers of culture, Schein (2010) emphasises that the culture refers to the deepest structure of the organisation which is rooted in the assumptions held by its cultural members. This is described as the historically established

structures that are not consciously considered by cultural members, but which influence their relationships with the environment, reality and other members (Schein & Schein, 2017). To develop an understanding of the deeper underlying assumptions, first the artefacts and values of the organisation need to be explored with the researcher making sense of these. Within the study of an organisations' culture, the insiders or cultural members may not know why their cultural works in the way it does (Schein & Schein, 2017).

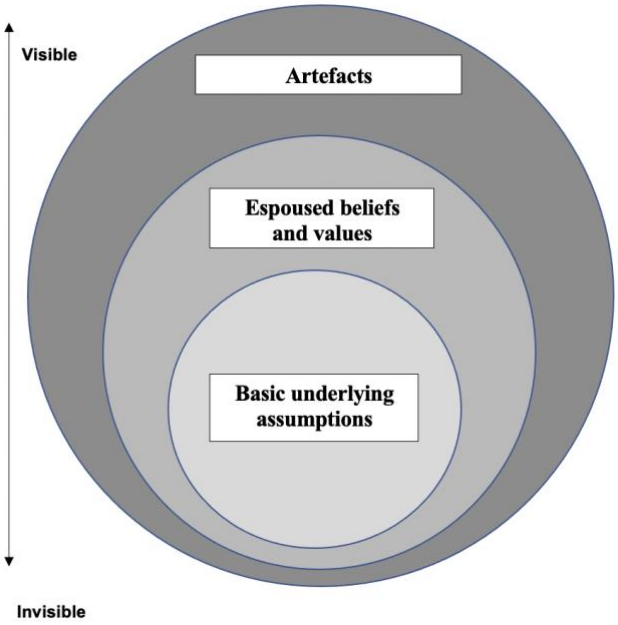

Figure 1 : Model of Organisational Culture as described by Edgar Schein (2010)

3.3.1.1 Artefacts

Artefacts represent the surface layer of the culture (Schein & Schein, 2017). These are the more visible aspects of the culture and represent the materialised expression of the values of the culture and are expressed in the organisations' structure, systems, and processes. Examples of cultural artefacts could include the language used, clothing, furniture and office layout, policies, the

organisation's mission and vision, and myths and stories shared (Patnaik, 2011; Schein & Schein, 2017). Although artefacts are the more visible aspects of the culture, they are the most difficult to decipher especially without in-depth knowledge of the culture or the group, therefore to have an understanding of the organisational culture, the deeper layers of the culture need to be exposed and explored (Bitsani, 2013; Dauber et al., 2012; Schein, 2010).

3.3.1.2 Espoused beliefs and values

The espoused beliefs and values represent the next layer of the culture and involve the thought processes and attitudes of members of the organisational culture (Schein & Schein, 2017). The espoused beliefs and values represents the goals, ideals, values, rationalisations and ideologies of the organisational culture (Schein, 2010). Another way to express this layer is in its representation as the group boundary or identity, with consideration of the rewards and punishment, rules for relationships as well as power and authority. These values are what guide the behaviour of members in key situations, with these values reinforced over time (Bitsani, 2013). These values reflect those developed by the founder of the cultural group and are then assimilated by the new members entering the organisational culture (Schein & Schein, 2017). it is important to note that there may or may not be congruence between the artefacts of the culture and the espoused beliefs and values (Patnaik, 2011).

3.3.1.3 Basic underlying assumptions

In the deepest levels of the organisational culture are the basic assumptions – these represent the unconscious and taken for granted beliefs and values of the cultural group (Schein & Schein, 2017). These are the deeply held assumptions that members of the cultural group share and represent the historically established structures that offer meaning and directions for the members and their relationship with reality, relationships and their environment (Schein & Schein, 2017). These assumptions are described as having an impact on the organisational culture, but are the most likely to be ignored when considering organisational change (Dauber et al., 2012; Patnaik, 2011). Schein also emphasises that there can be inconsistencies between the beliefs and values and the underlying assumptions of the organisational culture (Schein & Schein, 2017).

3.4 Culture formation

The process of organisational culture formation reflects the core values shared by the majority of the cultural members. This begins with the values established by the founder(s) of the cultural group and the reinforcement of the culture through the integration of new cultural members (Schein & Schein, 2017). The ultimate source of organisational culture is the organisations founders and their imposing a vision of what the organisation should be. In creating and sustaining culture, the founders appoint and retain members who share similar beliefs and attitudes (Schein & Schein, 2017). Those new members to the cultural group are socialised and indoctrinated into the world view of the existing cultural

members. Within cultural groups, the founders' own behaviour acts as a role model for members to follow (Patnaik, 2011). In organisations with longer histories – beyond the presence of the founder, there are other ways that the original culture is perpetuated. The stories, symbols and rituals within the culture and its composite subcultures link the organisation to its history and convey a message about what is important in the organisation (Stevens, 2014). The perspective of culture as an evolving construct that is shaped over time, starting from the founders of the culture group is important when considering subcultural groups within nursing. Within the changes to a cultural group, the environment and history of the cultural group play a role in how it is shaped – with aspects of the history of MHN and the evolution of nursing training and practice – explored in Chapter two, also representing changes within the cultural group over time.

3.4.1 Development of subcultures

Within any organisation it is expected that there will be a primary culture and then the formation of a multitude of subcultures. The subcultures reflect the common problems or experiences that cultural members face and can be reflected in the differing groups or professions of the organisation (Bellot, 2011). The subcultures reflect core elements of the primary culture such as organisational practices and values, but must have elements that are distinct from the primary culture (Stevens, 2014). The subcultures may support or compete with the primary organisational culture (Stevens, 2014). Within the

context of this study, NGs represent a subcultural group, as might MHN when compared to the overall culture of multidisciplinary mental health services.

3.4.2 Socialisation of new cultural members

Schein (2010) outlines that a good way to discover elements of a culture is to explore the ways that new members are socialised into the cultural group. This is because the established culture is perpetuated through the next generation of its cultural members. New members are socialised through assimilation into the existing culture whereby their communication, attitudes, and perceptions are influenced through social approval and feedback from their colleagues and superiors (Stevens, 2014; Waegemakers Schiff, 2009). The new member learns *how we do things around here,* and the policies, procedures and processes for completing the work (Ross, 2015).

The process of socialisation is described as dynamic as the new member enters the cultural group with their own set of values, attitudes and expectations (Hechanova et al., 2014; McCarthy, 2015). In experiencing a tension between the new members values and the existing culture, Kramer (1974) coined the term *reality shock* to describe the experience of new nurses entering the clinical setting and experiencing tension between their values and those of the clinical setting. This may reflect a dichotomy with the expectations of the new member and their reality. The new member may need to abandon their own values or the organisation altogether (Khoza, 2005; Kramer, 1974; Wright et al., 2011).

3.5 Organisational culture and retention

The culture of any organisation has been emphasised in the literature as an important determinant in the satisfaction and cohesion of the organisational members (Abu-Jarad et al., 2010; Jacobs & Roodt, 2008; Kulkarni, 2014). The culture itself may lead to tension, particularly if there is incongruence between the layers of the culture leading to difficulty in determining expectations of the culture. One of the challenges outlined by Bellot (2011) was in the definition and cohesion of the culture – if the organisational culture is poorly defined, frequently changing or poorly communicated, then there will be inconsistency in the behaviours of its members. Negative organisational cultures are associated with an increased risk of attrition and workplace dissatisfaction (Jacobs & Roodt, 2008; Kulkarni, 2014; Watts et al., 2013). Schein (2010) emphasises the need for congruence between the layers of the organisational culture, with congruence and clarity between the layers of culture needed for a stronger or more positive culture. The more the members accept the core values and the greater their commitment, the stronger the organisational culture. Strong cultures have a greater impact on employee behaviour and are associated with increased commitment of its members, job satisfaction and quality of work provided (Patnaik, 2011; Watts et al., 2013). Jacobs and Roodt (2008) state that hospitals with more positive organisational cultures were associated with lower employee turnover.

3.6 Chapter summary

This chapter explored the theoretical framework – Schein's (2010) *Model of Organisational Culture*. Schein's (2010) model provided a framework in which to explore a culture through exploring the layers – artefacts; espoused beliefs and values; and the underlying assumptions. To understand an organisations culture, understanding of each of the layers is required. Schein (2010) recommends the use of anthropological approaches as one way to understand an organisations culture, such as the use of ethnography. The next chapter explores the research design for this study, including the methodology utilised – and its anthropological basis.

Chapter four
Research design

"Until you got ice cream spilled on you, you're not doing field work"

Randy Pausch

4.1 Introduction

To develop an understanding of the cultural experiences of NGs entering MHN, a suitable research design was required. This chapter provides the blueprint for the methodology used (Grant & Osanloo, 2014). The four research questions underpinning this study included:

1. What are the experiences of NGs when encountering the culture of MHN?
2. Are there links between the experiences of new graduate nurses and their intention to remain in the field of MHN?
3. What are the processes involved in assimilating NGs into the workplace?
4. Where does the NG fit into the organisations' hierarchy, and how is this perceived by the NG?

A methodology was required that allowed for the construction of meaning of the NGs subcultural experience and worldview within the social and cultural context of MHN.

The methodology of ethnography has been adopted to explore the experience of NGs as it allows for the understanding of culture. As ethnography represents a methodology but also details specific methods – namely non-participant field observation, this has been incorporated in the research design. In addition to field observations, the use of semi-structured interviews, field notes, and a reflexive journal were included to increase the rigour of the research design, and to add depth to the analysis of the data. In considering the research design and cultural context, this chapter also includes a detailed overview of the research setting and participants, as well as ethical considerations and the approaches taken to enter, engage with, and exit the research setting.

4.2 Justification of methodology

Reality is a complex and ultimately subjective construct. The process of exploring the subjective experiences of reality for an individual or group, require a research design that is emergent and flexible – rather than fixed (Hancock et al., 2007). The term *naturalism* has been adopted as an alternative research perspective that proposes that the social world should be studied in its natural state, with naturalists arguing that social phenomena cannot be understood in terms of causal relationships (Hammersley & Atkinson, 1995). This is based on the belief that human actions are influenced by social meanings such as beliefs, values, and intentions (Hammersley & Atkinson, 1995). Therefore, to understand the behaviours and beliefs of an individual or group, an approach is required that gives the researcher access to the meanings that guide those behaviours (Hammersley & Atkinson, 1995). This category of enquiry is largely

referred to as qualitative research and differs from the more rigid, fixed and objective nature of quantitative research (Mack et al., 2010). Qualitative research has the benefit of allowing the exploration of phenomena from the participant's perspective, rather than focusing on the cause and effect of phenomena (Mack et al., 2010). The basic tenet of qualitative research is that it is conducted to describe and interpret people's experiences and their culture (Denzin & Lincoln, 1994).

This study sought to understand the subcultural everyday experiences of NGs entering the culture of MHN. Therefore, a suitable methodology was required that allowed for the study of culture. Anthropology is a discipline that involves studying human behaviour in context (Brewer, 2000). Ethnography is a methodology whose roots lie in anthropology which provides a framework and tools to uncover cultural patterns that represent the shared meanings and behaviours of the subcultural group (Brewer, 2000). In the study of cultures within organisations, ethnography is recognised as an appropriate methodology to explore the organisational culture itself and to develop a deeper understanding of the subcultural issues, such as the commitment of members to the cultural group (Schein & Schein, 2017). Schein (2010) recommends the use of an ethnographic approach to exploring organisational cultures, adding that it would be difficult to develop tools such as surveys or questionnaires to capture the elements of the cultural group due to the intricate complexity of culture. Savage (2006) acknowledges the use of ethnography in exploring organisational and healthcare settings, allowing for the exploration of

phenomena that quantitative research cannot reach. A strength of ethnography is the use of multiple methods, as well as its attention to the cultural context and the voice of participants (Savage, 2006). In the preceding review of the literature, no studies were found that used an ethnographic or fieldwork approach to exploring the subcultural experiences of NGs entering the culture of MHN. The approach used in this study is therefore novel.

4.3 Anthropology: the origins of ethnography

Anthropology as a discipline seeks to study the everyday lives of a group of people to develop an understanding of their lives. The goal of anthropology is to uncover the patterns of behaviours represented as cultural norms and to describe them from the peoples' perspective (Spradley, 1979). There were several pioneers of anthropology such as – Hanz Boas (1858-1942) and Bronislaw Malinowski (1884-1942). These anthropologists spent time studying foreign – typically exotic or tribal cultures, to learn how these cultural groups behave and interpret experiences. Bronislaw Malinowski made significant contribution to the discipline of anthropology. One of his contributions was the notion of *wholism*, whereby people and their social world are interconnected (Malinowski, 1922). He justified that fieldwork and analysis are integrated, that each without the other are meaningless and only hold significance when interrelated (Malinowski, 1922). Ethnography as a methodology was further developed by sociologists at Chicago University from an anthropological perspective to study patterns of city social life as outlined in the *Street Corner Society* (Whyte, 1943). One of the distinct changes reflected in ethnography is

that the early anthropologists studied exotic, isolated and strange cultural worlds, with this now being adapted to the cultures in more familiar social settings (Lambert et al., 2011).

4.3.1 Ethnography

Ethnography like its predecessor anthropology is concerned with understanding the inner world of a cultural group. The premise of ethnography is that when members of a social group interact with one another a culture develops, with humans symbolically encoding experiences with this represented as the structures, traditions and functions that shape the group (Geertz, 1973). The belief is that knowledge and reality are socially constructed, meaning that knowledge is constructed in and out of interaction between human beings and their world (Lambert et al., 2011). Cultural transmission then occurs within the group. With cultural transmission representing the process of passing on to new members the structures, traditions and functions that mould thought and patterns of behaviour within a group and keep the group functioning (Geertz, 1973).

Ethnography allows for the study of cultural systems (Whitehead, 2004). The ethnographer immerses themselves within the culture of the social group to make the strange familiar and to uncover a description of the cultural group from the perspective of the group – *seeing the world from their eyes* (Goodley, 2003; Spradley, 1979). This is achieved by becoming an *insider* and learning about the social structure, cultural patterns and the meanings that cultural

members give to those patterns. The ethnographer endeavours to gain an insight into the views and actions of cultural members within their cultural context, by providing rich detail – *thick description,* on the people, practices, perspectives, as well as the setting itself (Geertz, 1973; Reeves et al., 2008). Because ethnography is particularly concerned with the specific context that influences the culture and its members beliefs and behaviours, the conceptualisation of ethnography is not a particular method of data collection, but an underlying philosophy of representing the culture within a given population (Brewer 2000; Hodgson 2000). Therefore, ethnography as a mode of enquiry must be more than simply observational and descriptive, it must lead to a tangible understanding of the lived experiences of the participants within the culture being studied. However, the strength of ethnography is that the methods used produce a picture of the cultures and social groups from the perspectives of their members (Fetterman, 1989; Wolcott, 2010).

There are several elements of ethnography that are important. The most important element of ethnography is the use of fieldwork (Wolcott, 1999). This involves gathering information about people through participant or non-participant observation and questioning participants (Spradley, 1979). The ethnographer may draw on a number of qualitative and quantitative methods in addition to fieldwork to make sense of the meanings within a given cultural or social group (Goodley, 2003; Wolcott, 1999). The other elements include the researcher as the instrument, the cyclical nature of data collection and analysis,

the focus on culture, cultural immersion, and the tension of the researcher between emic and etic perspectives.

4.4 Research role conflict and bias

The worldview of the researcher must be declared at the beginning of the ethnography. Using ethnography requires the understanding of the researchers' world view as this can be influenced by the researcher or *ethnographers'* epistemological (way of knowing and explaining what exists) and ontological (the nature of existence and being) perspectives (Brewer, 2000). Researcher bias needs to be explored as this could affect how the research is conducted. This involves the researcher being aware of their perceptions and opinions to avoid tainting the research findings and conclusions (Cypress, 2017). Understanding how one's own views and values might influence the research findings adds credibility to the research (Jootun et al., 2009).

In exploring my worldview, I completed my transitional program as an RN into MHN in 2012. Prior to this I also experienced the transition into nursing in 2007 as an Endorsed Enrolled Nurse (EEN) – resulting in two different experiences of transitioning into the workplace, firstly as an EEN and then later as an RN. These experiences contributed to me wanting to learn more about MHN as a discipline and the process of preparing nurses for clinical practice. During my journey to becoming a mental health nurse – engaging in additional education and learning from experienced nurses, these experiences shaped my belief that the undergraduate nurse training was inadequate to prepare me for clinical

practice in MHN, leading to ambivalence about whether I wanted to continue working in MHN. These perspectives were declared in early reflexive conversations with the supervisory team and continued throughout the duration of research to ensure that my worldview did not influence data collection and subsequent data analysis. Although I hold the worldview that new nurses aren't adequately prepared for clinical practice in MHN, this research isn't concerned with the method of preparation or the quality of the clinical experience – but rather about understanding the subcultural experiences of NGs when they encounter the culture of MHN.

4.4.1 Balancing the insider-outsider perspective

As a mental health nurse, I needed to adopt a balance between the emic and etic perspectives, with me as the researcher considered both an insider and outsider by the cultural group. There can be concerns when conducting research in one's own environment, with the primary issues around role conflict, rationalisation of the research, and addressing issues of confidentiality (Brewer, 2000). Conflict can also arise when the researcher has a professional interest in the study topic (Houghton et al., 2010). However, there can be benefits, including the researcher having an 'insider' status which can increase the accuracy of the emic perspective, reduce the culture shock on the researcher, and minimise the impact of the researchers' presence in the setting. Despite a careful approach in addressing role conflict, it is acknowledged that the world of MHN is a unique community where communication and migration between units can occur, resulting in some familiarity with many mental health units and staff

members, making it difficult to entirely separate the researcher from potential role conflicts (Houghton et al., 2010; Orb et al., 2000). In addition to being a mental health nurse, I was a member of the health service staff – although not of the units included as study sites and I needed to address the potential conflicts between the research and clinical roles.

There were two primary instances where potential role conflict was identified: in communicating with the staff members of 'hospital site one' when the researcher was in her clinical role within the same hospital but in another unit – the researcher would occasionally need to meet with those staff members to facilitate transfer of care; and when a NG participant would complete a clinical rotation in the researchers' workplace and may work alongside the researcher as a colleague. The researcher anticipated working alongside up to two potential NG participants, however this only occurred with one NG participant in the research – in this case the participant worked alongside the researcher and then consented to participate in the research on their second rotation when in one of the research sites. Orb et al (2000) acknowledge the challenges of conducting research in a setting where they are known. Participants in the setting may feel coerced or distrustful of the research. However, they outline that clearly defining the roles and carefully negotiating the setting can ameliorate this.

I adopted several methods to decrease the impact and instances of role conflict. This involved delineation between my researcher and clinical roles. I did not

enter clinical settings during times of data collection and did not use my employee swipe access or keys, but rather wore only my university identification card and would request entry in the same manner as a visitor to each unit. I was only present with the expressed permission of the staff in each unit. I did not wear the same uniform as the nursing staff, but rather wore plain-clothes – with one of the main reasons to ensure that I was accepted as the researcher and not as a clinician. This was also done to avoid having the consumers of the service who may approach a nurse in uniform to address any needs or requests. While wearing a uniform might assist in maintaining an insider status, it would likely have impacted on the consumers of mental health services in a negative manner and may have affected the ethical conduct of this study. I gave assurance that any data collected would not be shared or used within the clinical role and that I was bound to maintain the participant's confidentiality – except in situations requiring reporting (outlined in Participant Information Statement, Appendix 5). I declared the potential sources of conflict during the ethical approval process and gave a full disclosure to each unit and participants about the researchers' clinical role within the same health service. To reduce the impact on the working relationship and strengthen rigour, my workplace was removed as a potential unit for data collection.

The potential research participants were also reminded of the voluntary nature of their participation and the need for the researcher to maintain their confidentiality especially after the research had concluded. It was made explicitly clear from the beginning of the research that the roles of the

participants and researcher would be clearly defined during those periods when research was taking place. It was made clear that any data collected (including sensitive information) will be dealt with confidentially and was to be kept separate from my clinical role.

4.4.2 Rigour and trustworthiness

Rigour refers to the process of being exact and is associated with quantitative research designs which is recognised as challenging in qualitative research due to the flexible and emergent nature of qualitative research (Cypress, 2017). Rigour also reflects the strength of the research design and the appropriateness of the methods to answer the research questions. In the world of qualitative research, the terms reliability and validity are replaced with trustworthiness (Lincoln & Guba, 1985). The term trustworthiness is used when referring to the truth, value, applicability, consistency and neutrality of an enquiry. Trustworthiness must be established if a study is to be considered methodologically sound and worthy (Shenton, 2004). This research adopted several strategies to ensure rigour and utilised a qualitative approach to measure the trustworthiness of the research, addressing credibility, transferability, dependability, and confirmability of the research (Gulati, 2011; Lincoln & Guba, 1985; Nowell et al., 2017). These are outlined as follows.

Credibility involves the researcher immersing herself within the research to capture reality accurately – it directly relates to the accuracy of those findings in representing reality. Shenton (2004) states that ensuring credibility is one of the

most important factors in establishing trustworthiness of research findings. Credibility of the findings are enhanced through providing a description of the context and engaging in fieldwork – with the researcher achieving prolonged engagement with the participants and setting, with an emphasis on “thick” description (Geertz, 1973). This also requires that the researcher build trust and rapport with the participants (Cypress, 2017). The researcher maintained a reflexive journal through the research.

Other methods I used to enhance the credibility of the research and develop a comprehensive understanding of the experience of NGs entering the MHN culture were triangulation, member checking and peer debriefing with my supervisors. Triangulation was accomplished by using multiple data sources – interview transcripts, field notes, and reflexive researcher notes. This enabled cross-checking of the data and acknowledged the limitations of each method on its own, with the use of multiple processes negating those limitations (Shenton, 2004). I regularly consulted with my supervisors and engaged in debriefing to allow for an objective view of the research and to provide peer scrutiny (Cypress, 2017). In terms of my own researcher credibility: I was familiar with the phenomenon under study and had insider status in the setting in which the research was carried out. My supervisors were experienced in various research methods, including ethnography and were themselves experienced mental health nurses. In my professional capacity I use, and have highly developed, observation skills. I also use questioning and building rapport to gain understanding of the experiences of consumers that I have engaged with.

These skills were readily transferred to the role of researcher using an ethnographic approach. Participants were also engaging in the research on a voluntary basis, and were able to ‘opt out’ at any point during the study, allowing data collection to involve those who genuinely wanted to participate in the research (Shenton, 2004).

Transferability for qualitative data, refers to the extent to which findings can be replicated in another setting. It involves presenting a sufficient amount of data and clearly describing the context so that outsiders can determine if the data is replicable in another setting (Shenton, 2004). This included the description of research methods and overall thick description (Cypress, 2017). The emphasis on the transferability of findings is not emphasised in qualitative research as it might be in quantitative research. The findings of this research and other qualitative research are specific to the context in which they were found, and are therefore are not intended to be transferable to another context (Shenton, 2004). However, to enhance transferability, this research involved detailed description of the contextual factors including settings and participants, and research methods used.

Dependability is concerned with the consistency of the findings. This involves clearly demonstrating the data collection and analysis processes and presenting the paradigm that informed the research – including the researcher’s bias and background (Shenton, 2004). The findings in ethnographic research reflect a snapshot of the culture bound in time and thus conducting the research

in exactly the same way may not produce the exact same results (Cypress, 2017). To increase the dependability of findings, I have described in detail the cultural context, research methods, and I have maintained an audit trail throughout the research process

Confirmability involves outlining the methods used in order for another researcher to engage in the same research and come to comparable findings (Shenton, 2004). This can be enhanced through maintaining an audit trail, triangulation of all data sources, and engaging in reflexive practices. Cypress (2017) emphasised the use of a reflexive journal throughout the research process to keep notes that are pertinent to the study with the audit trail allowing the research process to be examined – this would allow for analysis of where interpretations were made. It was also important to address researcher bias, to ensure that I was not selectively observing and recording information as this may taint the research findings and conclusions (Cypress, 2017; Nowell et al., 2017). Although I had opinions on the topic of transitional experiences and the overall construct of MHN, I put that knowledge and experience to the side. In this inquiry I wanted to hear about the experience of participants and learn from their stories and the meanings that they attributed to their subcultural encounters. This mirrored the reflexive approach taken to exploring the subculture of NGs.

4.5 Ethical considerations

This research was subjected to a peer-review process – with expert evaluation of the proposal and presentation of the project. This also involved the approval of three separate Human Research Ethics Committees (HREC). Human Research Ethical approval was obtained through the University of Newcastle's HREC – approval H-2016-0051 (Appendix 1). Further ethical approval was then obtained from the relevant health service HREC's (Appendix 2 & 3). This process involved gaining the consent of the health service to participate in the research, which allowed for any concerns or issues to be raised (Houghton et al., 2010). The participant consent form (Appendix 6), Participant Information Statement (Appendix 5), Research Information Statement (Appendix 4), and interview schedule (Appendix 7), along with the research protocol (Appendix 8) were submitted to each HREC for approval.

Although ethnography concerns itself with an emergent design, this style of study can be difficult when negotiating the ethical approval within the health service (Houghton et al., 2010). The process of gaining ethical approval in the case of this research was lengthy and involved several bureaucratic hurdles. The primary concerns to address in the research – in addition to confidentiality and consent, were: the impact of the research on potentially vulnerable groups – NGs and consumers of mental health services; conducting research across multiple sites and hospitals; and addressing the role conflict of being a researcher and clinician in the field (Houghton et al., 2010; Orb et al., 2000). As an existing clinical staff member within the health service, it was imperative to

address concerns around the privacy of participants and to confirm that their contribution to the research project would have no prejudice on their employment or treatment within the health service. One mental health unit was also excluded due to being employed within that unit.

Respect for the participants and culture under study was a primary theme, with the aim of the researcher to first do no harm. Respecting the voluntary nature of the research and conducting the research overtly which allowed for participants and other members in the clinical setting to ‘opt out’ of the research and to not participate (Houghton et al., 2010). Therefore, I requested permission to enter the field at every instance of data collection and offered staff members to ‘opt out’ or to raise any queries or concerns around the research. Potential NG and RG participants were requested to sign a consent form if they were consenting to participate in the research. The settings of the research have not been named to maintain anonymity of individuals and the workplace. Instead pseudonyms have been given to each of the participants and units with some characteristics of each site obscured to protect the health services’ identity (Houghton et al., 2010).

4.6 Accessing the field – the gatekeepers

To conduct this research and gain access to the units and the prospective participants, I needed the consent of key individuals. These key individuals are known as the *gatekeepers* as they have the power to grant or deny access to the research field (Brewer, 2000). The gatekeepers in this research were

identified as: the three HRECs; the executive managers for the health service; the Nurse Unit Managers (NUMs) for each setting; the nurse educators overseeing the transitional NGP; and the nurses who were in charge of shift during the data collection episodes.

The initial entry to the setting involved engaging with the executive managers utilising a ‘top-down’ approach. I initially contacted the executive nurse manager of the mental health service by email with an attached copy of the research protocol and university-based ethical approval. This process led to a follow-up meeting being arranged with the executive nurse manager and the district nurse educator overseeing the transitional program to discuss the research design and ethical considerations. A key aspect of the approval process was that as the researcher, I would liaise with the executive manager and nurse educators regarding the key research findings, with a goal of improving the NG experience and in promoting staff retention within the mental health service. This reciprocal relationship was key to the ongoing research process success. However, to gain the approval of the executive team to conduct the research, I was first required to gain the consent of each of the NUM’s whose settings were to be included in the study. However, gaining the initial consent of the executive managers was a necessity to ensure that the primary stakeholders responsible for the activities in the service were aware of the research and approved of those activities taking place. The consent of the executive team also proved to be essential to gaining the consent of individual NUM’s, as it became evident that each NUM was reluctant to consent to the research without the authority of

the executive managers – this represented an element of the bureaucratic hurdle.

The process of gaining consent from each NUM first required the presentation of information sessions within each unit. These initial sessions were conducted between January and April 2017. The majority of these information sessions were conducted during the morning to afternoon handover in each setting where ‘double staff’ were present. These sessions were accompanied by the district nurse educator who was overseeing the transitional program and was known by the staff in each of the units. During these sessions, I had the opportunity to meet with NUM’s, potential participants, and the staff members of each unit to explain the project aims, methods, practical and ethical considerations, and to gain consent to proceed. These information sessions created a platform for the staff members in each unit to raise questions or concerns around the research, and it also allowed for some familiarity, trust and rapport to develop with the researcher prior to data collection. Brewer (2000) states that building trust within the relationship takes time. The research information sheets (Appendix 4) were disseminated to the staff members at each site with additional copies supplied for staff members not able to be present for the information sessions. While I continued to build trust and relationships with staff members in each setting, it was interpreted that voluntary agreement to participate in the research indicated that I as the researcher was accepted, and it indicated trust from the participants. After HREC approval was obtained for the health service (Appendix 3), all other

instances of approval within the setting, such as conducting data collection, were negotiated with the nurse educators, NUM or designated nurse in charge (NIC) in each unit.

My intention was to conduct the field observations in one unit at a time and before conducting the interviews. However, several factors needed consideration. One was the delay in gaining simultaneous consent. I was given ethics committee approval to conduct research in each hospital as soon as the executive nurse manager's consent was obtained. This was first obtained from hospital site 1, then hospital site 3, followed by hospital site 2. The delay in gaining consent was affected by annual leave of key managers and the temporary assignment of replacement managers.

4.6.1 Selecting key informants

An ethnographic study requires recruiting key informants with knowledge of the subculture being studied to provide their perspective on the everyday experience – in this case NGs. In seeking to understand the experiences of NGs as they entered the world of MHN, this research involved purposive sampling of participants who were either completing a transitional NGP in a mental health setting or had completed one within the last five years. Purposive sampling is central to naturalistic enquiry (Reeves et al., 2008). An important aspect of sampling is identifying the inclusion and exclusion criteria of potential participants, particularly if there is a large selection of available informants (Fetterman, 1989). All NGs completing their transitional program within a mental

health setting in the chosen health service were suitable for the study and were all invited to participate in this research (n=18). They were invited to participate in both the non-participant field observation and the semi-structured interviews. However, to add depth to the findings, nurses who had completed a NGP in mental health in the last five years were also invited to participate in the semi-structured interviews only. The sample of participants was purposeful as they all had opinions, experiences and perceptions that were valid and gave voice to this research study (Mack et al., 2010).

4.6.1.1 New graduate nurse participants

Once the ethical approval to conduct the research was obtained within the health service, I liaised with the district nurse educator overseeing the NGP to present the research in a more detailed manner to the potential NG participants at one of the allocated study days for NGs. This presentation involved an outline of the research including aims, methods, and practical considerations and I encouraged the NGs to raise any queries or concerns during this time. The researcher left a copy of the Participant Information Statement (Appendix 5) and consent form (Appendix 6) for each of the NGs who were present (n=18). The researcher requested that each NG review the consent form indicating their consent, or refusal to participate in the research – knowing that they may change their mind at any time. This was to identify those consenting participants and to be mindful and respectful of NGs who were not consenting to the research – particularly if they were completing clinical rotation in a unit where consenting participants were present. The researcher requested that the

NGs return their consent forms in their own time to a closed box supervised by the district nurse educator. Potential NG participants were reminded of the voluntary nature of their participation in the research, and that their choice to participate, or not to participate, would not affect their treatment, or employment within the health service.

4.6.1.2 Recently graduated nurse participants

An additional group of RNs who had completed a NGP within the field of MHN within the last five years – recent graduates (RG), were invited to take part in the interview component of the research only. The rationale behind including RGs was to add depth to the research findings, and to allow for a greater source of participants as the researcher was also unable to predict the number of NGs who would consent to participate in the research. It was expected that up to fifteen RGs would be invited to participate in this research. The process of inviting RG participants occurred through a combination of word of mouth and liaising with the educators and NUM's in each unit. Over the course of the data collection period the I received participant consent in various ways – via phone call, directly, and through the educators and NUM's which were later confirmed in person. Most participants wanted to discuss the nature of the interview before giving their consent and then proceeded with the interview.

A total of fourteen NGs consented to participate in the research out of the eighteen who were invited. Three new NGs declined to participate, and one NG consented, but was unable to participate due to workplace absence. Out of the

fourteen consenting NGs, ten agreed to participate in both field observations and interviews, whilst two consented to field observations only, and the remaining two consented to interviews only. A total of twelve RGs agreed to participate in the interviews. Therefore, this research had a total of twenty-six participants – fourteen NGs, and twelve RGs outlined in *Table 1*.

In comparison to quantitative research where there is a focus on the generalisability of the findings as opposed to the depth, qualitative studies have smaller sample sizes. It is acknowledged that smaller sample findings can affect the generalisability of findings, however the emphasis in qualitative research is not on the generalisability of findings, but on the accuracy in representing the unique and context-specific phenomenon (Goodson & Vassar, 2011).

Classification	**Field observations only**	**Interviews only**	**Both field observations and interviews**	**Neither field observations nor interviews**	**Total consenting participants**
NGs	2	2	10	4	14
RGs	0	12	0	0	12
Total	2	14	10	4	26

Table 1 – Numbers of consenting NG and RG participants

The demographic characteristics of the 24 interview participants are outlined In *Table 2.* The two participants who agreed to participate in field observation, but not interviews did not provide demographic data.

Characteristic	Description	Number of participants
Age (years)	21 – 25	11
	26 – 30	6
	31 – 40	6
	41 – 60	1
Gender	Male	4
	Female	19
	Other	0
Rank	NGs	12
	RGs (RN second year)	7
	RGs (RN third year)	5
Interview length	0-19 minutes	7
	20-29 minutes	7
	30-39 minutes	5
	40-49 minutes	4
	50-59 minutes	0
	60 + minutes	1
Previous experience	Endorsed Enrolled Nurses (EEN)	2
	Assistant Nurses (AIN)	15
	Non-nursing health professions	2
	Non-health degree	2
	Non-health work experience without a qualification	3

Table 2 – Demographic characteristics of interview participants

In respect to undergraduate preparation for practice, all of the interview participants (n=24) had completed mental health theoretical units and clinical placement during their undergraduate nurse training (*Table 3).*

University	Number of participants
[redacted]	1
[redacted]	1
[redacted]	1
[redacted]	1
[redacted]	2
[redacted]	2
[redacted]	2
[redacted]	4
[redacted]	4
[redacted]	6
Number of undergraduate mental health units	
0	0
1	1
2	18
3 or more	5
Undergraduate mental health practical experience (clinical placement in weeks)	
0	0
2	2
3	2
4	10
5	1
6	3
8	4
10	1
11	1

Table 3 – Undergraduate preparation for practice

4.7 Research site

This research was conducted within an Australian metropolitan health service, with six mental health inpatient units across three separate hospital sites included in the study. Although ethnographic research usually involves the in-depth study of a single unit or cultural group (Hammersley & Atkinson, 1995), this research primarily focused on exploring the subcultural experiences of NGs as opposed to the culture of a specific mental health unit – or even the culture of MHN as a whole. The choice of research site was governed by the units in which NG participants were completing their clinical rotations and the HREC's' stipulation that the research must have minimal impact on consumers of mental health services. I was not permitted to conduct research in clinical areas and therefore the units chosen required staff-only areas whereby I could observe practices whilst limiting the impact of the research on consumers. After considering these factors, eight inpatient units were considered for this research. Consenting participants worked in six of the eight units. The number of participants dictated the amount of time spent, and data collected, in each unit.

Within this health service, mental health services are considered a 'district' stream, with an overarching hierarchy governing mental health services across sites that is separate to the general hospital. This structure is in existence despite the integration of mental health services within the general hospital campus. The concept of an over-arching hierarchy with similarity in structure and policy across the three hospital sites was a factor considered when

designing this research across more than one hospital site. Another concept was the insular nature of MHN, as I was aware of the shared culture and migration of mental health nurses between units and across hospitals and health services.

To protect the identity of the participating site, a full outline of the range of services and settings available and their relationship with one another will not be provided. The focus will be divided between outlining the NGP being undertaken by the NGs participants, and the settings included in this study. Each inpatient unit within the health service typically only employed a small number of NGs at any one time, with a duration of placement generally for six months. To reach data saturation with data collection confined to a smaller number of units, this study needed to be conducted over a longer period to explore the experiences of several consecutive NG participants. The benefits of the approach taken were access to a larger group of participants, while retaining the elements of a single cultural group, as the NGs were completing the same transitional program structure across a number of the participating mental health settings. The inpatient environment also provides for a rich source of data, with a larger number of clinicians interacting with one another. Such factors contributed to this setting being an ideal place to conduct the ethnography as it afforded the opportunity to study the participants in the natural setting where observations were being made where they naturally occurred.

The three hospitals will be identified by their pseudonym's: *hospital site 1, hospital site 2,* and *hospital site 3*. This study involved four acute inpatient mental health units, one mental health rehabilitation unit, and one older persons' mental health unit. The initial HREC application included two additional inpatient units – an additional rehabilitation unit, and an additional older persons' mental health unit, however the NG participants within these two additional units had declined to participate in the study, and therefore these units were then excluded from observation. The units included in this study are outlined below in *Table 4* with the number of beds included to indicate the size of the unit.

Hospital 1	Acute inpatient unit – 28 beds Rehabilitation unit – no consenting participants
Hospital 2	Acute inpatient unit – 28 beds Older persons mental health unit – no consenting participants
Hospital 3	Acute inpatient unit A – 30 beds. Acute inpatient unit B – 16 beds. Older persons mental health unit – 8 beds. Mental health rehabilitation unit – 14 beds;

Table 4: Research sites

The mental health services within this research catered for both inpatient and community-based mental health care, with a number of specialist services available reflecting a metropolitan health service. This service catered to

consumers experiencing a wide range of mental health concerns including mood disorders, psychotic illnesses, anxiety disorders, personality disorders, and substance dependency disorders – with the nature of care provided varying according to each individual consumers' need. Each unit was staffed by several Psychiatrists, Nurses (RNs and EENs) and allied health staff (Psychologists, Occupational Therapists and Social Workers). The medical team comprised of a Psychiatrist, Registrar (trainee Psychiatrist), and in some units an intern medical officer. Each unit was administered by at least one NUM with both clinical and managerial responsibilities. Hospitals 1 and 2 followed a shift pattern of: morning shift 0700 – 1530, afternoon shift 1330 – 2200, and night shift 2130 – 0730 hours. Hospital 3 had slight differences with morning shift 0700 – 1530, afternoon shift 1300 – 2145, and night shift 2115 – 0715 hours. There were frequent opportunities for nursing staff to work over-time to cover staffing requirements. Staff were organised on the roster by full-time, part-time and casual employment.

4.7.1 Mental health unit structure and location

The locational of each of the mental health units within the hospital grounds will be outlined to provide a brief overview of the research setting. Whitehead (2005) also explains the importance of physically mapping the study setting as it represents a cultural artefact. The placement of the mental health units in each of the three hospital sites differed. In hospital site one, the mental health units were integrated into the same building as the general hospital, whilst the mental health units in hospital sites two and three were on the same hospital grounds

but in separate buildings. Despite some differences between each of the mental health units in terms of location and unit structure, there were also a large number of similarities. Each of the six units were 'locked' units, with consumers unable to leave the unit of their own accord. The units ranged between eight and thirty beds. Each unit contained enclosed bedrooms down corridors of varying designs, with communal areas comprising of a kitchenette, lounge area, courtyard, and leisure areas – with features such as table tennis tables and exercise equipment. Each of the units had various colourful and personal features such as paintings and murals on the walls. Each unit had a nurses' station – a locked staff station at the centre of the unit, with these nurse stations completely enclosed with large glass panels and locked doors. Within the nurses' station of each of the four acute units, were screens with close-circuit television (CCTV) footage being livestreamed of different views within each unit, such as the courtyard, corridors, and activity areas. Further details of each of the units is outlined in the Appendix (Appendix 10, 11 and 12), including field drawings of the nurses' station in each unit to provide context to the settings.

4.7.2 The new graduate program

Within this research setting, the NGP was named the *Transition to Practice Program (TPP).* Other NGPs within New South Wales and across Australia had similar names as outlined in Chapter two. At this time, programs are not required to be accredited, leaving individual health services to determine their own NGP structure and development. In the case of the NGP in this study, the aim of the program was identified as enabling nurse graduates to progress from

novice to advanced beginner RN within the field of MHN. This process was expected to be achieved after completing the twelve-month program. The NGP comprised of twelve months of full-time employment, with completion of clinical rotations through different mental health settings. NGs were provided two workbooks to complete over the course of their program – *TPP program guide* (Appendix 9) and the *TPP Evidence of clinical skills in practice workbook* (Appendix 10). The *TPP program guide* outlined the requirements of NGs to successfully complete the program. This included completing the following activities at stipulated milestones in the NGP.

- TPP workbook reflective activities
- Mandatory education
- Study day attendance
- Mental health professional online development (MHPOD)
- Clinical skills and competencies
- Consumer journey presentations
- TPP In-service program
- Clinical supervision and reflection diary
- Use of Yammer communication tool for NGs to share resources and discussion

The workbook – *TPP Evidence of clinical skills in practice workbook* outlined the competencies that NGs needed to complete during the NGP. This included seven competencies and four activities, which are outlined in *Table 5* below.

Clinical proficiencies	• Effective documentation in clinical files • Mental health histories and mental state examination • Risk assessment and management • Recovery-based practice • Communication and building a therapeutic relationship • Psychopharmacology • Legal context of mental health nursing
Activity 1	Risk assessment and management
Activity 2	Psychopharmacology knowledge
Activity 3	Oral and IMI checklist
Activity 4	Consumer journey presentation

Table 5 – Activities in the TPP Evidence of clinical skills in practice workbook

Participants were required to complete all the components of the structured twelve-month program to satisfactorily meet the program requirements and receive a transcript of completion supplied by the health service. This transcript is then considered when the NG seeks ongoing employment in the health service. In comparison to the outlined requirements of NGs, any other new nursing member socialising into the health service would be required to complete general mandatory training only – this includes nurses who have completed a NGP elsewhere.

4.7.2.1 Mandatory training and education

Participants were required to complete a combination of face to face and online learning during the NGP. The majority of these modules were delivered in an online platform, with some modules also including additional face to face training. These modules ranged from short courses to programs ran over a number of days. The online modules required to be completed by NG nurses included:

- Safety for all: foundations and safe physical restraint
- Domestic violence screening
- Suicide awareness and prevention for clinicians
- Child protection training
- Sexual safety policy training
- DETECT – Detecting deterioration, evaluation, treatment, escalation and communicating in teams, training
- Electronic medical record – clinical documentation
- Identifying and responding to children and young people at risk of harm
- Health Education and Training Institute (HETI) online learning modules including those from the platform of Mental Health Professional Online Development (MHPOD). Participants complete twelve modules within the MHPOD series as outlined in the *TPP program guide* (Appendix 9)

4.7.2.2 Study-day attendance

To satisfy the program requirements, NGs were required to attend all ten study days over the duration of their NGP. These study days included opportunities to

debrief with other NGs also completing the mental health NGP and guest lecturers in addition to education modules on various mental health related topics. The study days were held monthly between March and December of each calendar year.

4.7.2.3 Clinical rotations in mental health settings

In this study, three hospital sites were combined under a single mental health specific NGP. Participants were employed by one of the three hospital sites and completed their clinical rotations within their employing hospital. The NGP in this study comprised of twelve months of learning with two commencement dates per calendar year – February and March, allowing a staggered commencement of NGs into the service. During those twelve months, NGs complete at least two clinical rotations in various mental health units. For this study, the units involved included acute inpatient mental health units, a mental health rehabilitation and an older persons' mental health unit. However, within the service there were also options of rotations to an Acute Care Team (ACT), Psychiatric Emergency Care Centre (PECC), and the Mental Health Intensive Care Unit (MHICU). Due to the ethical approval considerations, these three areas were not included in this study. The only community-based mental health team or unit incorporated into the NGP in this health services was the ACT, which was available to only one NG at a time in hospital site one. During the course of the research, three NGs experienced a clinical rotation in ACT due to the arrangement of a six month and two three-month placements. It was not known why NGs were only able to complete their programs in inpatient settings.

Though the concept of mental health care within the inpatient or acute setting may lead to a distorted perception of MHN by NGs, as the balance of community-based care may not be experienced by them.

4.8 Data collection

The premise in ethnography is the collection of data from multiple sources, with emphasis on prolonged immersion in the participants' subculture, to produce the characteristic rich or 'thick' representation of the participants reality and experiences (Geertz, 1973; Whitehead, 2004). Exploring and representing the complex and dynamic nature of culture becomes more accurate with multiple data sources, as each participants' experience of the culture is subjective. Through combining multiple sources using a balance between emic (insider) and etic (outsider) perspectives, increased trustworthiness of the research findings ensues (Bjerknes & Bjørk, 2012).

This study utilised non-participant field observation and semi-structured interviews as the primary data collection methods. In addition, field notes and reflexive researcher notes taken by the researcher were included as data sources. Each layer of data collected was designed to add depth, and to complement the previous findings – a form of cross-checking of the research findings, referred to as triangulation of data (Brewer, 2000). The findings that emerged throughout each episode of data collection guided the direction of research (Whitehead, 2004). This method of conducting research allowed for

the discovery of new knowledge and reflects the iterative and continuous nature of ethnographic research (Brewer, 2000; Savage, 2006).

This research commenced with non-participant field observation to familiarise the researcher with the participants and the setting. Although I had initially planned to conduct field observations in one unit before moving to the next unit, this plan had to be changed to accommodate the clinical rotations of participants and their shift patterns, as well as the staggered ethical approval received for each hospital site. Despite the allusion that the research design is linear of predetermined, this was intended only as a guide, as ethnography is designed to be flexible and responsive to what was discovered in the field (Brewer, 2000; Savage 2006). This meant that I had to complete field observations across more than one unit concurrently with those episodes of data collection determined by the availability of consenting participants.

Data collection took place from May until September 2017, with the conclusion of data collection reflecting data saturation with no new themes emerging in the findings (Hancock et al., 2007). Ethnographic research can vary in duration with some of the earlier forms of ethnographic research spanning years (Fetterman, 1989). However contemporary ethnographic studies may be conducted over a shorter period. Whilst my personal commitments and budgetary constraints as the researcher may have influenced the time spent in the field, it is the point at which the research question(s) have been answered and no new information has eventuated known as saturation, that defines the time to leave the field.

4.8.1 Justification of the methods

Although ethnography is primarily associated with qualitative-based methodology, the ethnographer may draw on a combination of qualitative and quantitative methods to make sense of the meanings within a cultural group (Goodley, 2003). As Whitehead (2004) states, ethnography is more than just a qualitative research methodology, quantitative methods can also be used when appropriate to gain an in-depth understanding of the phenomena under study. In this sense, Brewer (2000) argues that ethnography is not a specific method of data collection but a style devoted to richly describing and understanding a cultural group using any techniques and tools at hand. Therefore, the ethnographer needs to be open to all methods that may enable them to understand the cultural group they are researching and may need to draw on qualitative or quantitative data as well as classical or non-classical approaches to data collection (Whitehead, 2005).

Although ethnography is not a method of data collection, there are typical methods used by ethnographers to represent a culture. The essential method in ethnography is prolonged field observation – involving the researcher spending time within the cultural context. However this method alone is insufficient to represent the inherent subculture of a group (Whitehead, 2005). Additional methods include the use of interviews and analysis of cultural artefacts (Brewer, 2000; Hodgson, 2000); collecting cultural stories, and probing informal written and spoken documents produced by that subculture (Goodley, 2003) which allow the researcher to build depth to the research and to challenge preliminary

research findings (Brewer, 2000; Hodgson, 2000). Exploring and representing the complex and dynamic nature of the subculture becomes more accurate with multiple data sources, as each participants' experience of the culture is subjective. Through combining multiple sources using a balance between emic and etic perspectives, increased trustworthiness of the research findings ensues (Bjerknes & Bjørk, 2012).

4.8.2 Nonparticipant field observation

In the data collection process, it is important to have appropriate instruments. The use of field observation is considered the most essential data collection method in ethnography, involving the prolonged immersion of the researcher in the participants' environment (Goodson & Vassar, 2011; Whitehead, 2005; Wolcott, 1999). This allows the researcher to absorb themselves into the cultural group and use all of their senses and responses to gain an understanding of the phenomena under investigation. This involves observing participants and clarifying what the researcher has observed to discover the participants interpretations, social meanings, and activities (Brewer, 2000). The researcher becomes familiar with the spatial dimensions of the setting and the socio-dynamics of the culture, but also how these dynamics might change at certain times of the day and week (Whitehead, 2005).

There are four levels or approaches to observation as described by Fetterman (1989) ranging on a continuum from completely observing to completely participating. The first level is complete observer, which involves no social

interaction with participants also known as non-participant observation. The second level is observer as participant, which involves some level of interaction within a role but still relies on observation records and other data collection methods. The third level is participant as observer, where the researcher may hold other roles in the research setting other than research. and the fourth level is complete participant, where the researcher is conducting research covertly and the participants are unaware of the research objectives. I employed a complete observer approach – non-participant observation, which was adopted for several reasons. The primary reason was to address ethical considerations around the impact of the research on the consumers of mental health services and the NGs who were just starting out in their careers. I aimed to be as unobtrusive as possible, so that my interaction with NGs did not impose any additional stress on them as they navigated unfamiliar clinical settings.

Non-participant observation involved me observing the daily life of participants within their natural setting of the staff-only areas in each setting. The focus of the observations was on how each participant interacted with other members of the MDT and how they negotiated the existing culture. As a complete observer I openly revealed the nature of the research to those being observed (Fetterman, 1989). As the researcher, I took steps to adopt an outsider role so as to balance the emic and etic perspectives for this research. This was necessary, as I was considered an insider in the research setting as a staff member of a mental health team within the health service.

I had prior knowledge around the design and function of the mental health units in the health service as sites for this research, and in other health services. Mental health units are different in many ways to other healthcare units, in that they often involve a nurses' station being contained and locked, so consumers of the unit are unable to enter. This prior knowledge was incorporated into the research design, as the ethical approval process identified concerns around the research directly impacting consumers of mental health services. Therefore, the observations within this research were conducted within the staff-only areas of each mental health unit. I was mindful to limit the effect of the research on consumers and staff members of each setting. Observations were not conducted in clinical areas, and I was not present during clinical interactions, where consumers of the service were present. A large proportion of the MHN activities tend to occur within the staff-only areas. These types of activities include: nursing handover, staff meetings, medication dispensing, allocation of clinical load and meal breaks, training and education, debriefing sessions, general conversation and interactions amongst nurses and other members of the MDT.

Non-participant field observations were conducted across the six mental health inpatient units included in this study. There were four inpatient mental health units, one rehabilitation unit and an older adult mental health unit. A total of 31 episodes of data collection took place between May and September 2017 – these episodes are outlined in *Table 6* below. Each episode of observation did not exceed two hours, with participants consenting for up to three episodes of

observation to occur. It's important to show a cross-section of behaviour and routines, therefore observations were conducted on differing days and times of the day including weekends and after hours, to capture staff interactions during various processes and times of the day. Whitehead (2005) explains the importance of exploring the research setting and cultural dynamics, and how these might change at different points in time. I also did not conduct research on the night shift due to the low numbers of NGs completing night shift, and the minimal activities that are expected to take place over night.

	May	**June**	**July**	**Aug**	**Sept**	**Total**
Hospital 1 IPU	6 x 2 hour blocks			2 x 2 hour blocks		8 blocks = 16 hours
Hospital 2 IPU			4 x 2 hour blocks	3 x 2 hour blocks		7 blocks = 14 hours
Hospital 3 IPU A		3 x 2 hour blocks			3 x 2 hour blocks	6 blocks = 12 hours
Hospital 3 IPU B					1 x 2 hour block	1 block = 2 hours
Hospital 3 OPMHU		2 x 2 hour block				2 blocks = 4 hours
Hospital 3 Rehab		5 x 2 hour block			2 x 2 hour block	7 blocks = 14 hours
Total	6 blocks = 12 hours	10 blocks = 20 hours	4 blocks = 8 hours	5 blocks = 10 hours	6 blocks = 12 hours	**31 blocks = 62 hours**

Table 6 - episodes (blocks) of field observations

Periods of observation were limited to a maximum of two hours to allow for the researcher to accurately record field observations and to limit intrusion in the clinical setting. Brief notes were taken in the field and later expanded into electronic files at the conclusion of each episode of data collection. Approximately eight A4 pages of field notes were recorded for each two-hour period of observation in addition to one-two A4 pages of reflection.

The term ‘Hawthorne Effect’ is used to describe the phenomena whereby participants or those being observed may ‘act up’ or modify their behaviour in response to being observed. This effect may result in a false culture being recorded. According to Goodley (2003), these effects may be reduced with prolonged time spent in the field and documenting how those behaviours have changed. The natural process taken to record notes in the setting involved capturing first the activities and interactions of the NGs first, and then when there was little activity occurring, to look at the other aspects of the unit and note the smaller details and the components of the nurses’ station. To see their significance, to make sense of their piece of the puzzle. From this method of observation, it was possible to note the changes within the unit that were occurring and noticeable in each episode of data collection.

