Nurses Transitioning to Primary Health Care in Australia: A Practice Improvement Initiative

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Abstract

Introduction: Current nursing programs provide little pre-registration information and clinical exposure to primary health care nursing practice. Newly graduated nurses and those transitioning to primary health care report disorientation and confusion. Limited knowledge about the ideal elements of a program to support transitioning nurses is an imperative to understand how best to support nurses during this period. The peak body for nurses in primary health care was funded to develop and implement a 1-year transition to practice improvement initiative for nurses in Australia about to be employed in or who are new to primary health care. This quality improvement evaluation study aimed to determine the impact of the transition program on participants' nursing knowledge, skills, and confidence, and their overall satisfaction with the program.
Methods: A mixed methods evaluation of the project utilized data from online pre- and post-participation surveys, mentor meetings, and field notes. Descriptive statistics and paired *t*-tests were employed for quantitative items. Free text and field notes were subject to broad thematic analysis. Findings from qualitative and quantitative data were triangulated.
Results: Ninety-three nurse participants and 62 mentors were recruited. There were statistically significant differences between mean summed post-completion and pre-completion self-assessment rating scores for knowledge, skills, and confidence. Program elements were well received. The orientation workshop, mentoring, and education activities were identified as most influential in supporting transition. The self-assessment framework was identified as least influential.
Conclusion: A 12-month transition program was effective in building the knowledge, skills, and confidence of participants to deliver comprehensive and effective nursing services.

Keywords
primary healthcare, orientation, quality improvement, workforce

Introduction

The increasing burden of chronic conditions, ageing population, and rising costs have increased the focus on primary health care (PHC) (Murray-Parahi et al., 2020). When comprehensively enacted, PHC is the most effective, efficient, and equitable approach to enhance health and has been identified as essential in achieving universal healthcare (Murray-Parahi et al., 2020; World Health Organization & United Nations Children's Fund, 2018). In Australia, the United Kingdom (UK), and New Zealand, healthcare reforms have focused on how to build PHC workforce capacity to respond to the growing numbers of people with chronic illnesses and complex care needs (Parkinson & Parker, 2013). The most recent Department of Health and Ageing

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(2023) data shows that PHC nurses comprise 26.2% of the total nursing workforce in Australia. PHC nurses work in a range of settings, including general practice (family practice), community nursing, residential care settings, and non-government organizations (Guzys, 2020).

In 2018, the World Health Organization (WHO) and UNICEF identified nurses as critical for effective PHC service delivery (World Health Organization & United Nations Children's Fund, 2018). Globally, projected nursing shortages attributed to an ageing workforce have also been identified in a number of regions, including Western Pacific countries (World Health Organisation et al., 2020). The COVID-19 pandemic has impacted workplace conditions and may be influencing the wellbeing of Australian nurses, midwives, and care workers (Adelson et al., 2021). Furthermore, there is little pre-registration clinical exposure to PHC settings for nurses and a lack of familiarity with the scope of PHC nursing practice (Murray-Parahi et al., 2020). Ample evidence describes the important role nurses play in improving access to PHC and the quality of the care delivered (Abou Malham et al., 2020). Two systematic reviews comparing primary care physicians with nurses reported nurses provided equal or better care, improved health outcomes, and higher levels of patient satisfaction for physical problems and chronic conditions (Ansell et al., 2017; Laurant et al., 2018).

Although the potential value of transition programs within primary care as a nursing workforce development strategy has been demonstrated, there is scant literature on what constitutes a "best practice" transition program for PHC nursing practice (Aggar et al., 2017). Generic transition programs include elements such as orientation (Ashley, Halcomb, et al., 2018); education addressing knowledge gaps (Spector et al., 2015); skill development (Rush et al., 2013); preceptorship training (Clipper & Cherry, 2015); and formal support. Such programs can address "transition shock"—a term coined by Duchscher (2009) to describe the first 3–9 months where newly graduated nurses are vulnerable to experiences of disorientation, confusion, doubt, and a sense of loss (Ashley, Brown, et al., 2018; Duchscher, 2009; Rush et al., 2013; Spector et al., 2015). There is increasing recognition that this applies to nurses new to PHC and, for nurse practitioners, concern that the lack of transition programs contributes to leaving their first PHC position or leaving PHC nursing altogether (Gonzales et al., 2022).

