PILOTING A PROGRAM TO SUPPORT THE TRANSITION FROM CLINICAL NURSE TO NOVICE NURSE EDUCATOR

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15 December 2018

Project

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Ethics/Trial No: SCGOPHCG HRE 2016-0274

Citation for this report

Slatyer, S, Kimberley, A, Davis, S. (2017). *Piloting a program to support the transition from clinical nurse to novice nurse education.* Centre for Nursing Research, Sir Charles Gairdner Hospital, Nedlands, Western Australia.

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ACKNOWLEDGEMENTS

ABSTRACT

Background

Nursing education is a specialised profession. However, many nurse educators are appointed on the basis of their clinical rather than educational expertise and are expected to transition into the new role with limited support. Experiences of role ambiguity, anxiety, isolation and reduced job satisfaction are common. Building on previous work at Sir Charles Gairdner Hospital, indicating that role ambiguity, role blurring and feelings of isolation were widespread among Staff Development Nurses (SDNs), this project aimed to develop, implement and evaluate a Transition Support Program (TSP) tailored to the needs of novice SDNs. A secondary aim was to pilot processes to identify newly appointed SDNs throughout the hospital in order to provide the TSP at the point of transition.

The specific objectives were to:

1) Assess the extent to which SDNs in this setting experience issues of role ambiguity and overload; stress and anxiety; job satisfaction; structural empowerment; and self-efficacy in this hospital setting

2) Develop and evaluate a TSP targeted to novice SDNs

3) Compare levels of role ambiguity and overload; stress and anxiety; job satisfaction; structural empowerment; and self-efficacy between novice SDNs who receive the pilot TSP and those who receive usual support

4) Evaluate the feasibility and acceptability of the TSP.

Methods

The project used an action research design to address the problem of new SDNs' lack of clarity about what was required of them and how to equip themselves with resources and information, and their consequent experiences of isolation and stress. A nurse researcher (SS) and an experienced SDE (AK) collaborated to conduct one cycle with four phases: Reflection, Planning the TSP, Implementing the TSP, and Evaluation. A survey of experienced SDNs in permanent or acting positions was conducted at the two time points to investigate levels of stress, anxiety, job satisfaction, structural empowerment, and self-efficacy in this setting. The TSP was developed with input from an expert panel, and consisted of an e-learning educational resource, and structured mentoring. The TSP was implemented and evaluated using a randomised control trial (RCT) design. New SDNs who commenced between October 2016 and July 2017 were randomly allocated to receive the TSP and usual support (intervention group) or usual support alone (control group). Data were collected at

pre-intervention, post-intervention and two follow-up time points depending on how long the SDN continued in the role. Data were collected via a self-administered survey consisting of demographic questions and five validated instruments to measure role ambiguity; stress and anxiety, job satisfaction, empowerment, and self-efficacy. Investigator-developed questions assessed perceived feasibility and acceptability of the TSP. Qualitative interviews were also conducted with SDNs who received the TSP.

Results

The experienced SDN cohort (time 1, n=31; time 2, n=19) reported moderate role ambiguity and overload, although assessment of SDNs' levels of satisfaction revealed that these SDNs were largely satisfied in their roles and few were experiencing elevated levels of stress and anxiety. Similarly, SDNs reported generally positive levels of structural empowerment and self-efficacy. Correlations were only performed on data collected from the experienced SDNs at Time 1, being the larger sample size. Job ambiguity was found to be positively correlated with stress and negatively correlated with access to support, satisfaction with praise and recognition, and self-efficacy. Twenty novice nurse educators participated in the RCT. A large proportion were found to be acting in the SDN role. The only statistically significant difference between groups concerned satisfaction with scheduling, which increased more so in the control group. Qualitative themes indicated that structured TSP mentoring served to build confidence and reduce isolation in new SDNs and was highly valued. Mentoring tailored to individuals' needs encompassed organisational aspects, educational skills, leadership, and building networks.

Conclusions

Despite the lack of statistically significant changes observed in the RCT component of the project, analysis of the qualitative data indicated that the TSP was highly valued by new SDNs. The TSP, particularly structured mentoring, was effective in supporting nurse educators who are at risk of role stress. It is recommended that further project phases develop and embed sustainable processes to effectively transition novice nurse educators across the organisation.

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BACKGROUND

Nursing education is a specialised profession (Gilbert & Womack, 2012, McAllister, Oprescu & Jones, 2014). The role encompasses the education and assessment of nurses, identifying learners in difficulty, facilitating innovative teaching strategies, and evaluating nursing capabilities (McAllister et al., 2014). A global shortage of nurse educators has seen novice nurse educators appointed on the basis of their demonstrated clinical competence rather than educational expertise (McArthur-Rouse, 2007). Many novice nurse educators are also expected to transition into the role without sufficient preparation or training. Moreover, it is usual for the transition from clinical to educator role to take place within a clinical area. The nurse remains part of the ward team but with a changed focus and new responsibilities. Initially, support is needed to provide the novice SDN with clarity about the new role.

Experiences of role ambiguity, occurring when employees lack information about performance criteria, work methods, and how to time and prioritise tasks, are known to be stressful (Chang & Hancock, 2003; Rubino, Luksyte, Perry & Volpone, 2009). Role ambiguity has been linked to increased levels of burnout in health workers, and graduate and experienced nurses (Chang & Hancock, 2003; Tunc & Kutanis, 2009; Olivares-Faundez, Gil-Monte, Mena, Jelvez-Wilke & Figueiredo-Ferraz, 2014). In novice nurse educators, these issues have been associated increased anxiety and reduced job satisfaction (Cangelosi, Crocker & Sorrell, 2009; Sayers et al., 2011).

Therefore, clear direction about the dimensions of the nurse educator role through skill development, role modelling, and mentorship is necessary to motivate and sustain the new nurse educator (McAllister et al., 2014). High levels of structural empowerment including access to resources, information and support have been linked to employees' ability to overcome issues of role ambiguity and anxiety (Davies, Laschinger & Andrusyszyn, 2006). Without such support, novice nurse educators are likely to experience decreased job satisfaction leading to professional discontentment and high turnover (Davies et al., 2006).

Health Workforce Australia (2012) predicts that by 2025 there will be a significant nursing shortage, including of nurse educators. A global shortage of nurse educators already sees an increasing number of clinicians expected to take up positions as nurse educators without sufficient training or preparation (McAllister et al, 2011; Cangelosi et al., 2009). In Australia, McAllister et al (2011) indicated that potentially the lack of development for nurse educators may impact on nursing workforce shortages, the quality of education for nursing

graduates, and consequent patient care outcomes. Greater investment in the support for newly appointed nurse educators aims to increase job satisfaction, thereby decreasing turnover and related costs. The retention of adequately prepared educational experts in the clinical area is instrumental for the nursing workforce and the provision of safe and quality patient care (Sayers & Giacomo, 2010; Sayers et al, 2011; Pollard, Ellis, Stringer & Cockayne, 2007).

The current project builds on the findings of an earlier quality improvement project conducted at Sir Charles Gairdner Hospital (SCGH), which identified challenges faced by nurses who commence as a nurse educator (titled Staff Development Nurse) in clinical settings (Kimberley, 2013). In that exploratory work, role ambiguity, role blurring, and a sense of isolation were evident among the cohort of SDNs in this hospital, reflecting nurses' experiences widely reported elsewhere (Conway & Elway, 2007; Sayers, DiGiacomo & Davidson, 2011; McAllister, Williams, Gamble, Malko-Nyhan & Jones, 2011).