4.8.3 Semi-structured interviews

In-depth interviewing allows the researcher to clarify the data collected during the period of field observation, as well as providing data on the experiences and perspectives of the participants (Mack et al., 2010). The interviews allow the

researcher to contextualise the data collected through field observations, and for the researcher to access knowledge or information that might not be directly observable or easily accessible (Fetterman, 1989). The interviews were conducted in a semi-structured format which involved utilising a pre-determined interview schedule (Appendix 7). The interviews commenced with an informal and open-ended discussion about the nature of the research and what would be expected of the interview. I then again confirmed that the participant was consenting to participate in the research. The initial questions were around demographics and were conducted to contextualise the participants within the study – particularly around their level of clinical experience and undergraduate preparation for mental health practice. This was then followed by ten semi-structured interview questions relating to the experiences of NGs entering MHN. The content from the interviews were electronically recorded with permission of each participant and then transcribed verbatim into electronic files prior to data analysis with NVivo (version 12) software.

Each mental health unit had several purpose-built interview and meeting rooms that were able to be utilised to conduct the semi-structured interviews with privacy to the participants. The majority of the participant interviews occurred during the cross-over period between morning and afternoon shifts where additional nurses were present on the unit – this was negotiated with the unit staff to have the least impact on the clinical setting. This cross-over period is generally used for education sessions, mandatory training, tying up clinical matters and various other activities. I did not conduct interviews at times when

those mandatory education sessions took place or during pressing clinical matters. On a small number of occasions, the interviews were briefly interrupted by the participants colleagues who were checking a clinical matter with the participant such as signing a medication chart, but due to the conversational nature of the interviews this did not pose a problem to the data collection and interview process.

There was a total of 24 interview participants – NGs (n=12) and RGs (n=12), which is outlined in *Table 7* below. The interviews were conducted between May and September in 2017.

	May	**June**	**July**	**Aug**	**Sept**	**Total**
NG participants	2	4	1	2	3	12
RG participants	3	2	0	4	3	12
Total	5	6	1	6	6	24

Table 7 - semi-structured interviews and participants

4.8.4 Field notes

Field notes are known as observational or descriptive notes and are the written records of events that have taken place in the field. The process of recording field notes is considered essential to ethnography, as the researcher's perspective of the findings are interpretive (Whitehead, 2005). The initial field notes were deliberately brief and written in a short-hand format in a journal held

by the researcher, with these notes expanded on and typed into electronic files at the conclusion of each episode of data collection. All notes taken utilised pseudonyms to protect the anonymity of participants and their colleagues. All pages were numbered and at the conclusion of each episode of data collection, the hand-written pages were removed from the diary, its contents expanded into word documents, and the original hand-written notes bound and stored securely in a locked filing cabinet in my office. The field notes became a record of my observations, thoughts, and feelings during the research which contained rich information that informed the progression of the research.

4.8.5 Reflexivity

The researcher is considered the primary tool in ethnography, and so it is essential that constant self-reflection occur to enhance the accuracy of the research findings (Darawsheh, 2014; Goodson & Vassar, 2011). Since there is no perfect method in representing reality, reflexivity assists in maintaining transparency, neutrality, and credibility to the research findings, both in conducting the research, and in analysing the data (Brewer, 2000; Darawsheh, 2014). A criticism of naturalism is that the social researchers are a part of the social world under study (Hammersley & Atkinson, 1995). However, reflexivity can enhance the quality of the research findings as it demonstrates an understanding of the researchers position and interest in the research and is considered crucial in research where the participants may be known to the researcher (Jootun et al., 2009). The importance of reflexive practice is emphasised with the ethical issues that may arise from the close relationship

developed between the research and the participants (Reeves et al., 2008). As the research process involves ongoing data collection and analysis, and prolonged time in the field, the challenge of the researcher is to investigate the phenomenon whilst identifying and challenging bias and personal assumptions that may arise throughout the research process. Reflexivity is achieved with the researcher's ongoing analysis of their observations, experiences, and interpretations throughout the research period, with a goal of identifying potential biases that may distort the research findings and lead to the creation of false cultures (Goodson & Vassar, 2011; Whitehead, 2004). It was essential that a reflexive process was used to clearly differentiate between the my experiences and values, and those of the participants, with this evident in the reflexive notes made alongside field notes throughout the course of data collection and analysis.

4.8.6 Exiting the field

The process of entering and exiting the field required a careful approach, especially when sites may have been revisited or where the researcher may encounter members of the cultural group or participants in the research. It is important that respect is paid to both the development and the ending of the relationships built whilst in the field. Each participant was aware that they were consenting for up to three episodes of observation at a maximum of two hours in duration. The participants and the unit staff were updated as the research progressed around the expected duration of data collection within their unit. With that information becoming available as the research neared data

saturation and the participants had completed their participation in the research. By the fifth month of data collection, it became clear that data saturation had occurred due to the repetition of themes emerging from the interviews and observations. The research continued for a further 2-3 weeks – with at least one episode of observation occurring for each of the remaining consenting participants to represent each of the consenting NGs experiences. The process of explaining the impending cessation of research was then discussed at each of the research settings. Once data saturation was determined and a decision to end data collection in the field, an official conclusion of data collection was signalled via email to the director of nursing of the health service. This correspondence indicated that data collection had concluded, and I thanked the health service for allowing me to conduct the research. This was then followed by a meeting with the director of nursing in person.

Figure 2: Handmade chocolate gifts given to the new graduate nurse participants

Each of the NG participants were gifted with a small box of chocolates – *Figure 2,* as a token of gratitude for their participation in the research. RG participants were offered a café coffee/beverage to take to the interview and each unit was also provided with a large box of chocolates for the staff to share. Chocolates were also sent to the education team and the executive nurse manager in gratitude for their guidance and consent for the research to take place. This kind of gift is typical of what is given when nurses and visitors leave departments having spent a time in them.

4.9 Data analysis

At the heart of the ethnographic work is the identification of patterns within the subculture, which are identified in the analysis of the collected data. The ethnographer searches for repeated thoughts and behaviours in various situations and with various participants, and then seeks to interpret those findings rather than simply providing a description of the event (Basit, 2010; Fetterman, 1989; Spradley, 1979). Data analysis is a process involving the interpretation or *making sense* of the data that has been collected, by organising the data into categories and looking for the relationships within the data (Brewer, 2000; Nowell et al., 2017; Savage, 2006). The process of data analysis, collection and interpretation is inter-related, and as Brewer (2000) explains, it is a continuous process rather than a linear sequence of stages.

There are different methods for analysing data, however this inquiry used the approach of thematic analysis to analyse the data which involved an inductive

approach to identifying themes. Themes represent the important aspects of data of the patterned findings in relation to the research question, and identifying the broader meanings and implications of the findings (Braun & Clarke, 2006; Ryan & Bernard, 2003). Thematic analysis is not embedded with any particular theoretical framework and therefore applicable to a number of qualitative methodologies (Braun & Clarke, 2006; Reeves et al., 2008). Within the research process, data analysis can be considered the most complex phase of qualitative research. It is also important to provide a clear road map of the analysis with sufficient detail to ensure trustworthiness of the findings, as the researcher-as-instrument makes judgements around coding and identifying themes (Nowell et al., 2017).

This inquiry used Braun and Clarke's (2006) approach to data analysis which involves six phases to identify themes. Phase one involves familiarisation with the data; phase two involves generating initial codes; phase three involves searching for themes; phase four involves reviewing the themes; phase five involves defining and naming the themes; and phase six involves producing the report (Braun & Clarke, 2006). Although other sources were drawn upon, the structure provided by Braun and Clarke (2006) has been utilised by a number of researchers and is considered a sound data analysis tool (Nowell et al., 2017).

As outlined earlier in the chapter, the process of data collection and analysis involved ongoing involvement with the supervisory team to enhance rigour and trustworthiness of research findings (Gulati, 2011; Lincoln & Guba, 1985;

Nowell et al., 2017). This included discussion of research findings, and examples of initial codes and developing themes. This allowed for an objective view of the research and to provide peer scrutiny. The rigour and trustworthiness of research findings in ethnographic research is enhanced through prolonged time spent in the field, use of multiple data sources and reflexive practices with the supervisory team (Brewer, 2000; Cypress, 2017; Geertz, 1973).

4.9.1 Phase one: familiarisation with the data

This phase of data analysis can be achieved by becoming immersed in the data. Braun and Clarke (2006) emphasise that the researcher needs to be familiar with the breadth and depth of the content. To achieve this, all of the data were collected and analysed by the same researcher. Through immersion in the data, I was able to gain an understanding of how MHN and its culture were experienced by NGs from their perspective. Lincoln and Guba (1985) emphasise the need for data exploration and analysis to be an inductive rather than deductive process, requiring repeated engagement with the data. I had transcribed all of the field notes, reflexive notes and the interview transcripts verbatim into word documents. A hard copy was printed, and then electronic copies stored in a storage cloud and within the NVivo (version 12) software program. This program provided the platform for data storage and subsequent data analysis. Braun and Clarke (2006) acknowledge the time-consuming nature of transcribing interview notes, but also emphasise that this is a valuable method for enhancing familiarisation of the data.

The hard copies – represented in *Figure 3* of the transcribed data were explored in their entirety several times. This allowed for the researcher to reflect on the contents of each data source and to make memos and note any questions that arose from those notes which could inform the ongoing data collection. Initial ideas and notes were written within the pages of the hard copy notes as the content was being explored. Braun and Clarke (2006) emphasise the need to read through the entire data set at least once before beginning the process of coding. The transcripts were also checked against the original recordings. I spent time listening to the original audio recordings which allowed for reflection on the nuances within the interview conversations and to check for the accuracy of the transcription (Braun & Clarke, 2006; Lincoln & Guba, 1985). Familiarisation with the data involves prolonged engagement with the data and keeping records of all field notes and reflective thoughts (Nowell et al., 2017; Ryan & Bernard, 2003).

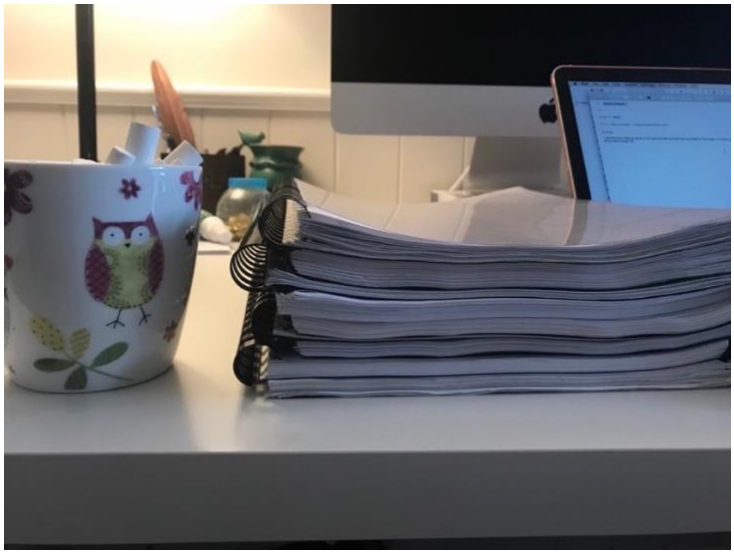

Figure 3 – typed pages from field notes and interviews.

4.9.2 Phase two: generating initial codes

Coding has an important role in data analysis. It involves organising the data in a systematic fashion into groups and collating data relevant to each code (Basit, 2010). The codes differ from themes which are broader. A code represents an element of data that is relevant to the inquiry (Basit, 2010; Braun & Clarke, 2006). In this inquiry, codes were identified through hand-coding in the hard copy and then in exploring the electronic copies in the NVivo (version 12) program. Hand-coding involved highlighting segments of text and using post-it notes and writing notes within the margins of the hard-copy notes. An example is provided in *Figure 4 – initial hand coding*. The initial data extracts were coded and then those coded segments were collated together (Braun & Clarke, 2006). This phase of data analysis also involves the development of a coding framework and audit trail (Nowell et al., 2017).

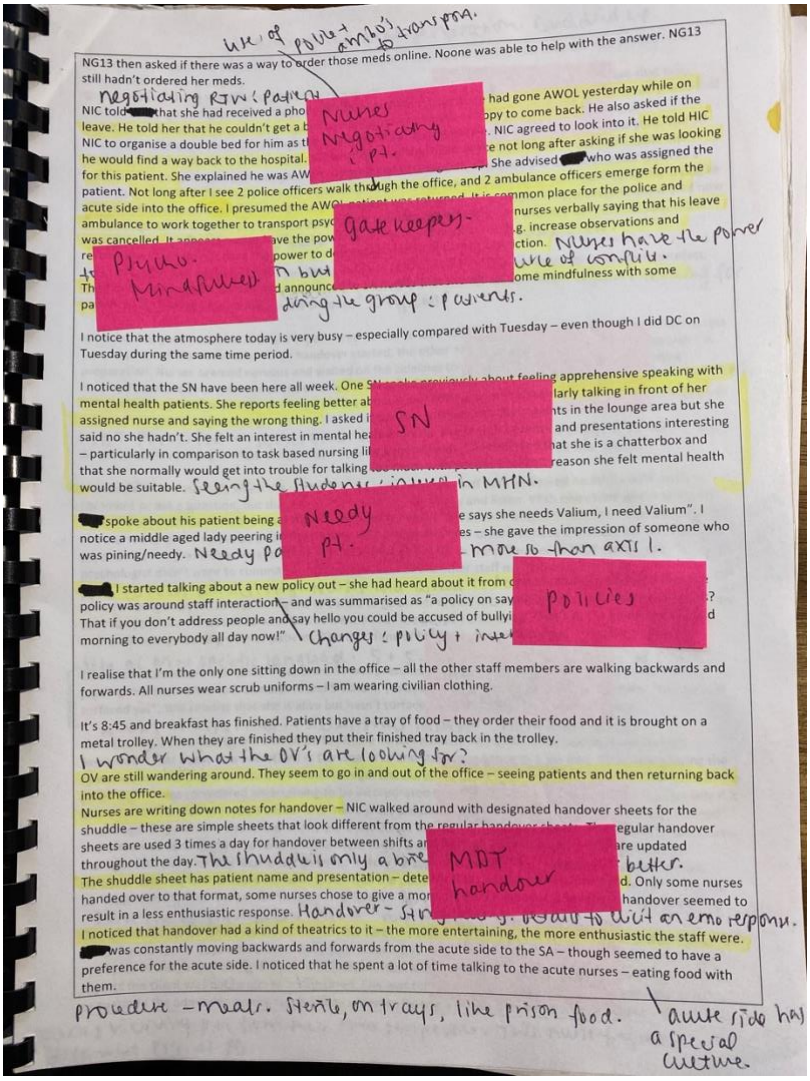

Figure 4 – initial hand coding

4.9.3 Phase three: searching for themes

Searching for themes involved collating the codes into potential themes and gathering the data relevant to potential themes and examining the associations across the themes and sub-themes (Nowell et al., 2017). Braun and Clarke (2006) outline that the phase of searching for themes occurs when you have identified a list of the different codes identified. This process then requires the researcher to combine codes to form over-arching themes. Within this process,

some codes may become themes, others sub-themes, or may be discarded altogether (Braun & Clarke, 2006; Nowell et al., 2017). An example of the development of themes is outlined in *Figure 5*.

Attraction to MHN, qualities, personal charactersitics	MHN personal characterisitcs	NG program - education and support
Chose MHN after clinical placement	MHN are unique - requires certain character traits. Resilient and easy going, humour, and life experiences, friendly, flexible. Humour and quirkiness - not cold and detached	Clinical and workplace support
MHN different from general nursing - disliked the task-based nature of general nursing	MHN handle a high level risk	Changes to the NGP structure
Prior MHN knowledge or experience	Language skills - can be challenging for P's with ESL	Focus on competencies
Chose MHN despite negative views from others	Focus on early proficiency - self doubt of proficiency	Balance of education and clinical
Attracted to the nature of the work and nursing relationships; it's appears fun and flexible. Those who do not fit in seem to struggle	Use of self as the tool - takes time to develop	Eductor plays a key role
MHN easier to get a placement	Nurse as the tool - differing perspectives, approaches and opinions	Initial transition shock and stress
Despite extensive prac and theoretical learning - still unprepared for practice	personal characteristics important when entering the culture.	NG role overload - OT, students, NGP
Choosing something that is different from general nursing - rather than abanonding nursing altogether	Self-preservation to prevent burnout - use of humour to prevent burnout	Learning MHN skills - practical skills
Attracted to the nature of the work and nursing relationships; it's appears fun and flexible	Rumination around work and practice	No guarantee of a job post NG year
Prior skill development in aged or dementia care - de-escalation and communication	Learning to adjust to a different pace	Conflict between education and clinical reality
Attratced to psychology, counselling and brian function.		NGP generic - not challenging for some and overwhleming for others
UG experience affected choice - some positive experiences drew me in		Inconsistent preceptoring
		No regulation of NGP
		Preparation for practice
		Not being rostered with preceptor
		NG socialise together - study days and network

Figure 5 – Example of searching for themes

4.9.4 Phase four: reviewing themes

This phase begins when a set of themes have been identified and are ready for revision. This process involved reviewing the themes and checking the compatibility with the coded extracts and entire dataset to generate a thematic map of the analysis (Braun & Clarke, 2006). Braun and Clark (2006) emphasise that the data within the themes needs to be congruent with one another but

have clear distinctions between the themes. This stage also involved discussion with the supervisory team. Nowell et al (2017) argue for the importance of the themes and subthemes being vetted by the team members.

4.9.5 Phase five: defining and naming themes

Defining and naming themes begins when there is a thematic map of the data (Braun & Clarke, 2006; Nowell et al., 2017). Ongoing analysis allows for the themes to be refined and to allow for the overall story to be pieced together. This process allows for clear definitions and names for each theme and sub-theme to be identified (Braun & Clarke, 2006). For each individual theme there needs to be a detailed analysis to identify the story and how this fits into the bigger picture (Braun & Clarke, 2006).

4.9.6 Phase six: producing the report

This last phase involved producing the report of the analysis. The reporting enabled the inclusion of extract examples as well as the analysis of these, and relating the analysis back to the research question(s) and literature review for an overall report (Braun & Clarke, 2006; Nowell et al., 2017). The purpose of this phase is to tell the story, and in this way it needs to provide a coherent account of the story across the themes with the use of extracts to provide examples of the points being made (Braun & Clarke, 2006). The narrative needs to go beyond the description of the data and make an argument in relation to the research question, with each theme distinct but relating back to the research question (Braun & Clarke, 2006). The elements of producing the

report also involve providing sufficient detail, thick description of the context, provision of an audit trail and the reasons for the research design choices (Nowell et al., 2017).

4.10 Limitations

As with any methodology and research design there can be limitations. The findings in this research study represent a snapshot taken in time and is based on the experiences and perspectives of the participants captured during the data collection period. The findings of this research are intended to be interpreted within the cultural context that they were found. These findings are therefore not intended to be generalizable to other contexts (Goodson & Vassar, 2011). It is acknowledged that smaller sample sizes are a limitation of ethnography – as the process of data collection and analysis is laborious and time-consuming. As this research involved contact with several vulnerable groups including NGs and research inside mental health units, there were limitations to the extent of cultural investigation. This research was confined to the staff-only areas of each setting, therefore, there may be aspects to the NG experience that may not have been captured due to the researchers' inability to enter the clinical environments.

4.11 Chapter summary

This chapter outlined the methodological framework for this research including a detailed description of the research design and methods used to address the

research aims. This chapter included the ethical considerations and methodological limitations as well as justification for the appropriateness of this research design. The next four chapters represent the findings of this study: attraction to MHN; the new graduate program; entering mental health nursing practice; and entering the culture of MHN. Chapter five involves exploring the first of the finding chapters – attraction of NGs to the field of MHN.

Chapter five
Attraction to mental health nursing

"As I enter a new phase of life and my circle broadens,

I start learning new things"

Kapil Dev

5.1 Introduction

There were four main themes found in this study: attraction to mental health nursing; the new graduate program; entering mental health nursing practice; and entering the culture of mental health nursing. These themes represent a chronological exploration of the NGs journey but also represents the increasing depth of their journey to entering the MHN cultural group. Exploring the journey that NGs take allows the reader to follow that journey and develop an understanding of the factors that shape NG experiences, as well as the factors that influence their commitment to MHN. This chapter represents the first of the four findings chapters – *attraction to mental health nursing*. The three main sub-themes of this chapter are: *the influence of undergraduate learning and clinical placement in mental health settings; choosing to enter mental health nursing;* and the *high stakes in choosing to enter mental health nursing.* This chapter addresses the research questions exploring factors that influence NGs decision to remain in MHN. The attraction to MHN and the expectations that graduates had of MHN played a significant role in their decision to remain in the field after

completing their NGP. This concept will continue to be explored across the remaining findings chapters.

5.2 Influence of undergraduate learning and clinical placement in mental health settings

The participants in this study described a positive shift in their perception of MHN that occurred during their undergraduate learning. A majority of the participants entered their nursing degree with no intention of choosing MHN and changed their minds as they progressed through the nursing curriculum. This supports existing research findings of the undergraduate exposure to MHN acting as a catalyst in their pursuit of a career in MHN (Happell & Gaskin, 2013; Wilkinson et al., 2016). In this study, most participants chose MHN after completing their clinical practice experience. One of the reasons suggested in the literature for an increased attraction to MHN after clinical placement is the consolidation of skills and knowledge after completing the mental health theoretical components of their undergraduate program which are realised when completing their clinical practice (Happell et al., 2008; Neville & Goetz, 2014). The following participant described her shift in preference for mental health settings after completing experience in MHN.

> *I initially didn't want to work in mental health nursing when I started my degree. I wanted to do something cool like ED* [emergency] *but when I did the placement which was here in acute care and in the inpatient unit* [mental health settings]*, I really, really, really just enjoyed it. I couldn't explain why. I just find it really interesting. Everyone has such a different*

> *story. It's different with every client, different every day. And in a nice way kind of entertaining, more so than 15 hip replacements. You get some good stories* (Interview, NG14)

Positive clinical experiences have been associated with more favourable attitudes towards MHN (Happell et al., 2008), as was described by participant NG14. The following participant described a similar shift in preference for MHN after completing practical experience.

> *It was never a thought, like when going into nursing I just thought general. But then I started doing my pracs in general and then it was like showering and meds and then like so much stress. Even as a student I felt stressed being on the ward. And then second year* [as a student] *I did my mental health prac here. I did my prac and then I loved it and then I did a few more general pracs and then it just got worse* [my attitude towards general nursing] *from there* (Interview, NG13)

The shift to a preference for MHN appeared to occur for most participants by the third year of undergraduate learning. This was even more so for participants who had completed mental health units in the second and third years of undergraduate learning and had been exposed to some practical experience in mental health settings. Some participants felt ambivalent throughout their second year, but after completing another practicum in general nursing, decided to pursue a career in MHN. Timing of their intention was described by the following participants.

> *I think it's because I always loved mental health. I think by second year once we started mental health, I was convinced that's the path I wanted to follow* (Interview, RG17)
>
> *I was pretty hell bent on it by the start of third year* (Interview, RG2)
>
> *By third year I figured* (Interview, NG3)

As Neville and Goetz (2014) outlined, it is difficult to separate clinical and theoretical mental health content from each other when exploring factors that influence attraction and retention, as these components have a strong influence on each other. Research demonstrates that only a small minority enter nursing with a desire to work in MHN (Happell et al., 2013). The findings of this study support that concept, with the majority of research participants entering nursing with no intention of pursuing a career in MHN. However, then changing their minds as they progressed through their studies.

5.3 Choosing to enter mental health nursing

Participants in this research were asked about their reasons for pursuing a career in MHN – prompted in the semi-structured interviews by the question *why have you chosen to enter mental health nursing?* The responses for this question were also enhanced with content from other interview questions and the collection of demographic data (Appendix 7). The findings from the semi-structured interviews have demonstrated that each participant had purposefully sought a career in MHN. Participants described choosing to enter MHN and they described entering the field with passion and ideals for change and

improvement – this was summarised as wanting to make a positive impact to the field of MHN. There were several reasons cited for choosing a career in MHN largely grouped as: mental health care is holistic; mental health nursing involves specialised skills, the mental health nursing relationships are colourful, and it's a perceived easy nursing specialty.

5.3.1 Mental health care is holistic

MHN was described by the participants as a holistic specialty, with a person-centred care approach to providing care. Participants identified this as an attractive component of MHN practice. They felt general nursing care focused on an injury or illness patched up quickly – not the person themselves. The treatment approach in general nursing was described as simplistic, emotionally detached, and task based. Participants viewed a deterioration in mental health as requiring a holistic approach.

> [Mental health] *is a lot more personal, less sort of task-orientated... It's more patient-centred, you see them recover differently. A person with an infection gets antibiotics and they get better, and they go, whereas here with mental illness, your whole life is affected* (Interview, NG3)

> *What I like about mental health is that every factor of your life that kind of explodes at once. You come in as a mess and you kind of have to go okay you've got family, friends, work, hobbies… all these different things that make you who you are and it's not a band-aid, it's not like you break your leg and then go* [gestures a cast and laughs] (Interview, RG2)

The ways in which participants described MHN practice emphasised the flexibility and complexity involved in care. That there may be many ways to accomplish the same task, and that MHN care involves improving multiple aspects of a persons' life. This became another opportunity for participants to emphasise the differences between general and MHN fields – specifically identifying general nursing as task-based and inflexible, and MHN as a holistic and flexible practice. Although flexibility was also described as unpredictability as well.

> *It's very flexible. Like I guess as opposed to medical nursing, every day is different. You walk in, you don't know what to expect. Things change all the time. I find that we work better together as a team. Because there's a lot more situations that involve more teamwork. It's not as task-orientated, it's sort of like you get things done in whatever order you can. Specifically, medications, physical obs, and you get to spend more time with your client* (Interview, RG17)

Participants described an emphasis on holistic practice, with a strong emphasis on flexibility this was also described as a creative process. These appeared to be the positive descriptions in describing uncertainty or unpredictability within MHN clinical practice.

> *I like the impact of it and I kind of feel like it's creative – mental health and I think you can get the same goal achieved in many different ways for each consumer* (Interview, RG2)

The concept of MHN as a holistic specialty was contrasted by some participants with the perception that general nursing is task-based in nature. Participants contrasted mental health and general nursing fields by the approaches to care. General nursing was described as being task orientated, whilst MHN was described as flexible, holistic and caring. The following interview participant described general nursing as robotic – '*just doing… okay you got these set tasks you have to do. You don't really have time to engage with or see the social side of their lives*' (Interview RG14). This next participant felt that entering MHN would allow for the pursuit of deeper therapeutic relationships.

> *I thought general was painful! I just hate the task-centred nursing and I always got in trouble for talking to the patients too long and being told I'm not a social worker, that I was a nurse and I needed to get the jobs done* (Interview, RG2)

A similar account was described by this NG who used the term 'real nurse' to describe the pursuit of a deeper therapeutic relationship with consumers of mental health services.

> *One of the stories I get from mental health nurses is that they chose mental health because, they were working on a medical ward and have been talking to the patients, and then the nurse in charge or whoever, would come in and say, "What are you doing? Why aren't you working?" And they'd go "I'm just talking to the patient", and the other nurse would be like, "you should be making beds or washing kidney dishes". And they would say "I've done everything. I've done my tasks. Now it's my time to be a nurse"* (Interview, NG3)

The concept of general nursing being *boring* and task-oriented greatly contrasts with comparisons of general and MHN within the existing literature. Participants in this study have described MHN as exciting and rated general nursing fields as *boring* and task-based, which contrasts from previous research findings suggesting graduates would find general nursing fields such as critical care more exciting (Happell, 2008; Stevens et al., 2013).

5.3.2 Mental health nursing involves specialised skills

Another feature which NGs found attractive was the specific skills or attributes they associated with MHN. The participants felt that the mental health nurse possesses the skills or inherent qualities to help the healing of another person. This is described as the mental health nurses being the tool of intervention. The following participant referred specifically to the therapeutic use of self in describing MHN.

> *It's therapeutic use of self. I think that's one of the most beautiful ways I've heard mental health described, is that you're not using x-rays, you're not using blood tests, you're not using scans and technology to fix someone. You're using your own personal skills and strengths to bring out their own. I think mental health brings people together and kind of forces people to reconnect. To use other humans to get through life which I think is really beautiful* (Interview, RG2)

The emphasis for participants was on the mental health nurse holding specialised skills to help people recover. Those skills were not described in a technical sense, but that the mental health nurse has the inherent ability to help

another person recover. Participants describe the nurse as being the tool of treatment and assessment in the recovery process. They described a desire to connect with consumers and emphasised that this was a practice inherent to MHN and factored as one of the reasons they chose the discipline.

5.3.3 The mental health nursing relationships are colourful

The relationships in MHN appeared to be a strong factor in influencing NGs to the field. Some participants noted key differences between the cultures of mental health and general nursing. Mental health nurses were described as being relaxed, humorous and connected to one another. There was strong emphasis on the importance of relationships in MHN, particularly among the nurses. Participants also described a teamwork approach to clinical practice that they found attractive. Mental health nurses were also described as being fun and expressing humour and flexibility in their clinical practices. NGs described an attraction to those qualities and wanting to be included in the cultural group. The following participants describe their experience of encountering MHN relationships.

> *I think from what I've seen as a student what I've experienced so far, there does seem to be more cohesion and teamwork in mental health nursing than what I've seen in other nursing* [fields]*. As a student I would remember you would kind of get buddied up with your nurse for the day in the medical ward, and that nurse would kind of do* [work with] *their patients. You didn't spend much time with your colleagues, you're always busy with your own thing. Whereas in mental health you bounce a lot more off your colleagues as well, you rely on them a lot more for that*

support. Also, I don't think I've seen much laughing and happiness in other nursing fields as I've seen in mental health (Interview, NG14)

The isolation of working alone or with one other person, was described as a reason for a lack of cohesion with colleagues in general nursing. The friendliness of the collegial relationships in MHN was seen as important and demonstrated to them that they were accepted and included as members of the team.

There is a better relationship between nurses in mental health compared to general. Because I feel like in general you get paired off with one person to work with in a section. And it's just that and you're so busy doing your own thing. Whereas in mental health you kind of need your colleagues there…I think the relationship between nurses in mental health is pretty good. I really like it I feel like it's more friendly compared to general (Interview, RG14)

Participants reported that the depth of collegial relationships and the personalities of the mental health nurses themselves were also factors that attracted them to MHN. They even felt that those who taught them about MHN during their degrees were more interesting and engaging people. They appreciated the diversity of age and gender too.

I find the personalities in mental health nursing more interesting to work with. And the team is really important to me. There is a lot more dark humour, which is a good way to deal with what you see… You have to seek happiness and it builds that part of your character. I really like that in mental health nurses. In my training all the people who taught mental

> *health were equally the most interesting personalities and the best communicators. I find that in general nursing people are more task oriented and are less relationship focused* (Interview, NG2)
>
> *I did my placements here* [in this mental health unit] *and I really enjoyed it. The staff were different here, they're more fun. Most of the staff are young here as well, there are more male staff as well, so I have some good mates* (Interview, RG10).

This participant had described that as a male nurse, the presence of other male nurses was seen as an attractive and important aspect of the workplace. This is also interesting as mental health care was previously a male-dominated area of nursing care, with MHN currently holding a higher number of male nurses than in other nursing specialties (Australian Institute of Health and Welfare, 2019a). There were elements of the MHN characteristics that participants could identify on placement during the undergraduate program as well. This gives an impression of a specific set of qualities that may be inherent to MHN, with participants identifying with elements of those features in their attraction to MHN. The emphasis was on the nursing group and what approaches and capabilities the mental health nurse had.

5.3.4 Perceived easy nursing specialty

Participants described the notion that MHN is perceived as an easy discipline. Outsiders to the discipline described MHN as being easy, lazy work. Some participants described fellow students as considering a career in MHN to increase their chances of securing a NGP position. None of the participants in

this study identified this as a reason for themselves but mentioned it when outlining why they chose MHN.

> *I had other friends that said we couldn't get anything that's why we chose mental health* (Interview, NG1)

> *I know speaking to some students that were picking their electives saying I might do mental health because it is easy to get into* (Interview, NG5)

Despite the perception of MHN being an easy discipline to gain employment in, participants emphasised that the work was not easy or lazy, especially if you are wanting to make a difference. This related back to the qualities of MHN, and that it would be difficult to work within the team and not provide care and do nothing. Though there was an element of choice in how much a mental health nurse chooses to do, with more effort associated with positive outcomes.

> *I feel people work here – not here in general, but in mental health because maybe they think it's easy. But it's not when you're one of the people who are trying to make a difference* (Interview, RG9)

While none of the participants in this study indicated that they chose MHN because it was easy to get into. They described it as a reason for other people to choose MHN. They described it as relating to other nurses holding negative attitudes towards MHN, and that their choosing MHN indicated that it was because it was easy as opposed to wanting to work in that field. This appeared to be an important distinction that these participants were making – they were

choosing MHN to help people and emphasised their attraction to the MHN culture.

5.4 High stakes choice

Despite participants describing a passion for MHN and a desire to pursue a career in this field, they described high stakes in choosing to enter MHN. These were mainly around the *stigma and perception of mental health nursing* and their *future after pursuing mental health nursing* particularly if they then changed their mind about a career path in the discipline.

5.4.1 Stigma and perception of mental health nursing

Participants in this study described challenges in choosing MHN due to stigma and the perceptions that people around them had of MHN. Research shows that negative perceptions of nursing fields affect undergraduate preferences (Hoekstra et al., 2010). Participants described encountering disproval from other health professionals, peers, family and their community for pursuing a career in MHN. They described MHN not being considered real nursing, and that graduates who had pursued a career in this field were taking the *easy way out*. They described ongoing stigma around mental health staff, the service, and practices themselves, and the consumers of mental health services. These findings are supported by other literature concerning the perceived lower status of MHN compared to other nursing disciplines (Hoekstra et al., 2010; Stevens et al., 2013).

The following participants describe their experiences of choosing MHN, particularly around encountering the opinions and responses of others. In the first example, the participant described a hesitation in specifying her unit of work as she experienced people responding with lengthy questioning and shock that she works in a mental health unit. She described approaching questions around work in a general sense and explaining that she works in a hospital. She explained trying to generalise by saying that she is a nurse and only revealing more, when probed for details.

> *They say what sort of nursing do you do? And I say I work in the mental health unit, or I work in mental health, and they go ohh! They are like 'why do you like working in mental health?' I just say the same reasons that I want to work in mental health nursing, it's really interesting and it's really different* (Interview, NG14)

Other participants had similar experiences but also pointed out misconceptions that people have about MHN. These participants have described challenging those perceptions and pointed out that mental health care has stigma around it, and then describing the need to defend MHN.

> *It's completely different to what's depicted. It is so different… I always said there is so much stigma attached. I think people think of mental health as just you know crazy people or specifically certain diagnoses. But there's so many different types of mental illness, it's broad* (Interview, RG17)

The perception of MHN as an easy or lazy specialty area contributed to the stigma associated with the field. Participants described this both as barrier to pursuing a career in MHN, but also as something they experienced on an ongoing basis. Participants described nurses in other specialty areas holding a negative view of MHN and insinuating that nurses who pursue this field are lazy.

> *Mental health nursing always has been blamed as 'we're just the lazy nurse'. Every time I have to speak to any of the nurses it's like 'oh it's easy, you don't have to do anything, it's like you don't have to do much work, just sit there and there's not much to do'* (Interview, NG9)

In addition to being described as lazy, MHN was also described with less respect than other nursing specialties. The following participant described the impression that her friends and fellow nurses who worked in other nursing specialties. He explains that MHN is looked down upon seen as a nursing specialty of a lower standard.

> *Friends of mine who did medical nursing, who we studied together with, they say mental health nursing is quite looked down upon… in medical wards. They talk like, mental health nurses don't know anything at all, like it's quite looked down upon* (Interview, RG15)

Participants described defending MHN as a complex and demanding area of nursing. They describe challenging the views of other nurses and highlighting the aspects of mental health care that require time and effort. The concept of MHN as a lazy choice was challenged by the participants who presented an

alternative view of MHN as dynamic, challenging and more skilful than other nursing specialty areas. Particularly with the skills that need to be developed. The following participant emphasised the complexity of MHN that requires the ability to detect subtle changes within a person as well as maintaining an ongoing therapeutic relationship and connection.

> *People think it's not real nursing, but actually it's hard work. You have to be focused on your patient all the time. And it's not only seeing the subtle change, but it is also seeing some changes deep inside their mind, and that's also hard* (Interview, NG15)

The stigma of MHN and the opinions of others act as barriers to NGs choosing to enter MHN. The participants in this research had similar experiences to those outlined in the literature (Wilkinson et al., 2016). Though they described the tension between passionately choosing MHN, they also needed to defend their choices and encounter stigma associated with pursuing MHN. Participants described having to convince those around them that a career in MHN was a worthwhile and positive venture creating somewhat of a high-stakes choice. This concept was described by the following participant with similar sentiments described within the findings.

> *I just found it really difficult to convince everyone around me that it was a good job!* (Interview, RG2)

Participants described experiencing a great level of tension in choosing MHN and had considered pursing general nursing to address concerns about their

future nursing career. Some participants were hesitant to choose mental health despite an attraction to the field. They described being actively discouraged from pursuing a career in MHN, supporting existing literature (Happell & Gaskin, 2013; Stevens et al., 2013).

> *I was always told if you want to do mental health nursing you have to do a year in clinical general fields to keep your skills up…* [this was stated by] *Uni teachers, clinical facilitators, and generally it's people who work in general fields as well* (Interview, NG5)

Despite being advised to pursue a career in general nursing first, she completed placement and was encouraged by a senior nurse in a mental health setting to pursue the area she feels passionate about. In response she altered her preferences for her NGP to reflect mental health settings and enrolled in mental health electives for the remainder of her undergraduate program.

5.4.2 Future after the new graduate program

Participants described some apprehension about pursuing a career in MHN despite wanting to enter this field. The most pertinent factor concerning them was the potential permanency in their decision should they later change their mind about MHN. They described an importance in the skills attained during their transitional year, and if they changed their minds about continuing their career in MHN, that they may not be able to enter general nursing due to a lack of general transitional experience. However, in the end these participants chose

to enter MHN despite their hesitancy. This tension is described by the following participant.

> *When I was filling out the paperwork for my new grad, I'm like what do I do? I'm torn… there is so much stigma around mental health, and if I go into mental health and I don't like it in a year then I'm not going to be able to get into general* (Interview, NG13)

This participant chose MHN on the encouragement of a family member, with the family member pointing out that she had enjoyed MHN practical experience much more and had come home happier after each day of placement.

The other concern around the future for NGs was their employment uncertainty after completing the NGP. The NGP in this study is a one-year temporary contract, which means that graduates would need to look for alternative employment thereafter. The concern that graduates raised in this context was that they were all graduating at the same time and therefore vying for the same jobs that would require filling. It was not guaranteed that any jobs would be advertised when the graduates completed their program, adding to their uncertainty about their future after completing the program. This was further exacerbated by the perception of limited job opportunities available in mental health settings as opposed general nursing, particularly in the health service included in this research. This was owing to the smaller number of beds and units available to MHN.

> *You have that pressure and it is so hard… processing everything that's happened in the year and then thinking 'I might not even have a job after this, and I've got to start again!'* (Interview, RG4)

The perspective of challenges in securing employment after the NGP provided an alternative view to MHN as an easy specialty to practice in as well as a specialty that is easy to gain employment in. There are several pressures and high-stakes choices that graduates must consider when choosing to pursue a career in MHN. Despite describing a commitment to MHN, the next challenge was in navigating the new graduate year to secure ongoing employment in this specialty.

5.5 Chapter summary

This Chapter explored the attraction of the participants to MHN which was largely shaped during a positive undergraduate MHN experience. Despite their attraction to MHN, there were some tensions identified with pursuing a career in this field, particular in encountering the disproval of family and peers and the stigma associated with mental health care. Additionally, there was a concern that if the participants changed their minds and wanted to pursue a career in a general nursing field, they may not be able to as they have consolidated their comprehensive general nursing skills within a mental health field. The next chapter explores the participants' experiences of the NGP and its influence on their decisions to work and stay in MHN. The NGP in MHN provides the gateway into the cultural group and the framework which allows NGs to consolidate their skills and knowledge in this field.

Chapter six
The new graduate program

"A journey of a thousand miles begins with a single step"

Lao Tzu

6.1 Introduction

The NGP in this study has been designed to provide transitional support for NGs entering mental health settings within the research site. Within this chapter is an in-depth description of the transitional program and the educational activities undertaken by NGs during their first year of registration. This chapter addresses the experiences of NGs in navigating their transition from student to advanced beginner clinician within the structure of the NGP. The main sub-themes are: *bridging the gap – the formal new graduate program as the gateway to clinical practice;* and *transition stress – thrown in the deep end.* The findings from this chapter explore the research questions around the process of assimilating NGs into the organisation as well as exploring how the NG fits within the organisations' hierarchy and how this is perceived by them. This chapter builds on the experiences described by participants who have chosen to pursue a career in MHN.

6.2 Bridging the gap – the formal new graduate program as the gateway to clinical practice

The NGP in this research setting has been outlined as a bridge in the gap between MHN education in the undergraduate program and what is expected in the health service for clinical practice in the mental health setting. It was a requirement for the service that all first-year nurses entering mental health complete the NGP. A more detailed overview of the components of the NGP has been outlined in chapter four. The purpose of the NGP, anecdotally, has been to consolidate the learning attained by NGs during their undergraduate studies, and provide support during their transition into the world of clinical practice and in socialising new members to the cultural group (Pelletier et al., 2019; Wilkinson et al., 2016). This process of socialisation of new members involves shaping their beliefs, attitudes, and behaviours they will have as they assimilate into the existing cultural group (Schein & Schein, 2017).

In entering the NGP, participants provided an account of their experiences within the field observations and the semi-structured interviews taken. In reflecting on the requirements of the NGP (see Appendices 9 and 10) participants described feeling stressed with completing the NGP requirements as well as managing the transition into the clinical setting. The following participant described his experience of the NGP.

> *NG3 showed me his workbook for the NGP. He had said that there was a lot of content to cover. He showed me that some of the competencies aren't as relevant in this clinical unit as some of the other units* (field note 3:4)

This participant generally described the competencies as a burden – a necessary task to complete the program. Previous cohorts of NGs (RGs) who participated in the interview component of this research, had a different experience with regards to competencies and requirements within the NGP. Despite both the NGs and the RGs being employed in the same hospital site, they had had different experiences. This was attributed to the ongoing changes within the NGP with different educators and general program changes as well as some participants completing their NGP in other sites. For example, RG11 completed her NGP two years prior to NG3, with a different educational team overseeing the content and requirements.

> *We had those* [competencies and workbooks]*. I don't think they were too fussed if we handed them in or not. Maybe they were more like a little guide, and we could just sort of look at them* (Interview, RG11)

RG11's experience was a contrast to the current cohort of NGs who need to complete the competencies to successfully complete the program. NGs in this study were concerned that if they didn't get a pass grade on the transcript, they would be unable to gain further employment. The requirement to complete the prescribed components of the NGP was described as stressful, with the stress

and barriers to completing the tasks impacting on their NG experiences and clinical skills development.

Despite challenges with the NGP requirements, the study day component was generally described favourably. The following excerpt describes the positive experiences of one of the participants around the study days.

> *I loved them because it was a day where you could also debrief. You could refocus, realign, and reflect on what you knew was good nursing. You get to consolidate a lot of the experiences that you've had both through the educational aspect of it, but also space to talk about it comfortably with people who are at the same level with you. That's why I love the study days* (Interview, RG2)

One of the reasons this participant favoured the study days, was because it contrasted with her experiences within the clinical setting. She described feeling overwhelmed and disappointed with her experiences in each unit. Whereas, when she came to the study days, she felt connected to her peers and felt part of the initiative to promote positive and recovery-oriented practices. Another aspect favoured by participants was a feeling of safety when attending the study days. This was attributed to feeling as though you could ask any questions and feel safe in asking those questions. This also related to the process of debriefing some of the experiences in the clinical setting – particularly when those experiences differed from the NGs expectations or prior learning. In contrast, some of the participants felt that the study days were not helpful. NG2 said:

> *Study days kill me… we're all at different levels. In terms of our understanding of mental health. And I don't think that's taken into account for this program. I just think that some of the work we're doing is a little bit simple for a few of us. I can totally see it's benefitting people who came into the mental health program who didn't have an interest in mental health or didn't understand it, or haven't worked in it before, but for those of us who have… each study day is getting more and more demotivating* (Interview, NG2)

This participant had described having a personal interest in MHN and had undertaken further studies in mental health during her undergraduate program and was currently studying a psychotherapy model with an external education provider whilst completing the NGP. She was completing a rotation within an acute mental health setting and described struggling with having to complete tasks for the NGP that she felt were too simplistic and not useful to her development. She had suggested that the service could have individualised learning so that each NG felt they were learning things that were relevant and valuable in their own journeys. This point challenges the concept of a standardised NGP, with all participants required to complete the same program requirements irrespective of prior knowledge or experience. This also challenges the concept of a NGP whereby each Australian state emphasises that it is not mandatory to gain employment but is considered beneficial in consolidating the skills gained in the undergraduate nursing program. In contrast, new nurses to the health service complete an individualised orientation and training structure based on areas for skill and knowledge development.

In terms of study day attendance, participants emphasised that 100% attendance was a requirement of the NGP. Interestingly, I had asked one of the participants, NG3, if he had attended a recent study day as he had been absent from the clinical unit due to illness and was therefore unable to participate in field observations. He told me that despite feeling too sick to attend the clinical setting for work, he attended the study day as he was concerned about jeopardising the completion of the course by missing one day.

6.2.1 Clinical rotations in mental health settings

The lack of choice or unpopularity of some units were discussed by participants. In the excerpt below, an agency nurse asked this participant about her placement in the mental health rehabilitation unit. The participant was comparing the pace of this unit with her previous rotation in the acute mental health unit that she had completed her first rotation in.

> *Hailey* [pseudonym] *then asked NG12 if she chose this placement in rehab and she said "no, they just put you wherever…" NG12 was telling Hailey about how slow the pace was slow here and she was trying to find her place and to adjust* (field note 3:4)

This participant described feeling a bit lost and not sure how to use that time in the rehabilitation unit. Interestingly, at one of the other sites, a participant described being offered a choice in placement. *NG4 pointed out that she was offered a choice between the older adult mental health unit or the PECC and*

she chose the PECC in her clinical rotation choices (field note 2:1). There may be some differences in the experiences of these participants as they were employed by different hospital sites. Another factor might be that the second participant was an existing staff member of the service and therefore her preferences may have been considered before other participants. The concepts of not being able to choose the unit for placement was described as difficult by the following participant. This participant went to the PECC unit for their first placement and then was placed in the rehabilitation unit for her second placement.

> [They think] *you should be lucky that you have a job. You know that kind of feeling? That I just have to say yes to it, which isn't the truth in nursing, you can get other jobs. But there's this idea that you just need to accept what's given to you and I think that that's kind of really… in the new grad year that's really reinforced again* (Interview NG2)

When asked if she would have chosen those placements, she said she would have chosen PECC but not the rehabilitation unit and felt that she would have benefitted from more acute mental health settings. She adds that some NGs were given the opportunity to choose their placements whereas other NGs had to accept the placements they were allocated. Similarly, another participant wanted a different experience. She had an acute inpatient placement and a rotation in the OPMHU. She indicated she wanted a community mental health placement and felt frustrated that this was not able to occur.

> *I would have preferred to have some sort of experience in community. Just to see the different divisions of mental health. That was something I really advocated for when we were doing the rotations last year as a new grad. I said I would really like to go to community, and they had said community was available* (Interview RG2)

Though despite not wanting to go to the OPMHU, this participant said that it was actually a positive and needed experience as she said she was feeling burnt out after six months in the acute unit. She pointed out that she didn't realise she was exhausted until she got to the OPMHU. The same participant also said she would have also liked to have gone to the PECC unit, though pointed out there were a number of issues due to short-staffing.

> *I think PECC would be ideal, though it was a bit stupid actually… one girl started in PECC – she was in PECC formally, but we were always short-staffed in the inpatient unit, so she was always down in the inpatient unit. And then for her second rotation she got the inpatient unit. So, she spent the entire year down there. Then the same thing happened to the person who got allocated PECC as their second rotation, who had started in the mental health unit* (Interview, RG2)

This participant had felt that different rotations were a positive thing. She felt that it was not a good thing to get settled into a unit.

> *It's so easy to get settled into a ward, and I don't think that's good for you… but it causes a higher stress to keep chopping and changing and get yourself on your feet, and like jump into different pools and stuff, but*

it's probably better in the long run to get lots of different experiences' (Interview RG2)

6.2.2 Clinical support

There were several activities relating to clinical support that NGs were required to attend throughout their NGP. Within the NGP, participants are expected to be assigned both a mentor and preceptor to guide them along their twelve-month journey. The mentor in this case is a Clinical Nurse Consultant (CNC), who meets with each NG monthly – or as otherwise arranged and is expected to provide support on clinical practice and debrief in the form of clinical supervision. However, the preceptor in contrast, can be any member of nursing staff more senior than the NG, who orientates and supports the NG within the unit they are working in. Although the NG was expected to have the same mentor over the course of their NGP, they were likely to have more than one preceptor, depending on the units they were entering and the circumstances within each unit. In addition to a mentor and preceptor, there were also nurse educators based within the service. There were two tiers of nurse educators for mental health – those located at each hospital site, and those who were based at the health service or district level. The educators based at a health service level were responsible for designing and overseeing the NGP and for coordinating clinical rotations and activities for the NGs, in addition to overall education for the service. Whilst the educators at each hospital site were responsible for providing education and support within the mental health settings for all nurses. Each hospital had their own mental health nurse educator. Participants associated a high level of importance to each of these

roles – mentor, preceptor, and educator and described the essential role that these key supports played during their NGP. The primary difficulty described by participants was when there was an absence of their key supports, or a lack of rapport. There were differences in levels of supports across sites and across time – with some participants completing their NGP two or three years prior to the current group of NGs, and they described differences in their experiences.

6.2.2.1 Relationship with key supports

Not only is the presence of key supports considered important to NGs, the relationship developed was also important. The following participant described a difficult rapport with her mentor. Although she felt clinical supervision was important, she found the process less helpful because that rapport was not established.

> *Clinical supervision I understand is very important, but I didn't really get along with my supervisor… There were no problems with my supervision, I just didn't gel on a personal level* (Interview, RG2)

Rather than struggling with her mentor, she described a process of debriefing and working through her experiences within the study days and with her peers, and only engaged with her mentor to complete the activity. Another participant NG2 described a difficult relationship with her mentor and related this to her clinical practice. Unlike some of the other participants, this participant was working in the same clinical unit as her mentor, which she described as a challenging experience – especially within the following scenario outlined:

> *We had a conflict of interest… with my mentor and myself. Because she worked in the same office, just a door away. And we had a person* [consumer] *who came in, who kind of broke the mould for what PECC was. She was* [admitted] *in there for a few weeks, multiple times. I've had a lot of experience with youth in that kind of situation, and it was only myself that she wanted to talk to, so it was considered that* [the consumer] *was splitting* (Interview, NG2)

This participant described a difficult situation around clinical care and a disagreement with her mentor on her approaches to caring for this consumer. She described her colleagues as making jokes around her care of consumers – particularly female consumers of a similar age.

> *It became… people coming in who are adolescents who have experienced sexual trauma or abuse recently. There would be jokes about me looking after them…* [my mentor said] *'I thought that you were over-relating and that your boundaries were obscured with the young women'* (Interview, NG2)

Despite the conflict that arose between this NG and her mentor, she described a situation where she confronted this situation and resolved it with her mentor around her approach to practice. She described initially experiencing some hostility from her mentor which gradually settled, but that she had to justify her actions and establish herself as a capable member of the team to resolve the conflict. This participant developed her own understanding of why this situation had developed.

> *They* [senior nurses] *see you as a new grad, but they don't see was someone who actually has experience and competency in an area, and then you're justifying yourself… I was like, just because I am a young woman that doesn't mean I have the same experiences that they* [the consumers] *do. I found that really difficult, and felt that I was being judged maybe a bit too soon* (Interview, NG2)

Despite a difficult experience with her mentor, this participant described the relationship improving after speaking to her and resolving some of their views about her practice. The concept of NGs feeling less capable – or feeling as though the team might perceive them as less capable was a common theme in the research findings in this study. This fits within the notion that the NG enters the culture in the status of a NG and is probationary and not considered a fully integrated team member until the NGP is completed. Despite this being described in a positive light, the process of gaining proficiency and being seen as competent presented a number of challenges for the participant. In contrast, the following participant described a positive experience with support but felt as though the team just wanted him to be capable – and to keep up with the other nurses within the unit.