Although programs designed to consolidate PHC knowledge, skills, and confidence are clearly needed, this endeavor requires a reorientation from healthcare focused on treating disease towards health systems that address the needs of communities and provides continuity of care (van Weel & Kidd, 2018). There is scant research on what constitutes the ideal elements of a transition to PHC program and limited awareness among health care teams and patients about the role of a PHC nurse (Gonzales et al., 2022). Recent research indicates that the global mental health crisis has been compounded by COVID-19. Given the first point of contact for many people is PHC, this highlights a need for nurses to incorporate identifying and responding to common mental health problems such as depression in their practice (Halcomb et al., 2022).

As the peak professional body for nurses working in PHC, the Australian Primary Health Care Nurses Association (APNA) has committed to building the capacity of PHC nurses through a range of focused projects. In 2015, APNA was funded by the Australian Government's Department of Health and Aged Care to develop and deliver a practice improvement initiative aimed at supporting the transition to PHC of both new graduates (with less than 3 years of experience in nursing) and more experienced nurses who had self-identified as requiring additional support. An initial pilot program was conducted with a formative evaluation that subsequently informed the implementation and evaluation of a Transition to Practice Program (TPP). The aim of this evaluation was to determine the impact of the TPP on participants' PHC nursing knowledge, skills, and confidence, and their overall satisfaction with the program.

Methods

Intervention Description and Team Involved

APNA's TPP was designed for both new graduates and experienced nurses working in different PHC settings. The content was informed by a review of the literature, an evaluation of the pilot program and meetings with PHC nurses and mentors who confirmed that nurses new to PHC commonly experience a lack of role clarity, inadequate orientation, periods of uncertainty, and lack of confidence (consistent with transition shock).

As there are no nationally agreed competencies or standards specifically for PHC nurses, extensive consultation was undertaken to identify 12 core education topics focused on PHC including promotion and prevention, chronic disease management, culturally safe care, quality improvement (QI), and self-care. The 12-month TPP comprises a 1-day face-to-face induction workshop, the provision of clinical and professional mentoring, 12 core modules based on the agreed PHC education topics, and a self-assessment framework that participants used to benchmark their progress and identify learning goals. In addition to these components, informal support was provided by APNA via teleconference. Service agreements with participants' workplaces were established to enable protected time (57 h over the 12-month program). This enabled participants to complete the self-assessment and education activities, attend teleconferences, and meet with their mentors. Participants were able to choose any of 25 additional modules as relevant to their clinical context.

Context, Eligibility, and Recruitment

Eligibility required registration with the Australian Health Practitioner Regulation Agency as a Registered Nurse (RN) or Enrolled Nurse (EN), recently transitioned into a PHC

nursing role (recency being self-determined) and working a minimum of 2 days per week. New graduates with less than 3 years in nursing and working in PHC were also eligible to participate.

Recruitment included promoting the TPP to people in the APNA contact database of members, advertisements in newsletters, and email notices to stakeholders and peak bodies. Prospective participants were asked to complete expression of interest forms, which were assessed by a panel of experienced PHC nurses.

Evaluation of the Impact of the TPP

This QI evaluation study used a two-phase concurrent triangulation mixed methods design as described by Creswell and Creswell (2017). The results of two consecutive rounds of implementation (Group 1 February commencing 2019 and Group 2 September 2019) form the data set for this study. Quantitative data was collected via a survey administered pre- and post-participation in the TPP. Qualitative data (free text comments) were collected as part of the post-participation survey. Analyses of both quantitative and qualitative data were undertaken separately, but both data sets were subsequently triangulated (along with demographic data) to validate and compare the evidence obtained from each data set. The aim of participant surveys was to elucidate the impact of the TPP on participants' attainment of the three domains of PHC nursing knowledge, skills, and confidence, and their satisfaction with the program.