The current project sought to address the problem identified by Kimberley (2013) of SDNs' lack of clarity about what was required of them and how to equip themselves with resources and information, and their consequent experiences of isolation and stress. The findings provide insight into what types of transitional support and modes of delivery can equip novice SDNs to navigate their changed roles and responsibilities.

METHOD

Setting

The study was conducted at SCGH, a 608-bed tertiary hospital employing over 2000 nurses. The hospital is home to Western Australia's comprehensive cancer, neuroscience and stroke centres. It receives over 70,000 emergency department presentations annually, of which 50% are admitted. There are approximately 60 SDNs in the hospital, with approximately 40% acting in the role at any one time. At least 20 SDNs are appointed in each 12-month period. Usual support for newly appointed SDNs comprises access to a self-directed learning pack and contact details of a Staff Development Educator (SDE) Liaison nurse who can provide support informal guidance and mentorship on request. However, there are no formal processes in place to inform SDEs when a novice SDN is appointed. Additionally, the amount of unit-based information and support provided to novice SDNs varies widely across the organisation, ranging from a brief handover to a few supernumerary days (Kimberley, 2013).

Aim and Objectives

This study aimed to develop, implement and evaluate a Transition Support Program (TSP) tailored to the needs of nurses who transition from clinical to educator roles within this hospital setting. The hypothesis was 'the implementation of the TSP will decrease levels of role ambiguity; stress and anxiety; and will increase levels of job satisfaction; empowerment; and self-efficacy in clinically-based SDNs who transition into a novice nurse educator role'. A secondary aim was to pilot processes to identify newly appointed SDNs throughout the hospital in order to provide the TSP at the point of transition.

The specific objectives were to:

5) Assess the extent to which SDNs in this setting experience issues of role ambiguity and overload; stress and anxiety; job satisfaction; structural empowerment; and self-efficacy in this hospital setting

6) Develop and evaluate a TSP targeted to novice SDNs

7) Compare levels of role ambiguity and overload; stress and anxiety; job satisfaction; structural empowerment; and self-efficacy between novice SDNs who receive the pilot TSP and those who receive usual support

8) Evaluate the feasibility and acceptability of the TSP.

Design

This study employed a participatory action research design to develop, implement and evaluate the TSP. Action research is by nature collaborative and focused on real-world problems (Koshy, Koshy and Waterman, 2011). Underpinned by critical social theory, the researcher works as a 'facilitator of change' to support practitioners to address a perceived problem in their area. As a collaborative research design, action research is appropriate to address theory-practice gaps as it draws on the practitioner's experience to develop findings that are meaningful in the context of day-to-day practice (Meyer, 2000). Practice change eventuates through cycles of reflection, planning, implementation and evaluation as problems are identified and solutions trialled (Koshy, 2010). A nurse researcher (SS) and an experienced SDE (AK) collaborated to conduct one cycle with four phases: Reflection, Planning the TSP, Implementing the TSP, and Evaluation.

Reflection

The nurse researcher and the SDE reflected on evidence in the literature pertaining to new nurse educators' experiences of role ambiguity, role blurring, and sense of isolation (Conway & Elway, 2007; Sayers, DiGiacomo & Davidson, 2011; McAllister, Williams, Gamble, Malko-Nyhan & Jones, 2011). The perspectives of nurses attending the hospital's nurse educator forum and the Australian Nurse Teachers' Society were also considered. Supported by the nurse researcher and drawing on her own experience of supporting new SDNs, the SDE proposed the components of a draft TSP. An eight-member expert panel consisting of a) clinically-based SDNs who had worked in the role for at least three years; b) non-clinical senior nurse educators; c) a member of the hospital nursing executive; and d) a senior registered nurse with expertise in mentoring and reflective practice. The expert panel participated in several discussions, facilitated by the nurse researcher and SDE, which reflected upon the needs of new SDNs and the appropriateness and feasibility of the proposed TSP. The perspectives of two experienced Clinical Nurse Specialists (CNS) were also sought. All reflective discussions were documented and summarised to inform planning of the TSP.

Planning and Implementation

The planning phase commenced with organisation of a survey of all existing SDNs to explore the extent to which role ambiguity and overload, stress and anxiety, job satisfaction, empowerment, and self-efficacy experienced across the organisation. The survey of the SDN cohort was to be conducted at two time points: Time 1 prior to implementation of the TSP and Time 2, again 10 months later. At each time point, a list of current SDNs was generated from the hospital database. Individually addressed envelopes containing study information, a survey invitation, and questionnaires were prepared.

During this phase, the TSP informed by recommendations of the expert panel was developed. The final program comprised two major elements: an educational resource and structured mentoring.

1. An *educational resource* providing an overview of the key aspects of the SDN role and responsibilities was developed and uploaded to the hospital's on-line learning platform (Moodle). The new e-learning package was estimated to take approximately 30 minutes to complete. Additionally, it could be printed should the SDN wish to retain a hard copy version.

2. A *structured mentoring program* with coaching and one-to-one support provided by the SDE through an initial face-to-face meeting supplemented with ongoing

communication in person or by email. The first mentoring session was initiated by the SDE, with subsequent sessions conducted at the request of the novice SDN. The majority of mentoring meetings were held away from the ward area – usually in an on-site café. A database was developed to hold field notes describing the characteristics of all TSP mentoring sessions.

Processes were developed to identify novice SDNs and to initiate contact with these nurses. The nurse researcher and SDE attended operational meetings of the Nurse Manager group and the Nurse Educator Forum to apprise them of the research, and engage their assistance in notifying the SDE of new SDN appointments, along with anticipated commencement date and time in the role.

Evaluation

A randomised controlled trial (RCT) design was used to evaluate the effectiveness of the TSP in a sample of novice SDNs. Inclusion criteria were all nurses appointed to an SDN position for a period of at least three weeks during October 2016 – July 2017. The minimum three-week period in the role reflected the time required to complete the e-learning resource and at least one structured mentoring session. Based on staffing information at the time, a sample of 20 new SDNs was anticipated. It was acknowledged that the small sample size would limit the ability to detect statistically significant differences between the intervention and control arms. However, the development of a tentative TSP and indications of feasibility and potential effectiveness would generate hypotheses and pilot processes and instruments to inform further research.

Nurse leaders in the clinical units (CNSs and nurse managers) provided names of nurses appointed into substantive or acting SDN roles to the research team. A research assistant based in the Centre for Nursing Research approached novice SDNs either prior to or upon commencing in the SDN role and provided them with study information including an invitation to participate. Those who agreed and returned the written consent form were assigned using concealed random allocation to receive either usual support (control group) or usual support and the TSP (intervention group). In order to minimise any change to usual support provided to control group participants, the SDE investigator (AK) was only notified of enrolled SDNs allocated to receive the intervention. She therefore was unaware whether other potential participants had declined, were ineligible (anticipated less than three weeks in the role), or had consented to be included.

Data Collection and Analysis

Experienced SDN cohort survey

A survey of experienced SDNs in permanent or acting positions was conducted at the two planned time points. At each time point, the research assistant referred to the list of current SDNs generated from the hospital database and emailed these potential participants with advice of the upcoming invitation to participate in the survey. The research assistant hand-delivered the prepared envelopes containing study information and questionnaire to each SDN's office. Completed questionnaires were returned to the Centre for Nursing Research in a sealed reply envelope via the internal mail. Completion of the survey signified implied consent to participate.