> *Mostly everyone was quite happy to teach me. Although because people had been there for a very long time, sometimes it did seem like they just wanted me to know how to do things, but that really depended on who I was working with. And I guess it did take a while for people to feel like they were happy to work with a new grad* (Interview, RG11)

This participant described now feeling accepted into the team. Their experience may be described differently as they are now in a permanent position, having already completed the NGP. This participant described the buffering effect that a preceptor had when entering this clinical unit. Especially when it was perceived that the preceptor wanted to teach and take that time to help the NG learn the ropes within the unit.

> *It was good because up there* [OPMHU] *I was given a preceptor and she was a really experienced nurse and she really liked teaching and I just loved working with her, she was so great* (Interview, RG11)

This was not the common experience of participants though as access to the preceptor presented an ongoing challenge for NGs limiting the opportunities for learning experiences.

6.2.2.2 Absence of key supports

Whether it was the presence of mentor, preceptor, or educator – participants described the importance of having the availability of key relationships during their transitional journey. Despite three different key supports available, NGs described increased difficulty in their transition without the presence of a preceptor or nurse educator in particular. The concept of a *lack of support* was emphasised when the NG lost a key support during their transition – such as the resignation or extended leave of their allocated educator or preceptor. The absence of the educator whether at a local or health service level was described as having the greatest negative impact on NGs during their transition.

The absence of the educator had an impact on the NG journey. An example of that impact was that participants were not able to clarify requirements of their NGP. The following participant was relying on correspondence from the educator to know when key dates within the NGP and hospital orientation were supposed to occur.

> *At the start it was pretty messy because the educator here resigned so there was no educator… I didn't even know what day to come. I didn't know what date orientation was because mental health is a different stream. We don't get any of the emails from the general stream, it's all just from one educator here. So, we had no educator here and no idea what was going on* (Interview, RG10)

In this scenario, the participant highlighted that NGs in mental health had a different program with a different education team, therefore he was not able to clarify information from other educators. As a new staff member, he also did not know the other NG nurses. Therefore, he was not initially able to receive clear communication about the NGP requirements.

The difficulty with an absence of educator was also described as impacting on the learning of NGs. Although the educator played a key role in providing structure for education and learning, their presence played a role in the level of support NGs felt. The following participant described feeling isolated in their allocated unit – the ACT, as the only NG at the time within that unit. She attributed a lack of educator support to being outside of the inpatient setting. Although she described the ACT nurses as being helpful and supportive, she

stated that not having regular contact with the educator from the inpatient unit left her feeling unsupported within the NGP.

> *I think that I didn't get much support. I think that I got a lot here* [inpatient unit], *but over there* [acute care team] *I think they sort of forget you. It's only the staff that look after you in ACT. I feel we got left behind a little bit because you were in ACT, but the educator was in the inpatient unit* (Interview, RG5)

The absence of an educator was described has having a detrimental role in the NGs sense of feeling supported. The following participant described her challenges in not having an educator for most of her NGP.

> *I kind of enjoyed spending time when I was on the ward. But to be honest I didn't feel really supported, because we didn't have an educator at the time. We had one when we just started, she lasted for about three weeks or something. She left when we were in two or three weeks of the NGP. She left… and then we had another one who was there for like a month or so. And in that way, I wasn't like really supported. That person left and then there was no one… and then Alice (pseudonym) was appointed towards the end of the year, towards the end of our program* (Interview, RG15)

One of the reasons that educators were seen as important by participants was that NGs wanted a person who they could ask 'silly' questions. There was a difference between the educator and the preceptor when it came to these types of questions, as the preceptor was a member of the team they were assimilating in to, and the NGs were working towards a competency that was similar to the

existing members of staff. Participants described the importance of the educator with them having a role that allowed NGs to ask those questions and seek clarification on topics that they felt would disadvantage them if they asked their peers.

> *I feel like we missed out on that opportunity to ask questions, to learn… As a new grad it doesn't matter how silly a question you ask, it will be answered without being judged* (Interview, RG15)

Another perspective that was described by this participant as important, was that clinicians working in the unit might not have the time to answer questions. Even if she were to ask her colleagues questions, she pointed out that it was a busy unit and they still had to attend to their workloads. She described that difficulty as something that bothered her during her NGP because even if they could answer her questions, they might not have the time to sit down and explain the concept so that she could understand it. This participant completed her NGP two years prior to the current NGs and describes still being frustrated that she experienced less support than what they have been given – and placed importance on learning during the transitional year. She described a difference between learning in your first year and the learning attained thereafter. That despite receiving support and education now, it doesn't compensate for a lack of educational support during the first year. She added that it was a feeling shared by other mental health NGs at the time.

> *It's not just my opinion…* [there were] *three of us in the mid-year intake. We had the exact feelings, we sat down with each other, and we spoke, we went for coffee and things like that* (Interview, RG15)

This participant says she didn't provide feedback to the educators overseeing the NGP, but noted that there is an educator now, and that current NGs in the hospital site have an educator for support. Though that was perceived as a difficult reminder for the lack of perceived support she felt she had received.

A more common occurrence was inconsistent preceptorship for NGs – whether the NGs were not assigned a preceptor, the preceptor took leave, or not being rostered on with their assigned preceptor. Although the preceptor was considered an important support, graduates described being able to draw on the support of their colleagues in the absence of the preceptor.

> *My preceptor went away, and I didn't get assigned a new one. And then I changed wards with the rotation and didn't get another one at all. But I guess I didn't feel like I needed one, because the ward was so supportive* (Interview, RG2)

In this case she described this experience as not being too detrimental as the other nurses in the unit provided the support that she needed. However, one of the concerns with the absence of preceptors was the difficulty in completing transitional program requirements. One of the roles that preceptors played was to provide support and orientation to NGs, but also to assist NGs in attaining their required competencies during the NGP. In the absence of a preceptor,

participants described having to approach any available nurses to sign off their competencies.

> *Everyone has helped me… Because when you come here first you have to do your five injections for that new grad book. So, with my first five* [injections], *I had five different staff* (Interview, NG1)

A similar experience was described by participant NG3 who described transforming all his colleagues the role of preceptor when his assigned preceptor went on leave for eight weeks. He laughed and re-enacted the scene:

> *'Poof', you're all my preceptors now!* [laughs] (field note 3:3)

A similar experience was described by RG1, who had said that her allocated preceptor went on holidays for much of her rotation into the unit. She described feeling supported by the nurses within the unit despite the absence of her allocated preceptor. She said that her mentor was working within the unit where she was completing her rotation and so her mentor was able to sign off her required competencies (Interview, RG1).

Even when the NGs preceptor was available, one of the other challenges was in finding time or a shift together where NGs would go over any learning needs or competencies. This challenge was outlined by participant RG16.

> *On many occasions new grads had to wait several days, or a week or two before they had a shift where they were on with their preceptor. And in other cases, many shifts were so busy that they didn't get any time to get together to discuss issues or look at completing competencies* (Interview, RG16)

The difficulty in reviewing any learning needs was apparent whether the preceptor was not present on the same shifts, or whether NGs were not assigned one. Although many NGs described feeling supported by the other nurses of the unit, not all of the participants had a positive experience.

> *When I came down here as a new grad in the second rotation, I didn't have a preceptor or anything. I would have preferred* [to have a preceptor] *because there was a lot to learn. Sometimes I would not be shown how to do things at all, so the first time I did an admission was really stressful because I had no idea where anything was, no idea what I had to do, no one told me* (Interview, RG11)

This participant described a difficult experience in transitioning to an acute inpatient unit, and this was perceived as a shock when leaving the OPMHU where she had felt well supported.

6.2.3 Orientation within the organisation

The first stage of orientation to clinical practice within the health service involved attending a general orientation within the hospital. This experience was described differently depending on which hospital site each participant completed their hospital orientation at. What was commonly described amongst

participants was the first day of orientation being shared with all specialty areas, and then a division in the group into more specific orientation for each employees' place of work.

The following excerpt is from a participant from hospital site one who described receiving seven days of orientation into the clinical setting. This level of orientation appeared to be unique to hospital site one, whereby it was commonplace to have an extended orientation period and then a gradual integration into the workplace with a partial workload that increased over a period of a few weeks.

> *We had four days of orientation with other new graduates* [within the general nursing program] *on Monday to Thursday. Then me, Stacey* [pseudonym] *and Hailey* [pseudonym] *came here to mental health and did three full days* with [the educators] *Mandy* [pseudonym] *and Gail* [pseudonym]*. The orientation was very good… they took so much time and effort for just the three of us* (Interview, NG14)

This participant had described a multi-faceted orientation including an overview of the service, exploration of the NGP structure, and attending any required paperwork during those additional three days of orientation. This experience was contrasted with one of the participants at hospital site three who described a briefer orientation process. Similarly, he described the first stage of orientation being shared with general nurses. Then on the second day the group were divided depending on their specialty.

> *The lecture hall was full for the first day, and that was the general medical one. And on the Tuesday was the mental health one, because of course we get separated…* (Interview, NG3)

After the first day of formal orientation for the whole hospital in hospital site three, the following components of orientation involved getting to know the specific mental health services that were available within this service, and then completing any administrative tasks. The hospital and unit orientation differed also. It was expected that all staff members undertake the hospital orientation at the beginning of their employment, however, the orientation to each clinical unit was expected to occur when completing rotations.

When completing a rotation into a new unit, NGs were expected to have several supernumerary days – shifts where the NG was an additional member of staff and were able to orientate themselves to the unit before undertaking the same clinical activities as the existing nurses of the unit. This time also allows NGs or any other new nurses to complete orientation tasks to enable them to work within the team which was outlined in the orientation policy for the service. Each unit was able to determine their own orientation requirements. Participants in this study described a variety of experiences relating to supernumerary days, with some NGs describing a well-supported orientation and others having no supernumerary days when transitioning to a new unit. One of the primary factors described by NGs that affected supernumerary time were the levels of staff available – with short staffing affecting supernumerary days for NGs. This was a factor that affected the process of orientation as well as the perceived

level of support received by NGs when entering the clinical setting. For the following participant in hospital site three, she described her experience of the orientation and supernumerary time.

> *You get two days supernumerary. They teach you everything in those two days and then from third day you get your own patient load… that's a challenge* (Interview, NG1)

The following participant described not receiving any supernumerary days when entering the clinical setting, which was attributed to short staffing in the unit. She described challenges as she arrived on the unit on her first day as a NG and was given a clinical load. This experience was compounded by her not knowing the routine of the unit or knowing where to find resources needed to provide clinical care. Unlike a majority of the other participants, she had not had any healthcare experience outside of her undergraduate learning.

> *I had a very difficult day on the first day here because they were my supernumerary days. I didn't have the supernumerary because they didn't have the staff. And I didn't know anybody. So, in the beginning of the shift I was like okay, I don't know these people's* [consumers] *faces. I go out and knock on the peoples' doors and they are still in bed. I was like, 'how you doing?' And they go… 'fuck off'* (interview, NG6)

The following participant described her transition into her new unit. This was her first rotation as a NG. She described receiving two supernumerary days. However, during those two days she did not receive an orientation to the unit due to short staffing. The NUM was absent at the time, and she explained that

the nurses in the unit attempted to provide an orientation whilst managing their own workloads.

> *The induction wasn't very well panned out. I had two days supernumerary, then a full patient-load the next two days after that. I didn't even have a proper orientation to the ward or anything* (Interview, NG5)

This participant described her initial experiences of entering the unit as highly stressful. However, she described finding her own routine and orientated herself to the unit, and this was the way she managed to navigate the challenge. She described this as a difficult and stressful experience and added that other NGs might find this a lot more stressful and difficult than she did. She described herself as a resilient and resourceful person who could cope with stress and compared her own character traits with other NGs and felt they might not cope as well as she had.

6.3 Transition stress – thrown in the deep end

Participants described feeling as though they were *thrown in the deep end* when entering the clinical setting as a NG and encountering responsibilities and tasks that they felt unprepared for. The experience of being *thrown in the deep end* was used by a number of participants to describe different facets of their transition experience. This transition stress appeared to be present despite the majority of participants outlining that they had completed a number of theoretical and practical units during their undergraduate learning. The concept

of transition stress has been acknowledged in the literature (Hooper et al., 2016; Pelletier et al., 2019; Tingleff & Gildberg, 2014). It is known that newly graduated nurses require support and opportunities to develop confidence as well as competence in their clinical practice (Mabala et al., 2019). The concept of being *thrown in the deep end* was associated with entering clinical practice; managing the transitional program content alongside clinical practice; and the focus on achieving early proficiency in practice.

> *I was actually thrown in the deep end, you had to learn to swim really quickly… so I just learned everything really quickly and just adapted to my own routine* (Interview, NG5)

Despite previous work within disability services prior to completing her undergraduate nursing program and reported feeling confident in utilising communication skills and managing difficult situations and behaviours of people, this participant described significant challenges when entering the clinical setting. Learning on the job was also described by the following participant. This participant was now in the middle of their second year of practice and described only starting to develop some confidence at the beginning of her second year.

> *Just recognition of the pressure that you're under. Not even just for the first month, that pressure continues for so long. I suppose understanding for new grads that the learning process is so… is so long. I only just felt confident at the start of this year!* (Interview RG2)

One of the more emphasised aspects of being thrown in the deep end, was in describing the lack of preparation that undergraduate preparation gave participants.

> *I feel like it's such a practical job that I felt I was thrown in the deep end when I started. I had done three years of nursing* [training] *but I didn't feel like I knew anything* (Interview, RG2)

This participant had completed two undergraduate mental health units and eight weeks of clinical practice experience in mental health settings. Despite her undergraduate experiences, she described not having the 'right' preparation skills and knowledge for clinical practice. This was emphasised as not being equipped with skills and knowledge to work within the mental health setting – even as a beginner nurse. This sentiment was also described by another participant who had completed two mental health theoretical units and three weeks of clinical placement.

> *I think coming out of studying and just 'getting it' was very different. When you're a student you don't do much. It's hard because you feel like a nuisance most of the time. So, when you come out… it throws you in the deep end* (Interview, RG14)

Another participant added that entering the clinical world also involved trying to catch up and learn everything that you need to know, or to have the knowledge quickly available.

> *New grad is very stressful and very frustrating. You want to know everything, but you can't do everything. It's a lot of responsibility – you need to know the people, know the patients, know the policy and procedures, and know what you're doing* (Interview, NG8)

The experience of being thrown in the deep end was perceived at different levels for each NG. The previous participant described a stressful situation in which she was concerned that she might lose her job if she wasn't able to keep up with everybody else clinically. She described a high level of pressure as she depended on her job to support her family. Another participant described it as difficult but also reflected on the different experiences depending on what was happening within the unit at the same time. This participant had completed her NGP the year before this research took place and had more of a philosophical perspective on the experience.

> *I guess it's different for everyone, but for me it was finding my feet. It felt like to some extent you were sprung into the deep end, and you just have to learn to swim. I think that's the best way to describe it. I think it depends on what time you come in as a new grad as well. When I first came in, things were quite chaotic. It was such a busy time when I first started, it was hard to get as much support as we probably could have* (Interview RG17)

Being thrown in the deep end was not confined to the NG year though, with the following participant describing the need for some challenges during the NG year to ease the stress of encountering more responsibility and expectation

after completing the NGP. But added that those challenges need to occur when the NG is supported and guided.

> *Because when it comes to second year they'll get chucked on the acute side and they don't have the skills fully developed – that's when they're 'my crap nursing, I can't do my job properly'… you feel overwhelmed, people are yelling at you, and you don't know what to say to this person and someone has to come and save you"* (Interview RG4)

The following participant spoke about the challenges of entering the team as a NG. She described the process of entering the new unit and developing the relationships with existing staff. Being a NG was described as a challenge within the hierarchy with other members of the team not always having favourable attitudes towards NGs. She explained entering the unit and hearing another nurse state, "*oh no, I have to work with a new grad, she doesn't know anything!"* (Interview, NG14). She added that another team member did not talk to her for three to four weeks and when would say hello, the person would stare blankly at her as though she didn't exist. She added, *"they just don't trust new grad's and that's fine… we don't know what we are doing"* (Interview NG14).

6.3.1 Managing the transition into clinical practice and new graduate program – focus on developing proficiency

The NGP in this service was designed as an educational and orientation program that graduates complete in addition to their clinical role. The majority of NGs were employed as full-time employees within the health service. Some of

the educational components of this program were incorporated into the NGs clinical role, with an expectation that some elements of the program be completed in the NGs own time. NGs described a challenging experience of managing the transitional requirements as well as becoming proficient members of the nursing team. NGs were expected to become proficient members of the unit on completion of their transitional year. Developing proficiency was also perceived as becoming an equal player within the team. The following participant described the difficulty in assimilating to the unit and developing proficiency.

> *I know they don't expect you to know everything and do everything like management and everyone else, but it feels like you need to be on the ball* [snaps fingers]*, know everything and if a patient asks you about a drug, I feel like I should know that already* (Interview, NG13)

The difficulty of transition included managing the shock of entering clinical practice as well as meeting the requirements of the NGP. The following participant described the difficulty of managing the NGP requirements as well as her allocated clinical workload within the unit.

> *I think that in terms of getting us getting our competencies signed off, it's quite difficult… it's a lot of pressure. It's really hard to come into work and to do full-time work… there is no time… There's a lot of stuff there* [NGP requirements], *and it kind of gets a bit confusing and messy* (Interview, NG14)

Another participant described a similar experience of balancing transitional and clinical requirements. The participants described the competing demands of completing NGP requirements, but also the competing clinical demands and unpredictable unit environment that affects the ability to complete tasks such as online educational modules.

> *The online stuff is absolutely bombarding me though. Especially on a ward like this I don't get any… I'd be lucky if I got any time for a break, let alone time to sit down and do HETI. And that goes the same for the weekends, because you've got care levels to do for the whole two hours. That's two hours, plus you have your notes, and you have your meds, so there's really no time for that* [HETI] (Interview, NG5)

Despite the intent of the NGP to consolidate learning for NGs, the balance of navigating the clinical environment and completing the competencies remained a challenge.

> *You start full-time, and they expect you to do these books and everything. Coming into it is a bit full-on because you feel like you have to work full-time and do this extra stuff on top of it. Where do you find the time to do it?* (Interview, NG13)

These points bring up questions on the best ways to support NGs and to consolidate learning without adding additional stress. NGs described having the same clinical workload as their more experienced colleagues which means they needed to develop proficiency quickly to complete their work and not negatively affect other members of the team. Participants described the difficulty in

balancing full-time workload and then the NGP activities and competencies. NGs described not always finding those activities beneficial, instead wanting to engage with their colleagues to consolidate their learning. NGs described the difficulty in being able to complete those online activities within work time and not necessarily having the support of their manager to complete online training and are needing to either make time or complete the training in their own time. The process of developing clinical skills and proficiency was already perceived as a time-consuming process by participants, who described the challenging process of learning where to find resources and learning to adopt the skills of their colleagues. The following participant highlighted that her priority was her clinical work, and that instead of the NGP content consolidating her learning, she perceived that it was impeding her learning.

> *My clients here… my actual work has to come first. The program wants me to do that* [HETI and competencies] *in my downtime on the unit. And I get frustrated with that because my downtime is really important, that's when other nurses will teach and talk about their own experiences. They want me, on top of my full-time job… I have a full case load here. I've done* [university] *for three years and I feel like spending time on that book on made up situations or whatever is not real. I've got 14 real people right here, and the nurses here are really willing to teach me, but that's* [NGP book] *going to take away from it, or I've got to make time in my own time. By giving me extra work, it makes it harder for me to transition, not easier* (Interview, NG7)

To meet the requirements of the NGP, participants described having to complete the additional education during their time away from work. This was

described as an added stress that was necessary to complete the program. Meeting the competency requirements within the NGP was also described as a challenge – especially in meeting the prescribed timeframes. Participants described stress associated with completing the tasks, resulting in NGs seeking to tick off the competencies rather than explore them, such as the experience described by NG14.

> *We've got like the timeframes and also got the things that are inside the timeframes and the way they listed like to sign them off and they don't all match up with each other and it would be like 'here you can sign this off?' but one of them you can't do, so you can't sign it off… but it's supposed to be signed off at 3 months… They give us this book and they say that you have to get it signed off by your preceptors – who you never work with… if you can't get it signed off by one of the preceptors it's fine, just get another RN to sign it off. But they don't have the time and they don't care about my new grad book. They don't give a crap about how many signatures I have in this amount of time, so that makes it really difficult* (Interview, NG14)

This was a theme that came up throughout the study, whereby participants did what they needed to complete the requirements of the NGP. This included ticking off competencies if they could find an RN willing to sign them off. This indicated a system of ticking off competencies as opposed to embracing the components of the NGP as learning opportunities. The major barrier for learning for NGs was identified as time and resources. The sense I gained from the participants is that NGs were chasing their colleagues around to get their

competencies signed off – as opposed to focus on learning the skills and developing proficiency.

6.3.2 New graduate nurse as preceptor

One of the prominent observations of NGs was observing them as the preceptor for undergraduate nursing students. This was an interesting observation given their description of overload of NGP objectives to complete, and the fact that they themselves were experiencing socialisation into MHN practice. During field observations it was often the NGs who were paired with undergraduate nursing students on each shift. There may be several factors to consider here – the number of NGs on shift and the emphasis on increasing the number of EEN's within mental health teams lowering the number of RN's available to preceptor nursing students within the clinical setting. This is in addition to a more senior member of nursing staff taking the role of Nurse-In-Charge (NIC). There may be other factors not considered in this case, including whether NGs seek out opportunities to preceptor nursing students in addition to their transitional requirements. To satisfy the requirements for placements, student nurses need to be supervised by an RN. In this case, often the NG was available and may be working in the less acute areas of the unit. The NG would then be providing education to the student nurse.

> *One of the senior nurses had a student with her and the other student was allocated to NG1. It just occurred to me that of course the students had to be buddied up with a Registered Nurse. So, looking at the staff dynamics there are two enrolled nurses on, so those staff members*

> *cannot have students. Therefore, that might explain partially why the new graduate nurses are being allocated to students* (field note 3:1)

Although there were times when more experienced nursing staff were the preceptors for students, it was observed more commonly with NGs – with this observed across all three hospital sites. In observing the interactions between student nurses and their preceptors, there were differences in the approaches taken by the NGs as opposed to the more senior nurses. I reflected on these observations during the clinical placement with an excerpt outlined below.

> *The interaction with nurses and student nurses is interesting. I have noticed that when students are buddied up with new grads, the placement is geared around shadowing the nurse. When the students are buddied with new grads who are experienced* (previous healthcare experience) *or with senior nurses, the student tends to be delegated activities and is less dependent on shadowing. In this case, NG4* [a former EEN experienced in the setting] *delegated to the student and the student would leave and return throughout the day* (field note 2:1)

This is an important observation to note, considering the research exploring the undergraduate student experience and attraction to MHN. It might be assumed that the student nurse would be buddied up with senior RNs, but in the observations within this research they are commonly placed with the NGs. What was not apparent in the observations was whether NGs felt okay with this arrangement or whether they sought out these opportunities. This also builds on the concept of being 'thrown in the deep end' with NGs both describing and demonstrating the experiences of being given tasks that may be too advanced

– both planned and unplanned. This is in addition to the clinical areas where NGs may be required to have more advanced skills such as in the more acute mental health settings.

6.4 Chapter summary

This chapter explored the participants' transitional program expectations and experiences. This included exploring the components of the transitional program to appreciate both the complexity of learning and the challenges that NGs have in orientating to a new setting. At the same time the NGs are finding time to complete formal requirements set out by the health service to successfully complete a NGP in mental health. The challenges experienced by NGs as they enter MHN field and consolidate their learning were highlighted. There are several aspects of their experience of being a NG that provide insight into how NGs are socialised into the profession and the significance of undergraduate mental health content in attracting new nurses to the field. Chapter seven explores the experiences of NGs entering the organisational culture and the mental health setting.

Chapter seven
Entering mental health nursing practice

"If you can't fly, then run. If you can't run, then walk.

If you can't walk, then crawl, but by all means keep moving"

Martin Luther King Jr.

7.1 Introduction

Entering mental health nursing practice follows the journey of the NG entering clinical practice within the mental health unit. This involves exploring the key artefacts and the practices within each setting. These represent the first level or most visible layer of the culture within Schein's (2010) *Model of Organisational Culture*. This chapter then details the journey of NGs relating to other members of the MDT; learning the routines and rules of each unit; and engaging in clinical activities within the mental health unit. This is represented in the sub-themes of: *adapting to the philosophy of care in the unit; mental health nursing within the organisation; the rule and routines in the mental health unit;* and *clinical activities in mental health units.* These experiences represent an important component of the socialisation of NGs as they learn the beliefs, values and practices of existing cultural members within each mental health unit.

7.2 Adapting to the philosophy of care in the unit

According to Schein and Schein (2017), the culture of an organisation or group determines the practices, behaviours, beliefs and attitudes of the members working there. This can be expressed in the philosophy of care espoused by the unit's staff. New members to each clinical unit are socialised to the practices through learning the expected behaviours and philosophy of caring. There were similarities across the mental health inpatient units used in this study, although some differences were found in the OPMHU and the rehabilitation unit. An overall description of the units was presented in chapter four with more detailed descriptions outlined in the Appendix (Appendix 10, 11 and 12). The experiences of participants adapting to the clinical setting of each clinical rotation demonstrates the philosophy of care of each unit.

When a NG enters the unit on their clinical rotation, they need to become familiar with the differing practices, beliefs, and philosophy of care of that unit. Data collected during this study demonstrated that there were different ways in which NGs were socialised to the unit philosophy. For example, in the rehabilitation unit, consumers and their families are given a verbal explanation of what the rehabilitation unit aims to achieve. New staff members are taught the verbal explanation by nurses in this unit. The rehabilitation focus was described as *goal setting to achieve functional gain* (field note 3:4). During one field observation episode, a consumer in the rehabilitation unit was yelling loudly – this was described as *responding to voices*. One of the nurses referred to this consumer as being an example of using rehabilitation to achieve

functional gain as opposed to curing the consumers' symptoms. She said that the consumer needed a lot of support to achieve small goals. She then said that underneath all that *"he's a sweet young guy who just wants friends and just wants to be loved and that some of the primary goals are to help find people who will accept him so that he doesn't fall back into the same drug crowds"* (field note 3:4).

In adapting to the care philosophy of the rehabilitation unit, one of the nurses emphasised that NGs joining the team might find the work slow and boring. The difference appeared to be in whether you are appointed a care coordinator – this involves being involved in the personal planning and review meeting (PPRM) process and working with a consumer on their goals. Lucy explained that casual and new staff would find the work boring as they would not be a care coordinator yet – though she added that new people entering the rehabilitation unit need to 'reframe' and adjust to the different pace and shift away from task-focused care of acute units, which was described as a shock to new members (field note 3:4). She emphasised that the work of care coordinators involves specific skills – constantly liaising with other health professionals and goal setting with consumers. It was also added that the consumers entering the rehabilitation unit have much more complex histories these days requiring even more time to help the consumer in their recovery journey.

In terms of adjusting to the unit philosophy, participant NG – the care coordinator for one of the rehabilitation unit consumers for the PPRM, described the difficulty she had in learning to follow the lead of the consumer in writing their goals, even though she knew it was essential that the consumer write their own goals. The NGs joining the rehabilitation unit are socialised into the practice of not interfering in the consumers' recovery goals, but rather to support consumers in making their own goals and leading their own recovery journey. NG7 pointed out that goals can change, that sometimes people achieve their goals, or the goals change. She cited an example of where she typed the goals up for the consumer and a senior staff nurse asked her whether the consumer wrote a particular goal. She confessed that she had added the goal as she 'just thought it was a good idea.' The senior nurse told her that she would need to amend the form and remove that goal as it did not reflect the consumer's aspirations or their capabilities. The senior nurse explained that the skill of developing goals was something the consumers needed to attain so that they could develop goals for themselves outside of hospital after discharge. NG7 said it was a really hard thing to not get involved – particularly when she could see areas for improvement (field note 3:4).

The following experiences highlight the different approaches and focus of care between units. One difference in the unit philosophies between the rehabilitation unit and the acute inpatient units was described by NG7. She noticed the emphasis on risk assessment and management in the inpatient setting and pointed out that when she transferred a consumer from the

rehabilitation unit to the acute unit, she was told that the consumer could not have the personal items she brought with her. She said that in the rehabilitation unit, consumers can have 'everything' – their phone, laptop, and money, but that these items were not allowed in the acute unit. NG7 said she felt embarrassed and did not realise this would be a problem in the acute unit. She said she did not register these items as being items of risk and added that she would face a steep learning curve in adapting to the acute unit routine and attitude when she completed her next rotation there (field note 3:4).

In contrast, the following participant spoke of the challenge in moving from the MHICU – a more acute inpatient unit, to the rehabilitation unit. She described the challenges of moving from a unit with a focus on risk management to a unit focussed on the longer-term recovery of consumers.

> *Massive challenge coming from MHICU to here* [rehabilitation]*! I'm struggling with that a lot. It's kind of weird because when I was in MHICU I didn't feel like it was that rewarding because it was so... if a patient escalates, we have to pretty much restrain them. And that was pretty much my day, baby-sitting. But then looking back, I was doing a lot more and felt really busy and when I started here, I didn't have a lot… I'm not a care coordinator yet, so it's more just slow and you know… so that's what I'm struggling with. But I think it will get better once I learn how to do all the things and become a care coordinator and be more involved in client's care* (Interview NG12)

NG12 elaborated on her experience of the practices of the acute unit when first entering the NGP. She reflected on this experience after moving to the

rehabilitation unit and viewing inanimate objects from a different light. For example, rather than a pen or a lighter being seen as potential weapons, they needed to be seen as inanimate items of property belonging to each consumer. This transition shock was common to many study participants as they rotated between units.

> *When I first went to MHICU I found the shock of how restricted it was. So, there it is restrictive care. We'd count our cutlery and they* [consumers] *weren't allowed to smoke and then they ate… the dining room was open for a 10-minute window to come in, and if you didn't come in then you weren't going to have food. So, it's very restrictive so that's why here I still get a shock when I think someone's got a lighter. It's like 'oh no!' but that's just what you do here. Or if they're using pens… in MHICU you weren't allowed to have pens, you had to just have the ink inside – you could use it as a weapon. Everything was very safety-based. And here it's a lot different, more relaxed and I guess it's a lot less of a threat to the safety of staff and to other clients but, that's a bit of a shock* (Interview NG12)

This participant provides a rich insight into the way that the philosophy of care within a unit shapes those beliefs and behaviours of the nurses there. This is also shaped by the artefacts within the unit and the meaning conveyed with those artefacts. This leads to the discussion of tension between managing risk and promoting recovery – an ongoing tension experienced by NGs as they navigate their own values and the cultural artefacts in the clinical setting.

7.2.2 Artefacts of the culture

In exploring the philosophy of care, it's also important to explore the items of significance in the unit and where they are located. According to Schein and Schein (2017), a number of features constitute artefacts in the cultural setting representing the visible aspects of the organisational culture. These artefacts are woven throughout the finding chapters, however, in relation to the philosophy of care and how this is experienced by participants, there are three main artefacts to explore in this sub-theme: the clothing worn by the MHN cultural members; the features of a locked unit and the posters and notes around the unit. The layout and structure of the mental health units also represent powerful artefacts with the description of each unit highlighted in chapter four under as well as in the appendix.

7.2.2.1 Clothing worn by cultural members

The clothing worn by cultural members represents an artefact of the culture. Exploring the clothing of cultural members was described by Schein and Schein (2017) as an important to developing an understanding the culture. In this research setting, each member of the MDT has a different 'uniform' or dress code. Consumers of mental health services do not wear the 'uniform' or hospital gowns that people receiving care in medical wards might typically wear, rather they wear their own clothes. The wearing of uniforms in mental health care has not been well-addressed in the literature, but in considering the de-institutionalisation of mental health services in the 1970s, uniforms were largely abandoned to promote recovery and the therapeutic relationships between

nurses and consumers (Chu et al., 2020). During field observations, I observed the use of uniforms in each of the research settings, with the following excerpt representing a reflection.

> *The staff in the nurses' station were a mix of doctors and nurses. These two groups were clearly distinguished with nurses in scrubs and doctors dressed in smart casual attire. The use of uniforms in mental health nursing is a debatable feature. Although it gives a sense of clinical status, it segregates nurses from the other groups – it creates a sea of staff who look the same and also differentiates them from the doctors, allied health, and consumers. Unlike in medical wards where patients often wear a hospital gown; nurses wear scrubs; and surgeons may wear scrubs or civilian clothing, in mental health nursing the only groups distinguished by uniform are the nurses, the health and security assistants and the administration and support staff* (field note 2:1)

In addition to the prescribed uniform, nurses in the acute unit are required to wear a duress alarm on their clothing, name badge, and identification card with accompanying swipe card and key. The nurses wore the duress alarm on different parts of their uniform, most typically on the front of the chest of the scrub top. This was explained as the position resulting in the least disruptions including 'man-down' alarms. I also reflected on the clinical experiences I had had in medical or general wards earlier in my career and remembered nurses wearing fob watches, colourful name tags and other adornments such as pens. Here in the mental health settings, very few adornments or accessories were visible on the nurses' uniform in any of the included settings. '*The aim seems to be minimalist – no emphasis on name badges, nurses all wear an ID card on*

their hip' (field note 3:1). Despite the mandated uniforms in the units of this health service, some units had variations to how these were presented.

> *I had observed that in hospital site three, nurses frequently substituted pieces of their uniform with civilian clothing such as jeans or coloured jumpers* (field note 1:1)

In some units this was as simple as wearing running shoes with their uniforms, or as elaborate as wearing civilian clothing – though this was observed more on the after-hours shifts and on weekends. In *hospital site 3's* rehabilitation unit, one of the nurses wore civilian clothing one day and then a similar colour-scheme to the uniform but of casual clothing (navy pants and a navy shirt) on another day.

> *The nurse said "this is my version of a uniform… I tend to chill out even more on a weekend". She says that she doesn't do it every day, just weekends and some public holidays. She pointed out that it is a little unfair to wear uniforms as they take consumers out to public places and they indicated that it impacts on them – "no one wants to be seen out with a nurse, it makes you look even more like a patient"* (field note 3:4)

7.2.2.2 Keys and a locked unit

A description of each unit can be found in the appendices and states the location of the unit within each hospital site, as well as the position of the nurses' station within each unit. Unlike the structure of general healthcare units, the mental health settings involved a secure nurses' station or office that can not be accessed by the consumers. The nurses' station was enclosed with

windows, wall panels, and the doors were locked, requiring keys or swipe cards to access them. Cultural members referred to these as ‘fish-bowls’ or the ’nurses’ station’. This same structure was found in the unit itself, where the consumers in each unit were unable to enter or leave without the facilitation of a staff member with a swipe card or key. The key or access card becomes an important artefact in this context. The keys represent belonging to the unit and represent status for cultural members. During one of my earlier field-observation sessions, and as an existing staff member of the mental health service, I noted the significance of the keys.

> *One thing I noticed about approaching each unit for field observation was the difficulty entering the unit. I felt powerless without my swipe, and I needed to rely on the nurses – if the nurse wasn’t in the nurses’ station, then entry to the unit could be delayed. I envisaged what it would be like to be in the shoes of consumers trying to enter or leave the unit. As a staff member without keys, it is a disempowered state – the lack of free movement is a powerful force to acknowledge* (field note 2:1)

The significance of the keys was noted by one of the participants who was joining the unit for her next rotation in the NGP. Having a key made a nurse a member of the cultural group.

> *NG14 approached the admin officer and asked her if she could borrow her key* [the staff here have swipe access but also a key for some doors]. *NG14 commented that she hasn’t been able to get her key from the previous new graduate nurse yet. She laughed and said that she felt like a student and said in a mock timid voice to another nurse ‘can I have*

> *your key please?!' Later in the shift, the admin officer called out to NG14 to tell her she had her key. NG14 said "finally, now I feel like I belong here!"* (field note 1:1)

In addition to needing a key to enter the unit, some units had a series of locked doors which needed to be passed through to enter and exit the unit, creating a secure environment. This was noted in *hospital site two*, where visitors need to pass through three doors to reach the consumer areas and staff needed to pass through four doors to reach the staff-only areas (field note 2:1). I reflected that all the units had some level of risk and monitoring systems such as CCTV and duress alarms – even the rehabilitation and OPMH units.

7.2.2.3 Writings on the wall – communication through posters and notes

The signs and notes found in each unit are considered physical artefacts within the cultural setting (Schein & Schein, 2017). In exploring the philosophy of care sub-theme, I began with looking around the nurses' station and determining what people may see on entering the unit. I looked at the artefacts on the walls (posters, notes and instructions) every time I entered a unit. There were differences in the signs and resources available to consumers in the clinical areas and those found in the staff-only areas. The signs within the staff-only areas generally related to risk and instruction. Those initial sightings of posters gave a sense of the type of unit the nurse was entering. Further meaning behind those notes became apparent as I spent time in the units and got a sense of the underlying values and beliefs.

In hospital sites two and three there were various signs around the nurses' station – the majority of them laminated. They had a theme of giving commands and instruction. There were also signs on the doors leading to the consumer areas that could not be seen by consumers. They were worded differently and included: *'do not leave the door open', 'do not communicate with the door open' and 'watch out patients may barge through'* (field note 2:1). These gave a sense that danger lurks on the other side of the door and that the concern in standing with the door open may compromise the safety within the nurses' station. The firmness of these instructions was also evident in the communication on notes around the nurses' station for other matters. Such as the note intended for the medical staff in hospital site two – *"teams please review ALL PATIENT's risk levels, care levels, and leave status and document in EMR prior to the weekend. Thanks!"* (field note 2:1). In contrast, the posters on the windows facing the consumer areas had information such as 'medication times', phone times, and the times that the tea trolley attends the unit (field note 2:1). This appeared to allow for non-verbal key information to be provided to consumers on the unit.

Management plans were common in the nurses' stations in the acute units. These were stuck to the wall inside the nurses' station. I noticed that these plans changed between field observation sessions – appearing to be moved or updated as plans changed (field note 2:1). In hospital site three, inpatient unit A, there were three A4 pages with instructions – two related to warnings about the partner or ex-partner of particular consumers. *'This person* [name] *is banned*

from the unit for abusive and threatening behaviour towards staff, do not let them in' (field note 3:1). The sign had the consumers name and their partners' name. I noticed when I first came there was only one of those signs, but in the following two weeks a second sign had been put up on the wall. With the frequent changes to plans observed during episodes of field observations, it appeared these were likely current plans. The third A4 page stated that a particular consumer was not allowed to access leave until she had had a shower and washed her hair (field note 3:1).

In addition to the notes regarding the care of consumers, some of the units had additional A4 pages in the kitchenette area that allowed for nurses to anonymously make requests or note agenda items for upcoming nursing staff meetings. In hospital site three inpatient unit A, there was an A4 page on the kitchenette door titled 'wish list for staff' – it was filled with hand-written requests. Next to this was an identical page titled 'agenda for staff meeting' – this was half-filled. The notes under the wish-list were a combination of practical and 'wish' requests, whilst the notes for the agenda were more direct with some notes written in capital letters or red pen giving a sense of higher importance (field note 3:1). A similar arrangement of notes was seen in the kitchenette for inpatient unit B, with around 30-40 requests written. Examples of wishes included: twelve-hour shifts, therapy dog, and more resources for activities. Some of the wishes were crossed out with 'done' written next to them (field note 3:2).

In contrast to the acute units, the rehabilitation unit has multiple posters around highlighting the recovery orientation to the unit and tips on ensuring the language being used is recovery-focused – these were evident in both the clinical areas and in the nurses' station (field note 3:4). I noticed lots of posters and items around the nurses' station that referenced '*personal goals'* and *'recovery*' (field note 3:4). An example of a visible artefact was a poster on the wall in the rehabilitation unit that related to the philosophy of care in the rehabilitation unit. A hand-written version of this poster has been illustrated in *Figure 6* below and serves as an example of a cultural artefact in the rehabilitation unit.

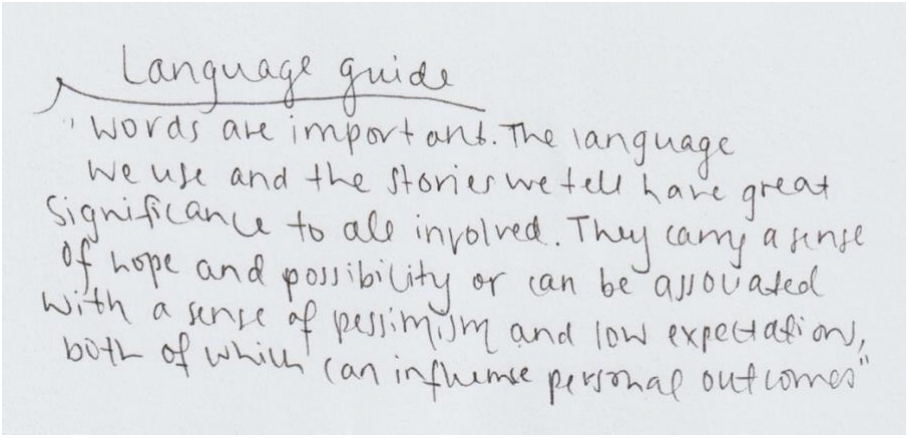

Figure 6 – Language guide poster in the rehabilitation unit near the nurses' station

In exploring the physical artefacts of the rehabilitation unit, NG7 pointed out what she considered important artefacts in the unit to be – she pointed out the poster on the staff fridge that was titled the 'six principles of strengths' and she highlighted the 'strengths certificate' wall in the staff room. She explained that it was important as a new member to obtain your certificate of strengths training

and join the other members of the team on the wall. She also pointed out that the PPRM was an important artefact of the unit, with several posters and notes relating to the PPRM posted around the unit. She said that every day, the work of the consumers and staff all centred around the PPRM (field note 3:4).

7.3 Mental health nursing within the organisation

This sub-theme theme relates to the role and status of the mental health nurse within the health service, and the relationship with other members of the MDT. The participants had already described feeling that the status of MHN was lower that other nursing specialties, which reflects findings in the literature (Benjenk et al., 2019; Wilkinson et al., 2016). This concept was explored in chapter five when participants explored their hesitations in choosing MHN due to the stigma associated and the status of MHN. This was emphasised as the perception of mental health nurses being lazy and less knowledgeable than nurses from other specialty areas. This sub-theme now explores the perception and status of MHN from the perspective of working within the cultural group – with participants able to shed greater light onto their status.

In conducting field observations across six units, I observed that the status of nurses was varied with nurses having greater autonomy and inclusion in the MDT in some units. Participant NG4 discussed the difference in status between the nurses in the inpatient unit and the PECC in *hospital site two*. She explained that in the PECC, nurses have greater autonomy and hold higher status. They

are involved in the treatment decisions and liaison with other agencies when consumers were discharged.

In contrast, in the inpatient unit, the nurses were no longer permitted to provide a handover of care on discharge, and instead this activity was only able to be carried out by medical staff. Participant NG4 added that this was not a good thing as it contributed to *dumbing the nurses down* – and added *"we are basically just handmaidens and security here!"* (field note 2:1). The impact of nurses being less valued was described by another participant RG1 who entered a site not included in this research. She described the nurses as '*very complain-y',* adding that it was because they felt disempowered. She attributed this to the following: *"they're like, 'we're not achieving anything anyway'. It was like their voice didn't matter, they couldn't make any change and they couldn't really do what they needed to do… too many rules. Their opinions weren't heard, and they were being given extra work that they never had before"* (Interview RG1). The status of the nurses largely related to their relationship with the other members of the MDT and the through the tools of communication within the team. This will be explored further in the next sub-theme.

7.3.1 Relationship with other members of the multidisciplinary team

Several disciplines make up the MDT in the mental health setting. There was an observed hierarchy within the units with the psychiatrist at the pinnacle of the MDT. In this research setting, each consumer is admitted under a Psychiatrist

and a Psychiatry Registrar – a trainee Psychiatrist. Other members of the MDT are allied health staff including Social Workers, Occupational Therapists, Diversional Therapists, and Psychologists. Nurses comprise the largest professional group in the MDT and are present in the units at all hours of the day and night. In addition to the MDT members are several support staff such as the health and safety assistants, administration officers and kitchen and cleaning staff.

The relationship between the members of the MDT varied across each unit – in some units there were close connections while in other units, relationships were strained. RG16 pointed out that: *"The nursing staff and the treating team – the Psychiatric consultants and registrars, is very good"* (Interview RG16). RG16 also noted that even the opinions of the junior nurses were respected.

I noted that positive working relationships were observed with nurses and doctors joking and interacting with one another. For example, in hospital site one, one of the Nurses Jo, playfully tapped the Psychiatrist on the arm and had a joke with him. The Psychiatrist smiled and joked back at the Nurse – then the NUM walked in laughing and said, *"oi, stop the staff assault!"* They were all laughing, and this gave a sense of cohesiveness (field note 1:1). In this same unit on another occasion, I could hear laughing coming from the administration corridor and could see in the window reflection a senior Psychiatrist, Administration Officer and some Registrar's laughing and watching a boxing match on the computer. They were each offering knowledge and opinion on the

topic and laughing together. This interaction also gave me a strong sense of unity in the MDT – it almost struck me as unusual as there were no barriers between the staff in terms of rank or communication – they were behaving like people in a social setting (field note 1:1).

A similar relationship between the nurses and the medical staff was observed in hospital site three - the rehabilitation unit. I witnessed the NUM joking with one of the doctors and she said, "*we work extremely well together!"* (field note 3:4). What was interesting in the rehabilitation unit was the relaxation of roles and hierarchy. The doctors and nurses were engaging in banter and were attending to consumers and letting consumers in and out of the unit using the intercom system equally. This appeared distinctly different to the acute units in hospital sites two and three, where the doctors and allied health staff were rarely observed contributing to these activities.

Conversely, participants in other units reported strained relationships between members of the MDT, particularly between doctors and nurses. Participant RG9 described the following:

> *The nurses I find, everyone is on the same page. I do feel like there is a big divide between all the multidisciplinary team and us. I feel like they're all included in the meetings, the ward rounds, discussions around the patients, but the nurses aren't included* (Interview RG9)

Participant RG17 observed that the doctors' perceptions of the nursing role varied. In hospital site one, he stated:

> *Most of the doctors are quite easy to communicate with. Other times there are doctors where it's a bit of a barrier. They sort of define the role – that's a nurse and that's what a nurse does… and they do what they do* (Interview RG17).

Participant NG8 highlighted the power imbalance between the doctors and nurses. "*The doctor has the power to decide whether to discharge or not, I'm just the assistant. Yes, I have my opinion, but it's not up to me"* (Interview NG8). The issues with communication among nurses and other members of the MDT appeared to have an impact on nurses' morale as well as on the care of consumers. For example, participant RG15 noted the following:

> *Sometimes there is a big gap in communication between nurses and the doctors, and that can sometimes lead to frustrations in patients with nothing documented. They've* [doctors] *said one thing to the patient and then never come back to us… so there is a gap of communication at times* (Interview RG15)

Another participant reported that when the nurses approached the doctors, they felt they were ignored. In hospital site three, RG16 pointed out "*if you brought up an opinion, they would be dismissive of your opinion"* (Interview, RG16). The nurses in hospital site two were discussing the doctors in their unit and said, *"they never listen to us – they always make plans without us and then blame us when things go wrong"* (field note 2:1).

An example of the effect of the tension between doctors and nurses on consumer care was seen in hospital site two, where I observed an older male

consumer who was loud and demanding. One of the second-year nurses rang the doctor who later attended the unit to review this consumer. The nurse wanted to discuss his legal status and his generally aggressive and disruptive behaviour which included constantly exposing himself and throwing food at other consumers. The nurse asked for something to help manage this behaviour, adding that the consumer was at risk of being assaulted by other consumers and that the nurses were unable to moderate his behaviour as no oral medications were charted. The doctor replied by saying, *"what I hear you saying is that you are frustrated by his behaviour…"* but added that they would not alter the treatment because it would negatively affect the consumer's placement options. Later, the nurse expressed frustration that the doctors decide the treatment but are not around to experience the consequences of those treatment decisions (field note 2:1).

The communication challenges between nurses and medical staff appeared to range from limited communication channels to abrasive interactions, with this encapsulated in the following example. One of the Psychiatrists in hospital site two entered the unit and asked a senior nurse what happening with a consumer who was due to have electroconvulsive therapy (ECT). The senior nurse rang the operating theatres to enquire about what time the consumer was due to have ECT. Theatre staff reported that they were not aware of this consumer or when this consumer was due to have ECT. The Psychiatrist appeared irritated by this information and said she would deal with the matter herself. Sarah, a nurse, reported that the consumer was observed walking around the hospital

grounds with a large bottle of cola which was half empty. The Psychiatrist became irritated when she heard this and said that theatres may refuse to perform the ECT as the consumer may not have undergone a suitable period of fasting. Sarah also pointed out that the nurses on night shift caught him eating sandwiches at 3am. The Psychiatrist seemed a little more irritated then and said "what were the staff doing last night? How were they helping to prepare him for ECT?" The Psychiatrist then turned to the senior nurse and asked who had let him out on leave. The senior nurse answered that she did not know who gave him leave and with the number of nurses working, it could have been anyone. One of the NGs on the shift answered that she let the consumer out – she said, "the patient told me he had leave and I checked the EMR which said he had leave, so I let him out". The Psychiatrist became even more irritated and said to the NG "Who are you? Do you know what you have done? Do you know what we have been trying to do all morning?" the NG replied that she was just trying to be helpful, the Psychiatrist said "why do you think you are helping? He's not even your patient!" The NG just mumbled sorry and walked away (field note 2:1). From my vantage point this discussion was very tense, and the senior nurse appeared to be unsure of what to say. This interaction reflected a breakdown in both verbal and written communication between the nurses and the Psychiatrist.

7.3.2 Communication tools – medical records and multidisciplinary handover

Communication methods varied between units. The focus for this sub-theme will be on the communication tools used by members of the MDT. This sub-theme includes the use of handover boards, clinical documentation and the MDT handover. The nursing handover and communication will be explored in Chapter eight as a deeper artefact of the MHN culture.

There was an electronic whiteboard in each unit displaying consumer and MDT information to enable communication between members of the MDT. The template below in *Figure* 7 from hospital site two represents an example of the format of this whiteboard, although there were minor differences in format between unit. Each unit had a large television screen on the wall displaying the whiteboard information which was updated throughout the day.

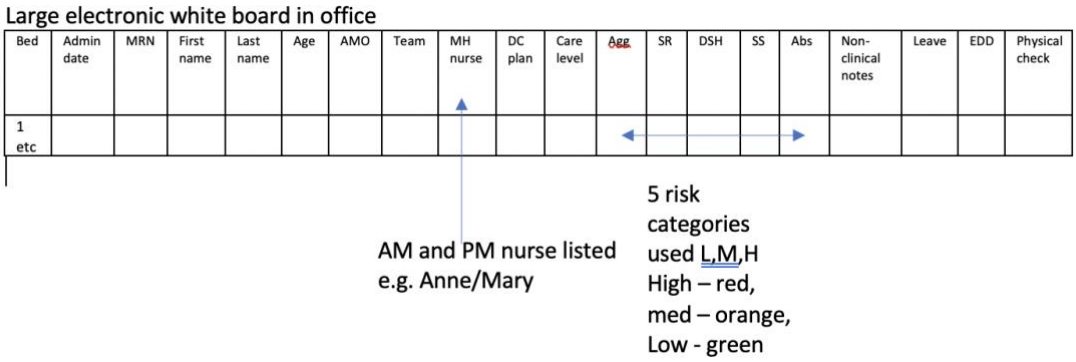

Figure 7 - Electronic whiteboard format for hospital site two

During the field observations I noticed the risk categories for each consumer on the electronic whiteboard. What was interesting was that despite the nature of

the units being deemed higher risk, or for consumers being admitted under mental health legislation, it was noted that most consumers had ‘low risk’ in most categories on the electronic whiteboard. In hospital site three, unit B, there were fifteen consumers admitted and only five high risk ratings were applied for the total number of consumers, despite being an acute unit. In the case of this unit, five separate consumers each had a ‘high risk’ for aggression with no other category meeting high risk. The rest of the categories were a mix of low or moderate risk. However, in this unit there were no consumers with a low risk in all five categories (field note 3:2). This made me consider whether there are other reasons for consumers to be admitted or contained in acute settings in this site. I wondered then if these risks categories applied to their overall risk level, or just their level of risk in the unit. I wondered this because the majority of consumers are admitted involuntarily, and one of the hallmarks of involuntary detainment is a significant risk of harm to self or others as outlined in chapter two. I wondered then how this factor is incorporated when the consumer is considered low risk in all five risk categories.

In hospital site three, unit B, I noticed that there’s another whiteboard behind the electronic whiteboard with the consumer’s name, bed number, team, allocated doctor/nurse/allied health staff. The administration officer explained to me that the electronic whiteboard came first, but because consumers would frequently ask who their nurse, doctor or social worker was, another board was put up on the wall to show those specific details. She said that the consumers can read those details through the glass for themselves.