The quantitative data comprised summed pre-commencement and post-completion participant self-assessment ratings (possible score range 0–15), provided for each of the 12 education modules in relation to the knowledge, skills, and confidence domains (range 0–180 for each domain). Differences between mean post-completion and pre-completion scores in each domain were analyzed using a paired t-test (unequal variances, two-tailed). "Intent to treat" analyses were applied, so that scores from partial completion of the TPP were included in analyses. Differences between Group 1 and Group 2 summed pre-commencement and post-completion participant self-assessment ratings for each domain, were also assessed using an independent t-test (unequal variances, two-tailed). At completion of the program an exit (post) survey was administered, and participants were asked to self-rate their knowledge, skills, and confidence levels prior to TPP commencement and after completion (possible score range 0–10). Differences were analyzed using a paired t-test (unequal variances, two-tailed). Participants were also asked to provide an assessment of their overall satisfaction with the TPP on a five-point Likert scale (Not at all satisfied to Extremely satisfied).

The exit survey asked participants to rate their intention to remain in PHC nursing and the influence of participation in the TPP on their intention to remain. The survey was repeated at 6 months post-completion to further ascertain participants'

current and future intention to remain working in PHC and the influence of the TPP on whether or not to leave nursing. Demographic work location data were collected pre and post (sex, age, registration status, PHC setting, primary health network [PHN], State/Territory and rurality of location based on the Modified Monash Model) (Australian Government & Department of Health & Aged Care, 28 June 2019).

The exit survey included open-ended questions to further reveal any changes in participant knowledge, skills, and confidence, changes in practice and recommendations for future implementation. Qualitative responses were collated and analyzed thematically using a qualitative descriptive approach (Kim et al., 2017). Themes were further mapped against the areas of interest, including satisfaction with working in PHC, any changes in knowledge, confidence, and practice subsequent to the program participation and recommendations for future implementation.

Ethical Considerations

This QI evaluation study collected data in iterative, short, and rapid cycles to inform ongoing improvements to the TPP and, as such, the authors did not seek permission from a human ethics research committee. Participating nurses voluntarily provided self-report data in all survey questionnaires and were informed that APNA routinely collects this data as part of their continuous quality improvement process for all programs. An Information Sheet was provided via an online link that informed participants about the use of the data, confidentiality and the fact that they could withdraw from the TPP at any time, without penalty. Results are presented according to the Standards for Quality Improvement Reporting Excellence publication guidelines (Ogrinc et al., 2016).

Results

The section outlines the aggregated findings from the two consecutive rounds of implementation.

Participants

Demographic and work location data for TPP participants was de-identified (Table 1). Almost 98% of participants were female with a median age of 37 years (mean 37.4, range 21–61 years). Almost 80% of participants were RNs with the majority (51.6%) recently graduated. More than 89% of participants worked in General Practice and 4.3% worked in Aboriginal and/or Torres Strait Islander Health Care Services.

More than 76% of participants came from three States, namely Queensland (31.2%), NSW (30.1%), and Victoria (16.1%). 38.7% of participants came from metropolitan

Table 1. Demographic and Work Location Data (*n* = 93).

	n	%
Sex		
Female	91	97.85
Male	2	2.15
Registration		
Enrolled Nurse	15	16.13
Registered Nurse	74	79.57
Registered Nurse and Midwife	4	4.30
Years of experience		
Recently graduated	48	51.61
3 + years nurse experience (not PHC)	45	48.39
Primary health care setting		
General practice	83	89.25
Aboriginal and/or Torres Strait Islander HCS	4	4.30
Aged care facility	3	3.23
Community health services	1	1.08
Correctional services/Prison	2	2.15
State		
Australian Capital Territory (ACT)	2	2.15
New South Wales (NSW)	28	30.11
Northern Territory (NT)	0	0.00
Queensland (QLD)	29	31.18
South Australia (SA)	11	11.83
Tasmania (TAS)	3	3.23
Victoria (VIC)	15	16.13
Western Australia (WA)	5	5.38
Rural location (Modified Monash category)		
MM1 (metropolitan areas)	36	38.71
MM2 (regional centres)	14	15.05
MM3 (large rural towns)	15	16.13
MM4 (medium rural towns)	14	15.05
MM5 (small rural towns)	12	12.90
MM6 (remote communities)	2	2.15