TSP trial

In the RCT, quantitative data were collected at up to four time points depending on how long the SDN remained in the role. These were: Time 1: pre-intervention, within one week of appointment; Time 2: post-intervention, three weeks after appointment; Time 3 follow-up, two months after appointment; and Time 4 follow-up, three months after appointment. To maintain blinding, the SDE providing the intervention was not involved in data collection. Additionally, the research assistant who distributed and collected the questionnaires (either by hand or internal mail) was not informed of participants' group allocation. Participants were requested not to reveal to the research assistant any details about the materials or support received during the data collection period.

Instrumentation

Data were collected via a self-administered survey consisting of demographic questions (Appendix A), and five validated instruments (Appendix B) to measure role ambiguity; stress and anxiety, job satisfaction, empowerment, and self-efficacy. Investigator-developed questions were also formulated to assess feasibility and acceptability of the TSP (Appendix C). The five validated instruments included:

(i) *Role Stress tool* (Chang & Hancock, 2003) measures role stress in terms of a) role ambiguity where there is a lack of clarity about role definition and performance, as well as the social and psychological aspects of performance; b) role overload, where there is perceived to be insufficient to time to complete tasks. Originally adapted from the work of Kahn, Wolfe, Quinn, Snoek & Rosenthal (1964) and Mohrman, Cooke & Mohrman (1978), the instrument is an 8-item tool constructed

as a 5-point Likert scale. The four items in the role ambiguity sub-scale are in the direction of clarity with higher scores representing role ambiguity. The remaining four questions comprise the role overload sub-scale, with higher scores indicating higher role overload. The tool has been used with Australian graduate nurses (n=110) during their transition into clinical roles (Chang & Hancock, 2003).

(ii)   *Depression Anxiety Stress Scales* (DASS21) (Lovibiond & Lovibond, 2004) is a survey instrument used to measure mood symptoms over the past week. The DASS21 is a 21-item version of the longer 42-item DASS. The DASS21 contains 3 subscales: depression, anxiety and stress. The DASS and DASS21 have demonstrated high internal consistency and strong psychometric properties in both normal and clinical populations (Brown, Chorpita, Korotitsch & Barlow, 1997; Antony, Bieling, Cox, Enns & Swinson, 1998; Lovibond & Lovibond, 2004). DASS21 scores are transformed to a 42-point scale for analysis.

(iii)   *McCloskey-Mueller Satisfaction Scale* (MMSS) (Mueller & McCloskey, 1990) is a 31-item, 5-point Likert scale questionnaire used to quantify job satisfaction. The categories include satisfaction with extrinsic rewards, scheduling, family/work balance, co-workers, interaction, professional opportunities, praise/recognition, and control/responsibility.

(iv)   *Conditions for Work Effectiveness Questionnaire II* (CWEQ-II) (Laschinger, Finegan, Shamian, & Wilk, 2001) consists of 19 items that measure the 6 components of structural empowerment described by Kanter (1977) that are access to: opportunity, information, support, resources, formal power, and informal power; and a 2-item global empowerment scale which is used for construct validation purposes. Items on each of the six subscales are summed and averaged to provide a score for each subscale ranging from 1-5. These scores of the 6 subscales are then summed to create the total empowerment score (score range: 6-30).   Higher scores represent higher perceptions of empowerment. The construct validity of the CWEQ-II was substantiated in a confirmatory factor analysis that revealed a good fit of the hypothesized factor structure (χ^2 = 279, df = 129, CFI = .992, IFI = .992, RMSEA = .054). The CWEQ-II also correlated highly with the global measure of empowerment (r = 0.56), providing additional evidence of construct validity.

(v)   *General Self-Efficacy Scale (GSES)* (Schwarzer & Jerusalem, 1995) is a 10 item scale with each item having a four choice response used to quantify general beliefs in one's ability to respond to and control environmental demands and challenges. This self-administered scale was designed for the general population and has been well-validated in samples from 23 nations. Positive coefficients have been found with favourable emotion, and work satisfaction, while negative coefficients have been found with depression, anxiety, stress, and burnout. No explicit permission is required for the use of this instrument in research studies.

Role ambiguity and role overload (Role stress tool), stress, anxiety and depression (DASS), job satisfaction (MMSS), empowerment (CWEQ-II) and self-efficacy (GSES) scores were summarised for the experienced SDN cohort at both time points and also at all time points for both for the control and intervention groups. Sub-scale scores were also calculated. Differences between the control and intervention groups from pre- to post-intervention in Role stress, DASS, MMSS, CWEQ-II and GSES scores were assessed using Wilcoxon's rank-sign test. Correlations between all outcome measures in the experienced SDN cohort and at pre-intervention for the intervention and control groups were examined using Spearman's rank correlation coefficient. The SDE conducting the TSP mentoring sessions documented the length and content of all sessions as field notes contained in an Excel database, which were summarised.

Qualitative interviews

The novice SDNs who received the TSP participated in semi-structured interviews to explore their experiences of the program, its strengths and weaknesses, perceived feasibility in routine practice, and suggestions for improvement. Ten open-ended questions were used to guide the interviews (see Appendix D). Additional probing questions were asked to explore emerging concepts. Interviews were conducted in a private room on the hospital campus but away from clinical areas, and were audio recorded and transcribed verbatim. Transcripts were read line by line to identify meaningful words, phrases and sentences, which were coded to generate categories and describe their properties and dimensions. Categories were collapsed into themes and anonymous quotes from participants used to illustrate each theme. The N-Vivo computer software program assisted with organising and analysing the data.

Ethical issues

The study was conducted in accordance with the National Statement of on Ethical Conduct on Human Research (NHMRC, 2013). Permission to conduct the study was obtained

from the Sir Charles Gairdner Osborne Park Health Care Group Human Research Ethics Committee, as the study hospital. Participation was voluntary and potential participants' decisions to participate, or not, were kept confidential. All participants provided informed consent to participate. Participants provided written informed consent before commencement. To protect participants' confidentiality, completed surveys were identified by numerical case numbers. The master list linking case numbers to participants' names was stored securely in the research office separately from the de-identified data. A research assistant who had signed a confidentiality agreement transcribed all interviews, which were de-identified during transcription.

The potential for dependent relationships between the SDE who was a co-investigator and new SDNs was recognised. Consequently, the SDE was completely separated from the processes of recruitment to ensure that SDNs did not feel any obligation to participate and that their consent was voluntarily and freely given. To uphold the ethical principle of justice, the TSP was offered to control group participants following the 3-month follow-up data collection. One nurse appointed into an acting SDN role requested inclusion into the study on the basis that she needed assistance. Recognising the potential for this nurse to be randomly allocated to the control group, which would deny access to the extra support, the nurse was not invited to participate in the research but rather was provided with the TSP outside of the study.

RESULTS

Experienced SDN cohort survey

A sample of experienced SDNs working in substantive or acting positions completed the questionnaire at time 1 (n=31, 46% response) and time 2 (n=19, 36% response). Of these, 14 SDNs completed the survey at both time points. The vast majority of the sample were female, with just over half aged between 30 and 50 years. While most were working in substantive positions, a sizable proportion was acting in the position (42% at time 1; 32% at time 2). Those acting as SDNs who reported their substantive roles were either clinical nurses (58% at time 1; 50% at time 2) while the rest were registered nurses. A number of SDNs held post-graduate qualifications (45% at time 1; 26% at time 2) with two SDNs holding masters in nursing qualification. Table 1 summarises respondents' characteristics of at each time point.