In reflecting on the communication boards in the units, I thought to myself that there are so many boards that the staff need to update – the EMR, the electronic whiteboard, the whiteboard in the nurses' station, the whiteboard outside the nurses' station and the handover and allocation sheets. I looked at the whiteboard with consumer names in the nurses' station, at the bottom of the board in red whiteboard marker it has "can all staff please update the board for continuity of care?" written with inverted commas and a question mark as though it were spoken. I could see that it was partially rubbed out as thought it was written a while ago. Later when I returned to hospital site three, unit A for data collection, I noticed the whiteboard outside the nurses' station was empty and one of the nurses shrugged and said, *"well no one was updating it, so what's the point?"* (field note 3:1). The concept of the whiteboard as a communication tool intrigued me. Especially after observing the interaction between the Psychiatrist and the NG in hospital site two regarding the consumer who was given leave, I wondered whether there were errors or inconsistencies in the whiteboards or other forms of communication (field note 2:1). The electronic whiteboards had to be manually updated, so if the nurse did not know that a change in the plan had occurred, it might not be entered onto the whiteboard.

Another aspect of communication involved the clinical notes entered into EMR. The participants spoke of the importance of writing the clinical notes and documenting what occurred on the shift, with the format of this note differing depending on the unit. NG9 explained that in hospital site two, the nurses would

copy the doctors risk assessment into their note and would then include around ten lines of narrative describing the consumers behaviour and any concerns over the shift (field note 2:1). NG4 also explained that some nurses accompany the risk assessment with a narrative of the shift and others include a mental state examination. She added that with the risk assessment component, nurses can increase the restriction or rating of the risk assessment, but only doctors can decrease it again (field note 2:1). An example of a narrative form was included in a guideline attached to the wall in hospital site two. It was described as the SOAP method – the acronym stood for:

- Subjective – consumer view of their problems.
- Objective – staff members view of the consumers' problem.
- Assessment – assessment of consumer mental state, current functioning, risk levels; and
- Plan – for future options including care level (field note 2:1).

As a contrast, the clinical notes in the rehabilitation unit tended to be a narrative where the consumers day was documented – their activities and literally the persons 'hopes and dreams'. NG7 explains that the reason for writing notes in this way was to get a sense of what the consumers were doing with their day and how these align with their goals. She said it would be *"a few lines around their day and that they don't complete the standard MSE and risk format that the inpatient staff use"* (field note 3:4).

Another aspect of MDT interaction and communication was the practice of *ward rounds*. Ward rounds were described as a meeting with the consumer and the

treating team. The involvement of nurses in the ward rounds differed in each unit. In hospital site three, unit A, NG6 was approached by the registrar to help locate a consumer for the ward round. NG6 returned to the nurses' station a short time later and announced that the Psychiatrist said he did not want her to stay for the ward round – he only wanted her to escort the consumers in and out of the room for the ward round (field note 3:1).

In contrast, in hospital site three, unit B, participant RG11 explained that they had started to introduce ward rounds with an emphasis on the nurse consistently attending the same Psychiatrist's ward rounds. Though added that it was in the early stages and that she had not attended the same ward round more than twice (Interview RG11). Participant RG11 explained that the doctors were reluctant to involve the nurses in their ward rounds. Her observation that the inconsistency in attending related to the unpredictability of the unit and that it can impact on what nurses can attend – with nurses prioritising safety within the unit as opposed to attending the ward round. RG11 highlighted the importance of the nurses and doctors working together as they may have different viewpoints. One of the reasons why this also was an issue is because RG11 highlighted that: "*some patients might feel more comfortable around the nurses and talk quite freely and then not discuss this with the doctors in the review… and then sometimes they* [doctors] *know a lot more because we've only had snippets of interactions with the patients during the day, and then in the interview they get the full story"* (Interview RG11). The ward round differed

from the MDT handover where discussions of the consumers occurred without them being present.

7.3.2.1 Multidisciplinary handover – *The Shuddle*

At the time of data collection, a formal MDT handover occurred in hospital site one, hospital site three rehab and OPMHU. The other units did not have a formal meeting with the nurses as a group, instead the handover would occur with the medical and allied staff and a representative from nursing such as a senior clinician or NUM. For the field observations only one formal MDT handover was able to be observed, this was in hospital site one. In this unit, the MDT handover was named the *'Shuddle'* – this was a shortened name for the *'safety huddle'.* I was familiar with the nature of this handover from working in this unit several years before data collection took place, however at that time it was named the *'morning meeting'* and was a general MDT handover. The Shuddle took place at 9am every Monday, Wednesday and Friday of each week and went for around half an hour. This involves the MDT discussion of each consumer on the unit – however the initial handover or discussion commences with the nurse, and then other members of the team are able to comment or ask questions.

In observing the Shuddle, there were some changes in the handover from when I had worked in the unit. The general handover had evolved to focus on the safety concerns within the unit. It was explained that in the current form, the focus is on the risks and administration of the unit. The nurses were advised to

discuss the changes in each consumers' presentation – rather than summarising the consumers history and presenting story. The NIC explained that the purpose of keeping the handover brief was to avoid telling the Psychiatrists and allied health what they already knew – *"they know the patients better than us, so why are we telling them how they got to hospital and what symptoms they have"?* (field note 1:1). She added that it was more relevant to highlight any risk issues and advise whether the consumer is improving or deteriorating.

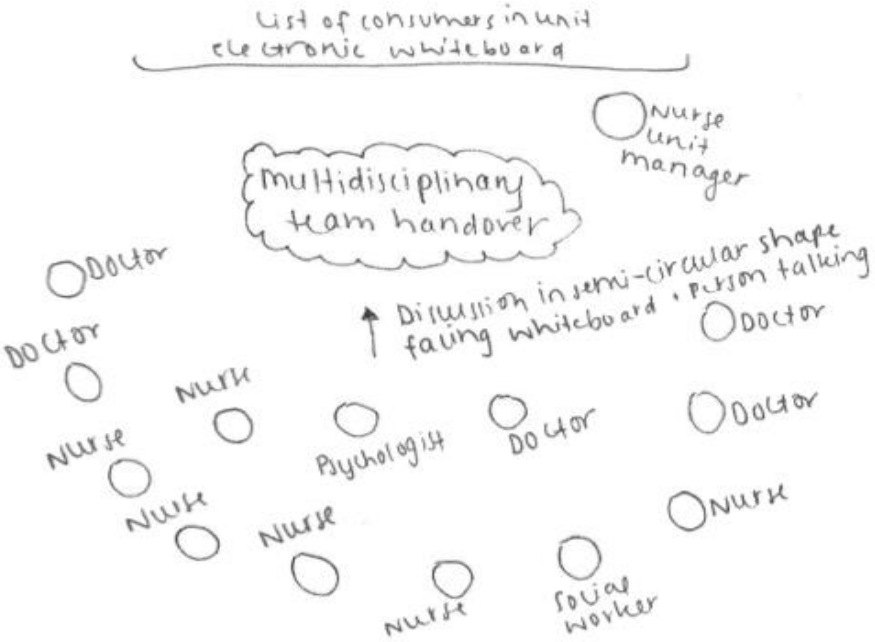

Figure 8 - multi-disciplinary handover in hospital site one

In the field drawing in *Figure 8*, I have depicted the way the members of the MDT were arranged for the handover. There was no specific arrangement or order of each discipline. The individual members were seated in a horse-shoe shape facing the electronic whiteboard outlining the names of all the consumers

in the unit. The NUM led the meeting and was standing next to the whiteboard. She was observed updating any details as the handover progressed. With the format of this MDT meeting, it was emphasised that doctors needed to be present. Participant RG1 explained:

> *We have the safety huddles three days a week. If the doctors aren't there it's pointless. I mean the allied health and social workers are there, but most of the stuff we are handing over is for the doctors, and if they are not there then we are repeating ourselves and also chasing them up* (Interview RG1)

To prepare for the meeting, the nurses were given a specific handover sheet which had two columns as a guide. The nurses would go through the clinical notes and write down notes for the meeting. The first column was headed *'patient name'* and the second column was headed *'presentation – deteriorated, unchanged, improved'*. In completing the handover, some nurses did not follow the format of the sheet and instead gave a more comprehensive handover. In observing this, the longer handovers tended to produce a less enthusiastic response from the other members of the MDT who were listening (field note 1:1). After completing the handover, the nurse then resumed their activities on the unit. The NUM explained that if there are new nurses or casual nurses, that she would provide their handover for them, adding that the handover can be daunting for new nurses (field note 1:1). Participant RG1 explained her experiences of participating in the MDT handover.

> *The Shuddle is scary as hell! They are quick though. We just say anything that's changed, so we have our own Shuddle sheet that says unchanged, deteriorated or improved. And at the end any problems that we need to address* (Interview RG1)

Another participant spoke about the way she was supported into participating in the handover and providing the handover to the other members of the MDT.

> *Sally* [pseudonym] *helped me plan what I would say in the first one and I just listened a lot to take note of what everyone else was saying because it's kind of brief. I was nervous about it, but today I didn't feel so nervous, and I just did it* (Interview NG14)

Interestingly, the Shuddle was also represented a platform for storytelling. I noticed an element of theatrics as some nurses provided handover. For example, one of the nurses handed over that a consumer had returned to the unit after failing to travel to Nimbin (a hippy-style village in NSW). The nurse then giggled about the odd ideas that the consumer was expressing. She said that the consumer had said, "*…a play was advertised in the local area and staff were acting in it for free.* [Nurse name] *was playing the Mona Lisa and the play was called the Moulin Rouge*. The nurse laughed when handing over and so did some of the members of the MDT. She expressed that it was entertaining to be incorporated into a consumers' delusional ideation – particularly if it was bizarre. The use of humour appeared frequently within the handover with different members of each discipline making jokes. However, the seriousness of the topic changed when discussing risk. This consumer was then discussed in

terms of what might need to occur to consider the safety in the unit considering his known history. The Psychiatrist advised the nurse that they will need to develop a management plan for over the weekend with additional medication and no further leave to *"nip it in the bud"* before the consumer escalated to needing a MHICU admission.

The handover also presented an opportunity for nurses to discuss consumers whom they felt to be challenging to care for. One particular consumer was handed over as being challenging, with the nurse saying, *"I'm sorry to say it but she's a PD"* – this was referring to 'personality disorder'. This was relating to the consumer being *"difficult to please"* (field note 1:1). Part of the challenge was that the consumer was reported to be a Professor of Psychology and the nurse felt there was a challenging power imbalance in the therapeutic relationship. The MDT handover also presented opportunities for education and discussion of symptoms and concerns with consumers. When one consumer was handed over as having a tic, this became a discussion with several members of the team with involvement of the Psychologist. The Psychiatrist advised the nurse that it was a *pseudo-tic* and added that it appeared that the consumer had observed YouTube videos on tics and was trying to emulate them. This then became an opportunity for different members of the team to offer strategies on caring for the consumer and assisting towards her discharge from the unit.

7.4 The rules and routines in the mental health unit

Participants described the process of learning the routines of each unit. Although they described MHN as not being task-based and being somewhat unpredictable and flexible, there seems to be rules and routines established that the new member must learn. With some units more regimented in the rules and routines than others. To complete a shift, the new nurse needs to first learn the routine and follow the assigned tasks that need to be completed, with this emphasised as *'the way we do things around here'*. There were differences described between the different shifts including between weekdays and weekends. The initial discussion of the routine was prompted by the interview question, '*what does a typical day look like?*' Interestingly, most participants described a morning shift when describing a 'typical day' in their unit. RG15 was based in hospital site one and said that although it was difficult to outline a typical day in MHN, there were some aspects of the routine that were consistent.

> *I come in and take handover. Then if my patients are awake, I go and introduce myself to them. If not, I sit down for a bit and have a quick look at the notes. I look at new plans from the doctors – sometimes it's in the handover. Then we do medications and then there are certain tasks we need to do such as care levels. After the vital signs are taken, I sit with a patient. That's my routine, that's how I divide my day. Every day is different, so It's really hard to put that into words* (Interview, RG15)

Participant RG11 described a similar structure to the day, however in hospital site three inpatient unit B, there were some differences in the approach, as

there was a team nursing approach – rather than caring for consumers individually. In this unit, the nurses would attend handover and then break into pairs, with one pair attending to the medications for all consumers and the other pair supervising breakfast, completing care level rounds and the physical observations for each consumer (Interview RG11). Then after these tasks were completed, there was uncertainty about what the shift would hold and depended on the requirements of the medical team, allied health or nursing management. For example, RG11 stated:

> *Around like 9 or 10 there'd be some meetings, if you're the nurse in charge you might go into the meeting and if you're not… you don't. The doctors might come for a ward round at 10, there'd be some ward rounds and some multidisciplinary team meetings* (Interview RG11).

NG12 compared two contrasting units in her clinical rotations – the MHICU and the rehabilitation units. She described the MHICU as being highly structured and restrictive and then a relaxed approach to the routine in the rehabilitation unit. She described liking the structure of the MHICU and finding this more appealing than the lack of structure in the rehabilitation unit (Interview, NG12)

> *It was busy, and that's what I like. Everything was structured pretty much by the hour, so you knew exactly what was happening and it was good. We'd do the meds at 8 o'clock, then we'd have breakfast and then groups together, and morning meeting. And we'd do a puzzle, read out quotes… stuff like that. And then like lunchtime, more meds… so a lot of structure! Mainly just based around meds. Here* [in rehab] *it's a lot different. It's a lot more… you come into work you see what the client*

wants to do, what time they get up and what time they want their meds (Interview, NG12)

This participant described the shock of coming into the rehabilitation unit after the structure of MHICU. Despite initially finding the MHICU too restrictive, she felt that the structure allowed her to stay busy and know what to do. Within the described routines, there were additional activities which needed to be considered. Hospital site two and the inpatient units A and B of hospital site three had a structured and regimented approach to completing the shared tasks of the unit which were allocating meal breaks and conducting care level rounds. There were other considerations such as ward rounds, clinical activities and transfers or escorting consumers to other healthcare settings. In some cases, these activities were predictable. An example of the pre-determined activities is outlined in *Table 8* below. The label 'staff' represents each of the nurses' names. These activities and allocations were pre-determined with the expectation that each nurse adhere to the stipulated timeframe of the activities. This reflects the allocation of tasks in hospital site three, unit A. A separate sheet was also used for determining the times for conducting care level rounds.

A copy of the whiteboard with allocations in office

	Group A Staff Staff	Group B Staff Staff Staff	Group c Staff Staff Staff	
Meds – Staff, staff Bloods – staff, staff Groups - Staff				Breaks 1000 staff 1100 staff 1200 staff 1300 staff
Responders -	MHICU - staff	Obs - Staff	Breaks - staff	
Psych rounds Dr 1000 staff Dr 1100 staff Dr 1300 staff				
Alarm exchange staff				

Table 8 - allocation of tasks in hospital site three inpatient unit A

In the more acute units, there was greater emphasis placed on adhering to the assigned times of these assigned activities. In hospital site two, participant NG4 explained it was considered essential that the nurses adhere to those allocated times, otherwise it would impact on the other nurses and the pre-determined activities (field note 2:1). This emphasised was observed in an interaction between the NUM and a nurse in hospital site three, unit A.

> *The NUM approached one of the nurses and asked why she hadn't taken her morning tea break yet, the NUM appeared irritable and pointed out that with the nurse not taking her allocated break, this then affected the timing of the breaks and activities for the other nurses. Sally looked embarrassed and said she had forgotten. As she left the NUM said out loud "it's written in black and white, how could you not know or forget?!"* (field note 3:1)

NG4 explained that pre-determining the workload began with of organisation of meal breaks and care level rounds. She added that some years ago, some nurses didn't contribute to completing the care level rounds and pre-allocating the workload was designed to create a fair and equal distribution of the workload over the shift (field note 2:1). However, in the sites where breaks and tasks were pre-allocated, there could be very little flexibility for nurses. For example, when organising an interview for NG6, I noted that she was allocated a 'special' from 10 until 11 am and then her combined meal break from 11am until 12pm. This was in addition to the allocated medication time in the morning and then needing to write notes after the afternoon handover and attending any educational in-services (field note 3:1). The first thought that came to mind was that any spontaneous activities such as sitting with a consumer or liaising with other members of the team could be hindered if the nurse was already committed to certain activities. In light of this, NG6 explained that each of the nurses structure their day around their allocated tasks.

> *You need to factor one hour in for the care level rounds, one hour for a break, and one hour for the special – 'there's three hours of your day gone already!' Then added that they needed to do physical observations, the medication rounds and then you need to check the notes and then write in the notes. In addition, you need to do a mental state assessment and risk assessment on each patient. If you didn't know the patient that that could take up to 30 minutes per patient to write each note* (field note 3:1)

This is in contrast to hospital site one, the OAMH unit and rehabilitation unit of hospital site three, where they did not structure the shift in this same way. As a new nurse to hospital site one, Sarah asked two other nurses '*how it worked here?'* and whether break times were predetermined. One of the nurses responded saying that they would work it out amongst themselves (rather than another nurse deciding when those breaks would take place). She emphasised that they work together and respond to what is needed (field note 1:1).

7.5 Clinical activities in mental health units

The learning of clinical activities varied depending on the unit that each new nurse was joining. It was emphasised that mental health nurses do all of the things that general nurses do in addition to 'holistic care' and 'therapeutic engagement' – which were considered features of MHN outlined in Chapter five. Examples of the similar activities were described as: taking urine samples, checking physical observations, completing electrocardiographs (ECG), giving intravenous fluids, checking blood sugar levels, administering medications, and assisting consumers with their activities of daily living (ADL) in the same way that general nurses might do (field notes 1:1). In addition, there were particular activities that were conducted that were emphasised as core activities of the mental health nurses which were taught to new members. These activities fell under broad themes and included: administering prescribed treatments; engaging with mental health consumers; maintaining safety and risk management; and managing unpredictability in the mental health unit.

7.5.1 Administering prescribed treatments

As a new member entering the unit, NGs needed to learn about the treatments that were prescribed and that needed to be administered. This was described as a challenge as many consumers could be prescribed a number of medications in addition to psychotropics, and then needed to learn the routines of administering treatments in each unit. Despite the move towards psychotherapeutic interventions in the 1970s (Alchin, 2010; Holyoake, 2014), the focus of treatment within the units in this research study centre around pharmacological management of symptoms. The medication rounds which are factored into the routine, remain a powerful artefact of the MHN culture.

There were different ways in which the medication administering occurred in each unit. In the majority of units, the nurse would dispense the medications in the nurses' station or medication room, and then take them to the consumers they were assigned to for the shift. The 'medication round' typically conducted at 0800 and 2000 hours each day was an important activity within the units. Additional medications are given outside of these times, but the medication rounds are when the majority of the medications are scheduled to be administered. New nurses are socialised to the routine of the unit and the manner in which medication administration occurs. For example, in hospital site three, unit B, the medication round is completed as a paired activity – with two nurses dispensing the medications for all consumers in the unit, with this activity outlined in the following excerpt.

> *Sandy is actively dispensing medications and passing them to NG3 to take to the consumers. NG3 tells me that this is the process that occurs here – two nurses are allocated to the medications with one of the nurses dispensing and the other taking them out to the patients. He added that if there is an S4D or S8 medication, that they both need to go out together to administer the medication. He added – "it's all about efficiency"* (field note 3:3)

The other units did not adopt a shared approach and instead each nurse would dispense the medications for each of the consumers allocated to them. In hospital site three inpatient unit A, the nurses were assigned to either group A, B or C. This involved staggering the administration of medications for the medication round. This arrangement was evident in *Table 8* in sub-theme 7.4 – *The rules and routines in the mental health unit.* The dispensing of medications involved the nurse checking the medication order, dispensing the required medications and then walking out to find the consumer whose medications are being prescribed. This differed from my experiences on general medical wards whereby the medication trolley might be wheeled down the corridor and the medicines would be dispensed at the bedside. The OPMH and rehabilitation units however dispensed medications in a similar fashion to the general wards (field note 3:3). In the rehabilitation unit, the nurse hands the whole box of medications to the consumer and the consumer dispenses them. The nurse then sights this and signs it off in the medication chart (field note 3:4). This was explained by NG7 as relating to the rehabilitation of consumers whereby they needed to be responsible for their own medications and it needed to be adapted to their usual routine.

In exploring the medication administration in the units, I reflected on the role that medications play in mental health care. In my previous experience it was very rare for a consumer to be admitted to the unit and not be administered medications – if they were not prescribed regular medications, they would likely at least have *pro re nata* medications which the nurse could administer if needed. In my own experience I know of a range of treatments that may be administered in mental health units – including ECT. However, it was not possible to observe these treatments occurring due to the limitations placed on field observation designed to protect consumers from being impacted by this research.

7.5.2 Engaging with mental health consumers

The participants described the importance of engaging with the consumers during the daily activities. Typically, this was achieved when completing other tasks such as physical observations or when responding to consumers requests. Consumers also engaged in the activities and therapy-based groups in the unit, primarily with allied health staff (field note 3:1). Activities scheduled during the week were primarily led by allied health staff. During the weekend these were generally led by the nurses and involved activities such as going for a walk or playing basketball in the courtyard. An example of the types of activities that may be provided is outlined in *Table 9* below.

Monday	Tuesday	Wednesday	Thursday	Friday
0930 ward forum	0930 ward forum	0930 ward forum	0930 ward forum	0930 ward forum
Morning tea	Morning tea	Morning tea	Morning tea	Morning tea
1030 gym/pool	1030 gym/pool	1000 calm group	1000 sing along	1000 pet therapy
1115 psychological skills	1330 community access group		1030 gym/pool	1030 art space (with church group)
1430 community access	1500 art session	1130 meal prep	1130 calm group	1300 gym with exercise physiologist
		1330 community access group		
			1500 medication info	
Afternoon tea	Afternoon tea	Afternoon tea	Afternoon tea	Afternoon tea
1600 gym/pool	1600 gym/pool	1600 gym/pool	1600 gym/pool	1600 gym/pool

Table 9 - Activity board in hospital site three, unit A

In observing the activities in the unit, I remembered when I first started MHN in a New South Wales-based hospital, that we were encouraged to take consumers for long walks on the beach and then to return to the unit. During the five months of field observations, these were not activities featured in these units other than a local walk to the park. With the nurses describing both the barrier of uniforms – '*no one wants to be seen with a nurse',* and then the workloads as barriers to taking consumers out on leave (field note 2:1). The nurses in the rehabilitation unit also stated they remembered taking consumers out for long walks but added that now they are too busy, and the consumers are too complex these days to go for lengthy outings (field note 3:4).

One of the roles that participants described holding was in assisting consumers with their ADL's. This was described more from the role of supervising or

prompting consumers. An example of an important activity was around supervising mealtimes. In the rehabilitation unit, the nurses guide the consumers to prepare their own meals – within their own capabilities, at an approximate time close to standard mealtimes – for example between 12 and 1pm for lunch (field note 3:4). In the acute units, the meals were pre-prepared by the hospital kitchen and sent to the unit on kitchen trolleys. The trolley was dropped to the front of the mental health unit and the HASA and nurses would then hand out the individual trays to each consumer (field note 1:1). The nurses would then supervise the consumers as they ate their meals. The approach to supervising meals had similarities across the acute units, with an example outlined in the excerpt below.

> *When the meal trolley arrived in the unit, the nurses then did an observation round and wandered down the corridors knocking on each consumers door. They appeared to converse with each consumer and then the consumers followed them out to the dining area. I recognised this behaviour as the meal call that was performed in each of the units I had worked in – you attend the rooms individually to announce that the meal had arrived and encourage all consumers to come and eat in the common area* (field note 2:1)

The nurses in hospital site three, unit A, also performed the same activity but they would lock the consumers bedroom door, so they were not able to return straight to their bedrooms. The belief articulated by the NG1 was that some consumers get comfortable in the unit and will just lie in bed all day or smoke in the courtyard, so it was perceived that for their good and in adapting to the routine, they are locked out of their bedrooms. In addition, it was explained that

the nurses are also more aware of the location of the consumers in the unit especially when supervising their mealtimes (field note 3:1).

There was the expressed belief in each unit that the mealtimes had to be observed, however, this was carried out differently in each unit. In hospital site one, the nurses typically sat in the nurses' station completing notes or other activities and would look out the window at the consumers (field note 1:1). In comparison, the nurses in hospital site two stood outside of the nurses' station and observed the consumers eating, which is described in the following excerpt:

> *The four subacute nurses were out in the dining area – they appeared to be standing near the subacute door, leaned against the wall. I found this to be an awkward position for the nurses. The nurses standing in a line, leaned up against to the nurses' station silently watching the consumers while they ate. My immediate thought was why aren't they sitting next to the consumers?* (field note 2:1)

Similar behaviour was observed on several field observations and that this was considered an activity that new members were taught. Participant NG1 in hospital site three, unit A, explained that one reason for observing the consumers at mealtimes was to prevent them from taking food from other consumers.

> *… it's behaviours of some, some patients have difficult behaviours, and they take the meals of two or three people, so you have to hand the meals out* (Interview NG1)

For participant NG12, the reasons for observing consumers during mealtimes related to safety. She related this to the MHICU unit and explained that they would need to count the cutlery and to ensure that the consumers attended to the dining area during their meal which was described as a small timeframe (around 30 minutes). This would allow them to closely observe the behaviours of each consumer and ensure no dangerous items were taken (Interview NG2).

7.5.3 Maintaining safety and risk management

The sub-theme of maintaining safety and risk management was regarded as a core task or role of nurses in mental health units. This related to conducting observations within the unit and in acting as the gatekeeper for the unit and for the consumers. Within the gatekeeper role was also the role in identifying and managing risk. The emphasis on these tasks were that the nurse had to perform these tasks from a therapeutic perspective, and it was seen as an unfortunate but necessary aspect of care. Balancing the management of risk and the development of the therapeutic relationship was described as a challenge by participants. This was presented as a tension between the desire to engage in the therapeutic relationship but to also maintain safety. The following participants describe the challenges in balancing the acute containment of risks and the desire for therapeutic engagement.

> *On acute* [side of the unit] *I just feel like I'm containing their behaviour all the time, I don't feel like I'm doing any good… it's restraint, answering the door and giving medication, I feel like I'm containing them and I'm not doing any good* (Interview, RG5)

Participant RG1 described similar challenges stating:

> *A lot of the time the focus is on risk… you're trying to help the person but at the same you're trying to not put them in a situation. For example, do you advocate for leave* [from the unit] *or not advocate for leave?* (Interview RG1)

In maintaining safety and risk management, the nurses appear to have greater ability to impose restrictive practices than to reduce them. Examples of restrictive practices include to withhold the leave conditions of consumers, utilise seclusion and restraint, administer injectable medicines, prevent the entry of visitors to the units, withhold belongings from consumers and move consumers to the more restrictive areas of the unit. However, they have limited capacity to remove the restrictions and instead may need the approval of a medical officer to remove restrictions.

7.5.3.1 Care level observations

Within the earlier sub-theme *7.4 – The rules and routines in the mental health unit*, the practice of conducting care level observations was mentioned in the context of the nurses' routine. New nurses are socialised into the practice of physically sighting consumers according to their prescribed care level – with this determined by the medical officer whom the consumer has been admitted under. In completing the observations, it was not required that the nurses engage with those consumers, but rather to note their location and status. This action held a high level of value within the organisation and was enforced by

overarching policies. The practice of doing a care level round involved carrying the clipboard with assigned care level sheets. In this health service, the care level frequency ranged from continuous observation to every two hours and had a corresponding care level number. At the time of the data collection, the health service was experiencing a change in policy to observations. However, during the field observations the following care level categories were used.

Care level 1 – continuous observation (within arms-length or within line of sight)

Care level 2 – observation every fifteen minutes

Care level 3 – observation every thirty minutes

Care level 4 – observation every two hours

The care level observations were required to be signed off at the corresponding times, depending on the care level assigned to each consumer. Care level 1 required 1:1 nursing otherwise referred to as a *special* or *specialling*, and care level 4 was considered the least intrusive in nature, with consumers on this level referred to as low risk and needing to be sighted every two hours. Each unit had a different method for managing those observations – this was often recognised as a shared activity, with nurses doing ’rounds’ to check on all consumers – rather than just the consumers that were assigned to them. The nurse would then sight each consumer and sign them off on the sheet. The consumers each had different care level allocations, so there could be a mix of different care level frequencies in each round, depending on the consumers that were due to be sighted. I observed NG12 completing an observation round from the nurses’ station.

> *NG12 leaves the nurses' station and does a round of observations down the corridor. I could see her pause and peer into each bedroom as she progressed down the hall (*field note 3:4)

In the acute inpatient units of hospital sites two and three, the nurses were allocated blocks of time to complete the observations which was explored earlier in this chapter in outlining the routines of each unit. This meant that the nurses needed to continuously complete observation rounds and stay out 'on the floor' during their allocated time. The other units of this study completed the rounds collaboratively and did not block out this time exclusively – it was seen as an informal shared process with everyone expected to contribute and help each other. What I had wondered in the process of observations, is if the pre-determination of care level rounds impacted on the ability for nurses to respond to other activities on the unit – such as critical incidences, liaison with other disciplines, or attending MDT activities such as ward rounds. Would the nurses then be unable to participate in those activities if they were having to remain on the round itself? (field note 1:1).

Despite care level one being outlined as a care level, these were not included in the observation rounds, as the consumers with care level one observations were assigned a nurse completing continuous observations. The approach to managing specialling in each unit also differed – in some units these were broken into hour blocks and shared amongst the nurses and in other units, one nurse was allocated to that consumer for the entire shift (field note 3:1). An example is provided for hospital site three, inpatient unit A. The nurses take

turns to special the consumer for an hour at a time. The nurses complete the special for an hour, and the care level rounds for an hour each shift. The NIC pointed out that there can be more than one consumer on care level one observations, so the nurse might need to complete two special sessions and one-hour of observations in the shift (field note 3:1). Hospital site two assigned one nurse to the special and the remaining nurses would have an additional consumer each for their allocation. This means that those nurses who may have been allocated four consumers on a regular day might have five or six on a day when a special is occurring (field note 2:1). The practice of care level one observations in some units increased the workload for the nurse assigned the task and for other nurses too.

7.5.3.2 Nurses as gatekeepers

Using the term ‘gatekeeper’ in this context reflects the socialisation of new nurses to the practices of letting consumers or visitors in and out of the unit; searching for contraband; and the activities relating to admission, transfer, or discharge of consumers within the units.

In letting consumers in and out of the unit, new nurses are socialised into the practices of monitoring the leave that consumers might take from the unit. All leave from the unit had to be approved by a medical officer – this included escorted or unescorted leave as well as any conditions including time off the unit and the permitted accompanying person. The nurses were then responsible for monitoring the leave that is taken. This was recorded in a leave register

requiring the signature of two nurses and documentation in the clinical notes. *I noticed the leave register – whenever a consumer wants to go on leave, a nurse will check whether the consumer has leave in the EMR and then they will sign the consumer out and require another nurse to co-sign* (field note 1:1). This practice was described by participant NG14 – she surmised her job as letting people in and out of the unit constantly. She said that she was initially slow at it at the beginning of the week as she didn't know the consumers and she needed to check EMR each time to determine how much leave each consumer had. She added that now it was easy to do – just a constant job (field note 1:1).

When consumers were being let back into the unit, they were searched with the metal detector and then signed back into the unit on the leave register (field note 1:1). The concern was raised when consumers did not return from leave, and this was termed – absent without leave (AWOL). In hospital site one a consumer rang to say he would return – he had gone AWOL the day before and advised the nurse that he couldn't get a bus to the village of Nimbin and therefore would return himself to the unit. Around 30 minutes later he was brought into the unit with two police officers and two ambulance officers. The nurses then discussed the return of this consumer and advised that his leave would now be cancelled.

In addition to monitoring the entry and exit of consumers to utilise their leave, nurses also were the gatekeepers for visitors. In the following example the husband of one of the consumers attended the unit and the NIC advised the

nurses to not let the consumers' husband in, adding, *"he's the reason why she's in here, she needs to sleep"* (field note 2:1). On another occasion another family member was visiting a different consumer and the nurse advised that they should not let the visitor in because the consumer was too unsettled, didn't have any leave granted, and she didn't want to wake her up (field note 2:1). In this sense the nurses are the gatekeeper of the unit and are given the authority to manage the entry and exit of visitors. New nurses are socialised into these practices and taught how to complete the tasks in the same ways as the existing nurses.

As gatekeeper to the unit, the participants described the importance of searching any person entering the units, or admitted to the unit for contraband – this involved checking the persons bags and pockets as well as using the metal detector to search for any items that may be concealed on the person's body. New nurses were socialised into the practice of identifying and removing items of contraband. In the following example, *NG8 carried a metal detector and began to wand the person entering the unit using a hand-held metal detector* (Field note 1:1). The types of items being searched for included weapons, drugs, electronic devices, but more commonly – cigarette lighters.

I've got the lighter!

The most common items to remove from consumers were lighters and cigarettes. In the following example, two senior nurses and NG1 went out to the

courtyard of hospital site three, unit A, and returned with one of the nurses stating, "*I've got the lighter!"* (field note 3:1). On a separate field observation session, a man was heard yelling in the dining room. A short time later the NIC returned to the nurses' station with a couple of lighters and a packet of cigarettes in her hand. It had appeared that the consumer had been caught with a lighter and cigarettes and was yelling in protest when the nurse came and removed them (field note 3:1). In hospital site one, one of the cleaning staff advised the nurses that a consumer was smoking in the bathroom, NG13 left the nurses' station and returned a short time later announcing, *"I've got a lighter!"* (field note 1:1). Despite the use of the metal detector to find lighters, the nurses were observed discussing that consumers were using alternative methods such as matches – so that they could not be detected with the metal detector, and putting lighters and cigarettes in their underwear, knowing that the nurses were not permitted to ask the consumer to remove their underwear or search their clothing beyond the pockets or other obvious places (Interview, NG1).

I reflected on the incidences of smoking that I observed on the unit. Only a few years ago the consumers were allowed to smoke in the courtyards of mental health units. This practice was abolished as the health service banned smoking on all hospital grounds. The issue in this case was the inability of consumers to leave the unit to smoke unless they had leave granted. In some cases, only a short period of leave could be granted and in other cases no leave due to the apparent risks in the consumers presentation. It was also not permitted for

nurses to take consumers out on leave to smoke either (field note 1:1; field note 3:1). In my own reflection, I personally was in two minds about consumers locked up against their will and being forced to quit smoking at the same time. But I'm also aware that being a health facility that it contradicts the principles of healthcare to facilitate smoking. This tension was also held by other mental health nurses. For example, in hospital site three, unit A. I asked if this unit was always strict about non-smoking after observing the removal of lighters several times. One of the senior nurses said they adopted the non-smoking policy a few years ago but had relaxed their policing of it as they felt they shouldn't have to police the consumers over non-smoking. She then added that over time the consumers have become disrespectful with it. They used to at least hide the cigarette when a staff member went past, and now they have become so brazen as to blow smoke into a nurses' face. Another nurse stated that they found that the consumers will smoke in the bathroom overnight and put a plastic bag over the smoke detector. The nurses had agreed that this behaviour put other consumers and the staff at risk, and if some consumers are going to be so brazen then the staff will enforce the non-smoking policy (field note 3:1).

In learning about the shift in smoking policy I also noticed a count down on the entrance to this same unit which had an A4 page which outlined how many days remained until the unit was completely non-smoking. On the note, the date 5/6/17 was written with the number '0', based on my arrival, the unit had been enforcing no smoking for three days (field note 3:1). When I returned to the unit a couple of months later for further observations, I asked the NIC if the smoking

ban was working and she said it wasn't and that the nurses are too tired and not motivated – she added that it was too difficult to police, with only some of the nurses enforcing the non-smoking policy. She then followed this with, *"we all need to be on the same page… if all staff work together and approach this in the same way, then there will be consistency"* (field note 3:1). She gave the impression that some nurses were more lenient than others or that some staff enforced the rules while others didn't which created difficulties in managing the behaviour.

Interestingly, despite the relaxed nature of the rehabilitation unit and the increased amounts of leave that consumers have, NG12 explained that there were also challenges with regards to consumers smoking in the unit. In the following excerpt the nurses intervened when a consumer went to the courtyard to smoke. *Sarah and NG12 jumped and told the consumer he couldn't go to the courtyard to smoke. Sarah challenged him and said, "yes I can see you have a lighter and you are going to use it"* (field note 3:4). The difference in the rehabilitation unit was that consumers could keep their lighters and cigarettes – they just weren't allowed to smoke within the unit. NG7 explained that the consumers are not allowed to take leave after 9pm, therefore until 7am the next day they would be unable to smoke. So, despite the reduced risks and focus on rehabilitation within this unit, identifying and managing behaviours such as smoking still remained a priority of care. However, it needs to be noted that these items are not removed from the consumer, they are just told not to perform the behaviour within the unit.

In addition to policing smoking on the units, the nurses also need to search for other items of contraband. The property checklist in *Figure 9* is a field drawing of the checklist on the wall of the nurses' station outlining what needs to be completed for consumers admitted to the inpatient unit – but also the types of items that need to be removed. It gave a sense of custodial practice by its layout and explanation. The NIC said that it often occurs that consumers accuse the staff of stealing or breaking their belongings, so to ensure that the staff are protected, they will co-sign everything together, and if possible, co-sign with the consumers (field note 3:1). An example of documenting an item would be a 'gold-coloured ring with a white or clear stone' instead of a 'gold diamond ring' – as then the consumer couldn't accuse the nurse of stealing the gold diamond ring and replacing it with a cheaper alternative.

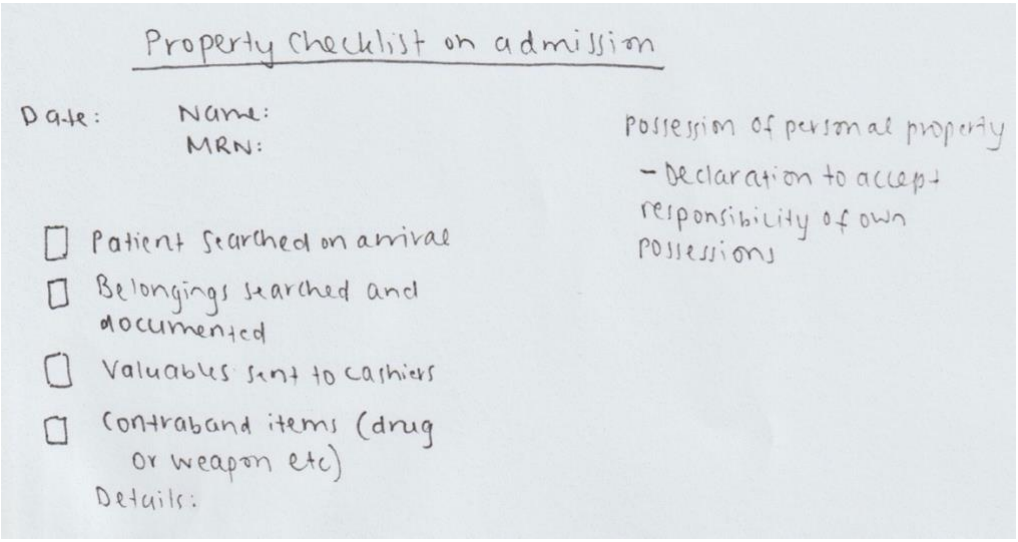

Figure 9 – property checklist on admission in hospital site three, unit A

In addition to removing valuable items, the practice of identifying contraband is taught to new members with the emphasis on removing items that could be considered dangerous – whether to the consumer themselves or others. Part of

the socialisation to the unit involved the NG learning to identify risks and items of contraband – this goes beyond the obvious items such as drug paraphernalia, to imagining how ordinary items could be used as a weapon. For example, in hospital site one a nurse was taking a Bible out to a consumer – she taps the hard-cover Bible and remarks that the hard-covered Bible could be used as a weapon by the consumer (field note 1:1). NG12 explained the potential use of pens as a weapon – pens were not given to the consumers in the MHICU but instead the ink was removed and stiffened with sticky tape for consumers to use (Interview NG12). Identifying and removing potential weapons fell under the belief that there should be no dangerous items out in the consumer areas. This also relates to the belief that whenever a nurse leaves the nurses' station, they are entering a danger zone and they need to increase the safety of those clinical areas. In reflecting on the socialisation process, NG12 remarked how difficult it was to look at these same items without seeing them as potential weapons.

> *That's why here* [rehabilitation unit] *I still get a shock when I think someone's got a lighter or a pen, it's like 'oh no!'* (Interview, NG12)

Primary roles for nurses in addition to those already described in this Chapter are the admission, transfer, and discharge of consumers from the mental health unit. The process of admission and discharge to the unit was considered lengthy with several forms to complete. It is also important to note that any consumer being admitted to any mental health unit needs to be admitted under mental health legislation – even if the consumer is requesting an admission, this

process needs to reflect the requirements of the overarching legislation. The correct assimilation of the legal paperwork was emphasised in all the units, though more so in the acute units. The major tasks of the admission were in ensuring the legal paperwork was present.

The discussion amongst the nurse was around the powerlessness in choosing which consumers get admitted to the unit. in hospital site three, the nurses discussed frustration around consumers who were described as *antisocial* who were admitted. Jake and Sarah both commented that a lot of antisocial consumers get admitted to the unit – "*if they commit crimes and say they're suicidal, then they will get an admission – we admit them all"* (field note 3:1). They had said the doctors who are on-call won't take the risk and would rather admit them. The other challenge described was the availability of beds and options available for discharging consumers. The NIC in hospital site two explained that many consumers did not have a discharge address and needed to stay in the mental health unit until suitable accommodation could be found (field note 2:1). In hospital site three inpatient unit A, the nurses were talking amongst themselves about the issues in finding accommodation.

> *We've had patients here in general ward for five years because they can't be placed. This unit is the subacute unit, if there is no accommodation then they stay here until we can find somewhere. People are also drawn to this area, they come from the western suburbs or from overseas and come to the beach, they are then picked up and brought to us* (field note 3:1)

This appeared to be an issue for the nurses where they discussed the difficulty in finding accommodation, managing discharges but also in consumers who stayed long-term in the unit – this was described as getting “too comfortable”. Examples of discharge plans for consumers in the hospital site three, unit B, included: out of area (OOA) – referring to a consumer not from the hospital catchment area, discharge to police custody, accommodation issues, mental health rehabilitation unit, and then for two consumers the plan was for a community treatment order (CTO) which would mandate that the consumer adhere to a treatment plan on discharge, the remaining consumers were listed as returning to their own home (field note 3:3). Not all consumers had a discharge plan or specified date, but this example shows the variation in discharge plans – not simply returning the place of residence before admission.

The process of completing the consumer’s discharge from the unit varied in each site. In some units, nurses had more autonomy and responsibility. For example, in hospital site one, NG13 was completing the discharge of a consumer and advised the student assigned to her that they needed to complete the paperwork, obtain a medical discharge summary and then contact the local mental health team to provide a handover of care and arrange a follow-up appointment time within seven days of discharge (field note 1:1). In hospital site two, the process of discharge and liaising with external agencies was completed by the medical staff. Interestingly, in the acute units, discharges tended to occur from the subacute side, and it was observed that the less inexperienced nurses in the subacute side were likely to complete this practice.

The nurses handling the discharge were responsible for handing over those consumers to external agencies such as general practitioners (GP) or community teams. I reflected on this afterwards – that the less experienced nurses may be charged with the task of conveying risk and understanding the nature of the consumers' presentation and their needs on discharge and may not be experienced enough to manage this adequately.

Nurses also had to arrange transfers between units. This can involve determining the most appropriate consumer to transfer. Although the NG did not typically have to complete this process – this fell to the NIC, they were also able to be placed in charge or may take on this role from their second year. The identification of potential consumers was also an important practice when the units were reaching capacity. This was especially challenging when the units were full, and the weekend was approaching. The nurses would need to identify consumers potentially suitable for leave or discharge to have beds available for new admissions. In an example of the discharge handover, NG4 was asked to arrange the transfer of a consumer to a care facility and to provide handover to the ambulance service.

> *NG4 began to give a handover on the phone to the ambulance officer and explained the risks of the consumer and the destination of the care facility. She requested that the consumer be restrained and gave a diagnosis of treatment-resistant schizophrenia* (field note 2:1)

The reasons for such a restrictive approach were outlined when one of the nurses spoke to NG4 and they discussed that she will likely return to the ward due to her previous disruptive behaviour at the care facility. This time the consumer was being placed at a higher care facility. NG4 explained that this consumer vowed to scream until the facility sent her back (field note 2:1). It appeared NG4 was increasing the likelihood that the consumer made it to the care facility and that the ambulance officers were warned of the difficulty that the transfer might pose.

7.5.4 Unpredictability in the mental health unit

This sub-theme refers to the unpredictable nature of mental health units with concurrent activities occurring. The unpredictability of the unit was largely described as the unit either being *quiet* or *full-on*. This related to changes within the consumers such as a number of more acute consumers admitted or the types of activities that needed to be completed. What became evident over the course of the field observations and in reflecting on my previous practice, was the contagious vibe of the ward – when there was increased activity and chaos it appeared to impact the staff and consumers with a heightened effect noted. In the interviews with participants, they had described MHN practice as being different to general nursing with each day unpredictable in its nature. However, participants emphasised that this was partially due to the unpredictable nature of the ward environment. It was unknown what would need to be completed and whether there were unexpected changes such as a consumer becoming distressed or agitated. The flexibility and unpredictability were described as an

initial attraction for NGs with this seen as appealing and providing excitement. However, this was also viewed as a challenge with nurses seeking ways to create predictability and efficiency to cope with a changing environment. One of the explanations for the changing vibe of the ward was the type of consumer that was admitted. RG11 explains:

> *A lot of it depends on what kind of patients you have because sometimes they just like to stay in their room the whole time and sometimes, they're just really demanding and they want lots of things that you can't give them, like lots of medications that they're not prescribed or leave* [from the unit]. *That can be really challenging, and it can change the ward quickly from being really nice, to then having people being verbally abusive and physically threatening and stuff. That can change things and everybody's tense. You hear a little noise, and everybody jumps because it's like 'what was that?!'* (Interview RG11)

I noticed this response during field observations in hospital site one where the acute side of the ward appeared unsettled. It was a Sunday morning and the nurses appeared exasperated and were moving in and out of the nurses' station to meet the requests of consumers, answer the phones and attend to other tasks – this was reflected as the constant slam of the door and the movement in and out of three different staff members. One of the nurses passed me and said, *'you wouldn't believe the day we've had, we need another seclusion room, there are just not enough!'* (field note 1:1).

To increase the predictability of workload, the practice of forecasting of the activity in the unit is taught to new staff members. For example, at the

commencement of one field observation episode, I was informed by NG9 that I would not see very much as the ward was quiet. Despite this, the change in the unit could occur quickly and it was described as not always easy to predict the nature of the unit. An example of this was reflected in my own field notes where I expected that the morning shift was going to be busy. "*Despite being a weekday morning, it is surprisingly calm and quiet in the nurses' station"* (field note 1:1). On a separate occasion I observed that the weekday morning was surprisingly calm, and then all of a sudden, the nurses' station was brimming with life as several staff members emerged from the subacute side of the ward (field note 1:1). Although there were differences in how I observed the atmosphere of the nurses' station, the majority of the field observation sessions involved observing spurts of activity whereby there would be a quiet and calm atmosphere and then a flurry of activities. Participant RG10 offered an explanation for the change in vibe of the ward and said that typically the mornings were busier due to the presence of doctors, allied health, and management. He adds that this also impacts on the ability to interact with consumers as the nurses are needing to respond to the requests of everyone.

The calm ward was valued by nurses, with the goal of preserving this state. This was explained as allowing the nurses time to complete the tasks needed. I noticed with the calmer atmosphere in the unit that I felt calmer too – I wondered if the nurses and consumers felt the same way? On the field observations when the ward was perceived as calm, I noticed the nurses appeared relaxed and could go about their work in a relaxed and leisurely

manner, they would be talking to one another in a friendly way (field note 2:1; field note 1:1). In noticing the calm ward and in writing the word ‘quiet’ there was a sense of superstition as I wrote it. It reminded me of one of the field observations when a doctor had said, *“where are all the patients?* [referring to the 10 empty beds] *It’s so quiet in here!”* The NUM jokingly threatened to smack the doctor if she mentions the word quiet again (field note 1:1). There is a superstition in healthcare that if you mention that something is quiet or easy, then you are inviting or attracting chaos. Ironically, when I attended the same ward the next day, the ten beds had been filled.

7.5.4.1 Concurrent activities – putting the fires out

Participants described the need to adapt to the unpredictable nature of the mental health units and the consumers. Whereby they may encounter a number of competing demands. There were different approaches to this, but generally they were conceptualized as *putting the fires out*. What participants described and what was observed during the field observations were nurses attending to multiple tasks concurrently, such as in the excerpt below.

> *NG13 mentioned how hard it was to write notes as consumers would constantly knock on the door. She mentioned there was always interruptions with the front door, consumer door and phones ringing. She mentioned that she still had to transfer a consumer to another hospital. She realised it was 12:30 and she still hadn’t finished her notes due to the interruptions* (field note 1:1)

Similar to the account of NG13, I noticed that the nurses were generally interrupted throughout the day. In one example, one nurse spoke to a consumer and then when they started to write the clinical note, another consumer knocked on the door, the phone started ringing and then a consumer buzzed at the door wanting to return from leave – these all occurred at the same time (Interview RG2). In response, the following participant RG2 said:

> *It's like what am I doing?! It's like what was I doing 10 minutes ago? Everything's incomplete, it's like you can't get one thing done at a time* (Interview RG2)

When some consumers began to knock at the door, Holly explained, "*you have to ignore them, or you can't get your work done"* (field note 1:1). What I observed in hospital site one, was a pattern of nurses speaking to the consumers, trying to document this, getting interrupted for a separate reason, and then trying to document that also – a pattern of being unable to finish one task completely. As soon as each nurse sat back down another consumer would knock. Holly said, *"oh no, I made eye contact… now I have to open the door, I've only been able to write two lines in half an hour!"* (field note 1:1). In this example, after attending to the requests of several consumers, Holly sat down to finish the note she had started and stated, "*now I can't remember what I had to write"* (field note 1:1).

The nurses appeared to manage the requests by enforcing rules, such as setting times for consumers to make phone calls or when the nurses might

assist with making coffee. This approach was described as a team approach with the emphasis on the nurses all '*being on the same page*' (field note 1:1). The belief taught to new members was that the needs of consumers would be endless as they are disempowered when they enter the unit, so it is important to learn to say 'no' and to not go looking for work. NG9 explained the process of learning to say 'no':

> *I found as a new grad, you kind of… you do everything for the patient. You get kind of burnt out because you try and do every request they have, which in mental health can be many, especially if they're quite elevated or manic. So, I guess it took a while to learn when to say no to people. That was one of my biggest challenges as a new grad* (Interview RG9)

The participants described the need to conserve energy and decrease the risking of burning out. When not responding to requests, the nurses were observed sitting in the nurses' station chatting and socializing. In this sense, the new nurse is taught to put out the fires and respond to needs as they arise. To respond to the request and then return to the nurses' station. In keeping with this practice, consumers were directed to approach the nurses' station to have their needs met – with available staff determining how those needs be met.

7.5.4.2 Managing aggression

Another element of putting the fires out was in managing aggression. New nurses were taught the skills to manage aggression by modelling the skills used by the established nurses. The nurses in the ward described expecting

aggression as a mental health nurse. One of the tools to manage this was prediction – using the risk assessment and mental state tools to capture information. I got a sense during the field observations that the threshold for aggression or risk in general is different depending on the unit and the individual clinicians. What may be considered high risk in one unit may be considered low or moderate risk in another unit. Risk interpretation is also subjective as well, with each nurse interpreting the level of risk differently. For example, the nurses in hospital site two were talking about a consumer that was considered an aggression risk and gave an example of them throwing a chair to exemplify this, whereas another nurse considered throwing a shoe into the corner an aggressive act (field note 2:1). In managing the aggression or difficult behaviour, the nurses discussed the difference in behaviours that were deliberate or attributed to being mentally unwell. An example was given of a consumer in hospital site one who was perceived to be deliberately drinking out of the communal milk carton and peeing on the sofa and the floor. She was described as intentionally and knowingly performing these behaviours. Paulina explained to NG14 that there is a difference between being behavioural and being unwell – she interpreted the consumer as peeing deliberately because she was feeling angry (field note 1:1).

To assist in responding to aggression, each nurse wore a duress alarm. The role of the duress alarm was that the nurses would wear the alarm for their own safety as well as being able to respond to the needs of their colleagues. In hospital site three, unit A, an alarm sounded in the nurses and the NIC said to

one of the senior nurses, *"you're up!"* This was referring to a responder call to another ward – the MHICU. It turned out to be a false alarm and a message was heard over a walkie talkie sitting on the desk that said, "*false alarm to MHICU".* The nurse pointed out to me that she was surprised that she had not ever been run over as she had to run to the MHICU and cross the road on hospital campus where cars come racing through to get a park. She said the urgency for these calls is high and you must run. I looked outside and saw the pouring rain. I was glad for her that she did not have to run through the rain today. I pointed that out and she said it does not matter the weather, you run. I asked what would happen if a second person was needed to respond the incident, the senior nurse said that the alarm would keep sounding and whoever else is free would go – it could be the responder assigned to unit B, or the responder assigned to breaks, or whoever else was assigned (field note 3:1). I noticed how the nurses came to life when an alarm went off. They were mulling around going about their duties, but as soon as that alarm went off, their demeanour changed, they were instantly alert and appeared almost ready for battle. They then almost as quickly went back to their original state and resumed duties without stopping. When the false alarm notification came through, the nurse sat back at her computer as though nothing had happened (field note 3:1). Managing aggressive represented a stressor for new nurses. The following participant described the challenge in managing aggression when it came to the team approach especially with the use of security.