areas (MM1), with just over 59% located evenly across regional centers through to small rural towns (MM2–MM5).

Program Outcomes

Of 93 TPP participants, 88 provided usable responses to questionnaire items. There were statistically significant differences between mean summed post-completion and pre-completion self-assessment rating scores for TPP participants in the knowledge, skills, and confidence domains.

In the knowledge domain, the mean summed self-assessment score increased from 88.6 (SD 26.35) pre-completion to 124.01 (SD 39.24) post-completion, $t(87) = 9.14$, $p < .0001$. In the skills domain, the mean summed self-assessment score increased from 82.23 (SD 24.86) pre-completion to 118.01 (SD 38.33) post-completion, $t(87) = 9.73$, $p < .0001$. In the confidence domain, the mean summed self-assessment score increased from 79.15 (SD 25.32) pre-completion to 115.59 (SD 38.68) post-completion, $t(87) = 9.91$, $p < .0001$. There were no statistically significant

differences ($p < .05$) between Group 1 and Group 2 participants' mean summed post-completion and pre-completion self-assessment rating scores in relation to each domain, supporting the decision to combine the group results.

In relation to the self-rated assessment of overall knowledge, skills, and confidence post-completion compared to pre-commencement of the TPP, 49 participants provided exit survey responses. The mean summed self-assessment score increased from 4.45 (SD 1.29) pre-completion to 8.00 (SD 2.13) post-completion, $t(48) = 12.05$, $p < .0001$. These exit survey results reflected the results of the summed post-completion and pre-completion self-assessment rating score comparisons, confirming the perceived positive impact of participation in the TPP. Finally, in relation to participant satisfaction with the TPP overall, 76.1% (35) were very or extremely satisfied, with the remaining 23.9% (11) being moderately or somewhat satisfied.

Workforce Participation Intentions

On completion of the TPP, 74.5% (38) agreed or strongly agreed that they would remain in PHC nursing, with 25.5% (13) neither agreeing nor disagreeing or disagreeing they would remain in PHC nursing. 82.4% (42) of respondents indicated that participation in the TPP was moderately, very, or extremely influential in their intentions to remain in PHC nursing. Table 2 presents the 6-month and 12-month post-completion of the TPP workforce participation results.

Qualitative Themes (Exit Survey)

This section reports participants' reflections on the components of the TPP, their perceptions of the impact on their confidence, knowledge, and skills and overall satisfaction with the program. This data enables a more nuanced understanding of the workplace barriers and enablers to the participants' engagement in the TPP. Direct quotations from participants are reported using participant codes (e.g., P1, P51).

Educational Activities

Participants reported the educational activities increased their confidence, knowledge, and skills. As one nurse noted, "*When I first started this course, I had just started working in G.P practice for the first time. So, a lot of things were new. I believe this program has helped a lot with knowledge, skill level, [and] my personal development (P65).*" Participants were very satisfied with the education resources, "*I am extremely satisfied with the program as it offered vast array of clinical educational modules that I can access anytime and anywhere (P51).*" The modules were relevant to PHC, "*All of the education was delivered in a professional way, easy to navigate and understand and very relevant to my role (P1).*" One participant commented, "*I have loved completing the educational activities, putting the theory*

Table 2. Workforce Participation Post-Completion of TPP Program.