**Table 1.** Experienced SDN cohort survey - Participant characteristics

	Time 1 (n=31)	Time 2 (n=19)
	n (%)	n (%)
Gender		
Male	3 (10)	1 (5)
Female	28 (90)	18 (95)
Age (years)		
20-30	10 (32)	4 (21)
31-50	16 (52)	10 (53)
51-69	5 (16)	5 (26)
Current position		
SDN substantive	18 (58)	13 (68)
SDN acting	13 (42)	6 (32)
Time in current position (years)		
Up to 1	10 (33)	5 (26)
1-5	11 (37)	7 (37)
> 5	9 (30)	7 (37)
Previous SDN experience		
Yes	19 (63)	15 (79)
No	11 (37)	4 (21)

Using the Role Stress scale (Chang & Hancock, 2003), in which scores range from 1-5 with higher scores indicating higher levels of role stress, the SDN cohort reported moderate role ambiguity (time 1, M=2.71, SD=0.76; time 2, M=2.66, SD=0.87) and overload (time 1, M=3.23, SD=0.70; time 2, M=2.88, SD=0.89). At both time points 1, the vast majority of SDNs reported normal levels of stress (time 1, n=25, 81%; time 2, 17, 90%), anxiety (time 1, n=26; time 2, n=18, 95%), and depression (time 1, n=27, 87%; time 2, n=18, 95%). However, at time 1, five SDNs reported moderate to extreme levels of stress and anxiety. At time 2, only one SDN reported stress and anxiety in the moderate range and no SDNs were found to have severe or extreme stress, anxiety or depression.

Assessment of SDNs' levels of satisfaction using the MMSS scale, (in which scores range from 1-5 with higher scores indicating higher levels of satisfaction, revealed that SDNs were largely satisfied in their roles (time 1, M=3.61, SD=0.35; time 2, M=3.78, SD=0.40). Subscale scores indicated that respondents were most satisfied with their co-workers (time 1, M=4, SD0.56, time 2, M=3.97, SD=0.7) and scheduling (time 1, M=3.97, SD=0.59, time 2, M=4.30, SD=0.33), and least satisfied with professional opportunities (time 1, M=3.23, SD=0.46, time 2, M=3.42, SD=0.43).

Figure 1. MMSS subscales indicating SDNs' satisfaction with aspects of work – Scores range from 1-5, with higher scores indicating higher levels of satisfaction.
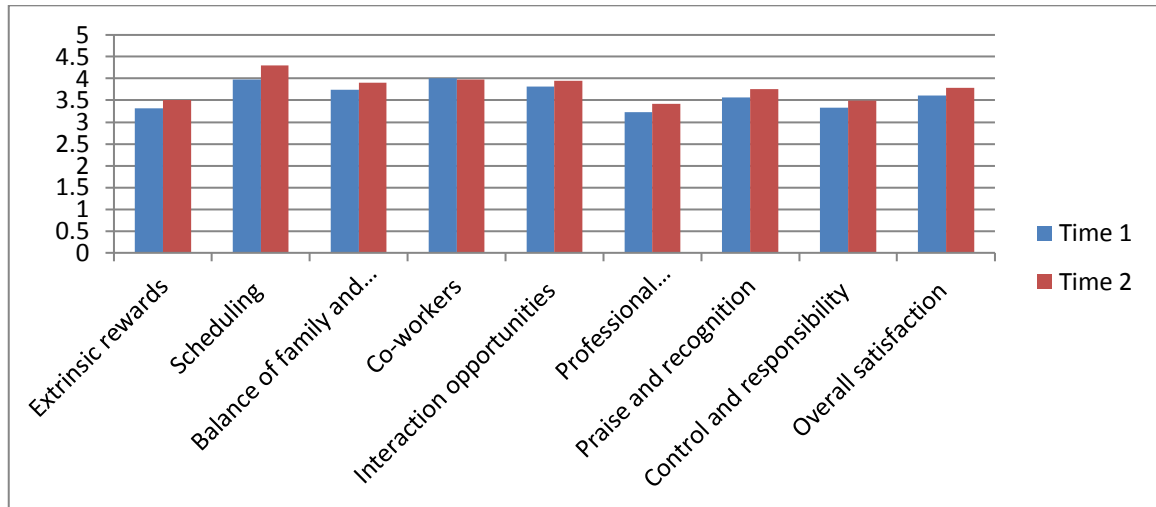
Similarly, experienced SDNs reported generally positive levels of structural empowerment using the CWEQ-ll scale. At time 1, SDNs felt they had most access to opportunity (M=3.78, SD=0.92) and informal power as measured by the embedded Organisational Relationships Scale (M=3.73, SD=0.58) and least access to resources (M=2.75, SD=0.70). Similarly at time 2, SDNs reported most access to opportunity (M=3.88, SD=0.72) but least access to support (M=3.02, SD 0.86). Table 2 provides SDNs mean scores for all subscales.

Lastly, this sample of experienced SDNs reported positive levels of self-efficacy as measured by the GSE, in which scores range from 10-40 with higher scores indicating greater self-efficacy. At time 1, SDNs mean sum score was 32.81 (SD3.46), while at time 2, SDNs mean sum score was 32.79 (SD2.92). While the instrument authors do not recommend classifying people as being high or low efficacious, and therefore do not designate cut-off point, they provide population norms based on samples of adults in Germany (n=16660) and the US (n=1594) which reported means of 29.28 (weighted variance 25.91), and 29.48 (SD=5.13) respectively. Correlations were only performed on data collected from the SDN cohort at Time 1, being the larger sample size. Job ambiguity was found to be positively correlated with stress (r_s=.480, $p < .01$), and negatively correlated with access to support (r_s= -.528, $p < 0.01$), satisfaction with praise and recognition (r_s= -.438, $p < .05$), and self-efficacy (M= -.388, $p < 05$).

Figure 2. CWEQ-ll subscales - Scores range 1-5, higher scores indicate higher levels of empowerment
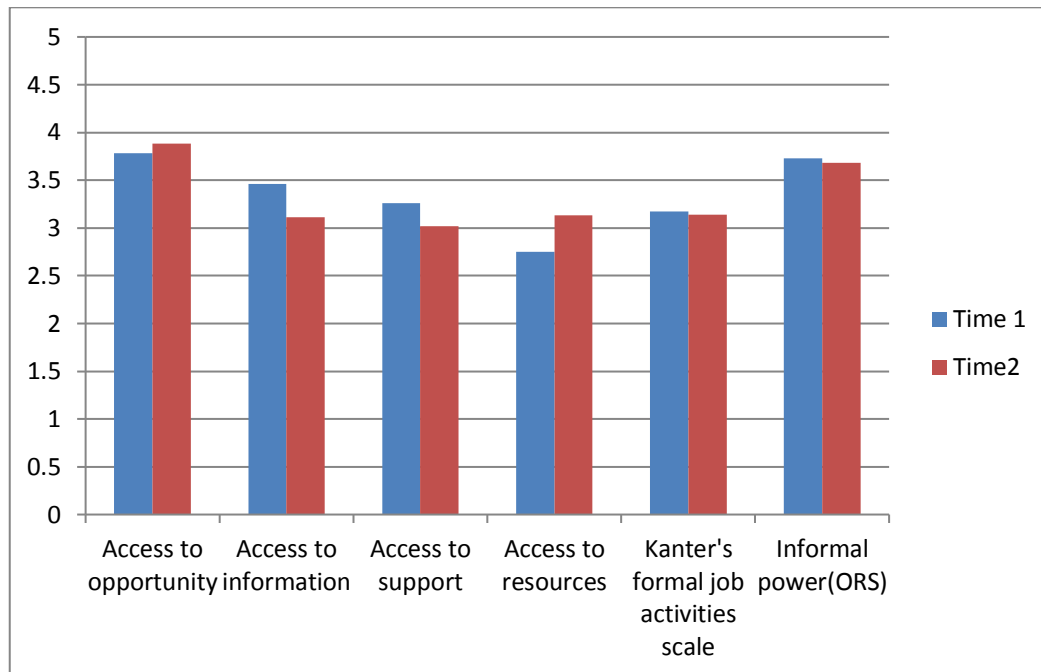
TSP trial

Twenty novice SDNs participated in the trial evaluating the TSP. All were were female, with just over half aged below 30 years. Almost all of these new SDNs were undertaking acting roles (n=8, intervention group; n=9, control group). Many of those acting SDNs held substantive positions as registered nurses (n=6, intervention group; n=4, control group), while the rest were clinical nurses. Several new SDNs held post-graduate qualifications (n=3, intervention group; n=5, control group). Of these, one new SDN held a masters in nursing qualification. Table 2 summarises the novice SDNs characteristics.