> *I find it still a bit difficult sometimes dealing with the really aggressive patients. I find it hard remembering what to do, especially with restraint and stuff. The challenge I have sometimes is sometimes I might feel someone could be a little too rough at times with the patients, especially security. I find it hard telling them to back off a bit. Especially with security sometimes if you do say don't be so rough, they don't want to come down* (Interview RG9)

NGs entering the organisation were sent for aggression management training during their NGP – this involved four days of training. In some of the units such as hospital site one, the NGs were not allowed to work on the 'acute' side of the unit until that training was completed (field note 1:1). When I spoke to NG13 about her experience completing the aggression management training, she said she had already had to use those skills. She stated – *"I was at training for four days, then I had four days off. When I came bac,k the ward was really acute. Someone on the acute side had to be restrained… I had to restrain their feet"* (field note 1:1). I didn't ask how NG13 felt about restraining a consumer, but she retold the story nonchalantly and seemed unphased about the experience. One of the activities that participants were socialised into was the role of responder in the event of a situation requiring the support of other staff. Participant RG4 spoke about the challenges of taking on that role as a NG.

> *It was scary if you were a new grad and a primary responder, it was so scary. You would carry a duress if you were on the response team. You're expected to run to a different ward and do a restraint on someone. When two people were kicking off, it didn't work, it was just chaotic…* (Interview, RG4)

Although this was seen as a challenging experience, it was also described as necessary whilst the NG was in a supported role, as after conclusion of the NGP, the NG was expected to be able to perform those roles along with the other members of the team. As RG4 explains, *"*[as a NG] *I'm still a qualified nurse, and you're not going to develop that experience unless you are thrown in with some support"* (Interview RG4). She gave further depth to her explanation:

> *If we've got a funny shift and there's three NGs on one shift and a couple of 'few-year out' nurses and we get into a restraint, that's going to be overwhelming for them and that's when you can start to get really burnt out or affected by what's happening. But if you get small doses and you build up your confidence with support, it's so much better* (Interview RG4)

This participant explained the need to maintain the safety of new member to the team but felt that without support or early opportunity to learn the skills, it created more challenges later for the NG after they have completed the NGP.

7.6 Chapter summary

This Chapter explored the clinical practice experiences of NG nurses who are being socialised into MHN in this research site. It further explored cultural artefacts as well as starting to explore the next layer of the organisational culture which are the espoused beliefs and values of the cultural group as represented in the routines and practices of cultural members. This involved exploring the socialisation of NGs into the clinical practices of the mental health

nurses and the role of MHN within the mental health unit. The next Chapter explores the MHN culture and the experience of NGs in entering the MHN cultural group.

Chapter eight
Entering the culture of mental health nursing

"The interaction of knowledge and skills with experience is key to learning"

John Dewey

8.1 Introduction

Entering the culture of mental health nursing represents the journey that new nurses take in entering the inner circle of the MHN culture and moving out of the NG nurse culture, representing the fourth and final findings chapter. This is represented in the sub-themes: *assimilation – learning the skills and traits of mental health nurses; language and communication in mental health nursing; nurse relationships;* and *assimilating new members into the culture.* Entering the culture of mental health nursing represents the final stage of acceptance and the point at which a new member may be accepted into the cultural group or may be excluded or choose not to enter the culture of mental health nursing.

8.2 Assimilation – learning the skills and traits of mental health nurses

In joining the MHN culture, NGs were learning the characteristics of mental health nurses. Participants identified several common characteristics of a

mental health nurse. This perspective differs from the description of mental health nurses in Chapter five – where the participants spoke about the group from the perspective of cultural outsiders. They referred to mental health nurses but did not include themselves in that group. They also described being shaped to fit the characteristics valued by the existing cultural group through learning the skills and traits of mental health nurses central to that group.

8.2.1 Defining mental health nursing

Despite articulating a passion for MHN in Chapter five, it was difficult for participants to describe MHN itself. The question posed to participants was ‘how would you define mental health nursing?’ (Appendix 7). This was described as difficult for participants to answer, with participants separating the qualities of the mental health nurse and the activities that mental health nurses engage in. The articulation of MHN appeared to reflect a holistic definition of ‘helping people’ but also was related to the activities undertaken by the mental health nurse in each setting. In explaining what a mental health nurse was, participants described a dichotomy of the mental health nurse providing holistic care whilst also describing restrictive or custodial practices. From the vantage point of the observer, there appeared to be an emphasis on custodial practices under the guise of holistic care. This will be explored under the following headings of *the qualities of the mental health nurse* and the *role of the mental health nurse* as enunciated by the participants.

8.2.1.1 The qualities of the mental health nurse

The participants described the particular traits or qualities that mental health nurses should have. These included: having a sense of humour, being resilient, being flexible and easy going, and having a sense of quirkiness or character. It was emphasised as important that the mental health nurse be warm and engaging and not be cold or detached. These relate more to the qualities of the mental health nurse as opposed to the activities that they engaged in. Participant RG1 suggested that mental health nurses should have "*good humour"* and emphasised that this because of the things that are experienced in MHN – *"you deal with some crazy stuff, you have to have a good sense of humour – you have to have a laugh"* (Interview, RG1). Similarly, NG2 described mental health nurses as being jovial and easy going.

> *I think the majority of them are more jovial and they don't take life too seriously. Because you have to carry so much hope and have to bring so much hope, but the small things that happen are generally seen as nothing. You need to be able to deal with crises with grace and deal with anything during the day with ease. I think mental health nurses in general are pretty easy going and fun* (Interview NG2)

Interestingly, the NGs described MHN separately from themselves, such as the example given by NG2. Whereas the recently graduated participants described themselves when talking about MHN such as in the example given by RG5 below.

> *We're pretty laid back. We've got pretty good personalities. We're a bit quirky in our own little way. We have a laugh, oh shit* [laughs]*. We can laugh, oh we've got a good sense of humour* [laughs] (Interview RG5)

This seemed to reflect the transition from cultural outsider to insider, that was expected after completing the NGP and securing ongoing employment in MHN. The participants described the process of learning the skills and traits of mental health nurses, whilst the existing culture was seeking new members who had the desired qualities and traits. It was emphasised that not all nurses would be suited to MHN depending on their personality type. As NG14 explained, *"it takes a different sort of person to work in mental health. It's definitely not for everyone and you need to have a thick skin"* Interview NG14). It was also emphasised that mental health nurses themselves are the tool for therapeutic engagement.

8.2.1.2 The role of the mental health nurse

Defining the role of the mental health nurse was described as being dependent on the clinical setting. Although the participants described MHN as a holistic approach to care, this was described more so as a desirable quality but was also reflected in the many roles or functions that the mental health could take on depending on the clinical setting and the way the nurses' role is shaped. An element of pride was attached to the broad skills associated with MHN, such as outlining that mental health nurses do *all the same things as general nurses* but also provide holistic care. Participants described a need to have a broad skillset to provide physical healthcare as well as mental health care. Though despite the definitions provided of MHN, it was also outlined that there were not clear

boundaries to the role and function. There is a distinction between the characteristics of the mental health nurse and then how these are represented within the role in each unit. For example, in the rehabilitation unit new nurses were taught to focus on skills of empowerment and goal setting whereas in the acute unit the focus was on identifying and managing risks. In participant RG2's experiences, she outlined that the challenges as a NG entering the mental health unit are *"… defining what on earth your role is!"* and added *"the definition of mental health nursing is just so loose, so broad!"* (Interview, RG2). She added that there is a tension between the type of nurse she expected to be and how the constructed role impacts on that expectation.

The lack of clearly defined role boundaries has been reflected in the literature as leading to role ambiguity (Cutcliffe et al., 2013; Lakeman, 2013). The role of mental health nurses seemingly is developed locally in response to the needs of the clinical unit, such as the MHN role in the mental health rehabilitation unit as opposed to the mental health inpatient unit. The primary tension that arose for participants was the balance between risk management and recovery practices. Participant NG11 described the challenges in the MHN and the different approaches that may be needed in providing care.

> *There are so many different presentations and people require so many different things. Like some people require a lot of nurturing and other people need just some firm boundaries. There's a lot of verbal de-escalation and distraction. There are some things like groups and also the other side of it which is like restraints and IM's and things like that. I*

> *feel like you've got the caring side and then you've got the sort of tougher side where it's more like containing behaviours* (Interview NG11)

Interestingly, when I explained the research project to one of the senior nurses in hospital site three, he gave his views on the culture of MHN. he explained that he had completed hospital training back in the 1970s and that MHN today does not resemble what it used to. He explained that MHN used to be about psychotherapy and now it's about medications and all the 'physical stuff'. He said it was the psychotherapy and connection with the consumers that attracted him to the profession in the 1970s and that he would never have entered MHN if it resembled what it does today. He felt that the nurses working in mental health units were general nurses first and then they learn some mental health nursing skills in the unit – that the basic skills of mental health nurses were not being taught, such as 'communications skills' and 'being' with consumers (field note 3:2). Participant RG11 also described MHN similarly – that mental health nurses do all of the things that general nurses, with additional skills specific to the setting such as interacting with consumers.

> *I would explain it* [mental health nursing] *as a combination of things. You do a lot of the stuff expected by nurses like giving out giving out medications and doing all of the vital signs and doing some kind of personal care stuff like helping people shower, sometimes doing some wound dressings, stuff like that. But then all of the other stuff that you wouldn't expect… it's just a lot of interacting with people and a lot of trying to manage emotions because a lot of people that come in are just so emotionally dysregulated and disinhibited, so a lot of it is just*

> *managing that and all different emotions and personalities on the ward… a lot of talking to people* (Interview, RG11)

The negative aspects of having a diverse role or skillset were encapsulated in the term *jack of all trades.* The concept of this related to the wide skillset and the shaping of the nurses' role to suit the clinical unit. This represented the wide applicability of the MHN role and the difficulty in defining the boundaries of the role. This was described as having a negative impact on participants. RG2 explains the impact of completing the required tasks and the impact on her role as a mental health nurse.

> *I want to be this type of nurse, but I don't have the time to do it and that upsets me sometimes. I want to run groups and take people on walks and really get to do that kind of one-on-one time. But you just get caught up chasing all those endless to-do's with documentation and all the stuff that just gets palmed off… you just have to do that as a nurse* (Interview RG2).

The activities in which nurses engage were explored in greater depth in the last chapter, so this concept relates more so to the impact that a diverse role and skillset may have to mental health nurses, and the NGs perception of the MHN role.

8.2.2 Separation of self – managing adversity and self-preservation

Participants described the transformation they must go through in learning to manage difficult situations and in avoiding burnout. One of the main skills was in emotionally detaching or not becoming affected by their experiences within the clinical environment. This requires the nurse to be comfortable in challenging situations and manage a high level of risk. The following participant RG16 described the tension that mental health nurses must undergo to maintain balance between managing difficult situations and maintaining composure.

> *A lot of the people that come into the acute mental health unit are very unwell… they're very needy. They come in and they're often making lots of requests so you're having them trying to grab your attention. And using up a lot of your time, which becomes quite stressful to the nurse on the shift. You've got to maintain your patience and composure and be a good listener. It's not easy to do all those things. Because of the risks involved with some of the patients we look after, you've got to be forever mindful of the risks with each individual patient, and you've got to follow the protocols on the ward in maintaining the safety of patients and that can be a challenge, you want to be able to get it right* (Interview, RG16)

Addressing the needs of the consumers was also balanced with developing the ability to say 'no' and to set boundaries to prevent burnout. This was also reflected in NGs learning to respond to needs as opposed to initiating care. Participants described initially entering the unit and responding to the needs

and requests of consumers but over time learning to say ‘no’ to prevent burnout – this was described as ‘limit setting’. Participant NG9 outlines his experiences:

> *It’s more about burnout and not to know when to say no to the clients… to the staff as well. Because sometimes if the clients are coming to you – a different nurses client coming to you and asks. I think you sometimes have to say, ‘I’m not your nurse, you have to get your nurse’. Because if you keep going and doing all those things, you get burnout, and sometimes I found with those things I find myself getting really tired. That’s what I feel is a challenge so that’s why I delegate my work as well now. So, I say no to the clients* (Interview NG9)

In the last chapter, the concept of managing challenging behaviour and risk within mental health care was explored. Participants discussed the challenges of encountering and managing risks, with activities such as seclusion and the restraint of consumers seen as a necessary but challenging experience. Though participants described the need to emotionally detach from the experience to fulfill their role. Participant RG2 described her own transformation in managing the experience of challenging situations. She spoke about her initial worries about aggression and how she then came to manage this. She described working on the acute side of the unit. *“It’s kind of bittersweet because the patients are more unwell and sometimes their presentations can be confronting but at the end of the day, when you realise aggression is aggression, it’s not that scary*” (Interview, RG2). The process of describing aggression progressed from initial fear and rumination to then not feeling afraid. *“I remember as a new grad I was like “I just want to get hit… it sounds bizarre,*

but my logic is that if I just got assaulted then it would be over and done with and I wouldn't have to fear it anymore" (Interview, RG2). Despite not ever being assaulted – in a nursing role or outside of it, this participant describes eventually coming to a point of not feeling afraid. "*I don't know what it is, I think it's just exposure. The longer that you're exposed to it, the less you fear it"* (Interview RG2).

Despite being early in their careers, the RG participants were able to provide valuable insights on the concerns with burnout and in managing stress. New nurses were taught to conserve energy by relaxing and debriefing with the other nurses when the ward is quiet – especially with the unpredictable nature of the unit. Participant RG1 emphasised the role that debriefing has in managing burnout. *"The nurses' station is that debrief zone. You go out and come back and debrief – then you can go back out again. I think that because mental health nurses debrief, they are able to keep going and not burn out"* (Interview RG1). Participant RG5 emphasised that being 'lazy' is also a form of self-preservation. Participant RG4 outlined the consequences of burnout from her experiences with a peer who had abandoned MHN due to burnout.

> … *she dropped out! It warped her worldview so much. You have to find a way to deal with what's happening and to learn your limits. You need to have your self-care strategies – and if you don't have them then it's going to hit you pretty hard!"* (Interview RG4)

8.3 Language and communication in mental health nursing

As NGs entered the culture of MHN, they described learning the language of the nurses in the mental health units. This is reflected in the terminology and specific language used, communication in debriefing, use of humour, and the nursing handover. As a component of communication, storytelling also represented an important cultural artefact reflecting communication between nurses within the mental health settings.

In observing the interactions between nurses in the research sites, there were specific terms used in nursing communication. For example, in hospital site two, one nurse entered the nurses' station and announced that a consumer had 'dropped like a sack of potatoes' after she was given medications (field note 2:1). With the other nurses nodding and appearing to understand this term to mean that the consumer was significantly subdued. Another term that was used frequently was 'let's do the books.' "*Ellen asks NG12 to 'write up the books and then we'll do them'. NG12 leaves the nurses' station and returns with two red books – the drugs of dependency (DD) books and starts to open the books at specific sections and write with red pen* (field note 3:4). The specific terms or local language applied to other facets of care such as medication regimens. Katherine approached NG7 and suggested they give a consumer 'two and ten'. When NG7 asked her what that referred to, she said 2mg lorazepam and 10mg haloperidol (field note 3:4). I reflected on the language used by Katherine – as a mental health nurse, I understood this to be a term used to describe

medications, though perhaps a different combination of medications. The combination of medications expressed as ‘two and ten’ appeared specific to this unit. I could see that these were locally understood codes developed in the unit that had meaning for the cultural members there.

Language was also expressed as humour, and this was considered important within the culture of MHN – both as a personality trait but also as a form of communication within the cultural group.

> *I noticed next to the acute patient door a big red button with ‘no’ written on it. I recognised this as a joke or gag toy as I had bought one for my daughter which when you pressed it said the word ‘no’ in different and comedic ways. I was interested as to its placement near the acute door of the nurses’ station – whether nurses had placed it specifically there as a comedic gesture to symbolise what they would like to say when requests are made. I did recognise this kind of behaviour as being common in places that I have worked previously – little funny signs or jokes that were only visible to the nurses and not the consumers* (field note 2:1)

I observed later that one of the nurses pressed the button when one of the consumers made a request – the consumer and the nurse both laughed in response.

8.3.1 Nursing handover – the sacred circle

Nursing handover was described as an important artefact of MHN. This represented an important forum for debriefing, sharing of information and connecting with the other

nurses of the team. The handover between nurses had a different quality to the handover between nurses and the other members of the MDT described in Chapter seven. There were several important components of the nursing handover – the context of handover, the handover structure, and the platform of handover for recommendations, education and debriefing amongst the nurses.

8.3.1.1 The context of handover

The place of handover was considered important to the cultural group in each setting – it was important that consumers and other members of the MDT not be present. In all of the units there were similarities, in that the handover in nursing shift from night to morning, and then from the afternoon to night took place in the nurses' station. Whereas the middle of the day nursing handover typically occurred in a room away from the nurses' station. This was explained as needing a place without frequent interruptions to discuss the care of the consumers. It needs to be noted that in the research site for this study, the primary handover does not occur at the bedside – there may be other elements of handover that occurs with consumers, but this was not observed during my field observations. In previous experiences on general medical wards, I noticed the handover was often conducted at the bedside, whereas in the mental health settings of this research, this appears to occur as a nurse-only activity away from consumers and other members of the MDT.

During one of my episodes of field observations in hospital site two, I observed the process of the nurses seeking a suitable place to conduct the middle of the

day handover that afforded privacy and could accommodate all of the nurses. This is outlined in the following excerpt.

> *The nurses who were having afternoon handover wanted to know where to go for handover. The administration officer told them that they could use the room opposite the tribunal room – she said that they can't use the tribunal room itself as it has already been booked. One of the nurses objected to the room chosen for handover and suggested that they go to the 'quiet' room. She said, 'I don't want to go to the diversional therapy room, I don't want the patients to be able to see us'. Another nurse said that they couldn't use the quiet room as there was a patient sitting in there. Another nurse didn't want to go to the diversional therapy room, so the only room left was the seclusion room* (field note 2:1)

In each of the handover sessions observed, it was noted that the nurses would sit in a circle or around a table, all facing each other. The handover generally involved the nurses who were beginning their shift assembling in the space where handover would take place, with the nurses from the preceding shift taking turns to provide their handover before resuming activities on the ward. The following is an example of the nursing handover in the rehabilitation unit of hospital site three.

> *Handover took 30 minutes and was finished for 1:30pm. This comprised of the afternoon nurses going into a small lounge room in the adjacent corridor near the NUM's office – a room with a small couch and two small armchairs arranged facing each other. The morning nurses came in one at a time to provide a handover of their allocated consumers. There was*

> *a total of twelve consumers being discussed with the nurses each handing over four consumers* (field note 3:4)

Beginning the handover on time was also important in all of the units – for example, if the shift began at 07:00 hours, it was expected that the handover begin at this time also. In hospital site two, I observed the night shift discussing wanting to start handover at 07:00. It was 06:58 and they were expressing frustration that the morning staff weren't all present. One of the night shift nurses suggested they would start handover at 07:00 on the dot – even if the rest of the morning shift weren't there yet (field note 2:1).

8.3.1.2 The handover structure

In exploring the handover structure, the handover sheet represents an important artefact of the handover, with every unit utilising a variation of a handover sheet at every shift change. The nurses in each unit discussed the important information that is shared from one shift to the next, with the sheet representing the expected categories of information. Although there were some variations to the format, each unit had a number of similarities. The handover sheet had the names of each consumer printed on the sheet under the corresponding room number they were staying in. Some units included pre-determined notes or information typed onto the handover sheet whereas other units presented blank sheets with just the demographic and room details of each consumer. In the rehabilitation unit, the handover sheet is double-sided and has in the left column the name, medical record number, age, diagnosis, legal stats, leave structure, care coordinator and PPRM date. The right-hand

column of notes generally related to rehabilitation goals and any other key points and was blank to allow for notes to be written. This format is outlined in *Figure 10.*

Room number	Name, age, diagnosis, legal status, leave, care coordinator, PPRM date	Rehab goals, support plans, appointments, physical health, mental health, med changes/adherence, risks/challenges, family, personal/environmental, strengths, resources, employment/study
1		
2		

Figure 10 - the handover sheet in the rehabilitation unit

In comparison to the rehabilitation unit handover sheet, the hospital site three, unit A, had a different format outlined in *Figure 11*, with the handover guided by the information outlined in each column.

Room	Name, age, date, doctor	Diagnosis	Assessment	Current mental state and risk	Leave	To-do, appt's,
1						
2						

Figure 11 – handover sheet in hospital site three, unit A

Central to learning about the prevailing culture was observing the nursing handover to determine what the nurses in each unit considered important to handover to the next shift, as well as the kind of language and aspect of care that was relevant to the unit. In the following example, the nurses in hospital site

one, were observed providing handover from the morning to the afternoon shift. The handover took the following format:

> *Each consumer was handed over by their name, care level, legal status, leave status and diagnosis. Then a brief handover followed – typically referring to how the consumer slept* [the handover from night staff] *and some brief description about the consumers' actions over the day. It seemed typical to describe the consumers behaviour and add a value to that behaviour. For example, "*[consumer name] *was really demanding and kept making requests, she has some real personality traits"* (field note 2:1).

A similar format was observed in hospital site two. This handover occurred from the night shift to the morning shift.

> *In hospital site two, the night shift nurse commenced the handover for the acute side. She introduced each person as – bed 1, then name, then a description like 'he's the guy… or she's the lady who…' and emphasised content related to the consumers mental state using terms such as tangential, irritable, responding, level of profile on the ward – high profile or low profile. To emphasise something the term 'plus, plus, plus' was used. She then finished each consumers' handover with any outstanding tasks to complete or recommendations for care* (field note 2:1)

I noticed differences in the handover between each of the units. The emphasis in the acute wards was on a structured ISBAR process, whereas in the rehabilitation unit this was more relaxed – other than introducing the consumer by name followed by room number and diagnosis. NG7 offered that "*all*

consumers end up being care level 4 and it doesn't really matter what their diagnosis is, the point of rehab are their goals and a recovery focus" (field note 3:4). The handover in the rehabilitation unit comprised a narrative of the consumers' day including their activities and how these aligned with their goals. This then included elements of the consumers' mental state, their attendance to ADLs, or any plans or appointments coming up (field note 3:4). In the OPMHU, the handover also included the ISBAR format and had more similarities to general nursing settings as opposed to mental health settings. The handover in the OPMHU was a blend of describing behaviours and pointing out the diagnoses and interventions, with discussion around the physical health needs and medical conditions relevant to the consumers (field note 3:3). In addition to having the correct focus for the handover, new members to the cultural group also had to learn how much information to provide. For example, the following excerpt outlines the experiences of a new nurse providing a nursing handover:

> *Some of them can roll their eyes and be like cut to the chase. I hate to cut to the chase! I really hate the whole… I mean I do agree that handovers need to be succinct, but I don't feel like it's fair to not mention everything in a way… and that's another thing that they don't teach you at Uni, to know how to handover and know what is relevant in a handover. Because it just seems to be every time you join a handover with a different set of nurses, you find that everyone wants to hear different things. Some people want to hear nothing, and some people want to hear everything, and will get upset if you didn't hand a specific thing over because they're probably not going to read the notes and see it there* (Interview RG2)

The interesting aspect of this experience was in identifying the differences in expectations for different groups of nurses and what is deemed necessary for the handover process.

8.3.1.3 Recommendations, education and debriefing

The MHN handover also fulfilled other functions such as providing opportunities to explore the recommendations of care, provide peer education as well as offering the chance for the nurses to debrief about their experiences over the shift. In the nursing handover in hospital site two, the nurse handing over recommended that a particular consumer be locked out of their bedroom and to use IMI medications if needed. This was for a consumer who was hysterically laughing to themselves (field note 2:1). Another example of recommendations included – *'if he is settled, he can go to the subacute side, if he is unsettled give the IMI medication that is charted'* (field note 2:1). The approach or level of tolerance was described as being dependent on the intended outcome. For example, in hospital site two, one nurse advised the other nurses what she would like to achieve. *"'I want to keep him voluntary so we can discharge him'. She gave the impression that there is sense of control, or a subjective line of tolerance depending on the desired outcome"* (field note 2:1). During one episode of handover in hospital site two a critical discussion around care strategies ensued. This is described in the following excerpt.

> *One of the consumers handed over in hospital site two led to critical nurse discussion. This consumer was the father of a known consumer on the ward. The nurses were discussing whether his daughter – who had*

been described as a prior and difficult consumer, would be allowed to visit on the ward. They described her as being difficult to manage and had an established management plan. It was hypothesised that this difficult consumer might try to harm herself when she visits the ward – "just because she can… she would do it out of spite". The concern was raised on how to manage this difficult situation. NG4 offered that difficult or abusive patients or family members can be banned from entering the unit if they pose a risk to patients or staff. The staff all brought up hypothetical situations that could or would occur if this former consumer visited her father on the ward. They suggested that she would bring a weapon to the ward and harm herself significantly because she could – resulting in needing an admission. The staff discussed potential wards for admission such as one family member in the PECC unit and the other in the IPU. The nurses resigned that even if all efforts were made to separate the patients, that the consultant psychiatrist would make the final decision anyway and could choose to admit the two related patients to the same unit if he or she wanted to. One nurse offered that if she brought a knife to the ward then the police would have to be called. Then this turned into a hypothetical situation discussion that if she brought a knife to the ward, the police would be called, and that the consumer would be arrested. The staff then favoured this idea saying that she would then be in gaol where she belonged. I got a strong sense of counter transference towards this woman from the nurses on shift, and a perception that all of her behaviour was malicious and deliberate (field note 2:1)

In observing this interaction, it was interesting to note that the conversation generally occurred between four out of the seven nurses on shift – with this discussion amongst the less experienced nurses – with less than five years of mental health experience, who happened to have the more dominant personalities or presence on the shift. The other three nurses who were more

experienced were going about their clinical work. This view contrasted from the initial interview with RG2 who felt that the more restrictive and punitive approaches to care came from the nurses with more than ten years of clinical experience.

The forum of handover also represented an important place for nursing education – particularly in shaping the new members in delivering handover in the desired way and using their handover as the forum to provide education. I noticed in hospital site one, when one of the more experienced nurses handed over, none of the nurses commented, but when NG13 provided handover, occasionally the nurses would ask her to clarify some information or to help her articulate some of her ideas.

> *When NG13 described a consumers' actions, Sarah or Ella would offer an explanation for that behaviour and NG13 would select the more accurate explanation for her description. Such as, when she reported a consumer as not having suicidal thoughts and being safe, Sarah said "I thought she was admitted for mania?", NG13 clarified that the consumer was trying to tell NG13 that she didn't currently feel suicidal, that that had occurred on a previous admission* (field note 2:1)

My personal reflection was that NG13's handover did not give an impression of a consumer admitted with mania as her focus was on the consumer not feeling suicidal rather than referring to mood or behaviour elevation. In exploring the experiences of NGs, RG2 explained that providing handover was a difficult experience as a NG. "… *being the inexperienced person, and not always being*

confident with my assessment sometimes, you can get really nervous in handovers because you're thinking 'ooh is what I'm saying accurate? Am I picking up on the right things here? What have I missed? I'm sure I haven't mentioned the risks…' (Interview, RG2).

Using handover as a forum for debriefing appeared to be an important artefact of each unit. When Sally in hospital site one handed over, she had three consumers to handover, of which the first consumer took fifteen minutes to handover with the remaining two consumers handed over in around one minute each.

> *Sally said, "oh my gosh, you do not want to work on acute, it's crazy". She seemed to handover in a way that conveyed debriefing. She spoke of a consumer having challenging behaviours and referring to them as being personality-based – and followed that with her having a history of 'CSA'* (child sexual assault)*. She described this consumer as being dependent, needy and difficult to manage. The handover conveyed a sense of debriefing and conveyed to the nurses the difficulty they may face on their shift* (field note 2:1)

Ironically, the remaining two consumers that Sally handed over had schizophrenia and were considered highly unwell, but only required one minute each to hand over. With a sense that the detail provided on the first consumer was more than what was required for the transfer of information, it involved repeating and describing different facets of the same content. It appeared to be an important activity for this nurse to complete to process the experiences she had had on the shift.

In considering the role of debriefing, NG6 offered that nurses faced challenges when there weren't enough opportunities to debrief, with this affecting the way that they as nurses viewed consumers (Interview NG6). The concept of debriefing and discussing the consumers was reflected by addressing the negative behaviours consumers might have and using labels such as "PD" to describe them. Participant RG2 spoke about the focus of handovers to discuss consumers as being PD's. She adds, "*whenever there's a PD being handed over, it's actually more of a debrief than a handover and because usually they're quite keen to tell you about the patient"* (Interview, RG2).

8.3.2 Story telling

Storytelling represented an important artefact for nurses and was observed frequently within the units in various interactions including handover and general conversations – with new nurses introduced to this practice. An observation made during the field observations is that there is a cross-over of information between hospitals and units. A number of the nurses had worked in other units and hospitals and share the stories form those places with each other – these stories included comments on the unit, the staff, the consumers, the management and other aspects such as lifestyle and parking. Sharing stories appears to hold significance in the culture, with this information shared with new members. For example, in the rehabilitation unit I observed two experienced nurses and a NG in conversation around their clinical experiences. The emphasis on the conversation was in discussing the units that were renowned for aggression and sharing their stories of those units (field note 3:4).

The expectation was that nurses will encounter aggression in mental health units, however, in some units this was more likely. When I was asked if I had ever been assaulted in MHN, I had said no, not in my whole career of MHN. One of the senior nurses look at me incredulously and said, *"in over ten years you've never been assaulted? Not even once?"* and I had said no (field note 3:4). It was considered an expectation that nurses in mental health settings would be assaulted. They discussed the nature of the units and the reasons for assaults or aggression such as the units being too large, and consumers being directly admitted to the unit instead of first going to the emergency department. I observed the following account of storytelling whereby the NG of the unit listened as the nurse explained.

> *The nurse in charge then brought up an incident that occurred on the weekend where a consumer was admitted who was unknown. He asked the nurse if he could go out for a cigarette saying that the emergency department staff told him he could, and when the nurse said there's no smoking and he had no leave, he head-butted the nurse. He described that nurse as being assaulted severely. He mentioned that after this occurred, they noted that the consumer had a significant forensic history* (field note 3:4)

Despite the NG mostly listening to the two experienced nurses talking, she also offered her experiences from completing a rotation in the MHICU. Both nurses had also worked previously in the MHICU, so this became a place of common ground to discuss experiences and approaches to care.

Sometimes the story telling is used to warn staff members of other units or staff (Field notes 3:4). In exploring the use of storytelling to discuss units and sites, one participant considered returning to a unit in another hospital, however in speaking with her former colleagues there, she was warned about the current nature of the unit. *"I've thought about going back, but I have a lot of friends there who have said that it's gotten much worse. Attacks are daily. We are talking about people* [nurses] *getting their teeth kicked out… things like that"* (Interview RG4).

Story telling was also used to provide historical context and educate NGs about the culture of MHN. At hospital site one, a nurse spoke about how different the experiences of current NGs are compared to when she had been a NG eight years previously. She said out loud, *"remember when we were all about fighting for our rights…? If there were any issues, we would be straight into the NUM's office… now if there's an issue, just resign and go casual"* (field note 1:1). She pointed out that when you have a mortgage and a family you cannot afford to fight for your rights. She said she would encourage the new nurses to fight for their rights but would warn them that if they like their job, they should be careful.

The nurses within the research site also appeared to use humour or re-enactments in storytelling. On one occasion I observed some nurses in hospital site two laughing as they discussed some of the activities that they had observed consumers engaging in.

> *Emily came into the nurses' station laughing and was telling the other nurses about a consumer who was laughing to herself. She discovered that the consumer had voices that were being funny and making her laugh – this appeared to be infectious as Emily came into the nurses' station laughing as she recounted the story* (field note 2:1)

Another nurse also described other clinical experiences that were considered humorous. She asked me if I had met John and told me he was one of the best consumers on the unit and explained the following.

> *She pointed out that when John wasn't agitated, he was hilarious and grandiose – he had 'millions of dollars' and said he would give her a million dollars. The HASA said he told her he would pay off her house and the NIC said he also said he would give her money too. They all agreed that it was wonderful that he would want to give them all money* (field note 2:1)

Sometimes the storytelling also involved acting out the scenario in addition to telling the story. I observed one nurse entering the nurses' station and explaining that the consumer spoke a different language to her, and that she could not understand what the consumer was saying. She re-enacted the scenario whereby a consumer opened the bedroom door, spoke unintelligibly and then closed the door quickly again. The nurses observing the re-enactment laughed and nodded in agreement at her account of the interaction with the consumer (field note 2:1).

8.4 Nurse relationships

The relationships developed between nurses appeared to play a significant role in the culture, with this emphasised to new nurses as they entered the cultural group. Across all three hospital sites there were different ways that the relationships between nurses was observed. In hospital sites one and two, and the rehabilitation unit in hospital site three, there appeared to be a higher level of cohesion between the nurses. Whereas the remaining units of hospital site three seemed to have strained relationships amongst the nurses. This seemed to affect the experience of the participants, with NGs indicating that they felt less attracted to these units. Exploring nurse relationships also involved exploring the nursing hierarchy, social relationships, and the teamwork approach to care as shared decision-making.

8.4.1 Nursing hierarchy

The rank of the nurses of each unit was presented in different ways – with some units emphasising rank more than others. In New South Wales, the Nurses Award outlines the different ranks for nurses. For this study, the relevant nursing ranks included Assistant In Nursing – AIN, Endorsed Enrolled Nurse – EEN, Registered Nurse – RN, Clinical Nurse Specialist – CNS, Clinical Nurse Consultant – CNC, Clinical Nurse Educator – CNE, and Nurse Unit Manager NUM. Within each of these roles, there were also hierarchies based on years of service. NGs represented the role of RN in the rank – RN1 or NG in the unit. RNs range from year one (RN1), to the eighth year and thereafter (RN8). Once

nurses reach their eighth year of clinical practice as an RN, they have reached the highest pay rate unless moving into a more senior or specialised role.

The NG was represented in different ways within the hierarchy. Each unit had a roster determining the shifts that each nurse would be assigned. This is an important document in identifying who is present on each shift and who is working on the unit at any given time. The rostering system remains a powerful artefact in the presentation of nursing rank, which was evident in all of the settings in this research. In all six units, NGs were typically at the bottom of the nursing roster for RN's and in some rostering systems, distinct from the other RNs in their own category. The roster itself was generally set out in a hierarchical fashion with the most senior members of nursing at the top of the roster. The one difference in this ranking was that in three units, full-time nurses were at the top of the roster with part-time nurses in their own category below the NGs. Within the RN component of the roster, nurses were arranged in their rank in four out of the six units. Interestingly, hospital site one and the hospital site three rehabilitation unit did not arrange the nurses by rank on their roster, with hospital site one not revealing the year rank of the nurses (other than nursing category) at all.

It was also interesting to note the purpose of the rostering in identifying the skill mix of nurses. One nurse in hospital site one spoke about the term *skill mix* and said she had hated it when she was a NG, and they would refer to a *crap skill mix* – which meant too many junior nurses were on the shift. She added that

"they would never say it was you, but you knew it was because you were one of the junior nurses on. The NUM would say it's not my fault, but I would still feel inadequate" (field note 1:1). There were different ways that ranks were emphasised for NGs during their NGP. Nurses in hospital site one outlined the limits that were placed on NGs. For example, NGs were not usually allowed to hold the S4D/S8 keys – despite being RNs. Two participants had different experiences of this, one able to, and one unable to, hold the keys as a NG even though they had completed their NGPs only one year apart. This may be explained by differences between units (field note 1:1).

In respects to hierarchy and rank, the following participant described feeling intimated when entering the medication room in hospital site two if senior nurses were in there, stating that it was quite small, so it was difficult to take the time needed to complete medication dispensing. Though interestingly, this scenario referred to nurses who were only a couple of years ahead of him in rank.

> *Like the medication room, there's no room and all that, and as a new grad you feel you're junior you can't really go in there cause all the seniors are in there. You just feel pressured* (Interview RG1)

Hospital site two and the OPMHU in hospital site three, appeared to emphasise and value the ranks of the nurses more so than other units. I noticed in OPMHU a stronger hierarchy among staff. Some wards seem to have a stronger hierarchy whereas in other wards it's much less visible such as in the

rehabilitation unit (field note 3:4). Each unit also had different ratios of nurses, with the rehabilitation and OPMH units having a higher number of senior nurses (the majority above RN8). One of the reasons suggested for this by an experienced nurse was that "*the younger nurses were drawn to the acute units where 'all the action is'…"* (field note 3:4).

Nursing hierarchies were present in other ways too, such as in terms of MHN experience and personality. Some nurses in each unit were more dominant regardless of their rank. In the OPMHU, I noticed the interaction between an EEN with NG3 and an RN3. The RN3 was the nurse-in-charge, but the EEN had many more years of clinical experience. Despite the higher rank of the RN3 and their NIC status, the EEN was the more dominant nurse on shift and directed many of the clinical activities.

Nursing hierarchy could also be used negatively in the treatment of new nurses. In the following example, I observed the interaction between NG3 and the experienced EEN in the OPMHU. In providing care for a consumer, a urine sample needed to be taken to the pathology chute in the next building. The NIC offered to take it, but the EEN told her that NG3 should take it and stated, *"we need to wear the young ones out first"* (field note 3:4). The NIC was relatively new herself and appeared uncomfortable about this but did not challenge the more experienced nurse. The EEN did not relay this exact wording to NG3 but asked him if he had done a urinalysis before and despite him saying yes, she handed him the tub with the collected urine, asked him to sign the form and

take it to the pathology chute (field note 3:4). I found this interesting as reflecting on nursing practices, generally the person who collects the sample should label and sign the specimen and then sign the request. Later when I did the interview with NG3 he told me the 10am nurse (the shift the EEN was doing) is the 'run-around' nurse. In this case, the EEN should have been the nurse to take the urine sample to the pathology collection point and NG3 was aware of this. During a later episode of field observation, the RN3 and NG3 were discussing staff dynamics and spoke of the challenges in being rostered on with shifts where there is tension between nurses. They spoke about being on the receiving end of challenging behaviour from nurses with the RN3 looking at NG3 and stated, *"you would know all about that!"* referring to the incidences described earlier in this paragraph (field note 3:4).

Interestingly, I noticed an encounter with the same experienced EEN from the OPMHU and an RN8 who came on shift in the afternoon. Despite the EEN being the dominant member of the team in the morning, the dynamic changed when the RN8 arrived on the evening shift, with the interaction described below.

> *I noticed a big change in the EEN's behaviour when the afternoon RN came on shift – the afternoon RN8 was the dominant nurse and the EEN retreated. It was a very powerful moment and difficult to watch. When EEN was fumbling about and getting sheets for handover, the RN8 was glaring at her with bulging eyes and making a mild mimicking motion with her lips. I saw NG3 and another nurse look away quickly. I remember the less experienced nurse and NG3 saying that the biggest things to watch for are personality clashes between nurses and that the shift can drag on*

> *and become very awkward when you are rostered on with two nurses who don't get along. I wondered if that situation that I just witnessed was one of those encounters that NG3 and the other nurse had mentioned* (field note 3:4)

A similar experience of the more dominant nurse directing clinical activities was observed in hospital site two. Erin was an RN2 and appeared to be the most dominant and outspoken nurse on the shift, despite the NIC being an RN5. The more experienced nurses were NG4 and an RN8 who went quietly about their work (field note 2:1). This made me think about the power dynamics within the units, the NIC or most senior nurse is not always the most dominant nurse or the recognised leader in the unit. In reflecting on the balance in nursing ranks on the unit, participant RG5 emphasised that: *"it's good to have a blend with senior and junior nurses working together",* but added, *"… as long as there's no powerplay happening… as long as the senior is not bossing the younger ones* (Interview RG5).

The role of the NIC is an important cultural artefact and was described as the representation of competence and skills. In this research site, NGs were generally not given in the role of NIC – although as an RN, they are able to perform this role. However, in the rehabilitation unit, NGs were able to fulfill the role of the NIC and were mentored in the role. In discussing the allocation of NGs to the NIC role, a nurse in the rehabilitation unit explained that it is a good opportunity for NGs to learn those skills while being supported by the team. This was a process determined by the NUM and when it was deemed that the NG

was ready for this role, they were then supported into taking on this role. It was explained that not every NG would be ready for this role and that it was important to wait until they were ready. It was made clear that the NIC completes the following activities in addition to their usual clinical duties.

> *… they allocate the patients, coordinate the shift, ensure all diary jobs are completed, ensure meals are assisted with and staff are coordinated with breaks; if a patient starts to deteriorate then it may mean facilitating a transfer to the IPU; if there are sick calls then it may mean organising replacement staff. They also need to do the drug check with the next shift. This involves getting the s4 and s8 registers and writing in the date, time, checked, count number and then signatures of two staff members. The nurse finished this off by saying, they need to do this on top of a clinical load* (field note 3:4)

Typically, the role of NIC in most units did not occur until the nurse was in her/his second year or later. When speaking to NG7 about her experiences and what she finds challenging in her role, she mentioned being the NIC and coming into a new workplace as a NG. She said she felt a little overwhelmed by being in-charge, added that although she feels apprehensive, she feels supported. She felt that being given the status of NIC as a NG made her feel accepted and included into the team (field note 3:4). She also said that there were always experienced nurses around and that they would help her when she was unsure what to do – *"they tell me what I need to do"* (Interview NG7).

The NIC was represented by artefacts in the nurses' station in each unit. In some units there was a computer designated for the NIC. In hospital site three,

unit A, the computer had a sign above that stated, ‘in-charge computer, do not use’ (field note 3:4). Despite the need for other nurses to share their computers and sometimes wait for an available computer, the NIC could always have access to their designated computer. RG4 spoke about an experience of using the NIC computer.

> *They’re really territorial about computers – the shift leader would have their own computer. I remember I logged in once to check emails and I was only taking two seconds and the in-charge came over and he was like, “what do you think you are doing as a new grad using the shift leaders’ computer?” He said, “ha, imagine you in-charge, it would be like the blind leading the blind!”* (Interview RG4)

In respect to power dynamics, during earlier field observations, I noticed in hospital site two the more senior nurses staying at the nurses’ station and the less experienced nurses being requested to stay out on the floor. I found the nurses have an interesting dynamic in hospital site three, unit A. During the sessions I attended, I observed that the nurses who are not in leadership positions of power mull around and wait for instruction or come to the nurses’ station and wait to be directed to leave again – rather than leading or initiating activities. It is almost like the nurses were not sure what to do next. This is demonstrated by the following excerpt.

> *The NUM walked in and said “why is everyone in the office? Everyone go out on the floor, go and spend time with the patients”. The nurses were kind of standing around not doing anything specifically – looking as though they weren’t sure what to do next. Two nurses walked out of the*

nurses' station and started walking down the corridor – they looked as though they were trying to find something to do – wandering aimlessly (field note 3:1)

8.4.2 Social relationships

Varying degrees of importance were placed on the development of social relationships between the nurses in the culture of each unit. Participants described the development of social relationships as important to the culture of MHN – though emphasised that this was more prominent in some units than others. In Chapter five, participants noted that one of the attractive qualities of MHN were the relationships among mental health nurses.

Social relationships were observed to manifest in different ways. A common activity was nurses eating together. Although each unit had a dedicated tea-room for nurses, it appeared commonplace for nurses to either eat at their desk or to share food such as takeaway food or coffee at the nurses' station. As part of their socialisation to the culture, new nurses were encouraged to eat together with the existing nurses in each unit. I noticed in most units that there would be cake, biscuits, or some other food on the table in the nurses' station which the nurses could eat. The nurses appeared to use the social relationships and sharing of food as a forum for debriefing before stepping back out into the clinical areas to work. This appeared as eat, talk, prepare self and then address clinical matters.

Another way in which social relationships were emphasised was in the ongoing conversations amongst the nurses. For example, in hospital site one, there appeared to be a strong bond between the nurses. It seemed to be commonplace for the nurses to engage in conversation as they go about their work. This appeared to be conversation around their personal lives and seemed to be on an equal level with all nurses interacting equally (field note1:1).

> *The majority of the nurses on shift were in the nurses' station. The atmosphere was relaxed, the staff were jovial and engaging in casual conversation. They were conversing as they were going about their tasks, such as checking EMR notes or ticking off boxes on the observation sheets* (field note 1:1)

RG16 explained that in hospital site one there was a good relationship between the nurses and added that he also had a good relationship with the other nurses.

> *…my relationship with other staff members, I feel is really good and I'm confident that, you know others feel the same about all of us including me. Because we've got an extremely, it's probably unique in some ways (laughs), because we really get on well. A lot of people socialise together* (Interview, RG16)

The importance of the social relationships was explained by NG12. She explained, *"if you're friends first then it's going to be a joy to work in the place. It's a bit of a drinking culture* [here]*! It all brings people together you know, so it's good"* (Interview NG12). This same participant described the attraction of the

acute units relating to the younger nurses that tend to be in those units. Although she described the rehabilitation unit as having a positive work culture, she preferred the relationships she developed in the MHICU with the younger nurses. *"There* [in the MHICU] *the nurses aren't 40 years old and looking down at me… we did everything together"* (Interview, NG12). Participant RG4 also described the importance of the relationships developed in the cultural group.

> *I found particularly with my new grad, they* [relationships] *were so important. I've become really close with everyone I work with. Only because you're in the same boat and they're the people you vent to. You're on the ward, you haven't gone for your morning tea break. People* [consumers] *are cranky, they're at you… it's full on. But you can come back into the staff station and debrief. It's so therapeutic and helpful to have someone who you can talk to* (Interview RG4)

In exploring the social relationships, one of the nurses who was in her eighth year of nursing referred to herself as an "oldie" and said that they do not get invited to the social events by the younger nurses. It was interesting as I remembered this nurse when she was a NG, and she was still quite young (mid 30s). She pointed out that in the "old days" she and the other established nurses would coordinate the social events and now the younger and newer nurses organise them and do not invite the senior staff – she added, "*I think it's because we're boring now!"* (field note 1:1).

I observed the nurses in hospital site two engaging in casual conversation in the nurses' station. After handover concluded, one nurse was handing out

invitations for a personal event and was inviting some of her colleagues to attend. They appeared to be grouped together and giggling (field note 2:1).

In exploring the value of social relationships of the group, I noticed in hospital site one that NG8 wasn't really interacting with the other nurses. During her interview she explained that she was too busy to talk to the other nurses and also didn't want to reveal personal details about herself, adding that sometimes people can be judgemental (field note 1:1). In comparison, the other nurses seem to be closely bonded and she seems to be on the outskirts – she sat alone writing notes, sat out in the lounge area with the consumers and then took her break away from the ward in the tea-room by herself.

8.4.3 Teamwork approach – nursing collaboration and shared decision making

One of the things that was evident in the mental health units was the shared approach to care. This involved collaboration and the sharing of views, opinions and approaches to care. This was described by the participants and nurses within each unit as an important artefact of MHN and of their work. As participant RG1 explains:

> *If you're not sure about something you can just ask someone. We work together, so they'll come out with you if you need help like with a bad conversation… or if you think a client is not going to react too well* (Interview RG1)

RG16 explain the importance of teamwork for both the new nurses entering the group as well as the more experienced nurses.

> *... you have that confidence, even if you may be a senior staff member on any shift, you feel that the confidence that has been instilled in the more junior staff members which enables us all to sort of carry each other through the shift. Because we know we back each other up very well. We communicate well… communication is definitely the key, and it makes things run smoothly* (Interview RG16)

One aspect of teamwork was in discussing the allocation of tasks for the shift and inviting the opinion and involvement of the other nurses on the shift. For example, in the rehabilitation unit, NG7 was the NIC and was consulting the other nurses to determine their preferences for the shift.

> *NG7 started the process of organising the morning and allocating tasks. She asked who wanted to have what break and who wanted to run the group. NG7 also brought up the topic of cooking group – she asked if anyone wanted to run the cooking group today and what they should cook. I noticed that the discussions that occurred this morning within the team reflects that bonding within the team – the team bond and plan their day* (field note 3:4)

Part of the teamwork approach also involved shared decision making. Clinical decision making tended to occur at the nurses' station away from the consumers. In other health settings this conversation was more likely to occur at the bedside. In the mental health units included in this study the nurses tended to determine the course of action and then advise the consumer of the

outcome. An example of shared decision making I observed was when Anna, a new EEN asks the NIC, *"what's happening with the new admission? She's really paranoid, she wants to leave, and she keeps staring at me. What do I do? She wants to know if she's voluntary or involuntary"* (field note 2:1). The NIC then worked with Anna to explore options.

In the rehabilitation unit, the experienced nurse and NG7 worked together to determine a treatment approach for a consumer.

> *One of the consumers walked past the nurses' station yelling loudly. He was yelling (responding to internal stimuli) and seemed quite frustrated with his experiences. NG7 was looking after him and was checking what medications she could give him. Ellen jumped up and asked him if he was feeling okay, he said "it's the voices, the voices… can I have PRN meds? I don't care which, whatever I have." NG7 checked the charted medications. There was promethazine, diazepam, and haloperidol charted. NG7 didn't seem sure as to what medication would be the best. Ellen suggested haloperidol at 10mg. Ellen then suggested she add the promethazine 25mg too – "to get on top of things and to nip it in the bud"* (field note 3:4)

One interesting feature of the process of shared decision making involved supporting the other nurses once a decision was made – even if the nurse did not agree with the decision. This was described in the following situation in hospital site two.

> *Two nurses started a conversation around a consumer named Angela. One nurse said, 'Angela is mad, I'm getting her PRN'. Two nurses walk from the medication room to the nurses' station with a kidney dish and blue gloves on. Another nurse jumps up from her computer when she notices them and says, 'what are we doing?' The nurses came together to prepare to give an injection to Angela. One nurse said, 'let's just get it done'. This activity involved four nurses, the NUM, and the HASA. The reason they said they were injecting Angela was because she had been refusing oral olanzapine and she was hysterically laughing. The nurses all walk out together as a group and one nurse is holding the kidney dish with the injection. The other nurses seem to be there as support or if the consumer requires restraint to be given the medication. One nurse points out that Angela has refused oral medications all day. Now they are just going to inject her to ensure she has the medication on board* (field note 2:1)

A similar occurrence occurred in hospital site one with the nurses discussing the medications that they should give the consumer and how to best manage the care of the consumer. The disagreement was evident related to the interpretation of the consumers behaviour. One nurse felt that the challenging behaviours were deliberate while the other two nurses felt that they reflected the consumer's mental illness. The first nurse appeared irritated by the other two nurses and said, *"I'm sorry, but I'm not going to put up with that behaviour!"* (field note 1:1).

Similar to the nurses describing the need to 'be on the same page' and make decisions collaboratively, there was also a sense of ensuring that the nurses supported each other. For example, when a consumer came to the nurses'

station in hospital site two, he knocked loudly and appeared irritated. He requested a particular nurse and when questioned about this, he said he wanted to chastise her for “checking on me every five minutes and harassing me!” The nurse who answered the door then closed the door and engaged the consumer in conversation instead of asking the requested nurse to speak with the consumer. The nurse in question appeared shocked and told another nurse that she only went in his room a couple of times to complete the care level rounds (field note 2:1). The approach appeared to be from a team perspective with another nurse diffusing the situation.

Although the nurses generally described the teamwork approach in a positive way, they did describe some negative aspects of the approach. One of these was when the other members of the team were not available or able to help. During one episode of field observations a nurse turns to me and asks me, *“where all the other nurses from the subacute side are – she says doesn’t need them right now but says she is frustrated that she’s managing the subacute side herself and has to cover everything”* (field note 1:1). This nurse then realised that NG8 was in the lounge area speaking with a consumer. She explained that NG8 deciding to stay in the common area with the consumers put more pressure on the other nurses, as they would have to answer the phones, the door and the requests of the consumers – which was described as a burden. Participants emphasised the importance of teamwork in MHN. This was from the perspective are having clear expectations for consumers and other members of the team, but also from the perspective of safety.

Participant RG4 emphasised the close relationships and dependency you might have on your colleagues. *"Mental health is very team-based… if you're in a restraint and relying on your colleague to hold that leg or to hold that arm or to give those meds!"* (Interview RG4). She then gives an example of being in a restraint with another NG who was injured. *"Another NG that I worked with, and I were in a restraint for this 14-year-old girl. We were both on the legs and she got kicked in the teeth – lost two of her teeth. Then she got kicked in the chest and shattered her ribs and chest and stuff. I felt pretty guilty because I was on the legs with her"* (Interview RG4). This participant had emphasised the need for trust and teamwork in the relationships in MHN.