	6 months post-completion		12 months post-completion	
	n	%	n	%
Still working as a nurse in PHC				
Yes	53	81.54	51	75.00
No	12	18.46	17	25.00
Intend to remain working as a nurse				
Strongly agree	23	53.49	31	62.00
Agree	18	41.86	13	26.00
Undecided	1	2.33	5	10.00
Disagree	0	0.00	0	0.00
Strongly disagree	1	2.33	1	2.00
Intend to remain working in PHC				
Strongly agree	18	32.73	23	46.00
Agree	21	38.18	18	36.00
Undecided	4	7.27	8	16.00
Disagree	0	0.00	0	0.00
Strongly disagree	0	0.00	1	2.00
Not applicable	12	21.82	0	0.00
Still working as a nurse if not in PHC				
Yes	10	15.38	14	20.90
No	2	3.08	3	4.48
Not applicable	53	81.54	50	74.63
Influence of TTP program on whether or not to leave nursing				
Not at all influential	4	7.02	5	8.47
Somewhat influential	0	0.00	0	0.00
Moderately influential	0	0.00	0	0.00
Very influential	0	0.00	0	0.00
Extremely influential	0	0.00	0	0.00
Not applicable	53	92.98	54	91.53

into practice each day in the workplace and having the backing and support from an external mentor. It has really allowed my confidence to grow and for that I am very grateful" (P76).

Self-Assessment Framework

Although participants were very satisfied with the education modules, responses to the self-assessment framework were mixed. The framework was designed for participants to track changes in their knowledge, skills, and confidence over the 12-month program. Not all found the framework user friendly, *"Remove the self-assessments. Didn't find these helpful at all (P69)."* Another participant recommended a more streamlined approach rather than an assessment for each of the 12 modules in the program, *"Less focus on too many self-assessments. More generalised easy way to do self-assessment (P13)."* However, others reported this encouraged reflection and assisted to prioritize their learning needs, *"… the self-assessments made the program relevant and individual focused. e.g., the self-assessments enabled me to work through the education and activities at my own pace and in order of relevance was important for my knowledge (P1)."*

Mentoring

The mentoring and informal support provided by APNA was identified as one of the most helpful components of the TPP. For one participant, *"The mentor-mentee experience was invaluable. This relationship consolidated the theory … and really enabled me to build my confidence, by speaking with someone passionate about both Practice Nursing and the APNA course"* (P63). This increased confidence was widely shared *"I felt with the support of my mentor and the staff involved in the transition to practice program, I am more confident … as I have only worked in public hospital. I am now running my own clinic … I could not have done that without that support (P55)."* Participants noted the importance of visiting their mentors' workplace, *"Opportunity to speak to a mentor and visit her practice was absolutely invaluable. Learning through her and online learning was excellent (P17)."*

Although mentoring was consistently rated highly, the amount received varied. Some participants indicated that they received less time than expected and that they had difficulties accessing their mentor, especially if they resided in different states, *"The time for me and my mentor to sit down and go through the tasks etc has been quite limited (P16)."* Many

reported needing more face-to-face time with their mentor, "*Initially I have seen my mentor in person, but she moved, and the communication method was email. To me, seeing her in person is better than exchanging emails (P8).*" Another stated, "*It was great having a nurse who I could call and ask questions, however I found it difficult to pick up any clinical skills as she wasn't available for face-to-face mentoring (P67).*" Co-location in the same practice or community facilitated access, "*My mentor was also the head nurse. This was great as it meant I never had to fight for protected time, and I always had access to my mentor (P71).*"

Satisfaction and Challenges

Participants were unanimous that the TPP was invaluable in helping them orientate to PHC and expressed high overall satisfaction with the program, "*I think if I did not do this course, I would still be a fish out of water (P55).*" For another "*I felt like the program was a lifeboat as a new nurse in GP. It gave me confidence to do my job (P71).*" Participants described their involvement in the TPP as enhancing understanding of PHC, "*I am much more confident and have a greater understanding of my role and my value to general practice (P26).*"