Table 2. Novice SDNs included in TSP trial - Participant characteristics

	Intervention (n=10)	Control (n=10)
	n (%)	n (%)
Gender		
Male	0 (0)	0 (0)
Female	10 (100)	10 (100)
Age (years)		
20-30	4 (40)	5 (50)
31-50	4 (40)	4 (40)
51-69	1 (10)	1 (10)
Current position		
SDN substantive	2 (20)	1 (10)
SDN acting	8 (80)	9 (90)
Previous SDN experience		
Yes	3 (30)	3 (7)
No	7 (70)	7 (70)

The only statistically significant differences between the groups at baseline was the level of stress as measured by the DASS which was higher in the intervention group (M=6.6, SD 4.33) compared to the control group (M=2.80, SD=3.43) although this was on the edge of non-significance (p=0.048). Despite this statistical difference, the level of stress in both groups fell within the normal range. Two SDNs in the intervention group were found to have moderate levels of anxiety, and two SDNs in the intervention group indicated mild levels of depression. Otherwise, participants in both groups scored in the normal range for stress, anxiety and depression. The groups were equivalent at baseline in all other measures. Table 3 summarises means and standard deviations for outcome measures at baseline.

The Time 1 dataset was examined for correlations between variables. In this cohort of novice SDNs, role ambiguity negatively correlated with satisfaction with co-workers (r_s= -.444, $p <$ 0.05), access to support (r_s= -.606, $p <$ 0.01), and access to resources (r_s= -.434, $p <$ 0.05). Stress was negatively correlated with self-efficacy (r_s= -.524, $p <$ 0.05) and satisfaction with scheduling negatively correlated with access to information (r_s= -.502, $p <$ 0.05), and resources (r_s= -.693, $p <$ 0.01). Perhaps not surprisingly, overall satisfaction was positively correlated with empowerment structures (r_s= .677, $p <$ 0.01) and general self-efficacy (r_s= .484, $p <$ 0.05).

Table 3. Means and standard deviations of outcome measures at baseline

Time 1	Intervention (N=10)		Control (N=10)		
	Mean	SD	Mean	SD	*p*
Role Stress tool (RS) - Scale 1 to 5 - Higher score indicated higher levels of ambiguity or overload					
Role Ambiguity	2.70	0.50	2.70	0.71	0.879
Role Overload	2.50	0.86	2.47	0.72	0.907
Depression Anxiety Stress Scale (DASS42) - Scale 10 to 42 - Higher score reflects greater level of stress or anxiety or depression					
Stress	6.60	4.33	2.80	3.43	0.048
Anxiety	4.60	4.72	1.20	1.40	0.066
Depression	3.00	3.92	1.80	2.57	0.465
McCloskey-Mueller Satisfaction Scale (MMSS) - Scale 1 to 5 - Higher score indicated higher levels of satisfaction					
Overall Satisfaction	3.62	0.48	3.78	0.28	0.364
Conditions for Work Effectiveness Questionnaire II (CWEQ-II) - Scale 1 to 5 - Higher score indicated higher levels of each scale					
Access to opportunity	4.03	0.55	4.00	0.44	0.845
Access to information	2.87	0.59	2.97	0.62	0.871
Access to support	3.23	0.67	3.10	0.55	0.695
Access to resources	3.17	0.82	3.33	0.65	0.729
Kanter's formal Job Activities Scale (JAS)	3.10	0.63	3.03	0.55	0.788
Informal power : Organizational Relationships Scale (ORS)	3.25	0.80	3.60	0.70	0.381
Scores of the 6 subscales	19.65	2.45	20.03	2.38	0.571
General Self Efficacy Scale (GSE) - GSE Sum Score: Scale (range 10 -40) Higher score reflect greater self-efficacy - GSE Mean Score" Scale (range 1 -4) Higher score reflect greater self-efficacy					
GSE_Sum_Score	31.80	3.55	32.10	2.73	0.372
GSE_Mean_Score	3.18	0.36	3.21	0.27	0.372

As the majority of participants were in acting positions, the duration of these SDN appointments were highly variable. The inclusion criteria stipulated that SDNs were expected to be in the role for at least three weeks. Therefore, all 20 participants provided data at Time 1 and Time 2. The number of SDNs who were available to provide follow-up data at Time 3

and Time progressively decreased. While seven participants in the intervention group provided data at all four time points, only four control group participants remained in their position long enough to do so. Accordingly, within group and between group comparisons were conducted at Time 1 and Time 2 only. Comparisons at later time points provided some indication of possible trends and are provided for interest with acknowledgement that the small sample sizes limit reliability of the results.

The only statistically significant change in the intervention group between Time 1 and Time 2 was a reduction in stress levels (time 1, M=6.6, SD=4.33; time 2, M=2.8, SD=3.79; p=0.031). In the control group, perceived access to opportunity decreased significantly (time 1, M=4.00, SD=0.44; time 2, M=3.67, SD=0.47; p=0.046). Otherwise, no significant within group differences were observed. The only statistically significant difference between the groups was satisfaction with scheduling which showed a greater improvement in the control group although this was on the edge of non-significance (*p*=0.046). Otherwise, no significantly different changes between groups were observed.

Characteristics of structured mentoring session

All 10 novice SDNs allocated to the intervention group attended at least three face-to-face mentoring sessions with the SDE (median=4, range 3-8 sessions). In each case, the first session was initiated by the SDE with subsequent sessions arranged at the novice SDN's request. The mean duration of sessions was 40.44 minutes (SD12.33, range 15-75 minutes). Figure 1 indicates the frequency with which mentoring sessions of various lengths (rounded to 5-minute blocks) were provided.

The novice SDNs, who were supported to articulate their most pressing issues, determined the content of these mentoring sessions. The SDE consistently noted the reflective nature of the discussions and SDNs' abilities in problem identification and willingness to take responsibility for their own development. Topics covered related to four domains: Organisational information; Educational skills; Leadership; and Building networks. Organisational information tended to cover hospital structures and processes including committees, divisional hierarchies, and accessing resources and computer drives. Educational skills mainly related to methods of assessment, types of content and modes of delivery, giving feedback, administrative processes and supporting new graduates. Leadership encompassed leading others and leading self.