Some NGs found the concept of a teamwork approach difficult, especially if they wanted to focus on the care of the consumers to whom they were assigned. Participant NG6 stated: "*I find it difficult to work in a team. You want to get something done but then you have to have to make sure other people have time too – so you work as a team. I say because I'm an individual or I'm better in that way so I kind of need to make sure that I make my time* (Interview, NG6). However, when nurses in the team worked differently or did not collaborate, this was described as creating problems. For example, participant RG1 stated, *"on the ward there are a lot of rules… some people stick to the rules to a T, others don't, which can lead to personality clashes"* (Interview RG1).

8.5 Assimilating new members into the culture

In the process of assimilating new members to the cultural group, the existing culture seeks members who are deemed compatible with the culture and have the characteristics desired by the group. This phenomenon was described both by the participants and the existing nurses within the research sites. Participants described the importance of being accepted into the cultural group. As previously discussed, participants described MHN as having a teamwork approach. Therefore, it was emphasised that being accepted is an important aspect of the NG transition – this relates to the NGs' sense of safety and inclusion. This relationship was identified as being important to both the NGs and the cultural group – the NGs need to feel safe, but the existing cultural group also need to have trust in the new nurse.

The NG seeking acceptance also related to securing employment after completing the NGP. This is because the NGP is a one-year temporary position and all NGs needed to apply for ongoing positions after completing the program. Participant NG8 explained the stress of gaining employment after completing the NGP as there was no certainty of a position, or of ongoing income. She explained that with family and mortgage commitments, this presented as an ongoing stressor (Interview NG8). It was also emphasised that there could be challenges in gaining a position in the field of MHN as there were a finite number of positions in relation to the number of NGs completing the program. She added that last year in hospital site one, there were six NGs needing a position with only two of them securing a permanent position, with

the rest employed as casual nurses and added that things might be worse this year *"… it makes me want to cry"* (Interview NG8). She described attempting to prepare herself for a position after her NGP and emphasised wanting to know what would make her more employable.

The speed of entering the cultural group differed for each NG. NG6 explained that for her first two days she felt like an outsider and then started to feel as though she was being included and accepted within the cultural group (Interview NG6). In exploring the process of becoming included, NG6 said taking the time to talk and get to know the other nurses was a way of being included into the cultural group. She pointed out that the nurses would also take the time to help her settle in and to help her – this would include giving guidance on her clinical approaches (Interview NG6). RG1 also explained her experience of entering the group.

> *They* [the culture] *are a tight-knit group, so sometimes you feel like you're coming in. They've been together a while, they work together, they know how each other work. But I feel like over time it's not too difficult to fit in* (Interview RG1)

She added that there are ways to determine if you're being included in the cultural group. *"I think when you talk to them more, they feel more comfortable, and they maybe put a bit more trust in you"* (Interview RG1). Participant RG5 spoke about the inclusion of new members from perspective as a previous NG and an established member of the cultural group. *"You've got to have a bit of*

edge about you... You've got to ask questions. You've got to be enthusiastic and get amongst it" (Interview RG5). She added that some new nurses are quiet and sit on the outskirts and stated that that is an issue. This participant then discussed the current NGs and the NGs from the previous year who had left the cultural group to illustrate her point. She identified the traits that these NGs had or didn't have relating in their ability to fit into the culture.

In observing the interactions between NGs and other members of the cultural group, I noticed differences in how the nurses interacted with each NG. I noticed for example in hospital site one, that NG13 had a stronger relationship with the nurses than NG8. NG13 appeared on several sessions to be laughing and joking with the other nurses, whereas NG8 appeared to work alone or spend more time out in the clinical areas with consumers rather than interacting with the cultural group (field note 1:1). NG8 explained that she did not want to spend too much time talking with the other nurses because she did not want them to know about her personal life (Interview NG8). Similarly, in hospital site three, rehabilitation unit, I noticed a difference between NG7 and NG15. NG7 appeared to be spending a lot of time with the other nurses whereas NG15 sat quietly in the nurses' station and did not appear to be conversing with the other nurses (Field 3:4). I was able to observe both NG7 and NG15 at the same time due to being rostered on the same shift as well as observing their interactions separately.

8.5.1 Assimilation – becoming a mental health nurse

The most defining moment for NGs becoming mental health nurses appeared to be when they gained a position in the cultural group on the completion of their NGP. However, during the NGP, there were indications that the NGs were being accepted. This included being invited to social events, being included in the general conversation and being given more responsibility. The emphasis was on the increased responsibility as it related to having confidence in the abilities of the NG. This finding was emphasised by participant RG16 who explained that NGs know they have been accepted when *"they are given additional responsibility and included in decision-making processes"* (Interview RG16). Participant RG4 gave her experience of knowing she was accepted into the cultural group.

> *You know the whole restraint where I got to go in and give IMI's and stuff? They* [the nurses not accepted into the cultural group] *would never get that experience. The senior nurse would be like, "oh no, you can just do care levels, that's your job for the day"* (Interview RG4)

Participant RG4 described the situation as being confronting and identified it as a *"full-on restraint with about thirty people in there"* – she added that the consumer had ripped down the courtyard door and had had a knife, had cut her throat and there was blood everywhere. She then added, "*I was the new grad, and I went into to give her the injections… it was so full-on"* (Interview RG4). This participant spoke about being accepted into the culture. "I was like wow; you want me to go in?" She added that she didn't always get time with her

preceptors, so it was hard to know how she was progressing. But she identified this as a defining moment:

> *They trusted me enough to go in there in such a powerful and high-pressure situation… I was thinking that there are thirty other people there and there were senior staff who knew this patient really well that could have gone in, but I got to go* (Interview RG4)

Participant NG7 spoke about the experience of being given opportunities to be the NIC in the rehabilitation unit. She added that although it was a little overwhelming, it also made her feel included in the culture as an equal member and gave her a sense of pride (field note 3:4). The adoption of the strengths training certificate in the rehabilitation unit was also emphasised as an indication that the new member had specific skills emphasised within the cultural group. By obtaining the certificate and including it on the wall was an indication that the new member was entering the cultural group (field note 3:4).

8.5.2 Excluding the unsuitable members of the culture

Some characteristics of NGs were considered undesirable. It was not evident that NGs deemed unsuitable were aggressively outcasted, but more passively excluded. Participants and nurses in the cultural group described this process of exclusion as weeding *them out quickly.* Participant RG2 explained that the personality of some nurses was just not suited to MHN (interview RG2). As I made notes about the activities of NG8, the nurses in the nurses' station discussed her practice and the practice of NGs in general. These nurses ranged

in rank between RN2 and RN7. They described the following within their own conversation:

> *NGs in general don't know how to do anything, even basic things like distracting someone who is psychotic… they tend to try to control the situation or to stand back". One nurse held her hands up in a defensive motion to demonstrate what the NG does… "Sometimes the new grad reacts with fear or put themselves in risky situations and don't even know it… a lot of this stuff can't be taught at Uni". "You learn as you do stuff… we don't have time to show you everything straight away"* (field note 1:1)

In the case of the participant NG8 and NG15, I observed them spending the majority of their time in the clinical areas on their own and when they entered the nurses' station, rarely engaged with the other nurses except to discuss clinical matters. This contrasted with the other NGs who were in frequent conversation with their colleagues or established members of the team. Participant RG4 spoke about the process of excluding new nurses that were deemed unsuitable:

> *Mental health particularl… staffing seems to be such a close-knit thing and then it tends to be as soon as they know you can't handle it or you don't fit in with the group, then it's like 'you're out!' I saw that a lot. Luckily for me it was an easy ride, but for a lot of new grads it was a totally different experience… this sounds terrible, but you get weeded out pretty quickly. Like there were people who I found were 100% in their niche in mental health nursing, they could deal with what was going on and their worldview was fairly unchanged… at the same time there were other people that were so turned upside down by what they saw and*

> *what they heard. I had a friend who was a NG with me, and we were on the ward together. I thought she was a brilliant nurse, and she was like, 'after this I'm not nursing ever again'* [she left the profession altogether] (Interview RG4)

Although the exclusion of unsuitable members appeared to occur within the cultural group, some new members explored their own regrets in entering the field. Participant RG2 spoke about the challenges of entering MHN and the trials she faced in transitioning from outsider to insider. She spoke of the tension between entering MHN with ideals about mental health care and improving the care for consumers and the clinical reality that to be accepted into the cultural group a NG may be powerless to change the culture and practice. This was described as *"the rose-coloured glasses coming off"* (Interview RG2).

8.6 Chapter summary

This final findings chapter outlined the NGs journey as they enter the cultural group of mental health nurses and learn the practices, behaviours, and beliefs of the group. To the culture of MHN, NGs must have the cultural group's desired qualities or traits and be able to learn the practices of managing challenging situations. New members are socialised into the language and communication strategies of the cultural group and encounter the hierarchy and social relationships which were considered important cultural artefacts. An important practice in the cultural group is teamwork and shared decision making with new members needing to work within the team's approach to care. Ongoing employment was contingent on new members being accepted into the cultural

group. Members who were accepted into the culture were given more responsibility and were included in the social aspects of the culture, while members who were considered unsuitable were passively excluded from the cultural group. An important aspect of assimilation was the new member accepting the cultural group and adopting the beliefs, behaviours and attitudes inherent to the group. Some new members encountered a clash between the values and practices of the cultural group and their own, resulting in disillusionment and feeling powerless to create change.

Chapter nine
Discussion

"Trust the wait. Embrace the uncertainty. Enjoy the beauty of becoming.

When nothing is certain, anything is possible"

Mandy Hale

9.1 Introduction

In the previous chapters, the experiences and perceptions of the participants informed by a thematic analysis framework were presented. In this chapter the major findings are discussed as they relate to the purpose of the study, which was to explore the experiences of NGs when encountering the culture of MHN, with a focus on exploring the links between the NGs and their intention to remain in MHN. Additional research aims were to explore the NGs experience of assimilating into the workplace and how they fit into the hierarchy of the organisation. This was achieved through the use of an ethnographic approach and the theoretical framework of Schein's (2010) *Model of Organisational Culture*. Through the use of non-participant field observations, semi-structured interviews, as well as field notes and reflexive researcher notes, I was able to gain an understanding of the subcultural experiences of new nurses entering the culture of MHN.

9.2 Overview of the findings

The findings from this study are outlined in *Figure 12 – research findings*. This represents the four finding chapters in pictorial form. The findings reflect the process of socialisation of NGs into the cultural group. The first of the findings chapters – *attraction to mental health nursing*, explored the attraction of NGs to MHN. Participants identified that undergraduate nursing education was important in attracting them to MHN. However, NGs encountered differences between their expectations, and the reality of clinical practice. Choosing to pursue a career in MHN presented a challenge as NGs reported stigma associated with MHN; concerns that they may not gain employment after completing their NGP; and that they may not be accepted into other nursing specialties after consolidating their skills in MHN.

The second findings chapter – *the new graduate program*, explored the experiences of NGs completing the NGP in the research site. The NGP represents a gateway into the cultural group. NGs must complete the NGP to gain employment. Despite its intention as a supportive framework for transition to practice, the NGP also represented a stressor for NGs as they were entering a new culture and at the same time as completing NGP requirements.

The third findings chapter – *entering mental health nursing practice,* explored the experiences of NGs in entering the mental health setting and learning the practices of existing mental health nurses. Despite an expectation to practice holistically, the reality was of task-based and risk-averse practices, with the

focus of the inpatient unit on maintaining safety and engaging in gatekeeping practices.

The fourth and final findings chapter – *entering the culture of mental health nursing,* explored the assimilation of NGs into the culture of MHN in this setting. As NGs chose to enter the culture of MHN they adopted the beliefs, behaviours, and attitudes of the existing mental health nurses. In turn the cultural group determined the suitability of the new members as they entered.

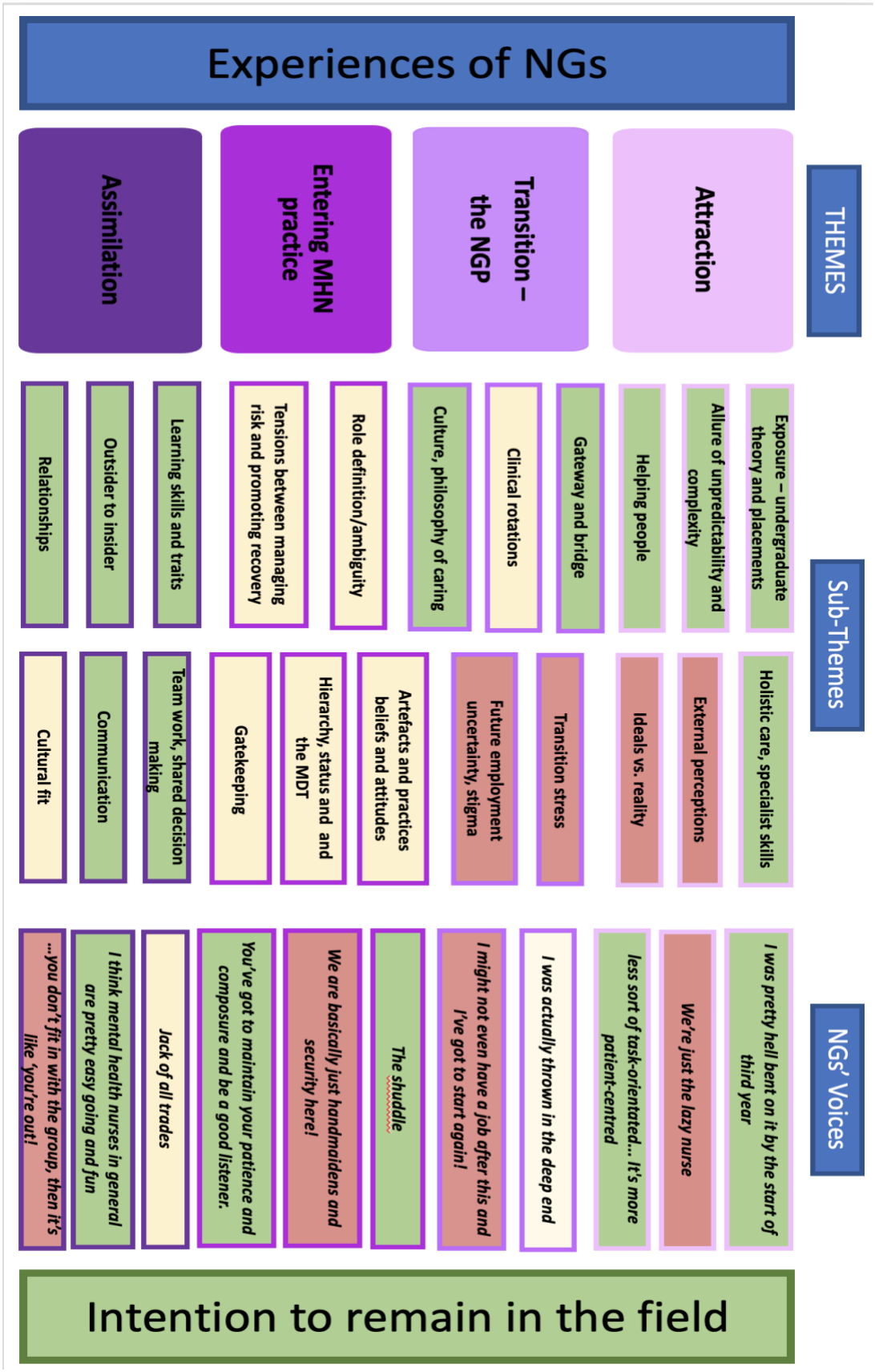

Figure 12 – Research findings

9.2.1 Finding one: Attraction to mental health nursing

The first major finding relates to the attraction of new nurses to MHN. The three main components of this theme were: *the influence of undergraduate learning and clinical placement in mental health settings; choosing to enter mental health nursing*; and *the high stakes* in choosing a career in this field. Exploring the attraction to MHN is important to understanding the NGs reasons for entering this specialty area, particularly when considering the literature around clinical preferences of undergraduate and graduate nurses. Preparation for practice plays an important role in setting expectations for NGs entering MHN and is important for both clinical practice and the MHN identity.

Participants in this study felt attracted to MHN based on their expectations of the MHN role which were partially the result of their exposure during their undergraduate degree. They had expectations that MHN would reflect holistic and recovery-oriented practices. However, they felt they did not have the right skills and knowledge to be able to engage in therapeutic practices. The finding that undergraduate training did not entirely prepare nurses for clinical practice in MHN is underlined by the fact that participants had graduated from ten different Australian-based university nursing programs.

Although exploring the educational preparation was not the focus of this thesis, participants referred to their undergraduate learning in discussion of their role expectations and experiences of transitioning into MHN. This is particularly important to understanding factors contributing to NG attraction and retention to

MHN. The participants in this study completed between one and three theoretical mental health units and completed between two and eleven weeks of clinical placement in mental health settings during their undergraduate degrees.

Research into the transition to comprehensive nursing curricula, has explored the attraction of graduates to MHN through undergraduate MHN theoretical and practical experience. In support of previous findings (Edward et al., 2015; Happell & Gaskin, 2013; Moxham et al., 2011), participants in this study felt attracted to MHN after completing theoretical and practical units in their undergraduate learning. They identified their undergraduate nursing educational experiences as a strong catalyst for their attraction to MHN – with the majority of participants not considering MHN until they undertook theoretical units and practical experience in mental health. This supports previous research outlined in Chapter two, exploring the use of theoretical and practical learning to attract graduates to the field of MHN (Happell & Gaskin, 2013; Hoekstra et al., 2010; Wilkinson et al., 2016). This is important as MHN has been identified as one of the least popular nursing specialties for graduates with only a small percentage of nurses attracted to a career in this field (Benjenk et al., 2019; Curtis, 2007; Happell & Gaskin, 2013; Moxham et al., 2011; Wilkinson et al., 2016).

In this study, the participants described MHN as an exciting and diverse specialty area involving therapeutic and holistic engagement with consumers while they rated general nursing as *boring*, which is an interesting contrast to

the literature. For example, research findings by Hoekstra et al. (2010) and Stevens et al. (2013) suggested graduate nurses would find general nursing fields such as critical care more exciting. One possible explanation for this alternative finding is the extent of mental health preparation received by participants in this study.

As it was outlined in Chapter two, the movement to university-based training was intended to elevate the status of nursing and increase its professionalisation, as well as improving the skills and knowledge within the profession as a way to attract new nurses (Cunich & Whelan, 2010; Dawkins, 1988; Hazelton et al., 2011). Nurses in the Australian context complete a comprehensive nursing curriculum as opposed to specialist nursing training. It was argued that this was to prepare graduates for a beginner practitioner role in any area of nursing (Happell & Cutcliffe, 2011; Wynaden, 2010). However, this notion has been challenged in the context of MHN, with concerns raised that nursing graduates are not adequately prepared for a career in in the field (Happell & Cutcliffe, 2011; Khankeh et al., 2014; McAllister et al., 2014; Walsh, 2015). The findings from this study outline that although participants felt attracted to MHN, they felt inadequately prepared for practice, with this emphasised as not having the right clinical skills and knowledge – despite undergraduate theoretical and practical experience in MHN. These finding support those of Hazelton et al (2011) and Kim and Yeo (2019).

Despite feeling attracted to MHN largely through undergraduate exposure, participants described differences between their expectations of MHN and the reality of clinical practice. Although this study did not seek to compare participants, it was noted that participants who had received a higher exposure to mental health content in their undergraduate degree appeared more passionate and committed to MHN. As research findings suggest there are strong links between clinical and theoretical preparation and more favourable attitudes towards MHN with increased undergraduate exposure to theoretical and practical mental health content (Happell, 2008; Happell & Gaskin, 2013). This raises the question of a lack of alignment between university curricula and clinical practice in the health services.

Challenges with the comprehensive nursing curricula In the Australian context is well known, with the comprehensive curriculum associated with a detrimental impact on the skills and knowledge inherent to MHN, as well as its status. There have been calls for increased MHN content in the curriculum, including increased clinical exposure to mental health settings to adequately prepare graduates for practice in MHN (Curtis, 2007; Happell & Cutcliffe, 2011; Neville & Goetz, 2014). Kunst et al (2017) and McAllister et al (2014) argued that the nursing curricula should be based on the best evidence to ensure nursing graduates have the skills and capability to provide high quality and holistic care. By not including adequate mental health content, this may not be achievable.

In exploring the culture of MHN, the merging of specialist MHN preparation into the comprehensive curriculum is met with a number of challenges. With the historical underpinning of MHN, there are differences with the origins of MHN as opposed to general nursing as outlined in Chapter two. MHN had its origins in providing the caretaking role within the asylum (Holyoake, 2014), and its skillset was largely drawn from sociology, psychology and anthropology with an emphasis on interpersonal relationships as key to practice as opposed to more bio-physically orientated approach of the general nurse (Happell & Platania-Phung, 2005; Prebble, 2001). The curriculum designed to prepare general nurses is lacking content concerning the interpersonal skills required for MHN practice. Inadequate preparation for MHN practice is associated with a deficit in knowledge and skills for new nurses. Without sufficient knowledge and skills, new nurses are not able to defend their specialised practice and arguably are resorting to completing tasks and fulfilling the requests of other members of the MDT. McAllister et al (2014) and Alchin (2010) further iterate that without a specialist knowledge base, MHN is likely to follow the lead of the medical model in the provision of mental health care, representing a shift towards historical practices of the nurse in the attendant or caretaker role.

It was identified that a lack of skills and knowledge was associated with a lower status for MHN in comparison to other nursing specialties. The introduction of a comprehensive curriculum demonstrates a lack of value associated with the preparation of mental health nurses. Despite the intention for mental health nurses to specialise at the post graduate level, nurses are no longer required to

have specialist training to work in MHN in the Australian context (Henderson & Martyr, 2013). This reflects the concerns raised around the progressive loss and dilution of specialist skills and knowledge in the future of MHN (Clinton & Hazelton, 2000; Hazelton et al., 2011). This is further compounded by a lack of appreciation for the complexity of MHN skills and knowledge with some reports suggesting MHN as a discipline would not be required, with general nurses able to fulfill this role within the general healthcare setting (Department of Health, 1971; Prebble, 2001). A lack of appreciation for MHN knowledge and skills through insufficient undergraduate preparation impacts on the discipline as well as the graduate who chooses to enter MHN.

Although participants described feeling attracted to MHN, they described the stigma associated with this specialty – particularly with the perceived lower status of MHN, and the challenges they faced when choosing to pursue a career in MHN. This included being discouraged from pursuing a career in this field, with a perception that they were taking the *easy way out* by pursuing MHN. The concept of graduates being discouraged from pursuing a career in MHN has been described in the literature (Happell & Gaskin, 2013; Happell et al., 2013; Stevens, 2014). The concept of MHN being regarded as a less desirable nursing specialty can also be linked back to the origins of the asylum attendants who were regarded as unskilled and of having a social rank similar to the people – referred to as *inmates* for whom they provided care (Slemon et al., 2017; Vrklevski et al., 2017). This contrasts with the more virtuous depictions of general nursing associated with Florence Nightingale.

Despite their attraction to it, participants felt that there were high stakes associated with choosing a career in MHN. A significant stressor experienced by NG participants was the need to secure employment after completing the NGP. The NGP represented a temporary position spanning one year, after which NGs would need to find ongoing employment. The finite number of positions and the number of vacancies available at the time of completing the program created angst for the NGs over the course of the NGP. Participants were concerned that they had consolidated their undergraduate learning in MHN, and this would lead to exclusion from employment in general settings, where there were more positions available, due to a lack of clinical knowledge and experience. These concerns led participants to focus on being accepted by the cultural group to enhance their likelihood of ongoing employment in MHN. This represents an alternative perspective to the retention of NGs in MHN.

9.2.2 Finding two: The new graduate program

The second major finding relates to the NGs experience of the NGP. The two main components of this theme were: *the NGP as the gateway to clinical practice* and *transition stress.* Exploring the NGP and the experiences of participants allowed for a deeper understanding of the process of consolidating skills and knowledge and socialisation into the cultural group for new nurses. In exploring the transition of NGs into clinical practice, the main findings arising from this study was a lack of clarity of the purpose of the NGP and the structure and content and how this relates to the transition of NGs into clinical practice. Within the literature, the aim of the NGP was for NGs to consolidate their skills

and knowledge in a supported manner (Parker et al., 2014; Pearson, 2019) as well as to allow for the socialisation of new nurses and the development of their professional identity (Meyer, 2019; Tingleff & Gildberg, 2014). The quality of the NGP has also been associated with attracting and retaining nurses to clinical practice (Pelletier et al., 2019; Rush et al., 2013; Walsh, 2018).

However, in exploring the NGP, it is noted that in the Australian context there is no regulation of how a NGP should be delivered, with NGPs locally developed to suit the needs of the health service and clinical area. One of the challenges in the process of socialisation was in determining the focus of the NGP – with challenges between the organisations goals in orientating the NG versus the NG's individual transition to practice needs (Malouf & West, 2011; Pearson, 2019). This has been identified in the literature with inconsistencies in the structure, duration, and function of the NGP (Hooper et al., 2016; Missen et al., 2014; Pearson, 2019; Rush et al., 2013; Walsh, 2018). The length of the NGP in this study was 12 months which was comparable to NGPs in the literature (Malouf & West, 2011; Pearson, 2019; Rush et al., 2013). In this study, all of the rotations were in inpatient settings except for hospital site one, with the inclusion of the acute care team, however, only three of 14 NG participants were able to complete a clinical rotation in this unit.

The focus on inpatient experiences was surprising given the process of deinstitutionalisation and the emphasis on mental health care being delivered in the community. Experiences of mental health care being delivered only in the

inpatient or acute setting may lead to a distorted perception of MHN by NGs, as they are not exposed to the balance provided by community-based care. Inpatient care represents the most restrictive form of mental health care with an emphasis on managing the acute symptoms experienced by consumers (Hudson, 2016; Kurjenluoma et al., 2017).

The NGP in this study represented an intensive program with mandatory components - theory, skill competencies and engagement with support structures. A significant proportion of the NGP was in providing base level mental health education designed to provide a minimum standard of mental health nursing knowledge and skills for NGs entering the service. This draws attention back to the challenges to the undergraduate preparation of new nurses and the attempts of health services to provide the educational preparation that may not be delivered within the curriculum, within the NGP. This approach risks overloading the graduate as they transition into clinical practice. In this study, graduates largely felt overwhelmed by the need to complete the educational components inherent to the NGP. This was emphasised as taking time away from clinical skill development and considered largely as repetition of their undergraduate learning.

One of the challenges experienced by NGs related to generic program content and structure versus individualised programs for consolidation of learning. Participants in this NGP were required to complete the same program requirements irrespective of their prior knowledge or experience. In comparison,

a new employee outside of the NGP would complete an individualised orientation and learning plan. In this study the NGP was developed by the district education team within the health service, with changes to the program over time reflecting the preferences of the educators. It was noted in the literature that there are inconsistencies in the structure, duration, and content of NGPs (Meyer, 2019; Pearson, 2019; Rush et al., 2013; Tingleff & Gildberg, 2014), with NGPs not currently regulated in the Australian context. The findings from this study compliment suggestions in the literature that collaboration is needed between health services and universities to improve the transition to practice for new nurses (Hooper et al., 2016; Procter et al., 2011).

Although it is not mandatory to complete an NGP to gain employment as an RN, they do represent an important gateway for NGs entering clinical practice in this mental health service with new nurses only able to enter through the NGP. However, in the NSW context, there were no guarantees of the nurse graduate gaining their preferred specialty or in gaining a place in a NGP at all, despite an attraction to, and undergraduate preparation for MHN. Conversely, graduates who are not interested in MHN may gain a NGP in MHN. It is emphasised that graduates accept the offer of the NGP irrespective of their preferences or risk not receiving another offer (NSW Health, n.d.). This finding was noted by Walsh (2018) whose study was also based in NSW. This is important in the transition of new nurses into mental health particularly in comparison to specialty-based undergraduate mental health nursing programs or the original hospital-based mental health nursing programs whereby graduates could engage in the

program and practice of their intention. This finding raises the question of the benefits of the NGP, particularly if NGPs are not mandatory for practice as a registered nurse and do not guarantee the specialty area of choice.

The concept of transition stress has been explored in the literature as a known phenomenon affecting new nurses (Duchscher, 2009; Kim & Yeo, 2019; Kramer, 1974; Pelletier et al., 2019; Tingleff & Gildberg, 2014). Read and Laschinger (2015) emphasised the link between positive and empowering work environments and the improved retention of nurses. Whilst negative experiences such as challenging workloads, poor relationships with colleagues and conflicts in the workplace were associated with decreased satisfaction (Kurjenluoma et al., 2017; Mabala et al., 2019; Pearson, 2019). Despite the workplace being considered positive in the transitional experiences for NGs in this study, the NGP represented a significant stressor. This was largely due to the heavy academic workload attached to the NGP at a time when the NG was navigating the clinical setting. This represented more of a stress for participants than the work environment itself. However, the concept of being *thrown in the deep end* was used by several participants to describe their experiences of entering MHN, representing culture shock associated with entering clinical practice; managing the transitional program content alongside clinical practice; and the focus on achieving early proficiency in practice. Although the participants encountered transition shock, this was not associated with negative clinical experiences or lack of support so much but more so with feeling unprepared for clinical practice. In the literature, negative clinical experiences

were associated with challenges in retaining the NG beyond the transitional year of practice (Hazelton et al., 2011; Tingleff & Gildberg, 2014).

Pearson (2019), Padagas et al (2021) and Sorensen et al (2018) also emphasised the need for NGPs to support new nurses with an emphasis on measures such as preceptorship, mentorship and debriefing during the early experiences of NGs entering the clinical setting. Phillips et al (2014) and Parker (2014) noted that the experience of transitioning can be improved through supportive structures. An emphasised component of the NGP in this study was the use of support structures. This included mentorship, preceptorship, and the presence of hospital-based and health-serviced based mental health nurse educators. The presence of supports is associated with positive experiences of transition and the development of competent clinical skills (Mabala et al., 2019; Missen et al., 2014; O'Brien et al., 2014; Procter et al., 2011; Tingleff & Gildberg, 2014) – which were largely described by the participants in this study. Labrague and de los Santos (2020) and Jackson (2018) suggest that preceptorship can improve the retention of NGs to clinical practice. Successful transition was demonstrated by the nurse building confidence and orientating to the role (Powers et al., 2019).

Despite the number of supports available within the NGP, participants described inconsistency in accessing them, particularly in respect to their preceptor or educator. Inconsistency in the provision of supports was noted in the literature as negatively affecting the transitional experience for graduates (Hazelton et al.,

2011; Tingleff & Gildberg, 2014; Wing et al., 2013; Wright et al., 2011). Inconsistency in accessing clinical support was noted in the literature despite the value of supports to the successful transition of NGs (Kinghorn et al., 2017; Wright et al., 2011). Though this was not necessarily viewed negatively with NGs describing receiving support from other team members filling the void. However, an interesting finding while exploring workplace support was the value placed in the educator above both the mentor and preceptor, which differed from the findings in the literature whereby the role of the preceptor or mentor have been identified as important in the transition of NGs (Jackson, 2018; Labrague & De Los Santos, 2020; Powers et al., 2019). The educator represented a clinician who was not directly a part of the cultural group in the setting and was seen as a person for NGs to seek knowledge from without appearing less knowledgeable or competent to their colleagues. This was important as NGs were seeking acceptance into the cultural group and a knowledge or skill deficit presented a barrier to acceptance.

9.2.3 Finding three: Entering mental health nursing practice

The third major finding relates to the NG entering mental health nursing practice. The four main components of this theme were: *adapting to the philosophy of care in the unit; mental health nursing within the organisation; the rules and routines within the mental health unit;* and *clinical activities in mental health units.* In entering mental health nursing practice, new nurses learn the practices of the existing cultural group as well as their role within the MDT. The philosophy of care for each unit played a role in shaping the clinical practices,

reflecting the practices, behaviour, and attitudes of the clinicians in the unit as well as the strategy of care. According to Schein (2010), the culture within the organisation or group determines the practices, behaviours, beliefs and attitudes of its members. In this study the NGs needed to become familiar with the differing practices, beliefs, and philosophy of care in the unit. This draws attention to the conflict between managing risk and promoting recovery – an ongoing tension experienced by NGs as they navigate their own values within the culture.

Adapting to the philosophy of care of the unit represents the inherent subculture of each unit. The focus of the rehabilitation unit was described as recovery and consumer-led where possible. This is contrasted by the acute units and the OPMHU where the focus is on managing the risks relating to the consumers presentation. Despite the philosophy of care inherent to each unit, the nature of care reflected the inpatient setting within locked units. All of the six included units in this study represented care within the locked unit, reflecting the original asylum centred around a custodial framework designed to segregate people from the wider community – particularly from the belief that they posed a risk to themselves or those around them (Junior et al., 2017; Slemon et al., 2017; Vrklevski et al., 2017). This leads to the discussion of the NGs experience of the role of the nurse, the rules within each unit and the clinical practices in the context of inpatient care reflecting short-term and intensive care, based on managing acute risks and symptoms (Hudson, 2016). Kurjenluoma et al (2017) highlight the challenges of acute inpatient admissions with consumers largely

experiencing greater symptom severity with shorter hospital admissions. NGs only experiencing the inpatient setting are likely to shape their views towards a risk-focused view of MHN practice.

The role and status of MHN compared to other nursing specialties and the status within the MDT represented an important component of the NG experience. In this study, the relationships between nurses and other members of the MDT differed across the inpatient settings, with the nurses having varying levels of autonomy and inclusion in decision making in some units and not others. This also related to the way in which the nursing role was shaped within the health service. Participants largely described challenges in engaging with other members of the MDT, particularly in representing the nursing profession and exploring care planning.

From a perspective of culture, an important artefact in the shaping of roles and identity is the uniform of cultural members (Schein & Schein, 2017). In this research setting, each member of the MDT has a different ‘uniform’ or dress code. In considering other members of the MDT and the consumers themselves, the only groups to wear uniforms were the nurses, health and security assistants and the support staff. Consumers wore plain clothes and medical, allied staff, senior management, and community-based nurses wore smart casual clothing. The uniform represents a powerful artefact in nursing in shaping the professional identity (Chu et al., 2020; Küçük et al., 2015; Spragley & Francis, 2006). Alongside the recovery movement in the 1990s, uniforms

were abolished in mental health settings to reflect recovery practices and to improve the therapeutic relationship (Chu et al., 2020). However, there has also been emphasis on the use of uniforms in MHN more recently, with one study outlining the preference of consumers' of mental health nurses in uniform (Küçük et al., 2015). The reintroduction of uniforms represented an interesting finding when considering the espoused values of recovery and holistic practices in contemporary mental health practice. Uniforms have been identified as a potential barrier in nurses developing the therapeutic relationships (Chu et al., 2020; Küçük et al., 2015; Spragley & Francis, 2006). The uniform as an artefact creates a distinct divide between these groups – particularly in the symbolic grouping of the nurses with the security and assistant staff and in considering the role that uniforms have in creating a therapeutic barrier.

In exploring the role of nursing within the MDT, a core role of MHN was in gatekeeper within the inpatient settings reflected as identifying and managing risk and providing supervision of consumers. Despite the move towards recovery-oriented care ideals, therapeutic practices were largely delivered by other members of the MDT – despite the role of therapy once held by nursing. This then relates to the discussion within the literature around the role of MHN within the MDT and the shifting of practices once held by MHN to other disciplines (Carlyle et al., 2012; Holyoake, 2014; Vrklevski et al., 2017). NGs entering MHN had expectations of engaging in therapeutic and recovery-oriented practices, however they experienced a role largely reflective of gatekeeping. In the shaping of the MHN identity within institutions and the MDT,

the focus on restrictive practices within the inpatient setting detracts from the focus on therapeutic engagement. These findings support the literature in that despite shifts towards therapy and recovery-oriented practices in the 1990s, mental health care has shifted back towards the medical model of care with the nursing role supporting the medical staff (Alchin, 2010; Hein & Scharer, 2015; Nolan & Hopper, 2000).

Although participants described MHN as being holistic and flexible with no emphasis on task-based care, the reality of practice in each setting reflected the establishment of rules and routines that the new member needed to learn. This was emphasised as *'the way we do things around here'*. Interestingly, the emphasis in the acute units was on rigid routines with shared activities such as observation rounds, medication rounds, meal supervision, and the provision of close observations for consumers deemed high risk. This represented a contradiction to the articulation of MHN as a holistic practice within a flexible framework.

The unpredictability of MHN – also articulated as flexibility, was described as an initial attraction for NGs with this seen as appealing and providing excitement. However, this was also viewed as an obstacle with participants seeking ways to create predictability and efficiency to cope with a changing environment. NGs described the need to engage in self-preservation in order to reduce the burnout effects from the unit. This involved restricting their care output and was frame as *setting boundaries* and *putting the fires out.* This resulted in a tension

experienced by NGs where they wanted to provide care for consumers, but also wanted to align with the approaches established by their colleagues. Participants identified the need to have routine and order to manage that workload leading to a conflict between responding to needs, being flexible and having predictability and order. There is tension between task-based and restrictive practices and the espoused beliefs of recovery-oriented and holistic practices. White et al (2019) explored the challenges faced by newly graduated nurses in developing therapeutic relationships with consumers in mental health settings due to a workplace focused on risks and task-based practices as well as deficits in supports. A similar focus was taken by Padagas et al (2021) who explored the experiences of NGs during their transition.

In exploring the clinical practice in MHN, the literature describes the reality of MHN clinical practice as confronting for NGs and associated with negative clinical experiences (Hazelton et al., 2011; Khankeh et al., 2014; McAllister et al., 2014; Procter et al., 2011; Tingleff & Gildberg, 2014). This related to the demonstration of power relations and the focus of safety and security measures, which have been described as confronting and distressing. Although NGs expressed dissatisfaction with differences in their expectations for clinical practice, they largely described the clinical practices as an unfortunate but necessary aspect of MHN practice. There was also a tendency for risk-averse and restrictive practices to be described under the guise of holistic and recovery care principles. It is noted in the literature that there are challenges in adopting recovery practices with the emphasis on brief hospitalisation and biomedical

approaches to care (Palmer, 2012). This is in conjunction with the increased complexity and severity of symptoms experienced by mental health consumers (Kurjenluoma et al., 2017).

Gatekeeping represented an important clinical practice for MHN. Gatekeeping is a practice long held within the cultural group evolving from the original psychiatric hospitals and asylums (Holyoake, 2014; Loukidou et al., 2010). Gatekeeping practices include identifying and managing the risks to consumer as well as the use of seclusion, locked units, medications and close observations as reflective of the safety discourse inherent to locked units (Harrington et al., 2019; Slemon et al., 2017). The role of gatekeeping and risk management was reinforced by the artefacts in the units such as CCTV, windows and ward layout for visibility, and care level observations, which supports the findings of the literature review in Chapter two (Holyoake, 2014; Slemon et al., 2017). New nurses were socialised into identifying and managing risk as well as items of contraband – this goes beyond the obvious items such as drug paraphernalia, to imagining how ordinary items could be used as weapons. The emphasis on these tasks was that the nurse had to perform them from a therapeutic perspective, and it was seen as an unfortunate but necessary aspect of care. With this focus on observation and risk management as contradictory to a recovery-focus of care that acknowledges the consumer as an equal partner as opposed to passive recipient of care (Harrington et al., 2019). Despite attempts to shift the gatekeeper role through redefining the image of MHN, the institution itself and the culture perpetuates this role. The

cultural group is shaped to prioritise safety and risk aversion over all other practices, with this underpinned by mental health legislation and hospital-based policy. The shaping of practice is not only found within the institution but argued to reflect societal expectations for safety in mental health care as well as reflect defensive rather than therapeutic practices to avoid litigation or blame in relation to the responsibility of patient-safety (Hewitt, 2009; Slemon et al., 2017).

The findings of this study demonstrate the power of artefacts in shaping the cultural practices within the inpatient setting. It is evident that the culture itself is experiencing tension between engaging in task-based and restrictive practices whilst espousing recovery-oriented and holistic practices, particularly with the artefacts supporting risk-averse practices. Despite the move towards community-based and least restrictive practices, safety and risk aversion remain values that underpin contemporary mental health care in Australia and around the world (Harrington et al., 2019; Holyoake, 2014; Slemon et al., 2017).

9.2.4 Finding four: Entering the culture of mental health nursing

The fourth and final major finding relates to the NGs' experience of entering the culture of MHN. The four main components of this sub-theme were: *assimilation – learning the skills and traits of mental health nurses; language and communication in mental health nursing; nurse relationships;* and *assimilating new members into the culture.* This represents the socialisation of NGs into the

cultural group and the journey of the NG becoming a member of the cultural group and entering the inner circle of the MHN culture and moving out of the NG nurse culture.

In joining the MHN culture, NGs learn the skills and traits of mental health nurses. This perspective differs from the description in *finding one: attraction to mental health nursing* where NGs discussed the traits of MHN as a cultural outsider. They referred to mental health nurses but did not include themselves in that group. Assimilating into the culture of MHN represented the deeper state of change that was observed when NGs identified themselves as mental health nurses. This shift in perspective is identified by Schein (2010) who describes assimilation as the member viewing the culture as an insider as opposed to outsider.

In discussing the skills and traits of MHN, role ambiguity was a challenge faced by NGs entering the culture of MHN. This reflects the findings in the literature (Barker & Buchanan-Barker, 2011; Cutcliffe et al., 2013; Lakeman, 2013; Procter et al., 2011; Schwartz et al., 2011). Participants in this study found it challenging to define MHN, tending to outline the tasks performed by MHN at one end of the spectrum and then contrasting this with idealism of holistic and recovery-focused care, but also suggesting that the role depended on the context of practice. There was a lack of consistency in the participants' responses when defining the role of MHN. This is consistent with the literature whereby challenges have been identified in articulating and defining MHN, but

also in defining the wide range of tasks and responsibilities that can be inherent to the role (Barker & Buchanan-Barker, 2011; Cutcliffe et al., 2013; Lakeman, 2013; Schwartz et al., 2011).

The participants expressed pride in describing the broad skills associated with MHN, outlining that mental health nurses do *all the same things as general nurses* but also provide holistic and therapeutic care. Participants described the need to have a broad skillset to provide general nursing care as well as mental health care. However, the complexity associated with having a diverse role and skillset was encapsulated in the term *jack of all trades.* This concept represented the wide applicability of the MHN role and the difficulty in defining the boundaries of the role. Challenges in defining the MHN role are well-known in the literature where they are reflected as representative of role ambiguity (Cutcliffe et al., 2013; Hercelinskyj et al., 2014; Lakeman, 2013). The emphasis in the literature is on the association between role ambiguity and increased risk of attrition (Barker & Buchanan-Barker, 2011; Harrison et al., 2017).

Changes to the MHN role over time and the increased genericism of the MHN role are associated with challenges to the MHN identity (Hercelinskyj, 2010). One aspect of the MHN identity is the title of the mental health nurse. It is linked to the places and time period they have worked and linked to the historical construct of the MHN identity such as the titles of psychiatric nurse and mental health nurse outlined in Chapter two (Barker & Buchanan-Barker, 2011; Cutcliffe et al., 2013; Lakeman, 2013). Adopting the title of mental health nurse

was argued to reflect a shift in ideology towards a nurse who engages in holistic care, working in partnership with people experiencing mental health issues and their family and community, and working towards recovery as defined by the person (Barker & Buchanan-Barker, 2011). However, in the context of this study, there are challenges in practicing under this definition, especially considering the structure of the institution and the lack of specialist training contributing to the MHN role and how this is perceived by NGs.

The assimilation of new cultural members describes the NG entering the cultural group. This can be defined as the socialisation, transition, or enculturation of new members. This transition differs from the one experienced during the NGP which represents a gateway into the organisation and a structure for the transition of NGs. In assimilating, the new member undergoes a transformation where their beliefs, behaviours and attitudes are shaped by the cultural group (Schein & Schein, 2017; Stevens, 2014; Waegemakers Schiff, 2009). The process of assimilation involves three aspects: the culture shaping the new member, what the culture seeks in the new member and the new member considering their own place within the culture. NGs in this study described their experience of entering MHN as a process of learning the beliefs, behaviours, and attitudes of the existing cultural group.

Nursing relationships are important to the cultural group – these are represented as the hierarchy, social relationships and the teamwork involved in nursing collaboration and shared decision making. NGs discussed

communication within nursing relationships emphasising the use of humour, the characteristics of sharing information (handover), the need for debriefing and storytelling being valued by the cultural group (Hercelinskyj, 2010; Palmer, 2012; Treloar, 2014). The role of storytelling is recognised in the literature as an important artefact of MHN (Treloar, 2014).

Within this study, the MHN culture was characterised as a tight-knit group. This was based upon the concept of safety – with the culture perpetuating the belief that mental health care represents danger. New cultural members were socialised into the practice of team-based approaches to care, and the need to protect other members of the team from the perceived dangers within the clinical setting. NGs reported finding the close relationships associated within the MHN culture attractive and wanted to be accepted into the tight-knit group.

The transition into clinical practice and the cultural group has been described as stressful for new nurses with this described as culture shock or transition shock (Cleary et al., 2009; Kramer, 1974; Meyer, 2019; Procter et al., 2011). The findings in this study support the literature whereby participants described feeling stressed as they assimilated into the cultural group. Despite the shaping of the NG during their undergraduate learning and within structure of the NGP, NGs found they needed to adopt the beliefs, practices, and behaviours of the cultural group to be accepted. In the process of assimilating new members to the cultural group, the existing culture seeks members who are deemed compatible and have the desired characteristics. Although participants

described the importance of being accepted into the cultural group, the process of acceptance presented challenges such as encountering a tension between wanting to achieve change within MHN and wanting to be accepted by the cultural group. This reflects the literature around the culture shock experienced by new nurses entering clinical practice, whereby new nurses need to resolve conflict between their own values and those of the cultural group (Cleary et al., 2009; Kramer, 1974; Meyer, 2019; Procter et al., 2011).

The NG seeking to be accepted also related to securing ongoing employment after completing the NGP. This is because the NGP is a one-year temporary position and all NGs need to apply for ongoing positions after completing the program. It was emphasised that there could be challenges in gaining a position in the field of MHN as there were a finite number of positions available. The most defining moment for NGs becoming mental health nurses appeared to be when they gained a position in the cultural group on the completion of their NGP. Due to the concerns of not gaining employment in general nursing once they entered MHN, NGs reported working on securing their ongoing employment by focusing on being accepted by the cultural group. This represents an alternative perspective to the retention of NGs in MHN.

For new members not finding it easy to assimilate into the group or deemed to not have suitable qualities, there was an element of exclusion. Participants and nurses in the cultural group described the process of unsuitable members being excluded from the culture as *weeding them out quickly.* This was explained as

the fact that some nurses' personalities were deemed as not suited to MHN. Although the cultural group excluded new nurses they considered to be unsuitable members, some new members appear to have had their own regrets of entering the field. This occurred when some people felt that their ideals about mental health care and improving the care for consumers dissonated with the reality of MHN. NGs realised that the need to be accepted into the cultural group meant that they were powerless to change the culture and practice. If they chose to remain, they needed to change to meet the expectations of the cultural group. They expressed this as *"the rose-coloured glasses coming off".*

It was evident that NGs experienced differences between their expectations and reality of MHN. They expressed this as culture shock. Many graduates entered MHN with an impression of MHN as a holistic and recovery-oriented practice. The reality they encountered led to a tension between risk management and recovery-oriented ideology. Culture shock can result in the NG abandoning the profession or cultural group (Cleary et al., 2011; Duchscher, 2009; Kramer, 1974), or compromising by abandoning their own values and adopting the values of the cultural group. This appeared to be the more commonly adopted approach among participants.

In this study, the point at which new members appeared to assimilate was when they secured a position after the NGP, reflecting the outsider status of NGs and their merging to insider status in the cultural group. This appeared to be shaped by the movement into a permanent position, confirming that the NG is choosing

to commit to MHN, and that by securing employment, the cultural group has accepted the new member.

9.3 Chapter summary

This chapter discussed the findings of the study in relation to the four findings chapters – *attraction to mental health nursing; the new graduate program; entering mental health nursing practice;* and *entering the culture of mental health nursing*. The findings from this study emphasise the significance to new nurses entering clinical practice of the preparation for practice, transition to practice and encountering the mental health nursing culture. During their undergraduate preparation for practice, NGs developed an interest in MHN relating to their theoretical and practical exposure to MHN content. Their undergraduate learning sets expectations about the role and practice of MHN. Although NGs feel attracted towards MHN, they describe not feeling prepared for MHN practice and described their undergraduate preparation as not entirely providing the right skills and knowledge for clinical practice. The NGP represents a gateway into the cultural group and represents a supportive framework for consolidating learning for NGs. However, the NGP also represents a significant stressor for NGs as they are challenged with completing NGP requirements whilst socialising into the cultural group and developing clinical practice skills. In encountering MHN clinical practice, NGs describe challenges related to their expectations versus the reality of clinical practice. The clinical practice of MHN centred largely around gatekeeping practices with the role within the MDT and cultural artefacts shaping the role and practices of

MHN. In entering the culture of MHN, NGs adopt the beliefs, behaviours, and attitudes of existing cultural members. In adopting the MHN identity, there are challenges faced with role ambiguity for MHN. This affects the NG as well as the wider MHN cultural group. Although the reality of MHN practice deviated from expectations with an incongruence between the spoused values of holistic and recovery-oriented practices and a reality of risk-averse and task-based practices, NGs need to determine whether they adopt the values and practices of the MHN group or leave the cultural group. The next and final chapter provides the conclusions reached during this study and includes the major implications of the study findings. This is followed by the recommendations arising from this study, the strengths and limitations of the study, and an autobiographical reflection.

Chapter ten

Conclusion and recommendations

"It is always important to know when something has reached its end. Closing circles, shutting doors, finishing chapters, it doesn't matter what we call it; what matters is to leave in the past those moments in life that are over."

Paulo Coelho

10.1 Introduction

This study has made an original contribution to the discipline of nursing – in particular, exploring the subcultural experiences of NGs entering the culture of MHN. This was represented as a series of findings – *attraction to mental health nursing; the new graduate program; entering mental health nursing practice;* and *entering the culture of mental health nursing*. As was identified in the beginning of this thesis, there are worldwide and growing shortages of nurses in mental health (Drennan & Ross, 2019; McAllister et al., 2014). This is the result of low numbers of graduates attracted to the discipline coupled with attrition due to ageing of the workforce and early retirement. A concerning finding in the literature was the attrition of nurses early in their career (Hooper et al., 2016). Research had focused on the contribution to this attrition through inadequate educational preparation of mental health nurses and the deskilling of the mental health workforce through lack of specialist training and loss of senior nurses to

early retirement (Happell & Cutcliffe, 2011; Neville & Goetz, 2014). Research had then shifted towards exploring the experiences of NG nurses with an emphasis on transitional programs to support and prepare new nurses for clinical practice (Procter et al., 2011). The literature review identified that NGs experienced negative clinical experiences as they enter MHN, and these experiences associated with increased risk of attrition (Hooper et al., 2016). These were related to the changes to the educational preparation of nurses in mental health, role ambiguity, inadequate preceptorship of graduate nurses, the reality versus the ideals of mental health services, and the health services role in the transitioning of graduate nurses into clinical practice (Hooper et al., 2016).

The purpose of this study was to explore the cultural experiences of NGs as they encountered the culture of MHN to address a gap in the literature. Additional aims were to explore the links between the NGs' experiences and their intention to remain in the field of MHN, as well as exploring the processes of assimilating new nurses into the workplace and the NGs placement in the nursing hierarchy. This research was informed by an anthropological perspective – using ethnography. The use of an ethnography represented a novel approach to exploring the experiences of new nurses entering clinical practice.

Previous research exploring new nurses entering MHN used primarily survey and interview methods to explore those experiences. The use of an

ethnographic approach allowed for the uncovering of cultural knowledge and processes within the mental health setting and the experiences of new nurses entering the cultural group to be made more explicit. In keeping with the methodological approach, data collection was undertaken in an Australian-based mental health service, using non-participant field observation and semi-structured interviews. Field and reflexive researcher notes were used as additional data sources. The ethnographic approach of participant observation allowed for the observation of the cultural context, whilst interviews generated insight into the experiences of NGs from their perspective. The period of research provided opportunity to observe and understand the process of assimilation. Data collection spanned five months until data saturation was achieved. Data were managed using NVivo (version 12) software and analysed using Braun and Clarke's (2006) thematic analysis method. To develop a greater understanding of the complexity of socialising into a cultural group – in this case, new nurses entering the culture of MHN – Schein's (2010) *Model of Organisational Culture* provided a theoretical framework to explore their experiences. This model allows for the understanding of the dynamics of cultural groups, the underlying assumptions and beliefs held by its members, and the process of assimilating new members into the cultural group.

10.2 Major findings

The findings of this study have identified the complexity of the experience for NGs and the processes they encounter in assimilating into the culture of MHN. By making explicit the cultural meanings, practices and processes these

findings and insights addressed a gap of knowledge in the literature around the experiences of NGs entering the culture of MHN. There were four major findings from this study that represent the journey taken by NGs as they enter the culture of MHN as a new member – *attraction to mental health nursing, the influence of the new graduate program, the experience of entering mental health nursing practice,* and *the impact of entering the culture of mental health nursing*. These findings demonstrate the depth of the journey taken by NGs entering the culture of MHN and the ways in which they are assimilated into the cultural group – moving from cultural outsider to insider. This thesis sought to draw attention to the culture aspect of the journey in addition to the NGs experience of the culture.