Service agreements were designed to increase engagement from the participants' workplace and ensure they could participate in both the education components and mentoring arrangements. Overall, these agreements were identified as a significant enabling factor, "*1 hour per week of paid protected time made such a difference to my experience. It took so much pressure off doing all the learning in my own time (P77).*" For some significant barriers to having protected time included interruptions for emergencies and routine activities such as taking blood. "*I found the protected time was often interrupted or sometimes unavailable due to work commitments in the day … protected time was allocated and … not used because of unforeseen increases in workload in the treatment room on that day (P28).*" Another noted that, "*For the majority of the year, it was a struggle to get protected time with my workplace, like it wasn't a priority for them as at times it was whether we were so busy, or we were short staffed (P10).*"

Participants working in general practice reported a range of issues in working in PHC. Low pay rates, poor communication with practice management, and inability to work to their full scope of practice were reported. As one noted, "*Pay scales in Primary health are appalling, I get over $14 per hour more in my job [in health] and I have way less responsibility (P38).*" This was a recurring theme, "*I am unhappy that I am paid lower than what I can earn in the acute setting. And I am employed in a casual capacity but still have to apply for leave and cover for colleagues' sick and annual leave (P63).*"

Restrictions to utilizing their full scope of practice were also reported by participants in general practice, "*Coming*

from a very autonomous role in the UK, I find it hard that nurses often don't get autonomy with things I once thought to be very basic. Usually due to Medicare billing criteria rather than my ability or competence (P57)." In some practices, internal policies were a barrier, "*We have our own SOP's [standards of practice] that we have to abide by within our company which does not allow for autonomy or scope of practice (P49).*" In other practices, "*The scope for expansion into chronic disease management and care about planning is limited (only one of our nurses does this role) and currently there is not an appetite for nurse clinics at the practice (P62).*" For some, the TPP helped participants increase their scope of practice, "*The program gave me the education, links and ideas for what further education I felt I needed to increase my scope of practice and also my confidence (P1).*"

Recommendations largely centered around increasing engagement with GP managers and ensuring participants could have the times allocated and agreed upon in service agreements, "*Making sure practise understands the level of support needed (P19*").

Triangulation

The qualitative findings confirm the quantitative results with significant improvements in knowledge, confidence, and skill in PHC practice reported. The education modules were relevant and well-received (as was the mentoring). Additional insights into the barriers and enabling factors that impact on participation in the TPP, especially for those located in general practice emerged. Lower wages and not being able to work to their full scope of practice were barriers, as was limited understanding of the TPP by practice managers. Service agreements and mentoring enabled participation and retention in the TPP.

Discussion

The TPP was developed in response to the absence of nationally delivered programs in Australia for nurses transitioning to PHC. This evaluation demonstrates that the TPP was relevant and effective for nurses transitioning to PHC. Participants reported significant increases in their knowledge, skills, and confidence about working in PHC. Consistent with the literature that highlights how socialization allows graduate nurses to acquire knowledge, skills, and an occupational identity with their profession, participants enjoyed the opportunity to meet with each other and with their mentors (Adams & Gillman, 2016).

Participants identified the clinical and professional mentoring as a key enabling factor in this program. Support from mentors and APNA were consistently reported as crucial components of the TPP. However, given the challenges that some participants in this study experienced in having protected time with their mentors, e-mentoring

which has been identified as helping to increase the involvement of nurses in mentoring programs could be an option to increase accessibility (Coventry & Hays, 2021). Nurses shape primary care in profound ways (Crisp & Iro, 2018) and practical strategies for effectively educating, supporting, and retaining them are needed and have been shown to be prerequisites for universal health coverage (Kurth et al., 2016). Although the mentoring component of the TPP was a significant enabling factor, finding suitable mentors for all participants was challenging—especially for those not working in general practice. This suggests that the TPP program needs to be sufficiently flexible to operate across a range of primary care settings.