Figure 3: Frequency of mentoring sessions of various lengths
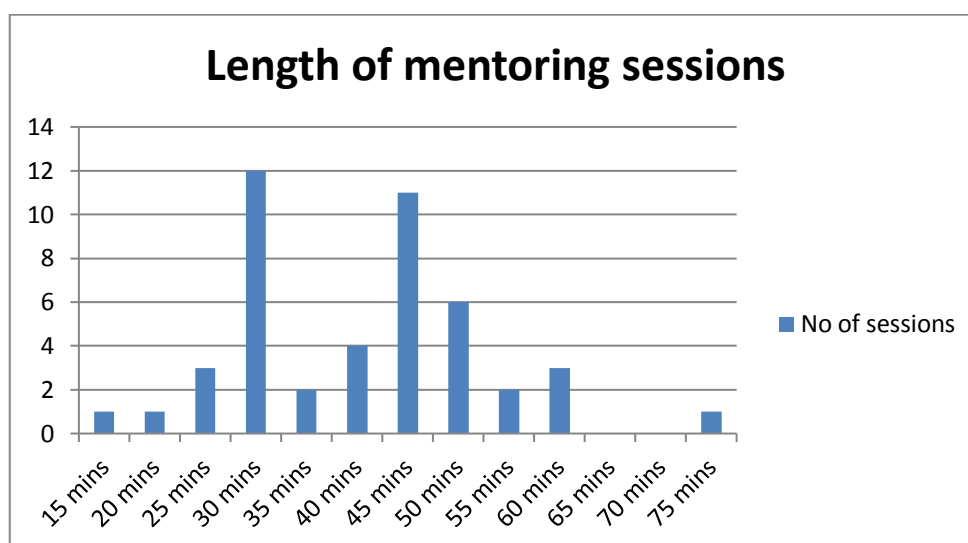
As these new SDNs became part of the ward leadership team, they found they required more expertise in conflict and performance management, how to develop and review standard operating procedures, and managing change. With thought as to managing themselves in this new role, they also sought information about different leadership styles as well as time management, task prioritisation, and 'saying no'. Lastly, the SDE found that she was regularly identifying appropriately skilled and connected people from within the hospital or from external organisations who could provide pertinent information and resources to the new SDN. In this way, the SDE linked the new SDNS to networks of experienced peers working in other units, expert educators, and specialty-specific professional organisations.

During their discussions, the SDE referred the novice SDNs to a number of tools and frameworks, such as Blooms taxonomy of questioning (Krathwohl, 2002) to support and guide their practice. She also recommended professional development opportunities where appropriate, including 'Teaching On The Run', a short course provided by the hospital, assessor training, and certificate level leadership courses.

Feedback on TSP structured mentoring

Eight of the 10 novice SDNs provided feedback on the mentoring sessions in their responses to the feasibility and acceptability questions. All eight SDNs described the frequency and length of the sessions as 'about right'. Most (n=7) found it easy to organise mentoring sessions with the SDE, although two commented that their busy shifts and clashing schedules could present barriers to these meetings. The only suggestion offered was to provide more structure in the sessions, with half led by the SDN regarding problems being

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experienced, and the other half led by the SDE with hints, tips, and teaching. When asked to comment on the TSP in general, two of the six SDNs who responded singled out the regular mentoring meetings as the most useful aspect. A third SDN offered the following overall comment: *"I found the meetings with (name of SDE) extremely helpful. It was a different opinion and also networking as this role can be isolating"* (P12).

Qualitative interviews

Eight of the 10 SDNs who received the TSP were interviewed. Six SDNs were in acting roles while the other two had been appointed into substantive positions. Analysis of the qualitative data generated three major themes that described: Feeling overwhelmed as a new SDN; The value of TSP structured mentoring; and Suggestions to improve the TSP.

Feeling overwhelmed as a new SDN

A number of SDNs described experiences of feeling overwhelmed after commencing in the SDN position. This related to unfamiliarity with processes and systems, and also the lack of guidance available. As one SDN remarked, *"Its been a learning curve and there was no document explaining the role" (P05).* She felt that her experience was not an isolated one and recalled the experiences of her local SDN colleagues, *"(Name's) been here for about four [years] and she said she learnt just by trial and error. (Name) whose position I now have, when I spoke to her, I think she always found it stressful"* (P05). It emerged that the SDN role was complex and opportunities to learn through role modelling prior to taking up a position were few. One young SDN recalled*:*

> *I didn't really know what to expect. I think with the SDN role, it's always sort of been . . . lots of things happening behind the scenes . . . that I really didn't know, didn't know much about at all . . . so when I came into doing my couple of days supernumerary with the previous SDN, I was quite overwhelmed with the amount of stuff . . . That goes on behind closed doors . . . and there's a lot of work involved. (P13)*

Later this SDN described her consequent sense of isolation as she struggled with the unfamiliarity of her new role:

> *I felt very isolated . . .Just from being used to being out on the floor with my peers and interacting with patients and, which I love, to kind of feeling a little bit lost and stuck in here without like having the confidence of knowing exactly what I'm doing, what I need to do in here. . . I do remember feeling quite isolated. (P13)*

One nurse endeavoured to cope by *"researching and studying" (P04)* to ensure her knowledge was up to date and she could provide answers when required. As far as the clinical aspects of the role were concerned, like other SDNs, she described drawing on previous experiences which helped her feel *"confident in their interactions with staff" (P4).* However, the educator role entailed significant organisational and administrative components which required a different, and for most SDNs, new skill set:

> *I think clinically, but being out on the floor and doing orientations and things I was more comfortable doing that than all the kind of administrative and office type things. . . . that's just taking your prior learning and putting it into action rather than all the administrative tasks, they were all new. (P08)*

It could also be confronting when the team dynamics inevitably changed as the SDN became part of the ward leadership group. This was challenging for one young SDN who explained:

> *You obviously have to be a bit more assertive . . . It was quite difficult to approach some people and say 'oh you're doing A and B wrong so what do you think you can do better?' . . . especially with a colleague that I know and I'm close with. I found that to be a bit of a struggle. (P04)*

It was evident that as the SDNs struggled to navigate the unfamiliar requirements of their new role, they found the TSP helpful. It emerged strongly in these interviews that the structured mentoring component was particularly valued.

Valuing the TSP structured mentoring

These SDNs offered few comments on the written e-learning package provided as part of the TSP, although one SDN declared it, "the most helpful thing I got . . . something I didn't get from the department and the booklet I use and continue to use" (P05). In contrast, all SDNs extolled the value of the mentoring sessions with the SDE. The following comments are typical of many:

> *We met up every two weeks or every three weeks depending on our schedule . . . I wasn't expecting the support that I got . . . I just didn't expect what she was going to explain to me and it was really helpful . . . a lot about the computer programs and how to access everything . . . what they expected out of my role. And sometimes I had some conflict with a couple of the grads in regards to giving them feedback and supporting them and (Name) was really helpful in that, giving me directions. And also when I had that study day presentation . . . she gave me a couple of really good feedbacks regarding how she would run a study day and*

how I can implement some of her ideas into mine and that was really helpful and it probably gave me a boost of confidence 'cause I was really nervous with that . . . generally it was really a very good support.(P04)

I found it very, very useful. It cleared things up for me . . . at the start when I was not actually clear on some aspects of my role. (Name) was very good at just kind of breaking it down more simply for me . . . and then I'd bring to her a clinical situations and say "I needed to give this person feedback and I gave it to them in this way and they didn't take it very well and how could I have done it better?" And she's got all these wonderful tools in terms of giving feedback and education and things so that was . . . very helpful. (P08)

An important aspect for some SDNs was that the mentor was external to their work unit. For one SDN this meant that the meetings were, *". . . really comfortable and I found that I can actually ask a lot of questions and not feel threatened"* (P04). Another agreed when she admitted that, *"we could talk more about things that were challenges for me but not in front of my CNS . . . [the SDE] had a lot of knowledge for me and it was also a debriefing as well"* (12). Similarly, another SDN appreciated that:

It was all completely impartial advice . . . (Name) didn't know who I was talking about or problems that they'd had previously . . . her advice was coming from an educator's perspective, not someone who would say 'oh you know they just need to be told to pick up their game'. (P08)

Meeting regularly with someone outside of the unit helped to lessen the isolation. For example, when asked about the mentoring, one SDN commented:

I think it serves many purposes. I think the mentoring for the actual person coming into the role is useful. I also think the fact that it connects us to CNE [Centre for Nursing Education] is very important because otherwise you sit here in your little office and because you're so busy doing the stuff that you need to do, you don't actually realise that there's anything else out there and there's people who can support you and provide you with stuff. (P05)

For many, this mentoring remained valuable well into their SDN journey. As this participant explained, "*I didn't feel confident in the role until at least 2 or 3 months into it and then I kind of felt like I knew what I was doing" (P08).* It was perhaps not surprising that one young nurse found that:

. . . as I grew into the role I realised that I had more questions so that was helpful to have (Name) every couple of weeks to have a chat because she could help me with those new questions. (P04)

Despite the consistently positive comments about the TSP emerging from these interviews, SDNs also offered some suggestions to inform its further development.