Chapter five – *attraction to mental health nursing* represented the first of the four finding chapters. This chapter relates to the attraction of NGs to MHN. Findings highlighted in this chapter are important when exploring the concept of attraction and retention of NGs to MHN. The undergraduate preparation of new nurses is significant in providing the required skills and knowledge for clinical practice as well as setting expectations for the MHN role and practice. Preparation plays a significant role in attracting new nurses to a career in MHN. However, new nurses describe several challenges when choosing MHN – particularly in encountering the stigma associated with MHN and experiencing discouragement in pursuing a career in this field. They also encounter challenges in securing ongoing employment after completing the NGP, with

further challenges in transitioning into general nursing practice if they change their minds about a career in MHN if they have consolidated their skills in MHN.

Chapter six – *the new graduate program* represented the second of the finding chapters. This explored the purpose of the NGP for NGs entering the workplace in MHN. The NGP represents the gateway to clinical practice and the cultural group for new nurses and is seen as a rite of passage into the health service. Although the transition process represents a structure to provide support and consolidate skills for new nurses, it also represents a significant stressor as NGs adapt to clinical practice, consolidate their undergraduate learning, complete the program requirements, and socialise into the clinical setting.

Chapter seven – *entering mental health nursing practice* represented the third finding chapter and represents the experiences of NGs entering clinical practice. Within this chapter the tensions are laid between the role of MHN that was envisioned of NGs and the reality of the MHN role as they commenced clinical practice. NGs described MHN as a holistic and recovery-oriented practice however their experiences were of inpatient settings valuing risk-averse and task-based practices reflective of gatekeeping. The philosophy of care within the units, the cultural artefacts, and role within the MDT are powerful in shaping the values of gatekeeping within the cultural group. These are important findings when exploring the experiences of NGs as they enter the culture of MHN, and how these experiences and their expectations shape their commitment to the organisation.

Chapter eight – *entering the culture of mental health nursing* represented the fourth and final findings chapter and represents the experiences of NGs in entering the culture of MHN. This is represented as the assimilation of the NG and their socialisation to the cultural group of mental health nurses. NGs entering the culture of MHN encounter the beliefs, behaviours and attitudes that are valued by the existing culture. Assimilation of new members involves the cultural group assessing the suitability of the new member and the new member determining their own cultural fit. The nature of assimilation is time-limited with the NGP spanning one year, requiring the NG to be recognised as a suitable member of the group to increase the likelihood of securing ongoing employment after completing the NGP.

10.3 Major implications of the findings

The findings from this study demonstrate the importance of culture in the experiences of NGs as they transition to MHN. They are outlined in relation to preparation for practice; transition to practice; mental health nursing culture; and NG nurse retention.

10.3.1 Implications for preparation for practice

The preparation for practice sets expectations for new nurses entering MHN and is an important gateway to clinical practice. Preparation for practice is linked to the cultural identity of MHN and the role of undergraduate education in the preparation of new nurses entering MHN. In exploring the cultural identity of

MHN, it was seen that MHN is distinct from general nursing when considering historical underpinnings. This involved considering the origins of MHN as a caretaker role within the asylum (Holyoake, 2014), and through the intended skillset of MHN largely drawn from sociology, psychology and anthropology with an emphasis on interpersonal relationships as key to practice, as opposed to more bio-physically orientated approach of the general nurse (Happell & Platania-Phung, 2005; Prebble, 2001). The emphasis on a curriculum designed to prepare general nurses affects the preparation of mental health nurses and results in nurses lacking the interpersonal skills required for MHN practice. This has been reflected in the literature as the progressive dilution of specialist knowledge and skills in MHN (Hazelton et al., 2011; McKeown & White, 2015). Without sufficient knowledge and skills, new nurses are not able to defend their specialist practice and arguably are resorting to completing tasks and fulfilling the requests of other members of the MDT (McAllister et al., 2014). Findings from this study suggest that undergraduate preparation does not provide the right skill and knowledge for MHN. This then begs the question on the point of attracting new nurses to MHN as they then feel unprepared for practice or are faced with practice that deviates from expectations.

Exposure to MHN content and experience during undergraduate nursing preparation is important to attracting nurses to MHN. However, there needs to be consideration around the preparation of nurses as expectations of the MHN role and practice are established during undergraduate preparation. Encountering differences in expectations and reality is associated with

decreased satisfaction and increased role ambiguity for new nurses. The preparation of mental health nurses is important for clinical practice but also for the MHN identity.

10.3.2 Implications for the transition to practice

The transitional or NGP represents an important structure in supporting new nurses entering clinical practice. There needs to be consistency in the purpose, structure, and content of programs to ensure that new nurses can successfully transition to clinical practice. In the Australian context there are no regulations concerning how a transitional program should be delivered. This has been identified in the literature with inconsistencies in the structure, duration, and function of the NGP (Hooper et al., 2016; Missen et al., 2014; Pearson, 2019; Rush et al., 2013; Walsh, 2018). Furthermore, the transition program represents a gateway to entering clinical practice for new nurses. However, nurses applying for a transition program are not guaranteed their preferred nursing specialty. Despite feeling attracted to MHN, a new nurse may not gain a position in a mental health nursing transition program and may need to consolidate their undergraduate learning in another nursing specialty. This finding raises the question of the benefit of the NGP and to whom the NGP benefits, particularly if NGPs are not mandatory for practice as a registered nurse; do not guarantee the specialty area of choice; and are not regulated.

A significant proportion of the NGP was in providing base level mental health education designed to provide a minimum standard of mental health nursing

knowledge and skills for NGs entering the service. This draws attention back to the undergraduate preparation of graduates and the attempts of health services to provide the educational preparation that may not be delivered within the curriculum, within the NGP. This then risks overloading the graduate as they transition into clinical practice. One of the challenges in the process of socialisation was in determining the focus of the NGP – with challenges between the organisations goals in orientating the NG versus the NGs individual transition to practice needs (Malouf & West, 2011; Pearson, 2019).

An emphasised component of the NGP in this study was the use of support structures. The consistent presence and access to supports is associated with positive experiences of transition and the development of competent clinical skills (Curtis, 2007; Hayman-White et al., 2007; O'Brien et al., 2014; Procter et al., 2011). Despite the number of supports available, inconsistency in accessing supports is associated with negative transitional experiences consistent with the literature (Wing et al., 2013; Wright et al., 2011). Although the presence of a mentor and preceptor is associated with positive transitional experiences, access to a nurse educator represented an important support for transitioning nurses. The nurse educator represents a clinician who was not directly a part of the cultural group in the setting and was seen as a person for NGs to seek knowledge from while not appearing less knowledgeable or competent to their colleagues. This was important as NGs were seeking acceptance into the cultural group and a knowledge or skill deficit presented a barrier to acceptance.

10.3.3 Implications for mental health nursing culture

The findings from this study have implications for the culture of MHN – particularly in relation to cultural identity, cultural practice, and cultural assimilation. Despite efforts to transform the culture of MHN, the culture is still anchored to the historical underpinnings developed by the founders of the cultural group and then perpetuated with the new members entering the cultural group (Bellot, 2011; Patnaik, 2011; Schein, 2010). The artefacts within the cultural group are powerful in perpetuating the culture of MHN.

10.3.3.1 Cultural identity

The existing culture shapes the identity of the new nurse entering the culture group. Role ambiguity represents a challenge for MHN with a lack of clarity in the skills and practices inherent to the MHN role. The contemporary MHN identity has evolved from the asylum attendant to the role in contemporary mental health services, with mental health institutions playing a key role in shaping the role and identity of MHN. Consistent with the literature, there is a tension between risk-averse and task-based practices and holistic and recovery-oriented practices in MHN (Hercelinskyj, 2010; Hercelinskyj et al., 2014; Palmer, 2012). The MHN identity is anchored to the historical role of gatekeeper in the asylum; created as the assistant to the medical staff; and experiencing challenges in role definition when considering other members of the MDT (Holyoake, 2014; Martyr, 2010; Vrklevski et al., 2017). Despite efforts to emancipate MHN and redefine the role, the challenge remains the cultural forces shaping the culture creating ambiguity in the role and identity of MHN.

This is important when considering the assimilation of new members into the cultural group who are not only inheriting the cultural history but are also encountering a fragmented professional identity represented through role ambiguity (Barker & Buchanan-Barker, 2011; Cutcliffe et al., 2013; Lakeman, 2013; Procter et al., 2011; Schwartz et al., 2011). McKeown and White (2015) noted the constant change and evolution of MHN with uncertainty in the identity, skills and practices of mental health nurses. This relates also to the identity and role of MHN and how the culture has been shaped over time. In the shaping of the MHN identity within institutions, the focus on restrictive practices within the inpatient setting detracts from the focus on therapeutic engagement. Without a strong identity and role boundary, MHN will continue to struggle to define itself and its practice. The identity of MHN is also impacted by the loss of specialist training in the Australian context and the challenges of wanting to promote recovery and holistic care whilst practicing within institutions valuing safety and risk management.

10.3.3.2 Cultural practice

New nurses entering MHN experience clinical practice deviating from expectations. Clinical practice within the inpatient mental health setting centred around task-based and risk-averse practices – though under the guise of holistic or recovery-oriented practices. Gatekeeping is an important practice to the cultural group, a practice that has evolved from the origins of the cultural group (Holyoake, 2014; Loukidou et al., 2010). Despite the advent of the recovery movement and espoused values of holistic and recovery-oriented

care, the reality of MHN care is of task-based and risk averse practices within the inpatient setting. New nurses are assimilated into the practices of the existing cultural group. This focus on observation and risk management is contradictory to a recovery-focus of care that acknowledges the consumer as an equal partner as opposed to passive recipient of care (Harrington et al., 2019).

The cultural group is shaped to prioritise safety and risk aversion over all other practices, with this underpinned by mental health legislation and hospital-based policy. The shaping of practice is not only within the institution but also reflects societal expectations for safety in mental health care as well as reflect defensive rather than therapeutic practices to avoid litigation or blame in relation to the responsibility of patient safety (Hewitt, 2009; Slemon et al., 2017). NGs completing NGPs only in inpatient settings are likely to shape their views on a risk-focused view of MHN practice within the structure on institutions. The locked unit reflects the asylum centred around a custodial framework designed to segregate people from the wider community – particularly from the belief that they posed a risk to themselves or those around them (Junior et al., 2017; Slemon et al., 2017; Vrklevski et al., 2017). While the organisation values of risk aversion and safety remain the discourse of inpatient mental health care, then MHN practices are likely to remain task-based and reflect risk management.

10.3.3.3 Cultural assimilation

The process of socialisation involves the culture shaping the new member and what the culture seeks in the new member, as well as the new member entering considering their own placement within the culture. In assimilating new members, the new member undergoes a transformation where their beliefs, behaviours and attitudes are shaped by the cultural group (Schein & Schein, 2017; Stevens, 2014; Waegemakers Schiff, 2009). The experience of transition is known to be stressful for new nurses characterised by a change of state involving identity formation, ability, and behaviour (Cleary et al., 2009; Kramer, 1974; Meyer, 2019; Procter et al., 2011). In creating and sustaining culture, the founders appoint and retain members who share similar beliefs and attitudes (Schein & Schein, 2017). In organisational cultures with longer histories – beyond the presence of the founder, such as in MHN, there are other ways that the original culture is perpetuated. Artefacts such as the stories, language, symbols and rituals or practices within the culture link the organisation to its history and convey a message about what is important in the culture (Patnaik, 2011; Stevens, 2014). Assimilating into the culture of MHN represented a deeper state of change that was observed when NGs identified themselves as mental health nurses. In discussing the nature of MHN and defining the mental health nurse, NGs discussed this separately from themselves as though they were not yet considered mental health nurses, whereas RGs referred to themselves when defining MHN and the inherent characteristics. This shift in perspective is identified by Schein (2010) who describes assimilation as the member viewing the culture as an insider as opposed to outsider.

In exploring the concept of culture shock and the assimilation of NGs into the cultural group, NGs experienced differences between their expectations and reality of MHN. NGs entered MHN with an impression of MHN as a holistic and recovery-oriented practice in which they would be able to practice in this framework. This then led to a tension between risk management and recovery-oriented ideology. Although culture shock can be associated with abandoning the profession or cultural group (Cleary et al., 2011; Duchscher, 2009; Kramer, 1974), another response to culture shock is for the new member to abandon their own values and adopt the values of the cultural group.

10.3.4 Implications for NG nurse retention

Undergraduate preparation plays an important role in the commitment of NGs to MHN. In the Australian context, exposure to undergraduate mental health content and practical experience is associated with attraction to MHN (Edward et al., 2015; Happell & Gaskin, 2013; Moxham et al., 2011). However, the undergraduate curriculum plays an important role in preparing graduates for practice in MHN as well as shaping expectations about the role. Despite ideals of MHN reflecting recovery practices, there needs to be congruence between the espoused values of the cultural group and the reality of clinical practice. NGs are largely unprepared for the demands of clinical practice reflecting findings in the literature (Kinghorn et al., 2017; Labrague & De Los Santos, 2020).

Incongruence between the NGs expectation of clinical practice and the reality of restrictive practices was also linked to dissatisfaction. This was described as *"the rose-coloured glasses coming off",* reflecting findings in the literature (Kurjenluoma et al., 2017; Sorensen et al., 2018). The NGP represents a gateway to the cultural group designed to support the transition of NGs entering clinical practice. However, the NGP represented a significant stressor for NGs as they navigated the clinical setting and the workload attached to the NGP itself. Workload challenges are associated with an increased risk of attrition of new nurses (Kurjenluoma et al., 2017; Mabala et al., 2019; Pearson, 2019). The support structures within the NGP can ameliorate the stress experienced by NGs entering clinical practice and promote commitment to MHN (Labrague & De Los Santos, 2020; Powers et al., 2019). However, inconsistencies in accessing clinical support is associated with dissatisfaction and reduced commitment of NGs to MHN (Kinghorn et al., 2017; Walsh, 2018).

A significant stressor experienced by NGs is securing ongoing employment after completing the NGP. The NGP represented a temporary position spanning one year, after which NGs would then need to find ongoing employment. This created angst for the NGs over the course of the NGP, as there was uncertainty in their ongoing employment. A further challenge was in their choosing to enter MHN, particularly if they later changed their mind and wanted to enter general nursing. Participants had consolidated their undergraduate learning in MHN and had concerns that this would lead to exclusion from employment in general settings due to a lack of clinical knowledge and experience. Due to the

concerns of not gaining employment in general nursing and their decision to enter MHN, this led to a focus on securing their ongoing employment by focusing on being accepted by the cultural group. This represents an alternative perspective to the retention of NGs in MHN.

10.4 Summary of recommendations

In light of the research findings, this thesis makes several recommendations for future practice, transition support, clinical practice, and research.

1. Strengthening the relationships between health services and Universities to ensure undergraduate theoretical and practical elements of mental health nursing education are reflective of preparatory needs for clinical practice.
2. Emphasising the role of postgraduate education for mental health nursing in relation to preparation for practice. Specialist mental health nursing education is essential to the mental health nursing role and practice.
3. Accreditation and regulation of transitional programs for new nurses entering clinical practice in mental health are important. This is to ensure consistency in the purpose and structure of transitional programs supporting the transition of new nurses into clinical practice. There needs to be a basis of evidence in the program components including support structures and consolidation of knowledge and skills while limiting the workload placed on new nurses during their first year of clinical practice.

4. Expansion of the transitional period to allow for further support as new nurses enter their second year of clinical practice outside of the transitional program network and encounter greater responsibility. Specifically concerning advanced skill development after the completion of the first year of practice.
5. Ensuring a blend of clinical experiences for new nurses as they transition and particularly allowing for community-based experiences. This is to allow for a broader perspective of the MHN role outside of the inpatient setting.
6. Emphasis of consistency in workplace support – ensuring the presence of the preceptor, mentor, and educator, and acknowledging the role that each of these supports play in the assimilation of new nurses.
7. The creation of a staggered intake for the transitional program, with two or more entry points over the course of the year to allow for more employment opportunities for graduates of the transitional program.
8. Addressing the role of MHN within the MDT. This requires evaluation of the mental health service and the role of each member of the MDT.
9. Addressing the cultural artefacts shaping the gatekeeping role of MHN. Particularly artefacts representing a safety discourse as opposed to recovery-oriented practices. This represents a challenging recommendation as the culture is deeply rooted in

gatekeeping practices. However, this is an important recommendation to the future of MHN and attracting and retaining future cultural members.

10. Research to explore the experiences of NGs entering other mental health settings – particularly in health services offering clinical rotations in community-based settings.
11. Research of MHN in nations that have retained specialist MHN training to explore the culture and impact on retention and further determine the impact of undergraduate preparation for new nurses entering MHN.

10.5 Strengths and limitations

There are many strengths to this study. The lengthy time spent in the field allowed for a deeper understanding of the NG experience. Interviews conducted for NGs and RGs also added depth to the findings. Researching in a setting familiar to the researcher added to the depth of data analysis by allowing for a richer and more complex understanding of the experiences of NGs. As a mental health nurse, and a nurse who has previously completed a NGP in a mental health setting, my knowledge of the context allowed for the nuances and meanings within the field to be better observed than might have otherwise occurred. Thick description allowed the experiences to be conveyed more fully. In this way, a compelling and complex description of the NGs experience was constructed.

There are several limitations when considering the research findings in light of existing research surrounding NGs in MHN. This study focused on the NG experience of transitioning to MHN – this experience was enhanced with the data available from RG participants. The findings relate to the experiences of the participants in this particular research site, so these findings are not specific to the broader context of MHN. However, inferences can still be made as there are some similarities in the process of conducting NGP and in the structure of mental health units in Australia. The findings from this study cannot be directly compared to findings of other studies as there are no published ethnographic studies of the experiences of NGs transitioning into MHN. However, the findings of this study have similarities to the studies presented in Chapter two relating to the experiences of new nurses entering MHN. The transitional experiences of other disciplines or ranks of nursing were also not explored in this study – these groups may hold similar or different views to the participants. However, the aims of this study were to explore the experience of the NGs in entering the culture of MHN. In exploring data collection choices, although the timeframes chosen represented different days and times of the week for field observations, there may have been activities or situations not observed, and so there may be additional elements in the NG experience not explored. It is challenging to learn everything within the setting. Choices were made to describe particular events, activities, and interactions over others. Not all units were able to be covered in this research site. There was a small sample size within a single health services which is reflective of qualitative methodology. However, this was strengthened by incorporating the views of RGs in addition to the NG participants across

three hospital sites. Another challenge was in having data collection confined to the staff-only settings, which meant there were elements of the NG experience that may not have been observed. However, this was less of a concern where the bulk of the practice occurred in the vicinity of the nurses' station allowing for the majority of the activities to be observed – with the added strength of interview data to explore the NG experience.

10.6 Conclusion

This study provides a greater depth to understanding the experiences of NGs as they enter the culture of MHN. The findings of this research demonstrate the complexity of the transition process and the different facets of transition not represented in the existing literature. Ethnography provided an effective method to explore the experiences of new nurses entering MHN by exploring the everyday activities as new nurse graduates joined the cultural group. The use of field observations provided an opportunity to observe the interactions between cultural members and observe the activities within the mental health unit. The semi-structured interviews allowed for the deeper experiences of participants to be explored. To meet the challenges of attracting NGs to MHN and retaining mental health nurses, changes need to be made in the undergraduate preparation of nurses, the structure and function of the NGP, and in the MHN culture – particularly when considering the ideal of holistic, consumer-centred and less restrictive nature of contemporary mental health care. Exploring the experiences of new nurses' sheds light on to the beliefs, behaviours and

attitudes held by the cultural group in relation to MHN care and in the assimilation of new nurses to clinical practice.

10.7 Autobiography

Undertaking of this study has been an invaluable learning experience for me. I gained a deeper understanding of the nature of research and the cyclical nature of the research process. I learnt that things do not fit neatly into categories and that research can be frustrating and tedious as well as exciting. In reflecting on my own experiences of transitioning, I was not aware of the significance of my own socialisation into the MHN culture or how my beliefs, behaviours, and attitudes had been shaped. I began my practice within inpatient environments where restrictive practices were the norm. The first shift in my thinking occurred when I moved into community-based services. This is where I really began to learn therapeutic engagement practices. I have now spent most of my clinical practice outside of the inpatient setting. Writing up this research represented a challenge – it required me not only to investigate the experiences of NGs, but also to situate this within the MHN culture itself.

Considering the culture and how this is shaped also meant that I needed to reflect on my own experiences and to take the etic perspective of mental health nursing practice. I took the journey with the participants to reflect on *what mental health nursing is*. My conclusion is that it is incredibly complex, shaped by historical factors and shaped by the context in which it is practiced. This has certainly been the case for the different roles I have held as a mental health

nurse. In entering mental health nursing, I have encountered the disproval of others and have felt the stigma associated with being a mental health nurse. Through this journey of exploring the culture and following the journey of the participants, I feel more passionate about bringing awareness to the forces shaping mental health nurses. This research journey has allowed me the opportunity to examine my own professional values. I have reflected on my own identity as a mental health nurse, my experiences of transition and the cultural practices I assimilated. This has sparked passion within me to continue the journey of exploring the culture and bringing awareness to the practices shaping mental health services.

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Appendices

Appendix 1 – Ethical approval University of Newcastle

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Professor Tony O'Brien**
Cc Co-investigators / Research Students:	**Doctor Graeme Browne** **Ms Mary-Ellen Hooper**
Re Protocol:	**An ethnographic study of the new graduate nurse's experience when encountering the culture of acute mental health services**
Date:	**25-Aug-2016**
Reference No:	**H-2016-0051**
Date of Initial Approval:	**25-Aug-2016**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **25-Aug-2016**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2016-0051**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress*, *Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
    - Causing death, life threatening or serious disability.
    - Causing or prolonging hospitalisation.
    - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
    - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
    - Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
    - Participant's study identification number;
    - date of birth;
    - date of entry into the study;
    - treatment arm (if applicable);
    - date of event;
    - details of event;
    - the investigator's opinion as to whether the event is related to the research procedures; and
    - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook
Chair, Human Research Ethics Committee

For communications and enquiries:
Human Research Ethics Administration

Research Services
Research Integrity Unit
NIER, Block C
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref

Appendix 2 – Ethical approval health service one

[redacted]

1 November 2016

Ms Mary-Ellen Hooper
School of Nursing & Midwifery
University of Newcastle

Dear Ms Hooper,

Re: An ethnographic study of the new graduate nurse's experience when encountering the culture of acute mental health services (16/09/21/4.07)

[redacted]

Thank you for submitting the above application for single ethical review. This project was first considered by the [redacted] at its meeting held on **21 September 2016.** This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the [redacted] as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the [redacted] website.

I am pleased to advise, the [redacted] Human Research Ethics Committee has determined that the above protocol meets the requirements of the *National Statement on Ethical Conduct in Human Research* and following acceptance of the requested clarifications and revised Research Information Statement and Participant Information Statement and Consent Form by Dr [redacted], Research Ethics & Governance, under delegated authority from the Committee, grants ethical approval of the above project.

The *National Statement on Ethical Conduct in Human Research (2007),* to which the Committee is obliged to adhere, includes the requirement that the Committee monitors the research protocols it has approved. Ethics Approval will be ongoing subject to the following conditions:

- A report on the progress of the above protocol is to be submitted at 12 monthly intervals. A proforma for the annual report will be sent at the beginning of the month of the anniversary of approval. Your review date is **October 2017.**
- All variations or amendments to this protocol must be forwarded to, and approved by, the [redacted] Human Research Ethics Committee prior to their implementation.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled.
- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
    - Notify the reviewing HREC of any adverse events that have a material impact on the conduct of the research in accordance with the NHMRC Position Statement:

[redacted]

Monitoring and reporting of safety for clinical trials involving therapeutic products May 2009
https://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e112_nhmrc_position_statement_monitoring_reporting_safety_clinical_trials.pdf

- Unforeseen events that might affect continued ethical acceptability of the project.

➢ If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform [redacted] as soon as possible.

The following documentation has been reviewed and approved by the [redacted] Human Research Ethics Committee:

Document	Version	Date
Research Information Statement -Observation	Version 2	undated
Participant Information Statement and Consent Form	Version 2	undated

Approval has been granted for this study to take place at the following site:

- [redacted]

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact [redacted] per the details at the bottom of the page. The [redacted] Research Ethics Committee wishes you every success in your research.

Please quote **16/09/21/4.07** in all correspondence.

[redacted] Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

[redacted]
Chair
[redacted] Human Research Ethics Committee

[redacted]

Appendix 3 – Ethical approval – Local Health District two

[redacted]

[redacted]

2 May 2017

Ms Mary-Ellen Hooper

[redacted]

Dear Ms Hooper

SSA Ref: 17/G/085
HREC ref no: HREC/16/HNE/401
Project title: An ethnographic study of the new graduate nurse's experience when encountering the culture of acute mental health services. An ethnography of the culture of mental health nursing

I refer to your Site Specific Assessment application for the above titled project. I am pleased to advise that on 1 May 2017, the District Director Mental Health Services granted authorisation for the above project to commence at the [redacted]

In addition to the documents approved by the lead Ethics Committee which provided the ethical approval for this study, the following documents have been reviewed and approved for this study [redacted]

- [redacted]
- [redacted]

The following conditions apply to this research project. These are additional to any conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and are submitted to the lead HREC for review, are copied to the Research Governance Officer.

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the Research Governance Officer.

[redacted]

Manager, Research Support Office

2017.05.02_ Ms Mary-Ellen Hooper - Approval Ltr_17-G-085 Page 1 of 1

[redacted]

Appendix 4 – Research information sheet

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Research Information Statement

Student researcher: **Mary-Ellen Hooper**
Primary Supervisor **Dr Graeme Browne**
Secondary Supervisor: **Professor Anthony O'Brien**

Project title: **An ethnographic study of the new graduate nurses' experience when encountering the culture of mental health nursing**

Background and purpose of the study

My name is Mary-Ellen Hooper and I am a Doctoral research student at the School of Nursing and Midwifery, the University of Newcastle. I have been a Registered Nurse working in mental health since 2007. This project is an ethnographic study of the subculture of New Graduate nurses working in mental health nursing. This study has grown out of my interest in mental health nursing and in particular how this is experienced by new graduates.

How will research be conducted?

This study involves me observing (like a fly on the wall) interactions between new graduate nurses and their colleagues and their general activities within the staff-only areas of each mental health inpatient unit in [redacted] I also plan to interview each of the new graduate nurse participants, as well as some recently graduated nurses.

- **Field observation**
  This involves my observing new graduates in the workplace as they go about their normal duties within the staff-only areas. I will conduct up to six (6) hours of observation per participant – in blocks of up two (2) hours at a time. I will also make confidential notes during this time so I do not forget things I see. Whilst I may also observe other nurses and staff during this time I will not be noting any other behaviour than the interaction with the nurses who have consented to be in this study and I will not be recording any names within the notes that I make.

Involvement is voluntary

I will seek the verbal agreement of any one that is present during the observation period. If you do not wish to be observed, then please advise me and I will not undertake any observation while you are present. You may also ask for the observation to cease at any time.

Risks and benefits of participating

You may or may not receive any direct benefit from taking part in this study. Your contribution to the study however, will help me to further understand the experiences of transitioning into mental health nursing as a new graduate nurse. I will ensure that all periods of observation in your workplace are kept to a minimum with my presence as unobtrusive as possible.

The findings from your contribution to this research will be combined and used in the writing up of my thesis. This will include submitting these findings in journal articles and presenting them as

conference papers. All data will be anonymously aggregated (combined). I will provide feedback by making the results of the study available to your workplace once the study is completed.

How will your privacy be protected?

Any information that you provide will not be disclosed to persons outside the research team – *except in situations where mandatory reporting is required, such is through illegal conduct.* Any reports or publications written will not identify you or any other persons that participate in this doctoral research project.

Your name and any other details that might identify you will not be recorded All transcripts and observation notes will identify participants with a unique identifier/pseudonym. All data collected will be stored in password-protected file on my computer hard drive and all field notes and interview data will be stored in a locked filing cabinet. All data will be destroyed after seven (7) years as per the University of Newcastle's data storage guidelines.

If you require any further information on this project, please do not hesitate to contact myself, or the primary or secondary supervisor listed below.

Yours sincerely,

Mary-Ellen Hooper
Student researcher
mary.hooper@uon.edu.au
[redacted]

Primary Supervisor
Dr Graeme Browne
University of Newcastle
School of Nursing and Midwifery
Port Macquarie Campus

Secondary supervisor
Professor Anthony O'Brien
University of Newcastle School of Nursing and Midwifery
Callaghan Campus

[redacted]

Complaints
This research has been approved by the [redacted] Human Research Ethics Committee of [redacted] Reference 16/09/21/4.07

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the

[redacted]

Appendix 5 – Participant information sheet

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Participant Information Statement

Student researcher: **Mary-Ellen Hooper**
Primary Supervisor **Dr Graeme Browne**
Secondary Supervisor: **Professor Anthony O'Brien**

Project title: **An ethnographic study of the new graduate nurses' experience when encountering the culture of mental health nursing**

Background and purpose of the study

My name is Mary-Ellen Hooper and I am a postgraduate student enrolled in a PhD at the School of Nursing and Midwifery at the University of Newcastle. I live in Sydney and I am a Registered Nurse in mental health nursing. I have worked in this field since 2007. My supervisors for this research project are Dr Graeme Browne and Professor Anthony O'Brien.

This project is an ethnographic study (qualitative) of the subculture of New Graduates working in mental health nursing. This study has grown out of my interest in mental health nursing and in particular how this is experienced for new graduates. I hope that by joining you in your workplace, I can learn about your experiences.

How will research be conducted?

This study involves me observing (like a fly on the wall) interactions between new graduate nurses and their colleagues and their general activities within the staff-only areas of each mental health inpatient unit. I also plan to interview each of the new graduate nurse participants, as well as some recently graduated nurses.

- **Phase I – Field observation** *(for new graduate nurses only)*
  This involves my observing you in your workplace as you go about your normal duties within the staff-only areas of your workplace. I may have to conduct up to six (6) hours of observation – in blocks of up two (2) hours at a time. I will also make confidential notes during this time so I do not forget things I see.

- **Phase II – Interviews** *(for both new-graduate nurses and nurses who have graduated in the last five years)*
  This involves my asking you to participate in an interview with questions relating to your experiences as a new graduate nurse in mental health nursing. This interview may take up to an hour to complete and will be taken at a time and place that is convenient to you and your workplace supervisor. I could also meet you before or after your shift if that is easier. I will need to digitally record the interview and you will have the opportunity to review the interview transcript once it is typed up.

Involvement is voluntary

At all times I (student researcher) will ensure that your interests and rights are protected. Choosing to participate in this research is entirely voluntary. Your decision to participate, not participate, or to withdraw from the research will not affect your future relations with [redacted]

[redacted] In the unlikely event that the study, or the presence of the student researcher during observation causes you distress, you can ask to leave the study and no longer participate. Alternatively, it can be arranged that I return at a later time.

Although the period of field observation involves the observation of new graduate nurses, other staff members within the setting may be observed interacting with you. I will also ask for verbal consent from any of your colleagues who may interact with you during the time that you are being observed. Every time I (student researcher) present to your workplace, I will ensure I have your consent and the consent of your colleagues to observe.

Risks and benefits of participating

You may or may not receive any direct benefit from taking part in this study. Your contribution to the study however, will help me to further understand the experiences of transitioning into mental health nursing as a new graduate nurse. It is possible that you may feel anxious being observed. The research team are aware that the process of progressing through the new graduate year may already be stressful, and thus I do not want to place undue stress on you during this time. All periods of observation will be kept to a minimum with my presence as unobtrusive as possible.

The findings from your contribution to this research will be combined and used in the writing up of my thesis. This will include submitting these findings in journal articles and presenting them within conference papers. All data will be anonymously aggregated (combined). I will provide feedback by making the results of the study available to you at your request and once the study is completed.

How will your privacy be protected?

Any information that you provide will not be disclosed to persons outside the research team – *except in situations where mandatory reporting is required, such is through illegal conduct.* Any reports or publications written will not identify you or any other persons that participate in this research. Your name and any other details that might identify you will be removed from the interview transcripts and the notes that I make. All transcripts and any observation notes will identify participants with a unique identifier/pseudonym. Any data collected from you will be stored in password-protected file on my computer hard drive and all field notes and interview data will be stored in a locked filing cabinet. All data will be destroyed after seven (7) years as per the University of Newcastle's data storage guidelines.

What do I need to do?

When field observations are being made, please go about your normal business. I will not be interacting with you and this is called non-participant observation. These periods of observation will not exceed two (2) hours at a time. Each participant will be observed for a maximum of six (6) hours in total. The in-depth interviews will involve up to an hour of your time. It will involve answering some questions relating to your experiences as a new graduate nurse. I will digitally record the anonymous interviews.

If you agree to participate in this study, please sign the attached consent form and return it to the student researcher in the supplied envelope. Alternatively, you can hand your sealed envelope to your Clinical Nurse Educator. For those who are new graduate nurses, you are invited to participate in both phases 1 and 2, whilst nurse graduates in the last five years are only able to participate in phase 2. Please indicate on the consent form which phase(s) you are consenting to participate in.

If you require any further information on this project, please do not hesitate to contact myself, or the primary or secondary supervisor listed below.

Yours sincerely,

Mary-Ellen Hooper
Student researcher
[redacted]

Primary Supervisor
Dr Graeme Browne
University of Newcastle
School of Nursing and Midwifery
[redacted]

Secondary supervisor
Professor Anthony O'Brien
University of Newcastle School of Nursing and Midwifery
[redacted]

Appendix 6 – Consent

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Consent

Title of study: **An ethnographic study of the new graduate nurses' experience when encountering the culture of acute mental health services**

Student researcher: **Mary-Ellen Hooper**
Primary Supervisor **Dr Graeme Browne**
Secondary Supervisor: **Professor Anthony O'Brien**

- I confirm that I have read and understood the Participant Information Sheet, for the above study and what my participation in the research will involve. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation in this study is voluntary and that I am free to withdraw at any time without giving any reason, and decisions to participate or decline in participating in the research will not affect my treatment in the workplace.
- I understand that I will not be identifiable in any data collected. However, verbatim quotations from my interview may be used anonymously in the report produced from this study, in papers produced for publication, and for conference presentation. If I choose to withdraw from the study, any data I have contributed will be destroyed.
- I agree to the use of audio-recording for interviews, and understand that the process of transcribing this data will be carried out by the student researcher Mary-Ellen Hooper. These tapes will be stored in a locked and secure place and will be destroyed seven (7) years after the research has been completed.

I **consent** to participate in: *(please tick which ever is applicable)*
Phase 1 – Observation *(new-graduate nurses only)* ☐
Phase 2 – Interview *(all participants)* ☐

I **do not consent** to participate in this study ☐

Name of participant	Date	Signature

NB. A copy to be retained by the participant, and the original to be retained in the researcher's site file.

Version 2 – 28th October 2016

Appendix 7 – Sample interview schedule

Interview Schedule

Thank you for agreeing to participate in this interview.
Are you aware that the interview will be audiotaped and transcribed verbatim?

1. Demographic information:
   Age; educational preparation; year that you commenced nursing; role title; additional formal education.

2. I am interested in your experiences as a new graduate in mental health nursing, what do you think it is important for me to know?

   Depending on the response to this question, the next questions may be used.

3. What has been your experiences of the transitional (new graduate) program?

4. Why did you choose to work in mental health nursing?

5. How would you describe mental health nursing to somebody who is not in the field?

6. Can you tell me about the challenges in your role?

7. Can you tell me about your relationship with other staff members?

8. What can you tell me about your experience adjusting to the culture of mental health nursing?

9. How is it different from other nursing fields?

10. What is it like for a new graduate to fit into this culture?

11. Is there anything else about being a new graduate nurse that you would like to tell me?

Appendix 8 – TPP program guide

Introduction and Welcome

[redacted]

look forward to you being part of the Mental Health workforce as you enter the beginning of an exciting and dynamic career in mental health nursing. The transition program will provide you with an amazing opportunity to be a part of a group of learners that encourages you to be curious and expand you knowledge. Every experience and encounter you are about to be part of will help shape the nurse you become, the possibilities are endless. The program will be inspiring, motivating and enabling. There will be some challenges however you will be well supported by the education team and clinicians that you work with.

We provide a contemporary evidence based TTPP program that upholds the [redacted] principles of:

- Orientation
- Induction
- Framework
- Support
- Learning & Development
- Person Centred Work Culture

Mental Health Nursing is an exciting, inspiring, rewarding and at times complex career choice for those nurses who wish to support and work with people who experience a mental illness.

Mental health nurses offer a range of clinical interventions aimed at promoting the individuals wellbeing and supporting the person's recovery by working with the individual to understand their own abilities and uniqueness. Mental Health nurses assist people to live lives that are meaningful and encourage opportunity to take personal responsibility and make choices regarding their own health care.

[redacted] is committed to ensuring a recovery oriented mental health service, this includes sensitivity and respect for each individual, particularly for their values, beliefs and culture.

While nurses need to understand the dynamics of mental health nursing, comprehensive nursing care involves more than focusing on pathology.

Mental health nurses recognise that each individual is an expert in their own lives and that recovery involves working in partnership with people and their carers to provide support in a way that makes sense to them. Focusing on illness only leads to an emphasis on problems. Mental health nursing involves focusing on the strengths of mental health consumers and supporting people's rights to be involved in the decision making about their own care.

The aim of your program is to support you in making the first step, keeping going and finally letting go (Drury, Francis, & Chapman, 2009) discuss the importance of to using existing foundations of knowledge and skills gained from your experience as a nursing student and apply it using new learning opportunities presented by the program enhancing transition into the workplace.

Table of Contents

Learning Objectives

COGNITIVE DOMAIN

Analyse and integrate clinical decision making skills through application in mental health nursing practice.

AFFECTIVE DOMAIN

Integrate nursing knowledge values, information and ideas into mental health nursing practice

Appreciate the centrality of the therapeutic relationship in mental health nursing practice.

PSYCHOMOTOR DOMAIN

Demonstrate respect for and value of the humanity of mental health consumers.

Demonstrate the ability to assess, plan, implement, evaluate and document nursing care in accordance with mental health consumer needs, nursing knowledge, available evidence and professional standards. Adapts the standard of professional practice and for the utilization of the policies, procedures and standards of New South Wales Health.

Stages of Learning: From novice to advanced beginner

The program applies the principles of adult learning to enable the transition from a novice to an advanced beginner.

Patricia Benner (1982) introduced the concept that expert nurses develop skills and understanding of nursing care over time through a sound educational base as well as a multitude of experiences. The aim of this program is to help you advance from a novice to an advanced beginner in the field of mental health nursing. The program is designed to provide a sound educational base while your clinical work offers you a multitude of experiences to embed the theory you examine in the program.

NOVICE (COMMENCEMENT OF THE PROGRAM):

- Taught general rules to help perform tasks
- Rules are: context-free, independent of specific cases, and applied universally
- Rule-governed behaviour is limited and inflexible for example, "Tell me what I need to do and I'll do it."

ADVANCED BEGINNER (COMPLETION OF THE PROGRAM):

- Demonstrates critical thinking and safe practice.
- Has gained prior experience in actual situations to recognize recurring meaningful components.
- Principles, based on experiences, begin to be formulated to guide and develop skills and expertise.

REMEMBER, YOU ARE RESPONSIBLE FOR YOUR OWN LEARNING, TO BE PREPARED FOR EACH STUDY DAY YOU NEED TO BE WORKING THROUGH THE RELEVANT MHPOD MODULES, WORKBOOK TOPICS AND PRESENTATIONS.

Time Allocation

This diagram represents your entire program, the whole learning environment in which you will be supported to move forward. As you can see, the study day aspect of the program is only a small percentage, the remainder is embedded within your clinical world; clinical supervision, support from your preceptor and mentor, time out to

Program Components: A whole environment learning approach

1. NSW Health Transition to Mental Health Nursing-Participant Workbook: reflective activities

You are supported to progress through the self-directed learning and reflective learning activities in the NSW Health Transition to Mental Health Nursing-Participant Workbook (TMHPN) (2013).

The resource will help you as a registered nurse make the transition to becoming a mental health nurse. This will assist the nurse to begin developing a broad knowledge and clinical base, required to care for consumers you will be working with. The workbook will be discussed at the study days and completion supported by your local education team.

2. Mandatory Training

Mandatory training includes -Safety for All: Foundations and Safe Physical Restraint (four days), Domestic Violence Screening, Child Protection, Sexual safety policy training, DETECT and HETI online learning.

Attendance to any training needs to be approved by your Nurse Unit Manager and your Clinical Nurse Educator will assist with the planning, ultimately keeping up to date with mandatory training is an individual responsibility. You will be required to check HETI regularly to ensure you are compliant.

3. Study day attendance -Co-facilitators and guest speakers

You are expected to attend and engage in 10 study days throughout the year.

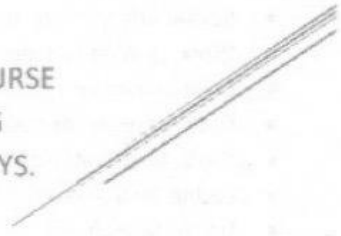
Any leave is to be arranged outside of these dates.

Attendance will be recorded and absenteeism will be reported to your line manager. Failure to attend study days will be reflected on the Transition to Mental Health Nursing Program Transcript and certificate on completion of the program in terms of reduced continuing professional development hours.

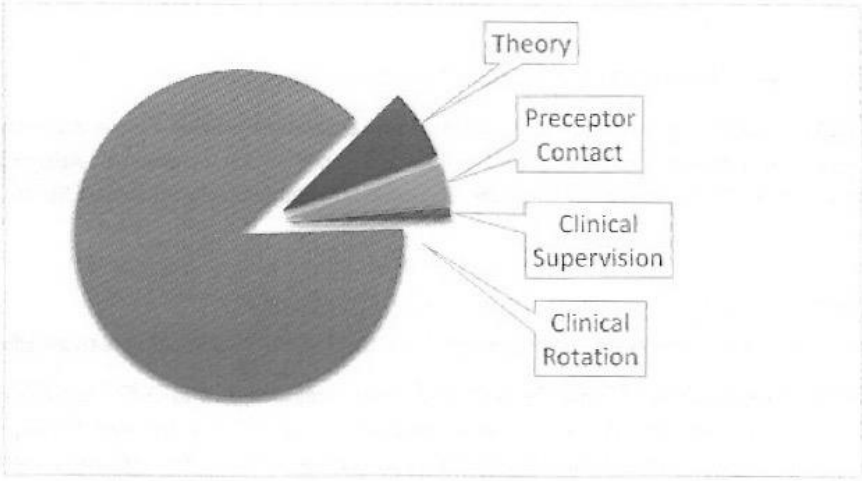
It is your responsibility to contact the program coordinator and inform them of your absence before the study day.

A range of study day co-facilitators and guest speakers will be invited as clinical leaders in their field to share their knowledge and expertise. Working in Mental health has many exciting career pathways and this will provide you with an understanding of the future opportunities for a long career ahead in mental health.

IMPORTANT: IT'S YOUR RESPONSIBILITY TO COMMUNICATE TO THE NURSE UNIT MANGER REGARDING ROSTERING FOR STUDY DAYS.



complete the MHPOD modules, workbook topics and consumer journey presentations and working with individuals and their carers to obtain a greater understanding of a person's lived experience.



4. Transition to Professional Practice 2017 Study Day Topics

- Self-care and resilience, resources.
- Communication, body language, boundaries, verbal de-escalation, reduction of restrictive practice
- Introduction to Strengths and recovery.
- Patient safety program information
- Mental state assessments, purposeful engagement and role plays.
- Assessment skills and role modelling
- Care planning, strengths focus and interpretation.
- Risk assessments and purposeful engagement.
- Clinical care of people who may be suicidal.
- Alcohol and other drugs: assessment and intervention
- Mental Health Act 2007
- Physical Health and Psychiatric Medications
- Let's talk about Adherence
- Storytelling, Peer Workers and Peer Educator role
- Recovery College information.
- Hearing Voices network
- Mental Health diagnosis, making sense, and interpretation.
- Intellectual Disability, how to engage with consumers, families and partners
- Distress Management Program
- Psychological input- what to do next.
- Trauma Informed Care
- Aboriginal Health and mental Health

Specialty Areas

- Sexual safety policy and education
- Working With Families
- Child and adolescent Mental Health
- Older persons Mental Health
- CALD, Multicultural Health
- Eating Disorders and mental health
- Domestic violence
- Perinatal Mental health

5. MHPOD

You are required to complete these mandatory online training topics within the first six months. The modules can be accessed via HETI on line. Completion will be assessed at your first performance appraisal with your manager and preceptor.

Further information about MHPOD modules is included in the NSW Health TPP participant workbook, and can be discussed with the education team. Below is a table that links the MHPOD module with the NSW Health workbook module.

TABLE 1: MHPOD MODULES

MHPOD MODULE	WORKBOOK MODULE
1. Professional Ethics	4.5
2. Building the therapeutic relationship	4.12
3. Mental health histories and MSE	4.8
4. Risk assessment & management	4.9, 4.10,
5. Pharmacological interventions	4.14
6. Effective documentation in clinical files	4.4
7. Impacts of medical conditions	4.6
8. Dual Diagnosis	4.7
9. Recovery	4.11
10. International and National Mental Health Policy	4.2
11. Culturally Sensitive Practice	4.15
12. Effective Working Within the Multidisciplinary Mental Health Team	4.16

6. Clinical Skills Workbook-assessment of clinical proficiencies

You will be required to complete the Transition to Professional Practice Program Evidence of Clinical Skills Workbook 2017 prior to the end of the study day program.

The aim of the workbook is to assess and guide your development and application of mental health nursing knowledge in the clinical domain.

Your final transcript will record the satisfactory completion. Every skill assessed relates to your NSW Health Transition to Professional Practice workbook and as an extension of MHPOD.

Final sign off will be endorsed by your local education team, and you will need to provide the completed workbook to your team prior to day 9 of the study day program.

A variety of tools will assess your clinical proficiency in seven core mental health nursing skills.

TABLE 2: SEVEN CORE MENTAL HEALTH NURSING SKILLS ASSESSED IN CLINICAL PRACTICE ARE:

LEARNING ACTIVITY	CLINICAL PROFICIENCIES
4.4	Effective documentation in clinical files
4.8	Mental health histories & mental state examination
4.9, 4.10	Risk assessment & management
4.11	Recovery-based practice
4.12	Communication & building the therapeutic relationship
4.14	Psychopharmacology
4.2	Legal context of mental health nursing

7. Consumer journey presentation

You will be required to prepare two presentations by the end of the program. This will involve working with a consumer and their carers that you have personally cared for in your role as part of the multidisciplinary team. Your preceptors and the education teams will be a valuable resource in discussing clinical decisions and questions regarding the structure and presentation of your consumer journey presentation.

You will be required to work with the local team and coordinate a time for you to present to your peers on the unit. Ongoing discussions and support will be provided as you come together for the study days. Information and instructions are part of the Clinical Proficiencies workbook.

8. Transition to Professional Practice In-service program

At each site both a mental health and generic Transition to Professional Practice In-service program is offered to all program participants across the Health District. It is an expectation that you familiarise yourself with local programs and attendance is encouraged.

9. Clinical Supervision

[redacted] recognises and supports that supervision of practice at the point of care, and through reflection in, and for practice, is essential to the development of nurses who are skilled and knowledgeable and capable of providing integrated and effective care.

Clinical supervision focuses on clinical practice and provides support and development within a relationship of mutual trust. It is an enabling partnership where you can constructively think about your practice, the care that you give and the issues that cause you concern, as well as celebrating the things that are going well.

It is also important within such a relationship that you share good practice and begin to explore the assumptions that you make about your practice and how you work with others, as this will help you value what you do.

Clinical supervision provides a personal, safe space for you to think about your professional and personal needs and can play a significant part in helping the practitioner to learn and develop from experience by providing effective professional support.

Ultimately clinical supervision is about valuing yourself in the workplace and coping with increasing work demands, allowing time out to think about and analyse what you are doing in an attempt to deliver a good standard of care.

You are responsible for establishing and maintaining clinical supervision with a group or as an individual. You need to negotiate agreeable dates with your supervisor well in advance and inform your nurse manager who will secure that date and time on the roster.

It is a requirement of you as an individual to maintain a record of attendance and notes on clinical reflection and learnings this will be best recorded as part of your professional portfolio.

Maintaining a reflective diary is an important part of the study process and continuing professional development (CPD)

10. Yammer

Yammer account - You will be provided with the opportunity to access a Yammer account. (Communication tool)

Yammer will provide the TTPP group with the ability to discuss ideas, share updates and resources, communicate as a group and access knowledge across the organisation. The education group will provide information and education on how to access Yammer, the etiquette and the policy requirements to utilise the communication tool. Link to social media policy:

[redacted]

11. Academic Transcript

On completion of your program, in study day 10 you will receive your academic transcript and graduate certificate (See Appendix 1 Sample Academic Transcript). This document is a record of completion of the learning activities that compromise the program.

Service Responsibilities

The [redacted]lental Health Services take responsibility for providing participants in this program the following:

- Leave to enable participants to attend study days regardless of staffing levels.
- Clinical support, that is, a suitable staff member to act as a preceptor and a mentor.
- Clinical supervision
- IT support (i.e. e-mail account and access to intranet facilities)
- Support and assistance in undertaking assessment activities (e.g. involvement in consumer assessments).

Program Coordinator responsibilities

The [redacted] coordinator is responsible for ensuring that participants receive all materials at commencement of the program, and will liaise with participants regarding any alteration to the timetable, location and content of the study days.

The [redacted]s a contact person for participants to discuss any concerns regarding their progress throughout the duration of the program. However the local education teams will be providing ongoing local support and guidance.

The [redacted] collaboration with the local education teams will establish and maintain a data base for the participant's record of attendance, contact details, record of rotation of placement, clinical supervisors and mentors and coordination of MHPOD and workbook completion.

Local education support team responsibilities

The site education support teams work very closely with the [redacted]n and are responsible for providing local site support and guidance to participants.

The site education team will oversee and provide the endorsement for satisfactory completion of MHPOD, the Evidence of Clinical Skills in Practice Workbooks and consumer journey presentations. The site education team will provide feedback to the [redacted]n to ensure requirements are complete.

The site education team will assist with the allocation of a preceptor and mentor and support the coordination of clinical supervision.

Preceptor responsibilities

A preceptor is an experienced clinician in mental health nursing who provides participant role support and learning in the Transition to Mental Health Nursing Program.

The preceptor will work closely with you for the duration of the program to assist you in acquiring new competencies required for safe, ethical and quality mental health nursing practice. Your preceptor will assist you with assessing the competencies in the Evidence of Clinical Skills Workbook.

Preceptors are also responsible for ensuring that each participant receives an adequate orientation to the clinical area. You will be allocated a preceptor at each rotation throughout the year.

Mentor Responsibilities

A mentor is someone who will support and encourage transition nurses to manage their own learning in order that they may maximise their potential, develop their skills, improve their performance and shape the way for professional development.

The mentor will work with you throughout the duration of the program. The mentor in collaboration with the participant is responsible for ensuring regular times are provided to meet.

Final Thoughts

Looking after yourself

We recognise the importance of looking after yourself throughout the year.

Vicarious trauma is the transformation of the therapists or helpers inner experience as a result of empathic engagement from exposure to survivor consumers and their trauma material. It refers to the cumulative transformative effect on the helper working with the survivors of traumatic life events.

Self-care is important and is defined by the World Health organisation as activities individual's families and communities undertake with the intention of enhancing health, prevent disease and limit illness and restore health. Throughout the year it will be important to reflect on self-care and this will be supported and discussed throughout the program.

Looking towards your future

Your clinical world is rich with learning opportunities, you will be working with many multidisciplinary clinicians who are eager to provide education and support, we encourage you to find out who these clinicians are, ask question be curious and reflect.

Remember to set aside at least 6 hours each week over the year to complete the MHPOD modules, consumer journey presentations and workbook topics.

Seek out every opportunity to embed in your nursing care the work examined in all areas of learning.

The education team wish you the best for the year ahead and look forward to getting to know you as you enter the exciting career of working in [redacted]

Explore the possibilities, the best is yet to come!