While core education activities were statistically significant in terms of increasing participants' knowledge and confidence, the self-assessment framework tied to each education activity was not universally well-received. Ideally, the self-assessment tool should act as a starting point to promote self-reflection and identify participants' strengths and areas of need for professional development. Research into the use of self-assessment tools with healthcare professionals has identified that professional skills can be developed through critical self-reflection and that lack of insight into professional skills is closely related to suboptimal professional performance (Stenov et al., 2017). There would be value in encouraging participants to engage with their mentors in the process of completing self-assessments and goal setting in future iterations of the TPP.

A key question for future implementation of the TPP is sustainability and providing a pathway to higher qualifications. At present there are no national requirements for nurses to undertake formal graduate programs or study when entering the workforce. Existing graduate programs that are available for some nurses as part of a "graduate year" program are often hospital or organization delivered programs focused on specific acute care or hospital-based health care services rather than formal post-graduate studies. The PHC focus of the TPP with the competency-based education component provides opportunities for certification and/or micro-credentialing that would enable participants to work towards further qualifications in PHC. It is important to tailor the program's eligibility requirements to optimize its availability for both newly graduated and more experienced transitioning nurses. Recruiting more nurses from settings other than general practice is important for future iterations of the program. Given the low numbers of participants from community health and other settings, it is difficult to generalize about the effectiveness of the program for those not working in general practice. Ongoing funding is required to provide the administrative support needed for the TPP.

Participants in our study confirmed the need for a program that supported their transition to PHC and focused on their scope of practice. They also reported ongoing problems in working to their scope of practice

which is consistent with literature arguing if employers are to attract and retain nurses, targeted orientation, and support programs are needed (Ashley, Peters, et al., 2018). In its current configuration, the program provides workplaces with financial support that compensates practices for releasing their nurses to attend the orientation workshop and for engaging a pool of mentors. Despite signing formal agreements with workplaces, participants in general practice commonly reported that they were not able to quarantine any protected time to complete the education activities or meet with their mentors. Participants reported that their potential role and scope of practice was poorly understood by practice managers. This is significant because nurses are increasingly employed in general practice and RN standards for practice have been available since 2014 (Nursing and Midwifery Board of Australia, 2016).

Despite these challenges, most participants in the TPP remained working in PHC over the course of the program. However, there are factors outside the control of APNA that are likely to impact on the retention of nurses in PHC, including low salaries, lack of career pathways, and poor understanding about general practice nursing in undergraduate programs that largely continue to focus on acute care nursing (McInnes et al., 2019). Low pay rates and not being able to work to their full scope of practice identified by participants in this study is consistent with findings identified by Halcomb et al. (2021) in their exploration of job satisfaction and intentions to remain in general practice in one PHN. In addition, perceptions held by nurses, academics, and others around the general practice nurse role and career pathways in PHC need to be addressed to promote PHC as a viable career opportunity for nurses (McInnes et al., 2019). Nursing in PHC settings is unique in terms of isolation and autonomy, thus, to develop a strong PHC workforce, transition programs are needed. The TPP continues to be implemented and undergo QI processes to inform the PHC environment. In the absence of national competencies for the PHC workforce in Australia, it is important to ensure the program continues to evolve and respond to the emerging needs of the PHC environment.

Strengths and Limitations

This QI initiative demonstrates that a rigorously and collaboratively developed transition program is relevant and valued by nurses new to working in PHC (mostly employed in general practice). Participants self-reported significant increases in their knowledge, skills, and confidence working in PHC. The relevance of the TPP for nurses working in other PHC roles is yet to be examined. Given all the data was self-report, clinical competence in implementing the learning from each of the 12 core education topics was not able to be assessed.

Implications for Practice

- Active engagement in a TPP is recommended for all nurses transitioning to clinical PHC roles in general practice.
- Transition should be supported with mentoring from an experienced PHC nurse (if possible, located to allow some face-to-face contact).

Conclusions

The TPP developed and delivered by APNA demonstrates the benefits experienced by nurses transitioning to roles in PHC. Ongoing evaluation and further development of the program is planned in tandem with identifying opportunities to ensure sustainability of this program.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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