Suggestions to improve the TSP

When asked if the mentoring component should be mandatory for all new SDNs or offered voluntarily, most participants recommended that SDNs be expected to attend at least one mentoring meeting because *"personally if it was offered to me, I don't know if I would have sought it out . . . maybe if you have one and see how it goes" (P13)*, and, *"mandatory, personally I think it should because then you can see if people are on the right track in their new role" (P13).* One SDN who had previously acted in the role and then was appointed into a substantive position expressed a strong view that:

> *if you have to do mandatory advanced life support and mandatory manual handling, you know all these tasks, then why aren't we actually addressing the psychological needs and the psychosocial needs of this environment. Why do we just address the hands on things and this is a job where you're dealing with people so why aren't we debriefing about things that we encounter or the way that we're feeling . . . for me personally I just think it would be nice to know you know I can go and sit at a table and go 'oh gosh, this is what's happened this week and I don't know what to deal with it, do with it' . . . You just feel like you're alone . . . . I think your project's amazing and I hope it brings something. (P05)*

The preferred timing should be relatively soon after commencement but allowing, *"a few weeks to settle in first, get your feet under the table and try and suss [sic] out what, what's been happening in that area and what you know is on the go and what they're tackling" (P09)*. It was also thought important to clearly communicate to all new SDNs what types of support was available:

> *I think to make it more obvious that when you came onto the role . . . (Name of SDE mentor) was great and the booklet was great but it seemed like an adjunct . . . it's just that I really quite enjoyed chatting with someone outside this department . . . to actually get a broader view of the whole thing . . . if that could be made somehow more formal so that it actually gave new people a chance to get away and clear their minds . . . we debrief the students when they come here, we debrief*

> *with the grads, why don't we debrief with other new staff members, you know going into new roles. (P05)*

Other suggestions included: a half day tutorial on electronic systems, particularly in regard to communication; more information about the myriad of meetings SDNs were expected to attend because, *"coming into the role, I've been going to all these meetings and I don't always know why I'm actually there and what I have to say or what is expected of me" (P12);* and provision of the e-learning package during the first mentoring meeting so its relevance could be explained and emphasised. Another recommendation was more support to navigate the changed dynamics in the clinical setting. For example, one young SDN would have appreciated:

> *. . . an introduction with the CNS [Clinical Nurse Specialist] as well to help understanding their new role would also be helpful, like including them in the role would also be, I think a good idea . . . I did find that, it was a little bit harder to communicate because I think she didn't really know my position . . . me being new to the role was probably a little bit . . . foreign. (P04)*

DISCUSSION AND CONCLUSION

This project used action research whereby a nurse researcher and nurse educator collaborated to address the issue of novice SDNs' experiences or role ambiguity and isolation in one Western Australian hospital. A support program delivered at the point of transition was developed, implemented and evaluated. The findings provide direction for tailoring the program for the needs of SDNs in this setting and potentially informing transition support for nurses in other areas at this hospital or elsewhere.

Despite the lack of statistically significant changes in outcome measures, the particular value of structured mentoring to these new SDNs emerged strongly in the qualitative data. These mentoring meetings were largely SDN-led, in that the novice SDNs brought challenging issues and questions for discussion. The first meeting was initiated by the SDE with subsequent meetings being optional and organised at the SDN's request. In all cases, SDNs opted for further meetings. All expressed their appreciation for the SDE's relevant knowledge, and approachable manner. In addition to information sharing, some experienced the meetings as a form of debriefing. Documentation of the meetings indicated that the topics, that were therefore directly targeted to SDNs' needs, focused on organisational aspects, educational skills, leadership, and building networks.

Mentoring in nursing is a well-established concept that is known to strengthen employees' organisational engagement, and increase satisfaction and career development (Greene & Puetzer, 2002; Tourigny & Pulich, 2005). The relationship between mentor and mentee focuses on the goals and needs of the mentee in the context of organisational succession planning. It is therefore considered "both a very powerful career and organisational development phenomenon" (Jakubik, Weese, Elides & Huth,, 2017, p 151). The current project indicated that such mentoring can require a considerable investment of the mentor's time. However, the distinct and consistently articulated benefits described by the novice SDNs suggests the potential for returns on that investment at both individual and organisational level. While this project sought to measure individual outcomes, albeit over a short time frame, further research to explore organisational outcomes such as SDN retention, is warranted.

It is possible that the lack of statistically significant change detected within and between groups related to the small sample size and the particularly short measurement period, i.e. three weeks. Indications from the qualitative data were that SDNs required up to several months to truly settle in and feel confident in the role. Moreover, despite the mentoring sessions being optional, all SDNs chose to continue meeting with the SDE. All SDNs had at least three meetings and one SDN had eight meetings. A larger study conducted over a much longer period would be necessary to capture any changes in the quantitative outcomes. However, processes and instrumentation piloted in this project would provide direction for such a larger, adequately powered study.

Evaluation of the first iteration of the TSP, piloted in this study, can inform a meaningful intervention for any future investigation. The findings of the current study confirm that mentoring is an essential element of any transitional support for SDNs. Suggestions to enhance the e-learning resource and to add components could develop the program, particularly with further input from the expert panel. In the shorter term, however, this project provides an opportunity for the study hospital to offer transition support perceived as valuable by nurses in this setting to all new SDNs at the point of transition. On this basis, the program remains in place, coordinated by the SDE and with mentoring support provided to the new SDNs by their relevant divisional SDEs.

Limitations to this study include the small sample size and single study site. The large proportion of SDNs appointed to acting roles in this sample was striking. This raises questions about the representativeness of the sample, although previous work and the experienced SDN cohort survey have revealed that approximately 30-40% of SDNs are in acting positions as any one time. It is likely that acting positions "turn over" frequently, meaning that a higher

number of SDNs transition into these roles over time than can be captured in a single cross-sectional snapshot. The implication for this study is that longitudinal follow-up was limited by acting SDNs short tenure in the role. Therefore, it is acknowledged that the quantitative findings are not generalizable to other clinical settings. However, triangulation achieved through the collection of quantitative and qualitative methods help to strengthen the findings. The qualitative interviews reached saturation and may be transferable to other similar settings.

In conclusion the findings of this study indicate that the TSP, particularly structured mentoring, was effective in supporting nurse educators who are at risk of role stress. It is recommended that further project phases develop and embed sustainable processes to effectively transition novice nurse educators across the organisation. Ultimately, the model of transitional support developed in this study may be translated for use with nurses who are appointed into a variety of advanced practice roles.