Appendix 1 Sample Academic Transcript

Program Requirements

Learning activities attempted in this course:

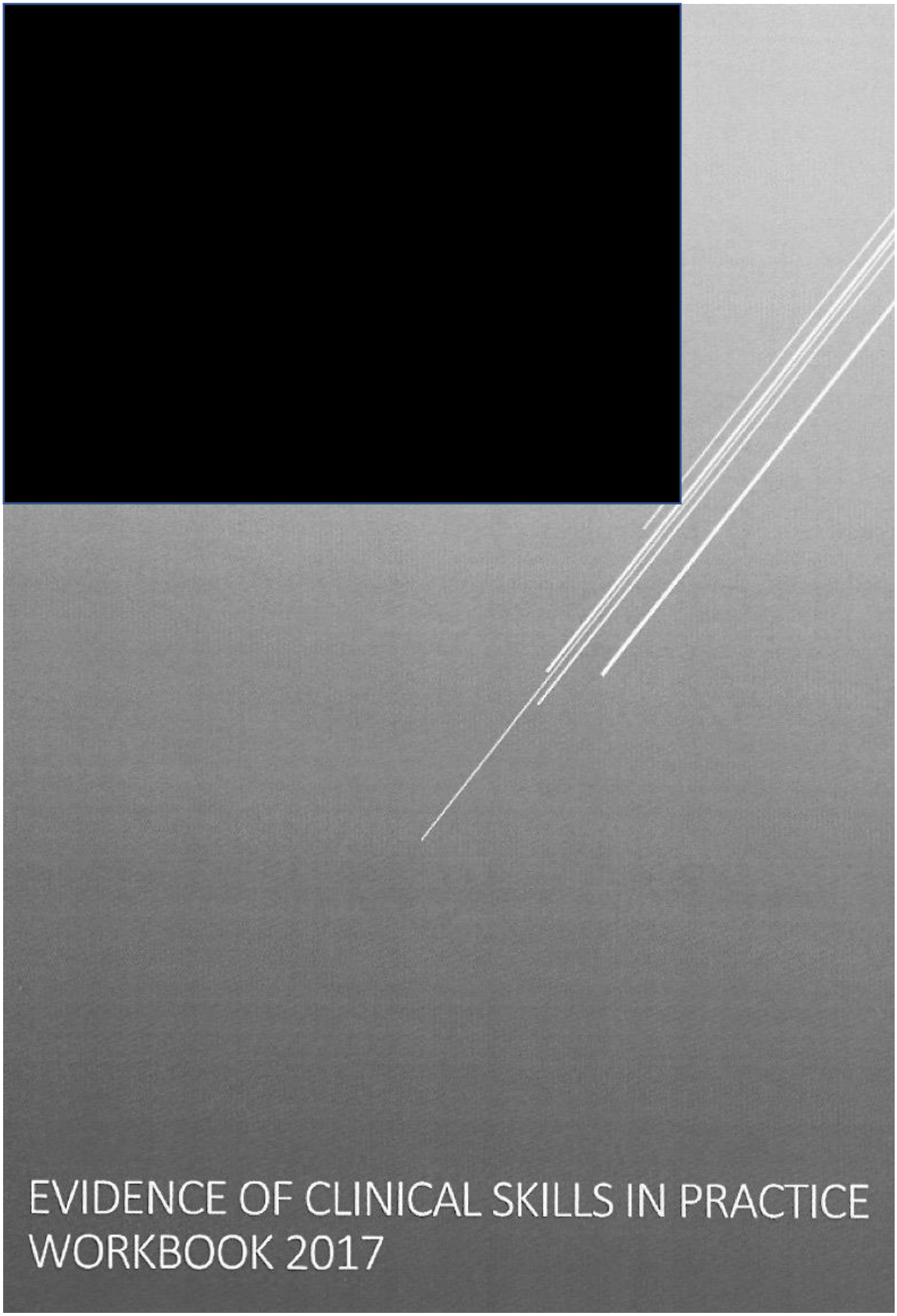
Assessment item	Grade
DETECT e-learning	Satisfactory
DETECT Workshop	Satisfactory
Transitional Support Program	
Study days	
Transition to Professional Practice Mental Health Nursing Workbook	
MHPOD Transition to Mental Health Nursing	
Evidence in clinical practice of core mental health nursing skills as an extension from MHPOD	
Completion of two consumer journey presentations	
Mental Health Transitional Registered Nurse - Orientation/ Induction program	
TPP in-service program	
Clinical Supervision	

Key to Grades

Grading Scale

Satisfactory	This assessment item is not weighted but graded as having met the requirements of the objective
Unsatisfactory	This assessment item is not weighted but graded as having not met the requirements of the objective

Appendix 9 – TPP Evidence of clinical skills in practice workbook



Contents

Name: _____

Hospital: _____

Introduction

This workbook is to be used in conjunction with the Transition to Professional Practice program guide.

You will be required to complete the Transition to Professional Practice Program Evidence of Clinical Skills Workbook 2017 prior to the end of the study day program.

The aim of the workbook is to assess and guide your development and application of mental health nursing knowledge in the clinical domain.

Every skill assessed relates to your NSW Health Transition to Professional Practice workbook and as an extension of MHPOD.

Final sign off will be endorsed by your local education team, and you will need to provide the completed workbook to your team prior to day 9 of the study day program.

There will be some challenges however you will be well supported by the education team and clinicians that you work with.
Your final transcript will record the satisfactory completion of the seven clinical proficiencies.

These clinical proficiencies can be the completed by working with the same person as part of completing the consumer journey presentations or you may choose a different consumer to work with.

Timeline

Time frame	Learning outcomes	Completion
Within the two weeks	Become confident in understanding: • Roles (different staff across service) • Ethics (Area • Team (who's who)	Date: Signature:
Within 1 month	• Complete the oral and IM checklist • Request and attend all study day • Observed documentation is reflective of policy requirements.	Date: Signature:
Within 2 months	• The major mental illnesses-symptom identification & care • Risk assessment • MSE • Basic de-escalation skills • MHA • Pharmacology • A&OD • Comprehensive assessment	Date: Signature:
Within 3 months	• Completed the MSE • Performance appraisal • Attending clinical supervision • Fortnightly sessions with preceptor • Demonstrate an ability to apply MH knowledge	Date: Signature:
Within 6 months	• Completed MHPOD on line modules • Completed on line and F:F DETECT training • Performance appraisal • Proficient performing • MSE • Comprehensive assessments • Working with families knowledge • Crisis Intervention • Care Planning focusing on consumers strengths • De-escalation skills	Date: Signature:

Within 9 months	Starting to implement techniques in: • Diversity • Safety for All principles	Date: Signature:
At 9 months	• Performance appraisal • Complete risk assessment • Complete Psychopharmacology	Date: Signature:
At 10 months	• 3rd and 4th MSE • Comprehensive assessment • Nearing completion of all clinical proficiencies	Date: Signature:
Within 12 months	Confident/proficient in- • Assessments • Building therapeutic relationships • Writing care plans & formulating impressions. • Starting to take charge of the clinical area Teaching others • Lead more crisis and input into specialised areas.	Date: Signature:
At 12 months	• Performance appraisal • All clinical proficiencies complete	Date: Signature:

Clinical Proficiencies

(1) Effective documentation in clinical files

- Observed documentation is reflective of policy requirements. Date, time, signed, clinically relevant, logical and coherent. Correct place of entry – uses correct entry site in EMR, five entries reviewed
- Documentation accurately reflects the clinical presentation
- Documentation entry reflects the:
- Admission process &
- Discharge process, two entries reviewed
- Documentation uses a structure with the following components:

☐ Strategic engagement

☐ Consumers goals & level of engagement

☐ Mental state examination (MSE)

☐ Risk assessment

☐ Changes in presentation

☐ Response to treatment – medications, psychological - group program

☐ Early warning signs, relapse prevention

☐ Clinical impression / summary (Inpatient setting - care level & leave)

☐ Plan- for next 24hrs

Workbook activity resource:

[redacted]

Completion

Signature: **Date:**

(2) Mental health histories and mental state examination

- Outline the aim of conducting each component of an assessment
- Conducts a full MSE in the 1st 3 months
- Conducts a further 2 MSE in the remainder of the year
- Conducts a comprehensive assessment in the last 3 months of the year
- Demonstrates the establishment of sound engagement (listening, observing behaviour & emotional responses and builds an understanding of the consumers view)
- Formulate an impression from the MSE conducted
- Identifies interventions and a plan with the consumer
- Documentation is reflected in eMR of content explored in MSE
- Develops a care plan with the consumer

Workbook activity resource:

- 4.8

Completion

Signature: Date:

(3) Risk assessment & management (use table in activity 1 to complete)

- Identifies the different areas of risk
- Identify environmental risks
- Perform a risk assessment in 3 areas following the template listed in **activity 1.**
- Explores the meaning and impact of the risk on the consumer.
- Describe other indicators of risk – age, types of stressors and change from baseline. What behaviours would you see that might be of concern?
- Determine the urgency of the risk, immediate interventions & evidence of prioritisation in workload. Describe the intervention.
- Document a risk assessment in eMR.
- Plan is in alignment with policy requirements i.e. suicide framework.
- Explain how the plan works involving the consumer.

Workbook activity resource:

4.9 & 4.10

Completion

Signature: Date:

(4) Recovery-based practice

- Assessor will observe how the Transition to Professional Practice participant discusses with a consumer what recovery means to them- goals, strengths.
- Collaboratively engages in writing a consumer wellness plan.
- Explain how the wellness plan is part of recovery based practice –e.g. Personal Choice, responsibility, autonomy, strengths, protective factors.
- Develops a care plans utilising the principles of the strengths model of care.
- Review a care plan throughout admission.

Workbook activity resource:

4.11

Completion

Signature: Date:

(5) Communication and building a therapeutic relationship

- Discuss Interpersonal skills with your preceptor e.g. empathetic understanding, unconditional positive regard and what it is to show genuine interest
- Discuss and demonstrate an understanding of communication skills e.g. active listening, open and closed questioning, reflecting content, reflecting feelings, summarising, reframing.
- Discuss and demonstrate an understanding of transference, countertransference and maintaining boundaries.
- Demonstrates the use of empathy.
- Demonstrates skills of engagement.
- Demonstrates a sense of purpose and direction within interviews (strategic engagement)
- Demonstrates clear concise accurate communication to the multidisciplinary team e.g. when requesting a review, updating care, seeking clarification
- Demonstrates clear concise accurate communication to external health care professionals e.g. discharge handover

Workbook activity resource:

4.12

Completion

Signature: Date:

(6) Psychopharmacology (use table in Activity 2 to complete)

- Identify 2 antipsychotics: you must chose Clozapine as one, a mood stabiliser, a tricyclic antidepressant, a SSRI/SNRI, a benzodiazepine then complete the **table in activity 2.**
- Observed to administer 5 oral and 3 IMI medications use **table in activity 2.**
- Engages a consumer in an education session regarding medication- type and reason for medication, adverse effects, precautions, dose range, monitoring effect.
- Describes acute sedation – which medications, routes, monitoring etc.
- Administration of a PRN using a clinical example. Explain to your assessor - what were the indications for PRN medication? What other interventions did you consider? How did you review the outcome?
- Describe the symptoms and clinical management of the following.
    - Neuroleptic malignant syndrome.
    - Lithium toxicity
    - Agranulocytosis
    - Movement disorders
    - Serotonergic Syndrome

Workbook activity resource:

4.14

Reference -MIMS

Completion

Signature: **Date:**

(7) Legal context of mental health nursing (appendix 1)

- Define mental illness in accordance with the Mental Health Act (MHA)
- Describe the differences between mental illness and mental disorder in accordance with the MHA
- Describe the legal processes that mandate a person being treated against their will?
- Describe the process of how a person comes into hospital against their? Who can do this? What forms need to be completed and when to detain a person under the MHA?
- Describe the rights of consumers.
- Describe how you would explain the statement of rights to a consumer
- Explain the process of appeal for discharge
- Describe your role in working within the MHA in relation to a – breach, enforcing care, leave requests
- Describe a clinical example of how & when you would enact duty of care?
- Describe how you would assess for capacity to give informed consent
- Describe the principles around nominating a primary carer for a voluntary and involuntary consumer

Workbook activity resource:

4.2

Completion

Signature: Date:

Activity 1 - Risk Assessment and Management:

Instructions: In the tables below, choose three types of risk and complete a risk assessment for each risk type. One of the risk types must be risk of suicide. The other types can be risks that are relevant to your clinical experience/area.

Suggested risk types: **Suicide – imminent high risk, Suicide / deliberate self-harm- ongoing, Sexual safety, violence, neglect, vulnerability.**

Risk 1

Type of Risk:	
Clinical Findings:	
Interventions – specific to consumer, consider the environment and safety plan.	
Contributing external factors	
Interventions and agreed plan	

Risk 2

Type of Risk:	
Clinical Findings:	
Interventions – specific to consumer, consider the environment and safety plan.	
Contributing external factors	
Interventions and agreed plan	

Risk 3

Type of Risk:	
Clinical Findings:	
Interventions – specific to consumer, consider the environment and safety plan.	
Contributing external factors	
Interventions and agreed plan	

Activity 2- Psychopharmacology knowledge:

Instructions: In the spaces below, choose an example of a medication for each drug group and complete the required information.

Medication type:	**Antipsychotic**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Medication type:	**Antipsychotic**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Medication type:	**Mood stabiliser:**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Medication type:	**Tricyclic antidepressant:**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Medication type:	**SSRI / SNRI:**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Medication type:	**Benzodiazepine:**
Generic Name	
Trade Name	
Therapeutic Effect	
Dose	
Adverse effect:	
Education points:	

Activity 3- Oral and IMI checklist:

Inpatient Mental Health Medication Checklist for New Staff

As a newly registered nurse on the Mental Health Unit you must complete the medication checklist for new staff.

New staff are to administer oral medication to five consumers and give three Intramuscular injections whilst being supervised by a permanent senior staff member/ preceptor. Administration must include:

- Correct procedure using the 5 rights, Aseptic non touch technique (ANTT):
- Knowledge of Infection Control and Work, Health & Safety Considerations
- Demonstration of product knowledge
- Reason for administration
- Possible side effects

Upon completion of supervised administration, Registered nurses may administer both oral and IMI medications without supervision within their scope of practice.

Supervised Oral Medications (activity 3)

Date:	Time:	Demonstrate correct procedure using five rights, product knowledge, reason for administration, , possible common side effects & correctly signs medication chart:	Supervisor/preceptor: Signature and printed name.
1.			
2.			
3.			
4.			
5.			

Activity 4. Consumer journey presentation

You will have the opportunity to be rotated through clinical specialties.

During these rotations you will be expected to prepare two consumer journey presentations.

This will require you to work with a consumer you have personally cared for in your role as a member of the multidisciplinary team and prepare related documents to support the plan.

These presentations can be the same person you have worked with as part of completing the clinical proficiencies skills requirements or you may choose a different consumer to work with.

The activities can be completed in any order during year.

Directions

You will be required to include examples of your direct involvement with the consumer and your presentation must reflect direct collaboration with the consumer and their carer's.

Activities/ Presentations:

1. Complete a collaborative care plan, wellness plan, consumer safety plan and leave and discharge information form. You will present this in a 20-30 minute presentation to your team.

2. Complete a comprehensive mental health assessment with a consumer including: Background history, past and current psychiatric history, psychosocial aspects including cultural and personal beliefs.
   Include reason for current contact with mental health and family and carer involvement. You will also need to include the consumer's strengths and discuss a collaborative care plan you have devised with the consumer. You will present this in a 20-30 minute presentation to your team.

All information regarding the consumer will be de identified to ensure confidentiality.

Your facilitators, educators and the Workplace Capabilities team will be a useful resource in discussing any clinical decisions and concerns regarding the development of your presentations.

Please refer to the marking criteria for more detail on what is expected of your written work.

As a Transition to Practice Mental Health Nurse you are required to meet the national standards for a registered Mental Health Nurse. This will include reflection to ensure evidence base practice.

Your presentations must reflect that you are meeting the domains. Please refer to the National Competency standards for the registered nurse from the Nursing and Midwifery board of Australia.

Domains

Professional Practice

Critical thinking and analysis

Provision and coordination of care

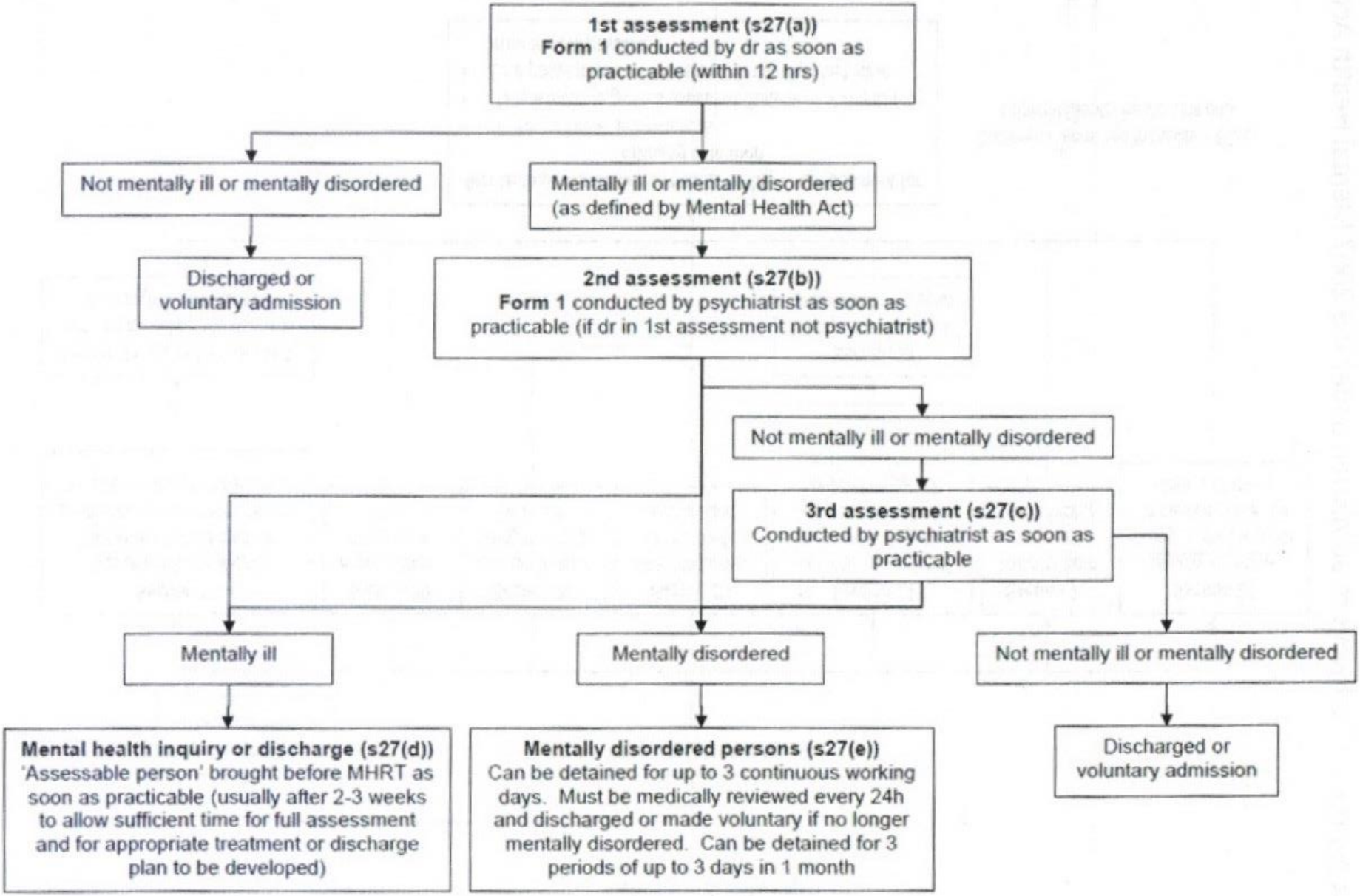
Collaborative and therapeutic practice.

Marking Criteria/expectations

Element	Comments	Satisfactory	Unsatisfactory
Presentation 1.	Presented to your team in a 20 min presentation.		
Care plan			
Wellness plan			
Safety Plan			
Leave and discharge information form			
Evidence of collaboration with consumer			

Presentation 2.	Presented to your team in a 20-30 minute presentation.		
Comprehensive Mental Health assessment			
Past and current psychiatric history			
Psychosocial aspects			
Cultural personal beliefs			
Reason for contact			
Evidence of carer/family involvement			
Strengths focus and care plan			
Evidence of collaboration with consumer			

Appendix 1 – Pathways to admission under the 2007 Mental Health Act.


1st assessment (s27(a))
Form 1 conducted by dr as soon as practicable (within 12 hrs)
Not mentally ill or mentally disordered
Mentally ill or mentally disordered (as defined by Mental Health Act)
Discharged or voluntary admission
2nd assessment (s27(b))
Form 1 conducted by psychiatrist as soon as practicable (if dr in 1st assessment not psychiatrist)
Not mentally ill or mentally disordered
3rd assessment (s27(c))
Conducted by psychiatrist as soon as practicable
Mentally ill
Mentally disordered
Not mentally ill or mentally disordered
Mental health inquiry or discharge (s27(d))
'Assessable person' brought before MHRT as soon as practicable (usually after 2-3 weeks to allow sufficient time for full assessment and for appropriate treatment or discharge plan to be developed)
Mentally disordered persons (s27(e))
Can be detained for up to 3 continuous working days. Must be medically reviewed every 24h and discharged or made voluntary if no longer mentally disordered. Can be detained for 3 periods of up to 3 days in 1 month
Discharged or voluntary admission

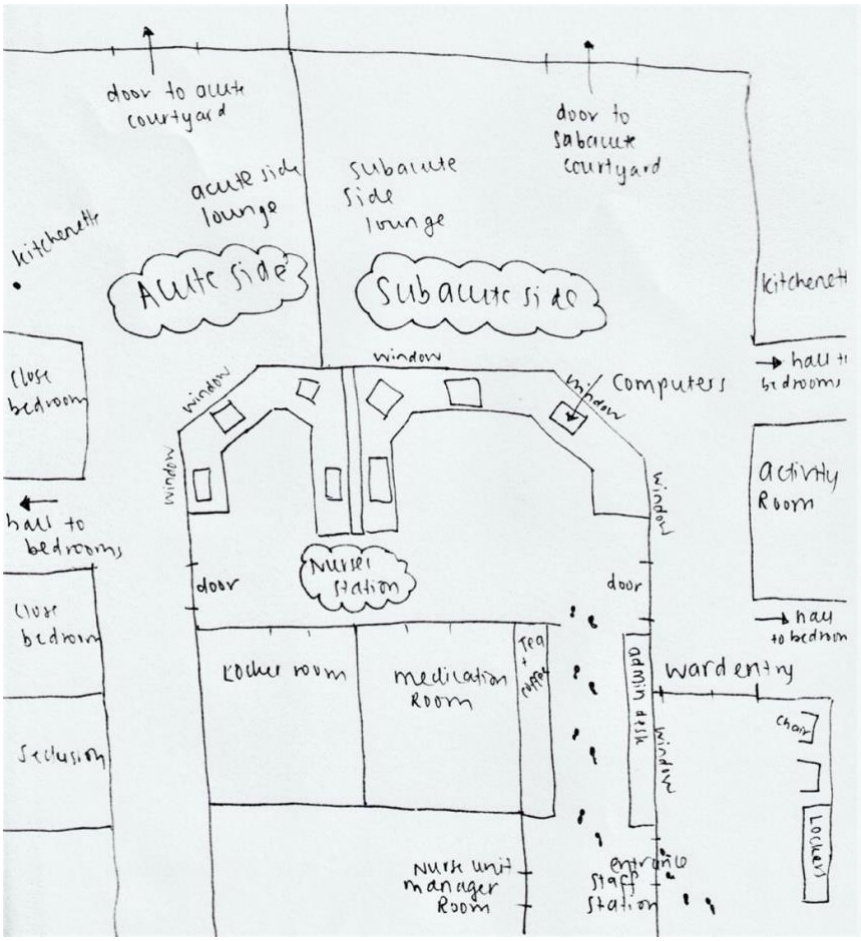
Appendix 10 – Hospital site one description

Hospital site one

The mental health unit in hospital site one has twenty-eight beds with ten on the acute side and eighteen on the subacute side of the unit. The nurses' station sits in the middle of those two sides and therefore both sides can be viewed from the nurses' station. Each side of the unit has a paved courtyard, with seaside inspired murals painted on the walls for consumers of the service to use. The wall of the courtyard is several metres high making it difficult for any person to climb the wall and leave the unit. On the subacute side there is a large, combined dining and living room area with various tables and sofas arranged. There was a separate room with glass walls that had a pool table and activity tables inside. On the acute side, the lounge area was smaller with fewer objects and furniture visible, such as only a couple of sofas and a couple of tables and chairs.

Within the nurses' station are two screens that depict eight different views taken by closed circuit television (CCTV) cameras. Despite being able to see down most corridors from the nurses' station, there were additional viewpoints that were visible from the CCTV screens. From these screens I could see that the corridors in the consumer areas have blue linoleum floors and walls painted in blue and creamy white. I reflected that despite working in this unit for a number of years, I would not be able to remember the colour of the floor or walls and noted that approaching this unit from an ethnographic perspective has allowed for the 'taken for granted' to be explored. Despite the various viewpoints from the nurses' station, it is not possible to see inside individual bedrooms or bathrooms – these viewpoints could only be achieved by directly entering the clinical areas and entering each individual bedroom and bathroom. The nurses' station itself is carpeted with a partition running down the middle which serves to divide the nurses' station into two halves. Each half has a horse-shoe shaped desk arrangement, with each side incorporating the partition into that U-shape formation. There are various computers that adorn the U-shaped desks, with enough for each nurse to have use of a sole computer for their shift. The nurses' station has windows

on three side giving the nurses' station an impression of a fishbowl. The walls and partition of the nurses' station are adorned with amateur drawings and paintings. On one of the walls are a number of drawings depicting various Christian names. I was told that these were completed by a consumer staying in the inpatient unit who had completed individual and artistic depictions of each nurses' name on A4 sized pieces of paper. These were of the nurses who were present on the unit during the time the consumer was admitted, representing a snapshot in time. A small model boat sat on the top of the walled partition inside the nurses' station that had small photos of various nurses smiling faces from the unit attached. I was familiar with this unit as a previous nurse a number of years prior, with these artefacts emerging sometime after I had left the unit.



Hospital site one – field drawing of the position of nurses' station within the mental health unit.

Appendix 11 – Hospital site two description

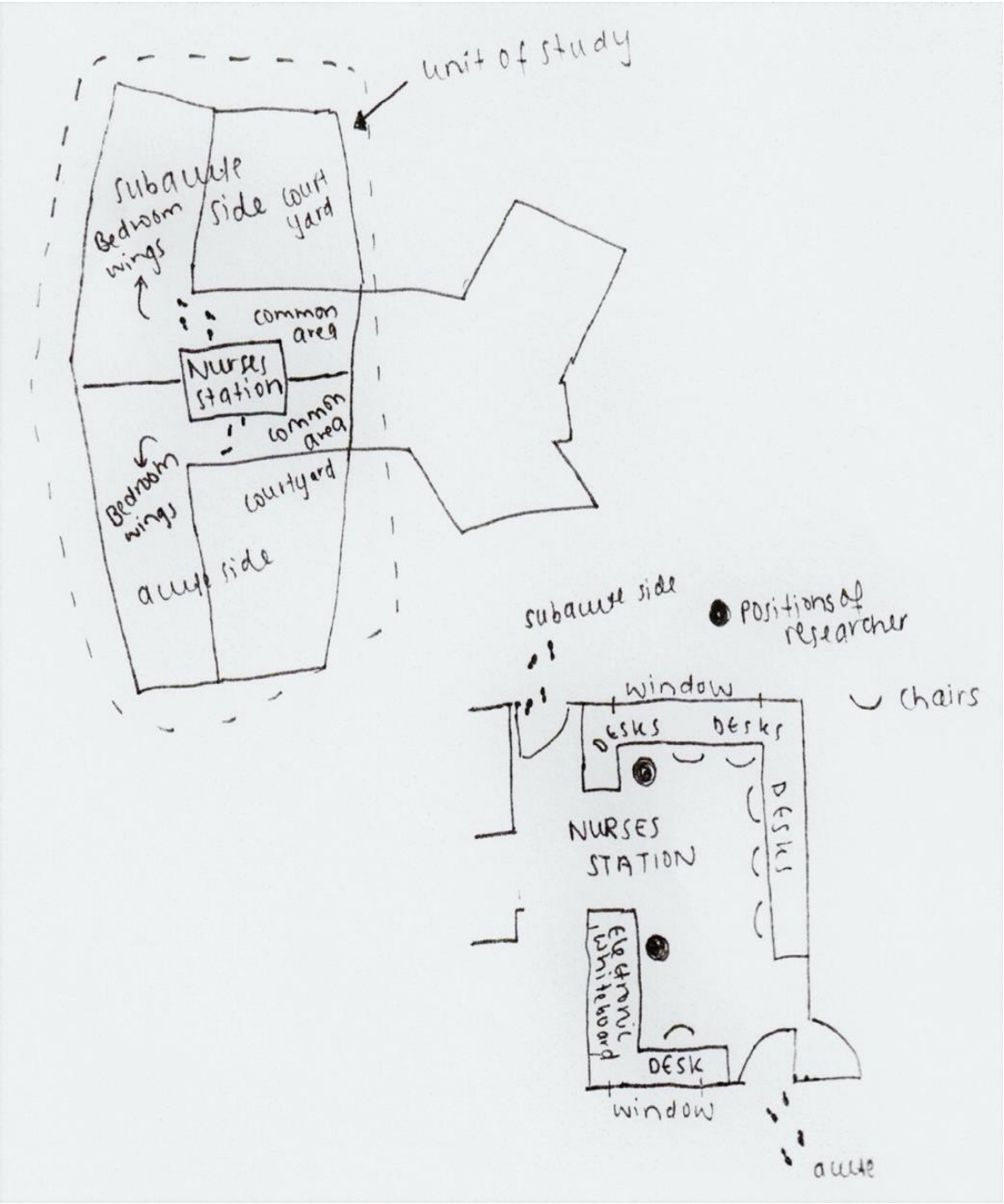
Hospital site two

The mental health unit in hospital site two is located on the same grounds as the general hospital but in a separate building. The unit can be entered by walking up a driveway to the front door consisting of glass double automatic doors that lead into a carpeted foyer with an administration desk to the right. The doors for the mental health unit and OPMHU (not included in this study) both branched off this same foyer.

Similarly, to hospital site one, the nurses' station sits in the middle of the unit with one half of the unit designated as the acute side, and the other half designated as the subacute side. From the nurses' station, the common areas of the subacute and acute sides could be seen. The courtyards in the consumer areas in this site had similar murals painted to hospital site one. I overheard the administration officer explaining to another person that the murals for hospital sites one and two were completed by the same artist. The murals are blue and green in colour and have a strong nature-based theme to them. The acute side courtyard had barrel-shaped plastic tubing running along the top of the wall – similar to that seen in correctional facilities to inhibit people from climbing over the fence. This fence on the subacute side had no additional barriers like the acute side. This fence reminded me of the garden fence in another hospital I had previously worked. In this other hospital, the fence was more symbolic and did not prevent consumers from climbing over and leaving the unit if they really wanted to leave. While I was reflecting on this memory, I overheard the administration officer suggesting that the fence should be higher to prevent consumers from absconding from the unit. Similarly, to hospital site one there were television screens depicting CCTV footage from the unit. This involved two screens, each screen showed four different camera angles of the unit. Although the consumer common areas could be seen from the nurses' station, additional views could be seen from the CCTV footage that could not be seen from the nurses' station. The floor had royal blue linoleum tiles. On the subacute side I could see a similar colour scheme, though the linoleum floor appeared to be a paler

blue in colour. Each of the bedroom doors were also pale blue in colour with a dark blue panel at the bottom of each door. Each door had a rectangular-shaped glass panel in the side above the door handle which allowed for viewing on both sides of the door. I could see that the subacute common area had sofas to one end that were arranged to face a large television that was enclosed behind a Perspex screen.

In the nurse's station itself, the walls are white with the floor carpeted with carpet tiles. The doors from the nurses' station into the clinical areas are heavy-set and have metal panel reinforcement near the door handle and lock. These are doors that are accessible by key or a swipe pass. The nurses' station was rectangular in shape with two narrow ends each with windows looking on to the clinical areas – one window looks into the acute side communal area and the other window looking out on to the subacute communal area. There is an L-shaped desk under the acute side window, which is occupied by the administration assistant, with a large electronic whiteboard on the adjacent wall to the acute window. The subacute window has a U-shaped desk underneath with four computers arranged side by side and two additional computers under the subacute window with one of these computers dedicated to the duress alarm system. On the wall opposite to the electronic whiteboard there are shelves with folders and books.



Hospital site two – field drawing of the outline of the inpatient unit depicting the placement of the nurses' station within the unit.

Appendix 12 – Hospital site three description

Hospital site three

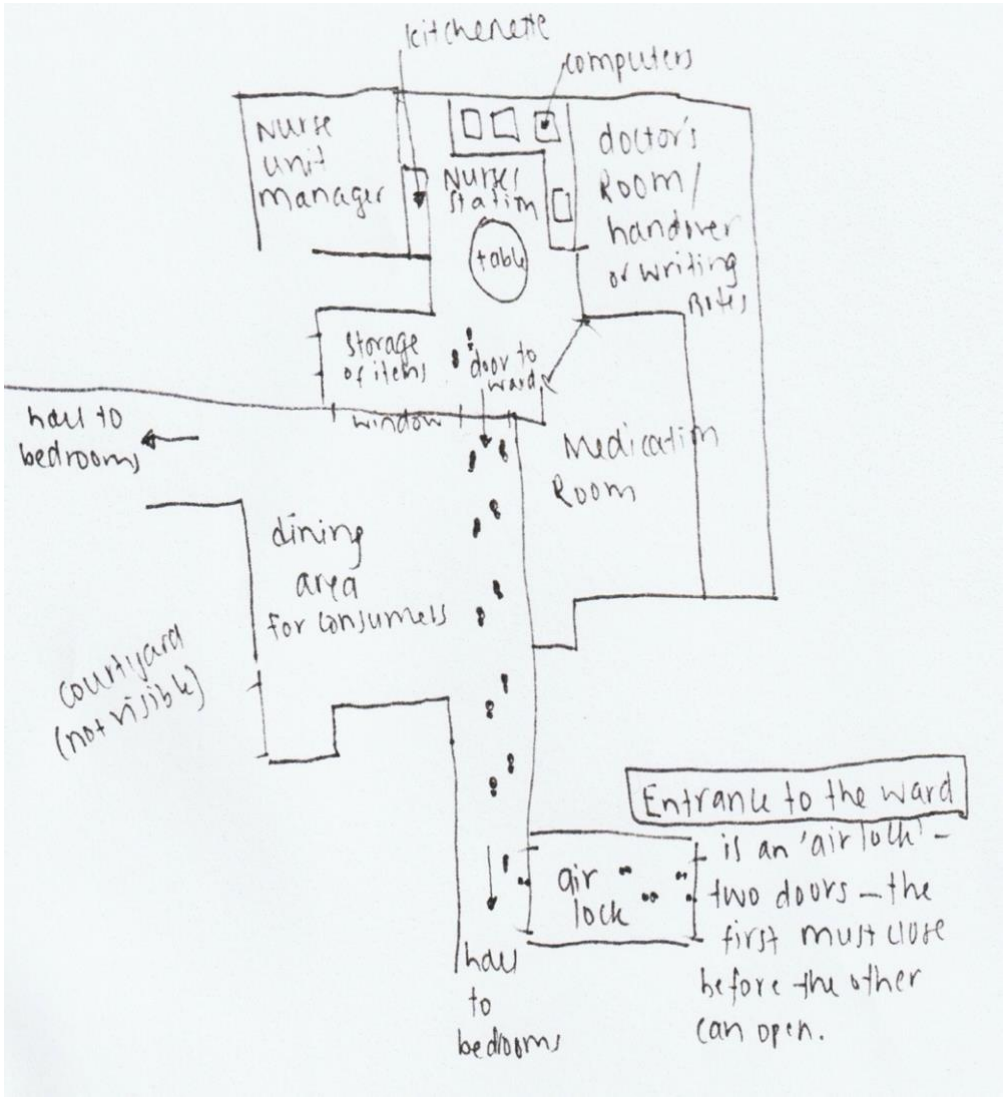
Like hospital site two, the mental health units in hospital site three are largely located on the grounds of the hospital but in separate buildings to the general hospital. Hospital site three included four separate mental health units that were included in this study – two separate acute inpatient mental health units, unit A (subacute) and unit B (acute), a mental health rehabilitation unit, and an older persons' mental health unit.

Mental health inpatient unit A

The mental health inpatient unit A and unit B are located in the same building with separate entrances. In order to enter unit A, visitors need to press a buzzer at the entrance, then a person is able to respond and come to the door to allow entrance. This involves entering an 'air lock' whereby only one door can be opened at a time. This airlock then leads to a corridor that opens up into the communal dining area for consumers and leads to the nurses' station. The building in which unit A and unit B shared was square in shape with the courtyard areas in the middle of the square and the perimeter of the square serving as the corridors for bedrooms and other rooms or offices. The nurses' stations for unit's A and B were in opposite corners of the square. From the nurses' station of unit A, the consumer dining area could be seen as well as the two branching corridors leading to consumer bedrooms. Unlike hospital sites one and two, the bedroom doors in this unit do not have windowpanes built into them. From an ethnographic perspective, I looked at the first impression I had of the unit and then attention to detail. The first impression I had was of a custodial environment with the heavy-set doors and long corridors. However, I focused my attention past the custodial appearance and saw the wooden-appearing linoleum floors and splashes of colour, such as orange and yellow, with brightly coloured amateur paintings in the dining room creating a more homely and cheery feel. I was pleasantly surprised about this after seeing the pale blues and white colours of hospital sites one and two – with the same colours of blue and white in previous mental health units that I had worked in. The

dining area had several long tables and a kitchenette and vending machine for consumers to use. On one wall was a whiteboard with a schedule of activities for the week.

The nurses' station had a larger room with smaller rooms branching off from it though still within the locked area. This included the NUM office, an additional room with computers, and the medication room. Within the nurses' station is a kitchenette with mini-fridge and coffee-making facilities. On one side was a window looking to the outside world and on the other side a window looking into the consumer dining area. Unlike the units already explored, this unit was not in the middle of the unit but on the edge or corner. There was an L-shaped desk in the nurses' station with six computer screens on it that were closely positioned to one another. There was a whiteboard on one wall with the names of the consumers in the unit on it. Under this whiteboard was a small bookshelf with paper files stored. I could see every unit seems has a series of paper files for each consumer and the old historical medical record archives. In the middle of the nurses' station was a medium-sized round table with several chairs. In the corner of the nurses' station is a small screen that displays footage of the front door of the unit. It shows camera footage from both a bird-eye angle and behind the person angled towards the door. On another screen of the L-shaped desk was a screen with CCTV footage. The floor in the nurses' station has royal blue linoleum, with the inside of the nurses' station walls and floor appearing worn with the odd scuff mark from age and marks from old posters or items previously affixed to the walls.



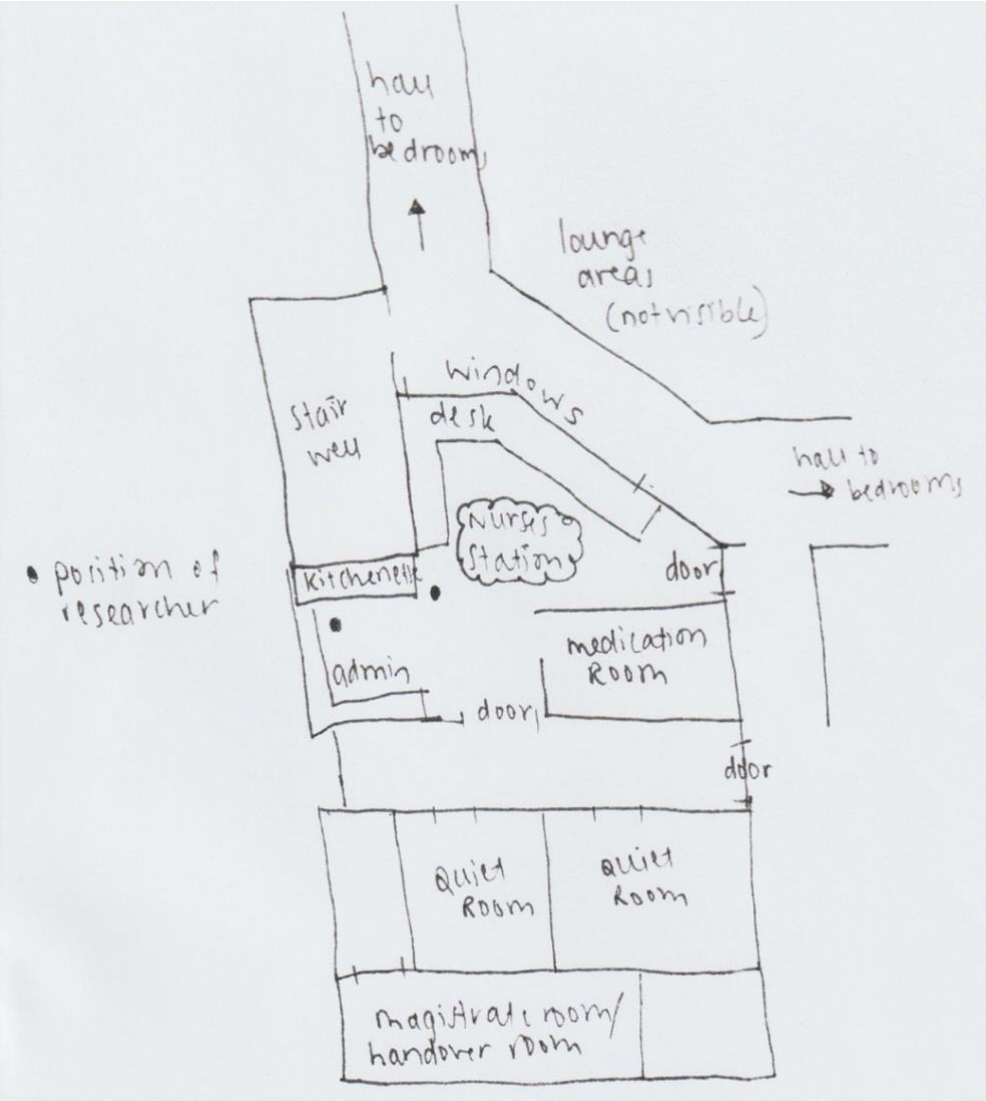
Field drawing of the position of the nurses' station within inpatient unit A in hospital site three

Mental health inpatient unit B (acute)

This unit is located on the opposite corner of the building to inpatient unit A. This unit is designed as the acute inpatient unit, whereas unit A is the subacute inpatient unit. This differs from the units in hospital sites one and two where the units were formally combined. In order to enter the unit, a person needs to press a buzzer and nurse will then allow the person to enter the unit. This involves passing through multiple doors to reach the consumer areas or the nurses' station. In the same fashion as the other units described, it is not

possible to enter the unit without a swipe card or being escorted into the building by a person who already has access.

From the nurses' station it is possible to see that there are two long corridors branching from it, with consumer bedrooms down each corridor. However, it is not possible to see this clearly. Each of the bedrooms has a heavyset door with no window (similar to unit A). Within the unit itself, each of the doors appeared to have metal reinforcement. There are two seclusion rooms which can be seen from the nurses' station. There is a lounge and dining area that is locked, and it was not possible to see these areas from the nurses' station. In the nurses' station itself, I noticed that it has an unusual shape to it with one half close to the consumer area and the other half with the administration area and medication room which was a little more out of sight of the consumers. On the wall outside of the medication room is a large electronic whiteboard – just like in the other units. There are two doors in the nurses' station leading directly into consumer areas and the third door that leads to the corridor with the entrance to the unit and the magistrate's room. I noticed that the medication room was similarly designed to the other units of this study. There is a bench running along the right-hand side with two fridges and some closed cupboards underneath. Above the bench were some shelves with general or 'ward-stock' medications and underneath some plastic tubs hooked onto the wall bracket with the consumers' 'own-medications' inside. On the bench is an open laptop which is used by the nurses to look at the electronic medication chart.



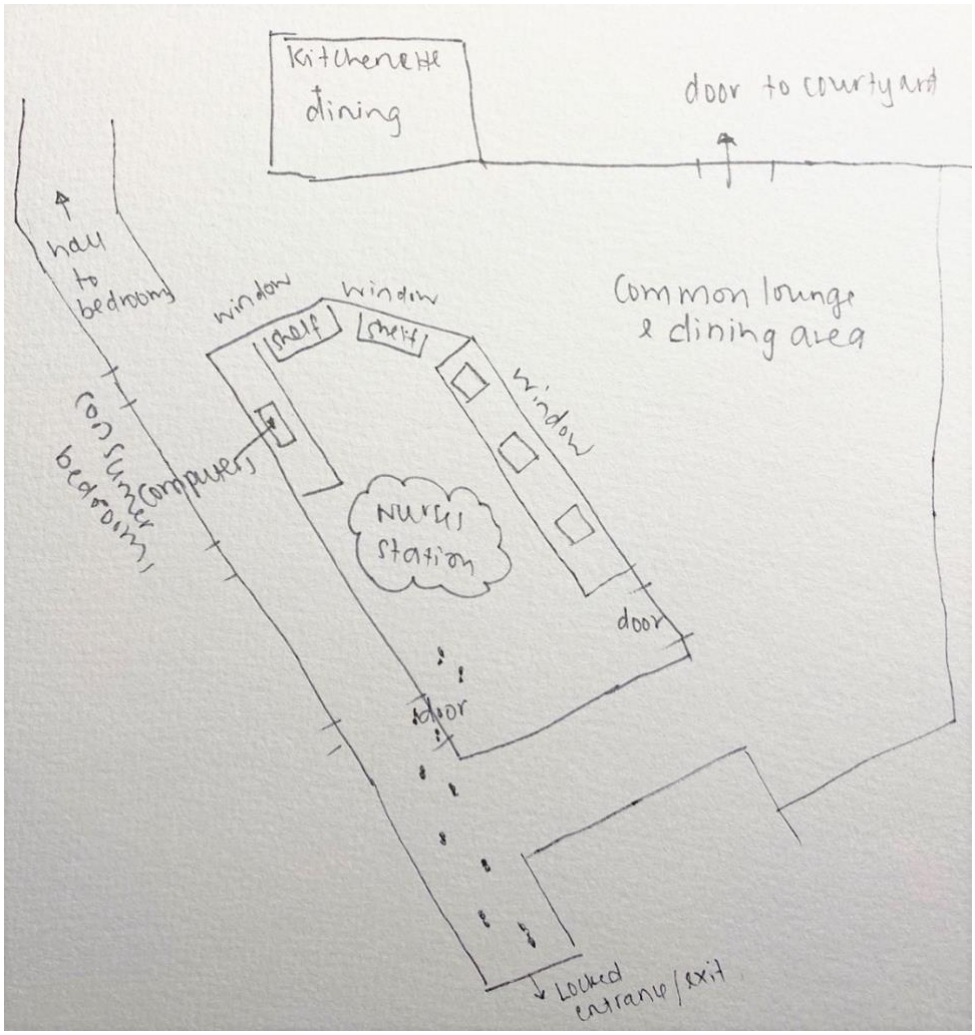
Field drawing of the position of the nurses' station in inpatient unit B

Older persons mental health unit (OPMHU)

The entrance to the OPMHU was shared with the rehabilitation unit. In order to access the unit, there are two locked doors that need to be passed – the first door allows for access to the building into the shared foyer with the rehabilitation unit, and the second door allows for entrance into the OPMHU. This is an eight-bedded unit that is locked similarly to the other units. The layout of this unit is unusual, as is the rehabilitation unit. The other units of this research had modified nightingale-style wards with longer corridors and rooms branching off

from the straight corridors. In the rehabilitation unit and OPMHU, the corridors were not straight creating pockets and blind spots. Interestingly, this was pointed out as both a positive and negative feature of the OAMHU by participants. The nurses' station is an elongated-pentagon-shaped room. There are five walls to the nurses' station, one side of the nurses' station has a long desk, and the other side has a shorter desk. There are two doors to the nurses' station and three sides of the pentagon have windows. There are four computers arranged in the nurses' station – three on the longer desk and one on the shorter desk. There are also two other computer screens – one for the front door camera and one as the electronic whiteboard. One of the doors of the nurses' station led to the consumer dining and lounge area and the other door led to the corridor with consumer bedrooms and the entrance to the unit. On each of the doors to the nurses' station was a sign that read, 'staff only – no entry'. Although the nurses' station was able to be locked, during my observations the nurses generally sat with the doors sitting open.

Outside the window above the longer desk is the combined lounge and dining room. There is a view of the lounge and dining area that opens onto a small courtyard. The loungeroom has a television on the wall and a bookshelf in the corner with books for the consumers to read. The dining room has multiple large tables and a kitchenette for the consumers to use. Outside in the courtyard are some pieces of exercise equipment. The walls of the unit were mostly cream in colour with some walls in the nurses' station and lounge area painted blue. Each of the consumers bedroom doors were painted in different colours – this was highlighted by the nurses as a way for consumers to distinguish their rooms more clearly.

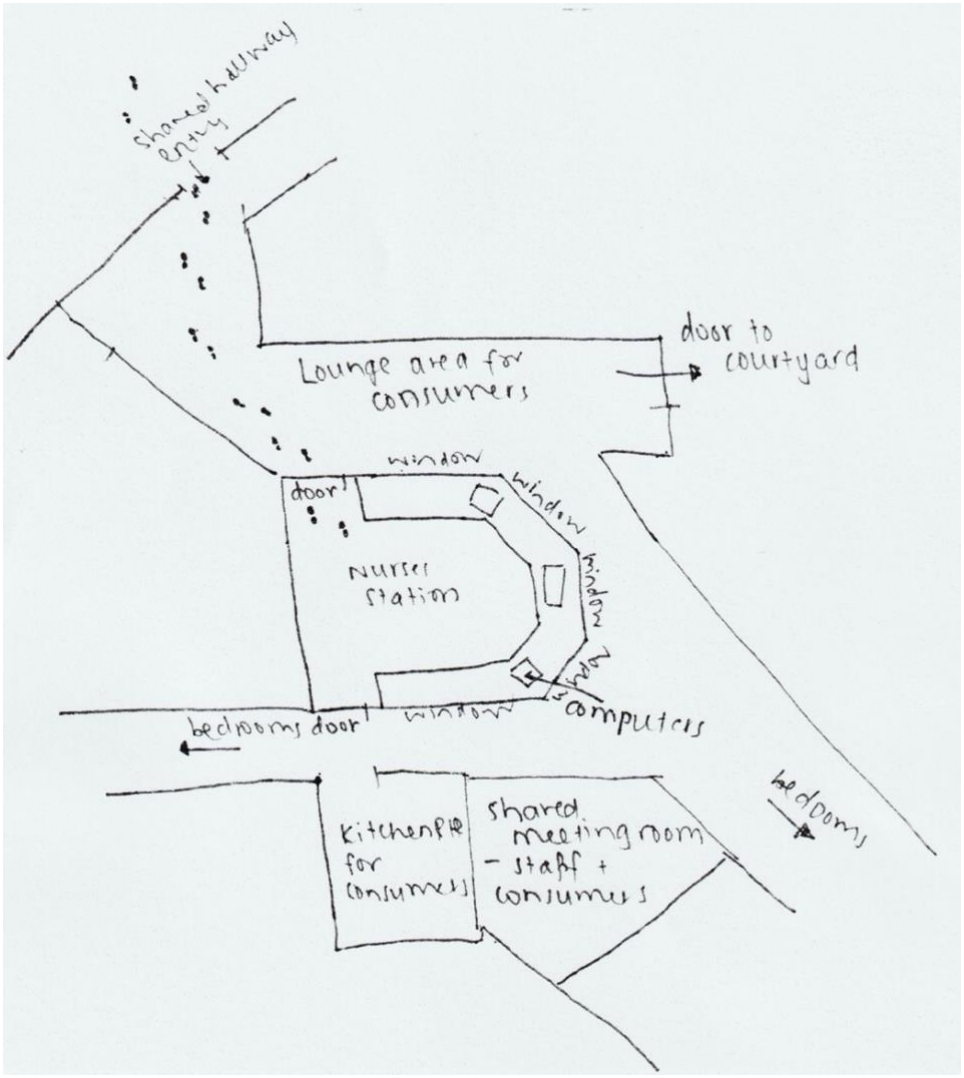


Field drawing of the position of the nurses' station within the OAMH unit

Mental health rehabilitation unit

The entrance to the rehabilitation unit is shared with the OPMHU and involves walking up a ramp to a small undercover area. The rehabilitation unit has an unusual layout which is difficult to document. The nurses' station does sit within the middle of the unit and is locked in the same way as the other units already discussed. There are fourteen beds, however, during the time of research only twelve beds were being used due to renovations occurring. The unit is not divided in any way and all consumers share the same space. On one side of the nurses' station was the lounge area and on the other side was the dining area and

kitchen. In the lounge area there are a couple of sofas and a television, and there are several pieces of exercise equipment and a large fish tank. The fish tank was endearing and not something that I expected to find in a mental health unit. In the nurses' station itself, the room was small and semi-circular in shape with two doors and windows along the circular side. A semi-circular desk ran along the window side with five computers all practically side by side and a large printer. Next to one of the doors was an intercom system and screen for monitoring the front door. On the solid wall of the nurses' station was a large television screen that was switched off – however this was intended to be used as an electronic whiteboard similarly to the other units.



Field drawing of hospital site three – rehabilitation unit and the nurses' station