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APPENDICES

APPENDIX A

Staff Demographic Form

ID Code: _____

Gender: F   M

Age: _____

Division:

☐   Medical

☐   Surgical

☐   Medical Specialties

Current Position:

☐   SDN (substantive)

☐   SDN (acting)

If SDN (acting), what is your substantive position: _____

If SDN (acting), anticipated total time in current position: _____

☐   CNS

When did you commence in current position? _____

Length of overall experience: _____

Qualifications (including postgraduate):
_____
_____
_____

Previous educational experience:
_____
_____
_____
_____
_____

Role Stress tool

Please think about your current role as Staff Development Nurse and indicate the extent to which the following statements apply to you.

	Never	Rarely	Sometimes	Often	Very often
1. Feeling that you have too little authority to carry out the responsibilities assigned to you.	1	2	3	4	5
2. Lack of clarity of job description and responsibilities.	1	2	3	4	5
3. Lack of information needed to carry out your job.	1	2	3	4	5
4. Thinking about the amount of work you have to do may interfere with how well it gets done.	1	2	3	4	5
5. Not knowing just what the people you work with expect of you	1	2	3	4	5
6. Feeling that you don't have enough time to do everything that others ask of you.	1	2	3	4	5
7. Feeling that you don't seem to have enough time to get things done.	1	2	3	4	5
8. Feeling unable to influence your immediate superior's decisions and actions that affect you.	1	2	3	4	5

DASS

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week.** There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much, or most of the time.

Over the last week

	0	1	2	3
1. I found it hard to wind down	0	1	2	3
2. I was aware of dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I experienced trembling (e.g. in the hands)	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3

19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life was meaningless	0	1	2	3

MMSS

How satisfied are you with the following aspects of your current job?

Please circle the number that applies.

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
1. Salary	5	4	3	2	1
2. Vacation	5	4	3	2	1
3. Benefits package (insurance, retirement)	5	4	3	2	1
4. Hours that you work	5	4	3	2	1
5. Flexibility in scheduling your hours	5	4	3	2	1
6. Opportunity to work straight days	5	4	3	2	1
7. Opportunity for part-time work	5	4	3	2	1
8. Weekends off per month	5	4	3	2	1
9. Flexibility in scheduling your weekends off	5	4	3	2	1
10. Compensation for working weekends	5	4	3	2	1
11. Maternity leave time	5	4	3	2	1
12. Child care facilities	5	4	3	2	1
13. Your immediate supervisor	5	4	3	2	1
14. Your nursing peers	5	4	3	2	1
15. The physicians you work with	5	4	3	2	1
16. The delivery of care method used on your unit (e.g. functional, team, primary)	5	4	3	2	1
17. Opportunities for social contact at work	5	4	3	2	1
18. Opportunities for social contact with your colleagues after work	5	4	3	2	1

	Very Satisfied	Moderately Satisfied	Neither Satisfied nor Dissatisfied	Moderately Dissatisfied	Very Dissatisfied
19. Opportunities to interact professionally with other disciplines	5	4	3	2	1
20. Opportunities to interact with faculty of the College of Nursing	5	4	3	2	1
21. Opportunities to belong to department and institutional committees	5	4	3	2	1
22. Control over what goes on in your work setting	5	4	3	2	1
23. Opportunities for career advancement	5	4	3	2	1
24. Recognition for your work from superiors	5	4	3	2	1
25. Recognition of your work from peers	5	4	3	2	1
26. Amount of encouragement and positive feedback	5	4	3	2	1
27. Opportunities to participate in nursing research	5	4	3	2	1
28. Opportunities to write and publish	5	4	3	2	1
29. Your amount of responsibility	5	4	3	2	1
30. Your control over work conditions	5	4	3	2	1
31. Your participation in organizational decision making	5	4	3	2	1

CWEQ-II

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

	No Knowledge		Some Knowledge		Know A Lot
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

IN MY WORK SETTING/JOB:

	None				A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

	None				A Lot
1. Collaborating on patient care with physicians.	1	2	3	4	5
2. Being sought out by peers for help with problems	1	2	3	4	5
3. Being sought out by managers for help with problems	1	2	3	4	5
4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
1. Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2. Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

GSES

Please indicate the extent to which the following statements are true for you.

1 = Not at all true…..2=Hardly true   3=Moderately true   4=Exactly true

	Not true at all	Hardly true	Moderately true	Exactly true
9. I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
10. If someone opposes me, I can find the means and ways to get what I want.	1	2	3	4
11. It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
12. I am confident that I could deal efficiently with unexpected events.	1	2	3	4
13. Thanks to my resourcefulness, I know how to handle unforeseen situations.	1	2	3	4
14. I can solve most problems if I invest the necessary effort.	1	2	3	4
15. I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
16. When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
17. If I am in trouble, I can usually think of a solution.	1	2	3	4
18. I can usually handle whatever comes my way.	1	2	3	4

ID Code: _____

Feasibility and Acceptability questions

1. Did you complete an Staff Development Nurse (SDN) education package (e-learning or Self Directed Learning Package) when starting in your new SDN role?

☐ Yes

☐ No

If no: why not?

_____
_____
_____

If yes:

a) When did you complete the education package? (please circle)

During work   **In your own time**

b) How did you find the amount of information provided in the education package? (please circle)

Too little   **About right**   **Too much**

c) How relevant was the information in the education package? (please mark the scale below)

Very relevant   **Not at all relevant**

⟵——————————————————⟶

d) How easy it was to use the e-learning package? (Please mark the scale below)

Very easy   **Very difficult**

⟵——————————————————⟶

Please describe any difficulties:

_____

_____

e) What did you find most useful about the SDN education resource?

_____

_____

_____

_____

f) How could the SDN education resource be improved?

_____

_____

_____

2. Have you met with a mentor since commencing in this SDN role?

☐ Yes

☐ No

If   no: why   not?

_____

_____

_____

If yes:

a)   How many times have you met your mentor? _____

b)   How did you find the frequency of these mentor meetings? (please circle)

   Not often enough   About right   Too often

c)   What was your mentor's role? (please circle)

   Peer mentor (another SDN)   CNE Liaison SDE

d)   On average, how long were these meetings? _____

e) How did you find the length of these mentor meetings? (please circle)

Too brief   **About right**   **Too long**

f) How easy was it to get together with your mentor? (Please mark the scale below)

Very easy   **Very difficult**

←——————————————————————————→

Please describe any barriers to mentor meetings:

_____

_____

_____

(Intervention group only)

3. How did the Transition Support Package (TSP) influence your transition into your new SDN role?

_____

_____

_____

_____

_____

_____

4. What did you find most useful about the TSP?

_____

_____

_____

_____

_____

_____

5. How could the TSP be improved?

_____

_____

_____

_____

_____

_____

6. Other comments about the TSP:

_____

_____

_____

_____

_____

_____

APPENDIX D

Trial Participants Interview Guide

1. Please describe your experience of moving into the Staff Development Nurse (SDN) role? *(What did you expect? How did the role differ from your expectations? How did you prepare? What local support did you receive? How did your relationships with ward staff change, if at all?)*

2. What challenges have you faced since commencing in the SDN role?

3. What helped you to cope with the transition from clinician to educator? *(Personal qualities? Previous experiences, Ward resources? CNE resources? Mentors?)*

4. What made this transition more difficult?

5. How useful was the Transition Support Program (TSP) during your early weeks as an SDN? *(e-learning package? Mentoring from the divisional SDE? Mentoring from peer SDN?)*

6. What parts of the TSP did you find most helpful?

7. And what was least helpful?

8. What would you change about the TSP? *(Anything missing? What would you add or remove from the e-learning package? Program length? Appropriate mentoring?)*

9. How should the TSP be provided to new SDNs *(By whom? Mandatory vs voluntary? Timing?)*

10. Is there anything you would like to add?